RAPID ASSESSMENT INSTRUMENTS: TOOLS FOR THE ACCOUNTABLE PROFESSIONAL

Steven L. McMurtry, PhD and Susan J. Rose, PhD

In the current era of managed care, direct contact time with clients is often severely constrained, and practitioners face a difficult task in dividing the minutes available among such varied tasks as problem identification, relationship development, intervention, and guiding the client toward termination. In addition, as funding sources’ requirements for accountability and quality control increase, practitioners must also complete initial assessments, monitor progress on an ongoing basis, and evaluate outcomes.

Managed care methods often seem paradoxical for mental health professionals, in that they limit client contact time—and thus measurement time—while mandating greater accountability that can be accomplished only through improved measurement. Not surprisingly, considerable demand has arisen for reliable and valid measures that can help meet accountability requirements, while maintaining a good fit with the professional training, treatment orientation, and time constraints of practitioners.

Fortunately, the number and range of standardized assessment scales available for use in practice and research have expanded rapidly in the past 10 to 15 years. Brief measures, sometimes referred to as rapid assessment instruments or RAI, are a particularly fast-growing subset. RAI are distinguished from other measures by their variety, ease of use, cross-disciplinary applicability, low cost, and, above all, brevity. Most include fewer than 50 items, some have fewer than 10, and all can be completed by most clients in a relatively brief time—often as little as one to five minutes. This allows standardized measurement to be a brief part rather than a principal component of client contacts.

Unfortunately, many professionals are unaware of these instruments or their breadth and diversity. Others know about RAI, but employ them only sparingly due to lack of information about the types of measures available; how to identify and select them; how to determine which are considered best; how to obtain the RAI they wish to try; or because they believe, often incorrectly, that the measures can only be applied by licensed psychologists specializing in psychometric testing. Our goal is to provide an overview of RAI, how they can be used, how they can be located and evaluated, and how to make them a tool for enhancing practice rather than simply another layer of paperwork.

Types of RAI

We define RAI as empirically tested measures with known psychometric properties.
The strength of social work as a profession resides in its capacity to provide competent and ethical interventions in sensitive human situations that frequently occur in complex social environments. Enhancing professional capacity to meet the challenges in the evolving landscape of mental health services remains the primary purpose of the Mental Health Specialty Practice Section. In 2004 the Mental Health Section Connection aims to address this purpose through the presentation of practice-relevant knowledge.

Focus on Enhancing Practice-Relevant Knowledge

Assessment and intervention with adult consumers of mental health services is the focus of this issue of the Mental Health Section Connection. Featured are up-to-date descriptions of important and useful practice technology and models. The contents of this issue include:

- **Rapid Assessment Instruments [RAI]: Tools for the Accountable Professional** In this substantive overview of RAI, Drs. Steven L. McMurtry and Susan J. Rose, faculty at the Helen Bader School of Social Welfare at University of Wisconsin-Milwaukee, summarize types of instruments, their differential use in clinical practice, and resources for obtaining RAI. This groundbreaking content is adapted from the authors’ forthcoming book on RAI.

- **ADHERE: A Practice Model for Enhancing Client Follow-Through with Recommended Treatments** This article describes a client-centered and ecologically oriented model for addressing treatment adherence, an enduring therapeutic concern of social workers across all practice settings. The authors, Lana Sue Ka’opua, PhD, ACSW, LSW, of the Cancer Research Center at University of Hawai‘i, and Brian Giddens, ACSW, LISW, of the University of Washington Medical Center, developed this conceptual model through a national collaboration that included practitioners, educators, and researchers associated with NASW’s “HIV/AIDS Spectrum: Mental Health Training and Education of Social Workers Project.”

- **Social History Updates** describes the consumer-friendly, practitioner-friendly system developed by Mark Smith, ACSW, LISW, associate director of Center Associates, a community mental health agency.

See Editor, Page 16
ADHERE: A PRACTICE MODEL FOR ENHANCING CLIENT FOLLOW-THROUGH WITH RECOMMENDED TREATMENTS

Lana Sue Ka’opua, Ph.D., ACSW, and Brian Giddens, ACSW

Helping clients adhere to a treatment regimen is a frequently expressed concern of social workers in the mental health and health practice specialties. To address this concern, ADHERE, a client-centered and ecologically-oriented practice model, was developed by the NASW HIV/AIDS Spectrum: Mental Health Training and Education of Social Workers Project (2003). ADHERE draws from research in HIV and other chronic illnesses and specifically focuses on intervention with psychological, sociocultural, and environmental factors associated with adherence, or dedicated follow through with a prescribed regimen (Becker, 1990; DiMatteo and DiNicola, 1982; Ka’opua & Mueller, 2004; Linsk & Bonk, 1999; Prochaska & DiClemente 1983). Although initially conceptualized to facilitate support for medication adherence to Highly Active Antiretroviral Therapy (HAART), ADHERE may offer helpful considerations to social workers and other healthcare providers involved in counseling and therapy, home health care, and mental health/health case management to persons living with a chronic illness and desiring to follow through with exercise, dietary, and/or routine clinic visits and screenings.

Living with a chronic illness is described as “unending work and care” (Corbin & Strauss, 1988) and adherence to a prescribed regimen is just one of many challenges facing the client and his or her significant others. For persons living with a chronic illness, a treatment regimen is often open-ended, or of indefinite duration. Adherence to such a treatment regimen is more difficult because the latter often competes with other tasks of daily living, including those related to illness, symptom, and pain management, occupational and family responsibilities, and biographical work, or coping with changing perceptions of self in relation to the world.

Intervention research indicates that adherence intent and behavior are associated with knowledge relevant to health recommendations, attitudes about the disease and its treatment, and sociocultural norms transmitted through the family and other groups with which individuals identify (DiMatteo & DiNicola, 1982). However, intent to adhere is not the only factor in following through with a recommended regimen. In the social environment, adherence behavior is powerfully influenced by factors that either enable or disable follow through behavior. Factors influencing adherence include: the extent and nature of social support from natural and professional networks, accessibility to health resources, and the availability of culturally acceptable, linguistically appropriate care.

See Model, Page 4
The ADHERE model identifies six considerations for practitioners assisting clients in treatment adherence at its intersection with mental health and health conditions.

**A: Assess client knowledge and readiness for treatment initiation.** Assessment optimally resides in a relational environment of collaboration involving client, significant others, social worker, and other members of the healthcare team. Because the diagnosis of HIV and other chronic illnesses may carry social stigma and because imperfect adherence often has negative connotations, it is important for the social worker to communicate acceptance for client beliefs, decision-making processes, and treatment choices. Assessment involves exploration of client and family understanding of the recommended regimen and is facilitated through the use of open-ended, non-confrontational questions, such as:

- What have you heard about this treatment?
- What do you believe are your options? What do those closest to you believe are the options?
- Do you believe that this treatment is doable for you?
- What do you think may keep you from following treatment recommendations?

In assessing knowledge and readiness, it is important for the practitioner to elicit current perceptions of health status, beliefs about treatment benefits and disadvantages, and to provide verbal and written information that is congruent with client’s knowledge and understanding. Attention to the use of linguistically and culturally appropriate terms and meanings, as well as explanations that consider client’s literacy level are critical in ensuring mutual understanding of regimen adherence and challenges.

**D: Dialogue periodically about health beliefs & illness-related attitudes.** Unanticipated barriers to follow-through may emerge over time. Therefore, on-going discussion is necessary to support adherence to a treatment regimen, especially when recommendations must be followed for an indefinite duration. Communication of empathy and unconditional positive regard for the client serves as the basis for discussing difficulties with adherence and lays an essential foundation for future discussion of treatment adherence. Challenges to optimal adherence and non-adherent behavior are relatively common and it may be helpful for the social worker to normalize adherence-related difficulties, purposefully assuring the client that the healthcare team does not equate adherence difficulties with being an uncooperative or “bad” client. Consequences of non-adherent behavior may then be discussed within the context of the client’s health goals and beliefs about what she or he considers to be an acceptable quality of life.

Carefully listening to the client’s attitudes about living with a chronic illness is fundamental to dialogue and necessarily includes:

- Attitudes about diagnosis, treatment, and quality of life.
- Past and current ways of coping with illness and other adverse life situations.
- Positive and negative experiences with providers and the healthcare system.

Anticipation of evolving client needs and potential strategies for addressing these needs may be linked to environmental barriers and are optimally addressed as part of the ongoing collaborative alliance between the client and social worker. Family members related by blood and/or choice, as identified by the client, may be important to include in such discussions, especially when the client is from a collectivist oriented culture and values interdependent family relationships.
**H: Holistic approach is important.** Based on the initial assessment and dialogue, the practitioner will have collected significant information about client strengths and needs. The practitioner will also have a sense of whether the client’s orientation is primarily individualistic or collectivist; and this informs decisions about whom to include in the treatment planning process. Elicitation of the client’s understanding of the illness is essential and optimally includes the client’s health beliefs, cultural practices, environmental barriers, and preferred learning and coping styles. Because a client may present with more than a single mental health concern, the social worker needs to take a holistic approach in addressing issues of drug use, physical health concerns, and resource needs.

There are several environmental barriers to engaging and sustaining the client’s participation in mental health treatment. The client who abuses drugs, often as a self-treatment for mental illness, can find that the drugs exacerbate the symptoms of mental illness and may have a diminished capacity to manage a treatment plan. Homelessness can make a client vulnerable, and requires expending countless hours and physical and psychic energy planning for a place to sleep. Being homeless may force a client to move from one area to another and can prevent a therapist from being able to reach a client when needed. Financial status is also a barrier. Community mental health used to be a guaranteed resource for mentally ill persons who had no funds; however, this critical safety net is rapidly becoming inadequate as restrictions increase and functionally, prevent access to unfunded patients.

Environmental barriers also encompass less tangible issues, such as culture and relationship/familial history. With which culture might a client identify? In some cases, the client may freely disclose this. In other situations, due to shame or perceived bias, the client may not speak of their culture but their behaviors may still be reflective of cultural influences. Cultural issues can be best understood by asking the client about their health beliefs, and their understanding of their health and/or mental health situation. It is the practitioner’s role to listen, and to try to understand how the client’s culture can positively and negatively influence adherence. For truly holistic care, the social worker may need to have available resources for other services and needs, and may strengthen their treatment plan by collaborating not only with the patient’s perceived support systems, but with other professionals and community programs.

**E: Empower client to implement the action plan.** Respect for the client’s choice is fundamental and the social worker optimally empowers the client to implement an action plan, regardless of whether a client decides to initiate treatments recommended by the healthcare team or to follow another alternative. The client who chooses to initiate a recommended regimen, may find it helpful to identify cues, reminders, and daily activities that serve as environmental reminders. For example, one young mother is cued to take her medication as soon as her children leave for school. Equally important is the development of an action plan considering unexpected events and/or changes in routines that potentially compromise adherence efforts. In the context of adherence to complex, HIV-related medications, other issues such as storage of medications need to be identified. Socially stigmatized medical conditions like HIV require attention to how the need for privacy affects adherence to a regimen. Open discussion of client successes and concerns is potentially empowering and may be facilitated by dialogue prompted by questions such as:

- How are you coping with this plan?
- Help me to understand how this plan is working for you—what do you think is going well? What needs some attention?

See Model, Page 6
• Give me an example of when this plan is difficult for you to follow. In the last three days how many doses of medication did you miss? On the average, how many doses are you able to take, as prescribed? Which medications/doses cause the most difficulty for you?

• How satisfied are you with your current regimen?

R: Reinforce strategies. Increasingly emphasized is the importance of appropriate and ongoing client education to ensure that the individual and members of his or her support system understand the multiple tasks of treatment adherence. Review of the treatment plan and reinforcement of what is working for the client are both essential components of this type of education. For the mental health practitioner, reinforcing strategies helps the client to focus on the desired outcome, and to relate the treatment process to a tangible goal. Discussing “successes” when they happen (e.g. following through with medications, keeping an appointment for a psychiatric consultation, working with a collaborating agency to secure a resource) can be appropriately integrated into the therapeutic work. In reviewing and reinforcing the client’s role in ensuring adherence to a treatment plan, the social worker can also continually reassess the worth of the plan with the client. Regular reassessment is key to noting changes in the client’s situation that might make the initial plan unworkable for the client. Given the challenging and even chaotic lives of some of our clients, the social worker must be prepared to adjust the plan accordingly, being flexible enough to recognize the impact of emerging barriers. It is important to note that problems with adherence may be a clinical issue, or may reflect the inability or unwillingness of a client to engage in mental health treatment. Unfortunately, many clients with extensive cultural and/or environmental issues get pegged as being the problem, when in fact there may be legitimate reasons why the client is unable to adhere to a treatment plan.

Evaluate progress and resources. What is the difference between review and evaluation? Evaluation tends to look over time at the work one is doing with a client and/or family. It is also an overall review of methodologies chosen, interventions attempted, and whether the client goals were met. Review tends to be more micro practice, scanning for changes in the client’s status and needs, and making adjustments along the way. The evaluation component is macro-focused, taking a retrospective examination of the progress made to date, and looking carefully at issues such as consistency in practitioner methodology, observing for overall improvements in client functioning, and looking for patterns in client behavior based on interventions utilized. Clinicians, as well as administrators, benefit from this global view, as it allows for greater chance of reflection and removes the practitioner from becoming caught up in the session-to-session struggles the client may be presenting. Evaluation should also extend to the broader array of resources the social worker relies on when using a holistic approach. Considerations include:

• Were the resources provided effective?

• Did the relationship between the provider(s) and the client (system) facilitate or impede progress?

• How do emerging changes in the service delivery system impact the client (system)?

In summary, helping clients in the critical health/mental health area of treatment adherence requires strong therapeutic skills, as well as an understanding of how factors in the client’s social environment impact upon
adherence behaviors. The person-in-environment perspective of social work practice optimally informs assessment and intervention. From this perspective, family, community, and cultural factors are considered with attention to how these factors either facilitate or disable treatment adherence. A clear understanding and thoughtful integration of ecological factors into intervention optimally, promote communication between client, the client system, the practitioner, and ultimately, the service delivery system. When this kind of communication is ongoing, the risk of non-therapeutic adherence and its related frustrations are minimized. This perspective is not a new one, but reinforces the unique and critical role of social work in mental health treatment.

References

Lana Ka’opua, Ph.D., ACSW, LSW, is Assistant Professor at the Cancer Research Center, University of Hawai’i; e-mail: lkaopua@crch.hawaii.edu. Brian Giddens, LICSW, ACSW is Associate Director of Social Work at the University of Washington Medical Center. Both are advisory committee members of the NASW HIV/AIDS Spectrum: Mental Health Training and Education of Social Workers Project.

The authors acknowledge Susan Hakailis, ACSW, Nathan Linsk, Ph.D., and Evelyn Tomaszewski, MSW for their intellectual contribution to this practice article.

SOCIAL HISTORY UPDATES
Mark Smith, ACSW, LISW

Many social workers employed in the mental health field provide brief mental health services. However, we also know that some mental health conditions are long term and that, in the community mental health setting, social work services are often needed by the client on an ongoing or intermittent basis over a period of years.

Often, state administrative rules require annual social history updates for consumers

See History, Page 8
receiving services. This is usually an effort to keep rapidly changing contact, patient care, and demographic information current, and serves as a basis for care managers to have readily available information.

However, the gathering of this information is not a billable service, is time consuming, and often irritates clients who may feel their treating mental health professionals should be familiar with this information through what they (the clients) have conveyed.

I am a social worker who has provided mental health treatment to people in the same geographic area for the past 17 years. The managed care and regulatory paperwork requirements are often frustrating. For example, consider the following scenario: A client has discontinued ongoing services with me, continues with psychiatric services with a colleague, and then presents again for my services. At that time, I discover he or she is due for an annual social history update.

An annual social history update is important and significant to best practices. Therefore, I sought to obtain a mechanism for completing this responsibility, while keeping face-to-face interaction focused on therapeutic issues.

The mechanism I use is the survey questionnaire below. A “flag” is placed in the computerized consumer record management system to remind me when the update is due. The survey is given to the consumer at the appointment that corresponds with the review date. After the consumer completes the information, I review it with the consumer and dictate a summary of the information on a page in the record, titled, Annual Social History Update (see Page 9).

To summarize, this approach enables social workers to have updated social history information available, keeps direct services time devoted to this need to a minimum, and facilitates the gathering of information on a consistent basis.

Mark Smith, ACSW, LISW, is associate director of Center Associates, in Iowa. He can be reached at msmith1@mchsi.com.
SAMPLE ANNUAL REASSESSMENT AND SOCIAL HISTORY SURVEY

The following information is used to update your record here at Center Associates. Annually, we ask you to take a few minutes and complete the following information. Thank you!

Name: ___________________________ Date: ___________________________

I. Living arrangements:

A. Please check any of the following changes that have occurred in the past year:

- ______ divorce
- ______ marriage
- ______ cohabitation
- ______ separation
- ______ death of spouse
- ______ death of other family member
- ______ new address
- ______ new telephone
- ______ name change
- ______ birth of child
- ______ other: ___________________________

B. Please explain any checked areas above: _____________________________________________________________________________________

II. Education and Employment:

A. Have you received additional education in the past year? ______ Yes _____ No

B. If yes, please explain: __________________________________________________________________________________________________________

C. During the past year, have you taken new employment or had a job change? ______ Yes ______ No

D. If yes, please explain: __________________________________________________________________________________________________________

III. Medical:

A. My physicians, physician assistants, and advanced registered nurse practitioners are: _____________________________________________

B. My medications are: __________________________________________________________________________________________________________

C. I am allergic to the following medications: ______________________________________________________________

D. During the past year, I have had the following surgeries or health problems: _________________________________

E. During the past year, I have been hospitalized for the following reasons: _______________________________________

IV. Substance Use:

A. I have used the following substances (check all that apply):

- ______ alcohol
- ______ tobacco
- ______ caffeine
- ______ marijuana
- ______ cocaine
- ______ methamphetamine
- ______ other: ___________________________

B. I have been in treatment for substance abuse during the past year: ______ Yes ______ No

C. Please explain: ______________________________________________________________________________________

V. During the past year, I experienced domestic violence or other abuse in my life: ________________

Yes ___ No

VI. Which of the following best fits your legal involvement:

- ______ A. No legal involvement
- ______ B. On mandatory outpatient status
- ______ C. Involved with the criminal justice system
- ______ D. Involved with the civil justice system (lawsuit, divorce, or other action)

Thank you for completing this survey. Please give it to the mental health professional with whom you have an appointment.

A Focus on Ethics

WHO ENSURES OUR COMPETENCE IN USING RAI AND OTHER STANDARDIZED MEASURES?

Gail Johnson, MSW, LCSW

This is the first article in a new regular column—A Focus on Ethics in Practice—of the Mental Health Section Connection. It is our goal to encourage discussion, and we hope that this column will become a vehicle for the exchange of information about current issues in ethical practice.

See Ethics, Page 10
Since both the Ka’opua/Giddens and the McMurtry/Rose articles address assessment, I was prompted to consider a related issue currently being worked on in the State of Wisconsin—namely, that of ensuring social work competence in the use of Rapid Assessment Instruments (RAI) and other standardized measures. Our work in Wisconsin leads me to wonder how other states are considering this critical ethical issue in social work practice.

Currently Wisconsin’s licensure act requires that a licensed social worker submit evidence that his or her academic training at the graduate or postgraduate level included: descriptive statistics; reliability and measurement error; validity and meaning of test scores; normative interpretation of test scores; selection of appropriate tests; test administration procedures; ethnic, racial, cultural, gender, and linguistic variables; and, finally, the testing of individuals with disabilities. He or she must also provide an affidavit from a professional who is qualified to supervise psychometric testing, indicating that the individual licensee has acquired supervised experience and specific qualifications for the responsible selection, administration, scoring, and interpretation of one or more particular psychometric tests—including, if appropriate, use of the tests in particular settings or for specific purposes.

The bottom line is that the Examining Board’s approval is needed before a social work licensee can do any kind of psychometric testing, including, for example, the Beck Inventories. Members of the Examining Board are working to come to an agreement with the Psychology Board that would allow professionals other than psychologists to use standardized tools like the Beck Inventories after meeting the requirements that the test’s publisher sets for administering them. In the McMurtry/Rose article, the statements that relate strongly to this issue are:

Training in the selection and use of RAIs must then be a standard curriculum component in social work education, not only with respect to degree training but in continuing education as well. It is also important to dispel the notion that social workers lack the skill or professional qualifications to employ such measures.

The NASW Code of Ethics, under Competence (1.04) (a) and (b), clearly indicates our responsibilities in this matter. Especially relevant is (a), which states, “That social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.”

In Wisconsin’s Code of Conduct, in the definition of gross negligence, there is reference to not complying with an accepted standard of practice. That standard of practice in Wisconsin is the NASW Code of Ethics. It is my understanding that this is also true in most other states. I would argue, then, that no need exists for such specific state Examining Board review and approval, since the NASW Code of Ethics defines competence and uses the same code for defining standards of practice. From a practical perspective, it also seems that state resources will be taxed further when most states, like Wisconsin, are facing serious financial problems. I am also concerned about turning to another profession to define our competence and practice. It seems to me that, historically, we have done this in mental health, and not always with the best results. The other issue is for us to be sure that schools of social work can assure the licensing boards and the public that social workers have the skills and professional qualifications for utilizing RAIs, because they have made it an integral component of the required
properties (e.g., reliability and validity) that are used to assess client problems, characteristics, attitudes, or behaviors, which can be completed by most clients in 15 minutes or less. As with other standardized measures, RAIs come in three main types: self-administered forms, other-administered forms, and observer-rating forms.

Self-administered RAIs, the most common type, are completed by clients in paper and pencil form or on a computer. The latter is becoming increasingly common for its ability to expedite scoring. It can be done through a stand-alone computer program or by directing clients to a Web site where the form is located. Well-known examples of self-administered RAIs include the Beck Depression Inventory (BDI), Rosenberg Self-Esteem Scale, and State-Trait Anxiety Inventory (STAI).

Other-administered forms usually consist of some type of interview schedule, often used with clients who have disabilities or reading limitations, which are administered by clinicians, researchers, teachers, family members, nurses, or other helping professionals. Many diagnostic inventories, such as the Structured Clinical Interview for DSM-IV (SCID), take the form of client interviews, but because they typically require far longer than 15 minutes to administer, these are not considered RAIs. Others, such as the Mini-International Neuropsychiatric Interview (MINI), are interview schedules that can be completed with most clients within a sufficiently short time to qualify as RAIs.

Observer-rating forms are measures that practitioners, researchers, family members, teachers, hospital staff, or other onsite helping professionals complete about a particular client, based on their familiarity with the individual or on knowledge gained from observations. Examples include the Brief Psychiatric Rating Scale (BPRS), Global Assessment Scale (GAS), and the Mini-Mental State Examination (MMSE). Practitioner-rating measures that must be preceded by a lengthy clinical interview cannot be properly defined as RAIs.

Uses of RAIs

RAIs can be used for a variety of purposes, including screening, readiness for treatment, formal diagnosis, non-diagnostic assessment,
monitoring change over time, and assessment of outcomes. These categories are not mutually exclusive, and a single instrument may span several of them.

Screening instruments are used to assist in determining whether a clinically meaningful problem exists that may warrant further services or more extensive assessment. This “case finding” function is one of the most common applications of RAIs, and because of the extreme brevity of many screening measures, multiple instruments may be administered in a short amount of time to check for a variety of problems. The four-item CAGE is a commonly used screening tool for problem drinking, and the Single-Item Depression Screener has been found to have comparable accuracy to lengthy measures in detecting depression in elderly clients.

Readiness for change measures are designed to evaluate whether commencement of services is appropriate, based on clients’ recognition of the need for intervention and/or their willingness to participate. These are most commonly, though not exclusively, used in addiction services, where client denial can be a serious barrier to progress. The University of Rhode Island Change Assessment (URICA) is an example of a client-readiness instrument applied to substance-use problems, as well as to other areas, such as child maltreatment and spouse abuse.

Diagnostic assessment measures are able to provide results that allow classification of client problems or behaviors into formal diagnostic categories, or that provide caseness scores, which indicate the probability that a particular diagnosis exists. Diagnostic RAIs are rare, but one important example is the Composite International Diagnostic Interview - Short Form (CIDI-SF) produced by the World Health Organization. It is an interview schedule comprising four modules that address major depression, anxiety, and alcohol and drug disorders.

Each module begins with a stem question that, if answered in a certain way, triggers subsequent items pertaining to the specific disorder. Different clients are thus asked varying numbers of questions, depending on whether their answers to stem questions lead to others in each module. The entire interview can be completed on clients who have no serious problems in these areas in an average of only a few minutes. Those who do have problems in one or more areas will take longer to complete the form, but the result will be a true diagnostic score (in the case of anxiety) or a probability of a diagnosis. Contingency-based measures like this are becoming increasingly common, and are often paired with computer administration and scoring programs.

Non-diagnostic assessment instruments differ from screeners in that, though they may be very brief, they do not focus solely on case finding and can be more broadly used for treatment planning as well. They also differ from diagnostic assessment instruments; though they may be designed to detect client problems that are of clinical concern, they do so without the intent of placing the problem in a formal diagnostic framework such as the DSM-IV.

Many measures developed by social work researchers fall into this group, including those in Walter Hudson’s Clinical Measurement Package, such as the Generalized Contentment Scale (GCS) and Index of Self-Esteem (ISE). Other instruments in this category are designed to measure problems or strengths in social and family relations. The Interpersonal Support Evaluation List (ISEL) is a frequently used measure of social support, for example, while instruments such as the Family Environment Scale (FES), Parenting Stress Index (PSI), and Conflict Tactics Scale (CTS) measure various aspects of family functioning.

Also included in this category are measures of client attitudes or personality traits that may
have only indirect clinical relevance, but can be useful in understanding an individual or group. Examples include prejudicial attitudes (Modern Racism Scale [MRS]), guilt or shame (Test of Self-Conscious Affect [TOSCA]), Type-A behavior pattern (the Framingham Scale), narcissism (Narcissistic Personality Inventory [NPI]), and many others.

**Measures for monitoring change over time**

Track improvement or deterioration in client functioning through repeated administrations during services. Typical features are brevity (so clients grow less tired of completing the instrument), stability (as evidenced by good test-retest reliability), and freedom from “response set” problems that occur when clients’ scores are influenced more by their previous answers than by how they actually feel. Many instruments from the screening and non-diagnostic assessment category may be used for this purpose, but others have been specially designed. Two examples are the Treatment Services Review (TSR), which was designed for substance-abuse treatment programs, and the Life Skills Profile (LSP), used in psychiatric rehabilitation.

**Outcome measures** are administered near to, or following, service completion, usually with the goal of assessing the effectiveness of services. Measures from many of the categories above may be used for this purpose, but others are specifically targeted toward post hoc assessment. Some seek to provide information on whether the client’s functioning has been brought to within normal ranges.

One example of these is the Behavior and Symptom Identification Scale (BASIS-32), which has been widely used to evaluate clinical effectiveness in mental health services. Instruments to measure satisfaction with services are another frequently used measure in this category. The Client Satisfaction Questionnaire (CSQ-8), though originally designed for use in mental health, has been used in a variety of service settings.

**Identifying and Selecting Measures and Obtaining Copies**

No single source exists to which practitioners can turn when searching for brief measures. Instead, anthologies and compilations have tended to focus on different subsets of the vast body of standardized scales in existence. Box 1 lists some examples. The test bank maintained by Educational Testing Services, which offers a searchable database (at: http://www.ets.org/testcoll/) is a useful online source.

Authors of new measures are expected to conduct empirical tests of their properties and performance and to publish the results. This usually occurs in journal articles, but may also be found in books or book chapters. This key reference is typically the best starting place when gathering information about a measure of interest.

Many of the most-used measures designed for clinical applications are marketed commercially. Names and Web addresses of a sample of scale publishers are shown in Box 2. The cost of instruments marketed by these firms range from 10 cents to more than $5 per copy, depending on length, scoring, supplementary materials, and other factors. Manuals describing administration, scoring, norms, and measurement properties must usually be purchased as well, and these vary in price from a few dollars to over $100. However, though costly, commercial measures are often better studied and initially tested on more diverse populations than others.

Some instruments are not marketed commercially, but are copyrighted by their authors. Others, if they are reprinted in their entirety

*See Rapid Assessment Instruments, Page 14*
in the key reference, may be copyrighted by the publisher of the work in which the key reference appeared. In either case, permission to reproduce must be obtained from the copyright holder prior to use. Making contact with the author is also recommended as a means of determining if revisions have been made to the measure or if versions in other languages are available. Finally, some measures are in the public domain and may be copied and administered at will.

**RAIs as Tools for Social Workers**

Knowing how to find and appropriately use RAIs is an important skill for social workers in a variety of practice arenas. For example, the use of RAIs in problem screening in multi-service settings can be of great value. Many people come in contact with an agency for a particular problem (e.g., child maltreatment, substance abuse, domestic violence, mental health concerns), but the early administration of a brief, multidimensional screening tool may identify underlying or ancillary problems that might otherwise be missed. Such uses allow for more accurate assessments without requiring staff to be experts in all areas.

Social workers often rely on clinical judgment to make these determinations, but the quality of these judgments depends on variables such as clinician experience, contact time with clients, and the quality of worker/client relationships. Clinician judgment can also be affected by lack of familiarity with particular client problems or populations. RAIs are intended not to supplant clinician judgments, but to provide a further means of ensuring their validity.

The use of RAIs to assess need, monitor change, and evaluate outcome is consistent with reliance on goal setting and mutual case planning for meeting these goals. It is also in the best tradition of social work values that encourage client self-determination, empowerment, and the working alliance between practitioner and client. We are in a period in which the already prodigious number and range of brief measures continues to expand and even to accelerate. Training in the selection and use of RAIs must thus be a standard curricular component in social work education, not only with respect to degree training but also in continuing education.

It is important to dispel the notion that social workers lack the skill or professional qualifications to employ such measures. RAIs are not customarily designed for formal diagnosis within frameworks such as the DSM-IV, or for determining how clients fit within complex personality models. They also do not include projective tests such as the Rorschach or TAT that require subjective judgments and rely on interpretive analyses. Instead, RAIs tend to focus on individual behaviors, characteristics, attitudes, or problems, and on providing a quantitative score indicating the frequency, intensity, or duration thereof. Many are deliberately designed for multidisciplinary use, while others have been specially developed by social workers for use by other social workers. Commercial publishers do require specific professional credentials in order to purchase, administer, and interpret certain measures, but licensed social work professionals typically qualify for all but a few of these qualification levels.

Practice ethics require that clients have a right to assume the help their social worker provides is informed, up-to-date, and has a reasonable expectation of successful outcome. Toward this end, social workers must be diligent in ensuring that their professional toolbox is stocked with the best equipment possible, and RAIs will likely increase in their importance as examples of this equipment. We believe it is critical for the field as a whole that social workers become not merely consumers of these tools, but active participants in their ongoing development and refinement.
General


Topic-Specific


health center serving several Iowa counties. A copy of the *Annual Reassessment and Social History Survey* used by Mr. Smith is provided as a template for practitioners seeking to maintain current client information in a time-efficient way.

- *Focus on Ethics in Practice* debuts in this issue, and will be a regular column. Gail M. Johnson, MSW, LCSW is a practitioner-educator with a longstanding interest in professional ethics. In this issue, our resident ethicist examines the *in vivo* link between ethics and competent use of standardized measures. Ms. Johnson refers to the Wisconsin experience, and encourages an information exchange via our Mental Health Section’s “Online Forum.”

**You are the Power behind this Section**

We hope these articles will spark your clinical interest, be practice-relevant, encourage further exploration, and possibly even motivate you to submit an article or book review pertaining to an area of mental health services that interests you. The second issue of the 2004 *Mental Health Section Connection* will focus on practice-relevant tools and models for use in child and adolescent mental health services. You are invited to submit a paper for that issue, which is slated for publication in the summer. In a very real way, you are the power behind this section, and we rely on your input to keep us on track with current social work needs. In our efforts to build a supportive infrastructure for social workers in mental health across the U.S., your feedback and practice contributions are genuinely valued.

Aloha and Warm Regards!

Lana Sue Ka’opua, PhD, ACSW
Mental Health Specialty Practice Section Committee and Editor