THE OHIO YOUTH PROBLEMS, FUNCTIONING,

AND SATISFACTION SCALES (SHORT FORM)

USER'S MANUAL

Benjamin M. Ogles, Ph. D., Gregorio Melendez, M. S.,
Diane C. Davis, M.S., and Kirk M. Lunnen, Ph. D.[1,2]

Ohio University

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EXECUTIVE SUMMARY

As the service system for children and adolescents with emotional and behavioral problems has evolved, additional emphasis has been placed on developing ongoing evaluation procedures to determine the effectiveness of community-based interventions. The number and quality of rigorous methodological studies as well as naturalistic studies of the changing service system are increasing. In addition, with the advent of health care reform, behavioral health care providers (both in the public and private sectors) are more often required to collect information regarding the effectiveness of services.

With this emphasis on outcomes, many providers and administrators are searching for outcome measures. Typically, administrators hope to find measures that are both practical and scientifically sound. With this goal in mind – practical yet empirical – we developed the Ohio Youth Problems, Functioning and Satisfaction Scales (Ohio Scales). This manual describes the background, conceptualization, and basic administration, scoring, and interpretation procedures for the Ohio Scales.

This manual was designed specifically for "front-line" users of the Ohio Scales. A Technical Manual provides additional information including psychometric studies conducted to date. Although the technical data are not included in this manual, the Ohio Scales have been shown to be promising measures that can be used to track the effectiveness of interventions for youth. Data collected to date demonstrate the measures are reliable, valid, and sensitive to change. Additional studies are under way to expand the situations and populations within which the scales are valid. For those interested in the more detailed, Technical Manual please contact the first author at (740) 593-1077 or ogles@ohio.edu. Questions can also be addressed by the Office of Program Evaluation and Research, Ohio Department of Mental Health at (614) 466-8651.

INTRODUCTION

Outcome! Certainly the 1990s will be remembered as the decade of outcomes. Across a broad range of industries, increasing emphasis is being placed on accountability for the outcome of services. Education, health care, and behavioral health care have been especially influenced by the focus on outcome. There are outcome task forces within states, credentialing bodies, associations, and organizations. Numerous articles and books are written to describe when, where, who, and how to assess the outcome of psychosocial interventions (e.g., Ogles, Lambert, & Masters, 1996; Sederer & Dickey, 1996; Speer, 1998). The institutions that fund services desire quality outcomes. Consumers deserve good outcomes. Providers want to show that they produce quality outcomes. Outcome is certainly the topic of the season.

Especially with the advent of managed care and the privatization of public services, the collection of outcome data is becoming an increasingly important way to account for the expenditure of funds. Both public and private funders of behavioral health services want evidence that the interventions they fund are effective. Outcomes are one of the primary avenues for demonstrating effective interventions.

Responding to the pressure for outcome data may be overwhelming for administrators and providers. The various decisions involved in the selection, implementation, and interpretation of outcome data present numerous, difficult issues. Research-based instruments and methodologies are often unsuitable for routine clinical use. Resources are often stretched to the limit even before the demands of outcome assessment are added to clinical services. While service providers acknowledge the importance of assessing outcome, they also desire cost-efficient and practical measures.

Assessing outcome within children's behavioral health services is especially challenging. Because the development of assessment tools for children's behavioral health services lags behind the efforts for adults (Weber, 1998), there is a paucity of quality measures. Children's outcome assessment also requires data from multiple sources (e.g., parents, youth, agency worker, & teacher). When examining the effectiveness of services for youth with severe emotional disturbances, the involvement of multiple systems can complicate outcome assessment (Burchard & Shaefer, 1992).

Within this climate, we set out to develop measures of clinical outcome for youth who receive behavioral health services. The goal was to develop practical measures (e.g., easily administered, scored, and interpreted) while meeting stringent psychometric criteria. The target population for the instruments is children ages 5 to 18 who have severe emotional and behavioral problems. These youth are more likely to be involved with multiple child-serving systems and to receive a longer duration of intervention. As a result, there is a need for instruments that can be administered at predetermined intervals to evaluate ongoing progress. The remaining portions of this manual describe the conceptualization and initial development of the Ohio Youth Problems, Functioning, and Satisfaction Scales (Short Form) along with the scoring and administration procedures.

INITIAL CONCEPTUALIZATION

As part of the conceptualization process, four areas of concern were considered relevant to the assessment of clinical outcomes for children with severe emotional and behavioral disorders.

1. A theoretical and conceptual model of outcome (Lambert & Hill, 1996);
2. The perspective of various stakeholders (both directly or indirectly affiliated with children's behavioral health services) (Gillespie, 1993);
3. Research concerning the effectiveness of behavioral health treatment for children with specific emphasis on current methods of outcome measurement (e.g., Bickman et al., 1995; Duchnowski, Johnson, Hall, Kutash, & Friedman, 1990; Evans, Dollard, Huz, & Rahn, 1990; Kutash, Duchnowski, Johnson, & Rugs, 1993; Stroul & Friedman, 1986); and
4. The problems associated with the service provision and assessment of at-risk populations.

A more detailed description of the conceptual foundation for the Ohio Scales is included in the Technical Manual. For this manual it is sufficient to note that each of the four areas was intensively scrutinized to produce a list of desirable characteristics for outcome assessment within the population of children who have severe emotional and behavioral disorders. The final list included 5 characteristics:

1. Measurement instruments need to be pragmatic in terms of time, expense, and clinical utility (Rosenberg, 1979).
2. Measures are needed that require minimal professional training for interpretation and that provide immediate and understandable results for parents and children receiving services.
3. Given the growing emphasis on consumer satisfaction with treatment and the involvement of parents and children in the treatment planning process (Barth, 1986; Friesen, Koren, & Koroloff, 1992), effective assessment devices should include input from multiple sources (VanDenBerg, Beck, & Pierce, 1992; Lambert, Christensen, & DeJulio, 1983; Ogles, Lambert, & Masters, 1996).
4. Multiple content areas of outcome should also be considered when assessing youth who have multiple and severe problems
5. The emphasis on pragmatics should be counterbalanced by the need to develop instruments with demonstrated psychometric properties (e.g. reliability, validity, sensitivity to change)

Based on this list of desirable characteristics for outcome assessment instruments, we developed practical measures of clinical outcome covering multiple content areas and multiple sources while maintaining a level of psychometric integrity. Our final goal was a practical set of instruments that would be useful for agencies and practitioners without the hassles of many research based instruments (e.g., lengthy, difficult scoring, difficult to interpret, costly, time consuming).

INSTRUMENT DEVELOPMENT

With this background, the Ohio Youth Problems, Functioning, and Satisfaction Scales (Ohio Scales) were developed (Ogles, Lunnen, Gillespie, & Trout, 1996). Three parallel forms (P-form, Y-form, and W-form) of the Ohio Scales were developed for completion by the youth's Parent (or primary caretaker), the Youth (self-report for ages 12 and older), and the youth's agency Worker/case manager respectively.[3]

Content Areas

After considering a large number of potential content areas, four primary areas or domains of assessment were selected: problem severity, functioning, hopefulness, and satisfaction with behavioral health services.

The parent, youth, and agency worker rate the problem severity and functioning scales. The youth and parent rate the satisfaction scales. Youth rate their own hopefulness about life or overall well being. Parents (or primary caretakers) rate their hopefulness about caring for the identified child. In addition, the Restrictiveness of Living Environments Scales (ROLES; Hawkins, Almeida, Fabry, & Reitz, 1992) is included on the agency worker form along with data regarding several key indicators that are not used when scoring the form.

Item Development

Item writing and selection for the Ohio Scales necessitated identifying the most common problem areas and typical areas of functioning. Five sources of information were considered when writing items for the instruments:

1. Problem behaviors listed as criteria for diagnosis of child and adolescent disorders in the DSM-IV,
2. A list of the most common "presenting problems" of youth with SED compiled by a regional behavioral health board (Cuyahoga County),
3. The results of the social validation survey (Gillespie, 1993),
4. Several commonly used instruments were collected and examined to ascertain the typical areas of assessment when evaluating children and youth along with typical items, and
5. Consultation with child service providers in three separate agency meetings involving 3 child program directors, 4 case manager supervisors, 23 case managers, and 5 parents.

[3] The original version of the Ohio Scales was slightly different than the Short Form of the Ohio Scales that is described here. Through consumer feedback and empirical evaluation, the original Ohio Scales were changed to produce the Short Form which is described in this manual. The detailed Technical Manual provides a description of the evolution of the Ohio Scales and the psychometric characteristics for both versions.

Item Descriptions

The "Problem Severity Scale" is comprised of 20 items covering common problems reported by youth who receive behavioral health services. Each item is rated for severity/frequency (0 "Not at all" to 5 "All the time") on a six-point scale. A total score is calculated by summing the ratings for all 20 items.

The "Functioning Scale" is comprised of 20 items designed to rate the youth's level of functioning in a variety of areas of daily activity (e.g., interpersonal relationships, recreation, self-direction and motivation). Each item is rated on a five-point scale (0 "Extreme troubles" to 4 "Doing very well"). Although the problem severity scale is similar to many other existing symptom rating scales that focus on the severity of behavioral problems, the functioning scale provides a broader range of ratings including “OK” and “Doing very well”. This provides an opportunity for raters to identify areas of functional strength. A total functioning score is calculated by summing the ratings for all 20 items. Higher scores are indicative of better functioning.

In addition to the problems and functioning scales, two brief (four item) scales on the parent and youth forms assess satisfaction and hopefulness. Four items assess satisfaction with and inclusion in behavioral health services on a six-point scale (1 "extremely satisfied" to 6 "extremely dissatisfied"). The total satisfaction score is calculated by summing the 4 items.

Four additional items on the parent and youth forms tap levels of hopefulness and well-being either about parenting or self/future respectively. Each of these is also rated on a six-point scale. The total hopefulness score is calculated by summing the 4 items.

Finally, the agency worker version of the Ohio Scales includes a copy of the Restrictiveness of Living Environments Scale (ROLES). Information regarding the initial development of the ROLES can be obtained by reviewing the original article written by Hawkins et al. (1992). The ROLES assesses the level of restrictiveness for the youth's placements during the past 90 days. A higher score means on average the youth is placed in a more restrictive setting.

Administration and scoring procedures for all three instruments are described below. (See Appendix A for copies of the three instruments).

ADMINISTRATION AND SCORING

The Ohio Scales were developed for quick administration, scoring and interpretation. With relatively minimal training, parents or case managers can administer, score, and interpret the meaning of scores for each of the scales. Each of the scales will be briefly discussed in this section.

There are three parallel forms of the Ohio Scales completed by the youth's parent or primary caretaker (P-form), the youth (Y-form), and the youth's agency worker (W-form). This allows assessment of the client's strengths and weaknesses from multiple perspectives. The youth form is designed for youth ages 12-18. The parent and agency worker versions are designed for youth ages 5-18.

The instrument is two pages long, placed on the front and back of a single sheet. The questions for problem severity and functioning are identical on the three parallel forms. The satisfaction and hopefulness scales are slightly different depending on the perspective (parent or youth). On the front side of all three forms is the 20-item problem severity scale. The remaining scales are on the back.

Problem Severity

All three forms include the 20 item problem severity scale. Each of these items is rated on a 6-point scale for frequency during the past 30 days: not at all, once or twice, several times, often, most of the time, or all of the time. The columns for each frequency are coded respectively from 0 (Not at all) to 5 (All of the Time). Each column's score can then easily be added at the bottom of the page. The sum of the six columns then becomes the individual's score on the problem severity scale. No items are reverse-scored.

Functioning

All three forms include the 20 item functioning scale in the bottom half of the back page. Each of these 20 items is rated using a 5-point scale: extreme troubles, quite a few troubles, some troubles, OK, or doing very well. Since raters might have somewhat different conceptions regarding what consitutes the various levels of functioning, we use comparable ratings on the Children's Global Assessment Scale (CGAS) as a reference:

Ohio Scales	CGAS
Doing very well (4)	Superior functioning in all areas; (CGAS 90's)
OK (3)	Good functioning in all areas; (CGAS 80's)
Some Troubles (2)	Some difficulty in a single area, but generally functioning pretty well (CGAS approximately 70's)
Quite a few Troubles (1)	Moderate problems in most areas or severe impairment in one area (CGAS approximately 50's)
Extreme Troubles (0)	Major impairment in several areas and unable to function in one or more areas (CGAS 30's or below)

A common question about the functioning scale involves the rating of items 3 and 13. For young children, raters often wonder how to rate items concerning vocational preparation (Item 13) or developing relationships with boyfriends or girlfriends (Item 3). On these items the rater should rate "OK (3)" if they are unsure or rate the youth based on what might be expected for their developmental level. For example, developmentally appropriate vocational preparation for a 7 year old typically involves school work, chores at home, and other work-like assignments. Note: If insufficient information is available to answer a specific item on the functioning scale, that item should be rated "OK (3)".

The functioning scale total is calculated in the same manner used on the problem severity scale. Each of the 20 items is rated on its 5-point scale. The rating for each item is circled. The columns for each frequency are coded respectively from 0 (extreme troubles) to 4 (doing very well). Each column's score can then easily be added at the bottom of the page. The sum of the five columns then becomes the individual's score on the functioning scale. No items are reverse scored.

As can be seen from the scoring method, a high score on the problem severity scale is considered to be more problematic (more frequent problems), while a low score on the functioning scale is considered to be more impairment. The method of scoring is thus congruent with what one would intuitively expect given the content of each scale.

Hopefulness

On the back side of the parent and youth versions, eight questions are printed at the top of the page. The first four questions ask for ratings of hopefulness (parent) or overall well being (youth). The specific questions vary somewhat on the two versions to fit the respondents. Each question is answered according to a 6-point scale with the specific scale items varying to fit the questions. In each question, response "1" is the most hopeful/well and response "6" is the least. The four items can then be totaled for a hopefulness scale score. On this scale, a lower total means more hope or wellness.

Satisfaction

The second four questions on the top half of the back page (P-form and Y-form) ask for ratings of overall satisfaction with behavioral health services received and ratings of their inclusion in treatment planning. The specific questions vary somewhat on the two versions to fit the respondents. Each question is answered according to a 6-point scale with the specific scale items varying to fit the questions. In each question, response "1" is the most satisfied/included and response "6" is the least. The four items can then be totaled for a satisfaction scale score. On this scale, a lower total means more satisfaction.

Restrictiveness of Living Environments Scale (ROLES)

On the agency worker version of the Ohio Scales (W-form), the space in the top half of the back side of the page is utilized quite differently since satisfaction and hopefulness ratings are only appropriate from the perspectives of the parent/caregiver and youth. The W-form includes a copy of the ROLES (Hawkins et al., 1986). The ROLES consists of a list of 23 categories of residential settings. Next to each specific setting is a blank line on which the agency worker writes the number of days (during the past 90 days) the youth was residing in that setting (The total of all the days will therefore add to 90). Although the authors of the Ohio Scales did not develop this scale, it was felt that tracking this information could be helpful to the agency worker. The worker should identify the categories that most closely resemble the settings in which the youth stayed.

Scoring for this scale is not included on the form, but it is possible to compute a score if the worker thinks it would be a meaningful measure of the child's treatment progress. Each setting is given a statistical 'weight' as listed in the table below. To get the ROLES total score, each weight is multiplied by the number of days in the blank next to the setting. The sum of these products is then calculated to get a total. The total is then divided by 90 to get the average restrictiveness for the previous 90 days. This is the ROLES score (see Hawkins et al., 1986).

Table 1. ROLES' Weights

Setting	Weight	Setting	Weight
Jail	10.0	Foster care	4.0
Juvenile detention/youth corrections	9.0	Supervised independent living	3.5
Inpatient psychiatric hospital	8.5	Home of a family friend	2.5
Drug/alcohol rehab. center	8.0	Adoptive home	2.5
Medical hospital	7.5	Home of a relative	2.5
Residential treatment	6.5	School dormitory	2.0
Group emergency shelter	6.0	Biological father	2.0
Vocational center	5.5	Biological mother	2.0
Group home	5.5	Two biological parents	2.0
Therapeutic foster care	5.0	Independent living with friend	1.5
Individual home emergency shelter	5.0	Independent living by self	.5
Specialized foster care	4.5		

For example, if during the last 90 days a child was placed in a juvenile detention facility for 2 days, a group home for 12 days, and with the biological father for 76 days, the ROLES score would be calculated in this way:

	Days		Weight[4]		Product
Detention Center	2	X	9.0	=	18.0
Group Home	12	X	5.5	=	66.0
With Father	76	X	2.0	=	152.0
Total	90				236.0

236 / 90 = 2.62 - The ROLES score for the past 90 days is 2.62.

The agency worker version also includes a several questions in the middle of the back side of the page. These items are 'Marker' questions and, similar to the ROLES, are meant to be helpful to the agency worker in tracking key information. There are blank spaces to write in information on "school placement" and "current psychoactive medications". In addition, several lines are available for recording the frequency during the past 3 months of arrests, suspensions from school, days in detention, days of school missed, and self-harm attempts.

[4] From the Table on the previous page.

CLINICAL USE OF THE OHIO SCALES

The Ohio Scales give the clinician a wealth of useful and easily understandable information. Perhaps most obvious is the ability to track a client's progress over time with repeated administrations of the instrument. Ongoing ratings of overall functioning and problem severity can be useful to clinicians and program administrators alike. Additionally, however, the initial administration of the Ohio Scales provides excellent information to aid in development of the client's treatment plan. It should be noted that the Ohio Scales were developed primarily to aid in the tracking of service effectiveness. As a result, they do not provide comprehensive information that might be associated with the administration of a diagnostic measure such as the Child Behavior Checklist (Achenbach & Edelbrock, 1983). Nevertheless, much useful information is available upon initial administration of the Ohio Scales.

Development of Treatment Plan

Administration of the Ohio Scales at intake provides an index of a youth's current problems and level of functioning. Answers to a standardized list of questions help ensure that the typical problems and areas of functioning encountered by youth who receive behavioral health services will be covered.

Critical Items. Specific responses to critical items should be checked first. Positive responses to items such as "hurting self (cutting or scratching self, taking pills)", "talking or thinking about death", "using drugs or alcohol" will require the immediate attention of the clinician. The youth may need to be assessed for serious risk of harm to self or others or for disturbed thinking. It may also be helpful to check whether the parent and youth give different information on these critical items.

Target Problems. In developing a treatment plan, the next section to check would be the problem severity scale on the front of the page. A quick scan will tell the clinician the problems that are endorsed as occurring most frequently. These problems are likely to be the most relevant to the treatment and can be included as target problems in the treatment plan. Again, any differences in the ratings by the parent and youth may prove helpful in dealing with both the youth and the family.

Functional Strengths. The next section to check would be specific responses to the functioning scale on the back of the page. Any functioning items that are rated highly may be noted as strengths. A rating of '3' or '4' on a functioning item identifies specific attributes or activities that can be included in the treatment plan as personal strengths. The clinician may also take note of any specific functioning questions that might improve rapidly and then be helpful in working on problems. For example, improvement in hobby participation or appropriate recreational activities might quickly aid improvement in self-concept or relationships with peers or family.

Compare Total Scores. In addition to initial use of individual item responses to aid with the specifics of a treatment plan, calculating scale total scores may also be

useful. Total scores for the youth can be compared to average scores in the comparison sample. This gives the clinician an overall indication of how the youth's scores compare to a sample of youth who are not receiving services.[5] For example, a parent who rated their child using the problem severity scale and obtained a total scale score of 45, could note that the score was above the average (39.35) for parents of children receiving clinical services and well above the average (10.29) of parent ratings of youth in the community who were not receiving behavioral health services. Means and standard deviations for a community sample and a clinical sample are presented in Table 2.

Table 2. Means and Standard Deviations on the Ohio Scales for Community and Clinical Samples.[6]

Population: Form	N	Problems M (SD)	Functioning M (SD)	Hope M (SD)
Community:				
• Youth	166	18.18 (15.04)	61.07 (12.99)	9.61 (3.78)
• Parent	329	10.29 (9.88)	63.95 (12.67)	8.31 (3.52)
• Agency Worker	40	17.58 (9.62)	67.03 (9.01)	NA
Clinical:				
• Youth	76	36.31 (20.96)	55.09 (13.42)	10.57 (4.35)
• Parent	137	39.35 (17.71)	41.65 (16.03)	13.81 (5.26)
• Agency Worker	134	41.04 (14.40)	33.94 (12.91)	NA

Charting Total Scores. In addition, figures were created to allow the charting of total scale score ratings (see Figures 1 & 2). The horizontal lines on the chart represent potential cutoff scores that can be used to identify youth with significant levels of problems or deficits in functioning when compared to a community sample.

For the problem severity scale, the lowest line represents the average parent[7] rating of problem severity in a community sample. (Any youth in the sample who had received behavioral health services, been arrested, or was assigned to a class for students with behavioral problems was excluded when calculating the average for the line). The next line moving up is one standard deviation above this mean (total score = 20) and the third line is two standard deviations above this mean (total score = 30). Children whose parents rate them as having more frequent problems than the second cutoff could be reasonably assumed to have clinically meaningful levels of problem behaviors.

[5] The community sample used for comparison purposes in this manual is a sample of over 300 5 to 18 year old youth (and their parents) in Southeastern Ohio.

[6] These numbers are the combined data for multiple samples described in the technical manual.

[7] Only parent cutoffs were included on the figures to avoid clutter. The actual means and standard deviations for the other sources are listed in Table 2.

For the functioning scale the top line represents the average parent rating of functioning in a community sample excluding the same cases mentioned above (youth who had been arrested, received behavioral health services, or attended a class for students with behavioral problems). The next line moving down is one standard deviation below this mean (total score = 52) and the third line is two standard deviations below this mean (total score = 40). Children whose parents rate them as having poorer functioning than the first or second cutoff could be reasonably assumed to have clinically meaningful impairment in functioning.

Comparisons could also be conducted between the agency worker ratings and the small sample of community youth rated by agency workers presented in Table 2. Many rater-based scales do not include norms. For example, the Hamilton Rating Scale for Depression has been used in hundreds of studies in various forms, but no normative sample is available (Grundy, Lunnen, Lambert, Ashton, & Tovey, 1994; Grundy, Lambert, & Grundy, 1996). As a result, we collected this initial data to begin the process of developing a rater based comparison sample that could be contrasted with clinical samples.

Figure 1. Comparing with the Community & Tracking Change in Problem Severity

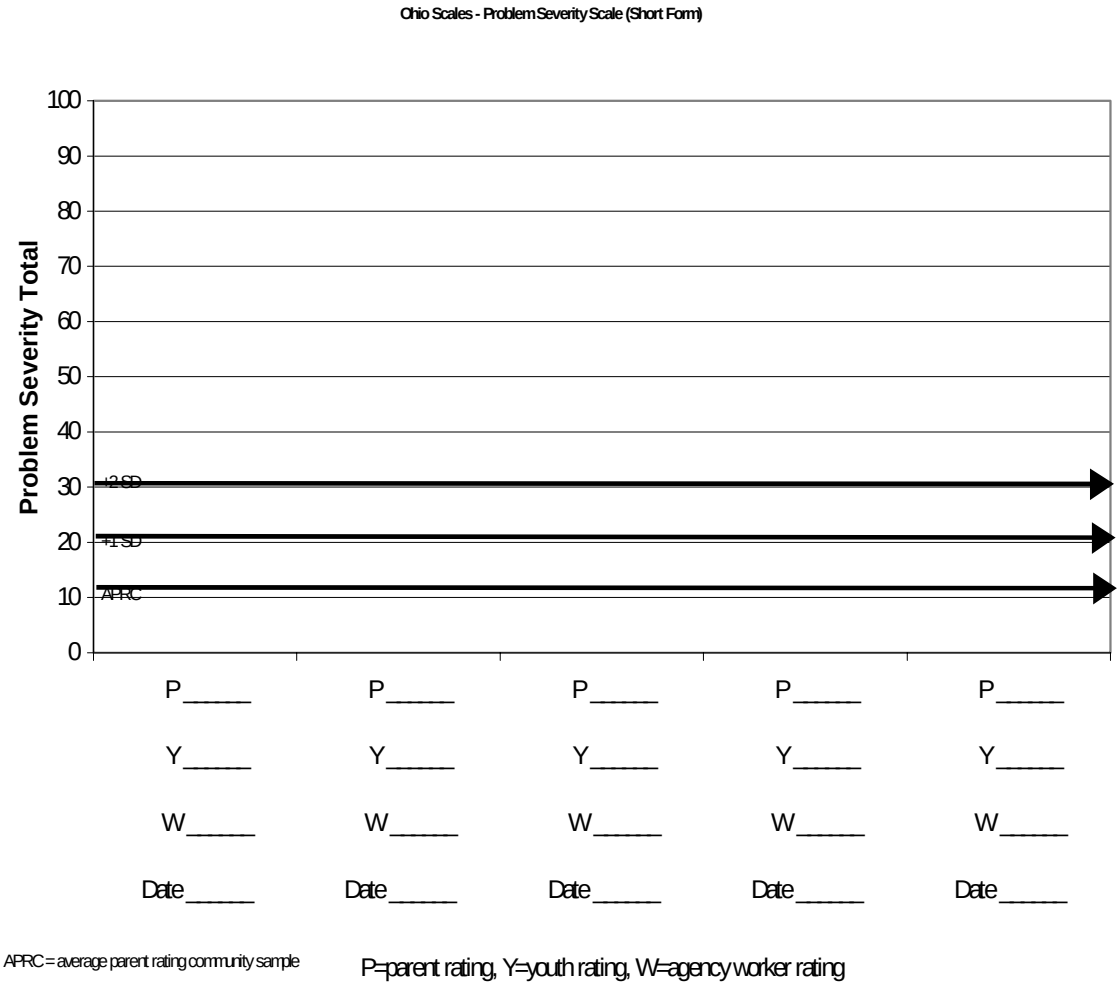

Figure 2. Comparing with the Community & Tracking Change in Functioning

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Tracking Changes Over Time

The easy administration of the Ohio Scales allows the instrument to be used as frequently as the clinician would like. Over time, it is then possible to track any improvement in an objective manner, free from the difficulties of relying on memory.

Change in Total Scores. There are several different ways to use data collected over time. Viewing scale total scores, it is possible to see the overall amount of improvement. In addition, total scale scores can be compared to the community sample. For example, the clinician can examine scale total scores at intake and after three months to see if any changes in overall problem severity or functioning occurred. Figures 1 & 2 were developed for tracking change in problem severity and functioning. Total problem severity and functioning scores for all three sources (child, parent, and agency worker) can be charted on the two figures. The lines, however, represent the means and cutoff scores for parent ratings in the comparison sample. Lines are labeled on the figures and are described above.

Change in Items. It may also be useful in some cases to selectively track specific problem areas that were identified for clinical work. In this case, the client may complete specific relevant questions (items) more frequently than the scheduled administration of the entire Ohio Scales. The Ohio Scales offer great flexibility for individual customization in order to provide the greatest usefulness possible.

Compare Change in Scales. In constructing case conceptualizations, the clinician may also find it useful to use scale totals (or even specific item responses) to better understand theoretically how a client is improving. Specifically, the clinician may look at the improvement over time in the problem severity scale versus the functioning scale. Does it seem with a particular youth that problems have been disrupting functioning and an improvement in the problem severity scale precedes an improvement in the functioning scale? On the other hand, does it seem with a particular case that functioning improvement provides help with problems? The Ohio Scales provides specific information on an individual's changes to help address issues such as these.

Aggregate Change. Tracking results over time also provides useful information to administrators as well as clinicians. Administrators may aggregate or average the improvement numbers for all clients or groups of clients to obtain information regarding specific programs. These numbers may be very useful in reporting to regulatory bodies or in attempts to gain agency funding. **It should be noted that average change scores reported in this fashion do not include information regarding the causes of change. Unless control groups or some other form of control has been used in an experimental fashion, client improvement could be due to other factors than**

treatment. As a result, administrators should be careful how they make attributions about evaluation data collected from a single group tracked over time.

Satisfaction with Service. The clinician may also examine the satisfaction scale to see if the client is satisfied with behavioral health services. In addition, the satisfaction scales may be aggregated to give an overall picture of client satisfaction with services. Reports of high client satisfaction with services can be helpful in communicating overall agency effectiveness. Conversely, if client satisfaction ratings are less favorable, this would provide important feedback to the administrator regarding specific programs.

Change in Hopefulness. One key ingredient for family involvement in behavioral health services is the parent's hopefulness about being able to parent and care for their child. When families seek services, they are often physically tired and emotionally discouraged by the challenges of raising a child with serious emotional and behavioral problems. Similarly, the youth may lack hope about the future. Because of this, the Ohio Scales incorporates a four item scale to track hopefulness over time. Clinician's may find useful information about the parent's or youth's level of hopefulness over time by tracking changes in the hopefulness total scale score.

Clinically Significant Change

In the current behavioral health care market, consumers of outcome data want evidence that clients benefit from treatment. The statistical tests that researchers offer, however, do not always provide the most relevant information. Statistical tests may be difficult for many outcome consumers to understand. In addition, statistical tests do not provide information regarding the effectiveness of treatment for any one individual. Similarly, the clinical relevance of client change is not considered in many research designs. As a result, methods for determining and displaying the clinical meaningfulness of client change may facilitate the description and dissemination of outcome data.

Jacobson and colleagues (Jacobson, Follete, & Revenstorf, 1984; Jacobson & Revenstorf, 1988; Jacobson & Truax, 1991) proposed a standardized method for determining clinical significance. This method is based on the assumption that clinically significant change involves a return to normal functioning. Jacobson and Truax (1991) propose two criteria for assessing clinical significance.

First, clients receiving psychological interventions should move from a theoretical dysfunctional population to a functional population as a result of treatment. In other words, if the distributions of individuals in need of treatment and "healthy individuals" are represented graphically, the client who has completed treatment should be more likely to be identified as a member of the healthy population distribution. For example, a youth receiving outpatient counseling should have a problem severity score after treatment that is more similar to the scores for the general population than to other clinical samples.

Second, the change for a client must be reliable -- the pre to posttreatment change must be large enough that differences can be attributed to "real" change and not to measurement error. Jacobson and Truax (1991) provide a method to calculate a Reliable Change Index (RCI). The change is considered reliable, or unlikely to be the product of measurement error, if the change index (RCI) is greater than 1.96. If the client meets both criteria, movement from one distribution to the other and an RCI greater than 1.96, then the change is considered "clinically significant".

A number of other issues must be considered when using the Jacobson method, but a thorough discussion of the difficulties and issues is beyond the scope of this manual. Similarly, the technical description of RCI calculations is beyond the scope of this manual. Interested readers can refer to the technical manual or other sources for a more detailed review (e.g., Ogles, Lambert, & Masters, 1996).

Client Meaningful Change. Using the Jacobson method and the averages for our samples, we can identify cutoff and change scores that are necessary for calculating meaningful change using the Ohio Scales. Table 3 presents the cutoff scores and change scores for the problem severity and functioning scales for all three raters of outcome. For example, if the parent ratings indicated that the total problem severity score decreased by 10 points and the most recent rating fell below 25, then the youth could be said to have made clinically meaningful changes. These numbers are based on the samples presented in the Technical Manual. Site specific norms may sometimes be more useful.

Description of Meaningful Change. In addition to determining if the client made a clinically significant change or not, we could use these data to describe the child's pre- and post-treatment status. For example, "Sigmund entered treatment with a problem severity score of 40. This is typical of youth who receive community support services. After 9 months of service, he had a problem severity score of 12 which is more similar to other youth living in his community (within 1 standard deviation of the community sample mean). The magnitude or size of change (28 points) also indicates that he made a reliable change for the better."

Table 3. Clinical Significance for the Ohio Scales - Short Form[8]

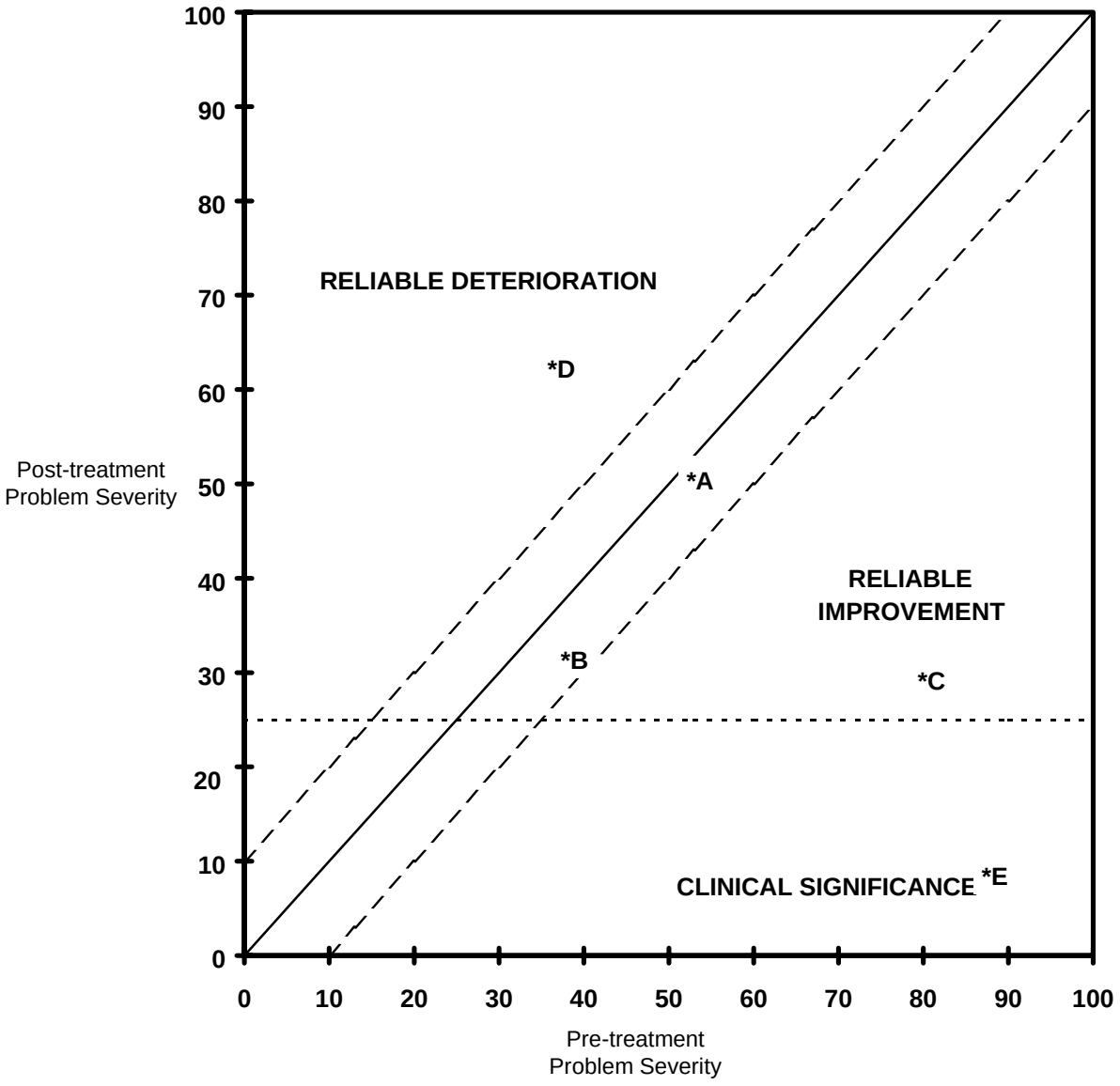
Scale	Change	Cutoff
Problem Severity	10	25
Functioning		
Parent	8	50
Youth	8	60
Agency worker	8	50

[8] Change scores and cutoff scores were determined mathematically and rationally balancing the need to find numbers that are empirically based yet practical in application. Note that the change and cutoff scores are identical for parents, youth, and agency workers on the problem severity scale.

Comparing Clinical Change. If needed we could go one step further and indicate how Sigmund's post-treatment score compared to individuals in the general population, distressed individuals, and non-distressed individuals by calculating percentile scores for each of the distributions. Of course this would require additional detailed data regarding the Ohio Scales. The point is that clear statements regarding the clinical meaningfulness of the change may be useful adjuncts to other descriptions of outcome.

Graphic Depiction by Group. A final method of utilizing the Jacobson method involves the graphic depiction of pre to posttreatment change for individuals or groups of individuals. For example, Figure 3 displays a graph with the parent rated problem severity at intake on the bottom of the graph and the posttreatment score on the left side of the graph. The horizontal line (posttreatment score = 25) represents the cutoff score necessary to be considered part of the healthy group following treatment. The diagonal line running from corner to corner is the line of no change. Clients who have the same pretreatment and posttreatment total will be plotted on this line (Client A). The dashed diagonal lines on either side of the "line of no change" represent the change scores necessary to result in an RCI greater than 1.96. Clients between the dashed diagonal lines (Client B) did not improve sufficiently to rule out random fluctuations or test unreliability as the source of the change (RCI < 1.96). Clients plotted outside the lines (above the top line or below the bottom line) can be considered to have made reliable changes (RCI > 1.96). For example, Client C made changes for the better (below the bottom line) and Client D made changes for the worse (above the top line). Individuals who made reliable improvement and had end of treatment scores similar to the healthy population are plotted below the diagonal and the cutoff score (Client E). A similar graph could be created for the functioning scale.

Figure 3. Clinical Significance on the Parent Rated Problem Severity Scale



PUTTING IT ALL TOGETHER - AN EXAMPLE

The primary purpose of this manual is to describe the basics of administration, scoring, and interpretation of the Ohio Scales. In the earlier sections, the main focus of the text was the use of the Ohio Scales for each individual. In this final section, an example report is provided that illustrates the potential use of the Ohio Scales for aggregate reporting.

BEGIN EXAMPLE REPORT

REPORT OF OUTCOMES FOR "THEBEST" COMMUNITY SUPPORT PROGRAM

Introduction

The Best Community Support Program has been studying the effectiveness of their services over the past year. - Insert other relevant information here - This report presents a summary of findings regarding the initial status of children entering community support services, the clinical outcome of services, and parent and youth satisfaction with services.

Procedure

One-hundred parents rated their child using the parent version of the Ohio Scales every three months during treatment. The 50 youth who were 12 or older also completed self-report forms. Finally, the agency workers rated the 100 youth using the agency worker Ohio Scales. - Insert other relevant data about the families who receive services -

Measures

- Insert a description of the Ohio Scales and other measures used here -

Initial Status

The initial scores of the parents and youth give some indication of the severity of problems and level of functioning for youth entering community support services. The average initial score on each scale is listed in Table 1.

Table 1. Average Initial Scores

Rater Scale	Intake X (SD)	Community X (SD)
Parent		
Problem Severity	39.4 (32.8)	10.29 (9.88)
Functioning	41.6 (15.8)	63.95 (12.67)
Youth		
Problem Severity	30.3 (30.8)	18.18 (15.04)
Functioning	50.6 (14.7)	61.07 (12.99)

X = average score; SD = standard deviation

The scores in and of themselves are not useful unless compared to other youth. As a result, the average scores for a comparison sample are also presented. Clearly, the youth who are entering community support services have significantly more problems and poorer functioning than other youth in the community. - The table could also be displayed graphically and include agency worker scores -

Clinical Outcome of Services

The families that agreed to participate in the study were asked to complete the Ohio Scales at intake and every three months thereafter while they were receiving services up to a one-year follow-up. - insert other relevant data about the outcome data collection -

Table 2 displays the number of individuals who completed the forms at each time point. - Insert other information about the reasons for continuing or dropping out of services -

Table 2. Number of Individuals Completing the Follow-up Ratings.

Rater	Intake	3 months	6 months	9 months	12 months
Parent	100	60	40	30	20
Agency Worker	100	60	40	30	20
Youth	50	30	20	15	10

While the number of dropouts was quite high we conducted analyses to examine the perception of problem severity and functioning change for those who did continue. Paired t-tests examining changes from intake to 3 months were first examined. Means, standard deviations, and significance tests for the measures are presented in Table 3.

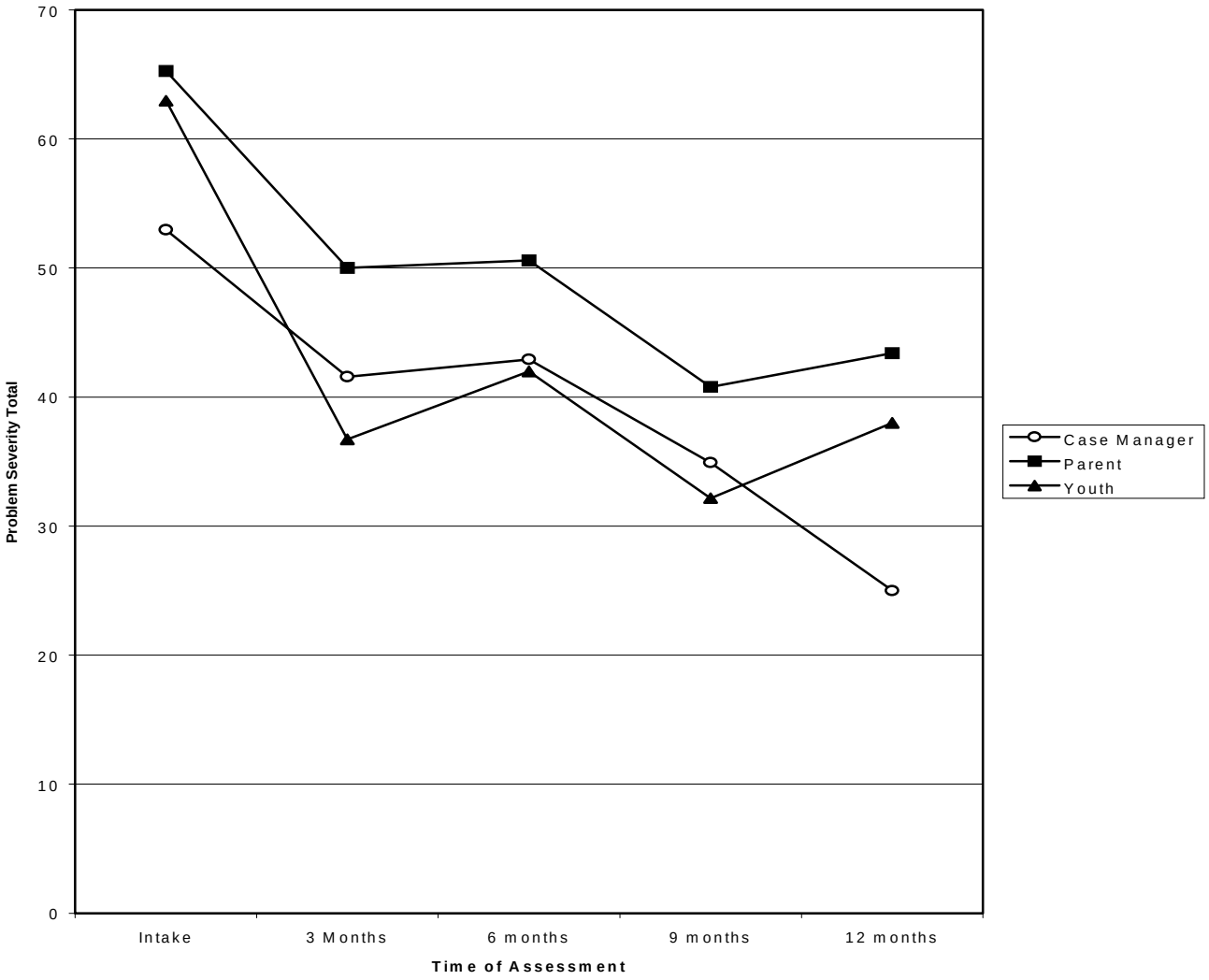
Table 3. Means, Standard Deviations, and Significance Tests for Three Sources of Information in Three Content Areas from Intake to 3 month Assessment.[9]

Rater Scale	Intake X (SD)	3 months X (SD)	T	Sig.
Parent (n = 60)				
Problem Severity	39.4 (18.8)	18.0 (12.0)	3.64	.001
Functioning	45.6 (15.8)	52.0 (14.2)	-1.24	.225
Agency Worker (n = 60)				
Problem Severity	42.4 (12.8)	16.6 (18.0)	3.06	.005
Functioning	41.6 (15.8)	48.3 (11.9)	-.634	.532
Youth (n = 30)				
Problem Severity	30.3 (30.8)	16.7 (23.2)	2.35	.057
Functioning	50.6 (14.7)	57.0 (13.7)	.624	.556

[9] All of this data is contrived and inaccurate.

As can be seen, the parents, community support workers, and youth all reported significant changes in problem severity. No changes were noted, however, in functioning. Figure 1 displays the change lines as rated by youth, parents, and agency workers for the problem severity scale.

Figure 1. Change in Problem Severity



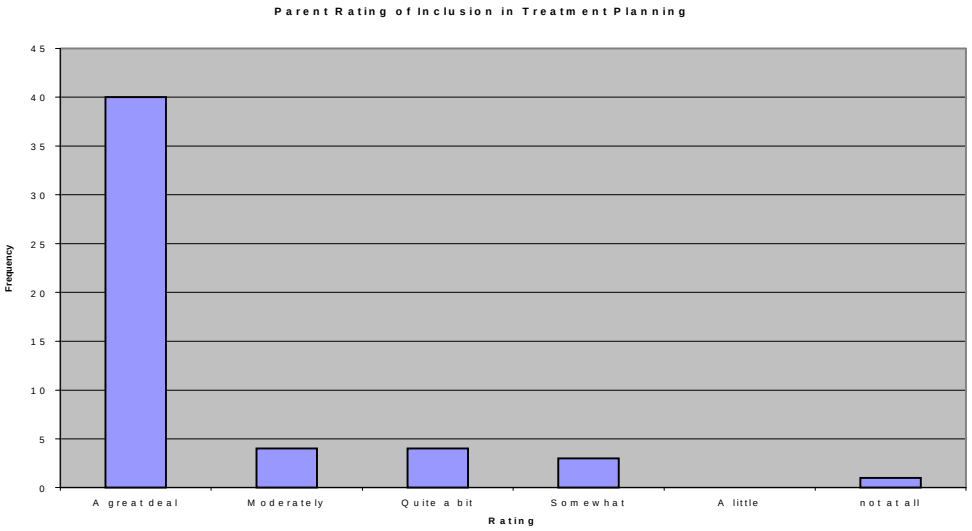
- Insert other graphs as appropriate for the data. A clinical significance graph (see Figure 3 above) may fit here too -

Hopefulness of Parents and Youth

- A similar description of changes in hopefulness for the parents and youth with appropriate graphs could be inserted here -

Satisfaction with Services

In addition to rating clinical improvement over time, the parents and youth also rated their satisfaction with services. The following figures illustrate the satisfaction ratings for parents and youth on the four satisfaction items.



- The other 7 graphs (one for each of the 4 items - P & Y forms) inserted here -

As can be seen, parents were generally satisfied with services (100% somewhat, moderately, or extremely satisfied), felt included in the treatment planning process (98% quite a bit, moderately, or a great deal), indicated that they were listened to when planning treatment, and felt some ownership of the treatment plan.

- Insert another paragraph describing the youth satisfaction graphs -

Overall, these ratings suggest that the families who were receiving services were pleased with the services they received and felt like they had access to, a voice in, and ownership of the treatment planning and implementation process.

Summary

Together the results of this report suggest that youth who participate in the community support program have significant problems upon entering into the program. They make meaningful changes while participating in the program especially when considering problem severity. Finally, they are generally satisfied with the services.

END OF EXAMPLE REPORT

CONCLUSION

After reviewing the current state of outcome measurement within children's behavioral health services, we developed three brief measures of outcome covering multiple content areas from multiple sources. Our intent was to develop measures that could be used to track the progress of youth with serious emotional disorders as they receive behavioral health services. We hoped to develop pragmatic yet empirically sound measures that are grounded in the theoretical and practical world of multi-need youth.

This manual summarizes the administration, scoring, and interpretation strategies that can be used with the Ohio Scales. Emphasis was initially placed on the immediate interpretation and usefulness of test results for each individual case. A final example was included to illustrate the potential use of aggregate scores for depicting program or agency outcome data. Noteably, the psychometric data for the Ohio Scales are not reported in this manual. Evidence of reliability, validity, and sensitivity to change is presented in the Technical Manual.

The ultimate usefulness of the Ohio Scales and this manual will be determined by those who use the scales. We welcome your comments and hope that the delicate balance between research rigor and pragmatics does not diminish the quality of the work. Please send comments to ogles@ohio.edu or Ben Ogles, Ph. D., Porter Hall 241, Ohio University, Athens, OH 45701.

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Ohio Youth Problem, Functioning, and Satisfaction Scales

Youth Rating – Short Form (Ages 12-18)

Y

Name: _____ Date: _____ Grade: _____ ID#: _____ Completed by Agency

Date of Birth: _____ Sex: ❑ Male ❑ Female Race: _____

Instructions: Please rate the degree to which you have experienced the following problems in the past 30 days.		**Not at All**	**Once or Twice**	**Several Times**	**Often**	**Most of the Time**	**All of the Time**
1.	Arguing with others	0	1	2	3	4	5
2.	Getting into fights	0	1	2	3	4	5
3.	Yelling, swearing, or screaming at others	0	1	2	3	4	5
4.	Fits of anger	0	1	2	3	4	5
5.	Refusing to do things teachers or parents ask	0	1	2	3	4	5
6.	Causing trouble for no reason	0	1	2	3	4	5
7.	Using drugs or alcohol	0	1	2	3	4	5
8.	Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9.	Skipping school or classes	0	1	2	3	4	5
10.	Lying	0	1	2	3	4	5
11.	Can't seem to sit still, having too much energy	0	1	2	3	4	5
12.	Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13.	Talking or thinking about death	0	1	2	3	4	5
14.	Feeling worthless or useless	0	1	2	3	4	5
15.	Feeling lonely and having no friends	0	1	2	3	4	5
16.	Feeling anxious or fearful	0	1	2	3	4	5
17.	Worrying that something bad is going to happen	0	1	2	3	4	5
18.	Feeling sad or depressed	0	1	2	3	4	5
19.	Nightmares	0	1	2	3	4	5
20.	Eating problems	0	1	2	3	4	5

September 1999 (Youth-1)

(Add ratings together) Total _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your life right now?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How energetic and healthy do you feel right now?
    1. Extremely healthy
    2. Moderately healthy
    3. Somewhat healthy
    4. Somewhat unhealthy
    5. Moderately unhealthy
    6. Extremely unhealthy
3. How much stress or pressure is in your life right now?
    1. Very little stress
    2. Some stress
    3. Quite a bit of stress
    4. A moderate amount of stress
    5. A great deal of stress
    6. Unbearable amounts of stress
4. How optimistic are you about the future?
    1. The future looks very bright
    2. The future looks somewhat bright
    3. The future looks OK
    4. The future looks both good and bad
    5. The future looks bad
    6. The future looks very bad

Total: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services you have received so far?
    1. Extremely satisfied
    2. Moderately satisfied
    3. Somewhat satisfied
    4. Somewhat dissatisfied
    5. Moderately dissatisfied
    6. Extremely dissatisfied
2. How much are you included in deciding your treatment?
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
3. Mental health workers involved in my case listen to me and know what I want.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all
4. I have a lot of say about what happens in my treatment.
    1. A great deal
    2. Moderately
    3. Quite a bit
    4. Somewhat
    5. A little
    6. Not at all

Total: _____

Instructions: Below are some ways your problems might get in the way of your ability to do everyday activities. Read each item and circle the number that best describes your current situation.	**Extreme Troubles**	**Quite a Few Troubles**	**Some Troubles**	**OK**	**Doing Very Well**
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing products	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____

Ohio Youth Problem, Functioning, and Satisfaction Scales
Parent Rating – Short Form

P

Child's Name: _____ Date: _____ Child's Grade: ____ ID#: _____ (Completed by Agency)

Child's Date of Birth: _____ Child's Sex: ❑ Male ❑ Female Child's Race: _____

Form Completed By: ❑ Mother ❑ Father ❑ Step-mother ❑ Step-father ❑ Other: _____

Instructions: Please rate the degree to which your child has experienced the following problems in the past 30 days.		Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1.	Arguing with others	0	1	2	3	4	5
2.	Getting into fights	0	1	2	3	4	5
3.	Yelling, swearing, or screaming at others	0	1	2	3	4	5
4.	Fits of anger	0	1	2	3	4	5
5.	Refusing to do things teachers or parents ask	0	1	2	3	4	5
6.	Causing trouble for no reason	0	1	2	3	4	5
7.	Using drugs or alcohol	0	1	2	3	4	5
8.	Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9.	Skipping school or classes	0	1	2	3	4	5
10.	Lying	0	1	2	3	4	5
11.	Can't seem to sit still, having too much energy	0	1	2	3	4	5
12.	Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13.	Talking or thinking about death	0	1	2	3	4	5
14.	Feeling worthless or useless	0	1	2	3	4	5
15.	Feeling lonely and having no friends	0	1	2	3	4	5
16.	Feeling anxious or fearful	0	1	2	3	4	5
17.	Worrying that something bad is going to happen	0	1	2	3	4	5
18.	Feeling sad or depressed	0	1	2	3	4	5
19.	Nightmares	0	1	2	3	4	5
20.	Eating problems	0	1	2	3	4	5

(Add ratings together) Total _____

Instructions: Please circle your response to each question.

1. Overall, how satisfied are you with your relationship with your child right now?
   7. Extremely satisfied
   8. Moderately satisfied
   9. Somewhat satisfied
   10. Somewhat dissatisfied
   11. Moderately dissatisfied
   12. Extremely dissatisfied
2. How capable of dealing with your child's problems do you feel right now?
   7. Extremely capable
   8. Moderately capable
   9. Somewhat capable
   10. Somewhat incapable
   11. Moderately incapable
   12. Extremely incapable
3. How much stress or pressure is in your life right now?
   7. Very little
   8. Some
   9. Quite a bit
   10. A moderate amount
   11. A great deal
   12. Unbearable amounts
4. How optimistic are you about your child's future right now?
   1. The future looks very bright
   2. The future looks somewhat bright
   3. The future looks OK
   4. The future looks both good and bad
   5. The future looks bad
   6. The future looks very bad

Total: _____

Instructions: Please circle your response to each question.

1. How satisfied are you with the mental health services your child has received so far?
   7. Extremely satisfied
   8. Moderately satisfied
   9. Somewhat satisfied
   10. Somewhat dissatisfied
   11. Moderately dissatisfied
   12. Extremely dissatisfied
2. To what degree have you been included in the treatment planning process for your child?
   7. A great deal
   8. Moderately
   9. Quite a bit
   10. Somewhat
   11. A little
   12. Not at all
3. Mental health workers involved in my case listen to and value my ideas about treatment planning for my child.
   7. A great deal
   8. Moderately
   9. Quite a bit
   10. Somewhat
   11. A little
   12. Not at all
4. To what extent does your child's treatment plan include your ideas about your child's treatment needs?
   7. A great deal
   8. Moderately
   9. Quite a bit
   10. Somewhat
   11. A little
   12. Not at all

Total: _____

Instructions: Please rate the degree to which your child's problems affect his or her current ability in everyday activities. Consider your child's current level of functioning.	Extreme Troubles	Quite a Few Troubles	Some Troubles	OK	Doing Very Well
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing products	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____

Ohio Youth Problem, Functioning, and Satisfaction Scales
Agency Worker Rating – Short Form

W

Child's Name: _____ Date: _____ Child's Grade: ____ ID#: _____

Child's Date of Birth: _____ Child's Sex: ❑ Male ❑ Female Child's Race: _____

Form Completed By: _____ ❑ Case Manager ❑ Therapist ❑ Other: _____

Instructions: Please rate the degree to which the designated child has experienced the following problems in the past 30 days.		Not at All	Once or Twice	Several Times	Often	Most of the Time	All of the Time
1.	Arguing with others	0	1	2	3	4	5
2.	Getting into fights	0	1	2	3	4	5
3.	Yelling, swearing, or screaming at others	0	1	2	3	4	5
4.	Fits of anger	0	1	2	3	4	5
5.	Refusing to do things teachers or parents ask	0	1	2	3	4	5
6.	Causing trouble for no reason	0	1	2	3	4	5
7.	Using drugs or alcohol	0	1	2	3	4	5
8.	Breaking rules or breaking the law (out past curfew, stealing)	0	1	2	3	4	5
9.	Skipping school or classes	0	1	2	3	4	5
10.	Lying	0	1	2	3	4	5
11.	Can't seem to sit still, having too much energy	0	1	2	3	4	5
12.	Hurting self (cutting or scratching self, taking pills)	0	1	2	3	4	5
13.	Talking or thinking about death	0	1	2	3	4	5
14.	Feeling worthless or useless	0	1	2	3	4	5
15.	Feeling lonely and having no friends	0	1	2	3	4	5
16.	Feeling anxious or fearful	0	1	2	3	4	5
17.	Worrying that something bad is going to happen	0	1	2	3	4	5
18.	Feeling sad or depressed	0	1	2	3	4	5
19.	Nightmares	0	1	2	3	4	5
20.	Eating problems	0	1	2	3	4	5

September 1999 (Worker-1)

(Add ratings together) Total _____

ROLES: Enter the number of days the youth was placed in each of the following settings during the past 90 days. (For example, the youth may have been in a detention center for 3 days, a group home for 7 days and with the biological mother for 80 days.)

_____	Jail	_____	Foster Care
_____	Juvenile Detention Center	_____	Supervised Independent Living
_____	Inpatient Psychiatric Hospital	_____	Home of a Family Friend
_____	Drug/Alcohol Rehabilitation Center	_____	Adoptive Home
_____	Medical Hospital	_____	Home of a Relative
_____	Residential Treatment	_____	School Dormitory
_____	Group Emergency Shelter	_____	Biological Father
_____	Residential Job Corp/Vocational Center	_____	Biological Mother
_____	Group Home	_____	Two Biological Parents
_____	Therapeutic Foster Care	_____	Independent Living with Friend
_____	Individual Home Emergency Shelter	_____	Independent Living by Self
_____	Specialized Foster Care	**90**	(***Total for the two columns should equal 90***)

Markers:	**Number in Past 90 Days**	
School Placement: _____	Arrests	_____
	Suspensions from school	_____
Current Psychoactive Medications: _____	Days in Detention	_____
	Days of School Missed	_____
_____	Self-Harm Attempts	_____

Instructions: Please circle the number corresponding to the designated youth's current level of functioning in each area.	**Extreme Troubles**	**Quite a Few Troubles**	**Some Troubles**	**OK**	**Doing Very Well**
1. Getting along with friends	0	1	2	3	4
2. Getting along with family	0	1	2	3	4
3. Dating or developing relationships with boyfriends or girlfriends	0	1	2	3	4
4. Getting along with adults outside the family (teachers, principal)	0	1	2	3	4
5. Keeping neat and clean, looking good	0	1	2	3	4
6. Caring for health needs and keeping good health habits (taking medicines or brushing teeth)	0	1	2	3	4
7. Controlling emotions and staying out of trouble	0	1	2	3	4
8. Being motivated and finishing products	0	1	2	3	4
9. Participating in hobbies (baseball cards, coins, stamps, art)	0	1	2	3	4
10. Participating in recreational activities (sports, swimming, bike riding)	0	1	2	3	4
11. Completing household chores (cleaning room, other chores)	0	1	2	3	4
12. Attending school and getting passing grades in school	0	1	2	3	4
13. Learning skills that will be useful for future jobs	0	1	2	3	4
14. Feeling good about self	0	1	2	3	4
15. Thinking clearly and making good decisions	0	1	2	3	4
16. Concentrating, paying attention, and completing tasks	0	1	2	3	4
17. Earning money and learning how to use money wisely	0	1	2	3	4
18. Doing things without supervision or restrictions	0	1	2	3	4
19. Accepting responsibility for actions	0	1	2	3	4
20. Ability to express feelings	0	1	2	3	4

(Add ratings together) Total _____