Document Description	Version No.
Clinical Guidance and Academic References for Psyomics Platform	**1.0**

psyomics

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Summary

All questionnaires implemented in the Psyomics Platform require completion of all mandatory fields before submission is possible. Individual scoring is calculated upon submission and displayed within the generated report. No partial submissions or manual scoring is permitted by the system.

- PTSD Checklist for DSM-5 (PCL-5)
- SCOFF
- Patient Health Questionnaire - 9 (PHQ-9)
- Generalised Anxiety Disorder - 7 (GAD-7)
- Social Phobia Inventory (SPIN)
- Panic Disorder Severity Scale (PDSS)
- Obsessive-Compulsive Inventory (OCI)
- Insomnia Severity Index (ISI)
- Alcohol Use Disorders Identification Test (AUDIT)
- Drug Abuse Screening Test (DAST)

Measure	Recommendations supporting the use of tool	Limitations of tool	Recommended cut-off
PTSD Checklist for DSM-5 (PCL-5)	Included within the NHS Talking Therapies for anxiety and depression Manual[1].	Focuses on subjective symptom reporting, does not include objective measures or functional impairment assessments.	31–33[2]

[1] NHS Talking Therapies. NHS Talking Therapies for anxiety and depression Manual (Formerly known as Improving Access to Psychological Therapies). (2018). Available at: https://www.england.nhs.uk/wp-content/uploads/2018/06/NHS-talking-therapies-manual-v7-1.pdf
[2] U.S. Department of Veteran Affairs, National Centre for PTSD. PTSD Checklist for DSM-5 (PCL-5). Available at: https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

		As a self-report tool, there is a risk of misreporting symptom presence and/or severity. Not suitable for use as a diagnostic tool. A comprehensive assessment by a clinician is needed for formal diagnosis.	
SCOFF	NICE recommends that a variety of assessment tools can be used to screen for eating disorders[3], and specifically mentions the SCOFF questionnaire. Included in NHS training[4].	Does not assess the complete range of disordered eating behaviors. As a self-report tool, there is a risk of misreporting symptom presence and/or severity. Not suitable for use as a diagnostic tool. A comprehensive assessment by a clinician is needed for formal diagnosis.	2[5]

[3] National Institute for Health and Care Excellence. How should I assess a person with a suspected eating disorder? (2024). Available at: https://cks.nice.org.uk/topics/eating-disorders/diagnosis/assessment/

[4] Oxfordshire Child and Adolescent Mental Health Service. Eating Disorders Spotting The Signs. Available at: https://www.southeastclinicalnetworks.nhs.uk/wp-content/uploads/2020/10/Session-4-Vickie-Kearney-Eating-Disorders.pdf

[5] Morgan JF, Reid F, Lacey JH. The SCOFF questionnaire: assessment of a new screening tool for eating disorders. BMJ. 1999;319(7223):1467-8. doi: 10.1136/bmj.319.7223.1467. Available at: https://www.bmj.com/content/319/7223/1467.long

Patient Health Questionnaire - 9 (PHQ-9)	Recommended for use by Royal College of General Practitioners[6] Recommended by NHS England - PHQ-9 is "used as the depression measure for all patients"[7] Included in the NHS Talking Therapies for anxiety and depression Manual[1] Recommended for use by the British Association of Counselling Professionals [8]	Does not assess functional impairment directly. As a self-report tool, there is a risk of misreporting symptom presence and/or severity. Not suitable for use as a diagnostic tool. A comprehensive assessment by a clinician is needed for formal diagnosis.	0–4: Minimal ≥5: Mild ≥10: Moderate ≥15: Moderately severe ≥20: Severe[9]
Generalised Anxiety Disorder - 7 (GAD-7)	Recommended for use by Royal College of General Practitioners[6] Recommended by the National Institute for Health and Care Excellence[10]	May not capture symptoms of other anxiety disorders such as social anxiety or panic disorder. As a self-report tool, there is a risk of misreporting symptom presence and/or severity.	0–4: Minimal ≥5: Mild ≥10: Moderate ≥15: Severe[10]

[6] Royal College of General Practitioners. Mental health toolkit. (2025). Available at: https://elearning.rcgp.org.uk/mod/book/tool/print/index.php?id=13115
[7] NHS England. Service information. Available at: https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/service-standards/
[8] British Association of Counselling professionals. Implementing routine outcome measures (ROMs) Research in practice. Available at: https://www.bacp.co.uk/events-and-resources/research/routine-outcome-measures/implementing-roms/
[9] Kroenke K, Spitzer RL, Williams JB, Löwe B. The Patient Health Questionnaire Somatic, Anxiety, and Depressive Symptom Scales: a systematic review. Gen Hosp Psychiatry. 2010;32(4):345-59. doi: 10.1016/j.genhosppsych.2010.03.006. Available at: https://www.sciencedirect.com/science/article/pii/S0163834310000563?via%3Dihub
[10] National Institute for Health and Care Excellence. Generalized anxiety disorder questionnaire. (2024). Available at: https://cks.nice.org.uk/topics/generalized-anxiety-disorder/diagnosis/generalized-anxiety-disorder-questionnaire/

	Included in the NHS Talking Therapies for anxiety and depression Manual[1]	Not suitable for use as a diagnostic tool. A comprehensive assessment by a clinician is needed for formal diagnosis.	
Social Phobia Inventory (SPIN)	Included in the NHS Talking Therapies for anxiety and depression Manual[1]	As a self-report tool, there is a risk of misreporting symptom presence and/or severity. Not suitable for use as a diagnostic tool. A comprehensive assessment by a clinician is needed for formal diagnosis.	19[11]

[11] Connor KM, Davidson JR, Churchill LE, Sherwood A, Foa E, Weisler RH. Psychometric properties of the Social Phobia Inventory (SPIN). New self-rating scale. Br J Psychiatry. 2000 Apr;176:379-86. doi: 10.1192/bjp. Available at: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/psychometric-properties-of-the-social-phobia-inventory-spin/9E4A3EE20D2B1A6C222CDB5807AC086A

Panic Disorder Severity Scale (PDSS)	Included in the NHS Talking Therapies for anxiety and depression Manual[1]	The PDSS does not assess comorbid conditions such as generalised anxiety or depression, which may influence overall symptom severity. As a self-report tool, there is a risk of misreporting symptom presence and/or severity. Not suitable for use as a diagnostic tool. A comprehensive assessment by a clinician is needed for formal diagnosis.	0–1: Normal 2-5: Borderline 6–9: Slightly ill 10-13: Moderately ill ≥14: Markedly ill[12]
Obsessive-Compulsive Inventory (OCI)	Included in the NHS Talking Therapies for anxiety and depression Manual[1]	Certain subscales may have limited utility due to being unable to capture routine collecting from hoarding. As a self-report tool, there is a risk of misreporting symptom presence and/or severity.	40[13]

[12] Furukawa TA, Katherine Shear M, Barlow DH, Gorman JM, Woods SW, Money R, Etschel E, Engel RR, Leucht S. Evidence-based guidelines for interpretation of the Panic Disorder Severity Scale. Depress Anxiety. 2009;26(10):922-9. doi: 10.1002/da.20532. Available at: https://onlinelibrary.wiley.com/doi/10.1002/da.20532

[13] National Collaborating Centre for Mental Health. The Improving Access to Psychological Therapies Manual Appendices and Helpful Resources. (2019). Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/iapt/nccmh-iapt-manual-appendices-helpful-resources-v2.pdf?sfvrsn=a607ef5_4

		Not suitable for use as a diagnostic tool. A comprehensive assessment by a clinician is needed for formal diagnosis.	
Insomnia Severity Index (ISI)	Recommended for use by NICE[14]	Focuses on subjective sleep difficulties and does not include objective measures. As a self-report tool, there is a risk of misreporting symptom presence and/or severity. Not suitable for use as a diagnostic tool. A comprehensive assessment by a clinician is needed for formal diagnosis.	8-14: Subclinical insomnia 15-21: Moderate insomnia 22-28: Severe insomnia[14]
Alcohol Use Disorders Identification Test (AUDIT)	Recommended for use by the Royal College of General Practitioners[6] Recommended for use by the UK Government Office for Health Improvement & Disparities[15]	As a self-report tool, there is a risk of misreporting symptom presence and/or severity. Not suitable for use as a diagnostic tool. A comprehensive assessment by a clinician is needed for formal diagnosis.	≥8: Hazardous drinking ≥16: Harmful drinking or possible dependence ≥20: Severe alcohol

[14] National Institute of Health and Care Excellence. (2024). How should I assess a person with suspected insomnia? Available at: https://cks.nice.org.uk/topics/insomnia/diagnosis/assessment/

[15] Office for Health Improvement & Disparities. Guidance on the 5 alcohol use screening tests. (2020). Available at: https://www.gov.uk/government/publications/alcohol-use-screening-tests/guidance-on-the-5-alcohol-use-screening-tests

			problems[16]
Drug Abuse Screening Test (DAST)	Recommended for use by Royal College of General Practitioners[6]	The DAST does not assess alcohol use disorder or risky drinking; separate tools like AUDIT are needed. Presence of psychiatric symptoms may lead to false positives in individuals with comorbid conditions such as anxiety or depression. As a self-report tool, there is a risk of misreporting symptom presence and/or severity. Not suitable for use as a diagnostic tool. A comprehensive assessment by a clinician is needed for formal diagnosis.	0: No problems reported 1–2: Low level of problems; monitor 3–5: Moderate level; further investigation warranted 6-8: Substantial level; suggests a severe drug problem requiring intervention 9-10: Severe level; suggests a severe drug problem requiring intervention[17]

[16] National Institute for Health and Care Excellence. How should I screen for problem drinking? (2023). Available at: https://cks.nice.org.uk/topics/alcohol-problem-drinking/diagnosis/how-to-screen/
[17] NIDA Clinical Trials Network. Drug Abuse Screening Test (DAST-10). Available at: https://cde.nida.nih.gov/sites/nida_cde/files/DrugAbuseScreeningTest_2014Mar24.pdf

Further information

PTSD Checklist for DSM-5 (PCL-5)

Overview

- **Purpose**: The PCL-5 is a 20-item self-report questionnaire designed to assess symptoms of post-traumatic stress disorder (PTSD) as defined by the DSM-5. It is used for screening, diagnosis, and monitoring symptom changes over time in individuals exposed to traumatic events[18].
- **Administration Time**: Approximately 5–10 minutes.
- **Target Population**: Adults aged 18 and older[18].
- **Source Paper**:
    - Blevins et al. (2015). The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and Initial Psychometric Evaluation. *Journal of Traumatic Stress*. DOI: 10.1002/jts.22059.
- **Recommendations supporting the use of tool:**
    - Included within the NHS Talking Therapies for anxiety and depression Manual[1].

Scoring information

- **Score Range**: Total scores range from 0 to 80 (20 items scored on a Likert scale from 0 = "Not at all" to 4 = "Extremely")[18].
- **Scoring Method**:
    - Sum the scores for all items to calculate the total score.
    - Symptom cluster scores can also be calculated for the four DSM-5 PTSD symptom clusters: intrusion (items 1–5), avoidance (items 6–7), negative alterations in cognition/mood (items 8–14), and arousal/reactivity (items 15–20)[2].
- **Reverse-Scored Items**: None.
- **Missing Data Handling**: Missing responses may invalidate scoring; complete data is generally required.

Clinical Interpretation

- **Cut-Off Scores**:

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[18] Blevins CA, Weathers FW, Davis MT, Witte TK, Domino JL. The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and Initial Psychometric Evaluation. J Trauma Stress. 2015 ;28(6):489-98. doi: 10.1002/jts.22059. Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1002/jts.22059?saml_referrer

  - A total score ≥31–33 is recommended for identifying probable PTSD in most populations[2], however, varied cut-offs are recommended for use in different populations and depending on the intended purpose[19].
- **Clinical Significance**:
  - A decrease of at least 10–20 points on the PCL-5 is considered clinically meaningful improvement during treatment monitoring[2].

Limitations and Considerations

- **Known Limitations**:
  - The PCL-5 focuses on subjective symptom reporting and does not include objective measures or functional impairment assessments.
  - As it is a self-report tool there is a risk of inadvertent or purposeful misreporting of symptom presence and/or severity which may compromise the reliability of the output.
  - Not suitable for use as a diagnostic tool; it should be used alongside structured clinical interviews or in conjunction with clinician training and knowledge for a comprehensive assessment or formal diagnosis.

SCOFF

Overview

- **Purpose**: The SCOFF is a 5-item self-report questionnaire designed to detect eating disorders (Anorexia nervosa and Bulimia nervosa)[20].
- **Administration Time**: Approximately 2 minutes[20].
- **Target Population**: Adults aged 18 and older[20].
- **Source Paper(s)**:
  - Morgan, J. F., Reid, F., Lacey, J.H. (1999). The SCOFF questionnaire: assessment of a new screening tool for eating disorders. BMJ, 319. 1467-1468.
  - Luck, A.J., Morgan, J.F., Reid, F., O'Brien, A., Brunton, J., Price, C., Perry, L., Lacey, J.H. (2002). The SCOFF questionnaire and clinical interview for eating disorders in general practice: comparative study. British Medical Journal, 325,7367, 755 - 756.

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[19] Blanchard EB, Jones-Alexander J, Buckley TC, Forneris CA. Psychometric properties of the PTSD Checklist (PCL). Behav Res Ther. 1996;34(8):669-73. doi: 10.1016/0005-7967(96)00033-2. Available at: https://www.sciencedirect.com/science/article/pii/0005796796000332?ref=pdf_download&fr=RR-7&rr=90db2b26d886cd7a

[20] Luck AJ, Morgan JF, Reid F, O'Brien A, Brunton J, Price C, Perry L, Lacey JH. The SCOFF questionnaire and clinical interview for eating disorders in general practice: comparative study. BMJ. 2002;325(7367):755-6. doi: 10.1136/bmj.325.7367.755. Available at: https://www.bmj.com/content/bmj/325/7367/755.full.pdf?casa_token=d_iOWaYerHoAAAAA:2-MkXyoMa2ewEMkecckSY145RqslHAlYqr_gKEiKts_nUmyMhVjyFVOkbDMeTl-KrSlQzv5ljBA

- **Recommendations supporting the use of tool:**
    - NICE recommends that a variety of assessment tools can be used to screen for eating disorders, and specifically mentions SCOFF[3].

Scoring information

- **Score Range**: Total scores range from 0 to 5, with each item rated as “Yes” or “No”[21]
- **Scoring Method**:
    - Sum the scores for all 5 items to calculate the total score.
    - A score of 2 or more suggests a likely case of Anorexia Nervosa or Bulimia Nervosa[21]
- **Reverse-Scored Items**: None.
- **Missing Data Handling**: Missing responses may invalidate scoring; complete data is generally required.

Clinical Interpretation

- **Cut-Off Scores**:
    - A total score ≥2 has been suggested as indicative of a likely eating disorder (Anorexia Nervosa or Bulimia Nervosa[21])
- **Clinical Significance**:
    - Changes in total score can be used to monitor symptom progression or treatment response over time.

Limitations and Considerations

- **Known Limitations**:
    - The SCOFF does not assess a full range of eating disorder behaviors (e.g., binge eating disorder).
    - As it is a self-report tool there is a risk of inadvertent or purposeful misreporting of symptom presence and/or severity which may compromise the reliability of the output.
    - Not suitable for use as a diagnostic tool; it should be used alongside structured clinical interviews or in conjunction with clinician training and knowledge for a comprehensive assessment or formal diagnosis.

Patient Health Questionnaire-9 (PHQ-9)

[21] Morgan JF, Reid F, Lacey JH. The SCOFF questionnaire: assessment of a new screening tool for eating disorders. BMJ. 1999 Dec 4;319(7223):1467-8. doi: 10.1136/bmj.319.7223.1467. Available at: https://www.bmj.com/content/319/7223/1467.long

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Overview

- **Purpose**: The PHQ-9 is a widely used self-report questionnaire designed to screen for, diagnose, and monitor the severity of depression based on Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. It assesses the frequency of depressive symptoms over the past two weeks[22].
- **Administration time**: Approximately 5 minutes
- **Target Population:** Intended use is in adults 18 and older[22]
- **Source Paper**:
    - Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. Journal of general internal medicine, 16(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x
- **Recommendations supporting the use of tool:**
    - Recommended for use by Royal College of General Practitioners[6]
    - Recommended by NHS England - PHQ-9 is “used as the depression measure for all patients”[7]
    - Included in the NHS Talking Therapies for anxiety and depression Manual[1]
    - Recommended for use by the British Association of Counselling Professionals[8]

Scoring information

- **Score Range**: Total scores range from 0 to 27 (9 items scored on a Likert scale from 0 = "Not at all" to 3 = "Nearly every day")[9].
- **Scoring Method**:
    - Sum the scores for all nine items to calculate the total score.
    - Scores can be categorized into severity levels: minimal (0–4), mild (5–9), moderate (10–14), moderately severe (15–19), and severe (20–27)[9].
- **Reverse-Scored Items**: None.
- **Missing Data Handling**: If one or two items are missing, completed questions can be averaged and used for missing scores[9]

Clinical Interpretation

- **Cut-Off Scores**:
    - A total score ≥10 is commonly used as a threshold for identifying clinically significant depressive symptoms in most populations[9].
- **Clinical Significance**:

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[22] Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep;16(9):606-13. doi: 10.1046/j.1525-1497.2001.016009606.x. Available at: https://link.springer.com/article/10.1046/j.1525-1497.2001.016009606.x

- A decrease of at least five points on the PHQ-9 is considered clinically meaningful improvement during treatment monitoring[23].

Limitations and Considerations

- **Known Limitations**:
  - The PHQ-9 does not assess functional impairment directly; additional tools are needed for comprehensive evaluation[24].
  - As it is a self-report tool there is a risk of inadvertent or purposeful misreporting of symptom presence and/or severity which may compromise the reliability of the output.
  - Not suitable for use as a diagnostic tool; it should be used alongside structured clinical interviews[24] or in conjunction with clinician training and knowledge for a comprehensive assessment or formal diagnosis.

Generalized Anxiety Disorder 7-Item Scale (GAD-7)

Overview

- **Purpose**: The GAD-7 is a brief self-report questionnaire designed to screen for and monitor the presence and severity of generalized anxiety disorder (GAD)[25]. It is also used to assess symptoms of other anxiety disorders[26].
- **Administration Time**: Approximately 5 minutes.
- **Target Population**: The GAD-7 was initially validated in a sample aged 18-95[25], and thus suitable for use in adults aged 18 and older.
- **Source Paper**:
  - Spitzer et al. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*. DOI: 10.1001/archinte.166.10.1092.

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[23] Kroenke K. Enhancing the clinical utility of depression screening. CMAJ. 2012 Feb 21;184(3):281-2. doi: 10.1503/cmaj.112004. Available at: https://www.cmaj.ca/content/184/3/281

[24] Teusen C, Hapfelmeier A, von Schrottenberg V, Gökce F, Pitschel-Walz G, Henningsen P, Gensichen J, Schneider A; POKAL-Study-Group. Combining the GP's assessment and the PHQ-9 questionnaire leads to more reliable and clinically relevant diagnoses in primary care. PLoS One. 2022 Oct 21;17(10):e0276534. doi: 10.1371/journal.pone.0276534. Available at: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0276534

[25] Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. doi: 10.1001/archinte.166.10.1092. Available at: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/410326

[26] Plummer F, Manea L, Trepel D, McMillan D. Screening for anxiety disorders with the GAD-7 and GAD-2: a systematic review and diagnostic metaanalysis. Gen Hosp Psychiatry. 2016;39:24-31. doi: 10.1016/j.genhosppsych.2015.11.005. Available at: https://www.sciencedirect.com/science/article/pii/S0163834315002406?casa_token=nhNu0qr04EkAAAAA:ssQQOWukMugLpGzZfSgZ8uoqRBZfQWotsuPK1cFklPyuIn5xKM01mI_w1O9EzZxvIlu0cseMsQ#s0040

- **Recommendations supporting the use of tool:**
    - Recommended for use by Royal College of General Practitioners[6]
    - Recommended by the National Institute for Health and Care Excellence[10]
    - Included in the NHS Talking Therapies for anxiety and depression Manual[1]

Scoring information

- **Score Range**: Total scores range from 0 to 21 (7 items scored on a Likert scale from 0 = "Not at all" to 3 = "Nearly every day").
- **Scoring Method**:
    - Sum the scores for all seven items to calculate the total score.
- **Reverse-Scored Items**: None.
- **Missing Data Handling**: If one or two items are missing, their average score can be imputed; otherwise, scoring may not be valid.

Clinical Interpretation

- **Cut-Off Scores**:
    - Scores can be categorized into severity levels: minimal (0–4), mild (5–9), moderate (10–14), and severe (15–21)[10].
- **Clinical Significance**:
    - A change of at least four points on the GAD-7 is considered a clinical relevant change in symptom severity[27].

Limitations and Considerations

- **Known Limitations**:
    - The GAD-7 focuses on generalized anxiety symptoms and may not fully capture symptoms of other anxiety disorders such as social anxiety or panic disorder.
    - As it is a self-report tool there is a risk of inadvertent or purposeful misreporting of symptom presence and/or severity which may compromise the reliability of the output.
    - Not suitable for use as a diagnostic tool; it should be used alongside structured clinical interviews or in conjunction with clinician training and knowledge for a comprehensive assessment or formal diagnosis.

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[27] Toussaint A, Hüsing P, Gumz A, Wingenfeld K, Härter M, Schramm E, Löwe B. Sensitivity to change and minimal clinically important difference of the 7-item Generalized Anxiety Disorder Questionnaire (GAD-7). J Affect Disord. 2020;265:395-401. doi: 10.1016/j.jad.2020.01.032. Available at: https://www.sciencedirect.com/science/article/pii/S0165032719313643?casa_token=5CwEPSI_Dj0AAAAA:1nYXKH1JdRbzbNYLa_m-eoMen1uGO3vFY1O9hHBhX9MncCRs3kDPq9MqMxf4sm5Hm7VxvzSUDg#sec0009

Social Phobia Inventory (SPIN)

Overview

- **Purpose**: The SPIN is a 17-item self-report questionnaire designed to assess the presence and severity of social anxiety disorder (SAD) symptoms, including fear, avoidance, and physiological distress in social situations.[11]
- **Administration Time**: Approximately 5–10 minutes.
- **Target Population**: Adults aged 18 and older, with the primary validation sample having a mean age ranging from 33 to 42.5[11].
- **Source Paper**:
    - Connor et al. (2000). Psychometric properties of the Social Phobia Inventory (SPIN). *British Journal of Psychiatry*. DOI: 10.1192/bjp.176.4.379
- **Recommendations supporting the use of tool:**
    - Included in the NHS Talking Therapies for anxiety and depression Manual[1]

Scoring information

- **Score Range**: Total scores range from 0 to 68 (17 items scored on a Likert scale from 0 = "Not at all" to 4 = "Extremely")[11].
- **Scoring Method**:
    - Sum the scores for all items to calculate the total score.
    - Higher scores indicate greater severity of social anxiety symptoms.
- **Reverse-Scored Items**: None.
- **Missing Data Handling**: Missing responses may invalidate scoring; complete data is generally required.

Clinical Interpretation

- **Cut-Off Scores**:
    - A total score ≥19 is commonly used as a threshold for identifying clinically significant social anxiety symptoms[11]
- **Clinical Significance**:
    - Changes in total score can be used to monitor symptom progression or response to treatment over time.

Limitations and Considerations

- **Known Limitations**:
    - The SPIN focuses on social anxiety symptoms and may not fully capture comorbid conditions such as generalized anxiety or depression.

- As it is a self-report tool there is a risk of inadvertent or purposeful misreporting of symptom presence and/or severity which may compromise the reliability of the output.
- Not suitable for use as a diagnostic tool; it should be used alongside structured clinical interviews or in conjunction with clinician training and knowledge for a comprehensive assessment or formal diagnosis.

Panic Disorder Severity Scale (PDSS)

Overview

- **Purpose**: The PDSS is a 7-item clinician-administered scale designed to detect and assess the severity of panic disorder (PD) symptoms, with or without agoraphobia, and to monitor treatment outcomes. A self-report version (PDSS-SR) is also available and widely used for similar purposes[28].
- **Administration Time**: Approximately 10 minutes for the clinician-administered version; slightly less for the self-report version.
- **Target Population**: Adults aged 18 and older. A different version of the PDSS has been evaluated for use in children and adolescents (PDSS-C)[29]
- **Source Paper(s)**:
  - Shear et al. (1997). Development and validation of a brief measure of panic disorder severity. *American Journal of Psychiatry*. DOI unavailable in sources.
  - Houck et al. (2002). Reliability of the self-report version of the panic disorder severity scale. *Depression and Anxiety.* DOI: 10.1002/da.10049
- **Recommendations supporting the use of tool:**
  - Included in the NHS Talking Therapies for anxiety and depression Manual[1]

Scoring information

- **Score Range**: Total scores range from 0 to 28 (7 items scored on a Likert scale from 0 = "None" to 4 = "Extreme").
- **Scoring Method**:
  - Sum the scores for all seven items to calculate the total score.
  - Higher scores indicate greater severity of panic disorder symptoms.
- **Reverse-Scored Items**: None.

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[28] Houck PR, Spiegel DA, Shear MK, Rucci P. Reliability of the self-report version of the panic disorder severity scale. Depress Anxiety. 2002;15(4):183-5. doi: 10.1002/da.10049. Available at: https://onlinelibrary.wiley.com/doi/10.1002/da.10049

[29] Elkins RM, Pincus DB, Comer JS. A psychometric evaluation of the panic disorder severity scale for children and adolescents. Psychol Assess. 2014;26(2):609-18. doi: 10.1037/a0035283. Available at: https://psycnet.apa.org/doiLanding?doi=10.1037%2Fa0035283

- **Missing Data Handling**: Missing responses may invalidate scoring; complete data is generally required.

Clinical Interpretation

- **Cut-Off Scores**[12]:
  - For individuals without agoraphobia:
    - Normal: 0–1
    - Borderline: 2–5
    - Slightly ill: 6–9
    - Moderately ill: 10–13
    - Markedly ill: ≥14
  - For individuals with agoraphobia:
    - Borderline ill: 3–7
    - Slightly ill: 8–10
    - Moderately ill: 11–15
    - Markedly ill: ≥16
- **Clinical Significance**:
  - A reduction of ≥40% in total score is considered a positive treatment response[12].
  - Remission is defined as a total score ≤5

Limitations and Considerations

- **Known Limitations**:
  - The PDSS-SR does not assess comorbid conditions such as generalized anxiety or depression, which may influence overall symptom severity.
  - As it is a self-report tool there is a risk of inadvertent or purposeful misreporting of symptom presence and/or severity which may compromise the reliability of the output.
  - Not suitable for use as a diagnostic tool; it should be used alongside structured clinical interviews or in conjunction with clinician training and knowledge for a comprehensive assessment or formal diagnosis.

Obsessive-Compulsive Inventory (OCI)

Overview

- **Purpose**: The OCI is a 42 item questionnaire developed to assess the presence and severity of obsessive-compulsive symptoms and behaviours across six domains: washing, checking, ordering, obsessing, hoarding, and mental neutralising. It is used for screening and monitoring symptom severity in individuals with obsessive-compulsive disorder (OCD).

- **Administration time**: 15-20 minutes
- **Target population**: Adults 18 and over.
- **Source paper**:
    - Foa, E. B., Kozak, M. J., Salkovskis, P. M., Coles, M. E., & Amir, N. (1998). The validation of a new obsessive-compulsive disorder scale: The obsessive-compulsive inventory. *Psychological Assessment*, *10*(3), 206–214. Scopus. https://doi.org/10.1037/1040-3590.10.3.206
- **Recommendations supporting the use of tool:**
    - Included in the NHS Talking Therapies for anxiety and depression Manual[1]
    - Evidence for use in both public and private healthcare settings[30].

Scoring information

- **Score Range**: Total scores range from 0 to 168 (42 items scored on a 5 point Likert scale from 0 = "Not at all" to 4 = "Extremely")[31].
- **Scoring Method**:
    - Sum the scores for all items to calculate the total score.
    - Subscale scores can be calculated by summing the items corresponding to each domain
    - In a typical OCI questionnaire, the following question items correspond to the each subscale
        - Washing (8 items): items 2, 4, 8, 21, 22, 27, 38, 42
        - Checking (9 items): items 3, 7, 9, 10, 19, 24, 31, 32, 40
        - Doubting (3 items): items 26, 37, 41
        - Ordering (5 items): items 14, 15, 23, 29, 35
        - Obsessions (8 items): items 1, 12, 13, 17, 20, 28, 30, 33
        - Hoarding (3 items): items 6, 11, 34
        - Neutralising (6 items): items 5, 16, 18, 25, 36, 39
    - Higher scores indicate greater severity of obsessive-compulsive symptoms
- **Reverse-Scored Items**: None.
- **Missing Data Handling**: Missing responses may invalidate scoring; complete data is generally required.

Clinical Interpretation

- **Cut-Off Scores**:

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[30] Dorset Healthcare NHS University Foundation Trust. Obsessive Compulsive Inventory (OCI). Available at: https://www.dorsethealthcare.nhs.uk/patients-and-visitors/our-services-hospitals/mental-health/adult-psychology-service/adult-psychology-one-one-therapy/obsessive-compulsive-inventor

[31] Foa EB, Kozak MJ, Salkovskis PM, Coles ME, Amir N. The validation of a new obsessive–compulsive disorder scale: The Obsessive–Compulsive Inventory. Psychological Assessment. 1998;10(3): 206–214. doi: 10.1037/1040-3590.10.3.206. Available at: https://psycnet.apa.org/record/1998-10845-002

    - 40 and above recommended for clinical cut-off in general as well as for use in IAPT services[13, 32]
- **Clinical Significance**:
    - Changes in total score can be used to monitor symptom progression or response to treatment over time.

Limitations and Considerations

- **Known Limitations**:
    - According to the original study using the OCI, the hoarding subscale may have limited utility due to being unable to capture routine collecting from hoarding.
    - As it is a self-report tool there is a risk of inadvertent or purposeful misreporting of symptom presence and/or severity which may compromise the reliability of the output.
    - Not suitable for use as a diagnostic tool; it should be used alongside structured clinical interviews or in conjunction with clinician training and knowledge for a comprehensive assessment or formal diagnosis.

Insomnia Severity Index (ISI)

Overview

- **Purpose**: The ISI is a 7-item self-report questionnaire designed to assess the severity of insomnia symptoms, including difficulty falling asleep, staying asleep, and waking too early. It is used for screening and monitoring treatment outcomes for insomnia.
- **Administration Time**: Approximately 5–10 minutes.
- **Target Population**: Initially validated in a sample of adults aged 17-84 across 2 studies [33].
- **Source Paper(s)**:
    - Morin, C.M. (1993). Insomnia : Psychological assessment and management. Guilford Press, New York.
    - Bastien CH, Vallières A, Morin CM. (2001). Validation of the Insomnia Severity Index as an outcome measure for insomnia research. Sleep Med. 2(4):297-307
- **Recommendations supporting the use of tool:**
    - Recommended for use by NICE[14]

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[32] Veale D, Lim FL, Nathan SL, Gledhill LJ. Sensitivity to change in the Obsessive Compulsive Inventory: Comparing the standard and revised versions in two cohorts of different severity. Journal of Obsessive-Compulsive and Related Disorders. 2016;9:16-23. Available at: https://www.sciencedirect.com/science/article/pii/S2211364916300045

[33] Bastien CH, Vallières A, Morin CM. Validation of the Insomnia Severity Index as an outcome measure for insomnia research. Sleep Med. 2001 Jul;2(4):297-307. doi: 10.1016/s1389-9457(00)00065-4. Available at: https://www.sciencedirect.com/science/article/pii/S1389945700000654?via%3Dihub#aep-section-id10

Scoring information

- **Score Range**: Total scores range from 0 to 28 (7 items scored on a Likert scale from 0 = "Not at all" to 4 = "Extremely")[34].
- **Scoring Method**:
    - Sum the scores for all seven items to calculate the total score.
    - Higher scores indicate greater severity of insomnia symptoms.
- **Reverse-Scored Items**: None.
- **Missing Data Handling**: Missing responses may invalidate scoring; complete data is generally required.

Clinical Interpretation

- **Cut-Off Scores**[34, 14]
    - Subthreshold insomnia: 8–14
    - Clinical insomnia (moderate severity): 15–21
    - Clinical insomnia (severe): ≥22
- **Clinical Significance**:
    - A reduction of 6 points or more is suggested as a clinically significant improvement of insomnia[35]

Limitations and Considerations

- **Known Limitations**:
    - The ISI focuses on subjective sleep difficulties and does not include objective measures such as actigraphy or polysomnography.
    - As it is a self-report tool there is a risk of inadvertent or purposeful misreporting of symptom presence and/or severity which may compromise the reliability of the output.
    - Not suitable for use as a diagnostic tool; it should be used alongside structured clinical interviews or in conjunction with clinician training and knowledge for a comprehensive assessment or formal diagnosis.

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[34] Morin CM, Belleville G, Bélanger L, Ivers H. The Insomnia Severity Index: psychometric indicators to detect insomnia cases and evaluate treatment response. Sleep. 2011 May 1;34(5):601-8. doi: 10.1093/sleep/34.5.601. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC3079939/#:~:text=Insomnia%20Severity%20Index%20(ISI),-The%20ISI%20is&text=The%20total%20score%20is%20interpreted,on%20the%20patient%20version%20only

[35] Yang M, Morin CM, Schaefer K, Wallenstein GV. Interpreting score differences in the Insomnia Severity Index: using health-related outcomes to define the minimally important difference. Curr Med Res Opin. 2009 Oct;25(10):2487-94. doi: 10.1185/03007990903167415. Available at: https://pubmed.ncbi.nlm.nih.gov/19689221/#:~:text=Odds%20ratios%20were%20derived%20from,of%20treatment%20interventions%20is%20needed

Alcohol Use Disorders Identification Test (AUDIT)

Overview

- **Purpose**: The AUDIT is a 10-item self-report questionnaire designed to screen for hazardous and harmful alcohol consumption, as well as potential alcohol use disorders (AUD). It is used for early identification of individuals at risk for alcohol-related problems and to guide intervention strategies.
- **Administration Time**: Approximately 2–5 minutes.
- **Target Population**: Adults aged 18–65 years across various settings[36]
- **Source Paper**:
    - Saunders, J. B., Aasland, O. G., Babor, T. F., de la Fuente, J. R., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption--II. *Addiction* (Abingdon, England), *88*(6), 791–804. https://doi.org/10.1111/j.1360-0443.1993.tb02093.x
- **Recommendations supporting the use of tool:**
    - Recommended for use by the Royal College of General Practitioners[6].
    - Recommended for use by the UK Government Office for Health Improvement & Disparities[15].

Scoring information

- **Score Range**: Total scores range from 0 to 40 (10 items scored on a Likert scale from 0 = "Never" to 4 = "Daily or almost daily")[37].
- **Scoring Method**:
    - Sum the scores for all items to calculate the total score.
    - Subscores can be calculated for three domains: hazardous use (items 1–3), dependence symptoms (items 4–6), and harmful alcohol use (items 7–10).
- **Reverse-Scored Items**: None.
- **Missing Data Handling**: Missing responses may invalidate scoring; complete data is generally required.

Clinical Interpretation

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[36]de Meneses-Gaya C, Zuardi AW, Loureiro SR, Crippa JAS. Alcohol Use Disorders Identification Test (AUDIT): An updated systematic review of psychometric properties. Psychology & Neuroscience. 2009;2(1): 83-97. doi: 10.3922/j.psns.2009.1.12. Available at: https://psycnet.apa.org/fulltext/2011-13717-012.pdf

[37] AUDIT Alcohol Use Disorder Identification Test. Scoring the AUDIT. Available at: https://auditscreen.org/about/scoring-audit

- **Cut-Off Scores**[38, 16]:
    - General population:
        - Hazardous drinking: ≥8
        - Harmful drinking or possible dependence: ≥16
        - Severe alcohol problems: ≥20
- **Clinical Significance**:
    - Changes in total score can be used to monitor symptom progression or response to treatment over time[15]

Limitations and Considerations

- **Known Limitations**:
    - The AUDIT may not fully capture binge-drinking patterns or cultural variations in alcohol use.
    - As it is a self-report tool there is a risk of inadvertent or purposeful misreporting of symptom presence and/or severity which may compromise the reliability of the output.
    - Not suitable for use as a diagnostic tool; it should be used alongside structured clinical interviews or in conjunction with clinician training and knowledge for a comprehensive assessment or formal diagnosis.

Drug Abuse Screening Test (DAST)

Overview

- **Purpose**: The DAST is a self-report screening tool designed to screen for drug use problems (excluding alcohol)[39] and identify individuals at risk of substance use disorders. “Drug use” as defined by the DAST refers to 1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.
- **Administration Time**: Approximately 5–10 minutes.
- **Target Population**: Adults aged 18 and older.
- **Source Paper(s)**:

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[38] Donovan DM, Kivlahan DR, Doyle SR, Longabaugh R, Greenfield SF. Concurrent validity of the Alcohol Use Disorders Identification Test (AUDIT) and AUDIT zones in defining levels of severity among out-patients with alcohol dependence in the COMBINE study. Addiction. 2006 Dec;101(12):1696-704. doi: 10.1111/j.1360-0443.2006.01606.x. Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1360-0443.2006.01606.x?sid=nlm%3Apubmed

[39] Skinner HA. The drug abuse screening test. Addict Behav. 1982;7(4):363-71. doi: 10.1016/0306-4603(82)90005-3. Available at: https://www.sciencedirect.com/science/article/pii/0306460382900053?via%3Dihub

  - Skinner (1982). The Drug Abuse Screening Test. *Addictive Behaviors*. doi: 10.1016/0306-4603(82)90005-3.
  - Yudko E, Lozhkina O, Fouts A (2007). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. J Subst Abuse Treatment. 32:189-198.
- **Recommendations supporting the use of tool:**
  - Recommended for use by Royal College of General Practitioners[6].

Scoring information

- **Score Range**: Total scores range from 0 to 10 for the DAST-10 version, with each item scored dichotomously (0 = "No," 1 = "Yes").
- **Scoring Method**:
  - Sum the scores for all items to calculate the total score.
  - Higher scores indicate greater severity of drug-related problems.
- **Reverse-Scored Items**: Question 3 is reversed scored with an answer of “No” receiving a score of 1.
- **Missing Data Handling**: Missing responses may invalidate scoring; complete data is generally required.

Clinical Interpretation

- **Cut-Off Scores**:
  - The cut-off scores for the DAST-10 are as follows[17]:
    - 0: No problems reported
    - 1–2: Low level of problems; monitor
    - 3–5: Moderate level; further investigation warranted
    - 6-8: Substantial level; suggests a severe drug problem requiring intervention
    - 9-10: Severe level; suggests a severe drug problem requiring intervention
- **Clinical Significance**:
  - Changes in total score can be used to monitor symptom progression or response to treatment over time.

Limitations and Considerations

- **Known Limitations**:
  - The DAST does not assess alcohol use disorder or risky drinking; separate tools like AUDIT are needed.
  - As it is a self-report tool there is a risk of inadvertent or purposeful misreporting of symptom presence and/or severity which may compromise the reliability of the output.

- Not suitable for use as a diagnostic tool; it should be used alongside structured clinical interviews or in conjunction with clinician training and knowledge for a comprehensive assessment or formal diagnosis.

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