Chapter 1

Peabody Treatment Progress Battery

(PTPB)

Introduction

The Peabody Treatment Progress Battery (PTPB) provides a cohesive, comprehensive, and evidence-based approach to enhancing mental health services for youths aged 11-18 years. The battery includes eleven clinically relevant measures of key mental health outcomes and clinical processes. The measures, especially with their repeated use, offer clinicians systematic feedback on their clients, both individually and in relation to other clients served. Such feedback provides rich clinical material for treatment planning, particularly for clients who are not improving as expected. As an integrated set of brief, reliable, and valid instruments, the PTPB battery can be administered efficiently and at low cost.

The PTPB is just one component of a feedback system known as Contextualized Feedback Systems® (CFSTM), developed by the Center for Evaluation and Program Improvement (CEPI) of Vanderbilt University’s Peabody College. (Bickman, Riemer, Breda, & Kelley, 2006). CFSTM, described in Chapter 15 of this manual, includes web-based training, data collection, and report functions.

The Concept of a Measurement Battery

In contrast to the typical single instrument, the PTPB is an integrated comprehensive set of measures not available elsewhere in the child and adolescent mental health field. Research clearly indicates that progress in treatment is multidimensional (Bickman, Karver, & Schut, 1997), and that feedback information is needed not only on traditional outcomes such as a reduction in symptoms, but also on the treatment process that mediate such outcomes. More than simply an outcome measurement system, the PTPB uses a common factors approach to the measurement of treatment processes (Karver, Handelsman, Fields, & Bickman, 2005). These common factors are elements not particular to any specific therapy (e.g., therapeutic alliance), but common across most therapies (Lambert, 2005), and are seen as largely responsible for the benefits of therapy. As common factors are not the specific ingredients of different therapies, they allow the PTPB to be used with almost any type of treatment or intervention.
Design of PTPB

The PTPB instruments are designed to be suitable for services research, but more importantly, to be useful in the working clinical environment. Research with clinicians indicates completion time is a major factor in determining the feasibility of measurement. The PTPB measures are brief and should take no more than five to eight minutes to complete each week, in accordance with the suggested schedule of administration (provided in Appendix A). However, there is a tradeoff between conciseness and depth. For example, the longest measure in the PTPB is the Symptoms and Functioning Severity Scale (SFSS-Full) with 26 items (27 for clinician version), including symptoms associated with the major categories of mental illness found in the American Psychological Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; 2000). While it is a useful indicator of global severity and internalizing and externalizing subscales, the SFSS-Full does not provide a diagnosis.

Because information needs vary with stage of treatment, the PTPB provides questionnaire sets for baseline or intake, concurrent with treatment, discharge and follow-up. These sets meet many of the criteria developed for the federal government of Australia (Bickman, Nurcombe, Townsend, Belle, Schut, & Karver, 1998): feasibility, comprehensiveness, flexibility, potential for improving clinical effectiveness, and psychometric soundness. The PTPB exemplifies what Kazdin (2005) calls evidence-based assessment, which includes feasible multiple measures of both outcomes and clinical processes that can be used over the course of treatment and that can be applied to several types of treatments and diverse problems.

**Feasibility**

Measures are feasible when they are applicable, acceptable, and practicable. Instruments should be easy to administer in clinical settings, and take little effort and time for respondents to complete. Little or no training should be required for administration, and the data yield should be easy to analyze and interpret. The PTPB instruments are designed to fit the needs of service providers and be acceptable to respondents.

**Comprehensiveness**

A measurement system should address the domains that stakeholders consider important. The assessment of only a single domain (e.g., symptoms) omits changes that occur in other domains of outcomes and clinical processes. In addition to comprehensive content, the measures should also represent the perspectives of different respondents. The PTPB instruments collect information from youths (11-18 years), caregivers and clinicians; a teacher and a child version of the SFSS are under development for inclusion in a future update, as is a treatment team member version of the TAQS.

**Flexibility**

A measurement system should be flexible. Service delivery organizations have different information needs that require diverse measures. The PTPB identifies critical core
elements of treatment progress (outcomes) and clinical process (common factors) that should be measured. The administration schedule depends on several factors including rapidity of change and type of respondent; however, frequent measurement concurrent with treatment is a key feature of the PTPB. The concurrent treatment questionnaire set features a staggered administration schedule. For example, depending on the domain being measured, some instruments are scheduled at two week intervals and others at two month intervals. Clinicians can modify the schedule based on their own clinical judgment or agency policy.

**Potential for improving clinical effectiveness**

A measurement system should provide information that enhances clinical effectiveness. The system should include ongoing monitoring that not only provides feedback on client progress but also helps to target aspects of the treatment process to be modified when progress is not satisfactory. The PTPB provides information relevant to ongoing clinical decision-making, treatment planning, and supervision.

**Psychometric soundness**

Regardless of its comprehensiveness and feasibility, the measurement system must be psychometrically sound—reliable, valid, and sensitive to the kind of change engendered by treatment. The instruments included in the PTPB have sufficient reliability and validity, and are designed to be sensitive to change. A description of the psychometric sample and test development procedures may be found in Chapter 2. The psychometric qualities for each instrument can be found in the individual test chapters that follow.

**Brief History of the PTPB Development**

Initial development of the symptoms and functioning measure (SFSS) began in 1996 by Bickman, Lambert and Summerfelt while consulting with a now defunct test development company. From 1997-2000 Bickman worked in Australia on measurement system development. A grant awarded by the Australian government resulted in the monograph, *Consumer Measurement System in Child and Adolescent Mental Health* (1998), which reviewed over 100 instruments and recommended a new measurement system be developed to meet psychometric and practice criteria. Research continued on a measure of adolescent functioning (Karver & Bickman, 2002) and on a measure of therapeutic alliance (Bickman, Vides de Andrade, Lambert, Doucette, Sapyta, & Boyd, 2004). In April 2004 the NIMH awarded a grant to Bickman on the use of feedback that included plans for instrument development (included in the first edition of the PTPB). The design and cognitive testing of the first edition PTPB measures took place from May 2004 to April 2005. Psychometric studies were conducted from May to September of 2005. Our collaborating partner on the psychometric study was a national social service agency that delivers home and community based services for youth and families.

Since the first version was issued, we have conducted extensive psychometric studies on a large sample of youth receiving home based services. The methodology followed as
described in chapter 2. One of the measures used in this battery (the Youth Counseling Impact Scale) has been recently published in the premier measurement journal, *Psychological Assessment* (Riemer & Kearns, 2010). The methodology used to assess the psychometric properties of that measure was used for all the other measures in the battery, thus assuring that the highest standards were followed in our measurement development process. The 2010 edition also introduces into the PTPB the Session Report Form (SRF), a session-by-session measure capturing the content and topics of clinical sessions (Kelley, Vides de Andrade, Sheffer & Bickman, 2010). Subsequently, each PTPB measure was featured in a 2012 Jan/March special issue for youth mental health measurement in the peer-reviewed journal *Administration and Policy in Mental Health and Mental Health Services Research*. The articles included in this special issue are listed below:

- The Peabody Treatment Progress Battery: History and methods for developing a comprehensive measurement battery for youth mental health (Riemer, Athay, Bickman, Breda, Kelley, & Vides de Andrade, 2012)
- The Symptoms and Functioning Severity Scale (SFSS): Psychometric evaluation and discrepancies among youth, caregiver, and clinician ratings over time (Athay, Riemer, & Bickman, 2012)
- Satisfaction with Life Scale (SWLS) in Caregivers of Clinically-Referred Youth: Psychometric Properties and Mediation Analysis (Athay, 2012)
- Measurement Quality of the Caregiver Strain Questionnaire-Short Form 7 (CGSQ-SF7; Brannan, Athay, & Vides de Andrade, 2012)
- Validation and Use of the Children’s Hope Scale- Revised PTPB Edition (CHS-PTPB): High Initial Youth Hope and Elevated Baseline Symptomatology Predict Poor Treatment Outcomes (Dew-Reeves, Athay, & Kelley, 2012)
- Development and Psychometric Evaluation of the Youth and Caregiver Service Satisfaction Scale (Athay & Bickman, 2012)
- The Relationship Between Change in Therapeutic Alliance Ratings and Improvement in Youth Symptom Severity: Whose ratings matter the most? (Bickman, Vides de Andrade, Athay, Chen, De Nadai, Jordan-Arthur, & Karver, 2012)
- Validation and Use of the Youth and Caregiver Treatment Outcome Expectations Scale (TOES) to Assess the Relationships between Expectations, Pretreatment Characteristics, and Outcomes (Dew-Reeves & Athay, 2012)
- Measuring Youths’ Perceptions of Counseling Impact: Description, Psychometric Evaluation, and Longitudinal Examination of the Youth Counseling Impact Scale v.2 (Kearns, Athay & Riemer, 2012)
- Motivation for Youth’s Treatment Scale (MYTS): A New Tool for Measuring Motivation among Youths and Their Caregivers (Breda & Riemer, 2012)
• The Session Report Form (SRF): Are Clinicians Addressing Concerns Reported by Youth and Caregivers? (Kelley, Vides de Andrade, Bickman, & Robin, 2012)

Intended Population

The PTPB is intended for use with youth aged 11 to 18 years, in varied service settings and clinical programs, including outpatient care, in-home treatment, and foster care. Intensity of treatment can range from multiple sessions within a week to biweekly treatment. The PTPB has not been tested for use in more restrictive service settings such as residential or inpatient treatment. All of the measures are currently available in English or Spanish, and are written at a fourth-grade reading level. The instruments can be completed individually by the respondent or, if needed, read aloud to a youth or adult caregiver. Plans are underway to extend the PTPB for younger child and adult populations, and in other languages.

Measures in the Peabody Treatment Progress Battery

The PTPB contains 11 instruments measuring both therapeutic processes and outcomes, including positive or strength-oriented outcomes (e.g., hope) and more traditional measures of problems. The treatment process instruments measure constructs that correlate with outcomes.

1. Symptoms and Functioning Severity Scale (SFSS)

Completed by the youth, adult caregiver and clinician, the SFSS is given at baseline, every (or every other) week throughout treatment, and at discharge. The SFSS is best considered a global measure of severity and is not an instrument that can be used to provide a diagnosis. Items are based on four of the most common mental health disorders for youth: ADHD, conduct/oppositional disorder, depression, and anxiety. There are parallel forms (Short Forms A and B) for the clinician, youth, and adult caregiver, each containing 13 items. An additional item is in the clinician version only that asks about youth self-harm. There are also parallel versions of the SFSS that include items in Short Forms A and B (SFSS-Full: 26 items for youths and caregivers; 27 items for clinicians). For all forms of the SFSS, items about alcohol use, drug use, and self-harm are not included in scale scores. Scores are reported as a total score, with two subscale scores (internalizing and externalizing). See Chapter 4 for more information on the SFSS.

2. Brief Multidimensional Students’ Life Satisfaction Scale – PTPB Version (BMSLSS-PTPB)

Completed by youth, the BMSLSS-PTPB assesses life satisfaction across five dimensions. This short questionnaire (6 items) is administered on the same schedule as the SFSS, and yields a total score. The PTPB version represents a revised version of the BMSLSS (Seligson, Huebner, & Valois, 2003). See Chapter 5 for more information on the BMSLSS-PTPB.
3. **Children’s Hope Scale-PTPB Version (CHS-PTPB)**

A self-report assessment of the youth’s beliefs in the ability to achieve goals, the CHS-PTPB also registers beliefs about initiating and sustaining movement toward these goals (4 items). Adapted from Snyder et al.’s Children’s Hope Scale (CHS; 1997) the CHS-PTPB provides a total score of youth hope, and is administered at baseline, once a month or at least every two months during treatment, and at discharge. See Chapter 6 for more information on the CHS-PTPB.

4. **Treatment Outcome Expectations Scale (TOES)**

The TOES (8 items) assess youths’ and adult caregivers’ expectations about the anticipated outcomes of treatment. Completed by the youth and the adult caregiver, the TOES provides a total score, and is administered at baseline only. It may be accompanied by the Treatment Process Expectations Index (TPEI), an additional list of nine recommended questions that assess youth and caregiver expectations about their role in counseling and the counseling process itself. See Chapter 7 for more information on the TOES and the TPEI.

5. **Therapeutic Alliance Quality Scale (TAQS) and Therapeutic Alliance Quality Rating (TAQR)**

The Therapeutic Alliance Quality Scale (TAQS) for youth measures one of the most studied components of effective therapy, the client’s relationship with the clinician. The youth version asks five questions concerning the bond the youth has with the clinician and agreement on goals and tasks. The TAQS provides a total score. The Therapeutic Alliance Quality Rating (TAQR) has a clinician and caregiver version that includes global items on alliance. The Caregiver version includes two items and the clinician version includes four items and serves to orient the clinician when reviewing the youth and adult caregiver versions of the TAQS/TAQR respectively. The TAQR is not a scale thus no summary score is provided. The TAQS and TAQR are completed every week throughout concurrent treatment. See Chapter 8 for more information about the TAQS and TAQR.

6. **Youth Counseling Impact Scale (YCIS v.2)**

A self-report questionnaire, the YCIS assesses the youth’s judgments of the short-term positive impact of counseling in regard to increased insight as well as positive changes in behavior, cognition or affect following the previous session (6 items). The YCIS v.2 provides a total score and subscale scores for insight and change. This measure is administered every two weeks or at least once per month during treatment. See Chapter 9 for more information about the YCIS v.2.

7. **Motivation for Youth’s Treatment Scale (MYTS)**

The MYTS assesses treatment motivation, a key predictor of seeking and staying in services, as well as of treatment outcomes. There are versions for the youth and adult caregiver (8 items each). Both provide a total score, with subscale scores for problem recognition and treatment readiness. There is a slightly different version for use at baseline and during the treatment phase; an item is re-worded so that it is appropriate for each time frame. See Chapter 10 for more information about the MYTS.
8. **Satisfaction with Life Scale (SWLS)**\(^2\)

A short instrument, the SWLS (Pavot & Diener, 1993) is completed by adult caregivers to measure their global judgments of life satisfaction. This five item questionnaire yields a total score, and has the same schedule as the caregiver strain measure. The SWLS is administered at baseline, once a month or at least every two months during concurrent treatment, and at discharge. See Chapter 11 for more information about the SWLS.

9. **Caregiver Strain Questionnaire–Short Form**\(^7\) (CGSQ-SF7)

The CGSQ-RvSF assesses the extent to which caregivers and families experience additional demands, responsibilities, and difficulties resulting from caring for a child with emotional or behavioral disorders. Components of caregiver strain include objective strain (i.e., observable negative consequences of caring for someone with special needs) and subjective strain (i.e., caregivers’ feelings associated with the objective strain). The CGSQ-SF7 represents a revised version of the CGSQ-SF10 (first edition of the PTPB), reduced in size from 10 items to 7 items for inclusion in this edition of the PTPB. This questionnaire provides a total score and two subscale scores, objective strain and subjective strain. It is completed by adult caregivers at baseline, once per month during treatment, and at discharge. See Chapter 12 for more information about the CGSQ-SF7.

10. **Service Satisfaction Scale (SSS)**

The SSS provides a general indicator of how well youth and adult caregivers perceive the mental health organization’s services (5 items). The SSS yields a total score, and is completed every two months during concurrent treatment, and at discharge. See Chapter 13 for more information about the SSS.

11. **Session Report Form (SRF)**

The SRF is a 25-item self-report measure completed by the clinician at the end of each clinical session intended to capture the session content and topics addressed in each treatment session. The SRF is completed every session during treatment and discharge. See Chapter 14 for more information about the SRF.

**Qualified Users of the PTPB**

**Qualifications**

Clinical users of the PTPB include mental health practitioners and accredited mental health service provider organizations with state or federal license to practice in their jurisdiction. To date, over 1300 individuals have registered to download the PTPB since it was first published in 2007.

**Safeguards**

All clinical users must safeguard client privacy at levels equal to or better than HIPAA requirements for protected health information (PHI). If identifiable client data are stored on computers, the computer system must meet or exceed HIPAA standards for electronic

\(^2\) The Satisfaction with Life Scale is in the public domain (http://s.psych.uiuc.edu/~ediener/hottopic/hottopic.html).
protected health information (EPCI). Completed testing forms and client data must remain in the secure control of licensed healthcare providers (individuals or organizations) for as long as they contain any identifiable client information.

References


