CBITS Clinical Assessments: Post Group Assessments

Instructions: Complete the following 3 assessments and the summary page for each child.

Post Group Tools:

1. Child PTSD Symptom Scale (CPSS)
2. Youth Ohio Scales (Ohio)
3. Youth Services Survey for Families (Y-SSF) [Caregiver]

Client Initials: _____

Client ID:_____

Client Date of Birth: ___/____/____

Post Group Results
Summary

Please attach the 3 post group assessments to this cover page.

A. Child PTSD Symptom Scale (CPSS)

Total Score (addition of responses to all 17 questions on CPSS) = _____

(Note: minimum of 0 and maximum of 51)

B. Ohio Scale – Problems:

Total Score (addition of responses to all 20 questions of A. Child Problem Severity) = _____

(Note: minimum of 0 and maximum of 100)

C. Ohio Scale – Functioning:

Total Score (addition of responses to all 20 questions of B. Child Functioning) = _____

(Note: minimum of 0 and maximum of 80)

D. Youth Services Survey for Families (Y-SSF):
Total Score for General Satisfaction = _____
(addition of responses to question numbers: 1, 4, 5, 7, 10, 11)

Next Steps: Complete the discharge form for each child.

Notes:

Client Initials: _____

Date of Completion: ___/____/____

Client ID:_____

Assessment Not Completed Reason:

Client Date of Birth: ___/____/____

□Too young
□Developmental delay
□Other:_____

The Child PTSD Symptom Scale (CPSS)

Below is a list of problems that kids sometimes have after experiencing an upsetting event. Read each statement below carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE LAST 2 WEEKS.

0	1	2	3
Not at all or only one time	Once a week or less/once in a while	2 to 4 times a week/ half of the time	5 or more times a week/ almost always

1.Having upsetting thoughts or images about the event that came into your head when you didn't want them to	0	1	2	3
2. Having bad dreams or nightmares	0	1	2	3
3. Acting or feeling as if the event was happening again (hearing something or seeing a picture about it and feeling as if you are there again)	0	1	2	3
4. Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc.)	0	1	2	3
5. Having feelings in your body when thinking about or hearing about the event (for example, breaking out into a sweat, heart beating fast)	0	1	2	3
6. Trying not to think about, talk about, or have feelings about the event	0	1	2	3
7. Trying to avoid activities, people, or places that remind you of the event	0	1	2	3
8. Not being able to remember an important part of the upsetting event	0	1	2	3
9. Having much less interest or doing things you used to do	0	1	2	3
10. Not feeling close to people around you	0	1	2	3
11. Not being able to have strong feelings (for example, being unable to cry or unable to feel happy)	0	1	2	3
12. Feeling as if your future plans or hopes will not come true (for example, not having a job or getting married or having kids)	0	1	2	3
13. Having trouble falling or staying asleep	0	1	2	3
14. Feeling irritable or having fits of anger	0	1	2	3
15. Having trouble concentrating (for example, losing track of a story on the television, forgetting what you read, not paying	0	1	2	3
16. Being overly careful (for example, checking to see who and what is around you)	0	1	2	3
17. Being jumpy or easily startled (for example, when someone walks up behind you)	0	1	2	3

(Add ratings together) Total _____

Adapted from Foa, E.B., Johnson, K.M., Feeny, N.C., & Treadwell, K.R.H. (2001). The child PTSD symptom scale (CPSS).

Client Initials: _____

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Ohio Mental Health Consumer Outcomes System
Ohio Youth Problem and Functioning Scales

Youth Rating – Short Form (Ages 12-18)

Y

A. Problem Scale

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

(Add ratings together) Total _____

Continue on next page →

Client Initials: _____

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B. Functioning Scale

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 projects	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 _____

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YOUTH SERVICES SURVEY FOR FAMILIES (YSS-F) *Note: select one answer for each question*				
We are interested in learning about how you feel about the care that your child or adolescent received recently. For each question circle the response that best describes your experience with the CBITS services. Your answers will have no effect on the services you receive now or in the future.				
1. Overall, I am satisfied with the services my child received				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
2. I helped to choose my child's services				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
3. I helped to choose my child's treatment goals				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
4. The people helping my child stuck with us no matter what				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
5. I felt my child had someone to talk to when he/she was troubled				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
6. I participated in my child's treatment				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
7. The services my child and/or family received were right for us				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
8. The location of services was convenient for us				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
9. Services were available at times that were convenient for us				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
10. My family got the help we wanted for my child				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
11. My family got as much help as we needed for my child				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
12. Staff treated me with respect				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
13. Staff respected my family's religious/spiritual beliefs				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
14. Staff spoke with me in a way that I understood				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
15. Staff were sensitive to my cultural/ethnic background				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree

Client Initials: _____

Date of Completion: ___/____/____

Client ID:_____

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As a result of the services my child and/or family received,				
16. My child is better at handling daily life				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
17. My child gets along better with family members				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
18. My child gets along better with friends and other people				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
19. My child is doing better in school				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
20. My child is better able to cope when things go wrong				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
21. I am satisfied with our family life right now				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
For Questions 22-26, please answer for relationships with persons other than the mental health provider				
22. As a result of the services my child and/or family received, my child is better able to do things he or she wants to do				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
23. As a result of the services my child and/or family received, I know people who will listen and understand me when I need to talk				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
24. As a result of the services my child and/or family received, I have people that I am comfortable talking with about my child's problems				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
25. As a result of the services my child and/or family received, in a crisis I would have the support I need from Family or friends				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree
26. As a result of the services my child and/or family received, I have people with whom I can do enjoyable things				
1-Strongly Disagree	2-Disagree	3-Undecided	4-Agree	5-Strongly Agree

Adapted from: SE Riley, AJ Stromberg, J Clark. Assessing Parental Satisfaction with Children's Mental Health Services with the Youth Services Survey for Families.

Journal of Child and Family Studies, 2005.