

Measurement-Based Care (MBC) Training Curriculum
For Psychiatry Residency Programs

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IMPORTANT NOTE: This is the summary of MBC training curriculum designed for implementation in psychiatry residency training programs and is published Innovations in Clinical Neuroscience journal:

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1. Introduction

- a. Measurement-based care (MBC) is the systematic administration of symptom rating scales and the use of results to drive clinical decision making at the level of the individual patient (1).
- b. Measurement-based care (MBC) has been out-of-reach for practicing psychiatrists and clinicians for decades (2-6).
- c. Recent research shows the superiority of MBC compared to usual standard care (USC) in improving patient outcomes (1, 2, 7, 8). A recent, blind-rater and randomized trial by Guo et al. (2015) showed that MBC is more effective than USC both in achieving response and remission and reducing the time to response and remission (9).
- d. The Standard for Clinicians' Interview in Psychiatry (SCIP) was developed as a measurement-based care tool for clinicians' use (10-14). The SCIP is the only instrument that includes 18 clinician-administered (CA) scales and 15 self-administered (SA) scales covering most adult symptom domains: generalized anxiety, obsessions, compulsions, posttraumatic stress, depression, mania, delusions, hallucinations, disorganized thoughts, aggression, negative symptoms, alcohol use, drug use, attention deficit, hyperactivity, anorexia, binge-eating, and bulimia. The SCIP rating scales meet the criteria for MBC because they are efficient, reliable, and valid. They also reflect the clinical decision-making process by which clinicians assess psychiatric disorders (15). **The SCIP is the**

only existing tool that allows for the comprehensive implementation of MBC in adult psychiatric practice.

- e. Psychiatry residency training offers a unique opportunity to enhance knowledge and promote the eventual adoption of MBC (2). If we teach residents MBC while they are in training and require them to implement MBC with their patients, they will be more likely to practice MBC for the rest of their careers.

- f. In addition to using the SCIP scales, psychiatry residents will have the opportunity to use other clinically useful scales with good psychometric properties such as the Patient Health Questionnaire (PHQ-9), the Standardized Assessment of Personality –Abbreviated Scale (SAPAS), the Mini-Mental State Exam (MMSE), the Clinically Useful Depression Outcome Scale (CUDOS), the Clinically Useful Anxiety Outcome Scale (CUXOS), and other scales (16-20).

2. Principles of Using the MBC Scales in Psychiatry Residency Training

1. Clinicians (attending and psychiatry residents) will use the scales with all appropriate patients with the goal of improving patient care. **No Institutional Review Board (IRB) approval or consent is necessary.**
2. Clinicians can choose to use the scales with patients who will benefit from them. Patients who tend to exaggerate or minimize symptoms or who are especially uncooperative may not benefit from using the scales.
3. Residents will make every effort to use the scales when time and opportunity permit. **In certain busy rotations and emergency situations, residents may not have time to use the scales.**
4. General guidelines for the timing and frequency of scale use with various diagnoses are outlined below. Clinicians may decide on the timing and frequency of scale use during patient encounters in outpatient, day hospital, or inpatient settings. **Scale use is therefore individualized.**
5. **Only self-administered scales will be used in outpatient settings due to time limitations.** The patient may complete the self-administered scale while he/she is in the waiting area. The resident can also give the scale to the patient in the office to complete while the resident is discussing the case with the attending. In both situations, the resident will not spend extra time administering the scales. The patient's completed self-administered scales will be available for the resident to use in clinical decisions pertaining to the patient.

6. Clinicians should use their skills of rapport-building, empathy, and flexibility in order to avoid the appearance of a rigid interview.

IMPORTANT NOTE: DO NOT SCHEDULE PATIENTS JUST FOR THE SAKE OF ADMINISTERING A SCALE. SCALE ADMINISTRATION SHOULD FOLLOW THE USUAL SCHEDULES OF THE PATIENTS AND SHOULD NOT INCREASE THE FREQUENCY OF THE PATIENTS' VISITS.

3. Implementation of MBC in Psychiatry Residency

The MBC curriculum implementation in psychiatry residency programs comprises three components: MBC didactics, MBC scale practice, and the completion of a web-based MBC course.

A. MBC Didactics:

MBC didactics are taught by faculty members and attendings who are experienced MBC trainers, or by newly-trained attendings who have completed the web-based MBC course.

- First-year residents receive Didactic Lecture #1 (MBC Basics) and Didactic Lecture #2 (Assessment of Psychopathology).

- Second-year residents receive Didactic Lecture #3 (Epidemiological Concepts) and Didactic Lecture #4 (Psychiatric Measures). Alternatively, these lectures can be given to third-year residents.

- Fourth-year residents usually do electives and see patients in various settings (inpatients, day hospitals, and outpatients). They should use the scales more frequently with appropriate patients when time permits.

B. MBC Scale Practice:

During inpatient rotations, residents practice scales with two patients per one-month rotation in units such as adult and dual-diagnosis units. In outpatient rotations, residents select two appropriate patients per month to complete the self-administered scales.

C. Completion of the Web-Based MBC Course:

I have developed the first comprehensive MBC training web course through the West Virginia University (WVU) Continuing Medical Education (CME) office. This course is offered for free, and trainees who complete it are awarded an MBC training certificate at no cost. All psychiatry residents must complete the web-based MBC course before graduation. The course can be accessed through the following link: (<https://ce.wvu.edu/web-course-list/mbc-training/>).

The primary goal of MBC implementation in residency is to teach residents the principles of MBC and provide opportunities to practice scales when they have the time and appropriate patients. The hope is that, upon completing their residency and starting their careers, MBC will be an integral part of their comprehensive patient assessment and care.

4. Guidelines for Timing and Frequency of Using the MBC Scales

Diagnosis	Scale(s)	When to administer the scale(s):
Generalized anxiety	SCIP anxiety scale	<p><u>Outpatient Setting (Self-Administered Scales):</u></p> <ol style="list-style-type: none"> 1. Baseline or first assessment opportunity. 2. Every 6 months. 3. Each time the patient starts a new anti-anxiety medication. 4. Repeat 6-8 weeks from starting a new anti-anxiety medication. Typically, that will be the next outpatient scheduled visit. 5. When there is a change in mental status or the clinician thinks there is a need to repeat the anxiety scale.
Major depression	SCIP depression scale	<p><u>Outpatient Setting (Self-Administered Scales):</u></p> <ol style="list-style-type: none"> 1. Baseline or first assessment opportunity. 2. Every 6 months. 3. Each time the patient starts a new antidepressant. 4. Repeat 6-8 weeks from starting a new anti-depressant medication. Typically, that will be the next outpatient scheduled visit. 5. When there is a change in mental status or the clinician thinks there is a need to repeat the depression scale. <p><u>Inpatient or Day Hospital Setting:</u></p> <ol style="list-style-type: none"> 1. Upon admission to inpatient or day hospital. 2. Upon discharge from inpatient or day hospital.

Bipolar disorder	SCIP mania scale	<p><u>Outpatient Setting (Self-Administered Scales):</u></p> <ol style="list-style-type: none"> 1. Baseline or first assessment opportunity. 2. Every 6 months. 3. Each time the patient starts a mood stabilizer. 4. Repeat 6-8 weeks from starting a new mood stabilizer. Typically, that will be the next outpatient scheduled visit. 5. When there is a change in mental status or the clinician thinks there is a need to repeat the mania scale. <p><u>Inpatient or Day Hospital Setting:</u></p> <ol style="list-style-type: none"> 1. Upon admission to inpatient or day hospital. 2. Upon discharge from inpatient or day hospital.
Obsessive compulsive disorder (OCD)	SCIP OCD scale	<p><u>Outpatient Setting (Self-Administered Scales):</u></p> <ol style="list-style-type: none"> 1. Baseline or first assessment opportunity. 2. Every 6 months. 3. Each time the patient starts a new medication for OCD. 4. Repeat 6-8 weeks from starting a new medication for OCD. Typically, that will be the next outpatient scheduled visit. 5. When there is a change in mental status or the clinician thinks there is a need to repeat the OCD scale.
Posttraumatic stress disorder (PTSD)	SCIP PTSD scale	<p><u>Outpatient Setting (Self-Administered Scales):</u></p> <ol style="list-style-type: none"> 1. Baseline or first assessment opportunity. 2. Every 6 months. 3. Each time the patient starts a new medication for PTSD. 4. Repeat 6-8 weeks from starting a new medication for PTSD. Typically, that will be the next outpatient scheduled visit. 5. When there is a change in mental status or the clinician thinks there is a need to repeat the PTSD scale.

<p>Schizophrenia</p>	<p>Three core schizophrenia scales:</p> <p>1. SCIP delusions scale 2. SCIP hallucinations scale 3. SCIP disorganizations scale</p> <p>Other scales used in schizophrenia:</p> <p>1. SCIP negative scale 2. SCIP aggression scale</p>	<p><u>Outpatient Setting (Self-Administered Scales):</u></p> <p>Administer the 3 core schizophrenia scales:</p> <ol style="list-style-type: none"> 1. Baseline or at first assessment opportunity. 2. Every 6 months. 3. Each time the patient starts a new antipsychotic medication. 4. Repeat 6-8 weeks from starting a new antipsychotic medication. Typically, that will be the next outpatient scheduled visit. 5. When there is a change in mental status or the clinician thinks there is a need to repeat the schizophrenia scales. <p><u>Inpatient or Day Hospital Setting:</u></p> <ol style="list-style-type: none"> 1. Administer the 3 core schizophrenia scales upon admission to inpatient or day hospital. 2. Administer the 3 core schizophrenia scales upon discharge from inpatient or day hospital. <p>Administering the SCIP negative scale and the SCIP aggression scale:</p> <ol style="list-style-type: none"> 1. Baseline or first assessment opportunity (inpatient, day hospital or outpatient setting). 2. Every 6 months or if clinically indicated (inpatient, day hospital or outpatient setting).
<p>Schizoaffective disorder, depressed type</p>	<p>SCIP depression scale</p>	<ol style="list-style-type: none"> 1. Follow schizophrenia guidelines. 2. Use depression scale as clinically indicated.
<p>Schizoaffective disorder, bipolar type</p>	<p>SCIP mania scale</p>	<ol style="list-style-type: none"> 1. Follow schizophrenia guidelines. 2. Use mania scale as clinically indicated.

Diagnosis	Scale(s)	When to administer the scale(s):
Alcohol use disorder	SCIP alcohol scale	<ol style="list-style-type: none"> 1. Once as a baseline (inpatient, day hospital or outpatient setting). 2. Repeat alcohol scale if clinically indicated (inpatient, day hospital or outpatient setting).
Drug use disorder	SCIP drug scale	<ol style="list-style-type: none"> 1. Once as a baseline (inpatient, day hospital or outpatient setting). 2. Repeat drug scale if clinically indicated (inpatient, day hospital or outpatient setting).
Attention Deficit Hyperactivity disorder (ADHD)	SCIP ADHD scale	<p><u>Outpatient Setting (Self-Administered Scales):</u></p> <ol style="list-style-type: none"> 1. Once as a baseline. 2. Repeat every 6 months. 3. One time when the patient starts a new medication for ADHD. 4. Repeat 6-8 weeks from starting a new medication for ADHD. Typically, that will be the next outpatient scheduled visit. 5. One time when there is a change in mental status or the clinician thinks there is a need to repeat the ADHD scale.
Eating disorders	SCIP anorexia, binge-eating and bulimia scales	<p><u>Outpatient Setting (Self-Administered Scales):</u></p> <ol style="list-style-type: none"> 1. Once as a baseline. 2. Repeat every 6 months. 3. One time when there is a change in mental status or the clinician thinks there is a need to repeat the eating disorders scales.
Other scales	e.g. PHQ-9	Scales will be used as clinically indicated.

5. Principles of rating symptoms and signs of mental disorders

Coding Symptoms of Psychopathology:

First, questions are asked regarding a specific period (past week, past month, past year, etc.). The interviewer decides on the specific time frame for the questions and scales. The interviewer may choose the past month when evaluating mood, the past year when evaluating alcohol use, and so on. The general principle is to code 0 for absent or subclinical symptoms.

Many questions have ratings of 0 (absent or subclinical symptom) and 1 (clinical symptoms):

Example: PANIC ATTACKS WITHOUT PHOBIA	kappa
<p>Have you gotten suddenly anxious and frightened for a short period of time (up to 60 minutes)?</p> <p>During that time, did you feel that your heart was racing or pounding, or did you start shaking or sweating, or did you feel you were choking?</p> <p>0 Patient had no panic attacks.</p> <p>1 Patient had panic attacks.</p>	0.92

Some questions have the following codes:

0 = Absent or non-significant.

1 = A symptom is present less than 50% of the time or less than 50% of times.

The mere presence of a symptom does not qualify for a rating of one. To receive a rating of one, a symptom must be more than what a normal person would experience, or cause at least some distress, or force the patient to seek professional help.

2 = The same as a rating of one. In addition, the symptom is present more than 50% of the time or more than 50% of times.

Example: Hopelessness	Kappa
<i>Have you felt hopeless about your future?</i>	0.82
0 Patient has no feelings of hopelessness.	
1 Patient feels hopeless less than half the time.	
2 Patient feels hopeless more than half the time.	

Some questions have possible responses of 0 (absent or subclinical), 1, 2, and 3 to allow for severity measurement and to generate a dimensional score when added to responses from other questions.

Example: Frequency of auditory hallucinations	kappa
<i>How often do you hear any noises (like music, whispering sounds) or voices talking to you when there is no one around?</i>	0.93
0 No auditory hallucination	
1 1-4 days / month	
2 5-15 days / month	
3 >15 days / month	

Coding Signs of psychopathology:

The SCIP interview includes observational items to assess for signs of mental illness.

The interviewer listens to the patient, asks him/her questions, examines the patient, and rates the observational items.

Some observational items have questions. For example, the interviewer observes the patient's speech and can ask about symptom of pressured speech over a specific period of time.

Example: Pressured speech	kappa
<i>Have you been talking faster than usual during that time (examples: people said that they were unable to understand you because you were speaking too fast or you felt a pressure to continue talking)?</i> 0 Patient has normal speech. 1 Patient has pressured speech less than half the time. 2 Patient has pressured speech more than half the time.	0.72

Some observational items require active interviewer observation, as in catatonia. The interviewer observes the patient, tests for mobility, rigidity, catalepsy, and waxy flexibility, and rates catatonia items.

Catalepsy: Patients maintain any odd or unusual posture the interviewer places them in.

- 0 Patient has no catalepsy.
- 1 Patient has catalepsy.

Waxy flexibility: Patient maintains a limb in a certain position. When the interviewer moves the limb, the limb feels as if it were made of wax.

- 0 Patient has no waxy flexibility.
- 1 Patient has waxy flexibility.

Some observational items are described and observed.

Flight of Ideas (a combination of pressured speech and derailment):	kappa
0 Patient has no flight of ideas.	0.62
1 Patient has flight of ideas.	

Apparent hallucinatory experiences:	Kappa
0 Patient has not been observed talking to self.	0.55
1 Patient has been observed talking to self, talking to a mirror, or running a conversation with unseen person.	

Derailment (looseness of association):	Kappa
0 Normal speech.	0.65
1 Patient has derailment (looseness of association): speech shifts to different topics, related or unrelated, but eventually comes back to the main topic.	
2 Patient has severe derailment (looseness of association): speech shifts to different topics, mostly unrelated and never comes back to main topic.	

Tangentiality:	Kappa
0 Normal speech.	0.57
1 Patient has some tangentiality: replying to a question is related in some distant way.	
2 Patient has severe tangentiality: replying to a question is totally unrelated.	

Incoherent speech:	Kappa
0 Normal speech.	0.41
1 Patient has incoherent speech: Each sentence by itself is valid and makes sense. However, the first sentence is unrelated to the next sentence.	

General Notes on Ratings:

- a. Do not over-rate symptoms. If the symptom is present and the clinician is not sure whether to rate 1 or 2, the code should be 1. If the clinician decides that the patient has a concentration problem, but he/she forgot to ask about the duration of the problem, the code should be 1 and not 2.
- b. A symptom rated 1 will qualify for diagnostic criteria.
- c. If the clinician is not sure whether the symptom is present after a thorough questioning, the clinician can make a judgment call about whether the symptom is

present or absent. If the clinician does not feel comfortable making a decision, he/she can choose the rating of “.” for “Not Sure” .

Special Notes on Delusions:

Delusions are ideas with the following criteria:

- a. The idea is false based on what most people of the same culture know (false idea).
- b. The patient is convinced that the idea is true (firm idea).
- c. If the patient is provided with evidence that contradicts the idea, the patient is still convinced that the idea is true (fixed idea).

If the patient has paranoid delusions less than half the time, the rating is one. If the patient has paranoid delusions more than half the time, the rating is two. Typically, a patient with delusions goes through three phases:

- a. Initial partial delusions:** The initial transition from normal thoughts to delusional thoughts. The delusional thoughts gradually occupy some of the patient’s time. As time goes on without treatment, the delusional thoughts occupy more of the patient’s time.
- b. Full delusions:** The delusions occupy most or the entirety of a patient’s time. Typically, when patients are admitted to hospitals, they have full delusions.
- c. Residual partial delusions:** As the patient receives antipsychotic medications and improves, the patient starts to question his/her delusional thoughts. The delusional thoughts occupy less and less of the patient’s time. Eventually, the delusional thoughts disappear.

6. Principles of creating reliable questions and clinically useful dimensions of psychopathology.

Principles of Designing the SCIP Questions:

As in the case of medicine, modern psychiatric diagnosis depends on the assessment of psychopathological symptoms and signs. The SCIP interview reflects a state-of-the-art approach to assessment and includes questions designed to evaluate symptoms and observational items for the signs of mental illness. **The SCIP questions were designed with four principles:**

- a. Questions are worded to be simple and easily understood by patients regardless of their intellectual level.
- b. Questions simulate what seasoned psychiatrists usually ask.
- c. The meaning of the questions and examples are embedded in the questions so that each question and the response reflect the criterion being examined.
- d. Responses to questions have the fewest possible subcategories to reflect the clinical significance of the symptom, **following the principle of least subcategories of symptom severity (LSSS)**. The fewer subcategories reflecting symptom severity, the more efficient the interview, and the more likely that clinicians will use the questions.

For example, one criterion for a major depressive episode is “diminished ability to think or concentrate.” Here is the SCIP question and possible responses:

Example: Loss of concentration	kappa
<p data-bbox="201 436 1240 596"><i>Have you found that your concentration has decreased and you are unable to complete a task (e.g. at work, reading an article, reading a book, or watching a movie), even though you were able to do that before?</i></p> <p data-bbox="396 688 987 722">0 Patient has no concentration problems.</p> <p data-bbox="396 751 1234 785">1 Patient has difficulty concentrating less than half the time.</p> <p data-bbox="396 814 1182 911">2 Patient has difficulty concentrating more than half the time.</p>	0.80

The question and responses explain the criterion, give examples of impaired concentration, and measure the severity of the problem (less than half the time or more than half the time).

Principles of Designing Clinically Useful Psychological Dimensions:

The SCIP study measured Kappa for 200 psychological symptoms and signs and 30 SCIP screening questions. Based upon reliable SCIP items, the SCIP dimensions were created. The SCIP questions were designed so that dimensional measures can be generated easily whether the interviewer is using the paper version or the SCIP software. ***The SCIP method of creating reliable and clinically relevant dimensions was based upon the following 9 principles:***

- 1. Reliable dimensions require reliable symptoms and signs.** Psychological symptoms and signs are the building blocks of psychological dimensions. The SCIP study confirmed the hypothesis that reliable psychological dimensions require reliable symptoms and signs. The absence of valid and reliable symptoms was the main limiting factor in prior attempts to create dimensional models (21). The SCIP reliable symptoms and signs removed this major obstacle. Based upon reliable SCIP items, the SCIP dimensions were created and have evidenced reliability (12).
- 2. Each item is given one score, regardless of the number of questions exploring the item.** Typically, a SCIP item is assessed with one question. The question has embedded examples, if needed, so that each question and the response reflect the criterion being examined. Sometimes, one criterion needs to be assessed using several questions. In that case, even if the patient responds “yes” to several questions evaluating the criterion, the score is the same as if the criterion was measured with one question.

For example, the symptom of suicidal ideation can be assessed by the following eight questions:

Have you had thoughts of suicide?

Have you had thoughts of ending your life?

Have you had thoughts about killing yourself?

Have you had thoughts of wishing to be dead?

Have you had thoughts that life is not worth living?

**Have you had thoughts that you would not care if you didn't wake
in the morning?**

Have you had thoughts the world is better off without you?

Have you had thoughts you would be better off dead?

If the patient responds “yes” to the first four questions, these questions still only reflect one criterion: suicidal ideation.

- 3. Dimensions are built upon significant symptoms and signs.** Absent or mild symptoms are coded “0” in the SCIP.
- 4. The principle of least subcategories of symptom severity (LSSS):** Symptom severity subcategories should be used sparingly and reflect the symptom’s clinical significance. The symptom of panic attacks can be assessed as absent or present (0, 1). The symptom of poor concentration in a patient with depression can be assessed as absent, less than half

the time and more than half the time (0, 1, 2). It is important to know how much of the time the concentration problem is present, because it may affect the patient's functioning at work or in school. The fewer subcategories reflecting symptom severity, the more efficient the interview, and the more likely that clinicians will use the questions. If there are too many unnecessary subcategories of symptoms severity, clinically useful dimensions cannot be created. For example, the Positive and Negative Syndrome Scale (PANSS) has seven subcategories: absent, minimal, mild, moderate, moderate severe, severe and extreme (22). For clinicians, the differences between minimal and mild, moderate and moderate severe, and severe and extreme are not useful or relevant. Not surprisingly, psychiatrists do not use the PANSS in clinical settings (6).

- 5. The frequency of symptoms:** The more frequent the symptom, the higher the score on the item. A good example is the frequency of auditory hallucinations:

How often do you hear noises (like music, whispering sounds) or voices talking to you when there is no one around?

- 0 Patient has no auditory hallucinations.
- 1 Patient has auditory hallucinations (1-4 days / month).
- 2 Patient has auditory hallucinations (5-15 days / month).
- 3 Patient has auditory hallucinations (>15 days / month).

- 6. The duration of symptoms:** The longer the duration of a symptom, the higher the score on the item.

Do you have an intrusive thought or image that does not make sense and keeps coming back to your mind even when you try not to have the thought or the image?

- 0 Patient has no obsessions.
- 1 Patient has obsessions less than 1 hour/day.
- 2 Patient has obsessions 1-4 hours/day.
- 3 Patient has obsessions more than 4 hours/day.

7. The recency of a symptom: More recent behavior has a higher score than temporally distant behavior. For example, in response to the timing of suicidal ideation question:

Have you ever had thoughts of suicide?

- 0 Patient has never had suicidal ideation.
- 1 Patient had suicidal ideation in past, but not in the past three months.
- 2 Patient had suicidal ideation during the past three months (excluding past week).
- 3 Patient had suicidal ideation during the past week.

Suicidal thoughts “during the past week” receive a score of 3 and “during the past three months” receive a score of 2. If the patient has had suicidal thoughts before the past three months, this receives a score of 1. A patient with suicidal thoughts during the past week, past 3 months, and past year receives a score of 6.

- 8. The quality of symptoms:** Certain qualities of some symptoms increase the score on the item. For example, auditory hallucination with and without commands.

Do you hear noises (like music, whispering sounds) or voices talking to you when there is no one around?

- 0 Patient has no auditory hallucinations.
- 1 Patient has auditory hallucinations.
- 2 Patient has auditory hallucinations with command.

- 9. Summation Principle:** The total score of a dimension is the sum of symptom presence, recency, frequency, duration and quality.

7. Evaluation of episodes

In psychiatry, an episode is a significant symptom or a cluster of symptoms occurring during a specific period of time during the course of a mental disorder. For example, a patient may have an episode of auditory hallucinations that lasted 3 months until the patient responded to clozapine. Another patient may have an episode of binge eating that lasted 5 months. More often, patients have episodes of a group of symptoms occurring together during a specific period of time. A patient may have an episode of depression (depressed mood with anhedonia, psychomotor retardation, hopelessness, poor concentration and suicidal thoughts) that lasted 2 months until the antidepressant medication took effect to alleviate the depression. To delineate one episode from another, a 2-month or longer interval without significant symptoms have been recommended (23). The DSM-5 followed the 2-month interval of absence of significant symptoms as demonstrated in dysthymia diagnostic criteria (“the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time”) (24). Depending on the timing of the episode, the following main episodes have been described:

1. **Present episode (PE):** is measured from the onset of significant symptom(s) to the present time. The present episode may vary from one day or a few days to several months or years, as long as no symptom-free intervals have lasted 2 months or more. A patient may have had a recent depressive episode that started 2 weeks ago until now. Another patient may have had a depressive episode for the last 3 years.
2. **Representative episode (RE):** A patient may have had several depressive or manic episodes in the past and the interviewer may choose to evaluate one representative episode. The clinician decides on the type of episode to serve diagnostic and clinical purposes. If a patient is presenting with a recent depressive episode, the clinician may

choose another depressive episode in the past as a representative episode to use when comparing the severity of depression between the two periods. For another patient presenting with a recent depressive episode, the clinician may choose a manic episode in the past as representative episode to confirm the diagnosis of bipolar disorder. The clinician can decide on the duration of the RE (e.g., a week if evaluating a manic episode, a two-week period if evaluating a depressive episode, or a month if evaluating a psychotic episode...etc.).

3. **Present State (PS):** The present state describes the psychopathology during the month before the interview and has been an essential part of the Present State Examination (PSE) developed by Professor John Wing (25-29). If the present episode is longer than a month, the present state is the most recent part of the present episode (23). The clinician makes a clinical judgment whether to use the PS or the PE for a particular patient, depending on the goals of the interview.

Finally, the diagnostic criteria of mental disorders may define the length of the period evaluated such as:

Manic episode: the usual period is one week or longer.

Major depressive episode: the usual period is 2 weeks or longer.

Eating disorders: the usual period is 3 months or longer.

Schizophrenia: the usual period is 6 months or longer.

Alcohol and drug disorders: the usual period is 12 months or longer.

Dysthymia: the usual period is 2 years or longer.

8. Appendix (Rating Scales)

The SCIP consists of 15 self-administered (SA) scales and 18 clinician-administered (CA) scales.

The SCIP Self-administered (SA) Scales

	Self-administered (SA) Scales	Number of items
1	Anxiety	7
2	Panic	5
3	Phobia	9
4	OCD	18
5	PTSD	16
6	Depression	12
7	Mania	11
8	Hallucinations	9
9	Delusions	9
10	Alcohol	8
11	Drug	7
12	Anorexia Nervosa	9
13	Binge and Bulimia	17
14	ADHD	20
15	Intake self-administered	18

The SCIP Clinician-administered (CA) Scales

	Clinician-administered (CA) Scales	Number of items
1	Anxiety	7
2	Panic	5
3	Phobia	9
4	OCD	18
5	PTSD	16
6	Depression	14
7	Mania	13
8	Hallucinations	9
9	Delusions	9
10	Disorganization	6
.	Core Schizophrenia	24
11	Aggression	6
12	Negative Symptoms	8
13	Alcohol	8
14	Drug	7
15	Anorexia Nervosa	9
16	Binge and Bulimia	17
17	ADHD	20
18	SCIP_SCREEN	30

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