What was the Question?

The understanding of Questionnaires and the correct implementation for Clinical Reporting in Psychiatric studies.

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Psychiatric conditions, such as depression, anxiety, and schizophrenia, often involve subjective symptoms that can be challenging to assess through direct observation alone. Questionnaires allow patients to self-report their experiences and symptoms, helping clinicians and researchers understand the severity and frequency of symptoms.

Many questionnaires are designed to quantify symptoms or behaviour, providing measurable outcomes that can be tracked over time. This helps to objectively assess the impact of a treatment or intervention, providing concrete data that can be used to evaluate effectiveness.

It is crucial to understand the convergence of Psychiatry and CDISC. CDISC QRS Supplements and TAUGs help ensure questionnaires are being reported correctly. We have worked with our psychiatrists to understand the purpose of Psychiatry Questionnaires, improving reporting where we may lack guidance from CDISC. This poster provides examples, guidance, and support for those questionnaires to ensure smoother study reporting and understanding of the study participants' safety.

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MADRS
Montgomery-Asberg Depression Scale

The MADRS, or Montgomery-Åsberg Depression Rating Scale, is a rater-administered tool used to assess the severity of depressive symptoms in individuals with mood disorders, particularly major depressive disorder (MDD). Consisting of 10 question items, with each item rated on a scale 0 to 6, it is used to track sensitive changes in core depressive symptoms over time, especially during treatment. MADRS ratings begin with general questions about symptoms and gradually progress to more specific inquiries to accurately assess symptom severity. The rater creates a supportive, non-judgemental environment to encourage open dialogue. The rater must determine whether the rating falls on the defined 'core' scale points (0, 2, 4, 6) or within the intermediate 'clinical judgment zones' (1, 3, 5), where 0 represents the absence of relevant thoughts or feelings.

Questions include Apparent Sadness, Reported Sadness, Inner Tension, Reduced Sleep, Reduced Appetite, Concentration Difficulties, Lassitude, Inability to Feel, Pessimistic Thoughts, Suicidal Thoughts. Initial MADRS assessments can take between 45 to 60 minutes, as raters work to help subjects articulate their experiences. Often, questions need to be repeated or rephrased, since many individuals may not have previously reflected deeply on their condition. The process requires specialized listening skills, the use of varied terminology, and repeated clarification to ensure understanding.

GAD-7
Generalised Anxiety Disorder Questionnaire

The Generalised Anxiety Disorder - 7 Item Scale (GAD-7) is a self-administered questionnaire designed for screening and measuring the severity of generalised anxiety disorder (GAD).

The GAD-7 consists of seven items that Subjects rate based on their experiences over the past 2 weeks prior to their visit, with each item scored from 0 (not at all) to 3 (nearly every day). The cumulative score, ranging from 0 to 21, indicates the severity of GAD symptoms, with higher scores corresponding to greater anxiety levels. Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. This interpretation makes GAD-7 a practical tool for Investigators to quickly assess anxiety levels and monitor changes over time.

The GAD-7 has gained widespread use across diverse healthcare settings, owing to its strong internal consistency and solid test-retest reliability. It has been validated across multiple populations and proven effective among various demographic and clinical groups.

HAM-A
Hamilton Anxiety Rating Scale

The Hamilton Anxiety Rating Scale (HAM-A) is a well-established clinical instrument used to measure the severity of anxiety symptoms and takes around 20 minutes to complete with the subject. Comprising 14 rater-administered items, the scale assesses various dimensions of anxiety as reported by the individual. Each item is rated on a graded scale, and the total score offers a comprehensive snapshot of the individual's overall anxiety level.

The scale adopts a holistic approach to anxiety assessment, covering domains such as emotional state, fears, tension, sleep disturbances, and cognitive functioning. Items are scored from "not present" to "severe," enabling investigators to assess both the presence and intensity of each symptom. Thanks to its broad scope and sensitivity to change, the HAM-A is a versatile tool for tracking symptom progression and evaluating treatment efficacy over time.

HAM-D
Hamilton Depression Rating Scale

Similar to the HAM-A, The Hamilton Depression Rating Scale (HAM-D) is widely used and is designed to assess the severity of depressive symptoms. It consists of a structured interview conducted by a trained rater, evaluating various aspects of depression such as mood, guilt, sleep disturbances, appetite changes, and somatic symptoms.

The original version includes 17 items, though extended formats with up to 24 items exist. Scoring varies by item, typically ranging from 0 to 2 or 0 to 4, with higher total scores indicating greater symptom severity. These scores help investigators categorise depression from mild to severe, supporting both diagnosis and treatment planning.

One of HAM-D's key advantages is its ability to capture both psychological and physical manifestations of depression. The structured format of the HAM-D ensures that essential signs aren't missed, offering a more comprehensive view of a patient's mental health status.

CSSRS
Columbia-Suicide Severity Rating Scale

The Columbia-Suicide Severity Rating Scale (C-SSRS) is a rater-administered tool designed for comprehensive suicide risk assessment. Available in over 100 languages, it has been successfully utilised in a wide range of settings, including those beyond traditional healthcare environments. The Risk Assessment version spans three pages. The first page features a checklist covering a broad spectrum of risk and protective factors relevant to suicide. This section is designed to help clinicians quickly assess an individual's immediate risk. The remaining two pages comprise the formal assessment, which captures more detailed information on suicidal ideation and behaviours.

Historically, suicidal thoughts and actions were viewed as a linear progression - from passive ideation to active intent and ultimately to suicidal behaviour. The C-SSRS challenges this model by distinguishing between ideation and behaviour using four key constructs: severity of ideation, intensity of ideation, suicidal behaviour, and lethality. These dimensions are based on evidence identifying factors most predictive of suicide attempts and completed suicide.

While suicide risk assessment is inherently complex, the C-SSRS provides a structured, evidence-based approach to support investigators in evaluating and monitoring suicide risk with greater accuracy and consistency. It is important to be mindful that when taking part in a clinical trial for depression, for some subjects it is the first time they have spoken of their idealisations or behaviours. It is an incredibly vulnerable and frightening experience. Empathy and understanding are required to ensure the subject feels safe in the clinical environment.

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WHAT IS THE QRS SUPPLEMENT?

The **QRS Supplement** is a collection of standardised metadata and implementation guidance for incorporating validated Questionnaires, Rating Scales, and Assessment Tools into CDISC-compliant clinical trial datasets - particularly within SDTM (Study Data Tabulation Model).

It ensures that when different trials use the same scale (like the Hamilton Depression Rating Scale, or HAM-D), they record, structure, and report the data in the same way, making results consistent, transparent, easily interpretable, and submission-ready for regulators like the FDA or EMA.

Each QRS supplement typically includes the Background of the Instrument (what it measures, target population and scoring methodology), Controlled Terminology, Annotated CRF guidance and SDTM Mapping. The QRS Supplement is important as it assists with regulatory compliance, data interoperability, data quality, and efficiency.

WHAT IS THE THERAPEUTIC AREA USER GUIDE (TAUG)?

A **Therapeutic Area User Guide (TAUG)** is a guidance document that defines how to standardise data collection and organisation for a specific therapeutic area (e.g., Alzheimer's, depression) in clinical trials.

Therapeutic Area User Guides extend the Foundational Standards to represent data that pertains to specific disease areas. TAUGs include disease-specific metadata, examples and guidance on implementing CDISC standards for a variety of uses, including global regulatory submissions.

This helps researchers, sponsors, and regulatory bodies use consistent data structures to make clinical data clear, interoperable, and submission-ready - especially for the FDA and other global regulators.

Therapeutic areas relevant to this poster with TAUGs include:

- Alzheimer's
- Post Traumatic Stress Disorder
- Major Depressive Disorder
- Schizophrenia

MADRS
Montgomery-Asberg Depression Scale

QRS Name	Short Name (–CAT)	SDTM Domain/ADaM Dataset	Permission	Version Release Date
Montgomery-Asberg Depression Rating Scale	MADRS		No Response Received	N/A

GAD-7
Generalised Anxiety Disorder Questionnaire

QRS Name	Short Name (–CAT)	SDTM Domain/ADaM Dataset	Permission	Version Release Date
Generalised Anxiety Disorder - 7 Item	GAD-7	QS	Public Domain	Version: 1.0 12 Mar 2014
Generalised Anxiety Disorder 7-Item Version 2	GAD-7 V2	QS	Exempt from Copyright	Version: 1.0 29 Aug 2022
Generalised Anxiety Disorder 7-Item Version 2	GAD-7 V2	ADaM	Exempt from Copyright	Version: 1.0 29 Aug 2022

HAM-A
Hamilton Anxiety Rating Scale

QRS Name	Short Name (–CAT)	SDTM Domain/ADaM Dataset	Permission	Version Release Date
Hamilton Anxiety Rating Scale	HAM-A	RS	Public Domain	Version: 1 16 May 2013 Version: 2 16 Dec 2015 Version: 2.1 19 May 2020

HAM-D
Hamilton Depression Rating Scale

Hamilton Depression Rating Scale 17-Item	HAMD-17	RS	Public Domain	Version: 1.0 7 Aug 2012 Version: 1.1 15 May 2013 Version: 2.0 23 May 2016
Hamilton Depression Rating Scale 21-Item	HAMD-21	RS	Public Domain	Version: 1.0 29 May 2013 Version: 2.0 16 Dec 2015
Hamilton Depression Rating Scale 24-Item	HAMD-24	RS	Public Domain	Version: 1.0 5 Dec 2016
Hamilton Depression Rating Scale 6 – Clinician Version	HAMD-6 CLINICIAN VERSION	RS	Granted	Version: 1.0 2 Aug 2016
Hamilton Depression Rating Scale 6 – Self-Report Version	HAMD-6 SELF-REPORT VERSION	QS	Granted	Version: 1.0 17 Oct 2016

CSSRS
Columbia-Suicide Severity Rating Scale

QRS Name	Short Name (–CAT)	SDTM Domain/ADaM Dataset	Permission	Version Release Date
Columbia Suicide Severity Rating Scale – Baseline	C-SSRS BASELINE	QS	Granted	Version: 1.0 7 Aug 2012 Version: 1.1 6 Feb 2013 Version: 1.2 3 Sep 2014
Columbia Suicide Severity Rating Scale Already Enrolled Subjects	C-SSRS ALREADY ENROLLED SUBJECTS	QS	Granted	Version: 1.0 13 Jun 2014
Columbia Suicide Severity Rating Scale Baseline Screening	C-SSRS BASELINE/SCREENING VERSION	QS	Granted	Version: 1.0 5 Nov 2014
Columbia Suicide Severity Rating Scale Baseline/Screening Version Phase 1 Study	C-SSRS BASELINE/SCREENING VERSION PHASE 1 STUDY	QS	Granted	Version: 1.0 4 Dec 2013 Version: 1.1 3 Sept 2014
Columbia Suicide Severity Rating Scale Screening	C-SSRS SCREENING	QS	Granted	Version: 1.0 29 May 2013
Columbia Suicide Severity Rating Scale Since Last Visit	C-SSRS SINCE LAST VISIT	QS	Granted	Version: 1.0 6 Feb 2013 Version: 1.1 3 Sept 2014

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RISK FACTORS AND CONSIDERATIONS

Over the past five decades, a wide array of psychiatric questionnaires and rating scales has been developed and refined to provide standardised, objective assessments of symptom severity across various mental health conditions. These tools, frequently used in clinical trials, also serve as effective screening instruments and are valuable in tracking symptoms and evaluating treatment response. While CDISC offers support through QRS Supplements and TAUGs, evaluating subjects in clinical trials often extends beyond the scope of the provided documentation and questionnaires.

These tools are only as useful as the accuracy with which their results are interpreted. Viewing the data through different clinical lenses can offer fresh insights into your findings and help uncover potential misinterpretations or overlooked patterns in your study.

SOCIAL ECONOMICAL FACTORS

Income Level: Lower-income individuals may be more likely to participate due to financial incentives.

Education: Education affects health literacy, understanding of informed consent, and ability to follow study protocols.

Employment Status: Unemployed or part-time workers may have more time to participate. Full-time workers may face challenges balancing trial participation with job responsibilities.

Family and Social Support: Support systems can influence whether someone is able or willing to join a trial. Caregiving responsibilities and cultural attitudes all impact participation.

Cultural: Social Media and "Fake News" lead to misinformation, can significantly distort public understanding of clinical trials. Social media posts and headlines often sensationalise or misrepresent clinical trial findings. Social media algorithms tend to reinforce users' beliefs.

Race, Ethnicity, and Cultural Background: Historical injustices have led to mistrust in some communities. Cultural beliefs around illness, medicine, or authority can influence willingness to participate.

Health: Individuals who seek participation in clinical trials for psychiatric disorders are often doing so from a place of deep emotional distress. Many are driven by a strong desire for relief, feeling overwhelmed by their current symptoms and willing to explore any opportunity that offers hope for improvement.

STUDY PARTICIPANT KNOWLEDGE

During screening visits, study participants often arrive having researched the investigational drug independently. Some may have prior experience with psychedelic substances, undertaken as a form of self-exploration or informal preparation. These individuals often hold idealised expectations, anticipating "life-changing" or "groundbreaking" experiences as part of their participation.

There have been instances where participants exhibit a placebo effect, in which the anticipation and hope invested in the trial lead them to perceive an improvement in their condition, even in the absence of an active treatment.

During participation in clinical trials, subjects may independently "practice" between visits, which can compromise the validity of subsequent results by introducing performance bias.

Participants are often informed about the concept of social desirability bias and the importance of providing honest, accurate responses throughout the study. Whether intentional or subconscious, participants may pick up on cues about the study's objectives and adjust their behaviour or answers accordingly.

SITE STAFF

The standard timeframe for administering questionnaires and rating scales is typically between 60 and 120 minutes. However, this duration can present a significant challenge both in terms of practical feasibility and maintaining the participant's focus and engagement throughout the assessment.

The subject may become increasingly familiar and engaged with the questionnaires and scales, often responding proactively - sometimes answering questions before they are fully asked - as a result of growing comfort and familiarity with the assessment process.

When participants enter psychedelic clinical trials, many do so with the expectation of experiencing a transformative "eureka" moment - anticipating sudden insight or immediate emotional relief. If they receive a lower-than-expected dose or placebo, this can lead to disappointment or distress. Trained facilitators play a critical role in these moments, guiding participants through the dosing process and helping to manage emotional responses with empathy, reassurance, and supportive care.

Raters and facilitators can often recognise when a subject has prior experience with therapy or participation in previous clinical trials. These individuals tend to be more familiar with clinical terminology and more comfortable articulating their experiences with anxiety or depression, often doing so calmly and clearly, without becoming overwhelmed.

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CONCLUSION

Questionnaires and rating scales have been highly successful in psychiatric clinical trials, and they continue to be essential tools for evaluating mental health conditions. Because psychiatric symptoms are often subjective and not directly measurable through labs or imaging, these tools play a central role in both diagnosis and monitoring treatment efficacy. Their effectiveness depends on how well they are designed, implemented, and interpreted.

Psychiatric disorders such as depression, anxiety, bipolar disorder, PTSD, and schizophrenia largely depend on self-reported symptoms. Questionnaires play a crucial role in translating these subjective experiences into quantifiable data. The use of CDISC data standards helps ensure consistent terminology, definitions, and reporting formats, promoting both patient safety and transparency.

However, in order to ensure studies are reported effectively, it is important to be mindful of the "human factor" in clinical reporting.

Questionnaires aren't without limitations. There is no guidance to manage Placebo effects or social desirability bias, variability between raters in clinician-rated tools, cultural differences in how symptoms are interpreted or reported, and these are factors that should be acknowledged and considered in analysing and reporting psychiatric studies.

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https://www.cdisc.org/standards/foundational/qrs

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