International Alliance of
Mental Health Research Funders

RFQ: How has the Common Measures Initiative Changed Measurement Practice and Data Sharing?

About the Initiative

The International Alliance of Mental Health Research Funders (IAMHRF) is a global alliance of funders united by a shared mission to drive impactful mental health research. The Common Measures in Mental Health Science (CMMHS) Initiative asks researchers to use a small set of common outcome measures (PHQ-9 and GAD-7 for adults, RCADS for children and young people) alongside their study-specific measures, and to share the resulting data, so findings can be compared and pooled across contexts. It began in October 2020; IAMHRF is now running evaluation activities for the Common Measures Board (CMB) to understand short-term impacts and to inform future decision-making.

What we need to know

The evaluation asks whether common measures are having the impact intended. This commission covers two linked questions: are researchers adopting the measures, and is adoption producing data others can reuse? We want a Supplier to answer:

Component A: uptake (trial registries)

- Has the use of PHQ-9, GAD-7 and RCADS in registered depression and anxiety trials changed since 2020, beyond the trend in comparable instruments, and can any change be plausibly attributed to the Initiative?
- Where is any change concentrated: by funder (CMB members against others), region and income setting, adult against youth samples, intervention type and context?
- How has measurement practice changed more broadly? Are common measures adopted as primary outcomes or added alongside existing instruments; are trials using more measures per condition; are local or free-to-use instruments being displaced?

Component B: from measures to reusable data (publications and repositories)

- Of published studies using a common measure, what share reports scores and makes item-level data findable in a repository under a reusable license? How has this changed since 2020?
- Where the drop-off between reporting and deposit occurs, what explains it (consent, licensing, journal or funder policy, repository availability, region)?
- From the repository side, what share of mental health deposits use common measures, is this growing, and where data exists, is deposited data being accessed or reused?
- For both components, what can these data not tell us, and how confident should the Board be in the rest?

Framing and constraints

We are not prescribing a method, but proposals should work within this frame and say where and why they would depart from it:

- **Sources.** Component A: ClinicalTrials.gov and the WHO ICTRP with depression and anxiety as primary conditions and adults and under-18s treated separately. Proposals

should state the denominator (all eligible trials, whatever measure they used) and how they will test whether registry outcome fields are complete enough for the design. Component B: a sampled, proportionate design rather than a census, for example a stratified sample of published studies (via OpenAlex or Europe PMC) with a short pilot to set sample size, plus targeted searches of major repositories (NIMH Data Archive, OSF, Zenodo).

- **Comparators.** A reasoned comparator set is central. We expect an explicit rationale for each instrument (for example citation count, frequency of use, cost and licensing, condition specificity), depression- and anxiety-specific as well as combined comparators, at least one free to use, and an account of how comparator choice could affect conclusions.
- **Design.** A quasi-experimental approach that separates the Initiative's effect from underlying trends, with a check on pre-2020 parallel trends, and a validation plan for automated extraction and hand coding (double coding, inter-rater reliability).
- **External vetting.** We ask each proposal to set out how it would ensure transparency and rigour, including supporting opportunities for external review and expert consultation regarding a selected approach.

Deliverables, timeline and budget

- **Protocol** (within four weeks of project start) covering both components, including the comparator rationale, sampling and pilot plan, feasibility check, analysis plan and vetting plan.
- **Coded datasets**, dictionary and code (~early February 2027).
- **Analytic report** (draft mid-March, final early-April 2027) with a short Board summary and slide deck, and a presentation to the IAMHRF Evaluation Group and, if invited, the CMB. Short monthly check-ins with the Evaluation Group.

Please include an indicative, itemised, budget in your proposal that is inclusive of all taxes, fees and expenses, priced separately for Components A and B, in USD. As a non-profit alliance, value for money forms part of our assessment; quotes should show days by role and any data access or tooling costs.

Experience required

The Supplier may be an individual or academic group, with demonstrated experience of systematic, large-scale extraction from trial registries or bibliographic databases, text mining, impact evaluation, including quasi-experimental designs, coding of published studies, data sharing and repository practice, and mental health outcome measures. Suppliers should declare any funding from CMB member funders and prior involvement in the Initiative.

How to respond

Send a proposal (max six pages) covering approach and comparator rationale, vetting plan, team, timeline, costs by component, conflicts of interest, and questions for IAMHRF, with 2-page CVs of all team members, to admin@iamhrf.org (subject "RFQ CMMHS – [Organisation]") by 16:00 GMT on October 15, 2026.