Mental Health Assessment Tools

Second Edition 2012

Laois Offaly Longford Westmeath Mental Health Services.

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*redacted due to copyright

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Disclaimer

Although all reasonable care has been taken in preparing the information published in this Portfolio, the authors do not guarantee the accuracy of it. The authors cannot be held responsible for any errors or omissions and accept no liability whatsoever for any loss or damage howsoever arising.

Permission is granted, for the printing of assessment tools from this Portfolio for use in clinical practice with the exception of the Beck's tools and the CAN which are subject to copyright.

The assessment tools/scales do not in any way replace clinical decision making. They are intended as an adjunct to assist in the process of assessment. Practitioners should be prepared to use their clinical judgement to make decisions regarding which tool/scale is appropriate and useful for each client/patient and the often rapidly changing needs of that person.

If any errors/omissions are noted please contact the mental health assessments group via e-mail at: mentalhealth.assess@hse.ie

Foreword:

The revised edition of the Portfolio of Mental Health Assessment Tools for Mental Health Practice is the result of ongoing work by the Mental Health Assessment review group based on evaluation, audit from the experience of the first edition and further literature search evidence. The review brings significant changes to the first copy and has focused on providing a user friendly evidence based compendium of assessments, incorporating evidence based practice into assessment and care aiming to improve patient outcomes (Fortinash & Holoday-Worret, 2007). Validated assessment is recommended in many leading health guidance documents and aligned to health strategy such as the HSE Transformation Programme (2006), National Council for the Professional Development of Nursing and Midwifery (NCNM) (2006, 2009, 2010) *A Vision for a Recovery* (MHC, 2005), and *Quality Framework* (MHC, 2006), *and A Vision for Change* (Government of Ireland, 2006).

This current publication has built on previous work of the 2008 Mental Health Assessment Tools with the following objectives:

- Enabling professionals in mental health practice to have the requisite skills to deliver comprehensive holistic assessment to improve overall patient /client care
- Integrating the use of validated assessment tools by mental health professionals to strengthen the care plan and interventions for patients/clients
- Increasing use of evidence-based practice
- Assisting in the delivery of consistent standardised approach to patients' care and monitoring
- Assisting delivery of outcomes focus care interventions with measurable data that is useful for identifying key performance indicators

The main revisions include:

- The format has reduced divisions from 6 to 5 sections.
- Additional assessments have been included. There are 28 assessments included in this edition. The Zung Anxiety scale is an additional Mental Health Screening Tool, AUDIT and CAGE alcohol problem screening tools are added to the Addiction Screening Tools. Camberwell Assessment of Need (CAN) and Relative Assessment Interview (RAI) are added to the Living Skills Screening Tools.
- The Life Skills Profile (LSP) has been reduced from 3 versions to the 20 item question version.
- The Social Network Map has expanded to include the family tree (Genogram).
- Updated versions of local Risk Assessment Tools are included.
- Some editing and revisions of other assessments are featured.
- In Section 5 - Making sense of Assessment Data, there is additional explanatory information on the Stress Vulnerability Framework Model. An additional local guideline matrix is offered for guidance on integration of assessment data to the process of care.

This portfolio of tools was supported at local level by an accompanying Education & Training Package. The Assessment Tools/scales contained in this Portfolio are for use by professional members of the Multi-Disciplinary Team in mental health practice who have had appropriate training on their application.

It is our hope that by having these tools and scales for use as part of the overall assessment of each client/patient in our services, we can deliver more comprehensive and timely interventions. The tools can also be incorporated into the measurement of care interventions and objectively assess progress for clients/patients.

It is important to acknowledge that this represents a very broad range of measuring tools and thus the users will have to decide which tools are applicable to various areas of practice and to different client/patient needs.

The Mental Health Assessment Tools Review Group 2012

Introduction

The Mental Health Commission (2005) specifies the importance of individualised care planning as one of the key aspects of holistic service delivery with each service user having an individual care and treatment plan that describes the levels of support and treatment required in line with his/her needs.
Effective skills of assessment are fundamental to nurses working in the mental health setting (Curran and Rogers, 2004, Gamble & Brennan, 2006).
The Commission on Patient Safety and Quality Assurance (2008) advise that clinical effectiveness based on outcome/performance measurement, using evidenced based practice is a standard requirement in healthcare. Having validated assessments in nursing practice complies with this standard. This revised Portfolio of Assessment is the work of the Mental Health Assessment Review Group. The review has built on the first publication and taken account of audit results from the experience of using the tools in practice and relevant national and international literature.

It is intended that any professional in the mental health services can utilise relevant and appropriate tools/scales from this portfolio.
Effective care delivery relies on a comprehensive assessment being made. The use of validated assessment tools enhances assessment and can be incorporated into the management of patient/client care in a variety of ways. They can be useful in providing evidence for clinical decisions. They are also useful where potential risk is suspected and can be used to measure the level of risk. The use of validated assessment tools is crucial to providing documentary quantifiable evidence of patient/client state of health and determining the patient/client's progress/difficulties with their plan of care.

The Portfolio is presented in five sections outlining various components of care. These are:

- Mental Health Screening Tools
- Medication Related Screening Tools
- Alcohol/Drug Screening Tools
- Living Skills Screening Tools
- Making sense of the assessment data. This guides users on how to incorporate information into practice using a Stress Vulnerability Framework from a psycho social model with strong emphasis on a recovery ethos with a useful guideline on integrating assessment data into the process of care.

Each measuring tool/scale is accompanied by explanatory notes for guidance on use. Supporting literature is provided and all tools/scales are referenced.
The portfolio is available to view and download from the HSE *Lenus* Library website: http://www.lenus.ie/hse/

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2012

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SECTION 1:

Mental Health Screening Tools

MINI-MENTAL STATE EXAMINATION (MMSE)

The Mini-Mental State Examination is a 30-point questionnaire used to detect cognitive impairment, assess its severity and to monitor cognitive changes over time.

Name of website*:* **Mini-Mental State Examination**

URL: www.minimental.com

Country: USA

Authors:

Mini-Mental™ State Examination (MMSE™) by Marshal F. Folstein, MD, Susan E. Folstein, MD, Paul R. McHugh, MD. Copyright ©_ 1975, 1998, 2001 by MiniMental, LLC. Mental Status Reporting Software (MSRS) Checklist™ by Mark A. Ruiz, PhD, Richard J. Latshaw, MS.

Brief Description:

Copyright of the MMSE has been enforced so it is not possible to publish further information here. A sample report can be viewed at the website Psychological Assessment Resources (PAR) Inc (www.parinc.com) by typing MMSE into the search box.

WHY

Cognitive impairment is no longer considered a normal and inevitable change of aging. Although older adults are at higher risk than the rest of the population, changes in cognitive function often call for prompt and aggressive action. In older patients, cognitive functioning is especially likely to decline during illness or injury. The nurses' assessment of an older adult's cognitive status is instrumental in identifying early changes in physiological status, ability to learn, and evaluating responses to treatment.

BEST TOOL

The Mini Mental State Examination (MMSE) is a tool that can be used to systematically and thoroughly assess mental status. It is an 11 question measure that tests five areas of cognitive function: orientation, registration, attention and calculation, recall and language. The MMSE takes 5-10 minutes to administer and is therefore practical to use repeatedly and routinely.

TARGET POPULATION

The MMSE is effective as a screening tool for cognitive impairment with older, community dwelling, hospitalized and institutionalized adults. Assessment of an older adults cognitive function is best achieved when it is done routinely, systematically and thoroughly.

VALIDITY/RELIABILITY

Since its creation in 1975, the MMSE has been validated and extensively used in both clinical practice and research.

STRENGTHS AND LIMITATIONS

The MMSE is effective as a screening instrument to separate patients with cognitive impairment from those without it. In addition, when used repeatedly the instrument is able to measure changes in cognitive status that may benefit from intervention. However, the tool is not able to diagnose the case for changes in cognitive function and should not replace a complete clinical assessment of mental status. In addition, the instrument relies heavily on verbal response and reading and writing. Therefore, patients that are hearing and visually impaired, intubated, have low english literacy, or those with other communication disorders may perform poorly

even when cognitively intact.

MMSE Scoring guide:

a) 25-30 suggests a normal scoring range
b) 18-24 suggests a mild to moderate impairment of cognitive functioning
c) Scores under 17 suggests a severe cognitive impairment

MMSE is a screening tool as opposed to a diagnostic tool.

References:

Anthony JC, LeResche L, Niaz U, VonKorff MR and Folstein MF (1982) Limits of the mini-mental state as a screening test for dementia and delirium among hospital patients. Psychological Medicine, 12: 397-408.

Cockrell JR and Folstein MF (1988) Mini Mental State Examination (MMSE), Psychopharmacology, 24: 689-692.

Crum RM, Anthony JC, Bassett SS and Folstein MF (1993) Population-based norms for the mini-mental state examination by age and educational level, JAMA, 18: 2386-2391.

Folstein MF, Folstein, SE and McHugh PR (1975) Mini-Mental State: A practical method for grading the state of patients for the clinician, Journal of Psychiatric Research, 12: 189-198.

Foreman, M.D., Grabowski, R. (1992) Diagnostic dilemma: cognitive impairment in the elderly. Journal of Gerontological Nursing, 18, 5-12.

Foreman, M.D., Fletcher, K., Mion, L.C. & Simon, L. (1996) Assessing cognitive function. Geriatric Nursing, 17,228-233.

MINI MENTAL STATE EXAMINATION

Patient ________________________ Examiner: __________________ Date: _______

Max Score	Score	
		ORIENTATION
5	( )	What is the (year), (season), (date), (month), (day).
5	( )	Where are we: (country), (county), (what part of the town/city – near the sea, eastern suburbs), (which building), (floor) e.g.
		REGISTRATION
3	( )	Ask if you can test the individual's memory. Name 3 objects (e.g. apple, table, and penny) taking 1 second to say each one. Then ask the individual to repeat the names of all 3 objects. Give 1 point for each correct answer. After this, repeat the object names until all 3 are learned (up to 6 trials). Number of trials needed: ____
		ATTENTION AND CALCULATION
5	( )	Spell "world" backwards. Give 1 point for each letter that is in the right place (e.g., **DLROW** = 5**, DLORW** = 3).
		<u>Alternatively</u>, do serial 7s. Ask the individual to count backwards from 100 in blocks of 7 (i.e. 93, 86, 79, 72). Stop after 5 subtractions. Give one point for each correct answer. If one answer is incorrect (e.g. 92) but the following answer is 7 less than previous answer (i.e. 85), then count the second answer as being correct.
		(The tester can ask the client both of the attention and calculation questions, but only use the result from the highest scoring question, allowing for up to a maximum of 5 points).
		RECALL
3	( )	Ask for the 3 objects repeated above. Give 1 point for each correct object. (Note recall cannot be tested if all 3 objects were not remembered during registration)

MINI MENTAL STATE EXAMINATION

		LANGUAGE
2	( )	Point to a pencil and ask the individual to name this object (1 point). Do the same thing with a wrist-watch (1 point).
1	( )	Ask the individual to repeat the following "No ifs and or buts" (1 point). Allow only one trial.
3	( )	Give the individual a piece of blank white paper and ask him or her to follow a 3 stage command: "take a paper in your right hand, fold it in half and put it on the floor" (1 point for each part that is correctly followed).
1	( )	Show the individual the "CLOSE YOUR EYES" message on the following page (but not the pentagons yet). Ask him or her to read the message and do what it says (give 1 point if the individual actually closes his or her eyes).
1	( )	Ask the individual to write a sentence on a blank piece of paper. The sentence must contain a subject and a verb, and must be sensible. Punctuation and grammar are not important (1 point).
1	( )	Show the individual the pentagons on the following page and ask him or her to copy the design exactly as it is (1 point). All 10 angles need to be present and the two shapes must intersect to score 1 point. Tremor and rotation are ignored.

____________ Total Score

ASSESS level of consciousness along a continuum:

30 ( )

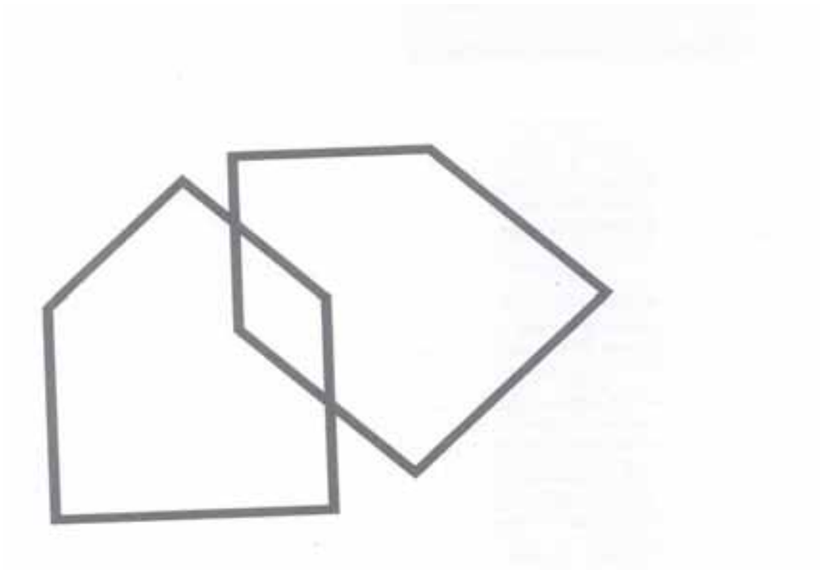
Alert	Drowsy	Stupor	Coma
30	20	10	0

Reading:

CLOSE YOUR EYES

Writing:

Construction:



KGV(M)

KGV (MODIFIED) SYMPTOM SCALE (VERSION 6)
Krawiecka, Goldberg and Vaughn (1977)
(Modified Lancashire 1998)

General guidelines for using the scale:

The purpose of the KGV(M) is to enable the user to elicit, and to measure the severity of, those psychiatric symptoms that are most commonly experienced by people who have psychotic illness' such as schizophrenia and bi-polar affective disorder. The measure is only reliable when used by an appropriately trained and experienced rater. Potential users of the measure are urged to obtain training which allows them to demonstrate acceptable reliability before employing the measure in clinical or research settings.

The measure comprises 14 symptoms. Ratings from symptoms 1 to 6 are based on information elicited from the subject using semi-structured questioning, and the time frame for the assessment of the symptoms is the month prior to the interview.
Ratings from 7 to 14 are based on systematic observation of the subjects behaviour during the interview.

For symptoms 1 to 6, questions are listed to guide the rater when eliciting and rating the severity of these symptoms. Questions in bold type are mandatory. All these questions should be asked when assessing a subject. The rater should never assume that they know how a subject will answer a mandatory question. Each mandatory question is followed by supplementary questions in ordinary type. The purpose of these supplementary questions is to elicit more detailed information concerning a particular symptom e.g. frequency, intensity, severity and duration in the last month.

If the subject's response to a mandatory question is clearly and unambiguously negative, the rater may pass directly to the next mandatory question. If the subject gives a positive response to a mandatory question or if their response is ambiguous and/or unclear the rater should ask the accompanying supplementary questions in order to clarify the nature of the subject's experiences before making a final judgement about the symptom in question. When necessary the rater should employ additional questions of their own to help with this process, until they have sufficient information to make a reliable judgement concerning the symptom. This pattern of questioning should be adhered to as far as is possible in every interview.

The wording of mandatory questions should not be altered since this may adversely affect the reliability and the validity of the assessment.
With practice, the rater will become skilled at asking these questions in a fluent and natural manner.

In addition to the specific eliciting questions provided for symptom 1 to 6, the following generic questions should be employed whenever a symptom is found to have been present in the last month.

For Anxiety, Depressed mood and Elevated mood:

1. Frequency.
How often have you felt.....in the last month? Have you felt.....all the time? Have you felt.....most days or only in a minority of days?

2. Duration.
When you feel.....how long does it usually last? Does it last for a few minutes or several hours? Does it last all day or only a part of the day? Have never been free of.....in the last month?

3. Subjective severity.
How strong is the feeling of.....? Is it an intensive feeling that is difficult for you to bear? Does it seem to overwhelm you? Is it usually a mild or moderate feeling?

4. Control.
When you start to feel.....can you control the feeling to an extent? Can you reduce or stop the feeling by turning your attention to other things, such as watching television or going for a walk, or chatting to someone? Can you put it completely out of your mind?

For Delusions:
1. Frequency.
How often have you thought about.....in the last month? Are these thoughts always on your mind? Do you think about.....most days or only on a minority of days? Do you find that.....is on your mind a lot recently? How much of the time?

2. Conviction.
How sure are you that.....? Are you certain, or is there a real possibility that you could be mistaken? Have there been days when you have had your doubts? Is there any possible explanation for.....? What is the likelihood that you are mistaken? On a scale of 0 to 100 percent, how convinced are you?

For Hallucinations:
1. Frequency.
How often have you heard/seen.....in the last month? Have you heard/seen.....every day?
Has it happened most days or just the odd few days recently?

2. True or psuedo hallucinations.
When you hear these voices/noises, where do they seem to be coming from? Do they seem to be coming from somewhere in the room or somewhere outside? Do you hear these voices/noises through your ears or do they seem to be inside your head?

3. True or psuedo hallucinations.
When you see.....how real do they appear to be? Do they look solid or can you see through them? Do they seem three dimensional or flat? Are they coloured or black and white? Do they look completely real? Do they move about in space?

For symptoms 7 to 14, observational guidelines are provided which list the particular component behaviours to which the rater must attend when assessing these symptoms. The rater should assess each behavioural component separately before arriving at an overall severity rating for the symptom. There is a tendency for most of the rater's time and attention to be given to the assessment of symptoms 1 to 6, since these symptoms must be actively elicited by detailed

questioning. The rater must be aware of this potential bias and ensure the adequate time and attention are also given to the observation and assessment of the scale's behavioural symptoms. In general, it is more difficult to achieve acceptable reliability when rating behavioural symptoms so the amount of care and deliberation given to the assessment of these symptoms should at least equal that given to the rating of the elicited symptoms.

Sometimes, the subject's responses to the eliciting questions may not appear to be consistent with aspects of their observed behaviour. For example, the subject may appear during the interview to be distracted by auditory hallucinations, yet give negative answers to all the questions. In order to resolve this situation the rater should rate the suspected elicited symptom as absent or negative (score-zero), but rate the behavioural symptom i.e. abnormal movements as present or positive (score 1 to 4) so as to indicate that abnormal movements were observed. The final section; co-operation would also be scored positive, where the rater would note their reservations about the subject's responses about hallucinations.

When assessing the severity of a symptom, the rater should not be influenced by possible causes of the symptom. For example, it will sometimes become clear that the subject has developed affective symptoms in response to severe life events, such as bereavement, unemployment or homelessness or in response to disturbing delusional ideas. However, the fact that a subject has become anxious or depressed following exposure to stressful life experiences or as a consequence of delusional ideas, does not mean their symptoms should be ignored or rated any less severely than might otherwise have been the case. Similarly, some abnormal behaviours may be caused or exacerbated by medication. These should be recorded under the appropriate behavioural items and a rating made based on the observed severity of the behaviour. For example, tardive dyskinesia or akathisia should be noted under abnormal movements and the fact that these may be caused by medication should not lead to them being ignored or rated less severely.

Finally, it is essential that the rater uses the KGV(M) data sheet to make detailed notes during the interview. There are two important reasons for this. First, to record the evidence upon which the ratings are based, allowing the rater to check the accuracy of their ratings and to maintain standards of reliability and validity. This would include information on the frequency, duration, subject severity, content and degree of control over the subject's symptoms.
Second, to record clinically useful information that can be drawn upon by the practitioner when planning clinical interventions. This would include information on the cognitive and behavioural antecedents and consequences associated with the symptoms, coping strategies and the responses of significant people such as family or other carers. It is as important to record this information as it is to record a rating of symptom severity.

A number of aggregate scores can be derived from the measure. A total symptom score is calculated by summing the scores for items 1 to 13 (Item 14 must be excluded from the total score as it is not a psychiatric symptom, but an index of the accuracy and completeness of the assessment). A positive symptom score can be calculated by summing the scores for delusions, hallucinations, and abnormal speech. A negative symptom score can be calculated by summing the scores for flattened affect, psychomotor retardation and poverty of speech; an affective score by summing scores for anxiety, depression and elevated mood.

Care must be exercised when interpreting these aggregate scores. All the symptom severity scales are structured in such a way that a score of 1; represents phenomena that lie within the range of normal experience and are not

definitely indicative of psychiatric illness. It is useful to be able to detect and record these relatively minor phenomena, since their presence may provide early warning signs of the onset of more severe psychiatric problems. But as a result it is possible for a subject to achieve substantial aggregate scores in the absence of any definite mental illness. It is therefore essential that when assessing the clinical significance of a subject's results, attention is paid to the individual symptom scores, in order to identify those scores which indicate definite psychiatric morbidity.

1. ANXIETY - ELICITING QUESTIONS

WORRYING: **Have you worried a lot in the last month?** What do you worry about? What is it like when you worry? Do unpleasant thoughts constantly go round and round in your mind?
Can you stop them by turning your attention to something else? How often have you worried like this in the last month?

TENSION PAINS: **Have you had headaches or other aches and pains in the last month?**
What Kind? e.g. a band around the head, tightness in the scalp, ache in the back of the neck or shoulders?

TIREDNESS OR EXHAUSTION: **Have you been getting exhausted or worn out during the day or evening, even when you have not been working very hard?** Do you feel tired all the time for no apparent reason? Is it a feeling of tiredness or exhaustion? Do you have to take a rest during the day?

MUSCULAR TENSION: **Have you had difficulty relaxing in the last month?** Do your muscles feel tensed up? Is it hard to get rid of the tension?

RESTLESSNESS: **Have you been so fidgety and restless that you couldn't sit still?** Do you have to keep pacing up and down?

HYPOCHONDRIASIS: **Do you tend to worry over your physical health?** What does your doctor say is wrong? What do you think may be wrong with you?

SUBJECTIVE NERVOUS TENSION: **Do you often feel on edge, or keyed up, or mentally tense?** Do you generally suffer from your nerves? Do you suffer from nervous exhaustion?

FREE FLOATING ANXIETY: **Have there been times lately when you have been very anxious or frightened?** What was this like? Did you experience unpleasant bodily sensations like blushing, butterflies, choking, difficulty getting breath, dizziness, dry mouth, palpitations, sweating, tingling sensations, trembling? How often in the last month?

ANXIOUS FOREBODING: **Have you had the feeling that something terrible might happen?**
A feeling that some disaster might occur but not sure what? Have you been anxious about getting up in the morning because you are afraid to face the day? What did this feel like?
Did you experience unpleasant bodily sensations?

PANIC ATTACKS: **Have you had times when you felt shaky, or your heart pounded, or you felt sweaty and you simply had to do something about it?** What was it like? What was happening at the time? How often in the last month?

SITUATIONAL ANXIETY: **Have you tended to get anxious in certain situations, such as travelling, or in crowds, or being alone, or being in enclosed spaces?** What situations? Did you experience unpleasant bodily sensations? How often in the past month?

ANXIETY ON MEETING PEOPLE: **What about meeting people e.g. going into a crowded room? Making conversation?**

SPECIFIC PHOBIAS: **Do you have any special fears, like some people are scared of cats, spiders or birds?**

AVOIDANCE: **Do you avoid any of these situations (specify as appropriate) because you know you will get anxious?** How often have you found yourself doing this in the last month?
How much does this affect your day to day life?

1. ANXIETY-RATING SCALE.

0 = The subject reports no anxiety in the last month.

1 = The subject reports mild anxiety. The subject's anxiety lies within the normal range of variation in mood experienced by the majority of people in the course of their daily lives. A mild and transient response to minor life stresses. The subject can easily and quickly stop their anxious thoughts and feelings by turning their attention to other things, or these thoughts and feelings quickly come and go of their own accord. No signs of motor tension or autonomic hyperactivity are present.

2 = The subject reports moderate anxiety. The subject is able to exercise some control over their anxiety, and can reduce or put a stop to the anxiety by turning their attention to other things, but this requires a distinct and sustained effort. If signs of motor tension or autonomic hyperactivity are present these are mild or of very brief duration.

3 = The subject reports marked anxiety. The subject has no control over the anxiety when it occurs and cannot turn their attention to other things, even when a distinct and sustained effort is made. At least one marked and persistent sign of motor tension or autonomic hyperactivity should accompany the anxiety. The anxiety has been present in this form on the minority of days in the last month.

4 = The subject reports severe anxiety. The subject has no control over their anxiety when it occurs and cannot turn their attention to other things, even when a distinct and sustained effort is made. At least one marked and persistent sign of motor tension or autonomic hyperactivity should accompany the anxiety. The anxiety has been present in this form on the majority of days in the last month.

NOTES:

A. Signs of motor tension include: physical restlessness, trembling, involuntarily tensed muscles, tension pains affecting neck, back or legs and tension headaches. Signs or autonomic hyperactivity include: *gastro-intestinal*: dry mouth, difficulty swallowing, epigastric discomfort, frequent loose motions; *respiratory*: feeling of constriction in the chest, difficulty inhaling, hyperventilation; *cardiovascular*: discomfort over the heart, palpitations, missed heartbeats, throbbing in the neck; genitourinary; frequency and urgency of micturition, failure of erection, lack of libido, increased menstrual discomfort; nervous system: tinnitus, blurring of vision, dizziness, prickling sensations, sweating, blushing.

B. Some of the subject's utilise avoidance strategies as a means of coping with their anxiety.
They may report experiencing little or no anxiety in the previous month because they have avoided those situations which would have provoked anxiety. For example, a person who experiences severe anxiety in public situations may have avoided this by staying at home all the time, relying on a relative or other carer to carry out essential tasks like shopping or going to work. In these circumstances it is recommended that the score for anxiety should be based on the level of reported anxiety experienced by the subject, but the presence of avoidance strategies, the frequency with which they are employed and the disruption they cause to the person's social functioning should also be noted.

2. DEPRESSION-ELICITING QUESTIONS

POOR CONCENTRATION: **What has your concentration been like recently?** Can you read an article in the paper or watch a TV. programme right through? Do your thoughts drift so that you don't take things in?

NEGLECT DUE TO BROODING: **Do you tend to brood on things?** So much that you neglect things like your work, or eating, or housework, or looking after yourself?

LOSS OF INTEREST: **What about your interests, have they changed at all?** Have you lost interest in work, or hobbies, or recreations? Have you let your appearance go?

DEPRESSED MOOD: **Do you keep reasonably cheerful, or have you been very depressed or low spirited recently?** Have you cried at all, or wanted to cry? When did you last really enjoy doing anything?

MORNING DEPRESSION: **Is the depression worse at any particular time of day?**

HOPELESSNESS: **How do you see the future?** Has life seemed quite hopeless? Can you see any future? Have you given up, or does there still seem some reason for trying?

SOCIAL WITHDRAWAL: **Have you ever wanted to stay away from other people?** Why? Have you been suspicious of their intentions? Afraid of actual harm?

SELF-DEPRECIATION: **What is your opinion of yourself compared with other people?** Do you feel better, or not as good, or about the same as most? Do you feel inferior or even worthless?

LACK OF SELF CONFIDENCE: **How confident do you feel in yourself?** For example when talking to others, or in managing your relations with other people?

IDEAS OF REFERENCE: **Are you self-conscious in public?** Do you get the feeling that other people are taking notice of you in the street, or a bus, or a restaurant? Do they ever seem to laugh at you or talk about you critically? Are people really looking at you or is it perhaps the way you feel about it?

GUILTY IDEAS OF REFERENCE: **Do you have the feeling that you are being blamed for something, or even being accused?** What about?

PATHOLOGICAL GUILT: **Do you tend to blame yourself at all?** If people are critical at all, do you think you deserve it?

LOSS OF WEIGHT DUE TO POOR APPETITE: **What has your appetite been like recently?** Have you lost any weight in the last three months? Have you been trying to lose weight?

DELAYED SLEEP: **Have you had any trouble getting off to sleep recently?** How much has it affected you?

SUBJECTIVE ANERGIA AND RETARDATION: **Do you seem to be slowed down in your movements, or have too little energy recently?** How much has it affected you?

EARLY WAKING: **Do you wake early in the morning?** What time do you wake? Can you get back off to sleep, or do you lie awake? How often has this happened in the last month?

LOSS OF LIBIDO: **Has there been any change in your interest in sex?**

IRRITABILITY: **Have you been much more irritable than usual recently?** How do you show it? Do you keep it to yourself, or shout/hit people?

DELUSIONS OF GUILT: **Do you feel as if you have committed a crime, or sinned greatly, or deserve punishment?** Have you felt that your presence might contaminate or ruin other people?

HYPOCHONDRIACAL DELUSIONS: **Is there anything the matter with your body?** Do you think you have some kind of serious physical illness? Have you told your doctor about this?

2. DEPRESSION - RATING SCALE

0 = The subject reports no depression in the last month.

1 = The subject reports mild depression. The subject's depression lies within the normal range of variation in mood experienced by most people in the course of their daily lives. A mild and transient response to minor life stresses. The subject can easily and quickly stop their depressive thoughts and feelings by turning their attention to other things, or, these thoughts and feelings quickly come and go of their own accord. No biological symptoms of depression are present.

2 = The subject reports moderate depression. The subject is still able to exercise some control over their depression, and can reduce or put a stop to the depression by turning their attention to other things, but this requires a distinct and sustained effort. If biological symptoms are present these are very mild or of low frequency.

3 = The subject reports marked depression. The subject has no control over their depression when it occurs and cannot turn their attention to other things, even when a distinct and sustained effort is made. At least one marked and persistent biological symptom of depression should be present. The depression has been present in this form for the minority of days in the last month.

4 = The subject reports severe depression. The subject has no control over their depression when it occurs and cannot turn their attention to other things, even when a distinct and sustained effort is made. At least one of the biological symptoms of depression and at least one indicator of severe depression should be present. The depression has been present in this form for the majority of days in the last month.

NOTES:

A. Biological symptoms of depression include: psychomotor retardation, sleep disturbance, diurnal variation in mood, loss of appetite, unintentional loss of weight, constipation, loss of libido, amenorrhea.

B. Indicators of severe depression include: a conviction of worthlessness or hopelessness, mood congruent delusions concerning guilt, ill health, impoverishment, nihilism, punishment and persecution, mood congruent hallucinations with a critical, threatening or catastrophic content, uncontrollable weeping, a complete loss of the ability to feel emotion, specific plans for committing suicide, or attempts at suicide with serious intent to die.

3. SUICIDAL THOUGHTS AND BEHAVIOUR - ELICITING QUESTIONS.

NEGATIVE EVALUATION OF LIFE: **In the last month, have there been times when you felt that life wasn't worth living?** How often have you felt like this recently?

ADVANTAGES FOR SELF: **Have you felt that you may be better off dead?** Do you feel that it would be a relief from your problems? Does it seem like the only solution to your problems, or could things still be put right by other means? Are you sure of this? How often have you thought like this recently?

ADVANTAGES FOR OTHERS: **Have you thought that other people would be better off if you were dead?** In what way would they be better off? Would they be happier if you were gone? Are you sure of this? How often have you thought like this recently?

ACTIVE DESIRE FOR DEATH: **Have you found yourself actually wishing you were dead and away from it all?** How often have you felt like this?

SUICIDAL THOUGHTS: **Have you had any thoughts about taking your own life?** Have you thought seriously about this? Has the idea of taking your life kept coming into your mind? How much of the time has this been in your mind in the last month?

PLANS FOR SUICIDE: **Have you made plans for taking your life?** What do you think you might do? Have you decided how and where you might do this? Have you decided on a time? What prevents you from carrying out your plans? Does the thought of dying make you feel afraid? Does it make you feel relieved? Are you resigned to the fact?

PREPARATIONS FOR SUICIDE: **Have you made any preparations for taking your life?** What have you done? Have you got the means to do it? Have you written a letter saying why you want to do this?

RECENT ATTEMPTS: **Have you actually tried to take your life recently?** What did you do? Did you expect to die? Do you intend to try again? When might you do this?

3. SUICIDAL THOUGHTS AND BEHAVIOUR - RATING SCALE.

0 = No thoughts that life is pointless and not worth living. No hopelessness about the future. No thoughts that self or others would be better off if subject were dead. No thought about possibility of taking own life. No active desire to die, or preparations for suicide, or attempts at suicide.

1 = Occasional brief thoughts that life has no point or is not worth living, and/or that the future is hopeless, and/or that self or others would be better off if subject were dead. No thoughts about possibility of taking own life.
No active desire to die, or preparations for suicide, or attempts at suicide.

2 = Frequent or prolonged thoughts that life has no point or is not worth living, and/or that the future is hopeless, and/or that self or others would be better off if subject were dead. Thoughts about possibility of taking own life, but no thoughts about specific methods of doing this. No preparations for suicide or attempts at suicide.

3 = Frequent or prolonged thoughts that life has no point or is not worth living, and/or that the future is hopeless and/or that self or others would be better off if subject were dead. Thoughts about committing suicide that include consideration of specific methods. No preparations for suicide or attempts at suicide.

4 = Firm belief that life has no point or is not worth living, and/or that the future is hopeless and/or that self or others would be better off if subject were dead. Has formed desire to kill self. Has a plan for committing suicide by a specific method and has made preparations for implementing this plan, or has made an attempt at suicide in the last month using a method which the subject thought could be lethal.

NOTES

A. Record a positive rating if the subject satisfied the relevant criteria at any time in the last month.

B. If the subject is given a positive score, a more detailed assessment of suicidal risk is recommended, using valid and reliable instruments e.g. Beck's suicide inventory, Beck's Hopelessness scale.

4. ELEVATED MOOD - ELICITING QUESTIONS

EXPANSIVE MOOD: **Have you sometimes felt particularly cheerful and on top of the world, without any reason?** How would you describe the feeling? Was it a feeling of ordinary happiness or something unusually intense? How long did the feeling last? Could you control the feeling? Was it a pleasant feeling or did it seem too cheerful to be healthy? How often have you felt like this in the last month?

SUBJECTIVE IDEOMOTOR PRESSURE: **Have you felt particularly full of energy lately, or full of exciting ideas?** Do things seem to go too slowly for you? Do ideas or images seem to pass through your mind at a faster rate than normal? Do you need less sleep than usual? Do you feel yourself getting extremely active but not getting tired? Did you stay up all night because you felt too full of energy to sleep? Have you developed any new interests recently?

GRANDIOSE IDEAS AND ACTIONS: **Have you seemed super efficient, or felt as though you had special powers or talents quite out of the ordinary?** Have you felt especially healthy? Have you been buying any interesting things recently? Have you told other people about how you were feeling, or about your ideas and plans? Did you feel that you had to tell everyone about it?

4. ELEVATED MOOD - RATING SCALE

0 = The subject reports no instances of elevated mood in the last month.

1 = The subject reports mild elevated mood. The subject experiences a feeling of happiness, or excitement, or enhanced well being, which lies within the normal range of variation in mood experienced by the majority of people in their daily lives. The feeling quickly subsides, either spontaneously, or when the subject's attention is turned to other things. The subject experiences no increase in the rate of mental processes or physical activity.

2 = The subject reports moderately elevated mood. The subject experiences a feeling of exceptional happiness, or excitement, or enhanced well being. The feeling persists for several hours or longer, and is not affected by attending to other things. The subject may also experience a slight increase in the rate of mental processes or physical activity.

3 = The subject reports marked elevated mood. The subject experiences a feeling of intense happiness, or excitement, or well being. The feeling persists for several hours or longer, and is not affected by attending to other things. The subject may also experience a marked increase in the rate of mental processes or physical activity, or a reduced need for sleep, or act upon grandiose ideas. Elevated mood was present in this form on a minority of days in the last month.

4 = The subject reports severely elevated mood. The subject experiences a feeling of intense happiness, or excitement, or well being. The feeling persists for several hours or longer, and is not affected by attending to other things. The subject may also experience a marked increase in the rate of mental processes, or physical activity, or a reduced need for sleep, or act upon grandiose ideas. Elevated mood was present in this form for a majority of days in the last month.

NOTES:

A. Include drug induced mood states and note the cause.

5. HALLUCINATIONS - ELICITING QUESTIONS

AUDITORY HALLUCINATIONS: **Do you ever seem to hear noises or to hear voices when there is no one about and nothing else to explain it?**

NON-VERBAL AUDITORY HALLUCINATIONS**: Do you ever hear noises like tapping or music? Do you ever hear muttering or whispering?** Can you make out the words?

VERBAL HALLUCINATIONS: What does the voice say? (If critical or accusatory). Do you think that it is justified? Do you deserve it? Do you hear your name being called?

VOICES DISCUSSING SUBJECT IN THE THIRD PERSON OR COMMENTING ON THOUGHTS AND ACTIONS: Do you hear several voices talking about you? Do they refer to you as s/he? What do they say? Do they seem to comment on what you are thinking, or reading, or doing?

VOICES SPEAKING TO SUBJECT: Do they speak directly to you? Are they threatening or unpleasant?
Do they call you names? Do they give you orders?

DISSOCIATIVE HALLUCINATIONS: Can you carry a two - way conversation with ______(name of the voice)?
Do you see or smell anything at the same time as you hear the voice? Who is it you are talking to? What is the explanation? Do you know anyone else who has this kind of experience?

TRUE OR PSEUDO AUDITORY HALLUCINATIONS: Do you hear these voices inside your head or can you hear them through your ears? Where do they seem to be coming from? Do they seem to come from somewhere in the room, or from somewhere else? Do they sound like someone in the room is talking to you? How long did the voice(s) last for? Were you half asleep at the time, or has it occurred when you were fully awake? How do you explain them?

VISUAL HALLUCINATIONS: **Have you seen things that other people cannot see?** What did you see?

FORMLESS VISUAL HALLUCINATIONS: **Have you seen shadows or flashes of light?** What did you see?

TRUE OR PSEUDO VISUAL HALLUCINATIONS: Did you see these things with your eyes or in your mind? How real did they look? Were they solid or could you see through them? Were they three dimensional or flat, like a photograph? Were they coloured or black and white? How long did the image last for? Were you half asleep at the time, or has it occurred when you were fully awake? Did the vision seem to arise out of a pattern on the wallpaper or shadows in the room? How do you explain it?

OLFACTORY HALLUCINATIONS: **Do you sometimes notice strange smells that other people don't notice?** What sort of smell is it? How do explain it? **Do you think that you, yourself give off a strange smell?** What sort of smell is it? How do you explain it?

SOMATIC HALLUCINATIONS: **Do you ever feel that someone is touching you, but when you look nobody is there?** How do you explain this? **Do you sometimes notice strange feelings inside your body?** How do you explain this?

GUSTATORY HALLUCINATIONS: **Have you noticed that food or drink seems to have an unusual taste recently?** How do you explain this?

HEIGHTENED PERCEPTIONS: **Have there been times recently when sounds have seemed unnaturally clear or loud, or things have looked vividly coloured or detailed?**

DULLED PERCEPTION: **Have things seemed dark, or grey or colourless?**

CHANGED PERCEPTION: **Does the appearance of things or people change in a puzzling way: e.g. in shape, size or colour?**

5. HALLUCINATIONS - RATING SCALE.

0 = The subject reports no unusual sensory experiences in the last month.

1 = The subject reports any of the following; illusions, eidetic imagery, intensified or dulled perceptions, distorted perceptions, brief and elementary hypnagogic and hypnapompic hallucinations.

2 = The subject reports any of the following; pseudo hallucinations, elementary hallucinations when fully awake.

3 = The subject reports true hallucinations occurring on a minority of days in the last month.

4 = The subject reports true hallucinations on a majority of days in the last month.

NOTES:

A. Illusions are misrepresentations of real stimuli.

B. Eidetic imagery is intense mental imagery which can be called up and terminated by voluntary effort.

C. Hypnagogic hallucinations occur at the point of falling asleep and hypnapompic hallucinations occur at the point of waking up. In non-psychotic subjects they are brief and elementary.

D. Elementary hallucinations comprise experiences such as brief noises, flashes of light, sensations of movement at the edge of the visual field.

E. True auditory hallucinations are noises or voices, which seem to come from a location, which is external to the subject's head. They sound as if they are coming from within the room or from outside in the street, or sometimes from a part of the subject's own body, e.g. their stomach. Pseudo auditory hallucinations are noises or voices that seem to be located in the subject's head.

F. True visual hallucinations have all or most of the qualities of a real object. They appear solid, three dimensional, coloured, and may move about in space. Pseudo visual hallucinations do not appear convincingly real because they lack most of the above qualities. They may appear translucent, flat and colourless.

G. The distinction between true and pseudo hallucinations cannot reliably be applied to hallucinations experienced in other modalities, e.g. smell, touch, deep sensation and taste. If the subject reports a clear instance of an hallucination affecting one of these senses, this should be rated as a true hallucination.

6. DELUSIONS - ELICITING QUESTIONS.

INTERFERENCE WITH THINKING: **Can you think clearly or is there any interference with your thoughts?**
What kind of interference? **Are you in full control of your thoughts?**

THOUGHT INSERTION: **Are thoughts put into your head which you know are not your own?** How do you know they are not your own? Where do they come from?

THOUGHT BROADCAST: **Do you seem to hear your own thoughts spoken aloud in your head, so that someone standing near might be able to hear them?** How do you explain this? Are your thoughts broadcast so that other people know what you are thinking?

THOUGHT ECHO OR COMMENTARY: **Do you ever seem to hear your own thoughts repeated or echoed?**
What is it like? How do you explain it? Where does it come from?

THOUGHT BLOCK OR WITHDRAWAL: **Do you ever experience your thoughts stopping quite suddenly so that there are none left in your mind, even though your thoughts were flowing quite freely before?** What is it like? How does it occur? What is it due to? **Do your thoughts ever seem to be taken out of your head, as though some external thought were removing them?** Can you give an example? How do you explain it?

DELUSION OF THOUGHTS BEING READ: **Can anyone read your thoughts?** How do you know? How do you explain it?

DELUSIONS OF CONTROL: **Do you ever feel under the control of some force or power other than yourself?** As though you were a robot without a will of your own? As though you were possessed by someone or something else? What is it like?

DELUSIONS OF REFERENCE: **Do people seem to drop hints about you, or say things with a double meaning, or do things in a special way so as to convey a meaning?** Can you give an example of what they do? Does everyone seem to gossip about you? What do they say? **Do people follow you about, or check up on you, or record your movements?** Why are they doing this?

DELUSIONAL MISINTERPRETATION AND MISIDENTIFICATION: **Do things seem to be specially arranged?**
Is an experiment going on, to test you out? Do you see any reference to yourself on TV or in the papers? Do you ever see special meanings in advertisements?

DELUSIONS OF PERSECUTIONS: **Is anyone deliberately trying to harm you, e.g. trying to poison or kill you?** How? Is there any kind of organisation behind it? Is there any other kind of persecution?

DELUSIONS OF ASSISTANCE: **Do you think people are organising things specially to help you?** What are they doing?

DELUSIONS OF GRANDIOSE ABILITIES: **Is there anything special about you? Do you have any special abilities or powers?** Can you read people's thoughts? Is there a special purpose or mission to your life? Are you especially clever or inventive?

DELUSIONS OF GRANDIOSE IDENTITY: **Are you a very prominent person or related to someone prominent like royalty?** Are you very rich or famous? How do you explain this?

RELIGIOUS DELUSIONS: **Are you a very religious person?** Specially close to god? Can god communicate to you? Are you yourself a saint?

DELUSIONS CONCERNING APPEARANCE: **Do you think your appearance is normal?**

DELUSIONS OF DEPERSONALISATION: **Is anything the matter with your brain?**

DELUSIONAL EXPLANATION: **How do you explain things that have been happening?** Is anything like hypnosis or telepathy going on? Is anything like electricity, or X-rays, or radio waves affecting you?

6. DELUSIONS - RATING SCALE.

0 = The subject reports no unusual ideas in the last month.

1 = The subject reports any of the following: overvalued ideas: ideas of reference.

2 = The subject reports partial delusions present during the last month.

3 = The subject reports full delusions present on a minority of days in the last month.

4 = The subject reports full delusions present on a majority of days in the last month.

NOTES:

A. An overvalued idea is an idiosyncratic belief held on inadequate grounds, which is not delusional or obsessional in nature, and which is not a conventional belief within the subject's culture or religion.

B. Ideas of reference arise in people who are overly self-conscious. The subject feels that other people are taking notice of him/her in ordinary public situations, recognises that this feeling originates within them-selves and is out of proportion to any possible cause, but cannot help having this feeling.

C. A delusion is a belief that is firmly held on inadequate grounds, is resistant to rational argument or evidence to the contrary, and is not a conventional belief within the subject's culture or religion. It is held with full conviction but is not arrived at by a process of logical reasoning and is not adequately supported by evidence. Delusions are usually false beliefs, but may occasionally be true or become true. It is not the falsity of the belief which determines whether it is delusional, but the nature of the mental processes which led to the belief.

D. A partial delusion meets all the criteria for a delusional belief except that it is held with less than full conviction. The following questions are suggested to assist the rater in distinguishing between full and partial delusions:
"How certain are you that (specify the belief) is true?"
"Do you think that you could be mistaken about (specify the belief)?"
"Do you have any doubts about (specify the belief)?"

E. Care should be taken when asking questions concerning thought insertion, thought broadcast, thought echo or commentary, thought block, and thought withdrawal. The basic experiences enquired about under these headings are not in themselves sufficient to justify a positive rating for delusions. To allow a positive rating for delusions, the rater must also establish that the subject has acquired delusional beliefs concerning these experiences. For example, the basic experience enquired about under the heading thought broadcast is that of hearing one's own thoughts spoken aloud in one's head. This should be taken as a simple description of the subject's experience and should not be classed as a delusional belief. If, in addition, the subject believes that their thoughts are so loud that other people can share their thoughts at a distance, this could be classed as a delusional belief concerning their experience of loud thoughts.

7. FLATTENED AFFECT - OBSERVATIONAL GUIDELINES.

Emotion is normally conveyed by variations in facial expression, vocal pitch and volume, hand and arm gestures, and body posture. When flatness of affect is present the subject shows a reduction in the range and frequency of these variations in expression, voice, gesture and posture. The resulting impression is that the subject finds it difficult, or in extreme cases impossible, to convey their emotional reactions during the interview. This does not necessarily mean that they lack emotional feelings, only that they may have difficulty conveying their feelings to others. When assessing flatness of affect, consider the following factors.

A. Variation in facial expression: there may be a reduction in the movement of some or all of the facial muscles that are normally used to form facial expressions. The subject may show no sign of a smile when talking about amusing or pleasant events, or may form a limited, partial smile with the mouth, while the muscles around the eyes fail to move. Similarly, when discussing sad or distressing topics the subject's face may show little signs of distress.

B. Variation in vocal pitch and volume: the subject's voice may show little or no variation in pitch or volume, regardless of the emotional content of the interview, and may have a monotonous quality. Alternatively, the same pattern of rising and falling pitch may be repeated throughout the interview, but the inflections do not correspond to changes in the emotional content of the interview and are not present to give emphasis to particular words or feelings.

C. Gesture and posture: hand and arm gestures, together with changes in body posture, are also used to help convey emotion. The subject who feels happy or excited may use frequent rapid hand gestures to add emphasis to their description of pleasant events. An angry subject may lean forwards towards the interviewer to give emphasis to the strength of their angry feelings. These gestures and changes in body posture may be reduced or entirely absent in the subject with flattened affect.

D. Depressed subject's may show a diminution in their range of facial expression, vocal range, and their of movements and gesture. These subject's may have an unvarying sad expression, their speech may exhibit repeated patterns of descending pitch, and they maintain a "closed posture," with limited use of gesture, little change in posture, and reduced eye contact. When this pattern of behaviour is observed in a depressed subject, it should not be rated as flattened affect, since the subject's face, voice and posture accurately reflect their depressed affect. When flattened affect is present, the subject conveys an inappropriately reduced emotional response, or no response at all.

E. Some subject's show a normal range of emotional expression during most of the interview, but appear calmly indifferent to emotive topics. For example, the subject may describe disturbing hallucinations or bizarre delusions in a matter of fact way, with little or no signs of concern or emotional distress. This should be rated as flattened affect.

7. FLATTENED AFFECT - RATING SCALE

0 = The subject exhibits no evidence of flattened affect during the interview.

1 = The subject's emotional responses appear mildly flattened. Emotive topics evoke an emotional response from the subject but this is slightly less than might normally be expected.

2 = The subject's emotional responses appear moderately flattened. Emotive topics evoke an emotional response from the subject but this is distinctly less than might normally be expected.

3 = The subject's emotional responses appear markedly flattened. Very little emotion is shown, even when discussing emotionally highly charged topics. The subject cannot convey the impact of distressing symptoms and events, and shows little sign of concern when discussing current problems and future plans.

4 = The subject's emotional responses appear severely flattened. No emotional expression whatever regardless of the topic discussed. The subject's face is expressionless, their voice unvaryingly monotonous or confined to a repetitive pattern of inflection which is unrelated to the content of their speech. There is no expressive use of gesture or posture.

8. INCONGRUOUS AFFECT - OBSERVATIONAL GUIDELINES.

In subject's with incongruous affect, the expressed emotion is not in keeping with the situation, or with the topic of conversation, or with the subject's own feelings. By contrast, subject's with flattened affect either exhibit no emotional response, or responses that are appropriate but less intense than might normally be expected. When rating incongruity, consider the following factors:

A. Inappropriate jocularity: the subject makes jokes or laughs when discussing unpleasant or distressing topics, or smiles or giggles repeatedly during the interview for no apparent reason.

B. Unprovoked tearfulness: the subject becomes tearful when discussing neutral or pleasant topics. The rater should ensure that the tearfulness is not due to an underlying depressive state.

8. INCONGRUOUS AFFECT - RATING SCALE.

0 = The subject exhibits no evidence of incongruous affect during the interview.

1 = The subject's emotional responses appear mildly incongruous. Slightly inappropriate or odd emotional responses occur during the interview.

2 = The subject's emotional responses appear moderately incongruous. Distinctly inappropriate emotional responses occur occasionally during the interview. The majority of emotional responses are not incongruous.

3 = The subject's emotional responses appear markedly incongruous. Distinctly inappropriate emotional responses occur frequently during the interview. The majority of emotional responses are incongruous.

4 = The subject's emotional responses appear severely incongruous. Distinctly inappropriate emotional responses occur constantly during the interview. All of the subject's emotional responses are incongruous.

9. OVERACTIVITY - OBSERVATIONAL GUIDELINES.

When overactivity is present there is an increase in the frequency, and/or speed, and/or extent of bodily movements. When rating overactivity, consider the following factors:

A. Generalised restlessness: during the course of an interview, healthy subject's will change their posture and position from time to time to avoid physical discomfort. The overactive subject changes posture and position more frequently than is normally required to maintain physical comfort and may engage in repetitive, unnecessary movements of the limbs. In mild form, the subject appears fidgety and restless but is able to remain seated. In more extreme form, the subject may find it impossible to remain seated and gets up from the chair to pace about the room.

B. Increased speed of movements: the subject performs movements more rapidly than is normal, walks or paces abnormally quickly, makes rapid shifts in postures and position, gestures rapidly.

C. Gross excitement: the subject runs about, jumps around, waves their arms wildly, shouts or screams, and may throw things.

9. OVERACTIVITY - RATING SCALE.

0 = The subject exhibits no evidence of overactivity during the interview.

1 = The subject appears mildly overactive. They are occasionally fidgety or restless but are able to remain still for substantial periods of time. The subject is never so restless that they get up from their chair and pace about the room.

2 = The subject appears moderately overactive. They are fidgety or restless for the majority of the interview and are able to remain still for only short periods of time. They may rise from their chair and pace about the room on one or two brief occasions, but it always possible for the subject to return to their seat and complete the interview.

3 = The subject appears markedly overactive. They are constantly fidgety or restless and unable to remain still for more than a few seconds. They may rise from their chair frequently and pace about the room. It may not be possible to complete the interview in a single session because the subject spends a substantial part of the time pacing.

4 = The subject appears severely overactive. The subject is grossly excited, remains seated for only brief periods, and spends most of the time pacing rapidly about the room or even running around. The subject cannot be interviewed.

NOTES:

A. The abnormal movements which are typical of medication induced akathisia should be rated under Abnormal Movements and Postures and not under this section of the measure.

B. The abnormal movements which are typical of medication induced tardive dyskinesia should also be rated under Abnormal Movements and Postures and not under this section of the measure.

10. PSYCHOMOTOR RETARDATION - OBSERVATIONAL GUIDELINES.

When psychomotor retardation is present there is a reduction in the frequency, speed and extent of voluntary movements, leading to delays in initiating tasks or movements requested of the subject. This physical retardation is accompanied by a slowing of thought which is reflected in the subject's speech, with delays before answering questions and pauses in conversation.

When assessing psychomotor retardation consider the following factors:

A. Slowness of voluntary movements: delays in performing movements, performing movements and gestures slowly, a low frequency of movements.

B. Slow speech: long pauses before answering questions, a reduced rate of speech, long pauses between phrases.

C. Catatonic stupor: a total absence of voluntary movement, accompanied by muteness, but with evidence of continuing conscious awareness.

10. PSYCHOMOTOR RETARDATION - RATING SCALE.

0 = The subject exhibits no evidence of psychomotor retardation during the interview.

1 = The subject exhibits mild psychomotor retardation. There is a slight slowness in movement accompanied by short delays in responding to questions and slight slowness in speech when answering questions.

2 = The subject exhibits moderate psychomotor retardation. There is distinct slowness in movements accompanied by definite delays before responding to questions and distinct slowness of speech when answering questions.

3 = The subject exhibits marked psychomotor retardation. There is a very pronounced slowness of movements accompanied delays before responding to questions and pronounced slowness of speech when answering questions.

4 = The subject exhibits severe psychomotor retardation. There is extreme slowness of movements or the subject is immobile, long delays before responding even to very simple questions, and speech is restricted to brief answers or the subject is mute.

NOTES:

A. The subject must show evidence of slowed thought processes to justify a positive rating for Psychomotor Retardation: for example, by a reduced rate of speech, or pauses between phrases, or pauses before answering questions.

11. ABNORMAL SPEECH - OBSERVATIONAL GUIDELINES.

When rating abnormal speech consider the following factors:

A. Flight of ideas: the subject's conversation moves abruptly from one topic to another, so that a new train of thought appears before the previous one is completed. There is some discernible connection between one idea and the next which makes the change in topic understandable. This connection may be words that rhyme (clang association) words that have a similar sound assonance), words with more than one meaning (punning), or words that have an association.

B. Knight's move thinking or derailment of thought: the subject's conversation moves abruptly from one topic to another so that a new train of thought appears before the previous one is completed. However, there is no discernible connection between one idea and the next and the change in topic is not understandable.

C. Incoherence: the subject utters strings of unrelated words or phrases. The speech lacks any logical or grammatical structure, suggesting that the structure and coherence of thinking has been completely lost.

D. Vagueness and talking past the point: the subject's speech fails to focus on the topic under discussion. Although the subject speaks grammatically, little or no relevant information is conveyed to the listener. This kind of speech may be described as exhibiting poverty of content.

E. Neologisms: the subject invents new words. Neologisms must be distinguished from incorrect pronunciation, the wrong use of words by people with limited education, and obscure technical and literary terms.

F. Perseveration and verbigeration: the subject engages in the repeated and inappropriate expression of the same sounds, words or phrases.

11. ABNORMAL SPEECH - RATING SCALE.

0 = The subject exhibits no evidence of abnormal speech during the interview.

1 = Mild abnormality of speech observed. The train of speech is occasionally disjointed but it is always possible to discern a logical connection between the ideas expressed by the subject. Or, occasional instances or vagueness or irrelevance but the subject always returns to the point without prompting. No neologisms, perseveration or verbigeration occur.

2 = Moderate abnormality of speech observed. There are occasional breaks in the train of speech where it is impossible to discern a logical connection between the ideas expressed by the subject, but the majority of the subject's speech is normal. Or, occasional instances of vagueness or irrelevance during which the subject needs prompting to return to the point of the question, but most replies are relevant. Or, frequent neologisms, perseveration or verbigeration against a background of predominantly normal speech.

3 = Marked abnormality of speech observed. Frequent breaks in the train of speech where it is impossible to discern a logical connection between the ideas expressed by the subject, only a minority of the subject's speech is normal. Or, frequent instances of vagueness or irrelevance during which the subject needs

prompting to return to the point, only a minority of replies are relevant. Or, frequent neologisms, perseverations or verbigeration repeatedly disrupt the flow of speech, but some meaningful communication is still possible.

4 = Severe abnormality of speech observed. Continual breaks in the train of speech where it is impossible to discern a logical connection between the ideas expressed by the subject, so no meaningful communication is possible. Or, all the subject's speech is markedly vague or irrelevant, with no relation between the interviewer's questions and the subject's answers. or, speech consists entirely of neologisms, perseveration or verbigeration.

NOTES:

A. Speech that is difficult to understand solely because it is spoken quietly or is mumbled should not be rated under this item. If the subject's speech is difficult to discern for either of these reasons the interviewer must attend closely to what is said and attempt to establish whether the logical and grammatical structure is intact or shows signs of breaking down.

12. POVERTY OF SPEECH - OBSERVATIONAL GUIDELINES

This item refers to restricted quantity of speech occurring in the absence of psychomotor retardation. In reply to questions the subject gives brief responses which impart the minimum of information, shows a reluctance to elaborate on their responses, but shows no evidence of slowed thought processes. Replies may be brief or monosyllabic, the subject may fail to volunteer information and need repeated encouragement to expand on their initial brief responses to questions, questions may be answered with a shrug or shake of the head, or not answered at all.

When assessing poverty of speech consider the following factors:

A. Reluctance to elaborate on replies to questions: the subject gives brief replies to questions and is reluctant to say more even when asked to do so by the interviewer.

B. Tendency to give brief or monosyllabic answers to questions without regard to their content: subject confines their answers to "yes," "no," "don't know," "not sure," etc.

C. Abnormal lack of spontaneous comments: the subject fails to volunteer information or to make comments of any kind.

D. Non-social speech: the subject seems reluctant to reply to the interviewer's questions, but murmurs inaudibly or unintelligibly during the interview.

12. POVERTY OF SPEECH - RATING SCALE.

0 = No lack of speech. Subject gives full and informative replies to questions and voluntarily provides additional relevant information.

1 = Occasional difficulties or silences but gives full and informative replies to most questions without repeated prompting or encouragement from the interviewer.

2 = Subject only speaks when spoken to and tends to give brief replies. The subject does not volunteer additional information without repeated prompting or encouragement from the interviewer.

3 = Most replies are monosyllabic despite prompting or encouragement from the interviewer. Frequently fails to answer at all.

4 = Speaks only two or three words. Or, murmurs constantly but says nothing intelligible to the interviewer.

NOTES:

A. Poverty of speech should be distinguished from poverty of content of speech. Speech which is vague and imparts little or no information to the listener exhibits poverty of content. With poverty of content the subject may be very talkative and yet be so vague as to convey no useful information at all. Poverty of content should be rated under the item Abnormal Speech.

13. ABNORMAL MOVEMENTS - OBSERVATIONAL GUIDELINES.

This section includes all movements, postures and facial expressions that appear to the interviewer to be abnormal or unusual. When assessing abnormal movements or postures consider the following:

A. Involuntary movements: tics, tremors, dyskinesia, akathisia, dystonia, choreaothetoid movements. Include all such movements even if thought to be caused by medication.

B. Mannerisms: odd, stylised movements or acts, usually idiosyncratic to the subject, sometimes suggestive of a special meaning e.g. the subject repeatedly salutes or uses elaborate hand gestures.

C. Stereotypes: persistent repetition of movements or postures e.g. rocking to and fro in a chair, rubbing head round and round with the hand nodding head. These movements do not seem to have a special meaning.

D. Catatonic movements: negativism (doing the opposite of what is asked), ambitendence (fluctuating between two alternatives), echopraxia (imitation of body movements), echolalia (imitation of words or phrases), mitgehen and waxy flexibility (excessive co-operation in passive movements).

E. Unusual postures: Voluntarily adopting strange postures, possibly with a special meaning to the subject, or holding uncomfortable postures for long periods.

F. Persistently rigid posture: the subject may sit rigidly in a chair or even stand upright for most of the interview. Include rigid posture that may be due to anxiety provided that this persists throughout most of the interview.

G. Persistently withdrawn posture: the subject adopts a closed posture, with head down and eyes averted from the interviewer. Include withdrawn posture that may be due to depression, provided that this persists throughout most of the interview.

H. Abnormal staring: prolonged periods of eye fixation with the interviewer to a degree that is culturally inappropriate, or prolonged staring into space.

I. Facial mannerisms or stereotypes: distinct idiosyncratic or repetitive movements of unclear meaning e.g. grimacing.

J. Involuntary facial movements: Facial tics, chewing movements.

K. Behaviours apparently resulting from hallucinations: include unusual behaviour that appears to be a response to hallucinations e.g. breaks off conversation in order to listen to voices, talks aloud or silently in response to voices, looks around at visual hallucinations.

13. ABNORMAL MOVEMENTS - RATING SCALE.

0 = No evidence of abnormal movements or postures.

1 = Slightly unusual movements or postures, which are inconspicuous and are not likely to attract the attention of others in social situations.

2 = Moderately unusual movements or postures, which are conspicuous and likely to attract the attention of others in social situations, but occur infrequently and are not sustained over long periods.

3 = Markedly unusual movements or postures, which are conspicuous and likely to attract attention from others in social situations, and occur frequently or are sustained over long periods.

4 = Extremely unusual movements or postures, which are conspicuous and likely to attract attention from others in social situations, and occur almost continuously throughout the interview.

NOTES:

When evaluating the degree of conspicuousness of an abnormal movement or posture, the rater should make a judgement about how noticeable it would be to other people if it were to occur in an ordinary day to day social context. For example, if the subject behaved in that way in a shop, or on a bus, or in a public space, what is the likelihood that other people would notice the behaviour? If it seems likely that others would notice it, would they attend to it briefly or persistently? Behaviour which might draw little attention in a ward or day hospital setting might be highly conspicuous in ordinary social situations.

14. ACCURACY OF ASSESSMENT - OBSERVATIONAL GUIDELINES

At the outset, all subjects must be given a clear explanation of the nature and purpose of the interview, and their co-operation should then be requested. If the subject is extremely reluctant to be interviewed, or if their ability to answer questions is grossly impaired by symptoms, it may be better to postpone the full interview until they are more willing or able to talk. However, if this is done, the scale's behavioural items should still be rated. Some degree of unease or reticence is common amongst subjects, particularly at the start of the interview.
During the interview, the interviewer should always be prepared to explain the reason for asking any particular question if requested to do so by the subject, and should offer reassurance and further explanation when difficult topics are being discussed. When assessing the accuracy of the assessment, consider the following factors:

A. Suspiciousness: the subject may feel that a deliberate attempt is being made to harm or to annoy. If persecutory delusions are present the subject may believe that the interviewer is involved in a wider conspiracy.

B. Hostility: the subject may be overtly angry and hostile, criticising the interviewer and refusing to answer questions, or cutting off the interviewer by saying no before the question is finished.

C. Misleading answers: the subject may give replies to avoid answering questions, or may frequently contradict themselves, or may deny that symptoms are present although there is evidence to the contrary.

D. Verbal over-compliance: this is the tendency to agree passively with the interviewer's questions without seeming to have any regard to their content. The subject repeatedly says "yes," or "I suppose so," without seeming to give proper thought to the questions. They may be trying to please the interviewer, or may be unable to concentrate sufficiently to give a considered response.

E. Resentment or apathy: the subject seems unwilling to co-operate, talks very reluctantly, seems apathetic or listless, or repeated says "no," without seeming to give proper thought to the questions.

F. Interviewing technique: the interviewer should always try to obtain sufficient information to enable an accurate rating to be made. If the subject provides insufficient or ambiguous or contradictory information, the interviewer should attempt to resolve these deficiencies by careful additional questioning, sensitively conducted.

G. In certain circumstances: e.g. following compulsory admission to hospital, the interviewer may feel that a lack of co-operation from the subject is understandable and to some degree justified. This should be recorded on the data sheet as a possible reason for the perceived lack of co-operation, but should not influence the rating itself which should be based solely on the adequacy of the information obtained during the interview.

14. ACCURACY OF ASSESSMENT - RATING SCALE.

0 = All elicited symptoms rated. All ratings based on complete and consistent information. Any contradictions, ambiguities and uncertainties fully resolved by further questioning of the subject.

1 = All elicited symptoms rated. All ratings based on adequate information. Minor unresolved contradictions, ambiguities or uncertainties remain after further questioning of the subject.

2 = A minority of elicited symptoms left unrated due to major unresolved contradictions, ambiguities or uncertainties.

3 = A majority of elicited symptoms left unrated due to major unresolved contradictions, ambiguities or uncertainties.

4 = All elicited symptoms left unrated due to major unresolved contradictions, ambiguities or uncertainties. Only observed behaviours rated.

NOTES:

A. If any rating is thought to be of doubtful accuracy, use this section of the data sheet record in detail which particular ratings are suspect and why they are judged to be suspect.

B. Remember that the score for this section should **not** be included when calculating the subject's total symptom score.

KGV(M) SCORE SHEET

NAME: ______________________ **DATE OF RATING:** ___________

RATER: _____________________

1. ANXIETY: **SCORE:** ___
2. DEPRESSION: **SCORE:** ___
3. SUICIDAL THOUGHTS AND BEHAVIOUR: **SCORE:** ___
4. ELEVATED MOOD: **SCORE:** ___
5. HALLUCINATIONS: **SCORE:** ___
6. DELUSIONS: **SCORE:** ___
7. FLATTENED AFFECT: **SCORE:** ___

8. INCONGRUOUS AFFECT: **SCORE: ___**
9. OVERACTIVITY: **SCORE: ___**
10. PSYCHOMOTOR RETARDATION: **SCORE: ___**
11. ABNORMAL SPEECH: **SCORE: ___**
12. POVERTY OF SPEECH: **SCORE: ___**
13. ABNORMAL MOVEMENTS: **SCORE: ___**
14. ACCURACY OF ASSESSMENT: **SCORE: ___**

K.G.V (M) Clinical Data Sheet **Assessor**

Assessment Date

Assessment No.

Anxiety

K.G.V (M) Clinical Data Sheet Assessor

Assessment Date

Assessment No.

Depression

K.G.V (M) Clinical Data Sheet **Assessor**

Assessment Date

Assessment No

Suicidal Thoughts & Behaviours

K.G.V (M) Clinical Data Sheet **Assessor**

Assessment Date

Assessment No

Elevated Mood

K.G.V (M) Clinical Data Sheet Assessor [ ]

Assessment Date [ ]

Assessment No [ ]

Hallucinations [ ]

K.G.V (M) Clinical Data Sheet Assessor

Assessment Date

Assessment No

Delusions

K.G.V (M) Clinical Data Sheet **Assessor**

Assessment Date

Assessment No

Flattened Affect

K.G.V (M) Clinical Data Sheet **Assessor**

Assessment Date

Assessment No.

Incongruous Affect

K.G.V (M) Clinical Data Sheet **Assessor** [ ]

Assessment Date [ ]

Assessment No. [ ]

Overactivity [ ]

K.G.V (M) Clinical Data Sheet **Assessor**

Assessment Date

Assessment No.

Psychomotor Retardation

K.G.V (M) Clinical Data Sheet **Assessor**

Assessment Date

Assessment No.

Abnormal Speech

K.G.V (M) Clinical Data Sheet **Assessor**

Assessment Date

Assessment No.

Poverty of Speech

K.G.V (M) Clinical Data Sheet. **Assessor**

Assessment Date

Assessment No

Abnormal Movements

K.G.V (M) Clinical Data Sheet **Assessor**

Assessment Date

Assessment No

Accuracy of Assessment

Risk Assessment Summary- Department of Psychiatry (DOP), Portlaoise.

Risk Assessment Summary- Department of Psychiatry (DOP), Portlaoise.

Name: ______________________________________ **Address:** ____________________________________ **Unit:** ______________________________________ **DOB:** ____________ **DOA:** __________	**The following criteria are devised to assist clinicians in the formulation and management of risk.** ***Where a risk is present insert a (√)*** **Y – Yes, risk present. N – No, no risk.** **U – Unknown, it is not possible to rate at present.**

Behaviours Indicative of Risk	**Y**	**N**	**U**	**Clinical Risks: Indicative of Risk**	**Y**	**N**	**U**
Physical harm to others				Early warning signs of relapse			
Threats/ Intimidation				Ideas of harming others			
Drug/Alcohol Abuse				Ideas of self harm/suicidal ideation			
Suicidal attempts				Delusions			
Plans to commit suicide				Command Hallucinations			
Deliberate self harm				Confusion/Disorientation			
Expressing dissatisfaction with care/treatment				Morbid Jealously			
Wandering (Internal/external/day/night)				Impulsive /lack of impulse control			
Language barrier				Family history of suicide			
Absconding from care environment							
Treatment related Disorders	**Y**	**N**	**U**	**Personal Circumstances Indicative of Risk**	**Y**	**N**	**U**
Non compliance to medication				Physical problems/frailty e.g...diabetes, mobility, sensory			
Failure to attend appointments				Recent severe stress/life event			
Compulsory admissions				Concern expressed by others (relatives, carers)			
Unplanned disengagement from services				Recurrence of circumstances associated with risk behaviour			
Admission to high/observation area in unit				Social isolation			
				Any forensic history			

Any other risk factors (specify)

Risk Determination

Risk	**Category**	**Time**	**Date**	**Assessor**	**Grade**
High – imminent risk of harm/injury to self or others					
Medium – background risk but no imminent risk					
Low – no evidence of risk of harm to self or others					

Risk Management

Level 1 General observation		**When the risk assessment is completed the Multidisciplinary Team shall rate the level of observation necessary to maintain an appropriate therapeutic environment**
Level 2 General observation – Night Attire		
Level 3 High Observation		
Level 4 Special Observation		

Risk Summary

Give brief details of positive risks identified and any protective factors and what residual (unprotected) risk remains.   Residual (unprotected) risks should be carried forward to care plan, and measures to manage these documented & followed up.

Signed: ________________________ (Doctor) Date: _________Time:____
Signed: ________________________ (Nurse) Date: _________Time: ____

Risk Assessment Summary version number: 3 (updated February 2012)
Compiled by: MDT, Department of Psychiatry (DOP), Midland Regional Hospital, Portlaoise.

References: International Limited, (1997-2005) FACE.
O'Rourke, Hammond & Bucknall (2001) RAMAS
The Sainsbury Centre for Mental Health (2004), *Clinical Risk Management: A Clinical Tool and Practitioner Manual*
HSE & Clinical Indemnity Scheme (2010) *Guidance Document Risk Management in Mental Health Services*

Longford/Westmeath Mental Health Services.

Risk Assessment

Name ______ Address ______	**The following criteria are devised to assist clinicians in the formulation and management of risk.** ***Where a risk is present insert a (✓)*** **Y – Yes, risk present. N – No, no risk. U – Unknown, it is Not possible to rate at present.**

A: ABSCONDING RISK	**Y**	**N**	**U**	**S: SUICIDE RISK (brief risk screen)**	**Y**	**N**	**U**
Expressing desire to leave/not come into hospital				*History of previous suicide attempt*			
Pacing/watching doors				*Current thoughts or plan that indicate risk*			
Active addictions (detoxing/craving) – strong desire take alcohol or non prescribed drugs				*Current problems with alcohol or substance abuse*			
Currently impulsive (dis-inhibited erratic)				*An expression of concern from others about suicide*			
History of impulsivity, defiance, non compliance, boundary breaking behaviour				*History of repeated self-harm*			
Previously absconded from (any) hospital				**F: FALLS RISK**			
Current suspiciousness re the hospital or staff especially command hallucinations				*Significant past history of falls*			
Expressing dissatisfaction with care/treatment				*Hypotension*			
Current social stressors increasing absconding risk				*Muscle rigidity*			
Risk of wandering – mobile and confused				*Visual impairment*			
V: VIOLENCE RISK (brief risk screen)				*Ataxia*			
Current thoughts plans or symptoms indicating risk				*An expression of concern from others about the risk of falls*			
Significant past history of violence				*Current behaviour suggesting there is a risk*			
Current behaviour with alcohol or substance abuse							
O: OTHER RISKS.							
	Y	**N**	**U**		**Y**	**N**	**U**
Risk of self neglect				*Risk of exploitation*			
Risk of non compliance with treatment plan				*Risk to children*			

Risk Determination

Place the appropriate heading A, S, F , O or V within the risk category rated most appropriate following clinical assessment

Risk	**Category**	**Time**	**Date**	**Assessor**	**Grade**
High – *imminent risk of harm/injury to self or others*					
Medium – *background risk but no imminent risk*					
Low – *no evidence of risk of harm to self or others*					

Risk Management

Special observation		**When the risk assessment is completed the Clinical Team should rate the level of observation necessary to maintain an appropriate therapeutic environment**
Observe and remain on ward		
Ground Leave		
Observe in geriatric chair		

Special nursing observations can only be initiated following consultation with a Consultant Psychiatrist.

Signed: ______ **(Doctor) Date:** ______

This risk assessment is subject to review in line with best practice and the best interest of the patient - ***Michael Hyland January*** *2012*

Depression Anxiety Stress Scale (DASS)
DASS Scale

General description of the scales

The DASS is a set of three self-report scales designed to measure the negative emotional states of depression, anxiety and stress. The DASS was constructed not merely as another set of scales to measure conventionally defined emotional states, but to further the process of defining, understanding, and measuring the ubiquitous and clinically significant emotional states usually described as depression, anxiety and stress. The DASS should thus meet the requirements of both researchers and clinicians.

Administering DASS

Each of the three DASS scales contains 14 items, divided into subscales of 2-5 items with similar content. The Depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia, and inertia. The Anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The Stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient.

Subjects are asked to use 4-point severity/frequency scales to rate the extent to which they have experienced each state ***over the past week*****.** Scores for Depression, Anxiety and Stress are calculated by summing the scores for the relevant items.

In addition to the basic 42-item questionnaire, a short version, the DASS 21, is available with 7 items per scale. Note also that an earlier version of the DASS scales was referred to as the Self-Analysis Questionnaire (SAQ).

As the scales of the DASS have been shown to have high internal consistency and to yield meaningful discriminations in a variety of settings, the scales should meet the needs of both researchers and clinicians who wish to measure current state or change in state over time (e.g., in the course of treatment) on the three dimensions of depression, anxiety and stress.

Characteristics of high scorers on each DASS scale

Depression scale

- self-disparaging
- dispirited, gloomy, blue
- convinced that life has no meaning or value
- pessimistic about the future
- unable to experience enjoyment or satisfaction
- unable to become interested or involved
- slow, lacking in initiative

Anxiety scale

- apprehensive, panicky
- trembly, shaky
- aware of dryness of the mouth, breathing difficulties, pounding of the heart, sweatiness of the palms
- worried about performance and possible loss of control

Stress scale

- over-aroused, tense
- unable to relax
- touchy, easily upset
- irritable
- easily startled
- nervy, jumpy, fidgety
- intolerant of interruption or delay

The DASS in research

The DASS may be administered either in groups or individually for research purposes. The capacity to discriminate between the three related states of depression, anxiety and stress should be useful to researchers concerned with the nature, aetiology and mechanisms of emotional disturbance.

As the essential development of the DASS was carried out with non-clinical samples, it is suitable for screening normal adolescents and adults. Given the necessary language proficiency, there seems no compelling case against use of the scales for comparative purposes with children as young as 12 years. It must be borne in mind, however, that the lower age limit of the development samples was 17 years.

Clinical use of the DASS

The principal value of the DASS in a clinical setting is to clarify the locus of emotional disturbance, as part of the broader task of clinical assessment. The essential function of the DASS is to assess the severity of the *core* symptoms of depression, anxiety and stress. It must be recognised that clinically depressed, anxious or stressed persons may well manifest additional symptoms that tend to be common to two or all three of the conditions, such as sleep, appetite, and sexual disturbances. These disturbances will be elicited by clinical examination, or by the use of general symptom check lists as required.

The DASS may be administered and scored by non-psychologists, but decisions based on particular score profiles should be made only by experienced clinicians who have carried out an appropriate clinical examination. It should be noted also that none of the DASS items refers to suicidal tendencies because items relating to such tendencies were found not to load on any scale. The experienced clinician will recognise the need to determine the risk of suicide in seriously disturbed persons.

The DASS and diagnosis

The DASS is based on a *dimensional* rather than a *categorical* conception of psychological disorder. The assumption on which the DASS development was based (and which was confirmed by the research data) is that the differences between the depression, the anxiety, and the stress experienced by normal subjects and the clinically disturbed, are essentially differences of degree. The DASS therefore has no direct implications for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD. However, recommended cut-offs for conventional severity labels (normal, moderate, severe) are given in the DASS Manual.

Original DASS

The DASS Scales were developed by Lovibond, S.H. & Lovibond, P.E.
For copies of the scale, a scoring template and further information, please see: www.psy.unsw.edu.au/dass

Please note that the scoring template in this portfolio is a locally adapted version meeting local needs which does not alter the scales in any way.

DASS	*Name:*	*Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, lifts, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I fear that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

DASS SCORE SHEET.	**Service location.**
Patients Name ………………………… Date of Assessment …………………	

STRESS

1	6	8	11	12	14	18	SCORE A
22	**27**	**29**	**32**	**33**	**35**	**39**	**SCORE B**

(Multiply Score A by 2 if completing 21 questionnaire/ Add score A and B if completing 42 questionnaire,)

STRESS SCORE

ANXIETY

2	4	7	9	15	19	20	SCORE A
23	**25**	**28**	**30**	**36**	**40**	**41**	**SCORE B**

(Multiply Score A by 2 if completing 21 questionnaire/ Add score A and B if completing 42 questionnaire,)

ANXIETY SCORE

DEPRESSION

3	5	10	13	16	17	21	SCORE A
24	**26**	**31**	**34**	**37**	**38**	**42**	**SCORE B**

(Multiply Score A by 2 if completing 21 questionnaire/ Add score A and B if completing 42 questionnaire,)

DEPRESSION SCORE

Patients Name .... **Date of Assessment ....**

	STRESS	ANXIETY	DEPRESSION
NORMAL	0-14	0-7	0-9
MILD	15-18	8-9	10-13
MODERATE	19-25	10-14	14-20
SEVERE	26-33	15-19	21-27
EXTREMELY SEVERE	34+	20	28+

RESULTS

STRESS:

ANXIETY:

DEPRESSION:

Adapted by Lisa Evans CNM11 (2008)

PSYRATS

Hallucinations Rating Scale

Reference:
Haddock, G., McCarron, J., Tarrier, N., Faragher, E.B. (1999) Scale to measure dimensions of hallucinations and delusions: the psychotic symptom rating scales (PSYRATS). *Psychological Medicine*, 29, 879-889.

General instructions:

The following structured interview gives a list of questions to elicit information on the patient's experience of psychotic symptoms

When asking questions the interview is designed to rate the patients experiences **over the last week**, for the majority of the items.
There is one exception to this, when rating conviction, ask the patient about their conviction at the time of the interview.

1 How often do you experience voices?
(e.g., every day, all day long, etc)

Frequency:

0 – Voices not present or present less than once a week.
1 – Voices occur for at least once a week.
2 – Voices occur at least once a day.
3 – Voices occur at least once an hour.
4 – Voices occur continuously or almost continuously i.e., stop for only a few seconds or minutes.

2 When you hear your voices, how long do they last?
(e.g., few seconds, minutes, hours, all day long)

Duration:

0 - Voices not present.
1 - Voices last for a few seconds, fleeting voices.
2 - Voices last for several minutes.
3 - Voices last for at least one hour.
4 - Voices last for hours at a time.

3 When you hear your voices, where do they sound like they are coming from?

- Inside your head and/or outside your head?
- If voices sound like they are outside your head, where about do they sound like they are coming from?

Location:

0 - No voices present.
1 - Voices sound like they are inside head only.
2 - Voices outside the head, but close to ears or head. Voices inside the head may also be present.
3 - Voices sound like they are inside or close to ears and outside head away from ears.
4 - Voices sound like they are from outside the head only.

4 How loud are your voices?
- Are they louder than your voice, about the same loudness, quieter or just a whisper?

Loudness:

0 - Voices not present.
1 - Quieter than own voice, whispers.
2 - About same loudness as own voice.
3 - Louder than own voice
4 - Extremely loud, shouting.

5 What do you think has caused your voice? Are the voices caused by factors related to yourself, or solely due to other people, or other factors? If the individual expresses an external origin: How much do you believe that your voices are caused by ______________ (add attribution) on a scale of 0-100 with 100 being that you are totally convinced, have no doubts, and 0 being that it is totally untrue?

Beliefs reorigin of voices:

0 - Voices not present.
1 - Believes voices to be solely internally generated and related to self.
2 - Holds < 50% conviction that voices originate from external causes.
3 - Holds > 50% conviction (but < 100%) that voices originate from external causes.
4 - Believes voices are solely due to external causes (100% conviction)

6 Do your voices say unpleasant or negative things?

- **Are you able to give an example(s) of what the voices say? (record example(s))**
- **How much of the time do the voices say these type of unpleasant or negative things?**

Amount of negative content of voices:

0 - No unpleasant content.
1 - Occasional unpleasant content (< 10%).
2 - Minority of voice content is unpleasant or negative (< 50%).
3 - Majority of voice content is unpleasant or negative (>50%).
4 - All of voice content is unpleasant or negative.

7 Rate using criteria or scale, asking patient for more detail if necessary

Degree of negative content:

0 - Not unpleasant or negative
1 - Some degree of negative content, but not personal comments relating to self or family e.g., swear words or comments not directed to self e.g., 'the milkman's ugly'.
2 - Personal verbal abuse, comments on behaviour e.g., 'shouldn't do that or say that'.
3 - Personal verbal abuse relating to self-concept e.g., 'you're lazy, ugly, mad, perverted'.
4 - Personal threats to self e.g., threats to harm self or family, extreme instructions or commands to harm self or others.

8 Are your voices distressing?

- How much of the time?

Amount of distress:

0 - Voices not distressing at all.
1 - Voices occasionally distressing, majority not distressing (< 10%).
2 - Minority of voices distressing (< 50%).
3 - Majority of voices distressing, minority not distressing (> 50%).
4 - Voices always distressing.

9 When voices are distressing, how distressing are they?

- Do they cause you minimal, moderate, severe distress?

- Are they the most distressing they have ever been?

Intensity of distress:

0 - Voices not distressing at all.
1 - Voices slightly distressing.
2 - Voices are distressing to a moderate degree.
3 - Voices are very distressing, although subject could feel worse.
4 - Voices are extremely distressing, feel the worst he/she could possibly feel.

10 How much disruption do the voices cause to your life?

- Do the voices stop you from taking part in daytime activities?

- Do they interfere with your relationship with other patients/friends/family?

- Do they prevent you from looking after yourself?

Disruption to life caused by voices

0 - No disruption to life, able to maintain social and family relationships (if present).

1 - Voices causes minimal amount of disruption to life e.g., interferes with concentration although able to maintain daytime activity and social and family relationships and be able to maintain independent living without support.

2 - Voices cause moderate amount of disruption to life causing some disturbance to daytime activity and/or family or social activities. The patient is not in hospital although may live in supported accommodation or receive additional help with daily living skills.

3 - Voices cause severe disruption to life so that hospitalisation is usually necessary. The patient is able to maintain some daily

activities, self-care and relationships while in hospital. The patient may also be in supported accommodation but experiencing severe disruption of life in terms of activities, daily living skills and/or relationships.

4 - Voices cause complete disruption of daily life requiring hospitalisation. The patient is unable to maintain any daily activities and social relationships. Self-care is also severely disrupted.

11 Do you have any control over the voices?

- Can you call up the voices?
- Can you make the voices stop/go away?

Controllability of voices

0 - Subject believes they can have control over the voices and can always bring on or dismiss them at will.

1 - Subject believes they can have some control over the voices on the majority of occasions.

2 - Subject believes they can have some control over their voices approximately half of the time.

3 - Subject believes they can have some control over their voices but only occasionally. The majority of the time the subject experiences voices which are uncontrollable.

4 - Subject has no control over when the voices occur and cannot dismiss or bring them on at all.

HALLUCINATIONS RATING SCALE (SCORE SHEET)

NAME ______________________ **ASSESSED BY** ______________________

DATE ______________________

DATE OF ASSESSMENT					
Frequency					
Duration					
Location					
Loudness					
Beliefs re origin of voice(s)					
Amount of negative content					
Degree of negative content					
Amount of distress					
Intensity of distress					
Disruption to life					
Controllability of voice					

PSYRATS
DELUSION RATING SCALE

Reference:
Haddock, G., McCarron, J., Tarrier, N., Faragher, E.B. (1999) Scale to measure dimensions of hallucinations and delusions: the psychotic symptom rating scales (PSYRATS). *Psychological Medicine*, 29, 879-889.

General instructions:

The following structured interview is designed to elicit specific details regarding different dimensions of delusional beliefs.

When asking questions the interview is designed to rate the patients experiences **over the last week**, for the majority of the items.
There is one exception to this, when rating conviction, ask the patient about their conviction at the time of the interview.

1. AMOUNT OF PREOCCUPATION WITH DELUSIONS

How much time do you spend thinking of your beliefs?
- all the time/daily/weekly etc.

0 No delusions or delusions which the patient thinks about less than once a week. (specify frequency if present)

1 Patient thinks about beliefs at least once a week.

2 Subject thinks about beliefs once a day.

3 Subject thinks about beliefs once an hour.

4 Subject thinks about delusions continuously or almost continuously. Subject can only think about other things for few seconds or minutes.

2. DURATION OF PREOCCUPATION WITH DELUSIONS

When the beliefs come into your mind, how long do they persist?
- few seconds/minutes/hours etc.

0 No delusions.

1 Thoughts about beliefs last for a few seconds, fleeting thoughts.

2 Thoughts about delusions last for several minutes.

3 Thoughts about delusions last for at least an hour.

4 Thoughts about delusions usually last for hours at a time.

3. CONVICTION (at the time of interview)

At the present time how convinced are you that your beliefs are true? Can you estimate this on a scale from 0-100, where 100 means that you are totally convinced by your beliefs and 0 being that you are not convinced at all.

0 No conviction at all.

1 Very little conviction in reality of beliefs, less than 10%

2 Some doubts relating to conviction in beliefs, between 10-49%

3 Conviction in belief is very strong, between 50-99%

4 Conviction is 100%

4. AMOUNT OF DISTRESS

Do your beliefs cause you distress?
How much of the time do they cause you distress?

0 Beliefs never cause distress

1 Beliefs cause distress on the minority of occasions

2 Beliefs cause distress on approximately 50% of occasions

3 Beliefs cause distress on the majority of occasions when they occur between 50-99% of the time

4 Beliefs always cause distress when they occur.

5. INTENSITY OF DISTRESS

When your beliefs distress you, how severe does this feel?

0 No distress

1 Beliefs cause slight distress

2 Beliefs cause moderate distress

3 Beliefs cause marked distress

4 Beliefs cause extreme distress, couldn't be worse

6. DISRUPTION TO LIFE CAUSED BY BELIEFS

How much disruption do your beliefs cause you?
- do they prevent you from working or carrying out daytime activity?
- do they interfere with your relationships with family or friends?
- do they interfere with your ability to look after yourself e.g. washing, changing clothes.

0 No disruption to life, able to maintain independent living with no problems in daily living skills. Able to maintain social and family relationships (if present)

1 Beliefs cause minimal amount of disruption to life e.g. interferes with concentration, although able to maintain daytime activity and social and family relationships and be able to maintain independent living without support.

2 Beliefs cause moderate amount of disruption to life causing some disturbance to daytime activity and/or social activities. The patient is not in hospital although may live in supported accommodation or receive additional help with daily living skills.

3 Beliefs cause severe disruption to life so that hospitalisation is usually necessary. The patient is able to maintain some daily activities, self-care and relationships whilst in hospital. The patient may also be in supported accommodation but experiencing severe disruption of life in terms of activities, daily living skills and/or relationships.

4 Beliefs cause complete disruption of daily life requiring hospitalisation. The

patient is unable to maintain any daily activities and social relationships. Self-care is also severely disrupted.

GENERAL QUESTIONS
Length of time of delusional beliefs (years) ? ....

Please specify individual delusional beliefs

....
..
....
..

DELUSIONS RATING SCALE (SCORE SHEET)

NAME______________________ **Assessed by** ____________________

DATE _______________________

DATE OF ASSESSMENT							
AMOUNT OF PREOCCUPATION							
DURATION OF PREOCCUPATION							
CONVICTION							
AMOUNT OF DISTRESS							
INTENSITY OF DISTRESS							
DISRUPTION							
TOTAL SCORE							

THE GERIATRIC DEPRESSION SCALE (GDS)

Introduction:
Permission is hereby granted to reproduce this material for not-for-profit educational purposes only, provided **The Hartford Institute for Geriatric Nursing, Division of Nursing, New York University** is cited as the source.

Name of website: www.hartfordign.org
E-mail notification of usage to: hartford.ign@nyu.edu.

Country: USA

Authors: Hartford Institute of Geriatric Nursing

References:

NIH Consensus Conference, (1992), Diagnosis and Treatment of Depression in Late Life. JAMA, 268(8), 1018-1024.

Koenig, H.G. Meador, K.G., Cohen, J.J. Blazer, D.G. (1988). Self-Rated Depression Scales and Screening for Major Depression in the Older Hospitalized Patient with Medical Illness. *Journal of the American Geriatrics Society, 699-706.*

Kurlowicz, L.H., & NICHE Faculty (1997). Nursing Stand or Practice Protocol: Depression in Elderly Patients.

McDowell I, Newell C., (1996) Measuring Health- A Guide to Rating Scales and Questionnaires, Second Edition. Oxford University Press.

Sheikh, R.L. & Yesavage, J.A. (1986). Geriatric Depression Scale (GDS). Recent Evidence and Development of a Shorter Version. *Clinical Gerontologist,* 5, 165-173.

Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O. Huang, V., Adey, M., Leirer, V.O. (1983). Development and Validation of a Geriatric Depression Screening Scale: A Preliminary Report. *Journal of Psychiatric Research*, 17, 37-49.

WHY SCREEN FOR DEPRESSION IN OLDER ADULTS:
Depression is common in late life, affecting nearly five million of the 31 million Americans aged 65 and older (Geriatric Nursing, 1992).

Both major and minor depression are reported in 13% of community dwelling older adults, 24% of older medical outpatients and 43% of both acute care and nursing home dwelling older adults. Contrary to popular belief, depression is not a natural part of aging. Depression is often reversible with prompt and appropriate treatment. However, if left untreated, depression may result in the onset of physical, cognitive and social impairment as well as delayed recovery from medical illness and surgery, increased health care utilization and suicide.

BEST TOOL:
While there are many instruments available to measure depression, the Geriatric Depression Scale (GDS), first created by Yesavage et al (1983). has been tested and extensively with the older population. It is a brief questionnaire in which participants are asked to respond to the 30 questions by answering yes or no in reference to how they felt on the day of administration. Scores of 0 - 9 are considered normal, 10 - 19 indicate mild depression and 20 -30 indicate severe depression.
There is also a 15 item questionnaire available and a 4 item one.
In some editions of the tool the depressive answers are shaded for ease of highlighting the areas of difficulty that the client has and thus can be focused in on. The edition here is not shaded.

TARGET POPULATION:
The GDS may be used with healthy, medically ill and mild to moderately cognitively impaired older adults. It has been extensively used in community, acute and long-term care settings.

VALIDITY/RELIABILITY:
Yesavage et al.(1983) found that the GDS has a 92% sensitivity and a 89% specificity when evaluated against diagnostic criteria **THE GERIATRIC DEPRESSION SCALE (GDS)** The validity and reliability of the tool have been supported through both clinical practice and research.

STRENGTHS AND LIMITATIONS: The GDS is not a substitute for a diagnostic interview by mental health professionals. It is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults especially when baseline measurements are compared to subsequent scores. It can be self administered or done with the health professional. It takes 5 to 10 minutes to complete.

THE GERIATRIC DEPRESSION SCALE (GDS)
This is a self rating instrument.

	Name of Client: **DOB:**		
	Assessor: **Date of Test**		
	Choose the answer for how you felt over the past week.	**Points for Response**	
		YES	**NO**
1	Are you basically satisfied with your life?	0	1
2	Have you dropped many of your activities and interests?	1	0
3	Do you feel that your life is empty?	1	0
4	Do you often get bored?	1	0
5	Are you hopeful about the future?	0	1
6	Are you bothered by thoughts you can't get out of your head?	1	0
7	Are you in good spirits most of the time?	0	1
8	Are you afraid that something bad is going to happen to you?	1	0
9	Do you feel happy most of the time?	0	1
10	Do you often feel helpless?	1	0
11	Do you often get restless and fidgety?	1	0
12	Do you prefer to stay at home, rather than going out and doing new things?	1	0
13	Do you frequently worry about the future?	1	0
14	Do you feel you have more problems with memory than most?	1	0
15	Do you think it is wonderful to be alive now?	0	1
16	Do you often feel downhearted and blue?	1	0
17	Do you feel pretty worthless the way you are now?	1	0
18	Do you worry a lot about the past?	1	0
19	Do you find life very exciting?	0	1
20	Is it hard for you to get started on new projects?	1	0
21	Do you feel full of energy?	0	1
22	Do you feel your situation is hopeless?	1	0
23	Do you think that most people are better off than you are?	1	0
24	Do you frequently get upset over little things?	1	0
25	Do you frequently feel like crying?	1	0
26	Do you have trouble concentrating?	1	0
27	Do you enjoy getting up in the morning?	0	1
28	Do you prefer to avoid social gatherings?	1	0
29	Is it easy for you to make decisions?	0	1
30	Is your mind as clear as it used to be?	0	1

Scoring:
Add up all the answers scoring number one.
Minimum score: 0 Maximum score: 30
Scores of 0 - 9 are considered normal
If the client scores 10 or above, it is an indicator of depression.
10 - 19 indicate mild depression
20 - 30 indicate severe depression.

BECK DEPRESSION INVENTORY (BDI)

Authors: Beck, A. T., A. J. Rush, B. F. Shaw, and D. Emery. *Cognitive Therapy of Depression*. New York: Guilford Press, 1979.

Devised By: The original version of the BDI was introduced by Beck, Ward, Mendelson, Mock & Erbaugh in 1961. The BDI was revised in 1971 and made copyright in 1978 (Groth-Marnat, 1990). Both the original and revised versions have been found to be highly correlated (Lightfoot & Oliver, 1985 cited in Groth-Marnat, 1990).

Brief Description: The Becks Depression Inventory created by Dr. Aaron T. Beck is a questionnaire consisting of 21 groups of statements to measure the severity of depression. The Becks Depression Inventory questionnaire is copyrighted by The Psychological Corporation.

Type of Instrument: The BDI is a 21 item self-report rating inventory measuring characteristic attitudes and symptoms of depression (Beck et al., 1961). The BDI has been developed in different forms including several computerized forms, a card form (May, Urquhart, Tarran, 1969, cited in Groth-Marnat, 1990); the 13-item short form and the more recent BDI-11 by Beck, Steer & Brown, 1996 (see Steer, Rissmiller and Beck , 2000 for information on the clinical utility of the BDI-11).

Description: The BDI is a self-administered 21 item self-report scale measuring supposed manifestations of depression. The BDI takes approximately10 minutes to complete, although clients require a fifth – sixth grade reading age to adequately understand the questions (Groth-Marnat, 1990).

The new edition of the Beck Depression Inventory is the most widely used instrument for measuring depression, it takes just 5 minutes to complete.
An invaluable tool for screening and diagnosis and is also used extensively to monitor therapeutic progress.
21 items assess the intensity of depression in clinical and normal individuals.
Each item is a list of four statements arranged in increasing severity about a particular symptom in depression.
The Beck Scales have been developed and validated to assist in making focused and reliable patient evaluations. Test results can be the first step in recognising and appropriately treating an effective disorder.
The Beck Scales can help identify those patients with depressive, anxious, or suicidal tendencies.

Journal Articles:

Beck, A.T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961) An inventory for measuring depression. *Archives of General Psychiatry 4*, 561-571.

Beck A.T., Ward C.H., Mendelson M. et al. (1961) An Inventory for Measuring Depression. Arch Gen Psychiatry; 4:561-571.

Beck, A.T., Rial, W. Y., Rickets, K. (1974). Short form of Depression Inventory: Cross-validation. *Psychological-Reports 34 (3),* 1184-1186.

Beck A.T. Beamesderfer A. (1974) Assessment of Depression: The Depression Inventory. Mod Probl Pharmacopsychiatry;7:151-169

Beck, A. T., and R. A. Steer. (1984) "Internal consistencies of the original and revised Beck Depression Inventory." Journal of Clinical Psychology 40: 1365 - 1367.

Beck, A. T., R. A. Steer, and G. M. Garbin. (1988) "Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation." Clinical Psychology Review, 8: 77-100.
Bech P. (1981) Rating Scales for affective disorders: Their Validity and Consistency. Acta Pyschiatr Scand; 64 (suppl 295):1-101.
Brown, C., Schulberg, H. C., & Madonia, M. J., (1995). Assessing depression in primary care practice with the Beck Depression Inventory and the Hamilton Rating Scale for Depression. *Psychological Assessment 7 (1),* 59-65.
Richter, P., Werner, J., Heerlien, A., Kraus, A., Sauer, H., (1998). On the validity of the Beck Depression Inventory; A review. *Psychopathology 31 (3),* 160-168.
Steer, R. A., Rissmiller, D. J.& Beck, A.T., (2000) Use of the Beck Depression Inventory –11 with depressed geriatric patients. *Behaviour Research and Therapy 38 (3)* 311-318.

SUBJECT TO COPYRIGHT – The table below represents a sample of questions only.
Further information and full scale available from:
www.pearsonassessment.com
Email: info@psychcorp.co.uk

BECKS DEPRESSION INVENTORY

Patient: ____________ Martial Status: _________ Age: ______ Sex: _______ Occupation: _____________ Education: _________

<u>Instructions:</u> This questionnaire consists of 21 groups of statements. Please read each one carefully, and then pick out **one statement** that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements seem to apply equally well, circle the highest number for that group of statements.Be sure that you do not choose more than one statement in any one group.

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all of the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about the future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things that I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things that I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

6. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

7. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all my faults.
3 I blame myself for everything bad that happens.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying but I can't.

11. Agitation
- **0** I am no more restless or wound up than usual.
- **1** I feel more restless or wound up than usual.
- **2** I am so restless or agitated that it is hard to stay still.
- **3** I am so restless or agitated that I have to keep moving or do something.

12. Loss of Interest
- **0** I have not lost interest in other people or activities.
- **1** I am less interested in other people or things than before.
- **2** I have lost most of my interest in other people or things.
- **3** It's hard to get interested in anything.

14. Worthlessness
- **0** I do not feel I am worthless.
- **1** I don't consider myself as worthwhile and useful as I used to.
- **2** I feel more worthless as compared to other people.
- **3** I feel utterly worthless.

15. Loss of Energy
- **0** I have as much energy as ever.
- **1** I have less energy than I used to have.
- **2** I don't have enough energy to do very much.
- **3** I don't have enough energy to do anything.

18. Changes in Appetite
- **0** I have not experienced any change in my appetite.
- **1a** My appetite is somewhat less than usual.
- **1b** My appetite is somewhat greater than usual.
- **2a** My appetite is much less than usual.
- **2b** My appetite is much greater than usual.
- **3b** I crave food all the time.

19. Concentration Difficulty
- **0** I can concentrate as well as ever.
- **1** I can't concentrate as well as usual.
- **2** It's hard to keep my mind on anything for very long.

21. Loss of Interest in Sex
- **0** I have not noticed any recent change in my interest in sex.
- **1** I am less interested in sex than I used to be.
- **2** I am much less interested in sex now.
- **3** I have lost interest in sex completely.

BECK SCALE FOR SUICIDE IDEATION (BSSI)

Purpose: Evaluate suicidal thinking.

Author: Aaron T. Beck

Description: The Beck Scale for Suicidal Ideation (BSI; Beck and Steer, 1991) is a self-report measure based on the semi-structured interview, the Scale for Suicidal Ideation or SSI (Beck et al., 1979). The SSI was developed for use with adult psychiatric patients. Steer and Beck (1988) suggest that the SSI is appropriate for research with adolescents as well, although very few studies of adolescents have used the SSI (e.g., Kashani et. al., 1991).

Administration: 5 to 10 minutes; self-administered or verbally by a trained administrator

Potential Use: Clinical assessment and clinical research.

Assessment and Detection of Suicidal Behaviour:

- The BSI begins with 5 items assessing wish to live, wish to die, reasons to live versus reasons to die, active suicidal ideation (e.g., "I have a moderate to strong desire to kill myself"), and passive suicidal ideation (e.g., "I would not take the steps necessary to avoid death if I found myself in a life-threatening situation").
- If the respondent totally denies active or passive suicidal ideation, s/he is directed to the last two items (#20 and #21) of the questionnaire assessing past suicide attempts and wish to die during the last attempt.
- If respondents do admit to at least some active or passive suicidal ideation, they complete Items #6 through #19, assessing duration and frequency of suicidal ideation, ambivalence regarding the suicidal ideation, specific deterrents to suicide and reasons for living, suicide plan and opportunity, expectations about following through with an attempt, and preparations in anticipation of suicide.

The BSI is one of the more thorough instruments for assessing severity of suicidal ideation, and one of the only assessment devices for assessing passive suicidal ideation. The total score yields a severity score, but individual items can be used as screens for active suicidal ideation, passive ideation, and past attempts. The items assessing thoughts of death are separate from items assessing suicidal ideation per se.

- The active suicide ideation screening item (#4) refers to "desire to kill myself," which implicitly assumes some rumination associated with "non-zero intent to kill oneself."
- The follow-up Item #15 even more clearly addresses issues of intent (e.g., "I am sure I shall make a suicide attempt").

Summary and Evaluation: The BSI is one of the more thorough instruments for assessing suicidal ideation, and one of the only scales to assess passive suicidal ideation in addition to active suicidal ideation. The BSI is appropriate for use with adolescents, but not younger children. The BSI also has been used in a small pilot study of dialectical behavioural therapy with suicidal adolescents who exhibited symptoms of borderline personality disorder. Nonetheless, test-retest reliability data

are not available for the BSI with adolescents, nor has the BSI been used in non-clinically ascertained samples. In adult samples, current suicidal ideation and suicidal ideation at its worst point has been found to be predictive of later suicide; however, the predictive validity of the BSI (and the interview form, the SSI) has not been demonstrated with adolescents.

Journal Articles:

Beck A, Kovacs M, Weissman A. (1979) Assessment of suicidal intention: the Scale for Suicidal Ideation. *Journal of Consulting and Clinical Psychology.*;47:343-352.

Beck A, Brown G, Steer R, Dahlsgaard K, Grisham J. (1999) Suicide ideation at its worst point: a predictor of eventual suicide in psychiatric outpatients. *Suicide and Life - Threatening Behavior.*;29:1-9.

Beck A, Steer R. (1991) *Manual for the Beck Scale for Suicidal Ideation*. San Antonio, Tex: Psychological Corporation.

Brown G, Beck A, Steer R, Grisham J. (2000) Risk factors for suicide in psychiatric outpatients: a 20-year prospective study. *Journal of Consulting and Clinical Psychology.*;68:371-377.

De Man A, Balkou S, Iglesias R. (1987) A French-Canadian adaptation of the Scale for Suicidal Ideation. *Canadian Journal of Behavioral Science.*;19:50-55.

De Man A, Leduc C. (1994) Validity and reliability of a self-report Suicide Ideation Scale for use with adolescents. *Social Behavior and Personality.*;22:261-266.

De Man A, Leduc C, Labreche-Gauthier L. (1992) Correlates of suicidal ideation in French- Canadian adults and adolescents: a comparison. *Journal of Clinical Psychology.*;48:811-816.

Esposito C, Clum G. (1999) Specificity of depressive symptoms and suicidality in a juvenile delinquent population. *Journal of Psychopathology and Behavioral Assessment.*;21:171-182.

Kashani J, Soltys S, Dandoy A, Vaidya A, Reid J. (1991) Correlates of hopelessness in psychiatrically hospitalized children. *Comprehensive Psychiatry.*;32:330-337.

Kumar G, Steer R. (1995) Psychosocial correlates of suicidal ideation in adolescent psychiatric inpatients. *Suicide and Life-Threatening Behavior.*;25:339-346.

Miller I, Norman W, Bishop S, Dow M. (1986) The modified scale for suicidal ideation: reliability and validity. *Journal of Consulting and Clinical Psychology.*;54:724-725.

Rathus J, Miller A. (2000) *Dialectical Behavior Therapy Adapted for Suicidal Adolescents: A Pilot Study*. In press.

Steer R, Beck A. (1988) Use of the Beck Depression Inventory, Hopelessness Scale, Scale for Suicidal Ideation, and Suicidal Intent Scale with adolescents. *Advances in Adolescent Mental Health*;3:219-231.

Steer R, Kumar G, Beck A. (1993) Self-reported suicidal ideation in adolescent psychiatric inpatients. *Journal of Consulting and Clinical Psychology.*;61:1096-1099.

SUBJECT TO COPYRIGHT – The table below represents a sample of questions only.

Further information and full scale available from:

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Email: info@psychcorp.co.uk

BECK SCALE FOR SUICIDE IDEATION

Patient: ____________________ Marital Status: ____________ Age: _________

Occupation: ________________ Education: _________________ Sex: _________

Directions: Please carefully read each group of statements below. Circle the one statement in each group that **best** describes how you have been feeling for the **past week, including today.**

Be sure to read all of the statements in each group before making a choice.

Part 1			
		2.	0 I have no wish to die.
			1 I have a weak wish to die.
			2 I have a moderate to strong wish to die.
3.	0 My reasons for living outweigh my reasons for dying.		
	1 My reasons for living or dying are about equal.		
	2 My reasons for dying outweigh my reasons for living.		

If you have circled the zero statements in both Group 2 & 4 then skip down to Group 20.
If you have marked a 1 or 2 in either group 2 or 4 then continue on through the groups.

Part 2			
6.	0 I would not kill myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc		
	1 I am somewhat concerned about killing myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.		
	2 I am not or only a little concerned about killing myself because of my family, friends, religion, possible injury from an unsuccessful attempt, etc.		
		8.	0 I do not accept the idea of killing myself.
			1 I neither accept nor reject the idea of killing myself.
			2 I accept the idea of killing myself.

10 0 I have brief periods of thinking about killing myself which passes quickly.
1 I have periods of thing about killing myself which lasts for moderate amounts of time.
2 I have long periods of thinking about killing myself.

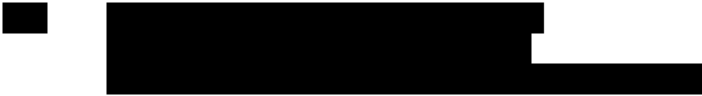
11. 0 I do not expect to make a suicide attempt.
1 I am unsure that I shall make a suicide attempt
2 I am sure that I shall make a suicide attempt.

13. 0 I have no specific plan about how to kill myself.
1 I have considered ways of killing myself, but have not worked out the details.
2 I have a specific plan for killing myself.

15. 0 I do not have the courage or the ability to commit suicide.
1 I am unsure if I have the courage or the ability to commit suicide.
2 I have the courage and the ability to commit suicide.

18. 0 I have made no arrangements for what will happen after I have committed suicide.
1 I have thought about making arrangements for what will happen after I have committed suicide.
2 I have made definite arrangements for what will happen after I have committed suicide.

19. 0 I have not hidden my desire to kill myself from people.
1 I have held back telling people about wanting to kill myself.
2 I have attempted to hide, conceal, or lie about wanting to commit suicide.



If you have previously attempted suicide, please continue with the next statement group.

21.
0 My wish to die during the last suicide attempt was low.
1 My wish to die during my last suicide attempt was moderate.
2 My wish to die during my last suicide attempt was high.

BECK HOPELESSNESS SCALE (BHS)

The Beck Hopelessness Scale is a powerful indicator of eventual suicide. It examines an individual's thoughts and beliefs about the future, loss of motivation and expectations.

Country: USA

Author: Aaron T. Beck.

Purpose: Designed to measure negative attitudes about the future.

Population: Ages 17 and over.

Time: (5-10) minutes.

Publisher: The Psychological Corporation.

Brief Description: The Beck Hopelessness Scale (BHS) is a 20-item scale for measuring negative attitudes about the future. Beck originally developed this scale in order to predict who would die by suicide and who would not. It is a self-report instrument that consists of 20 true-false statements designed to assess the extent of positive and negative beliefs about the future during the past week. Each of the 20 statements is scored 0 or 1. A total score is calculated by summing the pessimistic responses for each of the 20 items. The total BHS score ranges from 0 to 20. The conceptual basis for the scale derives from the writings of the social psychologist Ezra Stotland. Use this powerful predictor of eventual suicide to help you measure three major aspects of hopelessness: feelings about the future, loss of motivation, and expectations. Responding to the 20 true or false items on the *Beck Hopelessness Scale*® (BHS®), patients can either endorse a pessimistic statement or deny an optimistic statement. Predicts Eventual Suicide Research consistently supports a positive relationship between BHS scores and measures of depression, suicidal intent, and ideation.

Summary and Evaluation: The BHS is one of the most widely used measures of hopelessness. The scale has excellent internal consistency and test-retest reliability. The concurrent validity is well established across a wide variety of samples and frequently has been used in treatment outcome studies. There have been several studies that have supported the predictive validity of the BHS for suicide attempts and completed suicide.

Journal Articles:

Beck AT, Brown GK, Berchick RJ, Stewart BL, Steer RA. (1990) Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients. *American Journal of Psychiatry.*;147(2):190-195.

Beck AT, Resnik HL, Lettieri DJ. (1974) *The Prediction of Suicide.* Philadelphia, Pa: Charles Press.

Beck AT, Steer RA. (1989) Clinical predictors of eventual suicide: a five to ten year prospective study of suicide attempters. *Journal of Affective Disorders.*;17:203-209.

Beck AT, Steer RA, Beck JS, Newman CF. (1993) Hopelessness, depression, suicidal ideation, and clinical diagnosis of depression. *Suicide and Life-Threatening Behavior.*;23:139-145.

Beck AT, Steer RA. (1988) *Manual for the Beck Hopelessness Scale.* San Antonio, Tex: Psychological Corporation.

Beck AT, Steer RA, Kovacs M, Garrison B. (1985) Hopelessness and eventual suicide: a 10-year prospective study of patients hospitalized with suicidal ideation. *American Journal of Psychiatry.*;142:559-563.

Beck AT, Steer RA, McElroy MG. (1982) Relationships of hopelessness, depression, and previous suicide attempts to suicidal ideation in alcoholics. *Journal of Studies on Alcohol.*;43:1042-1046.
Brown GK, Beck AT, Steer RA, Grisham JR. (2000) Risk factors for suicide in psychiatric outpatients: a 20-year prospective study. *Journal of Consulting and Clinical Psychology.*;68:371-377.
Dahlsgaard KK, Beck AT, Brown GK. (1998) Inadequate response to therapy as a predictor of suicide. *Suicide and Life-Threatening Behavior.*;28:197-204.
Drake RE, Cotton PG. (1986) Depression, hopelessness and suicide in chronic schizophrenia. *British Journal of Psychiatry.*;148:554-559.
Dyer JAT, Kreitman N. (1984) Hopelessness, depression, and suicidal intent in parasuicide. *British Journal of Psychiatry.*;144:127-133.
Mann JJ, Waternaux C, Haas GL, Malone KM. (1999) Toward a clinical model of suicidal behavior in psychiatric patients. *American Journal of Psychiatry.*;156:181-189.
Nordstrom P, Asberg M, Asberg-Wistedt A, Nordin C. (1995) Attempted suicide predicts suicide risk in mood disorders. *Acta Psychiatrica Scandinavica.*;92:345-350.
Rudd MD, Rajab MH, Orman DT, Stulman DA, Joiner T, Dixon W. (1996) Effectiveness of an outpatient intervention targeting suicidal young adults: preliminary results. *Journal of Consulting and Clinical Psychology.*;64:179-190.
Salkovskis PM, Atha C, Storer D. (1990) Cognitive-behavioural problem solving in the treatment of patients who repeatedly attempt suicide: a controlled trial. *British Journal of Psychiatry.*;157:871-876.
Rifai AH, George CJ, Stack JA, Mann JJ, Reynolds CF. (1994) Hopelessness in suicide attempters after acute treatment of major depression in late life. *American Journal of Psychiatry.*;151:1687-1690.
Rudd MD, Joiner T, Rajab MH. (1996) Relationships among suicide ideators, attempters, and multiple attempters in a young-adult sample. *Journal of Abnormal Psychology.*;105(4):541-550.
Steer RA, Beck AT, Brown GK. (1997) Factors of the Beck Hopelessness Scale: fact or artifact? *Multivariate Experimental Clinical Research.*;11(3):131-144.
Van der Sande R, Van Rooifen L, Buskens E, Allart E, Hawton K, Van der Graff Y, Van Engeland H. (1997) Intensive in-patient and community intervention versus routine care after attempted suicide: a randomised controlled intervention study. *British Journal of Psychiatry.*;171:35-41.
Young MA, Fogg LF, Scheftner W, Fawcett J, Akiskal H, Maser J. (1996) Stable trait components of hopelessness: baseline and sensitivity to depression. *Journal of Abnormal Psychology.*;105(2):155-165.

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Further information and full scale available from: www.pearsonassessment.com
Email: info@psychcorp.co.uk

BECK HOPELESSNESS SCALE

Patient: ______________ Martial Status: _______ Age: ____ Sex: _____ Occupation: _____________

<u>Directions:</u> This questionnaire consists of 20 statements. Please read the statements carefully, one by one. If the statement describes your attitude for the **past week, including today**, darken the box with a "T" indicating TRUE in the column next to the statement. If the statement does not describe your attitude, darken the box with an "F" indicating FALSE in the column next to this statement.

Please be sure to read each statement carefully.

1	I look forward to the future with hope and enthusiasm.	T	F
		T	F
3	When things are going badly, I am helped by knowing that they cannot stay like that forever	T	F
		T	F
5	I have enough time to accomplish the things I want to do.	T	F
6	In the future, I expect to succeed in what concerns me most.	T	F
		T	F
8	I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.	T	F
9	I just can't get the breaks, and there's no reason I will in the future.	T	F
		T	F
11	All I can see ahead of me is unpleasantness rather than pleasantness.	T	F
12		T	F
13	When I look ahead to the future, I expect that I will be happier than I am now.	T	F
14	Things just don't work out the way I want them to.	T	F
15		T	F
16		T	F
17	It's very unlikely that I will get any real satisfaction in the future.	T	F
18	The future seems vague and uncertain to me.	T	F
19		T	F
20	There is no use in really trying to get anything I want because I probably won't get it.	T	F

BECK ANXIETY INVENTORY (BAI)

Purpose: Designed to discriminate anxiety from depression in individuals.

Population: Adults: 17 through 80 years.

Score: Yields a total score

Time: (5-10) minutes.

Author: Aaron T. Beck.

Publisher: The Psychological Corporation.

Suggested Uses: Recommended for use in assessing anxiety in clinical/research settings.

Description: The Beck Anxiety Inventory (BAI) was developed to address the need for an instrument that would reliably discriminate anxiety from depression while displaying convergent validity. Such an instrument would offer advantages for clinical and research purposes over existing self-report measures, which have not been shown to differentiate anxiety from depression adequately. The Beck Anxiety Inventory consists of 21 items, each describing a common symptom of anxiety. The respondent is asked to rate how much he or she has been bothered by each symptom over the past week on a 4-point scale. The test has been substantially helpful in thousands of clinical studies. The major advantage of the Beck Anxiety Inventory is that it can help a person suffering from anxiety, understand his body and mind connection. Once a person understands that, the chance of successful treatment increases greatly.

Scoring: The scale consists of 21 items, each describing a common symptom of anxiety. The respondent is asked to rate how much he or she has been bothered by each symptom over the past week on a 4-point scale ranging from 0 to 3. The items are summed to obtain a total score that can range from 0 to 63.

Journal Articles: De Ayala; R. J. Vonderharr-Carlson, D. J &. Kim, Doyoung (2005) Assessing the Reliability of the Beck Anxiety Inventory Scores, Educational and Psychological Measurement, Vol. 65, No. 5, 742-756.

SUBJECT TO COPYRIGHT – The table below represents a sample of questions only.
Further information and full scale available from:
www.pearsonassessment.com
Email: info@psychcorp.co.uk

BECK ANXIETY INVENTORY

Instructions: Below is a list of common symptoms of anxiety. Please read each item in the list carefully. Indicate how often you experienced each symptom during the PAST WEEK, INCLUDING TODAY by circling the corresponding number in the column next to each symptom.

		Never	Occasionally	Frequently	Almost all the time
		0	1	2	3
2	Feeling Hot	0	1	2	3
		0	1	2	3
4	Unable to relax	0	1	2	3
5	Fear of the worst happening	0	1	2	3
		0	1	2	3
7	Heart pounding or racing	0	1	2	3
		0	1	2	3
9	Terrified	0	1	2	3
		0	1	2	3
11	Feelings of choking	0	1	2	3
12	Hands trembling	0	1	2	3
13	Shaky	0	1	2	3
		0	1	2	3
		0	1	2	3
16	Fear of dying	0	1	2	3
		0	1	2	3
18	Indigestion or discomfort in abdomen	0	1	2	3
		0	1	2	3
20	Face flushed	0	1	2	3
		0	1	2	3

Minimal/Low Anxiety: That is usually a good thing. However, it is possible that the patient/client might be unrealistic in either their assessment, which would be denial or that they have learned to "mask" the symptoms commonly associated with anxiety. Too little "anxiety" could indicate detachment from oneself, others or ones environment.

Moderate Anxiety: Look for patterns as to when and why the patient/client experiences the symptoms above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved.

Severe Anxiety: Again, look for patterns or times when the patient/client tends to feel the symptoms they have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to mental and physical health.

Zung Self-Rating Anxiety Scale

The **Zung Self-Rating Anxiety Scale** was designed to quantify the level of anxiety for patients experiencing anxiety related symptoms.

Author: Zung, William WK. (1971) A Rating Instrument for Anxiety Disorders- Psychosomatics

Scoring: The self-administered test has 20 questions. Each question is scored on a scale of 1-4 ('none or a little of the time' to 'most of the time'). There are 15 questions worded toward higher anxiety levels and 5 questions, (statements 5, 9, 13, 17, 19), worded toward lower anxiety levels. **(NOTE: these five items are reverse scored afterwards).**

The scores range from 20-80.

20-44 Normal Range
45-59 Mild to Moderate Anxiety Levels
60-74 Marked to Severe Anxiety Levels
75-80 Extreme Anxiety Levels

ZUNG SELF-RATED ANXIETY SCALE

Name :______________________
DATE: **DD** **MM** **YYY**

Listed below are 20 statements. Please read each one carefully and decide how much the statement describes how you have been feeling **during the past week.** Circle the appropriate number of each statement.

STATEMENT	None or a little of the time	Some of the time	A good part of the time	Most or all of the time
1. I feel more nervous and anxious than usual	1	2	3	4
2. I feel afraid for no reason at all	1	2	3	4
3. I get upset easily or feel panicky	1	2	3	4
4. I feel like I'm falling apart and going to pieces	1	2	3	4
5. I feel that everything is all right and nothing bad will happen	1	2	3	4
6. My arms and legs shake and tremble	1	2	3	4
7. I am bothered by headaches, neck and back pains	1	2	3	4
8. I feel weak and get tired easily	1	2	3	4
9. I feel calm and can sit still easily	1	2	3	4
10. I can feel my heart beating fast	1	2	3	4
11. I am bothered by dizzy spells	1	2	3	4
12. I have fainting spells or feel like it	1	2	3	4
13. I can breathe in and out easily	1	2	3	4
14. I get feelings of numbness and tingling in my fingers and toes	1	2	3	4
15. I am bothered by stomach aches or indigestion	1	2	3	4
16. I have to empty my bladder often	1	2	3	4
17. My hands are usually warm and dry	1	2	3	4
18. My face gets hot and blushes	1	2	3	4
19. I fall asleep easily and get a good night's rest	1	2	3	4
20. I have nightmares	1	2	3	4

THE ROSENBERG SELF-ESTEEM SCALE

The Rosenberg Self-Esteem Scale (SES) is perhaps the most widely-used self-esteem measure in social science research.

Name of website: Rosenberg Self Esteem

Country: USA

Authors: Rosenberg, Morris (1965) *Society and the Adolescent Self-Image*. Princeton, New Jersey: Princeton University Press.

For further information on Rosenberg SES contact : The Morris Rosenberg Foundation c/o dept. of Sociology, University of Maryland, 2112 Art/Soc Building, College Park, MD 29742-13115
(Dr. Rosenberg was Professor of Sociology at the University of Maryland from 1975 up to his death in 1992. His wife Manny has given permission for use of the scale for educational/clinical use.)

Brief Description:
Rosenberg SES is the most widely used self esteem tool and most popular measure of global self esteem.
It is a 10 item self assessment questionnaire that measures self esteem.

This scale is in the public domain and can be used without securing permission.

References:

Blascovich, Jim and Joseph Tomaka. (1993). "Measures of Self-Esteem." Pp. 115-160 in J.P. Robinson, P.R. Shaver, and L.S. Wrightsman (eds.), Measures of Personality and Social Psychological Attitudes. Third Edition. Ann Arbor: Institute for Social Research.

Owens, Timothy J. (1994). "Two Dimensions of Self-Esteem: Reciprocal Effects of Positive Self-Worth and Self-Deprecation on Adolescent Problems." American Sociological Review. 59:391-407.

Owens, Timothy J. (1993). "Accentuate the Positive - and the Negative: Rethinking the Use of Self-Esteem, Self-Deprecation, and Self-Confidence." Social Psychology Quarterly. 56:288-99.

Owens, Timothy J. (2001). Extending Self-Esteem Theory and Research. Cambridge: University Press.

Rosenberg, Morris. (1965). Society and the Adolescent Self-Image. Princeton, New Jersey: Princeton University Press. (Chapter 2 discusses construct validity.)

Rosenberg, Morris. (1986). Conceiving the Self. Krieger: Malabar, FL.

Silber, E. and Tippett, Jean (1965). "Self-esteem: Clinical assessment and measurement validation." Psychological Reports, 16, 1017-1071. (Discusses multitrait-multimethod investigation using RSE).

Wells, L. Edward and Gerald Marwell. (1976). Self-Esteem: Its Conceptualization and Measurement. Beverly Hills: Sage.

Wylie, Ruth C. (1974). The Self-Concept (especially pp. 180-189.) Revised Edition. Lincoln, Nebraska: University of Nebraska Press.

Scoring of the ROSENBERG SELF-ESTEEM SCALE

To score the items, assign a value to each of the 10 items as follows:

Using the Likert procedure, responses are assigned a score ranging from 0 to 3.

Items 1, 3, 4, 7, 10 are positive scored

(for example item **1** Strongly Agree scores 3, Agree score 2, Disagree score 1 and Strongly Disagree scores 0)

Items 2, 5, 6, 8, 9 (with *) are reverse scored.

(for example item **2**, Strongly Agree score 0, Agree score 1, Disagree score 2, Strongly Disagree score 3)

The scale ranges from 0-30, with 30 indicating the highest score possible.

The higher the score indicates the higher the self esteem.

Note:

There are many editions of the SES available. All valid Rosenberg self esteem scales must list the 10 questions with 5 positives and 5 negatives.

Different editions of Rosenberg have variations in order of questions and in the wording of the questions and in scoring range with some of the assessments offering a scoring range of 0 to 30 and others 0 to 40.

Advice to Assessor:

When giving feedback/report on the Rosenberg, detail what the maximum score option is - in this version that is 30.

The list and order of questions of this SES are a replica of the original Rosenberg Scale.

Include the Assessment in care plan so that if replicated, the same version is being used.

THE ROSENBERG SELF-ESTEEM SCALE

Instructions

Below is a list of statements dealing with your general feelings about yourself. If you **strongly agree**, circle **SA**. If you **agree** with the statement, circle **A**. If you **disagree**, circle **D**. If you **strongly disagree**, circle **SD**.

1.	**On the whole I am satisfied with myself**	**SA**	**A**	**D**	**SD**
2. *	**At times I think I am no good at all**	**SA**	**A**	**D**	**SD**
3.	**I feel that I have a number of good qualities**	**SA**	**A**	**D**	**SD**
4.	**I am able to do things as well as most other people**	**SA**	**A**	**D**	**SD**
5. *	**I feel I do not have much to be proud of**	**SA**	**A**	**D**	**SD**
6. *	**I certainly feel useless at times.**	**SA**	**A**	**D**	**SD**
7.	**I feel that I am a person of worth, at least on an equal plain with others**	**SA**	**A**	**D**	**SD**
8. *	**I wish I could have more respect for myself**	**SA**	**A**	**D**	**SD**
9. *	**All in all, I am inclined to feel that I am a failure**	**SA**	**A**	**D**	**SD**
10.	**I take a positive attitude toward myself**	**SA**	**A**	**D**	**SD**

EVALUATIVE BELIEF SCALE

Purpose: The Evaluative Beliefs Scale (EBS) measures negative personal evaluations, a key class of beliefs within cognitive psychotherapy and thought to be closely linked to emotional disturbance.

Reference: Chadwick, Birchwood, Trower, (1996) Cognitive Therapy for Delusions, Voices and Paranoia.

Population: Adults.

Brief History of the scale: Developed primarily for working with patients with delusions. It is a self report measure of a persons' evaluation of their beliefs. Covers the major areas of interpersonal concern: namely unlovability, failure, inferiority, badness and weakness. An evaluation is defined as a good/bad judgement. The personal evaluative beliefs are grouped into three categories: self to self, self to others and others to self.

Personal evaluations are very important in how one judges oneself and what one believes to be true of oneself. Very often a person is unaware of his/her personal evaluations and this scale will highlight areas to work on and improve.
This scale is a useful cognitive behaviour therapy tool.

Scoring: Measures negative self evaluations in 3 categories with 6 questions in each one. The higher the positive scoring (agree strongly) a client attains the more emotionally disturbed she or he is likely to be. Insert detail of the level of agreement or disagreement (ie...agree strongly ,disagree slightly) in the response section of the scoring grid and this facilitates the client and nurse/therapist to visually appreciate areas to require interventions.

Scoring:

Self to self evaluation:

Question	Response
2	
6	
11	
13	
17	
18	

Self to others evaluation:

Question	Response
1	
4	
7	
8	
10	
15	

Others to Self evaluation:

Question	Response
3	
5	
9	
12	
14	
16	

EVALUATIVE BELIEF SCALE (Chadwick, Birchwood, Trower, 1996)
Below is a list of beliefs people sometimes report. Please read each one and tick how much you believe it to be true. Please give your 'gut' response.

		Agree strongly	Agree slightly	Unsure	Disagree slightly	Disagree strongly
1.	Other people are worthless					
2.	I am a total failure					
3.	People think I am a bad person					
4.	Other people are inferior to me					
5.	People see me as worthless					
6.	I am worthless					
7.	Other people are total failures					
8.	Other people are totally weak and helpless					
9.	People see me as a total failure					
10.	Other people are bad					
11.	I am totally weak and helpless					
12.	People see me as unlovable					
13.	I am a bad person					
14.	People see me as totally weak and helpless					
15.	Other people are unlovable					
16.	Other people look down on me					
17.	I am an inferior person					
18.	I am unlovable					

SLEEP SCALE

Name of website: www.WHO.com

Country: Australia

Authors: World Health Organisation Collaborating Centres in Mental Health, Sydney and London

Brief Description: A sleep diary that can be kept over one to two weeks adds a lot of useful information to the sleep history and may identify factors or patterns in an individual's sleep of which they are unaware. The sleep diary will provide a clear picture and good baseline assessment of the sleeping patterns of the client/patient.

Reference:
World Health Organisation (1999) *Management of Mental Disorders*, Volume 2, WHO ,United Kingdom Edition.

Directions for use:

- To be documented over one week at least in order to give a baseline of the sleeping pattern of the client.
- To be used in conjunction with the overall assessment of the patient/client and forms part of the care plan if appropriate.
- Interventions following the final collation of the time spent asleep etc… will be dependent on the patterns that have emerged.

SLEEP SCALE

Name of Patient: ______________________ **DOB** _____________

SLEEP DIARY

Date	Time of getting to bed	Time taken to fall asleep	No. of awakenings	Time spent awake during night	Time of awakening in morning	Time of getting up	Naps	Exercise (type & duration)	Drugs, alcohol & caffeine	Significant events today

SECTION 2:
Medication Related Screening Tools

LUNSERS: Liverpool University Side Effect Rating Scale

LUNSERS is a fully validated and comprehensive *self-rating scale* for measuring the impact of side effects from neuroleptic medication. The scale rates the severity of recognised neuroleptic side effects as well as some "red herring" items to distinguish where many effects are attributed inappropriately to drugs. Users of the scale should read the article below to familiarise themselves with the test.

Authors: Jenny Day & Richard Bentall (Day *et al, British Journal of Psychiatry (*1955), 166, 650 – 653).

Details: LUNSERS is a fully validated and reliable means of assessing neuroleptic side effects. It includes 41 known side effects of neuroleptics, and ten "red herring" items, including hair loss and chilblains, which are not known side effects of neuroleptic medication. The structure of the scale is such that the patient's experiences can easily be elicited from key items. It is also easy to detect patterns of response in scoring; for example, subjects who are consistently scoring highly may contradict themselves on opposing items. Furthermore, inclusion of symptoms that are not side-effects of neuroleptics allows detection of excessive response styles. The combination of these factors allows the reliability of the individual subject to be estimated.

Key Indication: The assessment of the impact and severity of side-effects of neuroleptic medication.

Scoring: The scoring is as follows:

Not at all	0
Very little	1
A little	2
Quite a lot	3
Very much	4

- LUNSERS total of all 51 items gives ranges of: **0 – 204 female and 0 – 196 male**
- Each separate score is placed in the **side effects by group section** and will indicate which group of side effects is most problematic for the patient
- Red herring items (numbers 3, 8, 11, 12, 25, 28, 30, 33, 42 and 45) should be scored separately as this score may indicate individuals who over score generally on the scale (a high score would be over 20 for these items).
- The real neuroleptic side effect score is the sum of the scores for the remaining items (i.e. all items excluding the red herrings).
- Hence, LUNSERS side effect scores fall between:
  0 – 164 female
  0 – 156 male

Further Information: For more information on LUNSERS please write to: Lancashire Care NHS Trust, 5 Fulwood Park, Caxton Road, Fulwood, Preston, PR2 9N, England.

LUNSERS: Liverpool University Side Effect Rating Scale

Instructions: The following scale is intended to be self-administered. Please indicate how much you have experienced each of the following symptoms in **the last month** by ticking a box for each of the 51 items.

Patients Name	
Raters Name	
Assessment Date	

		NOT AT ALL (0)	VERY LITTLE (1)	A LITTLE (2)	QUITE A LOT (3)	VERY MUCH (4)
1.	Rash					
2.	Difficulty staying awake during the day					
3.	Runny nose					
4.	Increased dreaming					
5.	Headaches					
6.	Dry mouth					
7.	Swollen or tender chest					
8.	Chilblains					
9.	Difficulty in concentrating					
10.	Constipation					
11.	Hair loss					
12.	Urine darker than usual					
13.	Period pains					
14.	Tension					
15.	Dizziness					
16.	Feeling sick					
17.	Increased sex drive					
18.	Tiredness					

		NOT AT ALL (0)	VERY LITTLE (1)	A LITTLE (2)	QUITE A LOT (3)	VERY MUCH (4)
19.	**Muscle stiffness**					
20.	**Palpitations**					
21.	**Difficulty in remembering things**					
22.	**Losing weight**					
23.	**Lack of emotions**					
24.	**Difficulty in achieving climax**					
25.	**Weak fingernails**					
26.	**Depression**					
27.	**Increased sweating**					
28.	**Mouth ulcers**					
29.	**Slowing of movements**					
30.	**Greasy skin**					
31.	**Sleeping too much**					
32.	**Difficulty passing water**					
33.	**Flushing of face**					
34.	**Muscle spasms**					
35.	**Sensitivity to sun**					
36.	**Diarrhoea**					
37.	**Over-wet or drooling mouth**					
38.	**Blurred vision**					
39.	**Putting on weight**					
40.	**Restlessness**					

		NOT AT ALL (0)	VERY LITTLE (1)	A LITTLE (2)	QUITE A LOT (3)	VERY MUCH (4)
41.	**Difficulty getting to sleep**					
42.	**Neck muscles aching**					
43.	**Shakiness**					
44.	**Pins and needles**					
45.	**Painful joints**					
46.	**Reduced sex drive**					
47.	**New or unusual skin marks**					
48.	**Parts of body moving of their own accord e.g. foot moving up and down**					
49.	**Itchy skin**					
50.	**Periods less frequent**					
51.	**Passing a lot of water**					
	TOTAL					

LUNSERS-RECORDING SHEET

DATE				
OVERALL SCORE				
ITEMS RATED				
VERY LITTLE (1)				
LITTLE (2)				
QUITE A LOT (3)				
VERY MUCH (4)				
EXTRA-PYRAMIDAL SE SCORE				
ANTICHOLINERGIC SE SCORE				
OTHER AUTONOMIC SE SCORE				
ALLERGIC REACTIONS SE SCORE				
PSYCHIC SE SCORE				
HORMONAL SE SCORE				
MISCELLANEOUS SE SCORE				
RED HERRING SCORE				
CURRENT MEDICATION				

LUNSERS – RECORDING SHEET
Rate the columns on the LUNSERS assessment sheet from 0 to 4.

PSYCHIC SIDE EFFECTS	SCORE	EXTRA-PYRAMIDAL SIDE EFFECTS	SCORE
2 – Difficulty staying awake during the day		19 - Muscle stiffness	
4 - Increased dreaming		29 - Slowing of movements	
9 – Difficulty in concentrating		34 - Muscle spasms	
14 – Tension		37 - Over-wet or drooling mouth	
18 – Tiredness		40 - Restlessness	
21 – Difficulty in remembering things		43 - Shakiness	
23 – Lack of emotions		48 - Parts of the body moving of their own accord e.g. foot moving up & down	
26 – Depression			
31 – Sleeping too much			
41 – Difficulty getting off to sleep			
Total Score ~ (Possible range 0-40)		***Total Score ~ (Possible range 0-28)***	
HORMONAL SIDE EFFECTS	**SCORE**	**ANTICHOLINERGIC SIDE EFFECTS**	**SCORE**
7 – Swollen or tender chest		6 - Dry mouth	
13 – Period problems ***Females Only***		10 - Constipation	
17 – Increased sex drive		32 - Difficulty passing water	
24 – Difficulty in achieving orgasm		38 - Blurred vision	
46 – Reduced sex drive		51 - Passing a lot of water	
50 – Periods less frequent ***Females Only***			
Total Score ~ (Possible ranges: 0-24, females 0-16, males)		***Total Score ~ (Possible range 0-20)***	
MISCELLANEOUS SIDE EFFECTS	**SCORE**	**OTHER AUTONOMIC SIDE EFFECTS**	**SCORE**
5 – Headaches		15 – Dizziness	
22 – Losing weight		16 - Feeling sick	
39 – Putting on weight		20 – Palpitations	
44 – Pins and needles		27 - Increased sweating	
		36 - Diarrhoea	
Total Score ~ (Possible Range 0-16)		***Total Score ~ (Possible range 0-20)***	
RED HERRINGS		**ALLERGIC REACTIONS**	**SCORE**
3 – Runny Nose		1 – Rash	
8 – Chilblains		35 – Sensitivity to Sun	
11 – Hair Loss		47 – New or Unusual Skin Marks	
12 – Urine Darker Than Usual		49 – Itchy Skin	
25 – Weak Fingernails		***Total Score ~ (Possible range 0-16)***	
28 – Mouth Ulcers			
30 – Greasy Skin			
33 – Flushing of Face		**TOTAL SCORE**	
42 – Neck Muscles Aching			
45 – Painful Joints			
Total Score ~ (Possible range 0-40)			

POSSIBLE RANGE FOR TOTAL SCORES:

LUNSERS SIDE EFFECT SCORES ONLY
WOMEN: 0 – 164
MEN: 0 – 156

LUNSERS ALL 51 ITEMS
WOMEN: 0 – 204
MEN: 0 - 196

Score sheet for the LUNSERS

Total each of the columns and place the scores in the table below ……..eg .. how many zeros …..ones. etc

Not at all = 0
Very little = 1
A little = 2
Quite a lot = 3
Very much = 4

Within this total…also include the red herrings at this point…they are subtracted later

Multiply the LUNSERS score using the numbers in the top column, add the scores and place them in the total column. Total the red herring scores, multiply them by the top number and then minus this from the LUNSERS scores

(example)

0	1	2	3	4	
25 (x)	2 (x)	15 (x)	7 (x)	0 (x)	Total
= 0	= 2	= 30	= 21	= 0	= 53

Red herrings

0	1	2	3	4	Total
0 (x)	0 (x)	4 (x)	0 (x)	0 (x)	
= 0	= 0	= 8	= 0	= 0	= 8
				LUNSERS score	53
				Score minus red herrings	= 45

0	1	2	3	4	
(x)	(x)	(x)	(x)	(x)	Total
=	=	=	=	=	=

Red herrings

0	1	2	3	4	Total
(x)	(x)	(x)	(x)	(x)	
=	=	=	=	=	=
				LUNSERS score	
				Score minus red herrings	=

On the following page, place each of the separate scores in the **side effects by group section.** This will indicate which group of side effects is most problematic for the patient

LUNSERS SCORE SHEET

Patients name		
Assessors name		
Date of Test		
Total LUNSERS score: (all 51 questions) Extra-pyramidal Side-Effects: Questions: 19, 29, 34, 37, 40, 43 & 48. Anti-cholinergic Side-effects: Questions: 6, 10, 32, 38 & 51. Other autonomic Side-effects: Questions: 15, 16, 20, 27 & 36. Allergic reactions Side-effects: Questions: 1, 35, 47 & 49. Psychic Side-Effects: Questions: 2, 4, 9, 14, 18, 21, 23, 26, 31 & 41. Hormonal Side-effects: Questions: 7, 13, 17, 24, 46 & 50. Miscellaneous Side-Effects: Questions: 22, 39 & 44.		**Score 0- 4** 0: 'Not at all' 1: 'Very little' 2: 'A little' 3: 'Quite a lot' 4: 'Very much'
"Red Herring" item score: (Questions: 3, 8, 11, 12, 25, 28, 30, 32, 42 & 45)		Score as above (>20 high)
Total minus "red herring" score		

(0-40 = low, 41-80 = medium, 81-100 = high, >101 = very high)

Neuroleptics and doses (including PRN's) at the time of assessment:

1.

2.

3.

4.

5,

Other relevant drugs and doses (e.g. anticholinergics, antidepressants,etc.):

DRUG ATTITUDE INVENTORY (DAI-30)

Purpose: The aim of this questionnaire is to gain some understanding of what people think about medications and what experiences people have of them. This helps to establish the likelihood of a person being compliant based on an understanding of their attitude towards taking prescribed drugs/ medications.

Population: Adults

Author: Adapted from "A self-report scale predictive of drug compliance in schizophrenics: reliability and discriminative validity", Hogan TP, Awad AG, Eastwood R, *Psychological Medicine* (1983), 13, 177-183.

How to fill in this questionnaire:

- Read each statement and decide whether it is true as applied to you or false as applied to you.
- If a statement is TRUE or MOSTLY TRUE to you, circle the T at the end of the line.
- If a statement is FALSE or MOSTLY FALSE to you, circle the F at the end of the line.
- If you want to change an answer, mark an X over the incorrect answer and circle the correct answer
- If a statement is not worded quite the way you would put it, please decide whether the answer is mostly true or mostly false to you.
- **There are no right or wrong answers. Please give YOUR OWN OPINION, not what you think we might want to hear.**
- Do not spend too much time on any one question.
- Please answer every question.
- The medications referred to are those for mental health needs only.

Scoring:
A total of 30 questions. 15 items that will be scored as True and 15 scored as False
PS = Positive score
NS = Negative score
TS = Total score
The Final score is the total sum of pluses and minuses.

- The more positive the score is the more compliant the client will be.
- The more negative the score is the less compliant the client will be.
- "Positive" answers will be scored as plus one and "Negative" answers score as minus one. e.g. a circle round the above letters counts as plus one (e.g. a circle or tick on the F of question one will score plus one, a circle or tick on the T of question one will score minus one).
- The final score for each person at each time is the positive score minus the negative score.
- A positive total final score means a positive subjective response = compliant, supportive of taking medication.
- A negative total score means a negative subjective response = non-compliant, non-supportive of taking medication.

1	**False**
2	**True**
3	**False**
4	**True**
5	**False**
6	**True**
7	**True**
8	**True**
9	**True**
10	**False**

11	**False**
12	**False**
13	**False**
14	**False**
15	**True**
16	**False**
17	**False**
18	**True**
19	**False**
20	**False**

21	**True**
22	**True**
23	**True**
24	**True**
25	**False**
26	**True**
27	**False**
28	**False**
29	**True**
30	**True**

The mental health assessment tools review group acknowledge that medication concordance is a more popular approach within a recovery ethos than medication compliance. The original DAI uses the term compliance.

PS (Positive Score)		NS (Negative Score)		TS (Total Score)	

DRUG ATTITUDE INVENTORY Name: ______________________ Date: ___________

No	Question	Response	
1	I don't need to take medication once I feel better	T	F
2	For me, the good things about medication outweigh the bad	T	F
3	I feel strange, "doped up", on medication	T	F
4	Even when I am not in hospital I need medication regularly	T	F
5	If I take medication, it's only because of pressure from other people	T	F
6	I am more aware of what I am doing, of what is going on around me, when I am on medication	T	F
7	Taking medications will do me no harm	T	F
8	I take medications of my own free choice	T	F
9	Medications make me feel more relaxed	T	F
10	I am no different on or off medication	T	F
11	The unpleasant effects of medication are always present	T	F
12	Medication makes me feel tired and sluggish	T	F
13	I take medication only when I feel ill	T	F
14	Medications are slow-acting poisons	T	F
15	I get along better with people when I am on medication	T	F
16	I can't concentrate on anything when I am taking medication	T	F
17	I know better than the doctors when to stop taking medication	T	F
18	I feel more normal on medication	T	F
19	I would rather be ill then taking medication	T	F
20	It is unnatural for my mind and body to be controlled by medications	T	F
21	My thoughts are clearer on medication	T	F
22	I should keep taking medication even if I feel well	T	F
23	Taking medication will prevent me from having a breakdown	T	F
24	It is up to the doctor to decide when I should stop taking medication	T	F
25	Things that I could do easily are much more difficult when I am on medication	T	F
26	I am happier and feel better when I am taking medications	T	F
27	I am given medication to control behaviour that <u>other</u> people (not myself) don't like	T	F
28	I can't relax on medication	T	F
29	I am in better control of myself when taking medication	T	F
30	By staying on medications I can prevent myself getting sick	T	F

If you have any further comments about medication or this questionnaire, please write them below:

SECTION 3:
Addiction Screening Tools

MICHIGAN ALCOHOL SCREENING TEST
(MAST)

Purpose: The MAST is a diagnostic tool designed to help identify all people with alcohol dependency syndrome, if they respond truthfully.

Country: USA

Authors: National Council on Alcoholism and Drug Dependence of the San Fernando Valley Inc.

Description: The MAST is a 25-item yes or no questionnaire, with a high level of face validity.

Please note in some web based available versions the scale has been reduced to a 22 item questionnaire

Cut off scores:
Three or less is considered no problem; four is considered suspicious of a drinking problem; five or higher is presumptive evidence of alcohol dependency syndrome.

Administration: The MAST can be administered in 15 minutes in the form of an individual structured interview/self administered. Minimal training is necessary for both conducting the interview and scoring.

Additional comments:

- The initial MAST sample was done only on men, which raises questions on its usefulness for women.
- It has uses as a screening tool, especially with populations with no major investment to hide their drinking and drink-related behaviour.
- It also has been effectively used with interviewing friends and relatives of the individual who is trying to hide their drinking problem.

References:

Bradley KA, Boyd-Wickizer J, Powell SH, Burman ML. (1998) Alcohol screening questionnaires in women: a critical review. JAMA; 280:166–71.

Haley WE. (1999) Psychotherapy with older adults in primary care medical settings. J Clin Psychol; 55:991–1004.

Hill A., Rumpf HJ, Hapke U, Driessen M, Ulrich J. (1998) Prevalence of alcohol dependence and abuse in general practice. Alcohol Clin Exp Res; 22:935–40.

Jones TV, Lindsey BA, Yount P, Soltys R, Farani-Enayat B. (1998) Alcoholism screening questionnaires: are they valid in elderly medical outpatients? J Gen Intern Med; 993; 8:674–8.

Liberto JG, Oslin DW, Ruskin PE. (1992) Alcoholism in older persons: a review of the literature. Hosp Community Psychiatry; 43:975–84.

Nguyen K, Fink A, Beck JC, Higa J. (2001) Feasibility of using an alcohol-screening and health education system with older primary care patients. J Am Board Fam Pract; 14:7–15.

Rydon P, Redman S, Sanson-Fisher RW, Reid AL. (1992) Detection of alcohol-related problems in general practice. J Stud Alcohol; 53:197–202.

Selzer ML. (1971) The Michigan alcoholism screening test: the quest for a new diagnostic instrument. Am J Psychiatry; 127:1653–8.

MAST: Name: _________________ Age ___Sex ___ (1st/2nd/3rd/4th/5th)
Please read each statement carefully and circle the response that best describes you.

1	Do you feel you are a normal drinker?	**YES**	**NO**
2	Have you ever awakened in the morning after drinking the night before and found you could not remember part of the evening?	**YES**	**NO**
3	Does your spouse/partner ever worry/complain about your drinking?	**YES**	**NO**
4	Can you stop drinking without a struggle after one or two drinks?	**YES**	**NO**
5	Do you ever feel bad about your drinking?	**YES**	**NO**
6	Do you ever try to limit your drinking to certain times of the day or to certain places?	**YES**	**NO**
7	Do your friends or relatives think that you are a normal drinker?	**YES**	**NO**
8	Are you always able to stop when you want to?	**YES**	**NO**
9	Have you ever attended an A.A. meeting?	**YES**	**NO**
10	Have you ever got into fights when drinking?	**YES**	**NO**
11	Has drinking ever created problems between you and your partner/family ?	**YES**	**NO**
12	Has your partner or family ever gone to anyone for help about your drinking?	**YES**	**NO**
13	Have you ever lost friends because of your drinking?	**YES**	**NO**
14	Have you ever gotten into trouble at work because of drinking?	**YES**	**NO**
15	Have you ever lost a job because of drinking?	**YES**	**NO**
16	Have you ever neglected your obligations, your family or your work for 2 days or more because of drinking?	**YES**	**NO**
17	Do you ever drink before noon?	**YES**	**NO**
18	Have you ever been told that you have liver trouble?	**YES**	**NO**
19	Have you ever had delirium tremors, severe shaking, heard voices or seen things that weren't there, after heavy drinking?	**YES**	**NO**
20	Have you ever gone to anyone for help because of drinking?	**YES**	**NO**
21	Have you ever been in hospital because of drinking?	**YES**	**NO**
22	Have you ever been a patient in a psychiatric hospital/ psychiatric ward of general hospital because of your drinking?	**YES**	**NO**
23	Have you ever attended a health clinic, or gone to a doctor, or clergy person for help with an emotional problem in which drinking has played a part?	**YES**	**NO**
24	Have you ever been arrested, or even for a few hours because of drunken behaviour?	**YES**	**NO**
25	Have you ever been arrested for drinking and driving?	**YES**	**NO**

MAST scoring:

A score of 3 points or less is considered not having alcohol dependency syndrome

A score of 4 points is suggestive of alcohol dependency syndrome

A score of 5 points or more indicates alcohol dependency syndrome

1 If NO, 2 points
2 If YES, 2 points
3 If YES, 2 points
4 If NO, 1 point
5 If YES, 1 point
6 If YES or NO 0 points
7 If NO, 2 points
8 If NO, 2 points
9 If YES, 5 points
10 If YES, 1 point
11 If YES, 2 points
12 If YES, 2 points
25 If YES, 2 points

13 If YES, 2 points
14 If YES, 2 points
15 If YES, 2 points
16 If YES, 2 points
17 If YES, 1 point
18 If YES, 2 points
19 If YES, 2 points
20 If YES, 5 points
21 If YES, 5 points
22 If YES, 2 points
23 If YES, 2 points
24 If YES, 2 points

DRUG USE QUESTIONNAIRE (DAST-20)

Purpose: The purpose of the DAST is to provide a brief, simple, practical but valid method of identifying individuals who are abusing psychoactive drugs. DAST also yields a quantitative index score of the degree of problems related to drug use and drug misuse.

Description: The DAST is a 20-item instrument which may be given in either a self-report or in a structured interview format. A "yes" or "no" response is requested from each of the questions.

Population: Usually used for adults. A form of the DAST has been adapted for use by adolescents (the word "work" has been replaced by "school") 6th class minimum, of reading level for use of the self-report form of the DAST.

Cut-off scores: Only two items are keyed for a "no" response: "Can you get through the week without using drugs?" and "Are you always able to stop using drugs when you want to?"

- A DAST score of six or above is suggested for case finding purposes, since most of the clients in the normative sample scored six or greater.
- It is also suggested that that a score of 16 or greater be considered to indicate a very severe abuse or dependency condition.

Administration: 15 minutes and 1-2 minutes for scoring.

Additional comments: The DAST is also able to discriminate drug-related problems from alcohol-related problems, indicating that the DAST is sensitive to problems resulting from drug use in particular and not to problems relating more generally to alcohol abuse. Concerns have been voiced that some respondents may misrepresent their drug and alcohol problems. However modest correlations between DAST scores and three measures of response bias have been found. As predicted, younger people tended to have more drug problems measured by the DAST than older people. Also, higher DAST scores have been negatively related to social stability, positively related to measures of impulsive and reckless behaviour and deviant attitudes. The test has been found to be highly correlated with DSM-III diagnosis of drug dependence among drug and alcohol patients, and in particular, psychiatric patients.

References:

Gavin, D.R., Ross, H. E. & Skinner, H. A. (1989) Diagnostic validity of the Drug Abuse Screening Test in the assessment of DSM- III drug disorders, *British Journal of Addiction,* 84(3), 301-307.

DRUG USE QUESTIONNAIRE (DAST-20)

Name: ___________________________ DOB _________ Date: ______________

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question. *Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.*

In the statements "drug abuse" refers to:

- the use of prescribed or over the counter drugs in excess of the directions and
- any non-medical use of drugs.

The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

No	Questions	Response	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Have you abused prescription drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
4.	Can you get through the week without using drugs?	Yes	No
5.	Are you always able to stop using drugs when you want to?	Yes	No
6.	Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
7.	Do you ever feel bad or guilty about your drug use?	Yes	No
8.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9.	Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10.	Have you lost friends because of your use of drugs?	Yes	No
11.	Have you neglected your family because of your use of drugs?	Yes	No
12.	Have you been in trouble at work because of drug abuse?	Yes	No
13.	Have you lost a job because of drug abuse?	Yes	No
14.	Have you gotten into fights when under the influence of drugs?	Yes	No
15.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16.	Have you been arrested for possession of illegal drugs?	Yes	No
17.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19.	Have you gone to anyone for help for a drug problem?	Yes	No
20.	Have you been involved in a treatment program specifically related to drug use?	Yes	No

SCORE: ____________________

DAST Scoring: Each "Yes" response = 1 point, except questions 4 & 5.
For questions 4 & 5 only, a "No" response = 1 point.

A score of 6 points or more = substance abuse problem (abuse/dependence).

The Alcohol Use Disorders Identification Test (AUDIT)
(W.H.O. 2001)

Reference:
Barbor, T.f., Higgins-Biddle, J.C., Saunders,J.B., Monteiro, M.J. (2001) *AUDIT- The Alcohol Use Disorders Identification Test – Guideline for use in Primary Care.* WHO, Geneva.

The AUDIT can be administered either
- by the patient, as a Self-report questionnaire (Form 1) *or*
- by a staff member, as an Interview (Form 2).

Form 1 includes a suggested sentence for introducing the AUDIT to the patient.

It is possible to shorten the 10-item AUDIT.
- If Q.1 is scored '0', or
- If Q.1 is scored 1-4, but Question 2 and 3 are scored '0', the patient/interviewer can skip to Questions 9 and 10.

Scoring:
Self-report version - the client is asked to place the score for each question in the right-hand column.
Interview version – the score is entered in the boxes provided.
In both cases, the scores are totalled at the bottom of the form.

Interpreting the scores:
0-7 = sub-threshold
≥8 = indicates hazardous drinking
- 8-15 = medium level of alcohol problems -advise.
- > 15 = high level of alcohol problems – counselling.

More detailed interpretation:
A score ≥1 for Q2 or Q3 usually indicates hazardous drinking.
A score >0 for Q5 or Q6 implies alcohol dependence.
A score >0 for Q7 or Q8 indicates alcohol-related harm has already begun.
Scores of 8 or more are recommended as indicators of hazardous and harmful alcohol use. A score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

Domains and Item Content of the AUDIT

Domains	Question Number	Item Content
Hazardous Alcohol Use	1 2 3	Frequency of drinking Typical quantity Frequency of heavy drinking
Dependence Symptoms	4 5 6	Impaired control over drinking Increased salience of drinking Morning drinking
Harmful Alcohol Use	7 8 9 10	Guilt after drinking Blackouts Alcohol-related injuries Others concerned about drinking

Form 1: AUDIT Questionnaire: Self-Report Version

Because alcohol use can affect your health and can interfere with certain medication and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.
Enter the relevant score in the right-hand box that best describes your answer to each question.

Questions	***0***	***1***	***2***	***3***	***4***	***score***
1. How often do you have a drink containing alcohol? *[If never, Skip to Qs 9 – 10]	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3 or 4	5 or 6	7-9	10 or more	
3. How often do you have six or more drinks on one occasion? *Skip to Questions 9 and 10 if total score for question 2 and 3 = 0	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were unable to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking? *[If never, Skip to Qs 9 – 10]	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you felt guilty or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured as the result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a friend, relative, or doctor or other health professional been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
						Total score

Form 2: The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year". Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol? (0) Never * [Skip to Qs 9 – 10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8 or 9 (4) 10 or more
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily **Skip to Questions 9 and 10 if Total Score for question 2 and 3 = 0*	4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never * [Skip to Qs 9 – 10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Weekly (3) Monthly (4) Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year	10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
Record total of specific items here	

CAGE QUESTIONNAIRE

Brief description: The CAGE is a very brief, relatively non-confrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present.

Target population: Adults & adolescents over 16 years. Additionally useful in the general medical population being examined in a primary care setting.

Administrative issues:
- Number of items: 4
- Time: less than 1 minute
- Administered by: professional or technician
- Training required: no
- Comments: easy to learn, easy to remember, easy to replicate

Scoring:
- Time required to score: instantaneous
- Scored by: tester

Clinical Utility of instrument:
- The CAGE is very useful bedside clinical assessment tool.
- It has become the favourite of family practice physicians, general interns and is also very popular in nursing.

Author: The CAGE Questionnaire was developed by John Ewing.

References:

Aertgeerts, B., Buntinex, F., Fevery, J. & Ansons, S. (2000) Is there a difference between CAGE interviews and writtem CAGE interviews. *Alcoholism: Clinical and Experimental Research,* 24(5), 733-736.

Ewing, J.A. (1984) Detecting alcoholism: The CAGE questionnaire, JAMA: *Journal of the American Medical Association*, 252, 1905-1907.

Mayfield, D., McLeod, G. & Hall, P. (1974) The CAGE questionnaire: validation of a new alcoholism instrument, *American Journal of Psychiatry,* 131, 1121-1123.

Reynaud, M., Schwan, R., Loiseaux-Meunier, M.N., Albuisson, E. & Deteix, P. (2001) *American Journal of Psychiatry,* 158(1), 96-99.

CAGE QUESTIONNAIRE

1. Have you ever felt you ought to **CUT** down on your drinking? **YES/NO**

2. Have people **ANNOYED** you by criticising your drinking? **YES/NO**

3. Have you ever felt **GUILTY** about your drinking? **YES/NO**

4. Have you ever had a drink in the **MORNING** to alleviate withdrawal symptoms, or get rid of a hangover (Eye-opener)? **YES/NO**

SCORING
Two or more positive responses = probable alcohol problem

SECTION 4:

Living Skills Screening Tools

Life Skills Profile

Authors: Alan Rosen, Dusan Hadzi-Pavlovic, Gordon Parker & Tom Trauer (1989).

The Life Skills Profile is available in three versions:
39 item questionnaire
20 item questionnaire
16 item questionnaire

This Portfolio features the 20 item questionnaire
(If any other versions are required, please contact the Mental Health Assessment Tools Review Group via e-mail at: mentalhealth.assess@hse.ie)

Details: The LSP-reflect functional strengths as well as disabilities. Scores similarly reward that orientation, so that a high score for each scale or for the total LSP would indicate high function or low disability.

- It is more important to focus on improving functioning or abilities in everyday life than on improving symptoms and signs of mental illness.
- Ability/disability measurement is very important at every stage of disorder, as disability can be very significant even in first episodes, whether associated with cognitive or negative symptom deficits, or in association with preoccupation with positive symptoms or mood disorders.
- Life Skills Profile measures dimensions of ability and disability, to gauge established or developing disability, or improvement in disability over time and/or with specific interventions.
- Life Skills Profile dimensional and total scores are organised in a bar-chart format, so results can be readily shared with patients and their families.
- LSP focuses directly on observable behaviours, and choice points are in ordinary language

Objectives

- It should be most relevant to those with severe and/or persistent psychiatric disorder
- It should assess general function and impairment of function, not state disturbance or symptomatic exacerbation
- It should complement but not compete with detailed measures of behaviour required for goal monitoring in a Living Skills Programme Assessment Schedule
- It should be completed from multiple points of view by those who are in closest contact with the patient
- It should be able to generate results useful to other members of the multi-disciplinary team.

Population

- Schizophrenia, all phases
- Other persistent or relapsing mental illnesses

Settings

- Community
- Acute
- Long-term care
- Residential

Psychometric Properties

- No gender difference
- Relative independence of each scale
- Family members report more burden completed LSP with a subjective bias, scoring their relative as more disabled

Scoring

- LSP is a 4-point scale from 1 (least functional) to 4 (most functional).
- LSP provides a high score when the person is functioning better, emphasising abilities and strengths, i.e. components of their lives where they are doing well. This is accordance with current rehabilitation and recovery approaches emphasising the person's strengths.

Scoring the LSP: All items are phrased so that the most functional rating is the left-hand anchor point, and the most dysfunctional rating is the right-hand anchor point, so that scores for each item should be assigned as '4' (extreme left anchor), '3' or '2' if intermediate and '1' (if extreme right anchor). Scale scores are generated by summing anchor scores as follows: The total LSP score is the sum of all item scores.

LIFE SKILLS PROFILE - 20

Instruction: Please complete the form as you assess ____________________'s general functioning (i.e. not during crises when he or she is ill, or becoming ill, but his or her general state over the past three months). Answer all items by circling the appropriate description.

Patient / Client / Resident's name:_____________________________________

ID Number:____

Age:________________________________ Sex: M / F (Please circle)

Rater's Name:________________________Date of Rating:_____

Answer all items by circling the appropriate description:

1. **Does this person generally have any difficulty with initiating and responding to conversation?**

No difficulty with conversation	Slight difficulty with conversation	Moderate difficulty with conversation	Extreme difficulty with conversation
4	3	2	1

2. **Does this person generally withdraw from social contact?**

Does not withdraw at all	Withdraws slightly	Withdraws moderately	Withdraws totally or near totally
4	3	2	1

3. **Does this person generally show warmth to others?**

Considerable warmth	Moderate warmth	Slight warmth	No warmth at all
4	3	2	1

4. **Is it generally difficult to understand this person because of the way he or she speaks (e.g. jumbled, garbled or disordered)?**

Not at all difficult	Slightly difficult	Moderately difficult	Extremely difficult
4	3	2	1

5. **Does this person generally talk about odd or strange ideas?**

No odd ideas	Slightly odd ideas	Moderately odd ideas	Extremely odd ideas
4	3	2	1

6. Is this person generally well groomed (e.g. neatly dressed, hair combed)?

Well groomed	Moderately well groomed	Poorly groomed	Extremely poorly groomed
4	3	2	1

7. Is this person's appearance (facial appearance, gestures) generally appropriate to his or her surroundings?

Unremarkable or appropriate	Slightly bizarre or inappropriate	Moderately bizarre or inappropriate	Extremely bizarre or inappropriate
4	3	2	1

8. Does this person wear clean clothes generally, or ensure that they are cleaned if dirty?

Maintains cleanliness of clothes	Moderate cleanliness of clothes	Poor cleanliness of clothes	Very poor cleanliness of clothes
4	3	2	1

9. Does this person generally neglect her or his physical health?

No neglect	Slight neglect of physical problems	Moderate neglect of physical problems	Extreme neglect of physical problems
4	3	2	1

10. Does this person generally maintain an adequate diet?

No problem	Slight problem	Moderate problem	Extreme problem
4	3	2	1

11. Does this person generally look after and take her or his own prescribed medication (or attend for prescribed injections on time) without reminding?

Reliable with medication	Slightly unreliable	Moderately unreliable	Extremely unreliable
4	3	2	1

12. Is this person willing to take psychiatric medication when prescribed by a doctor?

Always	Usually	Rarely	Never
4	3	2	1

13. Does this person co-operate with health services (e.g. doctors and/or other health workers)?

Always	Usually	Rarely	Never
4	3	2	1

14. Does this person generally have definite interests (e.g. hobbies, sports, activities) in which he or she is involved regularly?

Considerable involvement	Moderate involvement	Some involvement	Not involved at all
4	3	2	1

15. Does this person generally have problems (e.g. friction, avoidance) living with others in the household?

No obvious problems	Slight problems	Moderate problems	Extreme problems
4	3	2	1

16. What sort of work is this person generally capable of (even if unemployed, retired or doing unpaid domestic duties)?

Capable of full-time work	Capable of part-time	Capable only of sheltered work	Totally incapable of work
4	3	2	1

17 Does this person behave offensively (included sexual behaviour)?

Not at all	Rarely	Occasionally	Often
4	3	2	1

18. Is this person violent to others?

Not at all	Rarely	Occasionally	Often
4	3	2	1

19. Does this person behave irresponsibly?

Not at all	Rarely	Occasionally	Often
4	3	2	1

20. Does this person generally make and/or keep up friendships?

Friendships made or kept well	Friendships made or kept with slight difficulty	Friendships made or kept with considerable difficulty	No friendships made or none kept up
4	3	2	1

SCORE:

Withdrawal Questions:
1, 2, 3, 14 and 20: ____

Bizarre Questions:
4, 5 and 7: ____

Self-care Questions:
6, 8, 9, 10 and 16: ____

Compliance Questions:
11, 12 and 13: ____

Anti-Social Questions:
15, 17, 18 and 19: ____

Total = ____________________

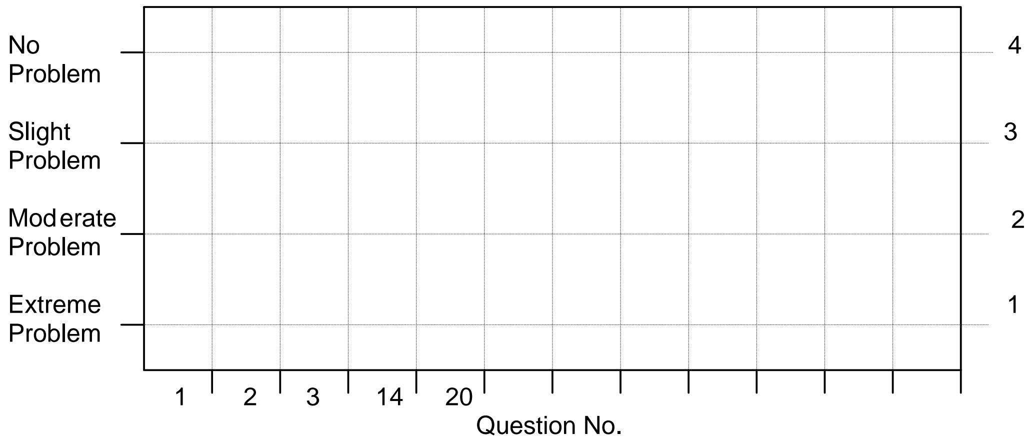
Life Skills Profile – 20
Scoring

Name: .... **Date:** ....

Assessor: ....

Withdrawal:

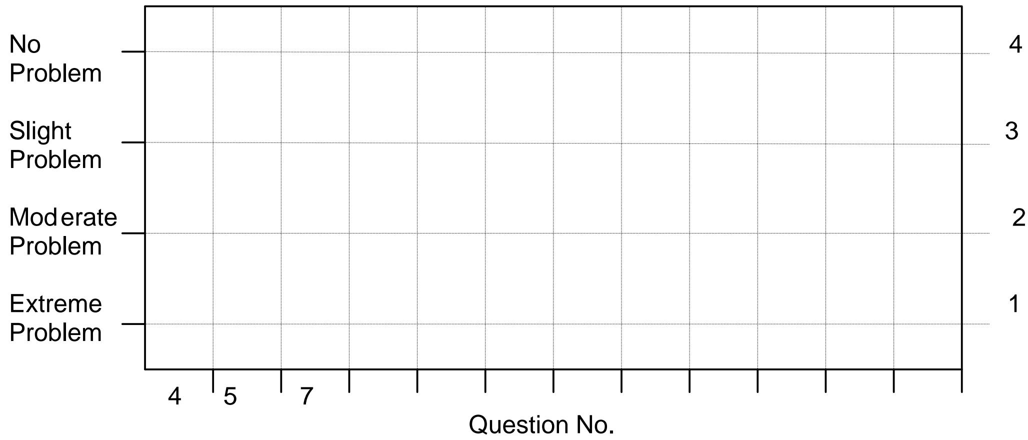
Withdrawal Questions	Response
Question 1	
Question 2	
Question 3	
Question 14	
Question 20	
TOTAL	



Comments:

Bizarre:

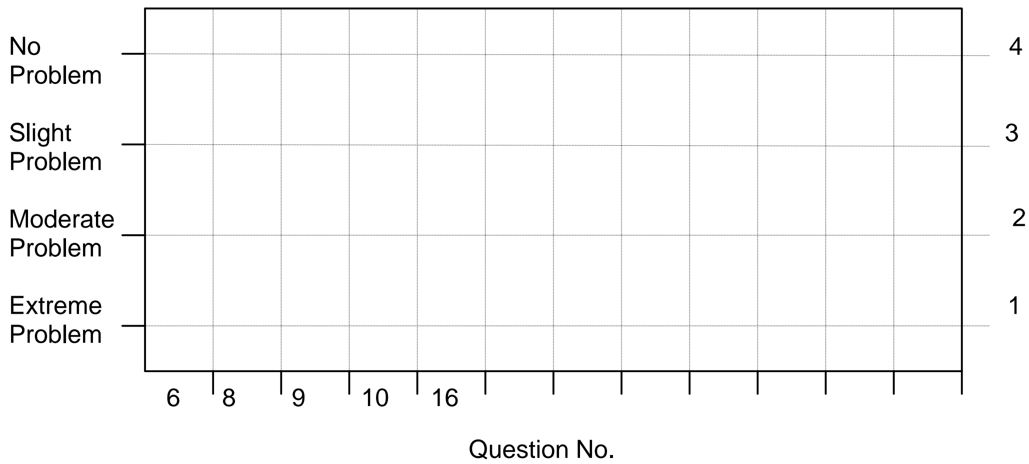
Bizarre Questions	Response
Question 4	
Question 5	
Question 7	
TOTAL	



Comments:

Self-care:

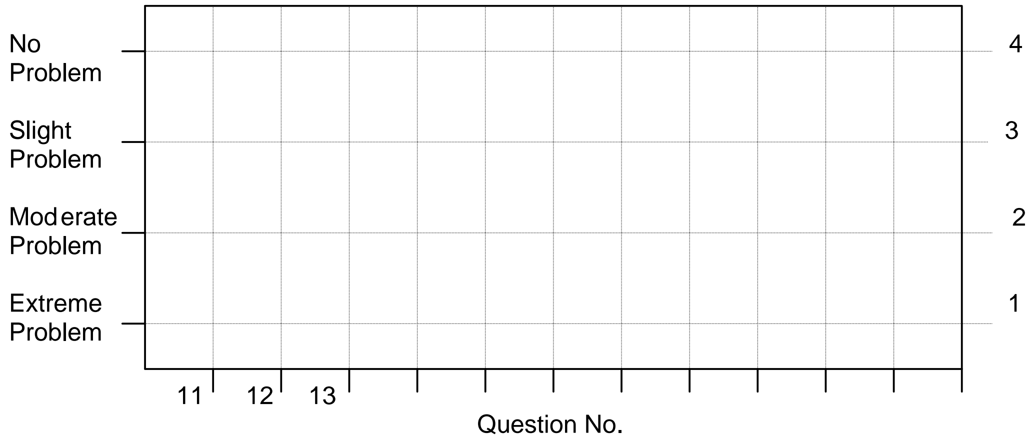
Self-care Questions	Response
Question 6	
Question 8	
Question 9	
Question 10	
Question 16	
TOTAL	



Comments:

Compliance:

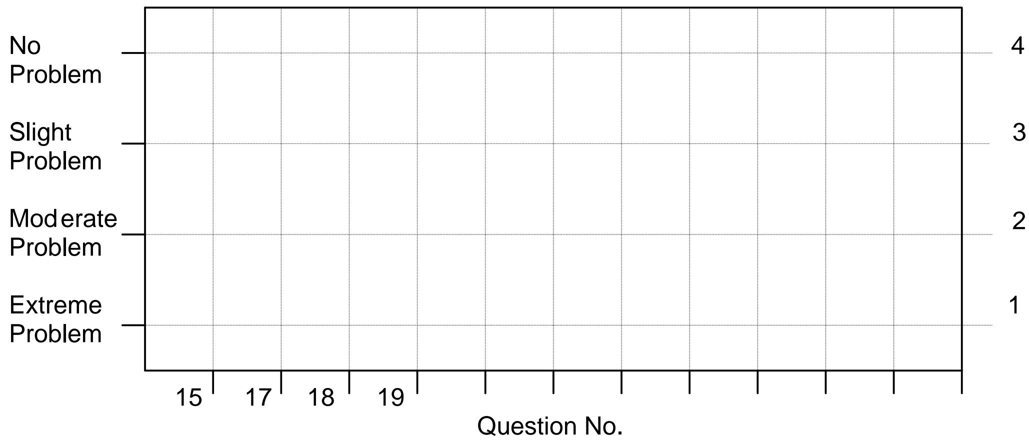
Compliance Questions	Response
Question 11	
Question 12	
Question 13	
TOTAL	



Comments:

Anti-Social:

Anti-social Questions	Response
Question 15	
Question 17	
Question 18	
Question 19	
TOTAL	



Comments:

Total Scores: sum of each question group as outlined

Withdrawal Questions:
1, 2, 3, 14 and 20: ____

Bizarre Questions:
4, 5 and 7: ____

Self-care Questions:
6, 8, 9, 10 and 16: ____

Compliance Questions:
11, 12 and 13: ____

Anti-Social Questions:
15, 17, 18 and 19: ____

Total = ____________________

SOCIAL FUNCTIONING SCALE (adapted version 2012)

Author: Birchwood, M. et al., 1990

Details: This scale is concerned with establishing the degree of social functioning of the individual, and attempts to identify the impact of negative symptoms of mental health and/or positive factors of social activity and independence. This scale can be completed relatively quickly and thus reduces any distress which may be seen as a consequence of lengthy interview schedules. The scale can be completed with the 1 named respondent or by any person who has close contact with the individual (eg. key worker).

Scoring: Complete from accounts from service users and/or their carers and relevant professionals. Do not use verbatim. The questions are just prompts.

Social Functioning Scale Adapted Version 2012 is used here. The Mental Health Assessment Tools Review Group has the permission of the author to adapt the scale for local population needs. Notes on the changes and the revised scoring are found at the end of the assessment document.

SOCIAL FUNCTIONING SCALE

Name:	Date:
Assessor:	

Part One: **Social Withdrawal**

1. What time do you get up?

	Before 9am	9-11am	11am-1pm	After 1pm
Average weekday	(3) ☐	(2) ☐	(1) ☐	(0) ☐
Average weekend	(3) ☐	(2) ☐	(1) ☐	(0) ☐

2. How many hours of the waking day do you spend alone? (e.g. in your room alone, walking alone, watching TV alone)

0 – 3 hours	Very little time spent alone	☐	(3)
3 – 6 hours	Some of the time	☐	(2)
6 – 9 hours	Quite a lot of the time	☐	(1)
9 – 12 hours	A great deal of time	☐	(0)
More than 12 hours	Practically all the time	☐	(0)

3. How often will you start a conversation at home?

Almost never	☐	(0)	Sometimes	☐	(2)
Rarely	☐	(1)	Often	☐	(3)

4. How often will you leave the house for any reason?

Almost never	☐	(0)	Sometimes	☐	(2)
Rarely	☐	(1)	Often	☐	(3)

5. How do you react to the presence of strangers?

Avoid them	☐	(0)	Accept them	☐	(2)
Feel nervous	☐	(1)	Like them	☐	(3)

Part Two: **Relationships.**

1. How many friends do you have at the moment? (people whom you see regularly, talk with, do activities with, etc.)

None	☐	(0)	Two friends	☐	(2)
One friend	☐	(1)	Three or more friends	☐	(3)

2. Do you have someone with whom you find it easy to discuss feelings and difficulties?

Yes	☐	(3)	No	☐	(0)

3. How often have you confided in them?

Almost never	☐	(0)	Sometimes	☐	(2)
Rarely	☐	(1)	Often	☐	(3)

4. Do other people discuss their problems with you?

Almost never	☐	(0)	Sometimes	☐	(2)
Rarely	☐	(1)	Often	☐	(3)

5. If not married/long term relationship, do you have a boy/girlfriend/significant partner?

Yes	☐	(3)	No	☐	(0)

6. Have you had any arguments with friends, relatives or neighbours recently?

Many major	☐	(0)	1 or 2 minor	☐	(2)
Continued minor or 1 major	☐	(1)	None	☐	(3)

7. How often are you able to have a conversation with someone?

Almost never	☐	(0)	Sometimes	☐	(2)
Rarely	☐	(1)	Often	☐	(3)

8. How easy or difficult do you find talking to people at present?

Very difficult	☐	(0)	Average	☐	(2)
Quite difficult	☐	(1)	Quite easy	☐	(3)
Very easy	☐	(3)			

9. Do you feel uneasy with groups of people?

Almost never	☐	(3)	Sometimes	☐	(1)
Rarely	☐	(2)	Often	☐	(0)

10. Do you prefer to spend time on your own?

Almost never	☐	(3)	Sometimes	☐	(1)
Rarely	☐	(2)	Often	☐	(0)

Part 3. – Social Activities

Part 3a. – Social Activities (passive/alone)

Over the past three months, how often have you participated in any of the following activities?

		Never (0)	Rarely (1)	Sometimes (2)	Often (3)
1.	Cinema				
2.	Theatre/concert				
3.	Watching an indoor sport				
4.	Watching an outdoor sport				
5.	Art gallery/museum/exhibition				
6.	Social networking- facebook/ texting etc.				
7.	Visiting places of interest				
8.	Being visited by relatives				
9.	Being visited by friends*				
10.	Church activity				
11.	Any other passive activity				

Part 3b. – Social Activities (active/socially with others)

Over the past three months, how often have you participated in any of the following activities?

		Never (0)	Rarely (1)	Sometimes (2)	Often (3)
1.	Meeting, talk etc				
2.	Evening class				
3.	Visiting relatives in their home				
4.	Visiting friends*				
5.	Parties/Formal occasions				
6.	Bingo/Card playing				
7.	Local mart				
8.	Nightclub/Social club/Disco				
9.	Playing an indoor sport				
10.	Playing an outdoor sport				
11.	Club/society				
12.	Pub				
13.	Eating out				
14.	Any other active activity				

*Includes girlfriend or boyfriend

Part Four: **Recreational Activities**

Part 4a. – Recreational Activities (passive/alone)

Over the past three months, how often have you participated in any of the following activities?

		Never (0)	**Rarely (1)**	**Sometimes (2)**	**Often (3)**
1.	Playing a musical instrument				
2.	Sewing/knitting				
3.	Reading				
4.	Watching T.V. /DVD				
5.	Listening to music/radio/Digital Devices				
6.	Hobby – collecting things				
7.	Artistic or craft activity				
8.	Any other recreation/pastime				

Part 4b. – Recreational Activities (active/socially with others)

Over the past three months, how often have you participated in any of the following?

		Never (0)	**Rarely (1)**	**Sometimes (2)**	**Often (3)**
1.	Gardening				
2.	Cooking				
3.	DIY activities/fixing things (car, bike etc)				
4.	Visit bookies, horse racing				
5.	Walking/rambling/running/gym				
6.	Driving/cycling (for recreation)				
7.	Swimming/Golf (either/or/both)				
8.	Shopping				
9.	Any other recreation/pastime				

Part Five: **Independence (Current competence)**

Place a tick against each item to show how able you are at doing or using the following currently:

	Adequately – no help needed (3)	Need help or prompting (2)	Unable or only with lots of help (1)	Not known (0)
1. Public transport				
2. Handling money correctly				
3. Budgeting				
4. Cooking for self				
5. Weekly shopping				
6. Look for a job				
7. Washing own clothes				
8. Personal hygiene				
9. Washing, tidying, etc				
10. Purchasing from shops				
11. Leaving the house alone				
12. Choosing and buying clothes				
13. Taking care of personal appearance				
14. Caring for pet or animal				

Any additional comments:

Part Six: **Independence (Performance)**

Place a tick against each item to show how often you have done the following over the past 3 months:

	Never (0)	Rarely (1)	Sometimes (2)	Often (3)
1. Buying items from shop alone				
2. Washing pots, tidying up, etc				
3. Regular washing, bathing, etc				
4. Washing own clothes				
5. Looking for a job				
6. Doing the food shopping				
7. Prepare and cook a meal				
8. Leaving the house alone				
9. Using own car, buses, trains, etc				
10. Using money				
11. Budgeting				
12. Choosing and buying own clothes				
13. Taking care of personal appearance				

Any additional comments:

Part Seven: Employment/Course

1. Are you in regular employment or full time student?

Yes ☐ No ☐

If yes: What sort of job/course?

How many hours a week do you work/attend?____________________

How long have you had this job/course?____________________

If no: When were you last in employment/course?____________________

What sort of job/course was it?____________________

How many hours a week did you work/attend?____________________

2. Are you undergoing any supported employment, rehabilitation or retraining courses (ie...sheltered workshops, supportive therapy units)?

Yes ☐ No ☐

3. If not employed (for more than 6 months):

Are you registered disabled?	Yes	☐	No	☐
Do you attend health services as a day patient?	Yes	☐	No	☐

*Do you think you are capable of some sort of employment?

Definitely Yes	☐	(3)	Would have difficulty	☐	(2)	Definitely No	☐	(0)

*How often do you make attempts to find a job?

Almost never	☐	(0)	Sometimes	☐	(2)
Rarely	☐	(1)	Often	☐	(3)

4. If not employed, how do you usually occupy your day?

Morning: ____________________
Afternoon: ____________________
Evening: ____________________

Scoring
10 = Full time gainful employment or full time student
9 = Part time gainful employment
8 = Unemployed for no more than 6 months and actively seeking work
7 = Undergoing supported employment, rehabilitation or retraining
0-6 = If none of the above, add together the scores from questions marked with * for a score of between 0-6.

Overall Score ☐

Scoring Section

Part 1. – Social Withdrawal

3						
2						
1						
0						
	Q1a	Q1b	Q2	Q3	Q4	Q5

Total score of social withdrawal ☐

Part 2. – Relationships

3										
2										
1										
0										
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10

Total score for Relationships ☐

<u>Part 3a.</u> – Social Activities (passive)

3										
2										
1										
0										
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11

Total score for Social Activities (passive) ☐

Part 3b. – Social Activities (active)

3														
2														
1														
0														
	Q1	Q 2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14

Total score for Social Activities (active) ☐

<u>Part 4a.</u> – Recreational Activities (passive)

3								
2								
1								
0								
	Q1	Q 2	Q3	Q4	Q5	Q6	Q7	Q8

Total score for recreational activities (passive)

<u>Part 4b.</u> – Recreational Activities (active).

3									
2									
1									
0									
	Q1	Q 2	Q3	Q4	Q5	Q6	Q7	Q8	Q9

Total score for Recreational Activities (active)

Part 5. **– Independence (Competence)**

	Q1	Q 2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14
3														
2														
1														
0														

Total score for Independence (competence)

<u>Part 6.</u> – Independence (Performance)

	Q1	Q 2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13
3													
2													
1													
0													

Total score for independence (performance) [ ]

SOCIAL FUNCTIONING SCALE

(SUMMARY SCORING SHEET AND QUALITATIVE INFORMATION)

Name ________________________________ **Date of Assessment**____________

Scale Item	Actual Score	Maximum Score	Comment
1. Social Withdrawal		**18**	
2. Relationships		**30**	
3a. Social Activities (passive)		**33**	
3b. Social Activities (active)		**42**	
4a. Recreational Activities (passive)		**24**	
4b. Recreational Activities (active)		**27**	
5. Independence (Competence)		**42**	
6. Independence (Performance)		**39**	
7.Employment		**10**	
Total Score *		**265**	

*The total score as a single score is of minimal clinical significance. The total score in repeated SFS will enable comparisons which reflect changes in the social functioning ability of a person. The real value lies in the detail of the SFS in determining the areas of strength and need in overall social functioning of the person. The scoring section graphs allows the scorer to identify at a glance areas of strength and need. Actual Score is the total for what the client has scored. Maximum Score is the maximum of what could be scored for each section. Comment allows for any clinically significant qualitative data that's should be recorded for each section.

Notes on changes and adaptations of the Social Functioning Scale

Part 1: Social withdrawal
Question 1 titled the sub questions as 1a and 1b to facilitate the scoring grid in the scoring section

Part 2: Relationships
Question 5 adjusted wording with additions of *long term relationship*, and *significant partner* to reflect social norms

Part 3: Social Activities
This section was divided into two subsections called *social activities passive/alone* and *social activities active/socially with others*. The questions are regrouped under the headings as it facilitates the differentiation between social activities that are done on a solitary basis and social activities that involve proactive participation by the person with others. Passive social engagement can demonstrate lack of social integration while active social engagement demonstrates positive interactions which can promote wellness.
Added numbering to each question in order to facilitate scoring on grid in scoring section
The scale remains 24 option questions but have combined some options and added three extra options as follows:

- ⇒ Combined exhibition to Art gallery/Museum option question
- ⇒ Inserted social networking – *Facebook/texting* question reflecting social norms
- ⇒ Combined parties and formal occasions option
- ⇒ Combined Disco with nightclub/Social club option.
- ⇒ Added local *Mart* to reflect common rural social activity
- ⇒ Added *Bingo/card playing* to reflect common social activity in client based population

Part 4: Recreational Activities
This section was divided into two subsections called recreational activities *passive/alone* and recreational activities *active/socially with others*. The questions are regrouped under the headings as it facilitates the differentiation between recreational activities that can are done on a solitary basis and recreational activities that involve proactive participation by the person with others.
Added numbering to each question in order to facilitate scoring on grid under scoring section.
The scale has reduced optional questions from 18 to 17 having combined some options and added three extra options as follows:

- ⇒ Added *DVD* to TV option question reflecting social norms
- ⇒ Added *Digital Devices* and *Music* to listening to radio option and deleted Record from that reflecting social norms
- ⇒ Combined fixing cars to DIY option
- ⇒ Added *running* and *gym* to walking /rambling option reflecting social norms
- ⇒ Combined swimming and golf option and inserted either/or/both for scoring purposes
- ⇒ Added visit bookies/horse racing option reflecting social norms
- ⇒ Decreased 3 question option on "any other recreation or past time" to 2 questions with 1 in each passive and active sub-section.

Part 5: Independence Competence Currently

Added *currently* to title section to increase clarity that information is being sought on current competence giving a current picture of the person's functioning level.
Added additional comments box to increase the qualitative data that can be ascertained to reflect social incapacity due to mental illness burden.
Increased questions from 13 to 14 options with addition of *Caring for Pet or Animal* reflecting relevant client base.

Part 6: Independence Performance over past 3 months
Added *over past 3 months* to add clarity to the title section
Added using *own car* to *using buses and trains* option to reflect relevant client base
Added additional comments box to increase the qualitative data that can be ascertained to reflect independence incapacity due to mental illness burden.

Part 7: Employment
Question 1: Added *full time student* option to regular employment, to capture people fully engaged in either work or education to reflect current client base.
Question 2: Changed *industrial therapy* to *supported employment* to reflect current options available. Added examples of *sheltered workshops, supportive therapy units* to reflect current supports available.
Question3: Added *for more than six months* to reflect original scoring data. Changed *hospital* to *health services* to reflect current options.
Score box: Added overall score box at end of employment section for ease of transferring scores to scoring section
*The questions allow for *work* or *course* options allowing for current occupation choices.

Scoring options are expanded to facilitate recording if the client is in work/course, not in work or course but may be capable of finding work or a course and is seeking same.

Scoring Section
This has been changed significantly as feedback from health professionals using the original SFS with the transformational scoring suggested that it was cumbersome and time consuming to use. The Transformational scoring section is not in this adapted version.
The adapted SFS has incorporated grid scoring for the first 6 sections of the scale that gives a snapshot visual view of where the client is functioning well and where the client has social functioning deficits (strengths and weaknesses). Clinically, it follows that where deficits exist interventions are required. Repeat SFS scores can be used to evaluate if interventions are effective or otherwise.
The summary score section is now at the end of the assessment and accommodates recording *Actual Score, Maximum Score,* and *Comment* for each of the 7 assessment sections.
Actual Score is the total for what the client has scored. Maximum Score is the maximum of what could be scored for each section.
Comment allows for any clinically significant qualitative data that should be recorded for each section.

The Assessment Tools Review Group acknowledge that the new scoring system being used in the SFS has not yet been validated and further research and testing is required to measure its validity, reliability, sensitivity and utility.

The adapted SFS has been pilot tested by Community Health Nurses with actual current clients with their permission.
The Assessment Tools Review Group acknowledges input from the pilot into this assessment, and acknowledges permission for adaptation from the author, Max Birchwood (2010).

Scoring options are expanded to facilitate recording if the client is in work/course, not in work or course but may be capable of finding work or a course and is seeking same.

BARTHEL INDEX OF DAILY LIVING

The Barthel index of daily living is a method of assessing and communicating to other health professionals the degree of disability in a particular individual.

Name of website: BARTHEL. Barthel Index of Daily Living

URL: http://www.patient.co.uk/doctor/Barthel's-Index-of-Activities-of-Daily-Living-(BAI).htm

Country: USA

Authors: Mahoney Fl, Barthel DW: (1965) Functional evaluation: The Barthel Index. *Md State Med J* 14:2.

Brief Description:

The Barthel Index consists of 10 items that measure a person's daily functioning specifically the activities of daily living and mobility. The items include feeding, moving from wheelchair to bed and return, grooming, transferring to and from a toilet, bathing, walking on level surface, going up and down stairs, dressing, continence of bowels and bladder.

How is the Barthel Index used?

The assessment can be used to determine a baseline level of functioning and can be used to monitor improvement in activities of daily living over time. The items are weighted according to a scheme developed by the authors. The person receives a score based on whether they have received help while doing the task. The scores for each of the items are summed to create a total score. The higher the score the more "independent" the person. Independence means that the person needs no assistance at any part of the task. If a persons does about 50% independently then the "middle" score would apply.

References:

Van der Putten JJMF, Hobart JC; Freeman JA, Thompson AJ. (1999) Measuring the change in disability after inpatient rehabilitation; comparison of the responsiveness of the Barthel Index and Functional Independence Measure. Journal of Neurology, Neurosurgery, and Psychiatry, 66(4), 480-48.

Wade D. (1992) Measurement of Neurological Rehabilitation. OUP.

BARTHEL INDEX OF DAILY LIVING

Name: ________________________ D.O.B ______________Ward ______________

BARTHEL		**Index of Activities of Daily Living**	Date	Date	Date	Date	Date	Date
BOWELS	0 1 2	Incontinent (or needs to be given enemas) Occasional accident (less than once a week, max once a day) Continent						
BLADDER	0 1 2	Incontinent or catheterised /unable to manage Occasional accident (max once per 24 hours) Continent for over 7 days						
GROOMING	0 1	Needs help with personal care Independent						
TOILET USE	0 1 2	Dependent on help Needs some help but can do something alone Independent -Can reach toilet/commode, undress sufficiently, clean self and leave						
FEEDING	0 1 2	Unable Needs help cutting up food, spreading butter etc, but feeds self Independent (food cooked, served and provided within easy reach but not cut up. Normal food – not only soft food)						
TRANSFER	0 1 2 3	Unable – no sitting balance, 2 to lift Major help: physical help 1 strong or 2 normal. Can sit Minor help: 1 person easily or supervision for safety Independent						
MOBILITY	0 1 2 3	Immobile Wheelchair dependent Help of one untrained person Independent						
DRESSING	0 1 2	Dependent Needs help but can do half unaided Independent						
STAIRS	0 1 2	Unable Needs help (verbal/physical, carrying aid) Independent up and down						
BATHING	0 1	Dependent Independent						
		Total Score						
		Signed						

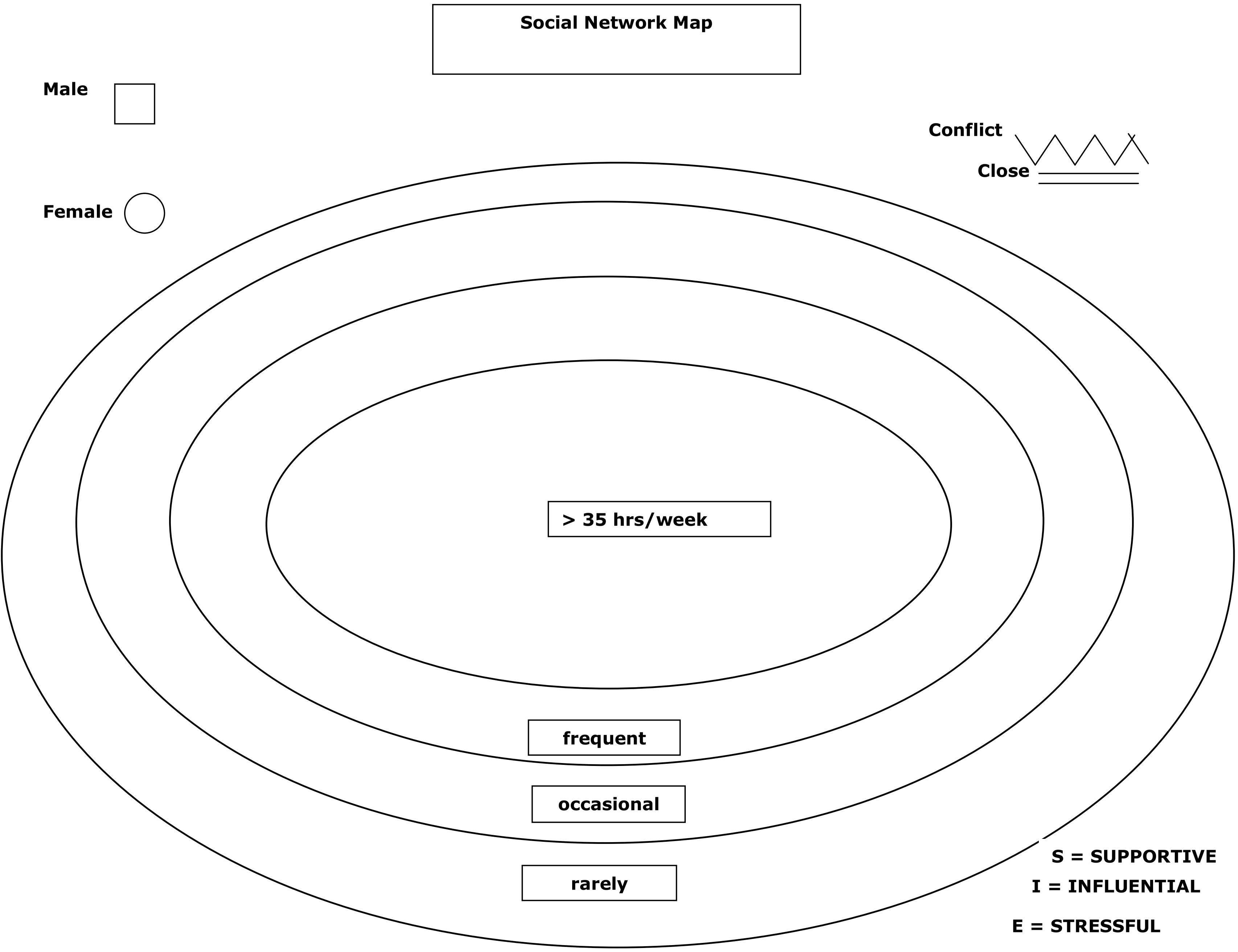
Total dependency	0 - 4	Moderate dependency	10 – 14
Severe dependency	5 – 9	Mild dependency	15 – 18
		Minimal dependency	18 – 20

The Social Network Map

Introduction:
This assessment enables the worker and service user to map out the service users social network. This is useful assessment tool in that it helps to graphically illustrate the kind of relationships that a person has within their social and living environment. This is particularly important given research literature that identifies the relationship of environmental factors and psychosis (the stress vulnerability framework). A further benefit of this tool is that it identifies positive as well as negative relationships, which are valuable to the intervention process. This will promote better bio-psychosocial understanding; improve coping, problem solving and goal planning.

Taken from: *Positive Practice in Mental Health – Psychosocial Interventions* (PSI) Handbook, 2007 Ireland.

Reference: Repper D., Westerman C. (1998)


Social Network Map
Male
Female
Conflict
Close
> 35 hrs/week
frequent
occasional
rarely
S = SUPPORTIVE
I = INFLUENTIAL
E = STRESSFUL

The Family Tree (Genogram)

A family tree can provide more indept information about a family that reveals relationship patterns and more importantly changes in those relationships. By plotting those relationships on a chart known as a family tree, the effects of the presenting complaint can be more easily understood and the family context of what is currently happening for a patient/client is also more clearly understood (Burnham, 1986).

Indept genograms are widely used in family therapy, as a therapeutic technique. For broader mental health nursing practice, a genogram can diagrammatically represent the client's family of origin and help to highlight the support relationships a client can draw on, in a similar way that the social network map is used.

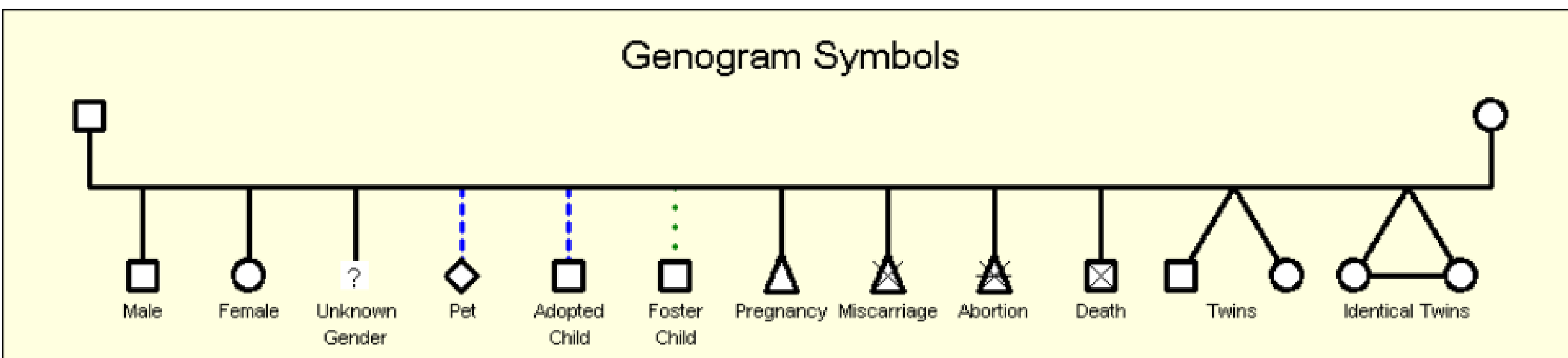
The family tree is like a sub-section of the larger social network map for the patient/client.

The basic genogram should include:

- names and ages of all the family members
- dates of birth, death, marriage, separation, divorce, and any other significant life events
- notations with dates about occupation, places of residence, illness and other changes in life course
- information on 3 generations (if possible)

(Burnham, 1986).

The following are the basic internationally accepted genogram symbols .



Close relationships are depicted as: ═════

Conflict relationships are depicted as: ~~~~~~

Reference:

Burnham, John, B. (1986), *Family Therapy.* Tavistock Library and Social Work Practice. UK.

Camberwell Assessment of Need (CANSAS)

Authors: Mike Slade, Graham Thornidroft, Linda Loftus, Michael Phelan, Til Wykes.

Royal College of Psychiatrists, London, UK.

Year: 1999, reproduced in 2005, 2008.

Publishers: Gaskell, London

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There are many versions of the Camberwell Assessment of Need (CAN) available. For this publication, the short version of CAN is included, known as Camberwell Assessment of Need Short Appraisal Schedule (CANSAS). If additional versions such as the clinical version or the research version are required, please contact the Mental Health Assessments Review Group: mentalhealth.assess@hse.ie

Introduction
The Camberwell Assessment of Need (CAN) is a tool for assessing the needs of people with severe and enduring mental illness. It covers a wide range of health and social needs, and incorporates both staff and user assessment. The CAN was developed for use by:

(a) professionals who are involved in the care of people with severe mental illness;
(b) people wanting to evaluate mental health services; or
(c) service users in rating their own needs

It was developed by the Section of Community Psychiatry (PRiSM), Institute of Psychiatry, Denmark Hill, London SE5 8AF, England

The following section provides a brief introduction to the subject of needs assessment in mental health, a comprehensive account of the development of the CAN.

Needs assessment

A consistent theme to emerge from evolving community mental health care services during the past decade has been the recognition of the importance of a needs-led approach towards the individual care of those with severe mental illness (SMI). In the UK, this is a central theme in mental health policy (National Health Service and Community Care Act 1990), encouraged by the introduction of the Care Programme Approach. However, despite the wide recognition that people with SMI usually have a wide range of clinical and social needs, there is continuing confusion and debate about how such needs should be defined and assessed (Holloway, 1993).

The concept of need:

There are a variety of approaches to defining need. The American psychologist Maslow established a hierarchy of need when attempting to formulate a theory of human motivation (Maslow, 1954). His belief was that fundamental physiological needs, such as the need for food, underpinned the higher needs of safety, love, self-esteem and self-actualisation. He proposed that people are motivated by the requirement to meet these needs, and that higher needs could only be met once the lower and more fundamental needs were met. This approach can be illustrated by the example of a homeless man, who is not concerned about his lack of friends while he is cold and hungry. However, once these needs have been met he may express more interest in having the company of other people.

Since the work of Maslow, other approaches have been developed for defining need with respect to health care. A need is defined as being present when a person's level of functioning falls below, or threatens to fall below, some specified level, and when there is some remediable, or potentially remediable, cause (Brewin *et al*, 1987). The sociologist Bradshaw (1972) proposed a taxonomy of three types of need: that which is either 'felt' or 'expressed' by the user; 'normative' need which is assessed by an expert; and 'comparative' need which arises from comparison with other groups or individuals. Such an approach helps to emphasise that need is a subjective concept, and that the judgment of whether a need is present or not will, in part, depend on whose viewpoint is being taken. Slade (1994) has discussed this issue with respect to differences in perception between the users of mental health services and the involved professionals, and he has argued that once differences are identified, then negotiation between staff and user can take place to agree a care plan.

Stevens & Gabbay (1991) have distinguished need (the ability to benefit in some way from health care), demand (wish expressed by the service user) and supply of services. These concepts can be illustrated by different components of mental health services. For instance, mental health services for homeless mentally ill people are rarely demanded by homeless people, but most professionals would agree that a need exists. In contrast, the demand for counseling services frequently outstrips supply.

Clearly, the need, demand and supply of services will never be perfectly matched. If mismatch is to be minimized then two fundamental principles must underpin mental health service development. First, services must try to address the identified problems and difficulties of local users (i.e. local services should be shaped by the specific needs of the population rather than being provided in line with any national template or historical patterns). Second, a continued effort to demonstrate what is, and is not, effective with different groups is required, so that resources are provided for effective interventions and not driven by demand or short-term political pressures.

Assessment of population need:

If mental health services are to be developed in response to the needs of specific populations, and resources allocated on the basis of identified need, agreed methods for assessing population need for mental health services are required. The ideal method is to identify all individuals with mental health needs, and aggregate the results of their individual need assessments. Such an approach is rarely feasible, and in its place a range of proxy measures have been developed to estimate the need for mental health services within given populations. Current service utilization rates are an inadequate measure of local need, as they are largely dependent on current provision. This is especially true in services which are already over-prescribed, such as inner-city in-patient beds. Measures of social deprivation which predict the prevalence of SMI and service utilization (Jarman, 1983, Thornicroft, 1991) can be used to allocate resources. The Mental Illness Needs Index (Glover *et al*, 1998) uses census data to give an approximate estimate of local need. Although such approaches can help to guide the allocation of resources, it is vital that specific local factors are also taken into consideration, such as the presence of a large psychiatric hospital, which may have resulted in many ex-patients being settled in the surrounding area. Another approach is to compare local provision with national figures, which give a crude comparison.

Individual needs assessment instruments

There is no perfect individual needs assessment tool. The requirements of different users vary, and there is inevitable conflict between factors such as brevity and comprehensiveness. Johnson *et al* (1996) summarized the features of an ideal needs assessment for use in clinical settings as brief, easily learned, quickly administered by clinical staff, valid and reliable. Numerous instruments have been developed by individual teams around the country to aid care planning and reviews. There is little consistency in

the information that is collected, with a tendency to concentrate on qualitative, rather than quantitative, data. Psychometric properties are frequently ignored. Although the development of such instruments helps to focus a team's approach, they do not provide valid or accurate information to service planners.

One established needs assessment tool is the CAN (Phelan *et al*, 1995).

Camberwell Assessment of Need
Short Appraisal Schedule (CANSAS)

What is the CANSAS?

The CANSAS is a tool for the comprehensive assessment of the needs of people with severe mental health problems. It is designed for research and clinical use. Interviewers will need to have experience of clinical assessment interviews, and reliability will be increased by training.

The Camberwell Assessment of Need Short Appraisal (CANSAS) is a short (single page) summary of the needs of a mental health service user. The CANSAS can be used in clinical settings because it is short enough to be used for review purposes on a routine basis. It can also be used as an outcome measure in research studies, especially when a number of assessment schedules are being used.
The CANSAS assesses 22 domains of health and social needs:

1. Accommodation
2. Food
3. Looking after the home
4. Self-care
5. Daytime activities
6. Physical health
7. Psychotic symptoms
8. Information on condition and treatment
9. Psychological distress
10. Safety to self
11. Safety to others
12. Alcohol
13. Drugs
14. Company
15. Intimate relationships
16. Sexual expression
17. Child care
18. Basic education
19. Telephone
20. Transport
21. Money
22. Benefits

Questions are asked about each domain to identify (a) whether a need or problem is present in that domain, and (b) whether the need is met or unmet. A need is met if there is currently not a problem in the domain, but a problem would exist if it were not for the help provided (i.e. they are getting effective help). A need is unmet if there is currently a problem in the domain (whether or not any help is currently being provided). At the end of an assessment, therefore, it will be possible to say how many needs the user has from these 22 domains, and how many of these needs are unmet.

Note: A CANSAS assessment by itself is wide-ranging ('comprehensive'), but not thorough, therefore not an adequate assessment on which to decide whether to offer help, but should be used to identify domains in which more assessment is needed.

Each CANSAS sheet can be used to make up to four assessments. One use would be to record staff and user assessments of need before and after an intervention. Another use would be to record the perceptions of a range of people at a specific point in time, such as the user, informal care-giver, key-worker and general practitioner. A third use would be to review changes in needs over time.

An assessment using the CANSAS involves an interviewer asking an interviewee questions about each of the 22 domains. The interviewer should be a professional with some knowledge of the difficulties which can be involved in interviewing people with SMI, such as impaired concentration, disorganisation and psychotic symptoms. The interviewer should also be familiar with issues relating to safety and confidentiality, as discussed by Parkman & Bixby (1996).

How do I complete the CANSAS?
The CANSAS assesses problems during the last one month in 22 domains of life.

This relatively short time span leads to a snapshot of the current situation. Assessment may involve an interview with a service user (the term used to cover patient/client/consumer – the person being assessed), a carer or a staff member who knows the user sufficiently well. It is important that the interviewee's reply is recorded directly, even if the interviewer disagrees with his or her view. User, staff and carer perceptions of need may differ, which is why they are recorded in separate columns.

The purpose of the interview should be explained. For the user, this explanation might take the form "I'd like to go through this questionnaire with you, which covers a whole range of areas of life in which people can have difficulties. I'll go through each of these areas in turn, and ask about any problems you have had in the last month. Is that okay?"

Time should be allowed for questions, and to ensure that the assessment is not rushed. A typical CANSAS assessment should take five minutes, but this will be affected by the number of needs identified and characteristics of the interviewee. For example, if the user has difficulties with concentration, then a break may be needed during the interview.

Each CANSAS assessment is recorded in a separate column. Thus one CANSAS sheet can be used for up to four assessments. The interviewee may be the user, the carer (e.g. a friend or family member) or a member of staff (e.g. the key-worker). If the user or carer is being interviewed, administration involves the interviewer going through the CANSAS, asking the user about each domain in turn. If a member of staff is the interviewee, this normally involves the member of staff filling in the CANSAS. Before starting the

assessment, the date of assessment and the assessor's initials are recorded in the box at the top of the column.

Each of the 22 domains is then assessed, in the order shown.

Circle the letter indicating who is being assessed (U = user, S = staff, C = carer), and record the date and initials of the interviewer. Work down the column using the suggested questions (shown in italics) to open discussion on each domain. Supplementary questions should be asked where necessary, with the goal of establishing:

(a) whether the user has a serious problem in this domain; and
(b) if the user does have a serious problem, whether he or she is getting effective help.

On the basis of the interviewee's responses, a 'need rating' is made for the last month:

0 = no need (i.e. no serious problem)
1 = met need (i.e. no/moderate problem due to help given)
2 = unmet need (i.e. serious problem, whether or not help is given)
9 = not known

The need rating is made using the following guidelines:

- If a serious problem is present (regardless of cause, or whether or not any help is being given), then **rate 2** (unmet need)
- If there is no serious problem because help is being given (e.g. family support, sheltered housing, psychotherapy, medication), then **rate 1** (met need)
- If there are no problems in this area, then **rate 0** (no need)
- If the person being interviewed does not know or does not want to answer questions on this domain, then **rate 9** (not known)

Note:

- Just because there is currently no problem, the need rating is not automatically 0. For example, a person with diabetes who is physically well because of the prescribed insulin would be rated as 1 (met need) for physical health
- A need can exist for a variety of reasons. For example, a person with a psychotic illness may currently be unable to go shopping because of a sprained ankle. He or she should be rated as having a need (i.e. need rating 1 or 2) in the Food domain, even though this need is not related to his or her psychiatric condition
- The CANSAS does not assess over-met need. For example, if a person was an in-patient for the last month, but has what he or she considers to be adequate accommodation outside of hospital, then accommodation should be rated as 0, even though he or she is currently being provided with hospital accommodation

Whoever is being interviewed, it is important that it is their views which are assessed. Specifically, there are no 'right' or 'wrong' answers. So, for example, the staff members should give their own views about the user's needs, rather than what they think the user's views are.

Note: Anchor points and some of the opening questions which appear in the Can-C and Can-R have been omitted from the CANSAS. It is therefore recommended that interviewers familiarise themselves with the full Section 1 for each domain (show in CAN-R and CAN-C). This could be done by completing Section 1 from CAN-R or CAN-C for the first few assessments, and transcribing the results onto the CANSAS form.

The need rating is made using the following algorithm:

If the interviewee does not know or does not want to answer questions on this domain then rate **9** (not known)

otherwise

If a serious problem is present (regardless of cause, or whether any help is being given or not) then rate **2** (unmet need)

otherwise

If there is no serious problem because of help given then rate **1** (met need)

otherwise

Rate **0** (no need)

For some of the 22 domains, there are some specific issues which have been found to require clarification

1 Accommodation

If a person is currently in hospital and does not have a home to be discharged to, the need rating should be 1. If a person is currently in hospital and does have an appropriate home to be discharged to, the need rating should be 0 (this is an example of overmet need, which the CANSAS does not assess)

2 Food

A need is present if the person is not getting an adequate diet, due to difficulties with shopping, storage and/or cooking of food, or because inadequate or culturally inappropriate food is being provided (e.g. by a hospital ward). However, if the problem is primarily due to difficulties with budgeting then this should be rated under the domain of Money, and the Food rating should be 0

3 Looking after the home

This domain concerns difficulties in maintaining the living environment, whether this is a hostel room or an independent home. It may not be possible for staff to rate this if the person is homeless, but the user may be able to state whether he or she believes that it would be a problem if he or she had a home

4 Self-care

This domain refers to personal hygiene, and does not include untidiness or bizarre appearance

5 Daytime activities

If the user is unable to occupy him or herself during the day without help then he or she has a need in this domain. Help given might include sheltered employment, attending a day centre, or activities with friends and relatives. If the primary problem is loneliness rather than boredom then this should be rated under the domain of Company

6 Physical health

Physical side-effects of medication should be considered, as well as any acute or chronic medical or dental condition

7 Psychotic symptoms

When asking the user about this domain, particular care should be taken to record his or her perceptions. For example, a user who denies hearing voices and having problems with his or her thoughts, and states that the depot injection is to keep him or her calm, should be rated as 0 (no need)

8 Information on condition and treatment

This should include information about local service provision, as well as information about the user's specific condition

9 Psychological distress

This should include depression and anxiety, regardless of the cause

10 Safety to self

Risk due to severe self-neglect or vulnerability to exploitation should also be rated, as well as risk of suicide and self-harm

11 Safety to others

Inadvertent risks (e.g. fire risk due to careless use of cigarettes) should be included, as well as risk of deliberate violence

16 Sexual expression

This includes difficulties due to medication side-effects, as well as a lack of safe sex practices and inadequate contraception

20 Transport

A need should be rated if a person is unable to use public transport for physical or psychological reasons

21 Money

This refers to ability to cope with the available amount of money. If the user says that he or she does not have enough money, this should be assessed in the domain of Benefits

At the end of the assessment, add up the number of met needs (need rating 1), and record in row A. Add up the number of unmet needs (need rating 2), and record in row B. Add these two numbers to give the total number of domains in which a need has been assessed, and record this figure in row C

Using information from a CANSAS assessment

How CANSAS assessment information is used will depend on why the assessment is being made. Information can be used for at least three purposes:

(a) CANSAS data can be used at the level of the individual user, by providing a baseline measure of level of need, or for charting changes in the user over time. For example, one approach would be to use the CANSAS routinely in initial assessments of new service users, to identify the range of domains in which they are likely to require further assessment and intervention.

(b) CANSAS data can be used for auditing and developing an individual service. For example, to investigate:
- (i) the impact on needs of providing an intervention for a group of service users, by looking at changes across this group;
- (ii) case load level of dependency for different workers;
- (iii) whether enough users have unmet needs in the domain of Benefits to make it worthwhile for a community mental health team to employ a welfare benefits advisor.

(c) The CANSAS can be used as an outcome measure for research purposes, such as the impact on needs of two different types of mental health services, or the reasons why staff and service user perceptions differ.

Camberwell Assessment of Need Short Appraisal Schedule (CANSAS)

	Need rating			
User/Client Name	**0 = no problem**	**2 =unmet need**	**1 = met need**	**9 = not known**
Assessment number	**1**	**2**	**3**	**4**
Circle who is interviewed (U = User, S = Staff, C = Carer)	U / S / C	U / S / C	U / S / C	U / S / C
Date of assessment				
Initial of assessor				

1 Accommodation *What kind of place do you live in?*				
2 Food *Do you get enough to eat*				
3 Looking after the home *Are you able to look after your home?*				
4 Self-care *Do you have problems keeping clean and tidy?*				
5 Daytime activities *How do you spend your day?*				
6 Physical health *How well do you feel physically?*				
7 Psychotic symptoms *Do you ever hear voices or have problems with your thoughts?*				
8 Information on condition and treatment *Have you been given clear information about your medication?*				
9 Psychological distress *Have you recently felt very sad or low?*				
10 Safety to self *Do you ever have thoughts of harming yourself?*				
11 Safety to others *Do you think you could be a danger to other people's safety?*				
12 Alcohol *Does drinking cause you any problems?*				
13 Drugs *Do you take any drugs that aren't prescribed?*				
14 Company *Are you happy with your social life?*				
15 Intimate relationships *Do you have a partner*				
16 Sexual expression *How is your sex life?*				
17 Child care *Do you have any children under 18?*				
18 Basic education *Do you have any difficulty in reading writing or understanding English?*				
19 Telephone *Do you know how to use a telephone?*				
20 Transport *How do you find using the bus, tube or train?*				
21 Money *How do you find budgeting your money?*				
22 Benefits *Are you getting all the money you are entitled to?*				
A. Met needs–count the number of 1s in columns				
B. Unmet need -count the number of 2s in columns				
C. Total number of needs – add together A + B				

RELATIVE ASSESSMENT INTERVIEW (RAI)

Reference: Barrowclough C. & Tarrier N. (1992) *Families of Schizophrenic Patients: Cognitive Behavioural Intervention*. Nelson Thornes, Cheltenham.

Aims

This interview is designed for use in obtaining information from relatives about their experiences of coping with schizophrenic illness in a family member.

The aims of the interview are:

1. To obtain information about the patient's psychiatric history, symptoms, behaviours and social and role functioning (collaborative psychosocial history of the patient).

2. To elicit the relative's response in terms of their behaviours, beliefs or thoughts, and subjective feelings towards the patient and the illness; and the consequences of the illness-related events to themselves and other members of the family. Here we are concerned to elicit positive and successful coping responses of the family members, as well as areas of difficulty.

Topics, which appear problematic, should be probed extensively since this information may be used to identify areas of need. Specific examples of both the relative's and the patient's behaviour should be noted.

There is also a Relative Assessment Interview for First Episode Psychosis (adapted from EPPIC: Working with Families Manual, Addington & Burnett, 2004). The focus of this interview is the immediate concerns of the family in relation to psychosis rather than seeking the collaborative psychosocial history of the patient. If this assessment is required, please contact the mental Health Assessment Review Group at: mentalhealth.assess@hse.ie

Style of Interview

The interviewer should attempt to become familiar with the interview schedule before carrying out the interview, since topics will come up out of order. An experienced interviewer can move around the schedule quite freely. The interviewer should use his/her judgement of the type and nature of the questions but all areas should be covered.

Questioning should begin with general questions, followed by specific questions to obtain more detailed information. The style of the interview should be relaxed and conversational and not time limited, with the interviewer giving empathic feedback that they are listening and understanding what the relative has to say.

Remember; the interview schedule is a guide to the interview and not a checklist.

BACKGROUND INFORMATION

Composition of Household

Who lives in the household? *If the patient does not live with the respondent, then where and with whom does he/she live?*
Elicit details about those who live with or who have contact with the patient, such as their age, sex, relationship to the patient, current education or employment status, including such details for the respondent and the patient if they are not already available.

Contact Time

How does the patient usually spend his/her day? How much contact does the relative have with the patient on a typical day?

Try to elicit how many hours each day the patient and the relative are in direct contact with each other (i.e. in the same room) and the nature of this contact - what do they do together - do they talk or interact in some way, or are they performing separate activities? Enquire whether the patterns differ throughout the week, such as between weekdays and weekends. Where possible, follow up any leads about how the respondent feels about the frequency and nature of their interactions with the patient, e.g. how they get along when together.

Similarly, ask about who else the patient sees, how frequently and for how long. It can be helpful to ask direct questions about specific periods during the days, such as meal times, evenings, etc. and how various household members spend their time or come together.

PSYCHIATRIC HISTORY (A)

Complete Psychiatric History

Obtain a brief chronological account of the whole history of psychiatric illness. Include approximate dates and duration of episodes. Useful questions include;

When did the patient's trouble first begin?
When did the respondent first notice something different about him/her?
When did the respondent first realise there was something wrong?
When was the patient last his / her normal self?
Was there a sudden or gradual deterioration?
How long has the patient's problem been going on?
How did the respondent and others react?
When the problems began?
What was the patient's reaction to his / her problem and its development?

(*For each symptom or problem spontaneously mentioned by the relative, ask about onset, severity context, reactions, how, the relative felt etc.*)

Current Episode (for relapse or acutely ill patients) or Recent Illness History

When the patient has had a recent relapse, obtain similar information as identified above about the current episode - its beginning and development. If no current episode, ask about patient's condition over the last three months.

For relapse patients, useful questions include;

Did the patient go into hospital this last time or see the doctor/other professional?
When did the patient begin to get worse?
What did he/she do?
What happened?
How did the patient feel about coming to the hospital or seeing the doctor?
How did he/she behave?

Ask the respondent to describe the events around the admission and how the patient and others, including the respondent, reacted to this. Ask directly about the relative's thoughts, feelings and behaviours in response to symptoms and problems. What were the effects and consequences of any coping strategies? Look for examples of attempts to "control" the patient's behaviour and elicit details.
For patients who have not recently relapsed

Could you tell me how the patient has been getting along in the past three months?

Generally speaking, do you think they have shown improvement, or got worse or stayed about the same?

Pinpoint areas of improvement or deterioration, that is, identify specific behavioural examples and elicit the relative's thoughts, feelings and behaviours in response to the patient's improved or deteriorated behaviour.

PSYCHIATRIC SYMPTOMS (A)

Have the Symptoms occurred in the last 3 months?

Patient Irritability

Enquire about any examples of the patient being irritable, snappy, losing their temper and so on.

What would happen - would they shout? Swear? Get impatient? Quarrel? Argue?
Ask how frequently this would occur and elicit details by asking the respondent to describe one or two specific examples.
What precipitated this sort of reaction in the patient?
When did it happen? Who was there? How did they react?
How similar / dissimilar are the situations described by the relative to other situations when the patient is irritable?
Has the patient got more / less irritable in the past three months?
When the patient behaves like this how do family members behave / feel?
How does the respondent behave / feel?

If the respondent reports no irritability in the patient in the last three months, ask whether the patient ever gets cross or impatient, or, if so, why?
Can the respondent remember the last time the patient lost their temper or became irritable?

Tension in the household and - irritability - of other family members

If the relative has suggested that arguments and quarrels do occur, elicit whether they result in an atmosphere of tension in the household. If so, how is this apparent? Does it affect people visiting the house? Or cause anyone to avoid the house or stay away? Who is involved and what do they do in the situation?

Probe all family members to find out if there are any arguments or disputes because of the patient, or concerning other matters. In most families there are disagreements from time to

time. How do the rest of the family get along together? Are there times when family members argue with one another? Which family members? What are the arguments about? What about the respondent? Are they involved in the disagreements? How do they feel / behave?

Nagging grumbling and irritability of other family members

Do you ever get irritable or snappy with the patient? For what reasons? What sort of things are complained about? What about other members of the family (specify by name)? *Ask about context, frequency, outcomes etc.* Ask also about any irritability, nagging or complaining between other family members about the patient.

Query whether there has been any change in irritability or nagging over the past three months and if so, for what reason.

PSYCHIATRIC HISTORY (B)

Instructions

Ask about the patient's symptoms for understanding which areas of the patient's functioning are problematic for the relative or family members; for learning about the relative's understanding of the illness and the symptoms as well as how they cope with difficulties; and what consequences the problems have had on the Individual relative and the family as a whole. Information already obtained does not need to be readdressed.

Some useful probes are:

Onset When did this first begin? Has it occurred in the last 3 months?

Severity How did this show itself? (Obtain examples) At worst what was this behaviour/ideas like?

Frequency How often did it happen? All the time? Every day, once a week?

Social Context Where does it happen? Who was there? What time of day?

Reactions How did you react? What effect did this have on you / how did you feel about it? (Similarly for the reactions of others).

Tension Does / did it make you feel on edge? Is / was there an atmosphere in the home?

Legitimacy Do you have any ideas why he / she behaves like that / does that?
Is this behaviour different from his / her normal self, how he / she used to be before the illness? Do you think he / she could do / have done any more to control it?

Coping How did you deal with this? How effective was this? Did you find any way of preventing it? Or making the situation better?

Introduce Topic

"I'd like to ask some questions about the way (patient's name) may have been affected by this trouble, I'll go through some of the symptoms or difficulties we sometimes see in people who have (patients name) kind of problem. Of course some of what I say may not but I would like to run through all of these and perhaps you'll tell me whether- or not he/she has been like this, particularly in the last 3 months".

Bodily functions

Sleep	Has the patient had any difficulties with his / her sleep recently? Such as, any difficulty in getting off? Nightmares? Waking up very early?
Appetite	Ask whether the patient has had any difficulties / changes with his / her appetite.

Has he / she complained of any physical problems, such as headaches, dizziness, any other aches or pains?

Activity

Underactivity	Has the patient been inactive or lacking in energy for example, doing less, sitting around, not helping out around the house? How different is this from past levels of activity?
Slowness	Has he / she seemed particularly slow in doing everyday things, for example; dressing, (shaving), making beds, washing up etc?
Overactivity	Has the patient had times of being unusually cheerful? Or of being excited or agitated? Or of being noisy or shouting a lot?
Violence	Have there been episodes of violence? What happened and to whom? Was anyone hit or hurt? Did you feel frightened? How did you cope with the situation? Do you feel threatened at present or worry that he / she could be violent again in the future?
Destructive Behaviour	Have there ever been incidents when property or objects have been broken?
Fears/Anxiety	Has the patient had periods of being afraid or anxious? Did the patient stop doing things or change in anyway because of their fears? How did others react to the patient when they were like this?
Worry	Has the patient been worrying about anything recently? If so, what? How does the respondent know? Has the patient talked about his / her concerns?
Overt misery	Ask whether the patient has been depressed? Miserable? Tearful? Said that life is not worth living? Blamed him / herself? Tried to harm him / herself? How did the patient complain about feeling this way? How did the relative respond and how did they feel when the patient told them? Have you been worried that the patient may harm him / herself or attempt to end their life?
Obsessions	Ask whether the patient has been unusually fussy or finicky about anything, like being very concerned about germs or cleanliness? Or has had routines of doing things only in a certain way, even though it may seem silly? Or doing things over and over again? - Like washing his / her hands or keep checking that the door is locked?
Personal care	Does the patient look after him / herself? Keep him/herself clean and tidy? Wash and dress appropriately, etc? Has this changed? Compared to others, i.e.; siblings?

Delusions/ Hallucinations — Ask whether the patient has expressed any strange ideas and if so, what about? That people were against him / her? Strange ideas about anyone in the family? Said that anything strange or odd was going on? Accused people of anything? Said that there was anything unusual affecting him / her? That there was anything strange about the TV, food and drinks, neighbours? acting in a strange way? Talking or laughing to him / herself? Adopting strange mannerisms or postures? How has this affected him / her What have you said to him / her about this? What happened when you said / did this? Has anyone else at home said / done anything?

Bizarre/ Behaviour — Ask whether the patient has done anything else that seemed strange or bizarre or unusual for him / her? Has his / her behaviour seemed different in anyway? Such as wandering off from home? Has he / she been drinking a lot? Or gambling a lot?

Household Tasks

Ask about household tasks such as shopping, cleaning, cooking, gardening, repairs etc. Who does them? Has the situation changed recently or in association with any other change in the patient's behaviour? Is the respondent satisfied with the situation? If not, has he / she tried to do anything about it and with what result?
Are you satisfied with the way things are done at home? Why not? Does this ever lead to disagreements?

Money Matters

Find out how well the patient handles money and whether there have been any changes. What are the problems? Who handles the household finances? Does the patient pay towards his / her keep? Is the respondent satisfied with this arrangement? If not probe further. What would the respondent like to happen?

Ask about any changes in the household’s finances since the patient became ill. Has his / her illness caused any financial burden or hardship? Has the relative had to make any sacrifices because of the patient? For example, if the relative has given up work to be with the patient have there been any financial difficulties because of this? How have the difficulties been manifest, e.g. not paying rent/bills, getting into debt, use of credit card, cutting down on spending etc?

Interests and Activities of the Relative

Introduction of questioning: "*I'd like to ask you a few questions about how you spend your time, what your interests are and so on, and any ways in which these things have changed since (patient) has been ill*"

Employment: — if employed, nature of work and number of hours employed.

Leisure: — how does the relative spend their leisure time/what are their interests/hobbies?

Social supports: — are there any friend/ relatives/ people who the respondent sees regularly? Is the respondent able to talk to them freely about any problems that come up at home? Do they find this helpful?

Parental household: — how much time do you and your husband/wife / partner spend together? What sort of things do you do / enjoy doing together? Do you find it helpful to talk problems over with your husband / wife / partner? If yes, how does it help? If no, why not and is there anyone else you find it helpful to talk to?

Changes in Interests, Occupations and Social Activities

Have you found that there have been changes in the way you spend your time since (patient's) problems first began? For example with work? With activities? With seeing friends? With the time you spend with your husband / wife / partner? Why have the changes taken place? What does the relative feel about them?

Relationship with the Patient

Obtain information about the relative's relationship with the patient and any changes due to the illness.

Ask how the relative and patient get on.
Do you find him / her a friendly person?
Is he / she easy to get on with?
Can you get close to him / her?
In what ways would you like him / her to be different?
In what ways does he / she get on your nerves?
Ask whether the relative ever talks to the patient about these complaints.
Ask whether the relative has avoided or kept out of the patient's way. Why?
Has the respondent felt any differently towards the patient?
Has the amount of affection for the patient changed in any way?

Elicit any change in the relationship on the part of the patient.

Has he / she behaved any differently towards you since this trouble started?
Has the amount of affection he/she has shown to you changed?
Or the amount of interest he/she has shown you?
In general, how would you say you got on together?
Can you tell when he or she is upset? Or happy?

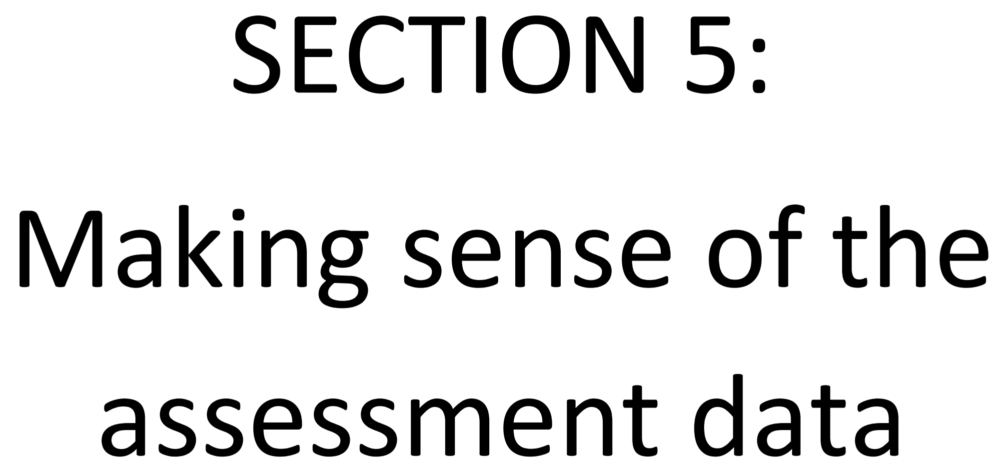
Elicit any large changes in the relative's behaviour or feelings since the illness began.

What difference has his / her illness made to you and the family?
From your point of view, what is the most disturbing aspect of his / her troubles?

Final Question

"*Is there anything else I have not covered or you would like to tell me?*"

Thank the relative for their co-operation.


SECTION 5:
Making sense of the
assessment data

Making sense of assessment data

Assessment/measurement tools are useful as part of the overall care plan for the client/patient. The information gathered guides the client/patient in their recovery. Having a structured framework assists the nurse and client/patient to see how the information helps to explain the symptoms/difficulties being experienced and offers support on identifying coping strategies. One such framework is the Stress Vulnerability Model.

Stress Vulnerability Framework Explained

A core component to Psycho Social Interventions Approaches is the stress vulnerability model (Zubin and Spring 1977, Nuechterlein et al. 1984). This Model proposes that each of us is endowed with a degree of vulnerability and that under certain circumstances will express itself in an episode of mental illness. There is a wide range of vulnerability factors that can predispose and trigger a mental illness episode within two categories:

1. Personal Vulnerability Factors which are internal to the individual such as genetics and neurophysiology.
2. Environmental Factors which are part of the life experience of the individual and are considered stressors to health in that they are generally significant in causing difficulties.

To offset/counteract and provide balance for the person is what can be termed coping strategies and environmental supports as follows:

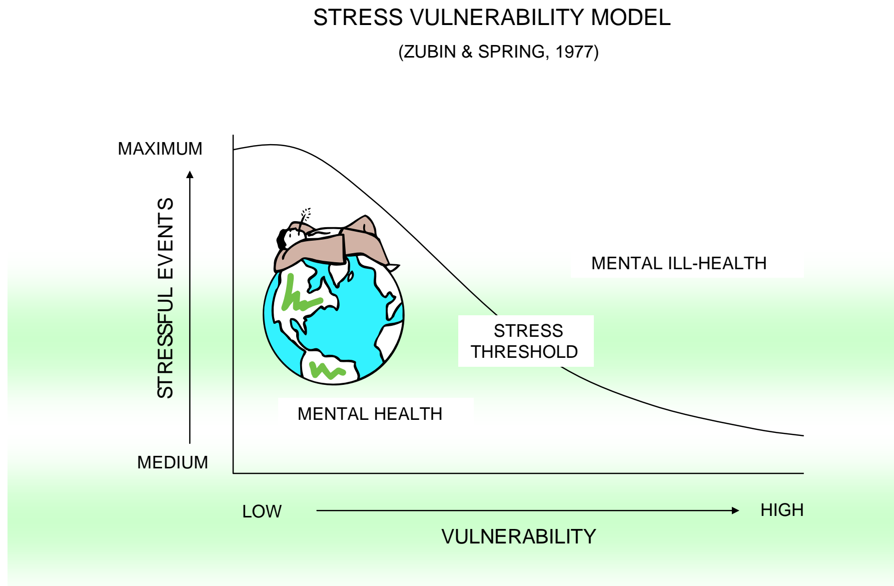
1. Personal Coping Strategies which are the responding adaptive mechanisms one uses to cope with life events etc…
2. Environmental Supports that each of us have access to and experience to help us in times of vulnerability and stress (Table1).

Table 1 Personal Vulnerability/Support Framework:

Personal Protectors	**Personal Vulnerability**
Prioritise Stressors Hobbies/interests Rest Exercise/yoga Chocolate Step back Holidays Education Medication Insight "Sickies" Make Plans Drink Spiritual values Time Management Retail Therapy Problem Solver Sex Share/Talk Yoga Exercise Draw upon experiences	Genetic Predisposition to sadness/mental illness Poor Coping Skills Physiological Trauma Intellectual problems Internalised Cultural Influences Core Scheme Personality Traits Poor physical health Self esteem / Self Worth issues Psychological Make up Lack of Communication skills
Environmental Supports/Protectors	**Environmental Stressors**
Mental Health Service Good Weather Law Transport Information Community Networks Accommodation Pets Friends/family Pleasant Surroundings Money Local Services Support Group/Community Resources Money Job Leisure Centre Refuge Centres Church Life Coaching Home	Poverty Finances change Life events Social isolation Trauma/Abuse Loss Accommodation difficulties Stress overload No confiding relationships Cultural Stressors Drugs/Alcohol abuse/overuse Separation Social Disadvantage Unemployment Imprisonment Expectations/Pressure

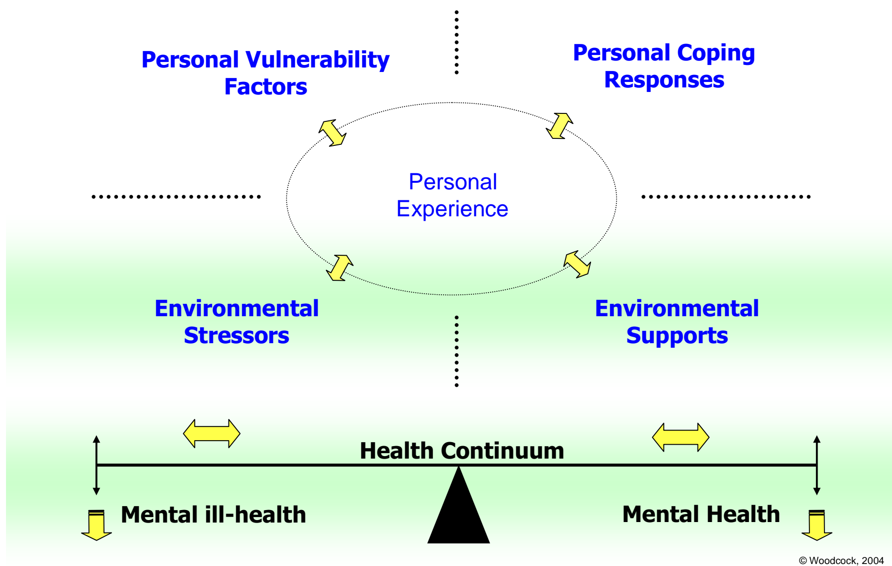
(This is not an exhaustive list and offers some example stressors and vulnerable factors only)

Every individual has a stress vulnerability threshold. Moving beyond a certain level of stress where the individual has particular vulnerabilities will impact on causing mental ill health (Diagram 1 -Stress Vulnerability Model).



No one single cause has been identified that explains the reason why someone would develop a serious mental illness. Research into causes of psychosis suggests that there are multiple factors that contribute to the development of mental illness. Such factors are acknowledged in vulnerability components within the stress vulnerability model.

The use of Psychosocial Interventions is incorporated into the Stress Vulnerability Model by using environmental supports to strengthen the persons' coping strategies and by providing supports at a time of need. The overall personal coping strategies are enhanced by external supports and by teaching/assisting the vulnerable person to recognise and use internal strengths and positive coping mechanisms (Diagram 2 Underpinning Conceptual Framework -SVM)



Vulnerability factors predispose the individual to an increased risk of developing the symptoms of psychosis. This predisposition may be 'inborn', such as through a family history of psychosis (genetic predisposition), or neurophysiological development of the foetus (biological predisposition). Predisposition could also be 'acquired'; examples include brain injury as a result of oxygen deprivation, or trauma (biological disposition) or specific to traumatic life events and experiences, which influence thinking styles and biases (psychological disposition).

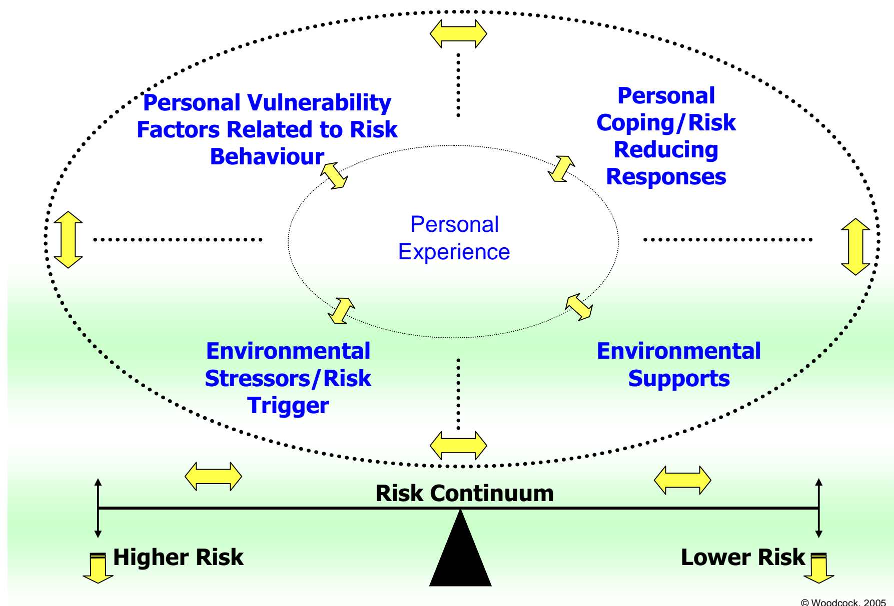
Within the stress vulnerability model, vulnerability alone is not considered sufficient to cause psychosis; rather psychosis must be 'triggered' by environmental processes or 'stress'. If the vulnerability is great, relatively low levels of environmental stress might trigger symptoms. Conversely, if vulnerability is lower or the individual is more resilient as a result of developing personal coping strategies and having supports, symptoms will develop only when higher levels of stress are experienced.

The stress component of the stress vulnerability model can take many forms, such as conflict and criticism, living conditions, a significant life event (e.g.

breakdown of relationship, a death of a key individual, loss of job), or abuse of substances.

The use and effectiveness of personal coping strategies and available supports offers an explanation as to why some people develop problems and others do not, particularly if they have experienced similar stressors. It may also explain why some people recover from the symptoms quicker than others.

There are studies indicating that individuals do utilise coping strategies as a way of managing stressors and psychotic symptoms. Clearly the more coping strategies are used, the better the chances of managing the stressors or preventing symptoms becoming problematic (Diagram 3- Risk Formulation).



The stress vulnerability model offers the continuing possibility of recovery over time. Even those with the most difficult problems may be able to avoid or reduce the likelihood of further episodes by finding ways of reducing their exposure to situations they find particularly stressful, or by developing and applying effective personal coping responses. Finally, it helps to explain the fact that people who are prone to psychotic experiences may have long periods of recovery, but may develop new difficulties ('relapse') at various times.

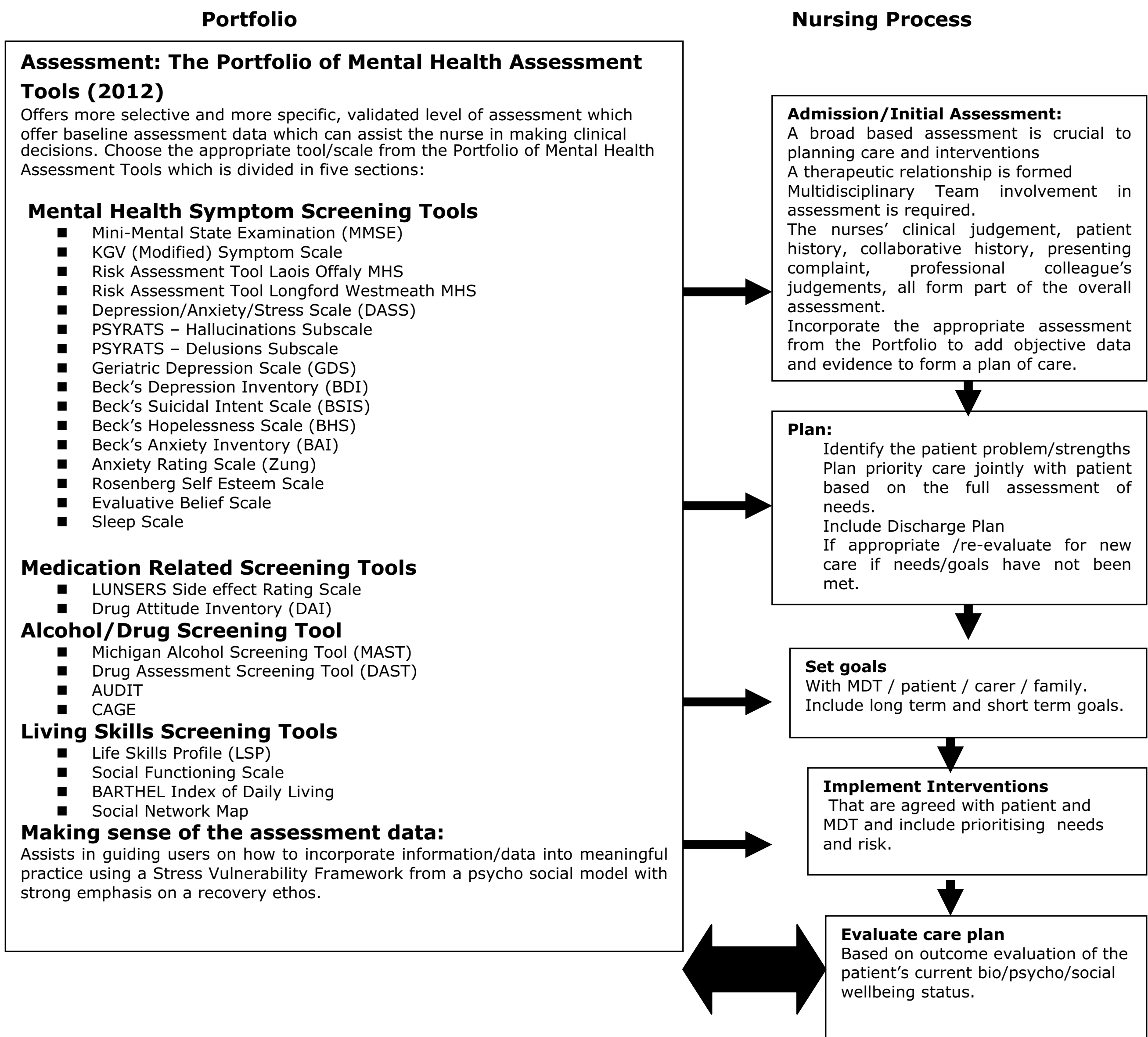
References:

Kinderman, P & Cooke A (2000) *Recent advances in understanding mental illness and psychotic experiences,* British Psychological Society

Woodcock R. (2004, 2005) Unpublished Work.

Guideline: Incorporating assessment tools into the nursing process of care planning

The use of assessment data must be conducted within the context of nursing care planning. An algorithm is provided which depicts the sequence of decision making and interventions that the mental health nurse engages in to provide appropriate, evidenced based interventions with patients through the nursing process.



The Assessment Tools/scales contained in this Portfolio are for use by professional members of the Multi-Disciplinary Team in mental health practice who have had appropriate training on their application.

The Assessment Tools/scales do not in any way replace clinical decision making, rather they can assist in the process. Practitioners should be prepared to use their clinical judgement to make decisions regarding which tool/scale is appropriate in the overall assessment and care for each patient /client and the often rapidly changing needs of that person.

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