



MANUAL OF PSYCHOSOCIAL REHABILITATION

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Manual of Psychosocial Rehabilitation

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Foreword by Gary Bond

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Foreword

Clinicians in the psychiatric rehabilitation field will welcome this manual for these reasons:

- 1 *It's realistic.* It addresses common issues in everyday practice, as embodied in “Sam,” a fictional yet believable composite client facing a series of life problems. Readers will recognize in Sam the clients they help every day on their recovery journeys. The authors are experienced clinicians who write with conviction and authenticity, as shown in the topics they have chosen and how they write about them. Their choices ring true, consisting of a balance among assessment, counseling, community integration, and self-help. Readers will appreciate the authors’ empathy for the challenges facing clinicians.
- 2 *It's filled with practical tools.* The *Manual* provides scores of user-friendly scales, counseling tips, checklists, and other tools. For example, for assessment tools, the authors give concrete details about ease of administration, scale interpretation, how the scales work in practice, how to obtain copies, and any associated costs. In my experience, clinicians greatly appreciate this tangible help.
- 3 *It's grounded in empirical research.* Because this manual is a companion book to a handbook explaining the rationale and research foundations for psychiatric rehabilitation practices, readers can be confident that the identified practices have successful track records in helping clients with severe mental illness. And, because the evidence is reviewed in the *Handbook*, the *Manual* can focus exclusively on real-world applications and avoid immersion in the underlying theory and empirical foundations. While the *Manual* can be used as a stand-alone book, the synergy between the two texts invites concurrent reading of relevant material from both sources for deeper understanding.
- 4 *It presents an integrated approach to psychiatric rehabilitation.* Psychiatric rehabilitation services are fragmented, with practice silos for different psychosocial service areas, such as for illness management, housing, and employment. Comprehensive textbooks mimic usual practice by devoting separate chapters to different service areas, with rare cross-referencing between areas. Clinicians and program managers struggle with coordination and communication between siloed programs. “How do I combine different evidence-base practices? How do they fit together? How do I manage all at once?” Rather than a compendium of practices, the *Manual* aims at a unified narrative by focusing on an individual client. It presents a holistic approach to psychiatric rehabilitation examined through the persona of Sam.

In the Internet Age, you can google anything, but you can't vouch for the credibility of the search results. By contrast, the *Manual* is dependably reliable. It belongs in the clinician's toolbox of frequently-consulted resources.

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Chapter 1

Introduction

*Robert King, Chris Lloyd, Tom Meehan, Frank P. Deane
and David J. Kavanagh*

Psychosocial rehabilitation (also known as psychiatric rehabilitation) is a term used to refer to a range of non-pharmaceutical interventions designed to help a person recover from severe mental illness.

Severe mental illness is mental illness that is both persistent and has a major impact on life functioning. Schizophrenia is the condition most commonly associated with severe mental illness but it is misleading to associate severity with diagnosis alone. There are many cases of people diagnosed with schizophrenia where the major impact of the illness is brief or where the effect on life functioning is minor. Equally, there are many people with mood and anxiety disorders or with personality disorders whose illness has a major and persistent impact on their life functioning. This book is not concerned with the treatment of a specific diagnostic group but rather with interventions designed to assist people whose mental illness has had a major and persistent impact on life functioning, regardless of diagnosis. It is also designed as a resource and guide for students who are learning how to work effectively with this population. In particular, we see it as an especially valuable resource for the student on placement in settings that provide psychosocial rehabilitation.

Some form of psychosocial rehabilitation is provided in most parts of the world. Sometimes it is provided within long-stay institutional or quasi-institutional settings but typically it is provided by community organisations, which may or may not be affiliated with clinical services. The people providing psychosocial rehabilitation may be health professionals such as nurses, occupational therapists, psychologists and social workers or they may be people without professional training but with skills and attitudes that enable them to assist such people, whether or not they have been trained as health professionals.

Contemporary psychosocial rehabilitation often takes place within a *recovery* framework, which we endorse. The recovery framework emphasises that recovery from mental illness is a process rather than an outcome. Recovery is a personal journey that is about the rediscovery of self in the process of learning to live with an illness rather than being defined by the illness. At an individual level, it is about the development of hope and a vision for the future. At the community level, it is about supporting engagement and

participation through provision of opportunity and making connection with the person rather than the illness. The recovery framework informs the way we approach psychosocial rehabilitation. In part, it means that we acknowledge that rehabilitation is only a component of recovery and that it must not seek to over-ride or replace the personal journey. It also means that we approach psychosocial rehabilitation in a spirit of collaboration and partnership with the client. Psychosocial rehabilitation is not something to be imposed on the person and even when, as often is the case, the person is subject to an involuntary treatment order or equivalent, we work with client goals and priorities and negotiate rehabilitation plans.

This book may be seen as a companion to our *Handbook of Psychosocial Rehabilitation* (King *et al.*, 2007). The *Handbook* sets out the principles and evidence base for contemporary practice in psychosocial rehabilitation. This book, which we call the *Manual*, provides the tools and resources to support evidence-based practice. The *Handbook* was well received as a primer in this field of practice but some reviewers noted that while the *Handbook* would assist the reader to work out the best approaches to psychosocial rehabilitation, many readers would still lack the resources to translate principles into practice. We hope that this book will contribute to filling that gap.

Terminology

As with the *Handbook*, we have preferred the term client to patient or consumer. This is based on research indicating that people with severe mental illness identify themselves as patients when in hospital, as clients when receiving community-based services and as consumers when in advocacy roles. We think that the term client both recognises that the service provider has expertise while maintaining an active role for the service recipient as the person seeking and utilising this expertise.

We have also maintained the use of the term rehabilitation practitioner or sometimes just practitioner to refer to the service provider. This recognises that people providing psychosocial rehabilitation come from a wide range of professional and non-professional backgrounds and that what they have in common is that they practise psychosocial rehabilitation.

Organisation of the book

The *Manual* has five main sections.

- Assessment Tools
- Therapeutic Skills and Interventions
- Reconnecting to Community
- Self-Help and Peer Support
- Bringing It All Together

The section on Assessment Tools provides information about standardised instruments that can be used to assist in both initial client assessment and evaluation of client progress.

We have focused on tools that are widely available, have good psychometric properties, are inexpensive or free, have a track record of successful use in psychosocial rehabilitation and require little or no training for use. As well as providing information about specific assessment tools, we provide a guide to when they might be used and information about how to obtain them. In most cases sample items are also provided.

The section on Therapeutic Skills and Interventions contains chapters that provide a 'how to' guide for five interventions. We don't suggest that this is an exhaustive set. However, the interventions chosen have high relevance to psychosocial rehabilitation and a track record for successful application with people who have severe mental illness and do not require extensive training. We do not expect that practitioners will become skilled in provision of these interventions simply by reading this *Manual*. We do, however, think that the *Manual* will provide a good starting point and will enable practitioners to learn from experience. We encourage practitioners to utilise supervision and to access other sources of training in the development of therapeutic skills.

The chapters in Reconnecting to Community set out programmes designed to develop capacity for both independent living and engagement with and participation in the wider community. These include very basic independent living skills, such as money management and cooking, that are often compromised by severe mental illness and more complex social skills that provide the foundation for effective participation in the community. The programmes are typically set out in a week-by-week format for application with groups but there are also tips about adapting the group programmes and tailoring them to individual needs. Many of the activities described will be affected by culture and local environment. We therefore encourage readers to adapt these programmes in accordance with prevailing culture and environment.

The penultimate section of the *Manual* is concerned with peer support, family support and self-help. The rationale for this section is that the evidence suggests that people affected by severe mental illness and those who care for them (especially family members) derive a great deal of benefit from supports and interventions that are substantially outside the psychosocial rehabilitation environment. The rehabilitation practitioner can assist by linking people to such supports and interventions and by providing support to self-help activity. In some circumstances, rehabilitation services may facilitate or sponsor peer and/or family support activities. It is also important for rehabilitation practitioners to be aware of the growing availability of high-quality self-help programmes (especially in the online environment). These can often complement psychosocial rehabilitation interventions provided one to one or in groups. These chapters provide the practitioner with both information and links to resources that will support an effective interface between the rehabilitation environment and the peer support, family support and self-help environments.

The *Manual* ends with two chapters under the heading *Bringing It All Together*. These chapters are concerned with review and evaluation of rehabilitation programmes at individual and service levels. The first of these two chapters focuses on review and redesign of an individual rehabilitation programme. It provides the practitioner with guidance on how to work with a client to identify what has been successful and what remains to be achieved while retaining a positive and strengths-based outlook. The second chapter provides guidance for evaluation of service-based programmes, especially group

programmes. The chapter will assist practitioners to determine whether or not the programmes are achieving the outcomes they were designed to achieve. Together, these two chapters emphasise that it is not sufficient to provide rehabilitation services. It is important to know that services are achieving expected outcomes both at individual level and at service level.

Sam

Sam is a young man recovering from severe mental illness. We introduced Sam in the *Handbook* and he makes regular appearances throughout this *Manual*. He is of course a fictional character, being a composite of many people we have worked with in our own practice experience. We hope that readers will find Sam to be a recognisable person who embodies many of the challenges and struggles associated with the recovery process. Sam has been a great help to us as we seek to make psychosocial rehabilitation a living process rather than an abstraction.

The authors

The authors have professional backgrounds in the fields of mental health nursing, psychology and occupational therapy. Some are primarily in service provision roles and others work primarily in research and teaching. Most of the authors are based in Australia, which has a strong international reputation in mental health because of its history of service planning and service innovation. However, the authors also bring rich international experience as a result of training, working or undertaking research or practice in various parts of North America and Europe. We have provided some additional information about the contributing editors.

Robert King is a clinical psychologist and professor in the School of Psychology and Counselling at Queensland University of Technology. He is an editor of the international journal *Administration and Policy in Mental Health and Mental Health Services Research* and a member of the research advisory committee of the International Center for Clubhouse Development. Robert worked as a mental health practitioner, team leader and service manager for 15 years before shifting his focus to teaching and research. He has strong links and collaborates with mental health researchers in North America, Europe and Asia. He has published over 100 refereed articles, books and book chapters in the field of mental health and is a regular contributor to international conferences.

Frank P. Deane is a clinical psychologist, professor in the School of Psychology and Director of the Illawarra Institute for Mental Health at the University of Wollongong. Frank worked as a clinical psychologist in a variety of settings in New Zealand and the USA before moving to Australia. He is currently the Director of Clinical Psychology Training at the University of Wollongong. He has published research articles in the area of help seeking for mental health problems, the role of therapeutic homework in therapy, medication adherence, recovery from severe mental illness and mental health and drug and alcohol treatment effectiveness.

David J. Kavanagh holds a research chair in clinical psychology at the Institute of Health and Biomedical Innovation and School of Psychology and Counselling at Queensland University of Technology, and has experience as a clinician and director of a community mental health service, among other roles. He has 28 years of research experience since receiving a PhD from Stanford University and is currently on the editorial boards of three journals, including *Addiction*. He has over 180 publications and leads the award-winning *OnTrack* internet-based treatment team at QUT. David has led or participated in many expert committees on mental health and substance use policy for national and state governments and professional bodies, and has extensive experience in delivering and evaluating training of practitioners in family intervention, co-morbidity and clinical supervision. His applied research has attracted several awards, including a Distinguished Career Award from the Australian Association of Cognitive-Behaviour Therapy in 2011.

Chris Lloyd is an occupational therapist with an extensive background in the area of mental health. She has worked in a variety of settings in Australia and North America with people of different ages and a variety of needs. Chris currently works as the Principal Research Fellow for the Gold Coast Health Service District and is an Adjunct Senior Research Fellow for the Behavioural Basis of Health at Griffith University. Her interests lie in the rehabilitation of people with a mental illness, particularly social inclusion, recovery and vocational rehabilitation. She has published widely, over 150 articles and four books.

Tom Meehan worked as a mental health nurse in Ireland before moving to Australia in 1987. He has worked in a variety of clinical, teaching and research positions and currently holds a joint appointment as Associate Professor with The Park Centre for Mental Health and the School of Medicine at the University of Queensland. Over the past 10 years, Tom has acted as chief investigator for a number of large-scale research and evaluation studies focusing on the rehabilitation of people with psychiatric disability. He has published widely and has delivered papers at professional conferences in Australia and overseas.

Reference

King R, Lloyd C, Meehan T (eds) (2007) *Handbook of Psychosocial Rehabilitation*. Wiley-Blackwell: Oxford.

Part I

Assessment Tools

Chapter 2

Assessment of Symptoms and Cognition

Tom Meehan and David J. Kavanagh

Sam is a young man who has been diagnosed with schizophrenia. You have been asked to review Sam for a new rehabilitation programme. You are interested in assessing symptom levels and related conditions such as cognitive functioning and substance misuse. It is clear from an interview with Sam that he is experiencing both positive and negative symptoms and he has some difficulty planning activities due to his cognitive impairment. Moreover, he describes difficulty getting off to sleep and feeling 'down' and sad on most days. While Sam claims that his symptoms have deteriorated in recent months, there are no previous assessments of functioning to provide a baseline for comparison. You decide to carry out an overall assessment using a range of measures to assess different aspects of his condition.

Clinical assessment is an integral component of case conceptualisation and treatment planning. While the assessment of symptoms is a major component of any clinical investigation, the assessment of other related conditions such as cognitive impairment and substance misuse should also be considered when determining treatment options for people such as Sam. It is clear that the level of distress experienced due to symptoms will influence the location of treatment (inpatient versus outpatient), the nature and approach to treatment (psychotherapy, medication or both), the level of clinical expertise required to provide the treatment, and the need for other support services such as accommodation, employment or training. Moreover, monitoring symptom levels is useful since a good outcome for many people with severe psychiatric disability is likely to be a reduction in the frequency, duration or severity of symptoms, rather than a complete cure.

Ongoing assessment and monitoring of symptoms and related domains is essential to key decisions such as titrating the degree of support required, providing early intervention to avert relapse, timing new initiatives such as a new job, and negotiating continuance or termination of an intervention. In the absence of adequate monitoring, it can also be difficult to know whether progress is being achieved, especially when it is slow or variable.

In this chapter, we identify a subset of measures that could be used in clinical practice to assess severity of psychotic symptoms, depression, anxiety, substance misuse, and cognitive impairment in people with psychiatric disability.

Symptom rating scales

The use of rating scales to assess changes in symptoms increased from the early 1960s, with the need to assess response to emerging psychotropic medications. For example, the Brief Psychiatric Rating Scale (BPRS) was introduced in the early 1960s to assess the effectiveness of chlorpromazine (Overall & Gorham, 1962). At the same time, measures of depression and anxiety, such as those developed by Hamilton, emerged to assess the effectiveness of the new antidepressant medications that were gaining popularity at that time (Hamilton, 1960). While these measures are still widely used, a range of more specific measures has been introduced to assess symptoms in different client groups (adolescents/elderly) and in clinical subgroups such as those with schizophrenia (e.g. the Calgary Depression Scale for Schizophrenia).

Measures described in this chapter

While a broad range of symptom measures currently exists, many are too lengthy, cumbersome and time consuming to be completed routinely by rehabilitation staff. Most of these are more suitable for research and evaluation purposes (e.g. where they may be completed every few months) rather than in clinical practice (where it may be necessary to have measures completed every 1–4 weeks). Therefore, we focus on some of the more clinically useful measures available (Table 2.1). These scales reach a compromise between the burden on the clients and practitioners to complete the measures and the quality of the data they provide. For example, while the BPRS (mentioned above) is a well-recognised measure of symptoms, it is not included here due to the considerable training that is required.

A short description of each measure is provided with an example of its structure. Some of the measures are provided in full (where copyright restrictions allow).

Self-report versus practitioner-rated measures

Approaches to the assessment of symptoms have been developed in two broad formats: (i) self-report measures (completed by the client) and (ii) those administered through interview with a practitioner (practitioner rated). Self-report measures (e.g. Kessler-10) offer some advantages over practitioner-rated measures: they generally take less time to administer and do not require extensive training in their use, making them less expensive to employ. In addition, the information being collected is obtained directly (i.e. without rater interpretation) from the individual being assessed. This is particularly important when collecting client perceptions or subjective experiences (such as in assessments of quality of life and satisfaction). However, self-rating scales do require that clients are able to read and be well enough to understand what is being asked of them. While some self-report measures can validly be administered in an interview format, most have not undergone checking to establish that this is the case, and care needs to be taken to avoid paraphrasing of questions (which may alter their meaning).

Table 2.1 Summary of measures.

Scale	Domains assessed	Structure	Cost
Measures of depressive symptoms			
Calgary Depression Scale for Schizophrenia (CDSS)	Depression in people with schizophrenia	Structured interview (9 items)	No cost
Hamilton Rating Scale for Depression (HAM-D)	Severity of depression	Structured interview (17 items)	No cost
Depression, Anxiety, Stress Scale (DASS)	Depression, anxiety, stress	Self-report (21- or 42-item versions)	No cost
Non-specific measures of psychiatric symptoms			
Behaviour and Symptom Identification Scale (BASIS-32)	Relations to self/others Depression/anxiety Daily living/role functioning Impulsive/addictive behaviour Psychosis	Self-report or practitioner interview (32 items)	Site licence must be purchased
Kessler-10 or Kessler-6	Psychological distress	Self-report (10 or 6 items)	No cost
Clinical Global Impressions (CGI) Scale	Illness severity Improvement Efficacy of medication	Practitioner interview (3 items)	No cost
Measures of cognitive functioning			
Brief Assessment of Cognition in Schizophrenia (BACS)	Verbal memory Working memory Motor speed Semantic fluency Letter fluency Executive function Attention and motor speed	Practitioner administered	Must be purchased
Substance misuse: brief screening measures suitable for repeated use			
DrugCheck Recent Substance Use (RSU)	Quantity/frequency of use in the last 3 months	Self-report/interview (10 substance types)	No cost
Problem List (PL)	Functional impact from most problematic substance in the last 3 months	(12 items)	
Alcohol Use Disorders Identification Test (AUDIT)	Alcohol use and related problems	Self-report (10 items)	No cost
Substance misuse: assessment of consumption			
Timeline followback	Consumption occasions and amounts over recent weeks/months	Self-report/interview	No cost
Opiate Treatment Index (OTI)	Substance use, injecting/sexual practices, social functioning, crime, health	Self-report in interview (11 substance types, 11 injecting/sexual, 12 social functioning, 4 crime, 50 health)	No cost

People with severe mental illness may not always be able to appraise their own behaviour or performance because of cognitive impairment, or may be unwilling to disclose personal failings, especially if they do not feel it is safe to do so (e.g. if discharge or new opportunities are believed to rest on non-disclosure). The establishment of trust is even more critical than in other contexts and observation or collateral reports may often be necessary to supplement self-reports. While interviews also rely extensively on self-report, they do provide opportunities for observation of behaviour and checking internal consistency of answers.

Assessment of depression

Depression can affect emotions, motor function, thoughts, daily routines such as eating and sleeping, work, behaviour, cognition, libido and overall general functioning. While some scales have attempted to consider all these domains, others have tended to be less inclusive and focus on the main symptoms of depressive illness. More recently, there has been a tendency to develop scales with specific populations in mind (e.g. The Calgary Depression Scale for Schizophrenia).

The Calgary Depression Scale for Schizophrenia

The Calgary Depression Scale for Schizophrenia (CDSS) was specifically designed to assess depression in people with schizophrenia. Unlike some of the other depression measures available, the CDSS includes an assessment of *suicidal thoughts* (Item 8) and *hopelessness* (Item 2). This is an important feature of the CDSS since those with a diagnosis of schizophrenia are at higher risk for suicide (Cadwell & Gottesman, 1990). Moreover, weight changes are not assessed as weight gain/loss can be related to the use of psychotropic medications.

The CDSS contains nine items which are assessed on a four-point response format ('absent' to 'severe'). Eight of the items are completed during a structured interview with the client while the final item (item 9) is based on an overall observation of the entire interview. The domains assessed are outlined in Table 2.2. A total score can be obtained

Table 2.2 Domains included in the Calgary Depression Scale for Schizophrenia.

Item	Domain assessed	Absent	Mild	Moderate	Severe
1	Depressed mood	0	1	2	3
2	Hopelessness	0	1	2	3
3	Self-depreciation	0	1	2	3
4	Guilty ideas of reference	0	1	2	3
5	Pathological guilt	0	1	2	3
6	Morning depression	0	1	2	3
7	Early wakening	0	1	2	3
8	Suicidal thoughts	0	1	2	3
9	Observed depression	0	1	2	3

Box 2.1 Assessment of the Hopelessness domain

- *How do you see the future for yourself?*
- *Can you see any future or has life seemed quite hopeless?*
- *Have you given up or does there still seem some reason for trying?*

0	Absent	
1	Mild	Has at times felt hopeless over the past week but still has some degree of hope for the future
2	Moderate	Persistent, moderate sense of hopelessness over the past week
3	Severe	Persisting and distressing sense of hopelessness

by summing all item scores to provide a total score of between 0 and 27. A total score of 5 or more is suggestive of depression (in those with schizophrenia).

A glossary is provided for each item to ensure standardisation of the approach followed in the administration of the instrument. The glossary for the *hopelessness* domain is provided in Box 2.1.

Issues for consideration

The CDSS is relatively brief and easy to score, and captures key symptoms of depression in people with schizophrenia. However, it is administered through a structured interview and its developers suggest that users should have at least five practice interviews in the presence of a rater who is experienced in administration of structured instruments before using it alone. Information about the scale and its development can be found in Addington *et al.* (1993), and a copy of the scale and information on its use can be obtained from www.ucalgary.ca/cdss. The CDSS is copyrighted and permission to use it can be obtained by emailing Dr Donald Addington at addingto@ucalgary.ca. It can be used free of cost by students and non-profit organisations.

Hamilton Depression Rating Scale (HDRS)

The Hamilton Depression Rating Scale (HDRS) was developed over 50 years ago and is now one of the most widely used scales for the assessment of depression. The original version included 17 items but a later version included four additional items considered useful in identifying subtypes of depressive illness. However, these four items are not included in the overall rating of depression and the original 17-item version remains more widely used (Bagby *et al.*, 2004).

While the HDRS (also known as the HAM-D) is usually completed following an unstructured interview, guides are now available to assist in having the scale administered in a semi-structured format (see Williams, 1988). Items are scored on a mixture of three-point and five-point scales and summed to provide a total score (range 0–54). It is now widely accepted that total scores of 6 and lower represent an absence of depression, 7–17 mild depression, 18–24 moderate depression and scores above 24 indicate severe depression. Box 2.2 provides an example of the item structure.

Box 2.2 Structure of Hamilton Depression Rating Scale (HDRS)

Instructions: To rate the severity of depression in patients who are already diagnosed as depressed, administer this questionnaire. The higher the score, the more severe the depression. For each item, circle the number next to the correct item (only one response per item).

Item 2: Feelings of guilt

- 0 Absent
- 1 Self-reproach, feels he/she has let people down
- 2 Ideas of guilt or rumination over past errors or sinful deeds
- 3 Present illness is a punishment. Delusions of guilt
- 4 Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

Item 4: Insomnia (early)

- 0 No difficulty falling asleep
- 1 Complains of occasional difficulty falling asleep, i.e. more than half an hour
- 2 Complains of nightly difficulty falling asleep

Issues for consideration

The HDRS is one of the scales most widely used for the assessment of depression severity. Nonetheless, it has been criticised for not including all the symptoms associated with depression (such as oversleeping, overeating and weight gain) and for inclusion of items related to other domains such as anxiety. Moreover, there are issues with the heterogeneity of rating descriptors for some items; for example, the depressed mood item contains a mixture of affective, behavioural and cognitive features (Bagby *et al.*, 2004).

Notwithstanding these shortcomings, the HDRS is popular in clinical trials and as a measure of depression severity in clinical practice. The scale can be administered in 20–30 minutes, is easy to score (item scores are summed to provide a total score) and there are established ‘cut-offs’ to indicate levels of depression. However, expertise in the clinical assessment of depression is required, along with training in the use of the scale. There are no restrictions on the use of the scale and copies can be downloaded from <http://healthnet.umassmed.edu/mhealth/HAMD.pdf>.

Depression, Anxiety, Stress Scale (DASS)

The DASS was developed in Australia (Lovibond, 1998; Lovibond & Lovibond, 1995) and contains 42 items assessing three separate but related constructs: depression, anxiety and stress. A brief version (21 items) is also available, and scores from it correlate highly with the 42-item scale. Responses options focus on the amount of time in the past week that an individual experiences a given problem, such as ‘*I couldn’t seem to experience any positive feeling at all*’. This and other items are rated on a four-point scale ranging from ‘Did not apply to me at all’ to ‘Applied to me very much or most of the time’. The scale’s structure is outlined in Box 2.3.

Issues for consideration

The DASS has the advantage of assessing anxiety and stress (in addition to depression) which are frequently found in people with depression. It is completed by the client which

Box 2.3 Structure of Depression, Anxiety, Stress Scale (DASS)

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				
	I couldn't seem to experience any positive feeling at all (D)	0	1	2	3
	I felt that I was using a lot of nervous energy (A)	0	1	2	3
	I found it hard to wind down (S)	0	1	2	3

D, Example of Depression item; A, Example of Anxiety item; S, Example of Stress item.

alleviates the need for practitioner training. In the 21-item version, seven items contribute to each of the domains assessed: depression, anxiety and stress. (Each domain in the 42 item version has 14 items.) Item scores in each domain are summed to provide a total score for that domain. The DASS is likely to be more useful in those with less severe problems (i.e. those without psychotic features) as the individual needs to be able to process the statements and provide a response to these. In Australia, the DASS is widely used by general practitioners and other practitioners as a screening tool.

Non-specific measures of psychiatric symptoms

As outlined earlier, a good outcome for many people with mental illness is a reduction in symptom levels. We have selected one client self-report measure to assess distress (Kessler-10) since it requires no training, is brief and easy to score. Moreover, this measure is now included in the suite of measures used to assess client outcomes in Australia. Finally, we have selected the Clinical Global Impressions (CGI) Scale for its brevity and utility in clinical practice.

Kessler 10

The Kessler 10 (K10) was developed to screen for psychological distress in national health interview surveys in the USA (Kessler *et al.*, 2002). Items were primarily derived from existing screening measures on depression, generalized anxiety or positive mood. The K10 (10-question version) provides a global measure of psychological distress based on questions about anxiety and depressive symptoms. All items ask respondents to rate the frequency of the symptom over the past 30 days, using the following options: all of the time (1), most of the time (2), some of the time (3), a little of the time (4), or none of the time (5) (Box 2.4). Scores for each item are summed to provide a total score (range 0–50). Cut-off scores have been developed and suggest that people scoring under 20 are

Box 2.4 Structure of Kessler-10

1. During the past 30 days, did you feel tired for no good reason ...

- | | | | | |
|----------------------|--------------------------|----------------------|----------------------|---------------------|
| 1. none of the time? | 2. a little of the time? | 3. some of the time? | 4. most of the time? | 5. all of the time? |
|----------------------|--------------------------|----------------------|----------------------|---------------------|

likely to be well, scores of 20–24 are indicative of mild mental disorder, scores in the range 25–29 represent moderate mental disorder, and scores above 30 represent severe mental disorder. A six-item version of the measure (K6) is also available and the total score derived from this correlates highly with that of the longer version.

Issues for consideration

The K10 is currently used as a client self-rated outcome measure in Australia. Initial feedback indicates that the measure is well accepted by clients and provides useful information to staff for treatment planning purposes. It is also widely used by general practitioners across Australia to screen for anxiety and depressive symptoms. The scale is brief, client rated (no need for staff training) and it is easy to score. However, questions remain about its ability to detect changes in clinical populations (as against its ability to screen for psychological problems). In addition, while the K10 measures distress, it does not cover psychotic symptoms. Notwithstanding this, the K10 is sufficiently brief as to enable additional measures to be used to cover these areas.

Clinical Global Impressions Scale

The Clinical Global Impressions (CGI) Scale (Guy, 1976), is among the brief assessment tools most widely used in clinical trials to provide a brief, global assessment of a patient's functioning prior to and after initiating psychotropic medication. The original version of the CGI had three single-item subscales that asked the treating practitioner to rate (i) illness severity, (ii) improvement and (iii) efficacy of medication, taking into account the patient's clinical condition and severity of side-effects (Guy, 1976). However, the ability of the first two scales to provide an overall assessment of functioning is now recognised. For this reason, only the first two scales are usually employed in clinical practice. The first of these, Severity of Illness (CGI-S), provides a rating of the patient's clinical condition. The practitioner is asked: 'Considering your total clinical experience with this particular population, how mentally ill is the patient at this time?' (rating period is the past 7 days). This question is rated on a seven-point scale ranging from 1=normal to 7=among the most extremely ill patients (see below).

The second scale, the Global Improvement Scale (CGI-I), provides a measure of the patient's improvement or deterioration from a previous baseline assessment using the measure. The practitioner is asked: 'Compared to the patient's condition at admission to the project, how much has the patient changed?'. This question is also rated on a seven-point scale ranging from 1=very much improved to 7=very much worse. Scores on both the CGI-S and the CGI-I are likely to be positively correlated in that change (positive/negative)