

FERNZ-

GUIDELINES FOR THE  
ADMINISTRATION OF  
THE FIRST EPISODE  
DATASET

New Zealand Early Intervention in  
Psychosis Society (NZEIPS) Inc.



## Introduction

The First Episode Research New Zealand (FERNZ) Outcome Project is a national initiative aimed at developing a consistent set of measures throughout New Zealand to examine factors influencing outcome of first episode psychosis. Coordination through the New Zealand National Steering Group has ensured that a large proportion of first episode psychosis clients in the four main centres, along with a number of smaller services, will be enrolled. A set of measures have been developed to give to all first episode psychosis clients presenting at participating early intervention services. This information will be collected, pooled together, and analysed to look at issues such as duration of untreated psychosis, lipids and medication use.

The fundamental view of the FERNZ project is that audit and evaluation, which addresses the needs of clients, family, and whānau, as well as informing ongoing service development, is integral to the establishment of effective services for first episode psychosis. It will also provide the foundations for a national overview of the impact of Early Intervention for Psychosis Services in Aotearoa New Zealand.

This booklet has been developed to assist with the administration of the first episode psychosis dataset. It is intended to help maintain consistency in the measures so that information from different Early Intervention for Psychosis Services can be combined. In this manner, a number of questions about first episode psychosis can be answered.

While we have tried to anticipate any questions and issues that may arise, no doubt there will be unforeseen issues and problems that will arise. It will therefore be useful to refer to the FERNZ webpage for any updates that may be made. As people have issues and problems with completing the questions, answers will be posted on the website and then included in the next version of this guide. The website is:

<http://www.earlypsychosis.org.nz/fernz.htm>

## Procedure

All participating services will administer baseline and discharge research measures to all clients with first episode psychosis. Research forms will be mailed to a central administration centre for input and analysis. Participants will be allocated a project number for identification, and personal information removed from data before it is stored in locked cabinets at the centre.

Each service will appoint a FERNZ liaison coordinator in order to collect forms and coordinate any questions that may arise. The baseline, 6 month, and discharge forms must be completed within one month of the event. The form will be checked by the nominated FERNZ liaison coordinator and mailed to the national coordinator. Measures may be collected more regularly, for example at twelve months, but this document deals with the minimum dataset. Once the database is operational, it is anticipated that services will be able to access their information to help with service development and planning. Completed forms should be mailed to:

Mark Turner  
Researcher  
Totara House Early Intervention for Psychosis Service  
Canterbury District Health Board  
194 Bealey Ave  
Christchurch

# **FERNZ Outcome Project**

**Chief Investigators:** Professor Roger Mulder  
Dr Mark Turner  
Dr Cecilia Smith-Hamel

## **Participating Centres:**

**Totara House, Canterbury DHB**  
**Aspiring House, Otago DHB**  
**Wellington Early Intervention Service**  
**EPI Centre, Waitemata DHB**  
**MidCentral EIP Service, MidCentral DHB**  
**Nelson EIS, Nelson-Marlborough DHB**  
**Hauora Waikato**  
**EPI Team, Counties Manukau DHB**  
**Cornwall House, Auckland DHB**  
**Kari Centre, Auckland DHB**  
**St Lukes FEP, Auckland DHB**  
**Taylor Centre, Auckland DHB**  
**Manaaki EIP Service, Auckland DHB**

## **Background**

The processes that make schizophrenia and other forms of psychosis a long-term disorder may be most apparent and cause the most damage in the first few years of the illness. Delay between onset of psychosis and first treatment is considerable and has been linked in research to poor outcome. The early phase of psychosis and schizophrenia can therefore be seen as a critical period with major implications for the prevention of disease and psychosocial deterioration.

Early Intervention in Psychosis (EIP) is a relatively new approach to managing and ameliorating the potentially devastating impact of bipolar disorder, schizophrenia spectrum disorders and other psychoses. New Zealand has probably the most comprehensive system of EIP Services available anywhere in the world and these services, while ethically justifiable, are under pressure to be reintegrated back into general mental health services.

Against this general background, a number of services across New Zealand have formed a network through the National Steering Group to i) standardise research and evaluation measures conducted with this client group, and ii) to address research questions of national interest in the development of services and in improving the outcome of this illness. By standardising methods of evaluation across different services, the FERNZ group will provide a large cohort of participants. This will increase the statistical power of investigations into factors influencing outcome.

Over a series of collaborative research meetings, the network has agreed to a set of 'core' questions for investigation in a naturalistic, prospective study of outcomes in first episode psychosis managed by Early Intervention services.

## **Procedure**

All participating services will administer baseline, 6 month and discharge research measures to all clients with first episode psychosis. NOTE: If client is discharged to another EIS, a separate EIS Discharge form is to be used. Research forms will be mailed to a central administration centre for input and analysis. Participants will be allocated a project number for identification, and personal information removed from data before it is stored in locked cabinets at the centre.

Anonymised data will be input in the Statistical Package for Social Sciences (SPSS), and stored in secure servers within a master database for analysis by the chief

investigators. The primary analytical procedure will be logistic and multiple regression to evaluate outcomes in relation to categorical and continuous variables.

### Measures

Following on from work conducted in 2002, the following measures have been included as representative of the information routinely collected in Early Intervention for Psychosis Services.

- DSM-IV clinical diagnosis and substance use ;
- Symptoms of psychosis assessed by the Positive and Negative Syndrome Scale (PANSS) ;
- Depression assessed by the Calgary Depression Scale for Schizophrenia (CDSS Note: this measure is now optional.
- Global Assessment of Functioning (GAF)
- Health of the Nation Outcome Scale (HoNOS) ;
- The Role Functioning Scale (RFS) a measure of level of functioning

In addition, a series of questions are asked regarding pathways to care, demographics, physiological measures, medication use, and issues related to the client's time with the Early Intervention Service.

### Core Research Questions

- 1 What are the participant outcomes at 2 years in terms of;
  - Symptoms/side effects
  - Quality of life;
  - Employment status;
  - Relapse
- 2 The pattern of medication use and its consequences on the metabolic syndrome
- 3 In the longer term, the database will allow examination of specific sub-groups for treatment response as well as the responses around information required for policy and management decisions.

### References

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MEASURES FOR EARLY INTERVENTION IN PSYCHOSIS SERVICES IN NEW ZEALAND

FERNZ-BASELINE

Name of Service \_\_\_\_\_

National Early Intervention in Psychosis  
STEERING GROUP  
AOTEAROA / NEW ZEALAND



Name of case manager \_\_\_\_\_

Clients First Name \_\_\_\_\_ Code No. \_\_\_\_\_

Form checked by nominated FERNZ liaison coordinator \_\_\_\_\_

**The Baseline assessment must be completed, checked by nominated FERNZ liaison coordinator, and mailed to National coordinator within ONE month of client enrollment in service.**

**1\* ETHNICITY**

Which Ethnic Group do you belong to?

Mark as many spaces as apply. Ethnicity is based on reports from client **and** family/whānau/significant others'

\_\_ New Zealand European

\_\_ Niuean

\_\_ Maori

\_\_ Chinese

\_\_ Samoan

\_\_ Indian

\_\_ Cook Island Maori

\_\_ Other; please state \_\_\_\_\_

\_\_ Tongan

\_\_ Arrived in New Zealand as refugee?

**2\*Gender** \_\_ Male \_\_ Female

**3\*Date of birth** \_\_\_\_\_

**4\*Date at entry to EIP Service** \_\_\_\_\_

**5\*NHI number:** \_\_\_\_\_

**6\*Last known address** in full \_\_\_\_\_

*We are going to use the small-area index of relative deprivation (NZDep2001) - you need to collect residential address (Street number and name, suburb, city/locality) which can then be automatically linked to meshblock and then to NZDep2001. It is important that the full address (including flat number/street number, suburb etc.) is included because this information will be sent to the Department of Statistics in order to obtain an approximate measure of socioeconomic status (SES).*

*If the client is currently in residential care/psychiatric inpatient service, use the last known residential address in order to assist in approximating SES.*

**7\*Living situation at entry to EIP Service**

- 1 Living with Parents
- 2 Flatting with others
- 3 Boarding
- 4 Living with partner and/or children
- 5 Supported Accommodation
- 6 living alone in flat or own home
- 7 No fixed abode
- 8 other; specify: \_\_\_\_\_

**8\* Marital Status**

- 1 Married/civil union
- 2 Single
- 3 Defacto (incl. same sex)
- 4 Divorced/separated

*If the client is currently in residential care/psychiatric inpatient service associated with first episode psychosis, use the last known residential address*

**9\* Level of Education at entry to EIP Service**

[Choose highest]

- 0 No Qualification
- 1 5<sup>th</sup>/6<sup>th</sup>/7<sup>th</sup> Form/ (year 11, 12, 13)/ (NCEA)
- 2 vocational qualification (Polytech/diploma etc.)  
started\_\_ completed\_\_
- 3 university degree  
started\_\_ completed\_\_

Tick if currently studying anywhere: \_\_\_\_\_

'studying anywhere' is an attempt to look at returning to education regardless of current main source of income (Q10)

**10\* Main source of income**Circle main and tick any others that apply

- 0 No income
- 1 Full time work
- 2 Part-time work
- 3 WINZ Benefit
- 4 Student allowance/loan
- 5 Other: eg: ACC, income protection, specify: \_\_\_\_\_

*Try to choose only one main source of income. If things are complicated, describe in 'other' and the data entry team will code appropriately.*

**11\* SOURCE OF REFERRAL**

- 1= Self referral
- 2= Family referral
- 3= General Practitioner
- 4= Counselor/ School counselor etc.
- 5= Community MH Service/ Psychiatric Emergency Service/ Forensic/
- 6= Psychiatric Inpatient Ward
- 7= Other New Zealand Early Intervention in Psychosis Service
- 8= Other: specify type of service, not name: \_\_\_\_\_

**12a\* MHA STATUS**

Was the client under the Mental Health Act anytime in the six months before or during referral to Early Intervention in Psychosis Service?

Yes\_\_ no\_\_

*Circle 'yes' only if the use of the MHA was associated with the first episode psychosis in some way.*

**12b\* INITIAL HOSPITALISATION**

Length of initial hospitalisation prior to and including referral to Early Intervention in Psychosis Service- How many days was this admission in total: \_\_\_\_\_

*If client not hospitalised enter '0' days*

*If the client is still hospitalised at the time this form must be submitted, enter '999' on this line*

*If the client was still in hospital for their initial hospitalisation at the time the baseline assessment has to be completed (1 month after referral to EIS), '999' should be placed in the baseline questionnaire. The initial hospitalisation is then recorded on the discharge form, as the actual length of the initial hospitalisation will not be known at the time this form must be finished.*

**13\* DURATION OF UNTREATED PSYCHOSIS \_\_\_\_\_(days)**

Onset of psychosis to initiation of appropriate treatment/involvement with mental health Service

If no antipsychotic medication prescribed, why?

- 1 patient refused
- 2 psychotherapy preferred
- 3 not indicated
- 4 other; specify \_\_\_\_\_

*Duration of untreated psychosis is a significant predictor of long-term outcome for a young person. It represents the length of time between onset of the first ever psychotic symptoms and when the diagnosis of possible or definite psychotic disorder was first made by a mental health service provider **and** appropriate treatment is initiated.*

*In keeping with Larsen et al. (1996, p. 254) description of the first episode, adequate treatment of initial psychosis may or may not include hospitalization but will include administration of antipsychotic medication in sufficient amount (e.g. haloperidol 5 mg/day) given for a sufficient period of time (e.g. 3 weeks) that would generally lead to a clinically significant response in non-chronic, non-treatment resistant clients. Note, we are also including non-pharmacological interventions.*

DUP is coded as the number of days. The recommended procedure for determining DUP is to list psychotic symptoms that the patient or carer has reported, and then ask a series of questions about each symptom in turn, to determine when they were first ever experienced.

Questions for assessing onset are;

- 'When did this first occur?'
- 'When did you first notice this?'
- 'When was the very first time that you ever experienced (specify symptom)?'
- 'Did anything unusual happen before then?'

When patients/clients or family/whānau/significant others' have difficulty being precise about the timing of a symptom, linking its onset to reference points such as birthdays, holidays, beginnings and endings of relationships, jobs, school terms and so forth, is recommended. General questions about onset of functional decline (time when patient/client was last at his/her highest level of premorbid function for more than six months) and prodrome will help reveal inconsistencies between times given for symptom onset and illness onset.

Note that DUP is assessed at both baseline and discharge, as more information may be available on which to accurately base this estimate with ongoing treatment/engagement.

#### 14\* DIAGNOSIS Coding System: DSM-IV

|   |    |
|---|----|
| Schizophrenia   | 1  |
| Schizophreniform Disorder                                   | 2  |
| Schizoaffective Disorder-                                   | 3  |
| Brief Psychotic Disorder                                    | 4  |
| Delusional Disorder (include shared psychotic disorder)     | 5  |
| Psychotic Disorder due to a general medical condition (GMC) | 6  |
| Substance-induced Psychotic Disorder                        | 7  |
| Psychotic Disorder NOS                                      | 8  |
| Bipolar Disorder  | 9  |
| Depressive Disorder with psychotic features                 | 10 |
| Prodromal   | 11 |
| Other please specify _____                                  | 12 |

#### 15\*ALCOHOL AND OTHER DRUGS

|                                  | 6 months before referral |     |                         | Current (at referral) |                         |
|----------------------------------|--------------------------|-----|-------------------------|-----------------------|-------------------------|
|                                  | Not used                 | Use | Abuse (inc. dependence) | Use                   | Abuse (inc. dependence) |
| Alcohol                          | 0                        | 1   | 2                       | 1                     | 2                       |
| Cannabis                         | 0                        | 1   | 2                       | 1                     | 2                       |
| Stimulants- speed, P etc.        | 0                        | 1   | 2                       | 1                     | 2                       |
| Herbal Highs [Benzylpiperazines] | 0                        | 1   | 2                       | 1                     | 2                       |
| Nicotine                         | 0                        | 1   | 2                       | 1                     | 2                       |
| Other                            | 0                        | 1   | 2                       | 1                     | 2                       |

If other, specify: \_\_\_\_\_

Please use DSM criteria for substance abuse /dependence [ie; a maladaptive pattern of substance use, leading to clinically significant impairment or distress]. A definition can be found at: <http://www.sis.indiana.edu/DSM-IV-Criteria.aspx>

## DSM-IV Substance Abuse Criteria

Substance abuse is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (such as repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; or neglect of children or household).
2. Recurrent substance use in situations in which it is physically

hazardous (such as driving an automobile or operating a machine when impaired by substance use)

3. Recurrent substance-related legal problems (such as arrests for substance related disorderly conduct)
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (for example, arguments with spouse about consequences of intoxication and physical fights).

Note: The symptoms for abuse have never met the criteria for dependence for this class of substance. According to the DSM-IV, a person can be abusing a substance or dependent on a substance but not both at the same time.

#### DSM-IV Substance Dependence Criteria

Substance dependence is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

1. Tolerance, as defined by either of the following: (a) A need for markedly increased amounts of the substance to achieve intoxication or the desired effect or (b) Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following: (a) The characteristic withdrawal syndrome for the substance or (b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance (for example, current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

American Psychiatric Association. 1994. Diagnostic and Statistical Manual of Mental Disorders: DSM-IV. Washington D.C.: American Psychiatric Association. (pp. 181-183)

#### **16\* PHYSIOLOGICAL MEASURES**

Height at referral (cms) \_\_\_\_\_  
Weight at referral (kgs) \_\_\_\_\_  
Waist Circumference (cms) \_\_\_\_\_

#### **17\*Fasting\* Lipids / Glucose**

HDL \_\_\_\_\_  
LDL \_\_\_\_\_ Glucose \_\_\_\_\_  
Total \_\_\_\_\_ Triglycerides \_\_\_\_\_  
Date recorded \_\_\_\_\_

Due to the possible association between the metabolic syndrome and first episode psychosis, it is important that these physiological indicators be part of routine clinical practice. The date is required so we can see if bloods are taken before or soon after initiation of antipsychotics.

**18\* MEDICATION used at entry to EIS**

Antipsychotic (*circle*) Date initiated \_\_\_\_\_ Other Medication (Tick if prescribed)

0 No antipsychotic prescribed

1 Risperidone; \_\_\_\_\_ Antidepressant

2 Olanzapine; \_\_\_\_\_ Mood Stabiliser

3 Quetiapine; \_\_\_\_\_ Benzodiazepines

4 Clozapine; \_\_\_\_\_ Other; specify: \_\_\_\_\_

5 Depot;

6 Risperidone Consta;

7 Ziprasadone;

8 Typical; specify:

**19\* MEDICAL HISTORY** Tick if present

\_\_\_ Head injury [*involving loss of consciousness*] \_\_\_\_\_ Diabetes

\_\_\_ Epilepsy \_\_\_\_\_ Other; specify: \_\_\_\_\_

\_\_\_ Thyroid Disease \_\_\_\_\_ Possible Autistic Spectrum Disorder

**20\* SUICIDAL IDEATION** *Suicide risk is a key issue for young people with early psychosis. Monitoring and responding appropriately to suicide risk is an essential component of quality mental health care. (Ask all questions)* Tick if 'Yes'

1. In the last year have you seriously thought about committing suicide? \_\_\_\_\_

2. In the last year have you made a plan for committing suicide? \_\_\_\_\_

3. In the last year have you attempted suicide? \_\_\_\_\_

If yes to a suicide attempt, ask Did it result in an injury or poisoning? \_\_\_\_\_

Did it require medical attention? \_\_\_\_\_

Did it require overnight hospitalisation? \_\_\_\_\_

**21\* FAMILY HISTORY OF PSYCHOSIS**

| Diagnosis           | In 1st degree relative<br>(mother/father, Sister/brother) |    | In 2nd degree relative<br>(Grandparent, cousin, Aunty/Uncle) |    |
|---------------------|---|----|--|----|
|                     | Yes   | No | Yes  | No |
| ?psychotic disorder | 1   | 0  | 1  | 0  |
| ?mood disorder      | 1   | 0  | 1  | 0  |
| Other               | 1   | 0  | 1  | 0  |
| Unknown             | 1   |    | 1  |    |

Note that family history of psychosis is just a general background question and not meant to be an in-depth interview.

# FERNZ-DISCHARGE



Name of Service \_\_\_\_\_

Name of case manager \_\_\_\_\_

Clients First Name \_\_\_\_\_ Code no. \_\_\_\_\_

Discharge form checked by nominated FERNZ liaison coordinator \_\_\_\_\_

The Discharge assessment must be completed, checked by nominated FERNZ liaison coordinator, and mailed to National coordinator within THREE months of client enrollment in service. The code number will be supplied by FERNZ data entry by cross-referencing with baseline NHI.

NOTE: If client is discharged to another EIS, separate EIS Discharge form to be used.

**Note:** If a client is discharged, fill in a discharge form. If the client then returns to an early intervention service, a new discharge form [but NOT a new baseline form] should be completed at final discharge.  
\*if client has previously been discharged but has since returned to early intervention service and therefore this is now to be counted as final discharge form instead) indicate here: \_\_\_\_\_

Date of re-entry to service \_\_\_\_\_

## 1\* Reason for Discharge

|  |    |
|--|----|
| Discharged no evidence of psychosis  | 0  |
| Recovery leading to early discharge  | 1  |
| Referred to more appropriate service; specify: _____<br>(for example A&D, Forensic, Cultural, Prison etc.) | 2  |
| Reached end of service time and discharged with no follow-up   | 3  |
| Reached end of service time and referred on  | 4  |
| Moved outside service catchment with follow-up   | 5  |
| Wishes no further involvement with service/lost to follow-up   | 6* |
| Suicide  | 7  |
| Death other than suicide   | 8  |

- *Score of 0 would be used if the client was picked up by a service and then discharged because they did not prove to have a psychotic disorder.*
- *Score of 1 would be given if the client had a psychotic disorder but was discharged because they didn't need intensive follow-up [perhaps for example a single drug-induced psychotic episode that did not recur]*
- *Score of 2 would be used if the client had first episode psychosis but was transferred to another service for some reason. Specify the type of service, rather than name, so that it can be coded accurately*
- *Score of 3 would be given if the client was successfully treated and it was thought that no follow-up would be required from a GP or other psychiatric services.*
- *Score of 4 would be used if the client was routinely discharged after being with a service for the appropriate [full] time.*
- *Score of 5 would be given if the client moved to a different area **with** arranged follow-up with a new service*
- *\*Score of 6 requires Clinician judgement of whether or not the client terminated treatment with the programme before the clinician would have advised. This indicator aims to capture the clinician's judgement about whether a client has terminated treatment prematurely because of treatment reluctance and, or, refusal.*

## 2\*Where discharged to:

|  |    |
|--|----|
| Discharged to G.P.                                     | 1  |
| Discharged to community MH team                        | 2  |
| Discharged to community MH team secondary to Clozapine | 3  |
| Discharged to Alcohol & Drug Service                   | 4  |
| Discharged to Forensic Service / prison                | 5  |
| Discharged to long term rehabilitation service         | 6  |
| Other Specialist MH service <i>specify type</i> _____  | 7  |
| Discharged to other early intervention service         | 8  |
| Other; specify type <u>not</u> name: _____             | 9  |
| Unknown  | 10 |

- Score of 1 if the client is discharged to a General Practitioner
- Score of 2 if the client is discharged to a community Mental Health team or its equivalent in your DHB
- Score of 3 if the client is discharged to a community Mental Health team, or its equivalent in your DHB, secondary to Clozapine. That is; client is still seeing mental health services predominantly for monitoring Clozapine
- Score of 4 if discharged to Alcohol & Drug Service because this is primary treatment need
- Score of 5 if discharged to Forensic Service / prison because of inappropriate behaviour etc.
- Score of 6 if discharged to long term rehabilitation service due to on-going symptoms etc.
- Score of 7 if discharged to Other Specialist MH service. Specify the type of service, rather than name, so that it can be coded accurately
- Score of 8 if the client transfers to another EIP Service NOTE: If client is discharged to another EIS, **separate EIS Discharge form to be used.**
- If scoring a 9 for other, Specify the type of service, rather than name, so that it can be coded accurately

**3\*Date of birth** \_\_\_\_\_

**4\*Date of discharge** \_\_\_\_\_

**5\*NHI number:** \_\_\_\_\_

**6\*Last known address** in full \_\_\_\_\_

*It is important that the full address (including flat number/street number, suburb etc.) is included because this information will be sent to the Department of Statistics in order to obtain an approximate measure of socioeconomic status (SES).*

**7\*Living situation at discharge**

- 1 Living with Parents
- 2 Flating with others
- 3 Boarding
- 4 Living with partner and/or children
- 5 Supported Accommodation
- 6 living alone in flat or own home
- 7 No fixed abode
- 8 other; specify: \_\_\_\_\_

**8\* Marital Status**

- 1 Married/civil union
- 2 Single
- 3 Defacto (incl. same sex)
- 4 Divorced

**9\* Level of Education at discharge [Choose highest]**

- 0 No Qualification
- 1 5<sup>th</sup>/6<sup>th</sup>/7<sup>th</sup> Form/ (year 10, 11, 12)/ (NCEA)
- 2 vocational qualification (Polytech/diploma etc.)  
started\_\_ completed\_\_
- 3 university degree  
started\_\_ completed\_\_  
Tick if currently studying anywhere: \_\_\_\_\_

**10\* Main source of income**

- 0 No income
- 1 Full time work
- 2 Part-time work
- 3 WINZ Benefit
- 4 Student allowance/loan
- 5 Other: eg: ACC, income protection, specify: \_\_\_\_\_

**11\* Duration of untreated psychosis \_\_\_\_\_ (days)**

Onset of psychosis to initiation of appropriate treatment/involvement with EIP/inpatient service  
If no antipsychotic medication prescribed, why?

- 5 patient refused
- 6 psychotherapy preferred
- 7 not indicated
- 8 other; specify \_\_\_\_\_

*This measure is repeated from baseline as Wellington EIP have found that duration of untreated psychosis can change once more information is available about the client.*

**12\* a) Number of admissions for psychotic relapse to inpatient service while with EIP**

|                       | First Admission | Second Admission | Third Admission | Fourth admission | Fifth admission + (sum all other admission days) |
|-----------------------|-----------------|------------------|-----------------|------------------|--|
| Length of stay (days) |                 |                  |                 |                  |  |

*Disregard admissions for clozapine trial or admissions unrelated to psychotic symptoms*

*Do not include admissions that started **before** referral to EIP Service [unless client was still in hospital at time Baseline assessment was completed], as these are covered in the baseline assessment.*

*'First Admission' [above] refers to any admissions while the client was with the EIS (not counting any hospitalisation before and during referral). However, if the client was still in hospital for their initial hospitalisation at the time the baseline assessment was submitted, '999' should have been placed in the baseline questionnaire and therefore 'First Admission' [above] refers to *that* initial hospitalization. It is important that a long initial hospitalisation is not counted twice [because it is recorded at baseline and then again here] or conversely, not counted at all [because the initial hospitalisation was still in progress a month after acceptance to the service (when the baseline assessment had to be submitted)].*

**Please don't count initial hospitalisation twice.**

*The purpose of this question is to examine use of inpatient services while the client is with EIP Services in terms of resource utilization for psychotic relapse. We are therefore disregarding admission for Clozapine trial. It is up to the casemanager to decide if the admission is in any way associated with first episode psychosis.*

**b) Total number of days client accessed respite services while with EIP Services: (tick)**

0     1-10     11-30     30+     respite not available

*This question calls for an estimate of the number of days the client accessed respite services. These can be crisis or planned respite.*

*i) Crisis respite*

*Home based or other community based service options for people in crisis as an alternative to admission to an acute inpatient service.*

*ii) Planned respite*

*Alternative care and support services to provide:*

- a) relief for family and caregivers, or*
- b) prevention of relapse where current living arrangements are deemed to be contributing to a deterioration, and a short term alternative may be preventative.*

**c) SUICIDAL IDEATION** *Suicide risk is a key issue for young people with early psychosis. Monitoring and responding appropriately to suicide risk is an essential component of quality mental health care. (Ask all questions) Tick if 'Yes'*

1. In the last year have you seriously thought about committing suicide?
  2. In the last year have you made a plan for committing suicide?
  3. In the last year have you attempted suicide?
- If yes to a suicide attempt, ask
- Did it result in an injury or poisoning?
  - Did it require medical attention?
  - Did it require overnight hospitalisation?

**13\* Diagnosis at discharge; Coding System: DSM-IV**

- Schizophrenia 1
- Schizophreniform Disorder 2
- Schizoaffective Disorder- 3
- Brief Psychotic Disorder 4
- Delusional Disorder (*include shared psychotic disorder*) 5
- Psychotic Disorder due to a general medical condition (GMC) 6
- Substance-induced Psychotic Disorder 7
- Psychotic Disorder NOS 8
- Bipolar Disorder 9
- Depressive Disorder with psychotic features 10
- Prodromal 11
- Other please specify \_\_\_\_\_ 12

| 14*Alcohol and other drugs          | last 6 months |     |                         |
|-------------------------------------|---------------|-----|-------------------------|
|                                     | Not used      | Use | Abuse (inc. dependence) |
| Alcohol                             | 0             | 1   | 2                       |
| Cannabis                            | 0             | 1   | 2                       |
| Stimulants- speed,<br>P etc.        | 0             | 1   | 2                       |
| Herbal Highs<br>[Benzylpiperazines] | 0             | 1   | 2                       |
| Nicotine                            | 0             | 1   | 2                       |
| Other                               | 0             | 1   | 2                       |

If other, specify: \_\_\_\_\_

Please use DSM criteria for substance abuse /dependence [ie; a maladaptive pattern of substance use, leading to clinically significant impairment or distress]. A definition can be found here: <http://www.sis.indiana.edu/DSM-IV-Criteria.aspx>

**15\* Did client receive specialist Alcohol & Drug treatment from within EIP team? (Circle)**

(outside team)      Yes      Not needed      Not wanted      Not available

*The aim of this question is to ascertain whether or not specialist Alcohol & Drug treatment is available within the EIS and whether or not adequate treatment was provided. This is based on the premise that clinicians with substance misuse identification and treatment skills tailored to the specific needs of people with first episode psychosis are a key element of Early Intervention Services.*

**16\* Did client receive specialised psychological input from within EIP team? (Circle)**

(outside team)      Yes      Not needed      Not wanted      Not available

*The aim of this question is to ascertain whether or not specialist psychological input is available within the EIS and whether or not adequate treatment was provided. This is based on the premise that psychological input tailored to the specific needs of people with first episode psychosis is a key element of Early Intervention Services.*

**17\* Did client receive specialised cultural input from within EIP team? (Circle)**

(outside team)      Yes      Not needed      Not wanted      Not available

*The aim of this question is to ascertain whether or not specialist cultural input is available within the EIS and whether or not adequate treatment was provided. This is based on the premise that cultural input tailored to the specific needs of people with first episode psychosis is a key element of Early Intervention Services. Cultural input refers to services tailored to the cultural needs of the client (whether they be Maori, Pacifica, Asian etc.) It is widely accepted by practitioners working in mental health services that cultural identity plays a significant part in the wellness of individuals and their communities whatever the culture. Note: Ethnicity is collected at Baseline assessment.*

**17\* Physiological measures**

Weight at discharge (kgs) \_\_\_\_\_  
 Waist Circumference (cms) \_\_\_\_\_  
 Height at discharge (cms) \_\_\_\_\_

**18\*Fasting\* Lipids / Glucose**

HDL: \_\_\_\_\_  
 LDL: \_\_\_\_\_  
 Total: \_\_\_\_\_  
 Fasting Glucose: \_\_\_\_\_  
 Triglycerides: \_\_\_\_\_

Due to the possible association between the metabolic syndrome and first episode psychosis, it is important that these physiological indicators be part of routine clinical practice.

### 19\* Medication at discharge

#### Antipsychotic

- 0 No antipsychotic prescribed  
 1 Risperidone; Total dose per day: \_\_\_\_\_  
 2 Olanzapine; Total dose per day: \_\_\_\_\_  
 3 Quetiapine; Total dose per day: \_\_\_\_\_  
 4 Clozapine; Total dose per day: \_\_\_\_\_  
 5 Depot; Dose: \_\_\_\_\_  
 6 Risperidone Consta; Dose: \_\_\_\_\_  
 7 typical; Total dose per day: \_\_\_\_\_

#### Other Medication *(Tick if prescribed)*

- \_\_\_ Antidepressant  
 \_\_\_ Mood Stabiliser  
 \_\_\_ Benzodiazepines  
 \_\_\_ Other;  
 specify: \_\_\_\_\_

### 19a\* Antipsychotic Medication history

|                        | Old/Initial Medication | Date of change | New Medication | Reason for change |
|------------------------|------------------------|----------------|----------------|-------------------|
| 1 <sup>st</sup> switch |                        |                |                |                   |
| 2 <sup>nd</sup> switch |                        |                |                |                   |
| 3 <sup>rd</sup> switch |                        |                |                |                   |
| 4 <sup>th</sup> switch |                        |                |                |                   |
| 5 <sup>th</sup> switch |                        |                |                |                   |

#### Key

*Note: include periods on no medication*

#### Reason for change

1=side effects 2=lack of efficacy 3=non-compliance 4=patient preference 5=other; specify

*Note: you can use numbers from 19 [above] to code the type of medication if you wish.*

***It may be useful to keep this medication history chart in the clients' file so you can update changes as they occur.***

### 20\* Client engagement with service:

Rate the clients overall engagement with EIP Service staff/programme; engagement is defined as "willingness to participate in programme as appropriate".

|                                       |   |
|---------------------------------------|---|
| No engagement with EIP Service        | 0 |
| Minimal engagement with EIP Service   | 1 |
| Some engagement with EIP Service      | 2 |
| Moderate engagement with EIP Service  | 3 |
| Excellent engagement with EIP Service | 4 |

*The service engagement is characterised by client and provider interactions that create value for all parties as a co-productive relationship.*

### 21\* Adherence with medication while with EIP service

|  |    |
|--|----|
| No adherence with medication                                   | 0  |
| Minimal adherence with medication                              | 1  |
| Some adherence with medication occasional refusal/'forgetting' | 2  |
| Moderate adherence with medication                             | 3  |
| Excellent adherence with medication                            | 4  |
| No medication  | 9  |
| Unknown  | 99 |

### 22\* EIP Service Engagement with Family:

Rate the EIP Service's ability to engage with family/whānau/'significant others' in relation to the client's recovery; engagement is defined as "ability to engage with family/whānau/'significant others' to participate in client's recovery as appropriate".

|   |   |
|---|---|
| No engagement with family/whānau/'significant others'           | 0 |
| Minimal engagement with family/whānau/'significant others'      | 1 |
| Some engagement with family/whānau/'significant others'         | 2 |
| Moderate engagement with family/whānau/'significant others'     | 3 |
| Excellent engagement with family/whānau/'significant others'    | 4 |
| No family/whānau/'significant others' available (overseas etc.) | 9 |

### 23\* Mental health act

Was the client under the MHA at any point in their time while under the care of the EIP service?: yes \_\_\_ no \_\_\_ *[do not include time prior to referral, which is covered in baseline assessment]*

# PANSS

## POSITIVE SCALE (P)

### **P1 Delusions**

Beliefs which are unfounded, unrealistic, and idiosyncratic. Basis for rating: Thought content expressed in the interview and its influence on social relations and behaviour.

### **P2 Conceptual disorganisation**

Disorganised process of thinking characterised by disruption of goal-directed sequencing, e.g., circumstantiality, tangentiality, loose associations, non-sequiturs, gross illogicality, or thought block. Basis for rating: Cognitive-verbal processes observed during the course of interview.

### **P3 Hallucinatory behaviour**

Verbal report or behaviour indicating perceptions which are not generated by external stimuli. These may occur in the auditory, visual, olfactory, or somatic realms. Basis for rating: Verbal report and physical manifestations during the course of interview as well as reports of behaviour by primary care workers or family.

### **P4 Excitement**

Hyperactivity as reflected in accelerated motor behaviour, heightened responsiveness to stimuli, hypervigilance, or excessive mood lability. Basis for rating: behavioural manifestations during the course of interview as well as reports of behaviour by primary care workers or family.

### **P5 Grandiosity**

Exaggerated self-opinion and unrealistic convictions of superiority, including delusions of extraordinary abilities, wealth, knowledge, fame, power, and moral righteousness. Basis for rating: Thought content expressed in the interview and its influence on behaviour.

### **P6 Suspiciousness/persecution**

Unrealistic and exaggerated ideas of persecution, as reflected in guardedness, a distrustful attitude, suspicious hyper-vigilance, or frank delusions that others mean one harm. Basis for rating: Thought content expressed in the interview and its influence on behaviour.

### **P7 Hostility**

Verbal and nonverbal expressions of anger and resentment, including sarcasm, passive-aggressive behaviour, verbal abuse, and assaultiveness. Basis for rating: Interpersonal behaviour observed during the interview and reports by primary care workers or family.

## NEGATIVE SCALE (N)

### **N1 Blunted affect**

Diminished emotional responsiveness as characterised by a reduction in facial expression, modulation of feelings, and communicative gestures. Basis for rating: Observation of physical manifestations of affective tone and emotional responsiveness during the course of interview.

### **N2 Emotional withdrawal**

Lack of interest in, involvement with, and affective commitment to life's events. Basis for rating: Reports of functioning from primary care workers or family and observation of interpersonal behaviour during the course of interview.

### **N3 Poor rapport**

Lack of interpersonal empathy, openness in conversation, and sense of closeness, interest, or involvement with the interviewer. This is evidenced by interpersonal distancing and reduced verbal and nonverbal communication. Basis for rating: Interpersonal behaviour during the course of interview.

**N4 Passive/apathetic social withdrawal**

Diminished interest and initiative in social interactions due to passivity, apathy, anergy, or avolition. This leads to reduced interpersonal involvements and neglect of daily activities.

**N5 Difficulty in abstract thinking**

Impairment in the use of the abstract-symbolic mode of thinking, as evidenced by difficulty in classification, forming generalisations, and proceeding beyond concrete or egocentric thinking in problem-solving tasks. Basis for rating: Responses to questions on similarities and proverb interpretation, and use of concrete vs. abstract mode during the course of interview.

**N6 Lack of spontaneity and flow of conversation**

Reduction in the normal flow of communication associated with apathy, avolition, defensiveness, or cognitive deficit. This is manifested by diminished fluidity and productivity of the verbal-interactive process. Basis for rating: Cognitive-verbal processes observed during the course of interview.

**N7 Stereotyped thinking**

Decreased fluidity, spontaneity, and flexibility of thinking, as evidenced in rigid, repetitious, or barren thought content. Basis for rating: Cognitive-verbal processes during the course of interview.

**GENERAL PSYCHOPATHOLOGY SCALE (G)****G1 Somatic concern**

Physical complaints or beliefs about bodily illness or malfunctions. This may range from a vague sense of ill being to clear-cut delusions of catastrophic physical disease. Basis for rating: Thought content expressed in the interview.

**G2 Anxiety**

Subjective experience of nervousness, worry, apprehension, or restlessness, ranging from excessive concern about the present or future to feelings of panic. Basis for rating: Verbal report during the course of interview and corresponding physical manifestations.

**G3 Guilt feelings**

Sense of remorse or self-blame for real or imagined misdeeds in the past. Basis for rating: Verbal report of guilt feelings during the course of interview and the influence on attitudes and thoughts.

**G4 Tension**

Overt physical manifestations of fear, anxiety, and agitation, such as stiffness, tremor, profuse sweating, and restlessness. Basis for rating: Verbal report attesting to anxiety and, thereupon, the severity of physical manifestations of tension observed during the interview.

**G5 Mannerisms and posturing**

Unnatural movements or posture as characterised by an awkward, stilted, disorganised, or bizarre appearance. Basis for rating: Observation of physical manifestations during the course of interview as well as reports from primary care workers or family.

**G6 Depression**

Feelings of sadness, discouragement, helplessness, and pessimism. Basis for rating: Verbal report of depressed mood during the course of interview and its observed influence on attitude and behaviour.

**G7 Motor retardation**

Reduction in motor activity as reflected in slowing or lessening of movements and speech, diminished responsiveness to stimuli, and reduced body tone. Basis for rating: manifestations during the course of interview as well as reports by primary care workers or family.

**G8 Uncooperativeness**

Active refusal to comply with the will of significant others, including the interviewer, hospital staff, or family, which may be associated with distrust, defensiveness, stubbornness, negativism, rejection of authority, hostility, or belligerence. Basis for rating: Interpersonal behaviour observed during the course of interview as well as reports by primary care workers or family.

**G9 Unusual thought content**

Thinking characterised by strange, fantastic, or bizarre ideas, ranging from those that are remote or atypical to those which are distorted, illogical, and patently absurd. Basis for rating: Thought content expressed during the course of interview.

**G10 Disorientation**

Lack of awareness of one's relationship to the milieu, including persons, place, and time, which may be due to confusion or withdrawal. Basis for rating: Responses to interview questions on orientation.

**G11 Poor attention**

Failure in focused alertness manifested by poor concentration, distractibility from internal and external stimuli, and difficulty in harnessing, sustaining, or shifting focus to new stimuli. Basis for rating: Manifestations during the course of interview.

**G12 Lack of judgment and insight**

Impaired awareness or understanding of one's own psychiatric condition and life situation. This is evidenced by failure to recognise past or present psychiatric illness or symptoms, denial of need for psychiatric hospitalisation or treatment, decisions characterised by poor anticipation of consequences, and unrealistic short-term and long-range planning. Basis for rating: Thought content expressed during the interview.

**G13 Disturbance of volition**

Disturbance in the willful initiation, sustenance, and control of one's thoughts, behaviour, movements, and speech. Basis for rating: thought content and behaviour manifested in the course of interview.

**G14 Poor impulse control**

Disordered regulation and control of action on inner urges, resulting in sudden, unmodulated, arbitrary, or misdirected discharge of tension and emotions without concern about consequences. Basis for rating: behaviour during the course of interview and reported by primary care workers or family.

**G15 Preoccupation**

Absorption with internally generated thoughts and feelings and with autistic experiences to the detriment of reality orientation and adaptive behaviour. Basis for rating: Interpersonal behaviour observed during the course of interview.

**G16 Active social avoidance**

Diminished social involvement associated with unwarranted fear, hostility, or distrust. Basis for rating: Reports of social functioning by primary care workers or family.

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# PANSS

## Symptom Assessment: PANSS

**Instructions:** Refer to rating criteria for item definitions and descriptions of anchoring points. Enter your rating from 1 to 7 for each item of the subscales listed below. **Note that PANSS needs to be completed by week 2 after Early Intervention for Psychosis Service takes clinical responsibility for client. This means that PANSS is not completed on clients who are inpatients until Early Intervention for Psychosis Service takes clinical responsibility.**

### Severity Rating Key

- 1= absent
- 2= minimal
- 3= mild
- 4= moderate
- 5= moderately severe
- 6= severe
- 7= extreme

### POSITIVE SUBSCALE

- P1 Delusions \_\_\_\_\_
- P2 Conceptual Disorganisation \_\_\_\_\_
- P3 Hallucinatory Behaviour \_\_\_\_\_
- P4 Excitement \_\_\_\_\_
- P5 Grandiosity \_\_\_\_\_
- P6 Suspiciousness/persecution \_\_\_\_\_
- P7 Hostility \_\_\_\_\_

### NEGATIVE SUBSCALE

- N1 Blunted affect \_\_\_\_\_
- N2 Emotional withdrawal \_\_\_\_\_
- N3 Poor rapport \_\_\_\_\_
- N4 Passive/apathetic social withdrawal \_\_\_\_\_
- N5 Difficulty in abstract thinking \_\_\_\_\_
- N6 Lack of spontaneity and flow of conversation \_\_\_\_\_
- N7 Stereotyped thinking \_\_\_\_\_

### GENERAL PSYCHOPATHOLOGY SUBSCALE

- G1 Somatic concern \_\_\_\_\_
- G2 Anxiety \_\_\_\_\_
- G3 Guilt feeling \_\_\_\_\_
- G4 Tension \_\_\_\_\_
- G5 Mannerism and posturing \_\_\_\_\_
- G6 Depression \_\_\_\_\_
- G7 Motor retardation \_\_\_\_\_
- G8 Uncooperativeness \_\_\_\_\_
- G9 Unusual thought content \_\_\_\_\_
- G10 Disorientation \_\_\_\_\_
- G11 Poor attention \_\_\_\_\_
- G12 Lack of judgement and insight \_\_\_\_\_
- G13 Disturbance of volition \_\_\_\_\_
- G14 Poor impulse control \_\_\_\_\_
- G15 Preoccupation \_\_\_\_\_
- G16 Active social aviodance \_\_\_\_\_

Psychosocial functioning of young people who are experiencing early psychosis can be significantly impaired. The level of psychosocial functioning in young people with early psychosis is a potential predictor of health outcome. In order to evaluate psychosocial functioning, 3 measures are used: The HoNOS, the Global Assessment of Functioning Scale and the Role Functioning Scale.

## HoNOS Chart

*Enter the severity rating for each item in the corresponding item box to the right of the item. Rate a 9 if Not Known or Not Applicable.*

|   |   |   |   |   |   |                      |
|---|---|---|---|---|---|----------------------|
| 1. Overactive, aggressive, disruptive         | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| 2. Non-accidental self-injury                 | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| 3. Problem Drinking or drug taking            | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| 4. Cognitive problems                         | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| 5. Physical illness or disability problems    | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| 6. Problems with hallucinations and delusions | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| 7. Problems with depressed mood.              | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| 8. Other mental and behavioural problems      | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| Specify _____                                 |   |   |   |   |   |                      |
| 9. Problems with relationships                | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| 10. Problems with activities of daily living  | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| 11. Problems with living conditions           | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| 12. Problems with occupation and activities   | 0 | 1 | 2 | 3 | 4 | <input type="text"/> |
| Total   |   |   |   |   |   | <input type="text"/> |

## Depression: CDSS **optional**

**Interviewer: Ask the first questions as written. Use follow up probes or qualifiers at your discretion. Time frame refers to last two weeks unless stipulated.**

**N.B. The last item, #9 is based on observations of the entire interview.**

**1. Depression: How would you describe your mood over the last two weeks? Do you keep reasonably cheerful or have you been very depressed or low spirited recently? In the last two weeks, how often have you (own words) every day? All day?**

- 0. Absent
- 1. Mild Expresses some sadness or discouragement on questioning
- 2. Moderate Distinct depressed mood persisting up to half the time over last two weeks: present daily.
- 3. Severe Markedly depressed mood persisting daily over half the time interfering with normal motor and social functioning.

**2. Hopelessness: 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 last two weeks, but still has some degree of hope for the future.
- 2. Moderate Persistent, moderate sense of hopelessness over last two weeks. Can be persuaded to acknowledge possibility of things being better.
- 3. Severe Persisting and distressing sense of hopelessness.

**3. Self Depreciation: What is your opinion of yourself compared to other people? Do you feel better, not as good or about the same as others? Do you feel inferior or even worthless?**

- 0. Absent
- 1. Mild Some inferiority; not amounting to feeling of worthlessness.
- 2. Moderate Subject feels worthless, but less than 50% of the time.
- 3. Severe Subject feels worthless more than 50% of the time. May be challenged to acknowledge otherwise.

**4. Guilty Ideas of Reference: Do you have the feeling that you are being blamed for something or even wrongly accused? What about? (Do not include justifiable blame or accusations. Exclude delusions of guilt)**

- 0. Absent
- 1. Mild Subject feels blamed but not accused less than 50% of the time.
- 2. Moderate Persisting sense of being blamed, and/or occasional sense of being accused.
- 3. Severe Persistent sense of being accused. When challenged, acknowledges that it is not so.

**5. Pathological Guilt: Do you tend to blame yourself for little things you may have done in the past? Do you think that you deserve to be so concerned about this?**

- 0. Absent
- 1. Mild Subject sometimes feels over guilty about some minor peccadillo, but less than 50% of the time.
- 2. Moderate Subject usually (over 50% of the time) feels guilty about past actions the significance of which he exaggerates.
- 3. Severe Subject usually feels s/he is to blame for everything that has gone wrong, even when not his/her fault.

**6. Morning Depression: When you have felt depressed over the last two weeks have you noticed the depression being worse at any particular time of day?**

- 0. Absent No Depression.
- 1. Mild Depression present but no diurnal variation.
- 2. Moderate Depression spontaneously mentioned to be worse in a.m.
- 3. Severe Depression markedly worse in a.m., with impaired functioning, which improves in p.m.

**7. Early Wakening: Do you wake earlier in the morning than is normal for your? How many times a week does this happen?**

- 0. Absent No early wakening.
- 1. Mild Occasionally wakes (up to twice weekly) 1 hour or more before normal time to wake or alarm time.
- 2. Moderate Often wakes early (up to 5 times weekly) 1 hour or more before normal time to wake or alarm.
- 3. Severe Daily wakes 1 hour or more before normal time.

**8. Suicide: Have you felt that life wasn't worth living? Did you ever feel like ending it all? What did you think you might do? Did you actually try?**

- 0. Absent
- 1. Mild Frequent thoughts of being better off dead, or occasional thoughts of suicide.
- 2. Moderate Deliberately considered suicide with a plan, but made no attempt.
- 3. Severe Suicidal attempt apparently designed to end in death (i.e.: accidental discover or inefficient means).

**9. Observed Depression: Based on interviewer's observations during the entire interview? The question "Do you feel like crying?" used at appropriate points in the interview, may elicit information useful to this observation.**

- 0. Absent
- 1. Mild Subject appears sad and mournful even during parts of the interview involving effectively neutral discussion.
- 2. Moderate Subject appears sad and mournful throughout the interview, with gloomy monotonous voice and is tearful or close to tears at times.
- 3. Severe Subject chokes on distressing topics, frequently sighs deeply and cries openly, or is persistently in a state of frozen misery if examiner is sure that this is present.

## Global Assessment of Functioning Scale.

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

**Code** (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.)

|     |  |
|-----|--|
| 100 | <b>Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.</b>  |
| 91  |  |
| 90  | <b>Absent or minimal symptoms</b> (e.g., mild anxiety before an exam), <b>good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns</b> (e.g., an occasional argument with family members).  |
| 81  |  |
| 80  | <b>If symptoms are present, they are transient and expectable reactions to psychosocial stressors</b> (e.g., difficulty concentrating after family argument); <b>no more than slight impairment in social, occupational, or school functioning</b> (e.g., temporarily falling behind in schoolwork).   |
| 71  |  |
| 70  | <b>Some mild symptoms</b> (e.g., depressed mood and mild insomnia) <b>OR some difficulty in social, occupational, or school functioning</b> (e.g., occasional truancy, or theft within the household), <b>but generally functioning pretty well, has some meaningful interpersonal relationships.</b>  |
| 61  |  |
| 60  | <b>Moderate symptoms</b> (e.g., flat affect and circumstantial speech, occasional panic attacks) <b>OR moderate difficulty in social, occupational, or school functioning</b> (e.g., few friends, conflicts with peers or co-workers).   |
| 51  |  |
| 50  | <b>Serious symptoms</b> (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) <b>OR any serious impairment in social, occupational, or school functioning</b> (e.g., no friends, unable to keep a job).  |
| 41  |  |
| 40  | <b>Some impairment in reality testing or communication</b> (e.g., speech is at times illogical, obscure, or irrelevant) <b>OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood</b> (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school). |
| 31  |  |
| 30  | <b>Behavior is considerably influenced by delusions or hallucinations OR serious impairment, in communication or judgment</b> (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) <b>OR inability to function in almost all areas</b> (e.g., stays in bed all day, no job, home, or friends)  |
| 21  |  |
| 20  | <b>Some danger of hurting self or others</b> (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) <b>OR occasionally fails to maintain minimal personal hygiene</b> (e.g., smears feces) <b>OR gross impairment in communication</b> (e.g., largely incoherent or mute).  |
| 11  |  |
| 10  | <b>Persistent danger of severely hurting self or others</b> (e.g., recurrent violence) <b>OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.</b>  |
| 1   |  |
| 0   | Inadequate information.  |

## ***The Role Functioning Scale***

### **Instructions**

Rate global items immediately after the interview. Use all available information supplied by client as well as information that may not have been specifically relevant to the individual items. **Rate rapidly on general impressions.** Include non-specific aspects of the client's behaviour in the interview situation – non-verbal cues, suspected denial, insight deficiency, etc. In making judgements, compare client to community norms and standards, not to what you may know of his/her earlier adjustments or to other clients. Rate the client for their role functioning over the PAST MONTH.

### **Working productivity (rate based on primary role performance)**

1. Productivity severely limited; minimal role performance (i.e. diminished adequacy, evidence of avoidance/friction, distress); minimal to nil leisure activities; either has no desire for work or only vague/unrealistic plans for future productivity (school, work, etc); virtually no skills or attempts to be productive.
2. Occasional attempts at productivity are unsuccessful; makes sporadic attempts to work, perform chores but with diminished adequacy; unable to discipline self to regular schedule; productive only under constant supervision with evidence of friction/ avoidance.
3. Limited productivity; carries out role in sheltered setting with minimal adequacy, friction/avoidance; may have one leisure activity and participate on sporadic basis; requires highly structured routine to maintain this level of functioning.
4. Marginal productivity; moderate adequacy in sheltered setting, minimal adequacy and/or some friction/ avoidance in independent role performance; performance fluctuates; may occasionally participate in leisure activities.
5. Moderately functioning in independent role performance; regularly participates in at least one leisure activity; role performance fluctuates with extended periods of success.
6. Adequate functioning in independent role performance; often not applying all available skills/abilities.
7. Functions optimally in independent role performance; carries out related tasks with ease and efficiency.

### **Independent living/self care (management of household, eating/ sleeping/ hygiene care)**

1. Lacking self care skills approaching life-endangering threat; presently in hospital or with recent multiple/ lengthy hospitalizations; conserved; mediocre to poor personal hygiene/grooming; no spontaneous attempts at self-care/independent living.
2. Marked limitations in self-care/independent living; needs constant supervision or significant case management to maintain tenuous community board and care placement; conserved and/or has rep payee; unreliable to consistently manage self-care; fair personal hygiene/ grooming: utilizes crisis services.
3. Limited self-care/independent living skills; needs some case management to maintain stable community placement; makes independent efforts to carry out personal hygiene/grooming tasks: requires some structured financial management; limited participation in managing household; no crisis contacts.
4. Marginally self-sufficient; needs routine assistance to maintain independent functioning; independently manages finances; consistently manages some aspects of household; adequate personal care.
5. Moderately self-sufficient; lives independently; reliably manages most aspects of household; consistent good personal care.
6. Adequate self care and independent living skills; requires only minimal assistance from friends, neighbours, and other helping persons.
7. Optimal care of health; independently manages household tasks and personal needs.

### **Immediate social network relationships (close friends, spouse, family)**

1. Severely deviant behaviours within immediate social network; frequently needs restraints or has recent history of assaultive/severely withdrawn behaviour, overtly dysfunctional or enmeshed communication and behaviour patterns with immediate contacts; few or nil close associations; often rejected by immediate network.
2. Markedly limited interpersonal relationships; significant animosity and/or ambivalence toward immediate relations; close contacts are dysfunctional, destructive and/or excessively dependent; minimal associations other than with family.
3. Limited interpersonally; indifferent or ambivalent toward close associations; minimal contacts with friends/family; often no significant communication/participation with immediate network.
4. Marginal functioning within immediate network; limited numbers of close associations; relationships fluctuate in quality, degree of communication/participation.
5. Moderately affective continuing and close relationship with at least one other person.
6. Adequate relationship with one or more immediate members of social network (e.g. friend or family).
7. Positive relationships with spouse or family and friends; assertively contributes to these relationships.

**Extended social network relationships (neighbourhood, community, clubs, agencies, organizations)**

1. Severely deviant behaviours within extended network; exhibits intrusive, bizarre and/or disruptive behaviours which cause inability to function within the community; may be significantly paranoid and/or engaging in markedly socially inappropriate behaviour (i.e. hoarding, eating from garbage cans); often rejected by extended networks.
2. Often totally isolated from extended networks; prefers isolated activities and/or experiences marked discomfort in social situations; moderately paranoid or withdrawn; involves self only under duress with socialization opportunities.
3. Limited range of successful and appropriate extended network interactions: some social discomfort; few spontaneous social interactions; often restricts community involvement to minimal survival level contacts.
4. Marginally effective and appropriate interactions within structured community settings: minimal social discomfort; accepts multiple public services supports in accord with multiple needs.
5. Moderately effective and independent functioning within the community; seeks and receives some public services support in accord with need.
6. Adequately interacts within neighbourhood or community; connected with at least one club or organization.
7. Positively interacts within at least one community club or organization; offers assistance to others in extended network.

## Role Functioning Scale

Rate the client for their role functioning over the PAST MONTH.

|   | <b>Working Productivity</b><br><i>(Rate the client primarily in the most expected role (ie., homemaker, student, wage earner))</i>   | <b>Independent Living, Self Care</b><br><i>(Management of household, eating, sleeping hygiene care)</i>  | <b>Immediate Social Network Relationships</b><br><i>(Close friend, Spouse, family)</i>  | <b>Extended Social Network Relationships</b><br><i>(Neighbourhood, community church, clubs, agencies, recreational activities)</i>  |
|---|--|--|---|---|
| 1 | Productivity severely limited; often unable to work or adapt to school or homemaking; virtually no skills or attempts to be productive   | Lacking self-care skills approaching life endangering threat; often involves multiple and lengthy hospital services; not physically able to participate in running a household | Severely deviant behaviours within immediate social networks (i.e., often with imminent physical aggression or abuse to others or severely withdrawn from close friends, spouse, family; often rejected by immediate social network | Severely deviant behaviours within extended social network (i.e., overtly disruptive, often leading to rejection by extended social networks)                             |
| 2 | Occasional attempts at productivity unsuccessfully; productive only with constant supervision in sheltered work, home or special classes                                       | Marked limitations in self-care/independent living; often involving constant supervision in or out of protective environment (e.g. frequent utilisation of crisis services)    | Marked limitations in immediate interpersonal relationships (e.g., excessive dependency or destructive communication or behaviour)  | Often totally isolated from extended social networks, refusing community involvement or belligerent to helpers, neighbours etc.)  |
| 3 | Limited productivity; often with restricted skills/abilities for homemaking, school, independent employment (e.g. requires highly structured routine)                          | Limited self-care/independent living skills; often relying on mental/physical health care; limited participation in running household  | Limited interpersonally; often no significant participation/communication with immediate social network   | Limited range of successful and appropriate interactions in extended social networks (i.e., often restricts community involvement to minimal survival level interactions) |
| 4 | Marginal productivity; (e.g. productive in sheltered work or minimally productive in independent work; fluctuates at home, in school; frequent job changes)                    | Marginally self-sufficient; often uses REGULAR assistance to maintain self-care/independent functioning; minimally participates in running household                           | Marginal functioning with immediate social network (i.e., relationships are often minimal and fluctuate in quality)   | Marginally effective interactions; often in a structured environment; may receive multiple public system supports in accordance with multiple needs                       |
| 5 | Moderately functional in independent employment, at home or in school. (Consider very spotty work history or fluctuations in home, in school with extended periods of success) | Moderately self-sufficient; i.e., living independently with ROUTINE assistance (e.g., home visits by nurses, other helping persons, in private or self-help residences)        | Moderately effective continuing and close relationship with at least one other person   | Moderately effective and independent in community interactions; may receive some public support in accord with need   |
| 6 | Adequate functioning in independent employment, home or school; often not applying all available skills/abilities  | Adequate independent living and self-care with MINIMAL support (e.g., some transportation, shopping assistance from neighbours, friends, other helping person)                 | Adequate personal relationship with one or more immediate members of social network (e.g., friend or family)  | Adequately interacts in neighbourhood or with at least one community or other organisation or recreational activity   |
| 7 | Optimally performs homemaking, school tasks, or employment related functions with ease and efficiency  | Optimal care of health/hygiene; independently manages to meet personal needs and household tasks   | Positive relationships with spouse or family and friends; assertively contributes to these relationships  | Positively interacts in community; church or clubs, recreational activities, hobbies or personal interests, often with other participants                                 |

**Score**