The PAS-ADD assessments

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The PAS-ADD assessments

• The PAS-ADD Checklist (Revised).
  • Designed for use primarily by care staff and families. The Checklist aims to help staff and carers make more informed referral decisions in relation to the behaviours they have observed.

• The Mini PAS-ADD Interview
  • Designed to enable a wide range of professionals working with adults who have ID to conduct in-depth reliable assessments of mental health symptoms through informant interviewing. It uses a glossary of symptom definitions to guide the coding. The Mini PAS-ADD Interview can be used by staff who do not have a background in psychiatry or psychology. However, all users should receive appropriate training.
The PAS-ADD assessments /cont.

• The ChA-PAS
  • The Child and Adolescent Psychiatric Assessment Schedule was developed was designed specifically for younger people, using the same model as the Mini PAS-ADD. In addition to the core psychiatric disorders included in the Mini PAS-ADD, the ChA-PAS covers two major behavioural disorders, ADHD and Conduct Disorder.

• The PAS-ADD Clinical Interview
  • The most recent development in the PAS-ADD series. It is the most comprehensive of the assessments, and is designed to produce full diagnoses under both ICD 10 and DSM V. It has two sets of questions, one for the person themselves, the other for an informant. The final part of the score form provides a framework for collating clinical data from other sources to aid the process of comprehensive case formulation.
Possible causative factors for mental illness

- Brain function, structure and neurology
- Beliefs, expectancies, plans and values affecting one’s emotional state
- Psychodynamic factors, e.g. early attachment problems
- Environmental/ecological factors

Individual professionals often have strong views about the relative importance of these factors
Psychiatric disorders tend to have characteristic patterns of symptoms.

Identifying the particular pattern exhibited by an individual is a central part of making a diagnosis.

Major classes of psychiatric disorder include:
- Depression
- Manic-depression
- Anxiety disorders
- Psychoses
- Mental health problems arising because of damage to the brain or nervous system

Many mental health problems can start at any time in the person’s life. However, some disorders such as Autism usually arise in childhood. Others, such as Dementia, are usually associated with later life.
Psychiatric assessment looks for patterns of symptoms

- Low mood
- Social withdrawal
- Loss of interest
- Guilt
- Loss of energy
- Exhaustion
- Hopelessness
- Loss of sex drive

DEPRESSION

A diagnosis reduces the potential treatments to choose from:
- Anti-depressants;
- Counselling;
- Cognitive therapy;
- Psychodynamic psychotherapy
Validity and utility of psychiatric diagnoses

“It is important to distinguish between validity and utility in considering psychiatric diagnoses. Diagnostic categories defined by their syndromes should be regarded as valid only if they have been shown to be discrete entities with natural boundaries that separate them from other disorders.

Although most diagnostic concepts have not been shown to be valid in this sense, many possess high utility by virtue of the information about outcome, treatment response, and etiology that they convey. They are therefore invaluable working concepts for clinicians.”

### Indicators of psychiatric disorders

<table>
<thead>
<tr>
<th>Self care skills</th>
<th>Social behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory</td>
<td>Sexuality</td>
</tr>
<tr>
<td>Biological functions: sleep, feeding, bowels, bladder</td>
<td>Perceptions of others, objects and environments</td>
</tr>
<tr>
<td>Activity, energy and movements</td>
<td>Insight</td>
</tr>
<tr>
<td>Attention and concentration</td>
<td>Self esteem</td>
</tr>
<tr>
<td>Speech</td>
<td>Challenging behaviours</td>
</tr>
<tr>
<td>Mood (Depressed or elated)</td>
<td></td>
</tr>
</tbody>
</table>
The advantages of structuring clinical interviewing

Using normal clinical procedures, diagnostic agreement between clinicians is typically low, even in relation to patients in the general population. "Reason for referral" is the single most influential factor in determining final diagnosis.

Although a diagnostic interview may frequently last an hour or more, conclusions are very often reached in the opening few minutes of the session.

E.g. Termelin (1968) demonstrated the influence of spurious initial bias or "set" on the subsequent diagnosis of experienced clinicians. One group was allowed to "overhear" a comment from a high prestige figure,
Is psychiatric assessment still unreliable?

In 2007 Aboraya reported on the effects of having introduced the DSM system 26 years previously. He reported:

“The DSM did improve the reliability of psychiatric diagnoses at the research level. If a researcher or a clinician can afford to spend 2 to 3 hours per patient using the DSM criteria and a structured interview or a rating scale, the reliability would improve. For psychiatrists and clinicians, who live in a world without hours to spare, the reliability of psychiatric diagnoses is still poor.

Even Spitzer and Frances, the directors of DSM-III and DSM-IV Task Force, admitted that the desired reliability among the practicing clinicians has not been obtained’

Psychiatric assessment looks for patterns of symptoms

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DEPRESSION
ICD 10 Criteria for Mild depressive episode

A. The general criteria for depressive episode (F32) must be met.

B. At least two of the following three symptoms must be present:

(1) depressed mood sustained for at least 2 weeks,
(2) loss of interest or pleasure in activities that are normally pleasurable;
(3) decreased energy or increased fatiguability.

C. An additional symptom or symptoms from the following list should be present, to give a total of at least four:-

(1) loss of confidence or self-esteem;
(2) unreasonable feelings of self-reproach or excessive and inappropriate guilt;
(3) recurrent thoughts of death or suicide, or any suicidal behaviour;
(4) complaints or evidence of diminished ability to think or concentrate
(5) change in psychomotor activity, with agitation or retardation
(6) sleep disturbance of any type;
The four-point rating scale

1 Symptom not present

2 Present to a mild degree

3 Present to a moderate degree, or severe for less than half the rating period

4 Severe for more than half the rating period
4. Rate avoidance of anxiety-provoking circumstances (or endurance with increased anxiety)

- Evidence of reluctance, but [P] can usually be persuaded to go, and can usually cope with any resulting anxiety.

- If given the choice, [P] would probably avoid confronting the circumstances on most occasions. If required to be there, [P’s] anxiety markedly increases.

- Extreme avoidance. If given the choice, [P] would never face the circumstances. If required to be there, severe anxiety usually occurs.
PAS-ADD Clinical Interview rating criteria: suicidal thoughts

17. Rate recurrent thoughts of death or suicide, or any suicidal attempts

☐ Occasional thoughts of death, but most of the time [P] does not have these thoughts. No suicidal thoughts have been expressed.

☐ Either:
  a) strong thoughts of death are often present; or
  b) [P] talked about committing suicide.

☐ Either:
  a) strong thoughts of death or suicide are a constant preoccupation; or
  b) [P] made an attempt at suicide that may have been designed to result in injury or death, or that actually resulted in injury.
Level of challenging behaviour in relation to psychiatric symptom score

Mean PAS-ADD

- none
- less severe
- more severe

Values:
- more severe: 3.0
- less severe: 2.0
- none: 1.0
Percentages of individuals meeting defined diagnostic criteria, in relation to level of challenging behaviour

<table>
<thead>
<tr>
<th>Disorder category</th>
<th>Level of challenging behaviour</th>
<th>Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None (N=86)</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>7.1</td>
<td>9.1</td>
</tr>
<tr>
<td>Depression***</td>
<td>8.3</td>
<td>15.4</td>
</tr>
<tr>
<td>Hypomania*</td>
<td>2.4</td>
<td>5.0</td>
</tr>
<tr>
<td>Psychosis</td>
<td>7.5</td>
<td>9.2</td>
</tr>
<tr>
<td>At least 1 of the 3 categories***</td>
<td>16.3</td>
<td>26.7</td>
</tr>
</tbody>
</table>

|                   | Less demanding (N=148)          |                  |
| Anxiety           | 8.1                             |                   |
| Depression***     | 11.5                            |                   |
| Hypomania*        | 3.4                             |                   |
| Psychosis         | 7.4                             |                   |
| At least 1 of the 3 categories*** | 22.3 |                   |

|                   | More demanding (N=86)           |                  |
| Anxiety           | 12.6                            |                   |
| Depression***     | 28.7                            |                   |
| Hypomania*        | 10.3                            |                   |
| Psychosis         | 13.8                            |                   |
| At least 1 of the 3 categories*** | 43.7 |                   |

*** (P < .001, chi-square); * (P < .05, chi-square)
Possible Forms of Relationship between psychiatric symptoms and challenging behaviours

Challenging behaviour may be the atypical presentation of certain psychiatric disorders in people with severe intellectual disabilities.

Challenging behaviour may be a secondary feature of psychiatric disorders among people with severe intellectual disabilities.

Psychiatric disorders may establish a motivational basis for the expression of challenging behaviours maintained by (operant) behavioural processes.
Complex case formulation

Bullying, fighting
Truanting

Low mood
Loss of self-esteem

Ecological factors?
Abuse
Lack of love
Conflict at home
Poor role models
Lack of boundaries
“In with the wrong crowd”

Hyperactivity
Lack of attention
Recklessness

ADHD?
Bipolar?

Depression?
Behavioural problems: Behavioural assessment

Bullying, Fighting, Fire setting
Physical cruelty, Robbing
Stealing, Uses a weapon

Abuse
Lack of love
Conflict at home
Poor role models
Lack of boundaries
“In with the wrong crowd”
Poor match between school and ability
History of inappropriate reinforcement
Lack of goals or opportunities for fulfilment
Bronfenbrenner’s ecological model
Mental health in the balance

RESOURCES

DEMANDS
Complex case formulation

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Truanting

Low mood
Loss of self-esteem

Depression?

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ADHD?
Bipolar?

Ecological factors?

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Behavioural problems: Behavioural assessment

**Bullying, Fighting, Fire setting**
**Physical cruelty, Robbing**
**Stealing, Uses a weapon**

- Abuse
- Lack of love
- Conflict at home
- Poor role models
- Lack of boundaries
- “In with the wrong crowd”
- Poor match between school and ability
- History of inappropriate reinforcement
- Lack of goals or opportunities for fulfilment
CONDUCT DISORDER

Behavioural problems: psychiatric assessment

- Bullying
- Physical cruelty
- Fire setting
- Robbing
- Stealing
- Uses a weapon
Worry about being abandoned
Chaotic relationships
Impulsiveness
Self harm
Splitting
Anger

Abuse
Lack of love
Conflict at home
Lack of boundaries
In with the wrong crowd
History of inappropriate reinforcement
Lack of goals or opportunities for self esteem
Borderline personality disorder

Worry about being abandoned
Chaotic relationships
Impulsiveness
Self harm
Splitting
Anger
Definitions of psychotic disorders

The term psychotic has historically received a number of different definitions, none of which has achieved universal acceptance.

**Narrowest definition:** Diagnosed only if there are delusions or prominent hallucinations, with absence of insight into their pathological nature.

**Slightly less restrictive definition:** delusions or prominent hallucinations, but individual realizes are hallucinatory experiences

**Wider definition:** Other positive symptoms may be the basis for diagnosis. These include disorganized speech, grossly disorganized or catatonic behaviour

**Widest definition:** Negative symptoms such as blunted affect can be part of the diagnostic criteria

An over-emphasis on negative symptoms and disordered language has probably contributed in earlier studies to an over-diagnosis of schizophrenia in people with ID.
ICD 10 Criteria for Schizophrenia

(1) At least one of the following must be present:

(a) thought echo, thought insertion or withdrawal, or thought broadcasting;

(b) delusions of control, influence, or passivity

(c) hallucinatory voices giving a running commentary, or coming from some part of the body;

(d) persistent delusions of other kinds that are culturally inappropriate and completely impossible

(2) Or at least two of the following:

(a) persistent hallucinations in any modality, when occurring every day for at least 1 month

(b) neologisms, breaks, or interpolations in the train of thought, resulting in incoherence or irrelevant speech;

(c) catatonic behaviour

(d) negative" symptoms, such as apathy, paucity of speech, and blunting or incongruity of emotional responses
Obsessive-Compulsive Disorder (OCD)

Usually begins in adolescence or young adulthood

We often talk of *obsessions when we really mean compulsions*

Obsessions are recurrent and persistent thoughts, impulses, or images that are unwanted and cause marked anxiety or distress. Frequently, they are unrealistic or irrational. They are not simply excessive worries about real-life problems or preoccupations.

Compulsions are repetitive behaviours or rituals (like hand washing, hoarding, keeping things in order, checking something over and over) or mental acts (like counting, repeating words silently, avoiding).
Problems of assessing OCD in people with ID

OCD is an anxiety disorder. The anxieties cause the person to engage in compulsive behaviours to attempt to allay the anxiety. The person:

(a) knows it is irrational and finds it unpleasant

(b) tries to resist doing it

Both of these can be very difficult to establish in someone with ID.

In addition, many people with ID show repetitive behaviours which may not be primarily to alleviate anxiety. How should we rate these?

Obsessional thoughts can rarely be identified unless the person has a relatively high level of language and development.
Conduct disorder

The essential feature of Conduct Disorder is a repetitive and persistent pattern of behaviour which violates the basic rights of others, or breaks major age-appropriate societal norms or rules.

Included in the DSM IV criteria are behaviours that are grouped into four major categories:

a) aggressive conduct;
b) Threat of, and actual physical harm to other people or animals;
c) deceitfulness or theft;
d) serious violations of rules.
Problems of applying these criteria to people with ID

1. People with ID may not understand the consequences of their actions

2. There is an implied assumption that the person understands the importance of rules, the basic rights of others and appropriate social norms, which is often not true for people with ID

3. Problems of determining what is age-appropriate behaviour for someone with reduced cognitive functioning (e.g. in relation to torturing animals).
Autism: changes in measured prevalence

• 1988: 0.4 children per thousand (Bland, Newman and Orn)
• 2002: 3 per thousand (Baron-Cohen et al)
• An eight-fold increase!
• One study* has estimated that 26.4% of the increased autism caseload in California is the direct result of a single diagnostic change causing individuals previously diagnosed with ID to now be labelled autistic.

*King, M, & Bearman, P. Diagnostic change and the increased prevalence of autism. International Journal of epidemiology, 38, 12 24-12
Overall prevalence depressive disorders in people with ID, as reported by various studies

In the population as a whole, DSM-IV-R suggests lifetime a prevalence of between 10-25% for women and 5-15% for men. Bland et al (1988) found a six month prevalence of 5.37% in their large-scale study.

<table>
<thead>
<tr>
<th>Study</th>
<th>Overall % prevalence</th>
<th>Other % prevalence</th>
<th>Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall % prevalence</td>
<td></td>
<td></td>
<td>Prevalence based on routine clinical investigations</td>
</tr>
<tr>
<td>Lund, 1985</td>
<td>1.7</td>
<td>0.0</td>
<td>Eaton and Menolascino, 1982</td>
</tr>
<tr>
<td>Gostason, 1985</td>
<td>2.6</td>
<td>0.0</td>
<td>Rojahn et al, 1993</td>
</tr>
<tr>
<td>Corbett 1979</td>
<td>3.0</td>
<td>2.2</td>
<td>Deb et al, 2000</td>
</tr>
<tr>
<td>Cooper 1997</td>
<td>4.1</td>
<td>6.7</td>
<td>Patel et al 1993 (People over 50)</td>
</tr>
<tr>
<td>(People under 50)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(People over 50)</td>
<td>6.0</td>
<td></td>
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</tbody>
</table>

On the basis of these figures, people with ID appear less susceptible to depression than the general population.
Mental disorders encompass a wide variety of different phenomena

*Extreme mood states*: eg depression, mania

*Abnormal arousal*: eg panic disorder, PTSD, Obsessive compulsive disorder

*Pathological thoughts*: eg psychosis

*Pervasive abnormalities of social understanding and behaviour*: eg autism

*Long term unacceptable personality traits*: eg personality disorders, psychopathy