WHO Psychiatric Disability Assessment Schedule (WHO/DAS)

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with a guide to its use

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The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this organization, which was created in 1948, the health professions of some 165 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

By means of direct technical cooperation with its Member States, and by stimulating such cooperation among them, WHO promotes the development of comprehensive health services, the prevention and control of diseases, the improvement of environmental conditions, the development of health manpower, the coordination and development of biomedical and health services research, and the planning and implementation of health programmes.

These broad fields of endeavour encompass a wide variety of activities, such as developing systems of primary health care that reach the whole population of Member countries; promoting the health of mothers and children; combating malnutrition; controlling malaria and other communicable diseases, including tuberculosis and leprosy; having achieved the eradication of smallpox, promoting mass immunization against a number of other preventable diseases; improving mental health; providing safe water supplies; and training health personnel of all categories.

Progress towards better health throughout the world also demands international cooperation in such matters as establishing international standards for biological substances, pesticides, and pharmaceuticals; formulating environmental health criteria; recommending international nonproprietary names for drugs; administering the International Health Regulations; revising the International Classification of Diseases, Injuries, and Causes of Death; and collecting and disseminating health statistical information.

Further information on many aspects of WHO's work is presented in the Organization's publications.

Preface

Much past research on mental disorders has been focused on hospital populations, and few attempts have been made to disentangle the clinical characteristics of the disorders, such as the symptoms and their course over time, from the disturbances in social adjustment and behaviour. Even less is known about the "natural history" and evolution of the different components of these complex conditions, and about the extent to which some of their manifestations could in fact represent maladaptive responses to particular aspects of the social environment.

One of the obstacles to progress has been the lack of easily applicable and standardized methods for assessing disabilities in psychiatric patients. Another has been the absence of agreed concepts and a general framework to which epidemiological, clinical, and social observations can be related.

In an attempt to overcome these obstacles, WHO initiated a pilot study in 1976 in seven countries, to explore the applicability, reliability, and validity of a set of instruments and procedures for the evaluation of functional impairments and disabilities in a population of patients with potentially severe psychiatric disorders. Through consecutive follow-up assessments, data were also collected on the "natural history" of such impairments and disabilities in different sociocultural environments with a view to identifying predictors of disease outcome at levels of social functioning. Details of the study are given in Annex 1.

One of the principal instruments of the collaborative study was the WHO Psychiatric Disability Assessment Schedule (WHO/DAS). This schedule was used to record information about the patients' functioning and some of the factors that might influence it. The version presented here was finalized by the collaborating investigators in 1984, after the completion of the field studies. The instrument has also been used in other studies, both within and outside the framework of the WHO mental health programme, in over 20 countries.

In addition to English, the schedule is available in Arabic, Bulgarian, Chinese, Danish, French, German, Hindi, Japanese, Russian, Serbo-Croat, Spanish, and Urdu. Anyone wishing further information on the use of the schedule, including details of training material, should contact the Division of Mental Health, World Health Organization, 1211 Geneva 27, Switzerland.

The collaborating investigators in the study for which the WHO/DAS was developed were: Dr I. Temkov, Dr T. Tomov, Dr M. Boyadjieva, Dr Z. Ivanov, Dr C. Todorov, Dr C. Popov, and Dr L. Zhivkov, Institute of Neurology, Psychiatry, and Neurosurgery, Sofia, Bulgaria; Dr R. Schwarz, Mr K. Maurer, Dr H. Biehl, Mrs C. Schubart, Dr G. Badelt, Dr J. Michael, and Dr A. Schwarz, Central Institute for Mental Health, Mannheim, Federal Republic of Germany; Dr R. Giel, Dr D. Wiersma, Dr A. de Jong, Dr H. C. Sauer, and

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The study was coordinated at WHO Headquarters in Geneva by Dr A. Jablensky (principal investigator), Mrs G. Ernberg, Dr H. Hugler, Miss K. Canavan, and Miss J. Sikkens.

Introduction

The WHO Psychiatric Disability Assessment Schedule is designed to assess the social functioning of patients with a mental disorder; it is applicable in a variety of cultural settings. The schedule consists of five parts: 1. Overall behaviour (pp. 4–7); 2. Social role performance (pp. 8–18); 3. Patient in hospital (for hospitalized patients only) (pp. 19–24); 4. Modifying factors (pp. 25–30); and 5. Global evaluation (p. 31).

Who should fill in the schedule?

The patient's behaviour and functioning should be rated, and the schedule filled in, by one of the following: a psychiatrist, a psychologist, a sociologist, or a social worker. Whatever the professional qualification of the rater, previous experience in rating behaviour, and a period of training in the use of this schedule, are required.

Sources of information

The schedule is not a questionnaire and the rating of the items included presupposes an ability to make a judgement on the basis of the information available. The sources of information are: (*a*) a key informant about the patient (usually a family member); (*b*) the patient; and (*c*) any written records, or data from other informants (e.g., workmates, colleagues). To obtain relevant information, the rater should be thoroughly familiar with the content of the items of the schedule; in the course of the interviews, he or she should ask appropriate questions and cross-examine informants and/or the patient. Although a key informant would be, in most instances, the main source of information, it is always advisable for the rater to have at least a brief interview with the patient, especially as regards the items marked with an asterisk in the schedule, which require corroborating information from the patient.

Making a rating

Under each heading in Sections 1 and 2, the guidelines given refer to the areas of functioning or behaviour that should be considered. Guidelines are also provided for choosing the appropriate step of the scale ranging from "no dysfunction" to "maximum dysfunction". In case of doubt, the general rule is that the rater should select the numerically lower step. In every instance, when a rating of 1, 2, 3, 4, or 5 is made, it is desirable to make a brief narrative note of the specific facts that justify the particular rating. Unless otherwise specified, the rater's criteria for selecting a particular step of the scale should take into consideration: (*a*) the severity (or intensity) of the particular behaviour that is being rated; and (*b*) the proportion of time in the past month during which the behaviour was manifest. If a manifestation occurring during the past month was severe but of brief duration, it can be rated at the

same level as a less severe manifestation occupying a greater proportion of the month.

Baseline for evaluation

For most of the items, the patient's behaviour or functioning (in the previous month, unless specified otherwise) should be evaluated against the presumed "average" or "normal" functioning of a person of the same sex and of comparable age and sociocultural background (general guidelines given under "no dysfunction").

Hospitalized patients

For patients who have been in hospital for more than two weeks before the evaluation, Section 3 should be rated in addition to Sections 1 and 2. For patients currently in hospital (admitted not more than 2–3 months ago) the ratings in Section 2 should refer to the month before admission. If the patient has been in hospital for more than 3 months, Section 2 should not be rated.

Contents

The WHO Psychiatric Disability Assessment Schedule

The WHO/DAS Identification Form

Name of facility _____

Patient's first name or initials _____

Identification number of patient in the facility _____

Card 1
Column

Project identification	Card no.	1–8
		9–10

Field research centre

01 =
02 =
03 =
04 =
05 =
06 =
07 =
08 =
09 =
10 =

Investigator who filled in this schedule 11–13

Name _____

Was this schedule filled in as part of a training exercise or for purposes of inter-observer comparison? 14

0 = No
1 = Yes, the person who filled in this schedule was present during the interview but did *not* interview the informant himself/herself (name of person who interviewed the informant: _____)

Patient's project identification no. 15–17

Sex Date of birth 18–24

Day Month Year

Date when this form was filled in 25–30

Day Month Year

Source of information used to fill in this schedule _____ 31–33

_____

_____

1. Overall behaviour

1.1 Patient's self-care during past month

Inquire about: (i) personal hygiene—washing; shaving; keeping clothes, hair, fingernails, etc., clean and tidy; toilet habits; (ii) feeding habits; (iii) keeping living space (e.g., own room) tidy

Card 1
Column
[ ] 34

Rate 9 if no assessment possible

No dysfunction: level and pattern of self-care normal within patient's sociocultural context; patient takes a reasonable interest in his/her appearance. — 0

Minimum dysfunction: patient maintains reasonable standards of (i), (ii) and (iii) with some (occasional) supervision; *or* standards are somewhat lowered when no supervision is available; some loss of interest in own appearance. — 1

Obvious dysfunction: lack of self-care beyond minimum dysfunction is clearly established; patient likely to make an unfavourable impression; mild deterioration in appearance. — 2

Serious dysfunction: marked decline in all aspects of self-care; evidence of neglect, e.g., vagrant or tramp-like appearance. — 3

Very serious dysfunction: to the extent of exposing the patient to hazards such as malnutrition, dehydration, or infection, and of a severity likely to necessitate social intervention. — 4

Maximum dysfunction: patient totally uninterested in own appearance, unable to care for self; constant supervision is necessary for (i), (ii) and (iii); gross self-neglect when supervision is less intensive. Use this code only in *extreme* cases, e.g., when patient wets or soils himself/herself if left unattended. — 5

1.2 Underactivity during past month

Inquire about: time during the day spent in what the culture considers to be doing nothing, e.g., lying awake in bed, or sitting still and unoccupied; not talking with others. Make an estimate on the basis of typical behaviour during the past one month. (Do not include time spent watching television and other passive but culturally sanctioned behaviours.)

Card 1
Column

☐ 35

Rate 9 if no assessment possible

No dysfunction: patient reasonably active and occupied during the day (taking into consideration cultural norms and expectations), without supervision or encouragement. — 0

Minimum dysfunction: on a typical day during the last month patient spent between 2 and 4 hours doing nothing. — 1

Obvious dysfunction: lack of activity for an average of 4–6 hours during the day. — 2

Serious dysfunction: lack of activity for 6–8 hours on the average; needs occasional prompting for the execution of simple tasks during the day. — 3

Very serious dysfunction: spends about 8 hours a day doing nothing; requires almost continuous supervision to keep going. — 4

Maximum dysfunction: patient does nothing during most of the day; would not carry out most elementary tasks without constant encouragement and supervision; nearly total lack of initiative for most of the time in the past month. — 5

1.3 Slowness

Inquire about: overall speed of movement and agility in carrying out daily activities during past one month.

Card 1
Column
36

Rate 9 if no assessment possible

No dysfunction: normal speed of movement and of carrying out ordinary daily activities. — 0

Minimum dysfunction: takes longer than normal to carry out ordinary tasks, but can manage once started; or shows periods of extreme slowness but at other times is normal. — 1

Obvious dysfunction: slowness of movement definitely present most of the time but does not interfere severely with the patient's daily routine. — 2

Serious dysfunction: slowness definitely present most of the time and interferes with most of patient's activities. — 3

Very serious dysfunction: slowness very marked and persists throughout the day; activities performed with great difficulty. — 4

Maximum dysfunction: all or most of the time during the past month patient has been extremely slow to move and carry out ordinary tasks like dressing, eating, etc. Slowness may amount to absence of movement for hours or longer at a stretch. — 5

1.4 Social withdrawal during past month

Card 1
Column

Inquire about: (*a*) active avoidance of interacting (verbally or non-verbally) with people, e.g., avoiding talking to people present; (*b*) active avoidance of being in the physical presence of other people. The latter includes avoidance of normally expected social activities outside the home, such as visiting relatives or friends, going out with friends, or participating in games.

Since behaviour of type (*b*) must be absent in order for behaviour of type (*a*) above to be manifested, (*b*) should be regarded as a more severe degree of disturbance than (*a*). Other manifestations of withdrawal, e.g., interacting with people via the telephone while avoiding their presence, should be rated (1) or (2).

☐ 37

Rate 9 if no assessment possible

No dysfunction: patient mixes, talks, and generally interacts with people in accordance with the expectations of his/her sociocultural context; no evidence of avoiding people. — 0

Minimum dysfunction: somewhat socially withdrawn and solitary but mixes with people if encouraged. — 1

Obvious dysfunction: maintains a very restricted range of social contacts; avoids being with other people. — 2

Serious dysfunction: clear tendency to self-isolation, but still responds to encouragement. — 3

Very serious dysfunction: marked tendency to self-isolation; not responsive to encouragement. — 4

Maximum dysfunction: during the past one month, has practically never mixed socially with anyone; is inaccessible; actively avoids both company and conversation; may frequently lock himself/herself up in a room; or wander aimlessly without attempting to make contact with people for most of the day. — 5

2. Social role performance

In filling in Section 2, please remember: (*a*) whenever possible, this section should also be rated if the patient has been admitted to hospital recently (not more than 2–3 months ago) and is currently in hospital; in such instances the ratings should refer to the month before admission; (*b*) the concepts underlying the ratings in this section refer to the performance of specific social roles and not to the more generalized disturbances rated in the previous section. This section should be rated also for patients currently in day-care facilities (select a suitable informant).