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## DIP Training – General Information

### **1. Demographic and social function module (DIP-DSFM)**

The demography and social functioning module includes selected items from the World Health Organization Disability Assessment Schedule (World Health Organization, 1988). This is supplemented by sections of the Lancashire Quality of Life Profile (Oliver et al, 1997) and the Current Social Contacts Scale described by Tucker (1982). In addition, a global rating is made using the Social and Occupational Functioning Scale (American Psychiatric Association, 1994).

Apart from standard demographic material (e.g. age, sex, marital status), the DIP includes items related to migrant status, family and household, education, and accommodation. In relation to accommodation, respondents are also asked whether they feel safe in their current neighbourhood or locality and whether they have been a victim of violence in the last 12 months. Aspects of social functioning, disability and impairment in key role domains are assessed by rating performance of household duties, general social contact isolation and withdrawal, access to friends and family, and intimacy. A set of 14 items explores participation in the workforce and perceived capacity for work (including housework and studying). Items related to finances, activities of daily living, self-care and use of leisure time are also examined.

### **2. Diagnostic module (DIP-DM)**

The diagnostic module is designed around the Operational Criteria Checklist for Psychosis (OPCRIT), a 90-item checklist linked to a computer diagnostic algorithm which has been widely used internationally (McGuffin, Farmer & Harvey, 1991). While the original OPCRIT does not specify a procedure for eliciting the information necessary for rating the diagnostic items, the DIP-DM module includes a structured clinical interview with questions and optional probes derived and adapted from the World Health Organization Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (Wing et al, 1990). Lifetime, past year and present state ratings for the items of the DIP-DM are possible.

The computer algorithm associated with OPCRIT uses the interview data to generate diagnoses. The OPCRIT computer algorithm is capable of generating diagnoses under a number of classification systems such as DSM-III-R, ICD-10 and RDC; a version capable of generating DSM-IV diagnoses will be available soon. The DIP-DM also assesses comorbidity including drug and alcohol abuse/dependence.

The ratings for the DIP-DM require more than a simple present or absent judgement and presuppose a level of clinical skill in the interviewer. Specific training is necessary to ensure reliability of ratings.

### **3. Service utilisation module (DIP-SUM)**

Since people with psychotic disorders are known to be high users of a large number of services, the service utilisation module of the DIP aims to capture, in a self-report format, as comprehensively as possible a variety of services likely to be used by this population, and to quantify the extent of their use in the year prior to the interview. Hospitalisation, both psychiatric and non-psychiatric, public and private, is recorded as well as visits to accident and emergency departments, and number of contacts with psychiatric emergency or crisis services, both hospital and community based. The number and type of continuing care visits in the community or clinics are recorded together with the type of health professional assigned as the patient's case manager. Other health professionals seen and services received, both psychiatric and non-psychiatric are noted, including whether the services met the patient's perceived needs. Involvement in rehabilitation or day programs is recorded as well as access to, and use of, government and non-government health and welfare agencies. Further information recorded in the interview includes availability of carers, legal guardianship and detailed information regarding medication.

The concluding part of the module aims to elicit subjective quality of life judgements (satisfaction with own independence and satisfaction “with life as a whole” in the past year) as well as an open-ended account of perceived need for services that were unavailable.

#### **4. DIP reliability and validity**

There has been a comprehensive assessment of the reliability and validity of the DIP. For the diagnostic module, inter-rater reliability was assessed on 20 cases rated by 24 clinicians. The level of inter-rater reliability was determined for the ICD-10 and DSM III-R diagnoses, and for the individual OPCRIT items. Inter-rater reliability was assessed calculating the overall pairwise agreement and a generalised kappa. The diagnostic groupings used for the analysis were: schizophrenia; schizoaffective disorder; bipolar, mania; depressive psychosis; and other psychosis. For ICD-10, the overall pairwise agreement was 0.82 and the generalised kappa was 0.74, indicating good agreement. For DSM III-R, the overall pairwise agreement was 0.78 and the generalised kappa was 0.65, again indicating good agreement. Agreement on the 90 OPCRIT/SCAN items was also assessed. Half of the items (50%) had an agreement of 0.6 or greater, that is, good to excellent concordance. Twenty-one percent of items (19) had a kappa of less than 0.40.

Seven cases were interviewed 2-11 weeks apart to determine test-retest reliability, with pairwise agreement of 0.8-1.0 for most items. To test validity, 10 cases were jointly assessed using the DIP and SCAN: in nine cases, clinical diagnoses were in agreement.

The validity and reliability of the Diagnostic Module have been assessed and published (Castle et al 2006, 2006). For other data on reliability and validity, see (Jablensky et al, 1999, 2000).

#### **5. DIP-DM software**

The DIP-DM software was written to allow data entry onto a Microsoft Access database of the information elicited using the Diagnostic Module. Once the data have been entered, the DIP-DM generates diagnoses according to the various operational definitions functional in the OPCRIT diagnostic algorithm. There are in-built validation rules that ensure the quality of the data being entered. The database stores both the diagnostic data and the raw data, ready for export into other software for manipulation or analysis. The clinician entering the data can have an immediate diagnostic printout, or the data can be stored for later analysis. The data can also be viewed directly on screen.

#### **6. The DIP Training Package**

While the DIP presupposes a certain level of clinical expertise, persons with minimal clinical background may be trained to a reasonable level of competence. Specific training for all users of the DIP is essential to ensure reliability of ratings.

The DIP training program includes an introduction to the concepts underlying the DIP, coverage of the glossary items, guidance on how to use the software, co-rating of video-recorded interviews, as well as in vivo interviews with psychiatric patients. Trainees are then encouraged to complete further interviews on their own, with direct feedback provided by the trainer. Trainees get a competency certificate when a reasonable level of inter-rater reliability is reached. As part of the training package, trainees receive the DIP-DM software and a comprehensive manual complete with software instructions and glossary.

Ongoing support is offered to users of the DIP as well as refresher courses and, more recently, a ‘train the trainer’ program has been introduced. Training seminars have been provided on group and individual bases for mental health professionals and postgraduate research students. Training by correspondence has been provided for a number of interested clinicians outside Australia.

The training program for the DIP has undergone close scrutiny over the last few years with the aim of developing a standardised ‘hands on’ training package. Consumer feedback has been actively sought and standardised consumer feedback questionnaires are completed at the end of each training program. Feedback provided impromptu by trainees throughout the training seminars is also incorporated in changes to the comprehensive manual as well as the training program itself.

The popularity of the DIP is due to the simplicity of training, ease and brevity of administration, and its ability to provide an almost immediate diagnosis. While the majority of research projects use the DIP to provide a lifetime diagnosis, many practising clinicians are now using the DIP to track changes in symptomatology over time, making it a useful tool for clinical practice.

### 7. Sample diagnostic printout

#### Diagnostic score based on LIFETIME Ratings

ICD-10	12 paranoid schizophrenia
DSM-IIIIR	12 schizophrenia
Research Diagnostic Criteria	8 narrow schizophrenia

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DSM-III 9 schizophrenia Feighner et al	4 probable schizophrenia
Carpenter	1 'level 5' schizophrenia
Schneider FRS	1 frs-schizophrenia
French classification	1 interpretive psychosis
Taylor Adams	4 schizophrenia
Tsuang-Winokur subtypes	1 paranoid
Crow subtypes	1 type
1 Farmer subtypes	1 'p' type

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Confounding Factors	1 alcohol / drug abuse
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### **8. OPCRIT codes and labels by diagnostic classification**

#### **OPCRIT: ICD-10**

- 1 mild depression
- 2 moderate depression
- 3 mild depression with somatic syndrome
- 4 moderate depression with somatic syndrome
- 5 severe depression without psychotic symptoms
- 6 severe depression with psychotic symptoms
- 7 severe depression with psychotic symptoms & mood congruent delusions
- 8 mania without psychosis
- 9 mania with psychosis
- 10 bipolar
- 11 undifferentiated schizophrenia
- 12 paranoid schizophrenia
- 13 hebephrenic schizophreni
- 14 catatonic schizophrenia
- 15 schizoaffective manic
- 16 schizoaffective depressed (moderate)
- 17 schizoaffective depressed (severe)
- 18 schizoaffective bipolar
- 19 delusional disorder
- 20 other non-organic psychotic disorders

#### **OPCRIT: DSM-III-R**

- 1 major depression
- 2 hypomania
- 3 mania
- 4 bipolar disorder
- 5 mania with psychosis
- 6 depression with psychosis
- 7 bipolar with psychosis
- 8 schizoaffective mania
- 9 schizoaffective depression
- 10 schizoaffective bipolar
- 11 schizophreniform disorder
- 12 schizophrenia
- 13 delusional disorder
- 14 atypical psychosis
- 15 probable schizoaffective manic or mania with psychosis
- 16 probable schizoaffective depressed or depression with psychosis
- 17 probable schizoaffective bipolar or bipolar with psychosis

#### **OPCRIT: DSM-III**

- 1 major depression
- 2 mania
- 3 bipolar disorder
- 4 mania with psychosis
- 5 depression with psychosis
- 6 bipolar with psychosis
- 7 atypical psychosis
- 8 schizophreniform
- 9 schizophrenia
- 10 paranoid disorder

**OPCRIT: Research Diagnostic Criteria (Spitzer et al)**

- 1 major depression
- 2 mania
- 3 bipolar disorder
- 4 schizoaffective mania
- 5 schizoaffective depression
- 6 schizoaffective bipolar
- 7 broad schizophrenia
- 8 narrow schizophrenia
- 9 unspecified functional psychosis

**OPCRIT: St Louis Criteria (Feighner et al)**

- 1 depression
- 2 mania
- 3 bipolar disorder
- 4 probable schizophrenia
- 5 definite schizophrenia
- 6 schizophrenia with secondary affective disorder - mania
- 7 schizophrenia with secondary affective disorder - depression
- 8 schizophrenia with secondary affective disorder - bipolar

**OPCRIT: "Flexible" criteria of Carpenter et al**

- 1 'level 5' schizophrenia
- 2 'level 6' schizophrenia

**OPCRIT: Schneider First Rank Symptoms (FRS)**

- 1 FRS-schizophrenia

**OPCRIT: French Classification (approximating to the French concepts of non-affective functional psychosis in Pichot and in C. Pull et al.)**

- 1 interpretive psychosis
- 2 chronic hallucinatory psychosis
- 3 delusional attack
- 4 chronic schizophrenia
- 5 bouffee delirante

**OPCRIT: Taylor & Abrams**

- 1 depression
- 2 mania
- 3 bipolar disorder
- 4 schizophrenia

**OPCRIT: Schizophrenia subtypes (Tsuang & Winokur)**

- 1 paranoid
- 2 undifferentiated
- 3 hebephrenic
- 9 subtyping probably not applicable

**OPCRIT: Schizophrenia subtypes (Crow)**

- 1 type I
- 2 mixed
- 3 type II
- 9 subtyping probably not applicable

**OPCRIT: Schizophrenia subtypes (Farmer et al)**

- 1 'P' type
  - 2 'H' type
  - 9 subtyping probably not applicable
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### 9. References

1. American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association, Washington DC.
2. Carpenter, W.T., Strauss, J.S., Bartko, J.J. (1973). Flexible system for the diagnosis of schizophrenia: a report from the WHO Pilot Study of Schizophrenia. Science, 182, 1275.
3. Crow, T.J. (1980). The molecular pathology of schizophrenia: more than one disease process? British Medical Journal, 280, 66-68.
4. Farmer, A.E., McGuffin, P. & Spitznagel, E.L. (1983). Heterogeneity in schizophrenia: a cluster analytic approach. Psychiatry Research, 8, 1-12.
5. Feighner, J.P., Robins, E., Guze, S.B., Woodruffe, R.A., Winokur, G. & Munoz, R. (1972). Diagnostic criteria for use in psychiatric research. Archives of General Psychiatry, 26, 57-67.
6. Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Evans, M., Carr, V., Morgan, V., Korten, A. & Harvey, C. (2000). Psychotic disorders in urban areas: An overview of the Study on Low Prevalence Disorders. Australian and New Zealand Journal of Psychiatry, 34, 221-236.
7. Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Morgan, V. & Korten, A. (1999). People living with psychotic illness: An Australian study 1997-98. Canberra: Commonwealth of Australia.
8. McGuffin, P., Farmer, A. & Harvey, I. (1991). A polydiagnostic application of operational criteria in studies of psychotic illness. Development and reliability of the OPCRIT system. Archives of General Psychiatry, 48, 764-770.
9. Oliver, J.P., Huxley, P.J., Priebe, S. & Kaiser, W. (1997). Measuring the quality of life of severely mentally ill people using the Lancashire Quality of Life Profile. Social Psychiatry and Psychiatric Epidemiology, 32, 76-83. Pichot, P.J. (1984). The French approach to psychiatric classification. British Journal of Psychiatry, 144, 113-118.
10. Pull, M.C., Pull, C.B. & Pichot, P. (1987). Des criteres empiriques francais pour les psychoses, II: consensus des psychiatres francais et definitions provisoires. Encephale, 13, 53-57.
11. Spitzer, R.L., Endicott, J. & Robins, E. (1975). Research Diagnostic Criteria, Instrument No. 58. New York, NY: New York State Psychiatric Institute.
12. Taylor, M.A. & Abrams, R. (1978). The prevalence of schizophrenia: a reassessment of using modern diagnostic criteria. American Journal of Psychiatry, 135, 945-948.
13. Tsuang, M.T. & Winokur, G. (1974). Criteria for subtyping schizophrenia. Archives of General Psychiatry, 31, 43-47.
14. Tucker, M.B. (1982). Social support and coping: applications for the study of female drug abuse. Journal of Social Issues, 38, 117-137.

15. Wing, J.K., Babor, T., Brugha, T., Burke, J., Cooper, J.E., Giel, R., Jablensky, A., Regier, D. & Sartorius, N. (1990). SCAN: Schedules for Clinical Assessment in Neuropsychiatry. Archives of General Psychiatry, *47*, 589-593.



16. World Health Organization, (1988). WHO Psychiatric Disability Assessment Schedule (WHO/DAS). World Health Organization, Geneva.

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