# Field trials on the PAS-ADD (now Moss-PAS) assessments

**PAS-ADD Clinical Interview**

Field trials investigated the validity of PAS-ADD in relation to the clinical opinion of referring psychiatrists (Moss, Prosser & Goldberg, 1996; Moss et al,1997). Inter-rater reliability of the lCD10 version gave a mean Kappa of 0.65 for individual item codes of, and Kappa 0.7 for agreement on index of definition (clinical significance of the symptoms) (Costello et al, 1996). The relationships between respondent (patient) and informant reports of symptoms, and the implications of deriving diagnoses solely from informant interviews, are discussed in Moss, Prosser, lbbotson & Goldberg (1996). The issues of using care staff as informants are discussed in Moss & Patel (1993).

The Spanish version of the PAS-ADD also underwent a full validation study (Gonzalez-Gordon et al, 2002)

**The Mini-PAS-ADD**

The psychometric properties of the Mini PAS-ADD were investigated in a study in which a group of subjects known to psychiatric services were rated on the Mini PAS-ADD by, (a) expert consultant psychiatrists in intellectual disability, (b) community support team (CST) members. The psychiatrists additionally gave their diagnostic opinion on the sample members and an estimate of the severity of any psychiatric illness.

Case identification for disorders covered by the Mini PAS-ADD showed 91% (43 of 47) agreement between the psychiatrists and CST raters (Kappa = 0.74).

**Validity in relation to clinical opinion**

(a) Psychiatrists' Mini PAS-ADD

The first validity consideration was the extent to which the clinicians' opinions were accurately reflected by the scores on the Mini PAS-ADD which they themselves had completed. Since the same person was providing the clinical opinion and the completed instrument, this is in effect a test of the combined adequacy of the symptom coverage and scoring algorithm. All 39 (100%) of disorders covered by the Mini PAS-ADD were detected. (Mini PAS-ADD case detection refers to all those patients who crossed the scoring threshold on any of the 7 scales). In addition, there were six false positives. Two of these had a sole diagnosis of challenging behaviour, the remaining four had diagnoses not covered by the Mini PAS-ADD.

An overall correct classification of 91% (62) "true" cases and non-cases was an encouraging indication of the validity of the instrument and its ability to discriminate between cases, ie

those patients with a diagnosis within the Mini PAS-ADD spectrum and those who were currently well or had another psychiatric disorder not covered by Mini PAS-ADD. It is worth noting that all of the false positives did actually have a mental health problem. None of the currently well group was falsely identified.

(b) Mini PAS- ADDs completed by CST members
In terms of the instrument fulfilling its main intended function, ie accurate case recognition, the crucial question was whether the CST raters, with their lesser knowledge of psychopathology, were also able to correctly identify cases identified by expert clinicians. Results showed his group of raters broadly achieved a very good level of performance in this respect. The percentage of correct classifications was, as would be expected, lower than that of the psychiatrists (81% versus 91%). This group of raters also had a slightly higher mean total score than that of the psychiatrists (17.5 versus 14.7, paired sample t-test $p<.05$, two-tailed), which would tend to produce more false positives than negatives. It remains to be seen whether this effect occurs in other studies, and how it responds to rater training. Overall, however, it is probably better to have a slight bias towards over-inclusion rather than the other way round, since this will minimise the proportion of true cases who are overlooked.

Psychometric properties of the Mini PAS-ADD can be found in Prosser et al (1998).

Results of a major study on the Dutch version of the Mini PAS-ADD have also been reported (Janssen & Maes, 2012).

**The PAS-ADD Checklist**
The PAS-ADD Checklist produces three scores, relating to:

1. Affective or neurotic disorder.
2. Possible organic condition (including dementia)
3. Psychotic disorder.

Factor analysis of the Checklist completed on a community sample of 201 individuals yielded eight factors, of which seven were readily interpretable in diagnostic terms. Internal consistency of the scales was generally acceptable. Inter-rater reliability in terms of case identification, the main purpose of the Checklist was quite good, 83% of the decision being in agreement. Validity in relation to clinical opinion was also satisfactory, case detection rising appropriately with the clinically judged severity of disorder (Moss et al, 1998). Subsequent independent studies have further investigated the Checklist's psychometric properties (Sturmey et al, 2005), and established norms for an adult sample (Taylor et al, 2004)

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