## Mastering the Kennedy Axis V: A New Psychiatric Assessment of Patient Functioning

*by James A. Kennedy, M.D.; Washington, D.C., American Psychiatric Publishing, Inc., 2003, 294 pages, $44 softcover*

## Fundamentals of Psychiatric Treatment Planning, Second Edition

*by James A. Kennedy. M.D.; Washington, D.C., American Psychiatric Publishing, Inc., 2003, 368 pages, $49 softccover*

**Stacey Dixon, Ph.D.**

For clinicians who have been disappointed with the lack of relevant information provided by the *DSM-IV-TR* Global Assessment of Functioning (GAF) (1) and its limited applicability to treatment planning, these two books by James A. Kennedy, M.D., provide a welcome alternative.

In *Mastering the Kennedy Axis V: A New Psychiatric Assessment of Patient Functioning,* Kennedy outlines the conceptual framework and rationale for his multidimensional approach to assessing a patient's functioning. The Kennedy Axis V can be considered as either an alternative to or an extension of the GAF.

Kennedy and other authors (2,3) have noted some problems with the GAF, which uses one number gleaned from clinical information routinely gathered during assessments to represent a person's overall functioning. At the higher ranges of the scale, the GAF provides mainly a measure of the person's level of functioning. However, at the lower ranges, the severity of psychotic symptoms—such as delusions that the person acts on with little or no impulse control—and violent behaviors may be what the scale is reflecting, in addition to or instead of the level of functioning. Another problem noted by the author is the fact that clinicians can too easily "pull [GAF] scores out of the air."

The Kennedy Axis V breaks out the areas of relative functioning into seven subscales that can then be used to generate a "GAF equivalent" score and a measure of the "dangerousness level." Kennedy asserts that any presenting mental health problem can be accounted for by the following seven self-explanatory subscale headings: psychological impairment, such as psychotic symptoms, poor motivation, mood disturbance, personality disturbance, poor focus or attention, eating disturbance, social withdrawal, and shyness; social skills, such as limited interpersonal or communication skills, lack of awareness of social norms, and sexually inappropriate behavior; violence, such as with persons who are threatening or assaultive, suicidal, homicidal, or sexually violent; activities of daily living or occupational skills, such as poor job skills, lack of self-care skills, poor workmanship, lack of basic survival skills, or poor hygiene; substance abuse, including use of nicotine and caffeine; medical impairment, such as hypertension, diabetes, tardive dyskinesia, and poor dentition; and ancillary impairment, such as homelessness, financial problems, presence of an abusive spouse, legal problems, incarceration, or need for guardianship. Each of these subscales generates its own score ranging from 0 to 100, with anchor points such as no symptoms, mild symptoms, and serious problems or impairment, which are familiar to GAF users.

The descriptors used for these anchor points give a broader scope of problems and better account for milder symptoms on the high end of the continuum compared with the descriptors provided by the GAF. The optional ancillary impairment subscale includes descriptors that would be particularly useful for forensic evaluations, discharge needs assessments, and placement planning. Kennedy even suggests using this subscale in place of *DSM-IV*'s axis IV. The medical subscale allows for better integration of medical issues into treatment planning by showing the psychological impact of medical problems (rather than just identifying them). Also, the Kennedy Axis V descriptors better allow for the rating of the impact of sociopathic behaviors on a person's level of functioning. The violence subscale and the dangerousness level score could be particularly useful for differentiating the level of risk and can be considered along with other information in making decisions about the types of treatment and programs that would best fit the patient's needs. For example, Kennedy notes that dangerousness levels of 50 or lower may signal a need for more intensive outpatient, residential, or inpatient care.

Kennedy's original purpose in designing the Kennedy Axis V was to better organize psychiatric information and to track outcomes. It appears that he has developed a simple means for doing both. He suggests rating patients for the current level of functioning (which reflects the current needs for treatment), for the level of functioning at discharge (which can be used as a measure of the impact of treatment when compared with the admission rating), or for the highest level of functioning during the past year (which may predict outcomes). In addition, the individualized problem descriptions, written by the clinician, allow for the tracking of even small changes over time. Profiles from the assessment can be used to match patients with the therapists, groups, programs, or facilities that represent the best fit. Kennedy provides several examples of such profiles. More good news for facilities reporting outcomes to the Joint Commission on Accreditation of Healthcare Organizations: data from the Kennedy Axis V can be reported via the ORYX system (4).

In addition to discussing the assessment's face validity, Kennedy cites studies that show good interrater reli-

*Dr. Dixon is director of treatment planning at Memphis Mental Health Institute in Memphis, Tennessee.*

ability and a high correlation between the GAF and Kennedy's GAF equivalent and psychological impairment subscale. Also, Kennedy and his colleagues have found that lower scores on the first four subscales, the GAF equivalent, and the dangerousness level have been correlated with longer inpatient stays.

Overall, the Kennedy Axis V seems very easy to use by any qualified mental health professional who is already in the practice of assessing a patient's functioning. With training and experience, the clinician should be able to complete this assessment within minutes. It has proven useful with patients ranging in age from 13 to 80 years, according to the author, although it is considered to be a reasonable instrument for use with patients as young as five years who have anywhere from the lowest to the highest levels of functioning.

*Fundamentals of Psychiatric Treatment Planning, Second Edition* is an updated edition of Kennedy's 1992 manual of the same name. To best comprehend the structure and conceptual underpinnings of this treatment planning approach, the reader is encouraged to first peruse *Mastering the Kennedy Axis V.* The specific problems identified on the subscales of the Kennedy Axis V can be translated into a list of problems for the patient's master treatment plan. As mentioned above, the subscales themselves were designed to broadly capture all possible presenting problems. From these problems, short-term and long-term goals are developed and treatment modalities—or the clinicians' interventions—are delineated.

Kennedy's assertion that accreditors, reviewers, and consultants often use his model as a standard for treatment planning is not an idle boast. From its inception, this model has offered a well-tuned, sensible approach that many clinicians, facilities, and treatment teams have found helpful in their efforts to develop good treatment plans. The model allows for flexibility in the degree of specificity of the documentation—depending on the anticipated length of stay, the thoroughness of the rest of the charting related to treatment progress, the clinical style of the treatment team, and the time constraints they face. One improvement noted in this edition is that the model now more clearly incorporates the nursing care plan into the master treatment plan to eliminate redundancy and to increase the nurse's participation in interdisciplinary treatment planning.

Two concerns come to mind as I review this otherwise excellent model of treatment planning. First, it would be tempting and far too easy for treatment team members using this model to develop a plan in a multidisciplinary—rather than truly interdisciplinary—process. Kennedy even suggests this process for teams facing constraints on their time and heavy workloads. The product, both on paper and in implementation, of such a multidisciplinary approach would likely look like the sum of its disjointed treatment efforts. Second, this approach to developing objectives and interventions could quickly appear "canned" instead of individualized. Again, the author suggests the use of lists of ready-made objectives or interventions to ease the time and paperwork burden of treatment planning. When teams become overreliant on such lists, the treatment planning process can lose its creativity and its specificity for the needs of the individual patient.

Kennedy lists as an advantage of this approach that treatment can be directed at the syndrome—for example, depressive symptoms—rather than at multiple problems that are included in the syndrome, such as sadness, loss of appetite, insomnia, or lethargy. I tend to agree, as long as the individual problems are included as descriptors. If they are not, the treatment plan loses its individualization. For example, "depressive symptoms" as a syndrome can present quite differently from patient to patient, especially during childhood and adolescence, when anger and acting out may be seen as often as or more often than sadness or lethargy. Thus a highly individualized treatment plan would specify the symptoms that are being targeted for the particular patient.

Both these books are written in a clear, concise manner and are published in a binder format that has tabs for easy access to the different chapters. *Mastering the Kennedy Axis V* provides multiple vignettes with scoring profiles for the reader to use to train and self-test. The second edition of *Fundamentals of Psychiatric Treatment Planning* offers both blank forms and completed samples of master treatment plans and treatment plan reviews. Personally, I found these vignettes and samples to be easy to use and to make good clinical sense. A bonus for the reader is the online support and updated information provided by the author at www.kennedymd.com.

### *References*


1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 4th ed, Text Revision. Washington, DC, American Psychiatric Association, 2000
2. Higgins J, Purvis K: A comparison of the Kennedy Axis V and the Global Assessment of Functioning Scale. Journal of Psychiatric Practice 6:84–90, 2000
3. Spitzer RL, Gibbon M, Williams JB, et al: Global Assessment of Functioning (GAF) Scale, in Outcomes Assessment in Clinical Practice. Edited by Sederer LI, Dickey B. Baltimore, Williams & Wilkins, 1994
4. Joint Commission on Accreditation of Healthcare Organizations: Performance Measurement. Available at www.jcaho.org/pms/index.htm


## Handbook of Diagnostic and Structured Interviewing

*by Richard Rogers; New York, Guilford Press, 2001, 516 pages, $55*

**Kenneth E. Fletcher, Ph.D.**

This thorough review of all the major diagnostic and structured interviews currently available—and a good many lesser-known ones—begins with an excellent discussion of the rationale for structured inter-

*Dr. Fletcher is affiliated with the department of psychiatry, the Graduate School of Nursing, and the Behavior Sciences Research Core at the University of Massachusetts Medical School in Worcester.*