ORIGINAL RESEARCH
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Kuwait-Mental Illness Disability Scale (K-MIDS): *A Proposal*

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ABSTRACT ~ ***Background:*** *It is widely agreed that the mentally ill constitute a sizeable chunk of the disabled population not only for those afflicted but also for their caregivers alike.* ***Objective:*** *To assess the degree of disability with subsequent medico-legal ramifications, clinicians largely rely on generic clinical impressions and short brief interviews that are by no means bias-free lacking in standardization and objectivity.* ***Methods:*** *To this end, authors, herein, draft, the K-MIDS or the Kuwait-Mental Illness Disability Scale.* ***Results:*** *Baseline Requirements and Scoring System of K-MIDS are devised largely drawing on authors' vast clinical expertise in this area.* ***Conclusions:*** *The assessment of functional disability related to serious mental illness remains an unmet need in the Gulf region where disability allowance is currently based on generic clinical impressions, brief interviews and collateral input. K-MIDS is intended to be a step moving forward. Psychometric properties are due second.* Psychopharmacology Bulletin. *2025;55(3):20–25.*

Defining disability is *not* straightforward, and sorely no unitary definition can cover all aspects of disabilities. For formalities, *impairment* refers to any loss of anatomy (structure) or physiology (function), *disability* denotes any restriction of activities imposed by this impairment, and *handicap* is the resultant disadvantage limiting role fulfilment.[1]

Though critics skeptical of the disabling nature of psychiatric disorders abound, it is widely accepted that the mentally ill constitute a sizeable chunk of the disabled population not only for those afflicted but also for their caregivers alike.[2]

Disability associated with mental illness remains a major contributor to the global burden of disease. These disorders include, inter alia, schizophrenia, bipolar mood disorder, obsessive-compulsive disorder, moderate-to-severe depression of (arbitrarily) at least 3 years' duration with a proof of continuous treatment.[3–4]

Disability germane to psychiatric diagnoses imply dysfunction in specific domains of daily living normally expected for a person of same age, sex and societal role.[5]

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Serious mental illness and disorders of intellectual development are currently within the ambit of disabilities certified and reimbursed by Kuwaiti Public Authority of Disabled Affairs (PADA). Authorities to give a disability certificate would be a medical board duly constituted by Ministry of Social Affairs jointly with Ministry of Health, for availing governmental support, aid and planning management. The medical board consists of *at least* three members- governmentally registered psychiatrists. Assessment has been always based on a brief interview of candidates by the designated board, corroborated by recently submitted medical reports typically coupled with relevant psychometry. At times, interviewing the primary care givers can be complementary to probe *dysfunction*. As such, decision on eligibility for any concessions/benefits, as well as validity/frequency of certification lies ultimately with medical board and chiefly based on clinical impressions that are *not* absolutely flawless. Hence there has been always a dire need for standardization and objectification of *psychiatric disabilities*[6] which is vital for service and support provision.

To this end, herein, we draft a proposal for the Kuwait-Mental illness Disability Scale or (K-MIDS) as a shorthand.

Validated global scales like WHO-Disability Assessment Schedule 2.0,[7] which is based on International Classification of Functioning, Disability and Health (ICF) as well as regional scales like Indian Disability Evaluation Assessment Scale (IDEA)[8] were thoroughly considered by these authors whilst laying the groundwork for K-MIDS. Pertinent published literature was revised pointing out the lacunae related to cultural factors and local needs.

K-MIDS, Baseline Requirements and Scoring System were all devised largely drawing on authors' vast clinical expertise in this area as currently active members (A.N.) or the previous head of PADA (B.A.). K-MIDS is then crystallized as a distillation of a multitude of surveys and focussed group discussions with stake holders and a few rounds of experts' consultations, with the aim of understanding and establishing the state of affairs currently in the State of Kuwait and Gulf region at large.

A brief pilot project (in Print) was carried out with a few cases to understand the feasibility of K-MIDS in practice. It was pretty promising that using K-MIDS very much tallied with decisions made by medical boards as usual in over 90% of cases.

Psychometric properties of K-MIDS are due next.

Baseline Requirements

- *Less than one- year-old medical report from a psychiatric clinic*. We stipulated a recently issued medical report (within one-year) by

treating psychiatrist to reflect clinical progress updates. Reports issued from public sector are only accepted. This can be Kuwait Centre for Mental Health (KCMH)—the only State psychiatric hospital or else peripheral psychiatric clinics embedded in general governmental hospitals to which patient's catchment area belongs. On the other hand, reports provided by private sector are only considered ancillary especially for long-standing case histories that happen to come in contact with public service only recently.

- *Deferral and re-evaluation in four months*. This typically applies to the case where patient has not been on medication for any period of time, to be treated for at least 3 months. This also extrapolates when there is an evidence of erratic adherence to treatment. Active symptomatology *together with* suboptimal treatment regimens, as judged by the evaluating committee would be included here as well. *TWO* exceptions are noted here. Those 65 years of age or above are exempted. Secondly, when there exist clinical inconsistencies, like for instance, an obvious discrepancy between clinical interview and provided reports- in these circumstances, we urge a referral to treatment provider for further assessment with an official memo and reschedule these cases as soon as requested new documents are secured.

Scoring

Eleven prognostication criteria were felt to be clinically relevant assessing impact of psychiatric disorder on functional status as a proxy of disability. These are depicted in Table 1 with a key for scoring. Scoring system has divided patients into *Two* groups based on age (18 years was set as a cut-off arbitrarily denoting age of workforce). For those retired on medical grounds or otherwise, *NO* points would be scored on *occupational impairment* dimension not to overinflate disability scale spuriously. To maintain objectivity, dimensions of *activity of daily living* (a bit tweaked pertinent to psychiatric diagnoses), *academic impairment, occupational impairment and social impairment* were all graded 1–6 (higher grades reflect higher degrees of severity).

Regarding the clinical parameters, we gave due emphasis on number of psychiatric diagnoses acknowledging ubiquity of comorbidities and the toll it takes on diagnostic severity, complexity, treatment resistance and likelihood of relapses.[9] Duration of illness in years was overemphasized as we do believe chronicity (vs episodicity) reflects downhill course given the neuroprogressive nature of major psychiatric disorders.[10] Presence of both positive and/or negative symptom domains was taken into consideration underscoring correlation with functional status[11] Polypharmacy, need for hospitalization or use of neuromodulation indicated severity

TABLE 1

K-MEDS

		0	1	2	3	POINTS
1	No of diagnosis*	1	2	3	>3	
2	Duration of the illness (yrs)	<2 year	2–5	5–10	>10	
3	Presence of positive symptoms	None	1–2	3–5	>5	
4	Presence of residual chronic or negative symptoms	None	1–2	3–5	>5	
5	Number of psychiatric medications	1	2	3–4	>4	
6	Response to treatment	Optimal	Partial response (more than 60% improvement)	Poor response (30–60% improvement)	No response (or < 30% improvement)	
7	ADL	Intact	Partially impaired (1)	impaired (2–3)	Significantly impaired (4 or more)	
8	IADL (N/A for ages < 18)	Intact	Partially impaired (1)	Impaired (2–3)	Significantly impaired (4 or more)	
9	Social impairment	Fair	Partially impaired (1)	Impaired (2–3)	Significantly impaired (4 or more)	
10	Occupational impairment (N/A for ages < 18 or still enrolled in education)	Fair	Partially impaired (1)	Impaired (2–3)	Significantly impaired (4 or more)	
11	Academic impairment (N/A for ages 18 and above unless still enrolled in education)	Fair	Partially impaired (1)	Impaired (2,3)	Significantly impaired (4 or more)	
		0				

Key for Scoring

Score calculation:
Total score for <18 (max of 3 × 9 = 27)
Total score for >18 (either occupational/or educational) max of 3 × 10 = 30

Younger than 18
0 no disability
Mild: 1–9
Moderate: 10–18
Severe: >18

Older than 18
0 no disability
Mild: 10 and below (49% of 30)
Moderate: 10–20 (49–77% of 30)
Severe: >23 (>77% of 30)

Older than 18 and is medically retired or regularly retired (don't record on occupational) → 0 no disability.
Mild: 1–9
Moderate: 10–18
Severe: >18

ADL due to psychiatric disorders
- **Walking,** or otherwise getting around the home or outside. The technical term for this is "ambulating."
- **Feeding,** as in being able to get food from a plate into one's mouth.
- **Dressing and grooming,** as in selecting clothes, putting them on, and adequately managing one's personal appearance.
- **Toileting,** which means getting to and from the toilet, using it appropriately, and cleaning oneself.
- **Bathing,** which means washing one's face and body in the bath or shower.
- **Transferring,** which means being able to move from one body position to another. This includes being able to move from a bed to a chair, or into a wheelchair. This can also include the ability to stand up from a bed or chair in order to grasp a walker or other assistive device.

IADL due to psychiatric disorders
- **Managing finances,** such as paying bills and managing financial assets.
- **Managing transportation,** either via driving or by organizing other means of transport.
- **Shopping This** covers shopping for clothing and other items required for daily life.
- **meal preparation or obtaining a meal.** This covers everything required to get a meal on the table.
- **Housecleaning and home maintenance.** This means cleaning kitchens after eating, keeping one's living space reasonably clean and tidy, and keeping up with home maintenance.
- **Managing communication,** such as the telephone and mail.
- **Managing medications,** which covers obtaining medications and taking them as directed.

Social impairment
1. Divorced/never married.
2. Limited circle of friends.
3. Limited interests.
4. Poor communication skills.
5. Doesn't attend social gatherings passively or actively.
6. Socially withdrawn from family members if living in the house or a minor.

Academic impairment
1. Deterioration in academic attainment.
2. Failed multiple subjects.
3. Repeated grades.
4. Expelled from school.
5. Changed multiple schools.
6. Unable to attend school/extended absence.

on clinical grounds.[12] Lastly, response to treatment based on clinical global impression and using standardized scales was incorporated into score since we do trust the importance of integration *measurement-based care* into routine psychiatric management.[13] ✤

Ethics Statement

No patients were involved and hence, no need for ethical committee approval as per local research regulations.

Disclosures

Authors declare no competing interest in this work.

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