ADVANCED SERIES ON SELF NEGLECT:
Biopsychosocial Assessment

PARTICIPANT MANUAL

MODULE 1

ADVANCED MODULE 1

7/12/2010

Version 2
This training was developed by the Academy for Professional Excellence, which is funded by a generous grant from the Archstone Foundation.

Curriculum Developer
Dr. Irving Hellman
Revisions by Erika Falk. Ph. D

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INTRODUCTION

THE ACADEMY FOR PROFESSIONAL EXCELLENCE

We are pleased to welcome you to the Advanced Series on Self Neglect, developed by Project MASTER, a program of the Academy for Professional Excellence.

The Academy for Professional Excellence was established in 1996 and provides training, technical assistance, organizational development, research, and evaluation to public and private health and human service agencies and professionals.

The Academy is a project of San Diego State University School of Social Work (founded in 1963), which offers both a bachelor’s and master’s degree in Social Work. The School of Social Work at San Diego State University was founded in 1963 and has been continuously accredited by the Council of Social Work Education since 1966.

The Academy has extensive experience in providing specialized services, including:

- multi-disciplinary competency-based trainings
- curriculum development
- needs assessment
- research
- evaluation
- meeting facilitation
- organizational development consultation services

MASTER is an Archstone Foundation funded program of the Academy for Professional Excellence which has the overarching goal is to develop standardized core curricula for new and experienced APS social workers and to share these trainings on a national scale. Professional training opportunities are a critical step toward ensuring APS social workers have the appropriate tools to serve their victims. MASTER has worked extensively with state and national partner agencies in the development of this curriculum.

Our partners include:

- National Adult Protective Services Association Education Committee (NAPSA)
- The Statewide APS Training Project of the Bay Area Training Academy
- California Department of Social Services, Adult Services Branch
- California State University Sacramento IHSS Training Project
- Protective Services Operations Committee of the California Welfare Director’s Association (PSOC)
- California Social Work Education Center Aging Initiative (CalSWEC)
ACKNOWLEDGMENTS

This training is the result of a collaborative effort between Adult Protective Services administrators, supervisors, staff development officers and workers across the state and the nation; professional educators; and the Academy for Professional Excellence staff members. Project MASTER would like to thank the following individuals and agencies:

**Agencies**
- Bay Area Academy, Statewide APS Training Project
- California Department of Social Services, Adult Services Branch
- California Social Work Education Center Aging Initiative
- Imperial County Department of Social Services
- Orange County Social Services Agency
- Riverside County Department of Public Social Services
- San Bernardino County Department of Aging and Adult Services
- San Diego County Aging and Independence Services

**Regional Curriculum Advisory Committee**
- Carol Mitchel, APS Manager and PSOC Representative, Orange County
- Beverly Johnson, LCSW, Staff Development Officer, Riverside County
- Brenda Pebley, APS Manger, Imperial County
- Carol Castillon, APS Supervisor, San Bernardino County
- Carol Kubota, LCSW, Staff Development Officer, Orange County
- LaTanya Baylis, Staff Development Officer, San Bernardino County
- Zachery Roman, Staff Development Officer, Los Angeles County

**Committees**
- Project MASTER Steering Committee
- APS Core Curriculum Committee
- Protective Services Operations Committee of the California Welfare Directors Association

**Evaluation Consultants**
- James Coloma, Evaluation Consultant
- Jane Birdie, Evaluation Consultant
- Cynthia Parry, Evaluation Consultant
By the end of this training, participants will be able to:

- Identify key indicators that differentiate between medical, mental health, and substance abuse problems.
- Recognize common medication problems and interactions.
- Discuss when a mental or physical assessment by a professional is needed.
- Demonstrate the use of an Eco-map.
- Identify how personal values and culture influence the worker’s ability to make an accurate biopsychosocial assessment.
- Discuss types of assessment questions that may assist in indicating when involuntary services should be provided or when the client’s refusal of services should be accepted.
PRESENTATION

Biopsychosocial Assessment
Navigating the Grey Areas

Funded by the Archstone Foundation
WELCOME AND INTRODUCTIONS

TIME ALLOTTED: 15 minutes

Slide #2: Housekeeping

Slide 3

Evaluation Process

Slide 4

Developing an ID Code

- What are the first three letters of your mother's maiden name? Alice Smith
- What are the first three letters of your mother's first name? Alice Smith
- What are the numerals for the day you were born? Nov 29th

Trainee ID Code: SMIA129
Dear Training Participant,

As a training program for the Academy for Professional Excellence at San Diego State University School of Social Work, MASTER (Multi-disciplinary Adult Services Training & Evaluation for Results) has begun a process of evaluating training delivered to Adult Protective Service workers. As part of this evaluation, we need your help.

At certain points during this training series, in addition to the usual workshop evaluation forms, you will be asked to complete an embedded skills evaluation within the training day. This embedded skills evaluation will take about 15 minutes. You will be asked to determine what types of questions are being asked in a written interview.

This evaluation has two main purposes:

1. To improve trainings’ effectiveness and relevance to your needs, and help you better serve adults and their families; and
2. To see if the training has been effective in getting its points across.

Our goal is to evaluate training, NOT the individuals participating in the training.

In order to evaluate how well the training is working, we need to link each person’s assessment data using a code. You will generate the code number using the first three letters of your mother’s maiden name, the first three letters of your mother’s first name, and the numerals for the day you were born. Please put this 8-digit ID code on each of your assessment forms, exactly the same way each time. ID code information will only be used to link demographic data to test data to ensure that the training is working equally well for all participants. Once this linking is done, we will only be looking at class aggregate scores, rather than individual scores.

Only you will know your ID code refers to you. All individual responses to evaluation exercises are confidential and will only be seen by the Academy’s training program and evaluation staff. Only group averages and percentages will be reported. Individual results will not be reported to your employer. Aggregate data may be used for future research to improve training for Adult Protective Service workers.
If you agree to participate, you will fill out a questionnaires administered before and after the training. The questionnaire will be coded with a unique identifier system and all responses will be confidential.

There are no foreseeable risks to you from participating. There is also no direct benefit to you. Your responses will contribute to the development of a series of evaluation tools that will be able to accurately assess the effectiveness of adult protective service training. It is hoped that these tools will assist the Academy for Professional Excellence in improving training for adult protective service workers and therefore improve services to adults and families in California.

Your participation is voluntary and you may withdraw your consent and participation at any time. Participation or non-participation will have no effect on your completion of this training series.

By completing and submitting the questionnaire, you agree to participate. You further agree to permit us to use your anonymous responses in written reports about the questionnaires.

Your help with this evaluation process is greatly appreciated. Your feedback will be instrumental in helping to improve adult protective service training for future participants. If you have any questions about the evaluation or how the data you provide will be used, please contact:

James Coloma, MSW  
Training & Evaluation Specialist  
Academy for Professional Excellence  
San Diego State University – School of Social Work  
6505 Alvarado Road, Suite 107  
San Diego, CA 92120  
(619) 594-3219  
jcoloma@projects.sdsu.edu
**MASTER IDENTIFICATION CODE ASSIGNMENT**

**YOUR IDENTIFICATION CODE:**

In order for us to track your evaluation responses while maintaining your anonymity, we need to assign you an identification code. We would like you to create your own identification code by answering the following questions:

1. What are the first three letters of your mother’s maiden name?
   Example: If your mother’s maiden name was Alice Smith, the first three letters would be: **S M I**. If the name has less than three letters, fill in the letters from the left and add 0 (zero) in the remaining space(s) on the right.
   
   ___  ___  ___

2. What are the first three letters of your mother’s First name?
   Example: If your mother’s maiden name was Alice Smith, the first three letters would be: **A L I**. If the name has less than three letters, fill in the letters from the left and add 0 (zero) in the remaining space(s) on the right.
   
   ___  ___  ___

3. What are the numerals for the DAY you were born?
   Example: If you were born on November 29, 1970, the numerals would be **2 9**. If your birth date is the 1st through the 9th, please put 0 (zero) in front of the numeral (example **0 9**).
   
   ___  ___

Combine these parts to create your own identification code (example: **S M I A L I 2 9**). Please write your identification code in the space at the top right corner of all evaluation materials you receive.

*Remember your identification code and write it at the top of every evaluation form provided to you throughout this training.*
Dear Training Participant,

By providing us with the following demographic information, you will be helping us to understand the effectiveness of this training for future participants. Your participation with this survey is completely voluntary and all of the information will be kept entirely confidential. Only group averages and percentages will be reported. Individual results will not be reported to your employer. Aggregate data may be used for future research to improve training for Adult Protective Service workers.

1. **What is the HIGHEST level of your formal education? (Check only ONE box)**
   - [ ] High School
   - [ ] MA/MS Degree
   - [ ] Some College
   - [ ] MSW
   - [ ] BA/BS Degree
   - [ ] PsyD
   - [ ] BSW Degree
   - [ ] PhD – Field related to social work? [ ] Yes [ ] No

2. **How long have you been in your current position?**
   - [ ] Less than 1 Year
   - [ ] 1 – 2 years
   - [ ] 3 – 5 years
   - [ ] 6 – 10 years
   - [ ] 11+ years

3. **Do you hold a current license as a mental health practitioner?**
   - [ ] Yes
   - [ ] No
   - If yes, which one?
     - [ ] LCSW
     - [ ] MFT
     - [ ] Lic./Registered Psychologist
     - [ ] Other: _______

4. **How do you identify yourself in terms of ethnicity/race?**
   - [ ] African American
   - [ ] Hispanic/Latino
   - [ ] American Indian/Alaskan Native
   - [ ] Multi-racial (specify): _________________
   - [ ] Asian/Pacific Islander
   - [ ] Other (specify): _________________
   - [ ] Caucasian/White

5. **What is your age?**
   - [ ] 25 or younger
   - [ ] 26 – 35
   - [ ] 36 – 45
   - [ ] 46 or older

6. **What is your gender?**
   - [ ] Male
   - [ ] Female

7. **Is English your second language?**
   - [ ] Yes
   - [ ] No
   - If yes, what is your first language? _________________

8. **What STATE do you work in?**
   - [ ] _________________
   - a. If you work in CALIFORNIA, what COUNTY do you work for? _________________
9. Which of these best describes your primary job assignment? Please provide clarification if your job function is not typical of that category (e.g. MSSP Nurse in Aging Services, APS Trainer, Community Information Police Officer):

- APS Only
- (01) Line Worker
- (02) Supervisor
- (03) Manager
- (04) Other:
- (29) Case Managers (IHSS or Other Homemaker Services)
- (13) Aging Services
- (20) Mental Health
- (14) Code Enforcement
- (21) Nursing (APS or Public Health)
- (15) Financial Abuse Trainer or Advocate
- (22) Prosecution/Court Services
- (16) Law Enforcement
- (23) Public Authority
- (17) Legal Services
- (24) Public Guardian
- (18) Long Term Care Provider
- (25) Regional Center/Disability Services
- (19) Medical (not APS, Public Health, or LTC)
- (26) Victim/Witness Assistance
- (27) Other (specify): ______________________

a. If you work for APS, what type of investigations do you conduct?
- Disability Investigations Only
- Elder Investigations Only
- Both

10. How many years of experience do you have working with each of these populations:

- Seniors
  - Less than 1 yr
  - 1 – 2 yrs
  - 3 – 5 yrs
  - 6 – 10 yrs
  - 11+ yrs
- Disabled
  - Less than 1 yr
  - 1 – 2 yrs
  - 3 – 5 yrs
  - 6 – 10 yrs
  - 11+ yrs
- Protective Social Services - Adults
  - Less than 1 yr
  - 1 – 2 yrs
  - 3 – 5 yrs
  - 6 – 10 yrs
  - 11+ yrs
- Protective Social Services - Children
  - Less than 1 yr
  - 1 – 2 yrs
  - 3 – 5 yrs
  - 6 – 10 yrs
  - 11+ yrs

11. Have you had any specialized training in gerontology?
- Yes
- No

a. If yes, what type (check all that apply)?
- Gerontology Graduate Studies (Focus Area)
- Gerontology Graduate Studies (Coursework)
- Continuing Education Training
- Other: ______________________

12. Which of the following statements best describes your feelings about attending this training series?
- I am excited about attending this training series and believe it will help me do my job better.
- I am unsure about what this training series has to offer me.
- This training series is a requirement. I am looking forward to getting it over with.
- I have no feelings, either positive or negative, about attending this training series.

13. I am concerned about the amount of time this training series will require me to be away from my cases:
- Yes
- No
Slide # 5

**NAPSA Definition of Self-Neglect**

Self neglect is the result of an adult’s inability, due to physical and/or mental impairments or diminished capacity, to perform essential self-care tasks including: providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; and/or managing financial affairs.

Slide # 6

**Why Focus on Self-Neglect?**

- Comprises highest percentage of allegations in APS caseload
- Is an independent risk factor for death
- Associated with diseases of old age, dementia, depression, psychosis and executive dysfunction
- Complex, requires interdisciplinary collaboration

Slide # 7

**Strategy for the 3-day training**

- Biopsychosocial Assessment
- Engaging Reluctant Clients
- Legal, Ethical and Practice Issues in Self Neglect
Learning Objective 1
Identify key indicators of medical, mental health, and substance abuse issues that impact cognition and functioning in self-neglect investigations.

Is it dementia, delirium or depression?

Learning Objective 2
Recognize common medication problems and interactions and their effect on functioning.

Will changing his meds, clear his mind?

Learning Objective 3
Recognize how social supports impact the effects of diminished capacity.

Does he have to be conserved?
Biopsychosocial Assessment Basics

TIME ALLOTTED: 60 minutes

Slide # 11

The Biopsychosocial Model

- 3 realms of life functioning
- Become more interconnected with age and disability
- Problems in one realm, may spread to other realms
- If one realm is affected, others may have to be expanded to compensate

Slide #12

Specific Components of Assessment

- **Bio**
  - Medical Conditions/Diagnoses
  - Medications and Interactions/Side Effects
  - Delirium
  - Dementia
- **Psycho**
  - Mental Illness
  - Substance Abuse
  - History of Decisions/relationships
- **Social**
  - Social Supports
  - Willingness to accept interventions
Goal of Biopsychosocial Assessment

- Functional
- Strength-based
- Recognize and differentiate between difficult medical and psychological conditions
- Acceptance of multiple ways to approach situations

What are the implications of your assessments of self-neglecting clients?
Slide # 16

**Decision-Making Capacity**

“A threshold requirement. Imposed by society, for an individual to retain decision making power in a particular activity or set of activities”

Daniel Maron, JD, Ph.D.

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Slide # 17

**Attributes of Capacity**

- Receive, comprehend, and relate relevant information
- Express choice consistently
- Appreciate the nature of their condition
- Balance risks, benefits, and burdens of choices
- Communicate rational behind choices
- Receive, comprehend, and relate relevant information

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Slide # 18

**The 3 D’s**

- **Dementia**
- **Delirium**
- **Depression**
Slide # 19

**Dementia Defined**

- It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain. It includes a memory deficit plus a deficit in at least one other cognitive domain.

- Final common behavioral pathway for many diseases/etiologies that affect the brain

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Slide # 20

**DSM-IV Criteria**

- The development of a memory impairment
- And another cognitive disturbance (aphasia, apraxia, agnosia or disturbance in executive functioning)
- Which cause significant impairment
- And doesn't occur exclusively during the course of a delirium
- And is not better accounted for by another Axis I disorder

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Slide # 21

**DSM-IV Criteria Cont.**

- **Aphasia** - Language disturbance
  - EXAMPLE: Naming, fluency, repetition, reading, writing

- **Apraxia** - Impaired ability to carry out motor activities despite intact motor function
  - EXAMPLE: Buttoning shirt, brushing teeth, wiping the table

- **Agnosia** - Failure to recognize or identify objects despite intact sensory function
  - EXAMPLE: Doesn't recognize son, know what a cup is for

- **Disturbance in executive functioning** - Planning, organizing, abstracting
  - EXAMPLE: Cannot operate coffee maker, address an envelope, etc.
Causes of Reversible Dementias

- Drugs, dehydration, depression
- Electrolyte imbalances, emotional disorders
- Metabolic disorders
- Endocrine disorders
- Nutritional Deficiencies
- Trauma, tumor
- Infections (urinary tract)
- Acute illness, arteriosclerosis complications
- Seizures, strokes, sensory deprivation

Medical Conditions

These medical conditions can impact cognition:
- Dehydration
- Congestive heart failure
- Chronic lung disease
- Urinary tract infection
- Diabetes
- Mini-stroke
### Appendix G. Medical Conditions Affecting Capacity

**Dementia** is a general term for a medical condition characterized by a loss of memory and functioning. Primary degenerative dementias are those with disease processes that result in a deteriorating course, including Alzheimer’s disease, Lewy Body Dementia, and Frontal Dementia (each associated with a type of abnormal brain cell).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Etiology</th>
<th>Symptoms</th>
<th>Treatability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic Dementia</td>
<td>A fairly common form of dementia, caused by long-term abuse of alcohol, usually for 20 years or more. Alcohol is a neurotoxin that passes the blood-brain barrier.</td>
<td>Memory loss, problem-solving difficulty, and impairments in visuospatial function are commonly found in patients with alcohol dementia.</td>
<td>Alcohol dementia is partially reversible, if there is long-term sobriety—cessation of use. There is evidence to suggest that some damaged brain tissue may regenerate following extended sobriety, leading to modest improvements in thinking and function.</td>
</tr>
<tr>
<td>Alzheimer’s disease (“AD”)</td>
<td>Most common type of dementia, caused by a progressive brain disease involving protein deposits in brain and disruption of neurotransmitter systems.</td>
<td>Initial short-term memory loss, followed by problems in language and communication, orientation to time and place, everyday problem solving, and eventually recognition of people and everyday objects. In the early stages, an individual may retain some decisional and functional abilities.</td>
<td>Progressive and irreversible, resulting ultimately in a terminal state. Medications may improve symptoms and cause a temporary brightening of function in the earlier stages.</td>
</tr>
<tr>
<td>Bipolar Disorder or Manic Depression</td>
<td>A psychiatric illness characterized by alternating periods of mania and depression.</td>
<td>May affect functional and decisional abilities in the manic stage or when the depressed stage is severe.</td>
<td>Can be treated with medications, but requires a strong commitment to treatment on the part of the individual. Varies over time; periodic re-evaluation is needed.</td>
</tr>
</tbody>
</table>

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This list is meant to define terms as used in this book, and is not meant to define terms more universally. The glossary uses definitions from the *Diagnostic and Statistical Manual of Mental Disorders*, where available, and where not, definitions are based on the consensus of the working group.

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<td>Coma</td>
<td>A state of temporary or permanent unconsciousness.</td>
<td>Minimally responsive or unresponsive, unable to communicate decisions and needs a substitute decision maker.</td>
<td>Often temporary; regular re-evaluation required.</td>
</tr>
<tr>
<td>Delirium</td>
<td>A temporary confusional state with a wide variety of causes, such as dehydration, poor nutrition, multiple medication use, medication reaction, anesthesia, metabolic imbalances, and infections.</td>
<td>Substantially impaired attention and significant decisional and functional impairments across many domains. May be difficult to distinguish from the confusion and inattention characteristic of dementia.</td>
<td>Often temporary and reversible. If untreated may proceed to a dementia. It is important to rule out delirium before diagnosing dementia. To do so, a good understanding of the history and course of functional decline, as well as a full medical work-up, are necessary.</td>
</tr>
<tr>
<td>Frontal or Frontotemporal Dementia</td>
<td>Broad category of dementia caused by brain diseases or small strokes that affect the frontal lobes of the brain.</td>
<td>Problems with personality and behavior are often the first changes, followed by problems in organization, judgment, insight, motivation, and the ability to engage in goal-oriented behavior.</td>
<td>Early in their disease, patients may have areas of retained functional ability, but as disease progresses they can rapidly lose all decisional capacity.</td>
</tr>
<tr>
<td>Jacob-Creutzfeldt Disease</td>
<td>A rare type of progressive dementia affecting humans that is related to “mad cow” disease.</td>
<td>The disease usually has a rapid course, with death occurring within two years of initial symptoms. These include fatigue, mental slowing, depression, bizarre ideations, confusion, and motor disturbances, including muscular jerking, leading finally to a vegetative state and death.</td>
<td>There is no treatment currently and the disease is relentlessly progressive.</td>
</tr>
</tbody>
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<td>Diffuse Lewy Body Dementia (DLB)</td>
<td>A type of dementia on the Parkinson disease spectrum.</td>
<td>DLB involves mental changes that precede or co-occur with motor changes. Visual hallucinations are common, as are fluctuations in mental capacity.</td>
<td>This disease is progressive and there are no known treatments. Parkinson medications are often of limited use.</td>
</tr>
<tr>
<td>Major Depression</td>
<td>A very common psychiatric illness.</td>
<td>Sad or disinterested mood, poor appetite, energy, sleep, and concentration, feelings of hopelessness, helplessness, and suicidality. In severe cases, poor hygiene, hallucinations, delusions, and impaired decisional and functional abilities.</td>
<td>Treatable and reversible, although in some resistant cases electroconvulsive therapy (ECT) is needed.</td>
</tr>
<tr>
<td>Developmental Disorders (&quot;DD&quot;), including Mental Retardation (&quot;MR&quot;)</td>
<td>Brain-related conditions that begin at birth or childhood (before age 18) and continue throughout adult life. MR concerns low-level intellectual functioning with functional deficits that can be found across many kinds of DD, including autism, Down syndrome, and cerebral palsy.</td>
<td>Functioning tends to be stable over time but lower than normal peers. MR is most commonly mild. Some conditions such as Downs syndrome may develop a supervening dementia later in life, causing decline in already limited decisional and functional abilities.</td>
<td>Not reversible, but everyday functioning can be improved with a wide range of supports, interventions, and less restrictive alternatives. Individuals with DD have a wide range of decisional and functional abilities and, thus, require careful assessment by skilled clinicians.</td>
</tr>
<tr>
<td>Parkinson’s Disease (PD)</td>
<td>Progressive brain disease that initially affects motor function, but in many cases proceeds to dementia.</td>
<td>PD presents initially with problems with tremors and physical movement, followed by problems with expression and thinking, and leading sometimes to dementia after a number of years.</td>
<td>PD is progressive, but motor symptoms can be treated for many years. Eventually, medications become ineffective and most physical and mental capacities are lost. Evaluation of capacity must avoid confusion of physical for cognitive impairment.</td>
</tr>
<tr>
<td>Condition</td>
<td>Source</td>
<td>Symptoms</td>
<td>Treatability</td>
</tr>
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<td>---------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Persistent Vegetative State</td>
<td>A state of minimal or no responsiveness following emergence from coma.</td>
<td>Patient is mute and immobile with an absence of all higher mental activity. Cannot communicate decisions and requires a substitute decision maker for all areas.</td>
<td>Cases of PSV usually lead to death within a year’s time.</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>A chronic brain-based psychiatric illness</td>
<td>Hallucinations and delusions; poor judgment, insight, planning, personal hygiene, interpersonal skills. May range from mild to severe. Impact on functional and decisional abilities is variable.</td>
<td>Many symptoms can be successfully treated with medication. Capacity loss may occur when patients go off their medications.</td>
</tr>
<tr>
<td>Stroke or Cerebral Vascular</td>
<td>A significant bleeding in the brain, or a blockage of oxygen to the brain.</td>
<td>May affect just one part of the brain, so individuals should be carefully assessed to determine their functional and decisional abilities.</td>
<td>Some level of recovery and improved function over the first year; thus a temporary guardianship might be considered if the stroke is recent.</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>A blow to the head that usually involves loss of consciousness.</td>
<td>Individuals with mild and moderate TBI may appear superficially the same as before the accident, but have persisting problems with motivation, judgment, and organization. Those with severe TBI may have profound problems with everyday functioning.</td>
<td>Usually show recovery of thinking and functional abilities over the first year; thus a temporary guardianship should be considered if the injury is recent.</td>
</tr>
<tr>
<td>Vascular Cognitive Impairment</td>
<td>Multiple infarcts that cause cognitive impairment</td>
<td>Functional strengths and weaknesses may vary, depending on the extent and location of the strokes.</td>
<td>May remain stable over time if underlying cerebrovascular or heart disease is successfully managed.</td>
</tr>
<tr>
<td>Vascular Dementia (“VaD”)</td>
<td>Multiple strokes that accumulate and cause dementia.</td>
<td>Functional strengths and weaknesses may vary, depending on the extent and location of the strokes.</td>
<td>May worsen if cerebrovascular disease continues to cause progressive impairment.</td>
</tr>
</tbody>
</table>

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Slide # 24

**Irreversible Dementias**

- Alzheimer's Disease
- Vascular Dementia
- Parkinson's Disease
- Frontal-Temporal Dementia
- Dementia with Lewy Bodies
- Alcohol-related Dementia

Slide # 25

**Dementia**

* A deterioration of cognition (thinking abilities) and behavior to a point that it interferes with customary daily living activities

**Distribution of Types of Dementia**

- Alzheimer's: 56%
- Cerebrovascular Causes: 14%
- Multiple Causes: 12%
- Parkinson's: 8%
- Other Causes: 6%
- Brain Injury: 4%

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**DSM-IV Criteria**

- The development of a memory impairment
- And another cognitive disturbance (aphasia, apraxia, agnosia, or disturbance in executive functioning)
- Which cause significant impairment...
- And doesn't occur exclusively during the course of a delirium
- And is not better accounted for by another Axis 1 disorder
Slide # 27

Basic Dichotomies

- Subcortical dementia
  - dementia that affects parts of the brain below the cortex.
  - Subcortical dementia tends to cause changes in emotions and movement in addition to problems with memory.

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Slide # 28

Neuropathology of AD

- Tau Tangles
  - Normally, the tau protein supports tubes inside neurons that allow movement of nerve impulses. In Alzheimer’s, the tau forms tangles and the tubes collapse.

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Slide # 29

Neuropathology of AD

- Amyloid plaques, which are found in the tissue between the nerve cells, are unusual clumps of a protein called beta amyloid along with degenerating bits of neurons and other cells.
Slide #30

Stages of Alzheimer’s Disease

Stage 1: Early Signs
- Aphasia
- Apraxia
- Agnosia

Stage 2: Cortical Signs
- Incontinence
- Mobility Difficulties
- Muteness
- Feeding Difficulties

Stage 3: Physical Decline

Slide #31

AD vs. normal aging

<table>
<thead>
<tr>
<th>Signs of Alzheimer’s</th>
<th>Typical Age-related changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor judgment and decision-making</td>
<td>Making a bad decision once in a while</td>
</tr>
<tr>
<td>Inability to manage a budget</td>
<td>Missing a monthly payment</td>
</tr>
<tr>
<td>Losing track of the date or season</td>
<td>Forgetting what day it is and remembering later</td>
</tr>
<tr>
<td>Difficulty having a conversation</td>
<td>Sometimes forgetting what word to use</td>
</tr>
<tr>
<td>Misplacing things and being unable to retrace steps to find them</td>
<td>Losing things from time to time</td>
</tr>
</tbody>
</table>

Slide #32

Dementia: Early Stage

- Gradual loss of memory and thinking skills
- Inability to complete tasks
- Problems learning new information or forgetting previously learned information

Masking the Problems
- Engage in superficial chit-chat
- Make amusing remarks
- Deflect questions
- Change subject
Slide # 33

Dementia: Middle Stage

- Decline in language abilities and perception
- Difficulty carrying out simple activities
- Problems with executive functioning
  - Loss of ability to think flexibly
  - Loss of ability to sort information
  - Avoidance of new or difficult events/situations

Masking the Problem
- Retain social skills
- Interact at social level

Slide # 34

Dementia: Late Stage

- Physical decline
- Gait disorders
- Incontinence
- Problems feeding self
- “Sundowning”
- Agitation
- Aggression
- Combativeness
- Loss of ability to speak
- Loss of self-recognition

There is no masking the problem.

Slide # 35

Vascular Dementia

- 2nd most common cause of dementia
- Up to 20 percent of all dementias
- Caused by brain damage from cerebrovascular or cardiovascular problems - usually strokes
- May co-exist with AD
- May improve, remain static or worsen
- Wandering, depression, incontinence common
Slide # 36

**Parkinson’s Disease**

- Parkinson’s disease: stiffness of the limbs, shaking at rest (tremor), speech impairment and shuffling gait.
- Estimates of 1% of population 65+ have PD; 41.3% of those meet criteria for dementia.

Slide # 37

**Dementia with Lewy Bodies**

- Visual hallucinations, parkinsonian motor symptoms & fluctuating consciousness hallmark symptoms
- Often misdiagnosed as psychiatric
- Can look like Alzheimer’s
- Cells die in the brain’s cortex, & the mid-brain - substantia nigra.

Slide # 38

**FrontoTemporal Dementia**

- 2-10% of all dementias
- Earlier onset (40-65)
- Often misdiagnosed as psychiatric disorder because:
  - Socially inappropriate
  - Disinhibited, may steal
  - Neglect responsibilities
## THE CLINICAL DEMENTIA RATING SCALE

<table>
<thead>
<tr>
<th></th>
<th>NONE</th>
<th>QUESTIONABLE</th>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Memory</strong></td>
<td>No memory loss or slight</td>
<td>Consistent slight forgetfulness; partial recollection of events; “benign” forgetfulness</td>
<td>Moderate memory loss: more marked for recent events; defect interferes with everyday activity</td>
<td>Severe memory loss, only highly learned material retrained: new material rapidly lost</td>
<td>Severe memory loss only fragments remain</td>
</tr>
<tr>
<td><strong>Orientation</strong></td>
<td>Fully oriented</td>
<td>Fully oriented but with slight difficulty with time relationships</td>
<td>Moderate difficulty with time relationships; oriented for place at examination; may have geographic disorientation elsewhere</td>
<td>Severe difficulty with time relationships; usually disoriented to time, often to place</td>
<td>Oriented to person only</td>
</tr>
<tr>
<td><strong>Judgement and Problem Solving</strong></td>
<td>Solves everyday problems and handles business and financial affairs well; judgement good in relation to past performance</td>
<td>Slight impairment in solving problems, similarities and differences</td>
<td>Moderate difficulty in handling problems, similarities and differences; social judgement usually maintained</td>
<td>Severely impaired in handling problems, similarities and differences; social judgment usually impaired</td>
<td>Unable to make judgements or solve problems</td>
</tr>
<tr>
<td><strong>Community Affairs</strong></td>
<td>Independent function as usual in job, shopping, volunteer and social groups</td>
<td>Slight impairment in these activities</td>
<td>Unable to function independently at these activities though may still be engaged in some; appears normal to casual inspection</td>
<td>No pretense of independent function home; appears well enough to be taken to functions outside the family home</td>
<td>Appears too ill to be taken to functions outside the family home</td>
</tr>
<tr>
<td><strong>Home and Hobbies</strong></td>
<td>Life at home, hobbies and intellectual interests well maintained</td>
<td>Life at home, hobbies and intellectual interests slightly impaired</td>
<td>Mild but definite impairment of functions at home; more difficult chores, and complicated hobbies and interests abandoned</td>
<td>Only simple chores preserved; very restricted interests, poorly maintained</td>
<td>No significant function in the home</td>
</tr>
<tr>
<td><strong>Personal Care</strong></td>
<td>Fully capable of self-care</td>
<td>Needs prompting</td>
<td>Requires assistance in dressing hygiene and keeping of personal effects</td>
<td>Requires much help with personal care; frequent incontinence</td>
<td></td>
</tr>
</tbody>
</table>

Score only as decline from previous usual level due to cognitive loss, not impairment due to other factors. Morris, J.C. (1993) The Clinical Dementia Rating (CDR): current version and scoring rules. *Neurology, 43*, 2412-4
Assignment of CDR rating

Use all information available and make the best judgment. Score each category (M, O, JPS, CA, HH, PC) as independently as possible. Mark in only one box, for each category, rating impairment as decline from the person’s usual level due to cognitive loss alone, not impairment due to other factors, such as physical handicap or depression. Occasionally the evidence is ambiguous and the clinician’s best judgment is that a category could be rated in either one of two adjacent boxes, such as mild (1) or moderate (2) impairment. In that situation the standard procedure is to check the box of greater impairment.

Aphasia is taken into account by assessing both language and non-language function in each cognitive category. If aphasia is present to a greater degree than the general dementia, the subject is rated according to the general dementia. Supply evidence of non-language cognitive function.

The global CDR is derived from the scores in each of the six categories (“box scores”) as follows. Memory (M) is considered the primary category and all others are secondary. CDR = M if at least three secondary categories are given the same score as memory. Whenever three or more secondary categories are given a score greater or less than the memory score, CDR = score of majority of secondary categories on whichever side of M has the greater number of secondary categories. When three secondary categories are scored on one side of M and two secondary categories are scored on the other side of M, CDR=M.

When M = 0.5, CDR = 1 if at least three of the other categories are scored one or greater. If M = 0.5, CDR cannot be 0; it can only be 0.5 or 1. If M = 0, CDR = 0 unless there is impairment (0.5 or greater) in two or more secondary categories, in which case CDR = 0.5.

Although applicable to most Alzheimer’s disease situations, these rules do not cover all possible scoring combinations. Unusual circumstances occur occasionally in Alzheimer’s disease and may be expected in non-Alzheimer dementia as well are scored as follows:

(1) With ties in the secondary categories on one side of M, choose the tied scores closest to M for CDR (e.g., M and another secondary category = 3, two secondary categories = 2, and two secondary categories = 1; CDR = 2).
(2) When only one or two secondary categories are given the same score as M, CDR = M as long as no more than two secondary categories are on either side of M.
(3) When M = 1 or greater, CDR cannot be 0; in this circumstance, CDR = 0.5 when the majority of secondary categories are 0.

Slide # 39

**FrontoTemporal Dementia**

- Other common symptoms include
  - Loss of speech and language,
  - Compulsive or repetitive behavior,
  - Increased appetite,
  - Motor problems such as stiffness and balance problems.
  - Memory loss also may occur, although it typically appears late in the disease.

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Slide # 40

**The 3 D’s**

- **Dementia**
- **Delirium**
- **Depression**

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Slide # 41

**Delirium**

- Disturbance in alertness, consciousness, perception, and thinking
- Sudden onset
- Caused by infection, dehydration, changes in chemical balance, head trauma, post surgical recovery
- Medical emergency
- Treatable and reversible
Symptoms of Delirium

**Acute Confusional State**
marked by:
- Attentional Deficits
- Fluctuations in Level of Arousal
- Disturbed Sleep-Wake Cycle

**Hyperactive “Florid”**
- Agitation, Anxiety, Disorganization

**Hypoactive “Quiet”**
(Worst Outcome)
- Apathy, Depression, Confusion, Stupor
  (Confused with Depression/Dementia)
Etiologies:
- Infection, Trauma, Medications, Pain
Confusion Assessment Method (CAM)

Measures:
- Acute Onset
- Inattention
- Disorganized Thinking
- Altered Level of Consciousness
- Disorientation
- Memory Impairment
- Perceptual Disturbances
- Psychomotor Agitation
- Psychomotor Retardation
- Altered Sleep-Wake Cycle

Measures:
Confusion Assessment Method (CAM)

(Adapted from Inouye et al., 1990)

Patient’s Name: ______________________________ Date: __________________

Instructions: Assess the following factors.

Acute Onset
1. Is there evidence of an acute change in mental status from the patient’s baseline?
   ___ YES ___ NO ___ UNCERTAIN ___ NOT APPLICABLE

Inattention
(The questions listed under this topic are repeated for each topic where applicable.)
2A. Did the patient have difficulty focusing attention (for example, being easily distractible or having difficulty keeping track of what was being said)?
   ______ Not present at any time during interview
   ______ Present at some time during interview, but in mild form
   ______ Present at some time during interview, in marked form
   ______ Uncertain

2B. (If present or abnormal) Did this behavior fluctuate during the interview (that is, tend to come and go or increase and decrease in severity)?
   ___ YES ___ NO ___ UNCERTAIN ___ NOT APPLICABLE

2C. (If present or abnormal) Please describe this behavior:
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Disorganized Thinking
3. Was the patient’s thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable, switching from subject to subject?
   ___ YES ___ NO ___ UNCERTAIN ___ NOT APPLICABLE

Altered Level of Consciousness
4. Overall, how would you rate this patient’s level of consciousness?
   ______ Alert (normal)
   ______ Vigilant (hyperalert, overly sensitive to environmental stimuli, startled very easily)
   ______ Lethargic (drowsy, easily aroused)
   ______ Stupor (difficult to arouse)
   ______ Coma (unarousable)
   ______ Uncertain
Disorientation
5. Was the patient disoriented at any time during the interview, such as thinking that he or she was somewhere other than the hospital, using the wrong bed, or misjudging the time of day?
   ____ YES  ____ NO  ____ UNCERTAIN  ____ NOT APPLICABLE

Memory Impairment
6. Did the patient demonstrate any memory problems during the interview, such as inability to remember events in the hospital or difficulty remembering instructions?
   ____ YES  ____ NO  ____ UNCERTAIN  ____ NOT APPLICABLE

Perceptual Disturbances
7. Did the patient have any evidence of perceptual disturbances, such as hallucinations, illusions, or misinterpretations (for example, thinking something was moving when it was not)?
   ____ YES  ____ NO  ____ UNCERTAIN  ____ NOT APPLICABLE

Psychomotor Agitation
8A. At any time during the interview, did the patient have an unusually increased level of motor activity, such as restlessness, picking at bedclothes, tapping fingers, or making frequent, sudden changes in position?
   ____ YES  ____ NO  ____ UNCERTAIN  ____ NOT APPLICABLE

Psychomotor Retardation
8B. At any time during the interview, did the patient have an unusually decreased level of motor activity, such as sluggishness, staring into space, staying in one position for a long time, or moving very slowly?
   ____ YES  ____ NO  ____ UNCERTAIN  ____ NOT APPLICABLE

Altered Sleep-Wake Cycle
9. Did the patient have evidence of disturbance of the sleep-wake cycle, such as excessive daytime sleepiness with insomnia at night?
   ____ YES  ____ NO  ____ UNCERTAIN  ____ NOT APPLICABLE

Scoring:
For a diagnosis of delirium by CAM, the patient must display:
1. Presence of acute onset and fluctuating discourse
   AND
2. Inattention
   AND EITHER
3. Disorganized thinking
   OR
4. Altered level of consciousness

Source:
Confusion Assessment Method (CAM) Diagnostic Algorithm

Feature 1: Acute Onset and Fluctuating Course
This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions: Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day; that is, did it tend to come and go, or increase and decrease in severity?

Feature 2: Inattention
This feature is shown by a positive response to the following question: Did the patient have difficulty focusing attention; for example, being easily distractible, or having difficulty keeping track of what was being said?

Feature 3: Disorganized Thinking
This feature is shown by a positive response to the following question: Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

Feature 4: Altered Level of Consciousness
This feature is shown by any answer other than "alert" to the following question: Overall, how would you rate this patient's level of consciousness? (alert [normal], vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], or coma [unarousable])

Source:
Slide # 46

The 3 D's

Dementia
Delirium
Depression

Slide # 47

DSM-IV Criteria

- Five (or more) symptoms have been present for 2-weeks and at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
- The symptoms cause clinically significant distress or impairment.
- The symptoms are not due to the effects of a substance or a general medical condition.
- The symptoms are not better accounted for by Bereavement.

Slide # 48

Symptoms of Depression

- Sleep Disturbance
- Loss of Energy / Libido
- Change in Appetite / Weight
- Psychomotor Retardation / Agitation
- Poor Concentration / Attention
GERIATRIC DEPRESSION SCALE
(Short Form)

Choose the best answer for how you have felt over the past week:
1. Are you basically satisfied with your life? YES / NO
2. Have you dropped many of your activities and interests? YES / NO
3. Do you feel that your life is empty? YES / NO
4. Do you often get bored? YES / NO
5. Are you in good spirits most of the time? YES / NO
6. Are you afraid that something bad is going to happen to you? YES / NO
7. Do you feel happy most of the time? YES / NO
8. Do you often feel helpless? YES / NO
9. Do you prefer to stay at home, rather than going out and doing new things? YES / NO
10. Do you feel you have more problems with memory than most? YES / NO
11. Do you think it is wonderful to be alive now? YES / NO
12. Do you feel pretty worthless the way you are now? YES / NO
13. Do you feel full of energy? YES / NO
14. Do you feel that your situation is hopeless? YES / NO
15. Do you think that most people are better off than you are? YES / NO

Answers in bold indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes a score >5 points is suggestive of depression and should warrant a follow-up interview. Scores >10 are almost always depression.
Slide # 49

Symptoms of Depression

- Anhedonia - Loss of Interest in Usual Activities
- Somatic Complaints
- Dysphoria - Flat Affect
- Sense of Hopelessness/Worthlessness
- Suicidal Ideation

Slide # 50

Characteristics

- Depression in the elderly is often undiagnosed or under-diagnosed.
- Depression is treatable with medication and psychotherapy

Slide # 51

Research on depression treatments

- Antidepressant meds (SSRIs) have fewer side effects for the elderly.
- Different meds work for different people and may take up to 8 weeks to work.
- Continuing to take meds after symptoms disappear can prevent relapse.
- Combining medication with psychotherapy appears to provide maximum benefit.
**ACTIVITY: Differentiating the D's**

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read each case study</td>
<td>Make a list of each client's symptoms</td>
<td>Discuss with your group</td>
<td>Determine whether the client suffers from dementia, delirium or depression</td>
</tr>
</tbody>
</table>

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CASE STUDIES

Case Study #1 – Rosemary Cellini
Mrs. Cellini, age 83, was referred to APS because she was found outside mumbling to herself. When her neighbor approached her, she quieted down but didn’t make any sense. She appeared to have lost weight as well. The neighbor stated that she talked to Mrs. Cellini last week when she returned from a brief hospitalization and she seemed ok at that time. Now, Mrs. Cellini doesn’t even recognize her own house.

When you visit, she appears confused and disoriented. She is quite thin and has a bruise on her forehead, but cannot explain what happened. She talks about her mother and how she just went to the store and how much she loves her. (You had heard from the neighbor that client’s mother lived in Italy and died 10 years before). It is difficult to follow her conversation as she often stops in mid-sentence and she seems distracted. The house is in good repair but is untidy. There is very little food in the refrigerator and there is about a week’s worth of dirty clothing on the floors. Mrs. Cellini has current medication in her house for hypertension and diabetes.

Case Study #2 – Proful Dixit
Mr. Dixit, age 77, was referred to APS by the Health Department because they had received complaints about the environmental conditions in the home which have deteriorated over the last year. Although there were some minor violations, the concern was the client who was found dirty and disheveled. The officer stated that Mr. Dixit seemed embarrassed and nervous. When the officer told him about the violations, he seemed not to understand what the issues were, but smiled and said his son would take care of everything.

When you visit, Mr. Dixit greets you pleasantly but does not volunteer information. The house appears to be in the same condition as described by the Health Officer. Mr. Dixit is surrounded by newspapers, magazines, and take-out food containers. His clothing is urine stained, but he does not appear to notice it.
There are several cats in the home. He seems to have difficulty understanding what you are saying, but nods his head politely. Mr. Dixit has medication for arthritis, high cholesterol and Parkinson’s.

**Case Study #3 – Mary Jo Jackson**

Mrs. Jackson, age 73, was referred to APS after the police did a welfare check requested by Mrs. Jackson’s daughter who lives out of state. Initially, Mrs. Jackson failed to answer the door for the police. Then, she appeared to be confused about why the police were there and refused any assistance.

When you visit, Mrs. Jackson appears to have difficulty focusing on your conversation. You have to repeat your questions as she often doesn’t respond immediately and then seems to have lost the thread of the conversation. When you ask Mrs. Jackson about her family, Mrs. Jackson seems uninterested in discussing her past or her daughter’s current concerns. She says she’ll call her daughter “later”, when she feels up to it. The house is in reasonable repair but is very untidy. There is little food in the home and the client appears unconcerned getting more food in. She asks to you leave because she doesn’t feel up to answering questions.
In each of your groups, answer the following questions for all three clients:

<table>
<thead>
<tr>
<th>Case Study #1</th>
<th>Case Study #2</th>
<th>Case Study #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosemary Cellini</td>
<td>Proful Dixit</td>
<td>Mary Jo Jackson</td>
</tr>
</tbody>
</table>

1. What are the indicators that client may have a mental status problem?

2. Does the client appear to have dementia, delirium or depression?

3. What more information do you need and how would you get it?
Assessment Tools

TIME ALLOCATED: 120 minutes

Slide # 53

Assessment Tools

Slide # 54

Mental Status Assessment Skills

- Do your homework:
  - Know your client
  - Educational level
  - Language issues
  - Cultural factors
- Set the stage
- Join with client
- Be prepared for responses
Assessment Scales and Tools

- Advantages and disadvantages
- When/how to use
- Types of assessment tools
  - Cognitive
    - Folstein Mini-Mental State Exam
    - St. Louis University Mental Status Exam (SLUMS)
    - Montreal Cognitive Assessment (MoCA)
    - Clock Drawing Test
  - Psychological
    - Geriatric Depression Scale (GDS)
    - Cornell Scale

Cognitive Domains

- Orientation
  - Useful because standard.
  - Mostly tests recent and longer-term memory
  - Response is also influenced by level of alertness, attentiveness, and language capabilities.
  - If there has been a precipitous change in orientation, this could signal a critical medical condition such as delirium.
  - Screens: MMSE, MoCA, SLUMS

Cognitive Domains

- Attention
  - Nonspecific abnormalities that can occur in
    - Focal brain lesions,
    - Diffuse abnormalities such as dementia or encephalitis, and in behavioral or mood disorders.
    - Impaired attention is also one of the hallmarks of delirium.
  - Screens (e.g.): MMSE-registration, serial 7s, digit repetition; MoCA-digits, letter vigilance; Trails A etc.
Slide #58

**Cognitive Domains**

- **Memory**
  - Immediate memory: recall of a memory trace after an interval of a few seconds, as in repetition of a series of digits.
  - Recent memory: ability to learn new material and to retrieve that material after an interval of minutes, hours or days. (e.g. word lists)
  - Remote memory: recall of events that occurred prior to the onset of the recent memory defect. Note: this cannot be reliably tested unless you have verifiable information.
- **Screen**s (e.g.): MMSE- registration, 3-item delayed recall; MoCA- registration, 3-item delayed recall etc.

Slide #59

**Cognitive Domains**

- **Language**
  - Verbal Fluency: This refers to the ability to produce spontaneous speech fluently without undue word-finding pauses or failures in word searching. Normal speech requires verbal fluency in the production of responses and the formulation of spontaneous conversational speech.
  - Comprehension- Commands (MMSE fold paper, SLUMS paragraph etc.), general ability to follow directions on exams
  - Naming- (MMSE watch, pen; MoCA camel etc)
  - Repetition- MMSE sentences
  - Reading/Writing- MMSE write a sentence

Slide #60

**Cognitive Domains**

- **Visual-Spatial Organization**
  - Very sensitive to brain dysfunction- can pick up mild delirium and otherwise silent lesions.
  - In a person’s history, listen for getting lost in previously familiar environments, difficulty estimating distance or difficulty orienting objects to complete a task.
  - Visuospatial disturbance is a sensitive indicator of delirium and can occur in any dementia syndrome; it often occurs early in the course of Alzheimer’s disease.
- **Screen**s (e.g.): Clock drawing, Clox; overlapping pentagons etc.
Cognitive Domains

- Executive Functioning
  - Constellation of cognitive skills necessary for complex goal-directed behavior and adaptation to a range of environmental changes and demands.
  - Includes planning strategies to accomplish tasks, implementing and adjusting strategies, monitoring performance, recognizing patterns, and appreciating time sequences.
  - Deficits associated with disruptive behaviors and self-care limitations among patients with Alzheimer's disease.
- Screens (e.g.): Clock drawing; CLOX; verbal fluency tasks (category and letter); EXIT-25

MMSE (Mini Mental State Exam)

Advantages
- Well-known
- Huge normative data with age and education norms
- Translations for all languages we need
- Correct administration directions printed
- Quick, easy

Disadvantages
- Copyright issues
- Low ceiling, misses mild cognitive impairment
- Often incorrectly administered and interpreted

SLUMS (St. Louis University Mental Status Examination)

Advantages
- Free
- Simple Directions/Administration
- Good coverage of domains
- Integrates clock drawing
- Has education corrected norms

Disadvantages
- Language translations in development
- Some stimuli very small
- Would require staff re-training
- Outside providers less familiar
Saint Louis University Mental Status (SLUMS) Examination

1. What day of the week is it? (1 point for the right answer)
2. What is the year? (1 point)
3. What state are we in? (1 point)
4. Please remember these five objects. I will ask you what they are later: apple, pen, tie, house, car. (No points yet)
5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.
   o How much did you spend? (1 point)
   o How much do you have left? (2 points)
6. Please name as many animals as you can in one minute. (No point for naming 0-4; 1 point for naming 5-9; 2 points for naming 10-14; and 3 points for naming 15 or more.)
7. What were the five objects I asked you to remember? (1 point for each object remembered.)
8. I am going to say a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.
   o 87 (0 points)
   o 649 (1 point)
   o 8537 (1 point)
9. (Draw circle.) This circle represents a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.
   o (2 points for hour markers labeled correctly)
   o (2 points for correct time)
10. (Show a triangle, a square and a rectangle.) Please place an X in the triangle. (1 point)
11. Which of those objects is the largest? (1 point)
12. I am going to tell you a story. Please listen carefully because afterward, I'm going to ask you some questions about it.
   Jill was a very successful stockbroker. She made a lot of money in the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped working and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.
   o What was the female's name? (2 points)
   o When did she go back to work? (2 points)
   o What work did she do? (2 points)
   o What state did she live in? (2 points)

MoCA (Montreal Cognitive Assessment)

Advantages
- Free
- Translations in many languages
- More sensitive than MMSE
- Interest in tool increasing

Disadvantages
- Takes longer than MMSE
- More complicated to administer than MMSE
- Some directions not printed on form
- No clear age and education norms
- Relatively small normative data
- Some stimuli very small
- Outside providers less familiar

Clock Drawing

Clock Drawing: Free Condition
## MONTREAL COGNITIVE ASSESSMENT (MOCA)

### VISUOSPATIAL / EXECUTIVE

- **Copy cube:**
  - **Points:** \[ \] /5
- **Draw clock:**
  - **Points:** \[ ]

### NAMING

- **Rhinoceros:** \[ ]
- **Lion:** \[ ]
- **Camel:** \[ ]

### MEMORY

- **Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.**
  - **1st trial**
  - **2nd trial**

### ATTENTION

- **Read list of digits (1 digit/sec). Subject has to repeat them in the forward order:** \[ ] 21854
- **Subject has to repeat them in the backward order:** \[ ] 742
- **Read list of letters. The subject must tap with his hand at each letter. No points if ≥ 2 errors:**
  - **FBACMNAAJKLBAFKDEAAAJAMOFAB**

### LANGUAGE

- **Repeat:** I only know that John is the one to help today. [ ]
  - **Fluency / Name maximum number of words in one minute that begin with the letter F:** [ ] \( N \geq 11 \) words

### ABSTRACTION

- **Similarity between e.g. banana - orange = fruit:** [ ]
- **Train - bicycle:** [ ]
- **Watch - ruler:** [ ]

### DELAYED RECALL

- **Has to recall words with no cue:** [ ]
- **Category cue:** [ ]
- **Multiple choice cue:** [ ]

### ORIENTATION

- **Date:** [ ]
- **Month:** [ ]
- **Year:** [ ]
- **Day:** [ ]
- **Place:** [ ]
- **City:** [ ]

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© Z. Nasreddine MD  Version 7.1  www.mocatest.org  Normal ≥26 / 30

Add 1 point if ≤12 yr edu

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**ADVANCED MODULE 1**

**-50-**

**7/12/2010**

Version 2
Montreal Cognitive Assessment
(MoCA)

Administration and Scoring Instructions

The Montreal Cognitive Assessment (MoCA) was designed as a rapid screening instrument for mild cognitive dysfunction. It assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations, and orientation. Time to administer the MoCA is approximately 10 minutes. The total possible score is 30 points; a score of 26 or above is considered normal.

1. Alternating Trail Making:
   Administration: The examiner instructs the subject: "Please draw a line, going from a number to a letter in ascending order. Begin here [point to (1)] and draw a line from 1 then to A then to 2 and so on. End here [point to (E)]."
   Scoring: Allocate one point if the subject successfully draws the following pattern: 1 – A – 2 – B – 3 – C – 4 – D – 5 – E, without drawing any lines that cross. Any error that is not immediately self-corrected earns a score of 0.

2. Visuoconstructional Skills (Cube):
   Administration: The examiner gives the following instructions, pointing to the cube: “Copy this drawing as accurately as you can, in the space below”.
   Scoring: One point is allocated for a correctly executed drawing.
   • Drawing must be three-dimensional
   • All lines are drawn
   • No line is added
   • Lines are relatively parallel and their length is similar (rectangular prisms are accepted)
   A point is not assigned if any of the above-criteria are not met.

3. Visuoconstructional Skills (Clock):
   Administration: Indicate the right third of the space and give the following instructions: “Draw a clock. Put in all the numbers and set the time to 10 after 11”.
   Scoring: One point is allocated for each of the following three criteria:
   • Contour (1 pt.): the clock face must be a circle with only minor distortion acceptable (e.g., slight imperfection on closing the circle);
   • Numbers (1 pt.): all clock numbers must be present with no additional numbers; numbers must be in the correct order and placed in the approximate quadrants on the clock face; Roman numerals are acceptable; numbers can be placed outside the circle contour;
   • Hands (1 pt.): there must be two hands jointly indicating the correct time; the hour hand must be clearly shorter than the minute hand; hands must be centred within the clock face with their junction close to the clock centre.
   A point is not assigned for a given element if any of the above-criteria are not met.

MoCA Version November 12, 2004
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www.mocatest.org
4. **Naming:**

   **Administration:** Beginning on the left, point to each figure and say: "Tell me the name of this animal".

   **Scoring:** One point each is given for the following responses: (1) camel or dromedary, (2) lion, (3) rhinoceros or rhino.

5. **Memory:**

   **Administration:** The examiner reads a list of 5 words at a rate of one per second, giving the following instructions: "This is a memory test. I am going to read a list of words that you will have to remember now and later on. Listen carefully. When I am through, tell me as many words as you can remember. It doesn’t matter in what order you say them." Mark a check in the allocated space for each word the subject produces on this first trial. When the subject indicates that (s)he has finished (has recalled all words), or can recall no more words, read the list a second time with the following instructions: "I am going to read the same list for a second time. Try to remember and tell me as many words as you can, including words you said the first time.” Put a check in the allocated space for each word the subject recalls after the second trial.

   At the end of the second trial, inform the subject that (s)he will be asked to recall these words again by saying, "I will ask you to recall those words again at the end of the test.”

   **Scoring:** No points are given for Trials One and Two.

6. **Attention:**

   **Forward Digit Span:** **Administration:** Give the following instruction: "I am going to say some numbers and when I am through, repeat them to me exactly as I said them." Read the five number sequence at a rate of one digit per second.

   **Backward Digit Span:** **Administration:** Give the following instruction: "Now I am going to say some more numbers, but when I am through you must repeat them to me in the backwards order." Read the three number sequence at a rate of one digit per second.

   **Scoring:** Allocate one point for each sequence correctly repeated, (N.B.: the correct response for the backwards trial is 2-4-7).

   **Vigilance:** **Administration:** The examiner reads the list of letters at a rate of one per second, after giving the following instruction: "I am going to read a sequence of letters. Every time I say the letter A, tap your hand once. If I say a different letter, do not tap your hand”.

   **Scoring:** Give one point if there is zero to one errors (an error is a tap on a wrong letter or a failure to tap on letter A).
Serial 7s: Administration: The examiner gives the following instruction: "Now, I will ask you to count by subtracting seven from 100, and then, keep subtracting seven from your answer until I tell you to stop." Give this instruction twice if necessary.

Scoring: This item is scored out of 3 points. Give no (0) points for no correct subtractions, 1 point for one correction subtraction, 2 points for two-to-three correct subtractions, and 3 points if the participant successfully makes four or five correct subtractions. Count each correct subtraction of 7 beginning at 100. Each subtraction is evaluated independently; that is, if the participant responds with an incorrect number but continues to correctly subtract 7 from it, give a point for each correct subtraction. For example, a participant may respond "92 – 85 – 78 – 71 – 64" where the "92" is incorrect, but all subsequent numbers are subtracted correctly. This is one error and the item would be given a score of 3.

7. Sentence repetition:
   Administration: The examiner gives the following instructions: "I am going to read you a sentence. Repeat it after me, exactly as I say it [pause]: I only know that John is the one to help today." Following the response, say, "Now I am going to read you another sentence. Repeat it after me, exactly as I say it [pause]: The cat always hid under the couch when dogs were in the room."

   Scoring: Allocate 1 point for each sentence correctly repeated. Repetition must be exact. Be alert for errors that are omissions (e.g., omitting "only", "always") and substitutions/omissions (e.g., "John is the one who helped today," substituting "hides" for "hid", altering plurals, etc.).

8. Verbal fluency:
   Administration: The examiner gives the following instruction: "Tell me as many words as you can think of that begin with a certain letter of the alphabet that I will tell you in a moment. You can say any kind of word you want, except for proper nouns (like Bob or Boston), numbers, or words that begin with the same sound but have a different suffix; for example, love, lover, loving. I will tell you to stop after one minute. Are you ready? [Pause] Now, tell me as many words as you can think of that begin with the letter F. [time for 60 sec]. Stop."

   Scoring: Allocate one point if the subject generates 11 words or more in 60 sec. Record the subject’s response in the bottom or side margins.

9. Abstraction:
   Administration: The examiner asks the subject to explain what each pair of words has in common, starting with the example: "Tell me how an orange and a banana are alike". If the subject answers in a concrete manner, then say only one additional time: "Tell me another way in which those items are alike". If the subject does not give the appropriate response (fruit), say, "Yes, and they are also both fruit." Do not give any additional instructions or clarification.

   After the practice trial, say, "Now, tell me how a train and a bicycle are alike". Following the response, administer the second trial, saying: "Now tell me how a ruler and a watch are alike". Do not give any additional instructions or prompts.
Scoring: Only the last two item pairs are scored. Give 1 point to each item pair correctly answered.
The following responses are acceptable:
  Train-bicycle = means of transportation, means of travelling, you take trips in both;
  Ruler-watch = measuring instruments, used to measure.
The following responses are not acceptable: Train-bicycle = they have wheels, Ruler-watch = they have numbers.

10. Delayed recall:
   Administration: The examiner gives the following instruction: "I read some words to you earlier, which I asked you to remember. Tell me as many of those words as you can remember. Make a check mark (✓) for each of the words correctly recalled spontaneously without any cues, in the allocated space.

   Scoring: Allocate 1 point for each word recalled freely without any cues.

Optional:
Following the delayed free recall trial, prompt the subject with the semantic category cue provided below for any word not recalled. Make a check mark (✓) in the allocated space if the subject remembered the word with the help of a category or multiple-choice cue. Prompt all non-recalled words in this manner. If the subject does not recall the word after the category cue, give him/her a multiple choice trial, using the following example instruction, "Which of the following words do you think it was, NOSE, FACE, or HAND?"

   Use the following category cue and/or multiple-choice cues for each word, when appropriate:
   FACE: category cue: part of the body multiple choice: nose, face, hand
   VELVET: category cue: type of fabric multiple choice: denim, cotton, velvet
   CHURCH: category cue: type of building multiple choice: church, school, hospital
   DAISY: category cue: type of flower multiple choice: rose, daisy, tulip
   RED: category cue: a colour multiple choice: red, blue, green

   Scoring: No points are allocated for words recalled with a cue. A cue is used for clinical information purposes only and can give the test interpreter additional information about the type of memory disorder. For memory deficits due to retrieval failures, performance can be improved with a cue. For memory deficits due to encoding failures, performance does not improve with a cue.

11. Orientation:
   Administration: The examiner gives the following instructions: "Tell me the date today". If the subject does not give a complete answer, then prompt accordingly by saying: "Tell me the [year, month, exact date, and day of the week]." Then say: "Now, tell me the name of this place, and which city it is in."

   Scoring: Give one point for each item correctly answered. The subject must tell the exact date and the exact place (name of hospital, clinic, office). No points are allocated if subject makes an error of one day for the day and date.

TOTAL SCORE: Sum all subscores listed on the right-hand side. Add one point for an individual who has 12 years or fewer of formal education, for a possible maximum of 30 points. A final total score of 26 and above is considered normal.
### MoCA scores

<table>
<thead>
<tr>
<th></th>
<th>Normal Controls (NC)</th>
<th>Mild Cognitive Impairment (MCI)</th>
<th>Alzheimer's Disease (AD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of subjects</strong></td>
<td>90</td>
<td>94</td>
<td>93</td>
</tr>
<tr>
<td><strong>MoCA average score</strong></td>
<td>27.4</td>
<td>22.1</td>
<td>16.2</td>
</tr>
<tr>
<td><strong>MoCA standard deviation</strong></td>
<td>2.2</td>
<td>3.1</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>MoCA score range</strong></td>
<td>25.2 - 29.6</td>
<td>19.0 - 25.2</td>
<td>21.0 - 11.4</td>
</tr>
<tr>
<td><strong>Suggested cut-off score</strong></td>
<td>≥26</td>
<td>&lt;26</td>
<td>&lt;26</td>
</tr>
</tbody>
</table>

*Although the average MoCA score for the AD group is much lower than the MCI group, there is overlap between them. The suggested MoCA cut-off score is thus the same for both. The distinction between AD and MCI is mostly dependent on the presence of associated functional impairment and not on a specific score on the MoCA test.*

### Sensitivity and Specificity (%) MoCA and MMSE

<table>
<thead>
<tr>
<th>Cut-off</th>
<th>Normal Controls</th>
<th>Mild Cognitive Impairment</th>
<th>Alzheimer Disease</th>
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<tbody>
<tr>
<td>≥26</td>
<td>(90)</td>
<td>(94)</td>
<td>(93)</td>
</tr>
<tr>
<td>&lt;26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;26</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Group</th>
<th>MoCA</th>
<th>MMSE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(n)</td>
<td>(90)</td>
<td>(94)</td>
<td>(93)</td>
</tr>
<tr>
<td>(90)</td>
<td>87</td>
<td>90</td>
<td>100</td>
</tr>
<tr>
<td>100</td>
<td>18</td>
<td>78</td>
<td></td>
</tr>
</tbody>
</table>
## MoCA Items Average scores

<table>
<thead>
<tr>
<th>Item</th>
<th>NC</th>
<th>MCI</th>
<th>AD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AVG</td>
<td>SD</td>
<td>AVG</td>
</tr>
<tr>
<td>Trails</td>
<td>0.87</td>
<td>0.34</td>
<td>0.56</td>
</tr>
<tr>
<td>Cube</td>
<td>0.71</td>
<td>0.46</td>
<td>0.46</td>
</tr>
<tr>
<td>Clock</td>
<td>2.65</td>
<td>0.65</td>
<td>2.16</td>
</tr>
<tr>
<td>Naming</td>
<td>2.88</td>
<td>0.36</td>
<td>2.64</td>
</tr>
<tr>
<td>Memory</td>
<td>3.73</td>
<td>1.27</td>
<td>1.17</td>
</tr>
<tr>
<td>Digit span</td>
<td>1.82</td>
<td>0.44</td>
<td>1.83</td>
</tr>
<tr>
<td>Letter A</td>
<td>0.97</td>
<td>0.18</td>
<td>0.93</td>
</tr>
<tr>
<td>Serial 7</td>
<td>2.89</td>
<td>0.41</td>
<td>2.65</td>
</tr>
<tr>
<td>Sentence rep</td>
<td>1.83</td>
<td>0.37</td>
<td>1.49</td>
</tr>
<tr>
<td>Fluency F</td>
<td>0.87</td>
<td>0.34</td>
<td>0.71</td>
</tr>
<tr>
<td>Abstraction</td>
<td>1.83</td>
<td>0.43</td>
<td>1.43</td>
</tr>
<tr>
<td>Orientation</td>
<td>5.99</td>
<td>0.11</td>
<td>5.52</td>
</tr>
<tr>
<td>Total*</td>
<td>27.37</td>
<td>2.20</td>
<td>22.12</td>
</tr>
</tbody>
</table>

SD=Standard Deviation. AVG=Average
*Total is adjusted for education

Clock Drawing Test

This is a simple test that can be used as a part of a neurological test or as a screening tool for Alzheimer's and other types of dementia.

**The person undergoing testing is asked to:**
1. Draw a clock
2. Put in all the numbers
3. Set the hands at ten past eleven.

**Scoring system for Clock Drawing test (CDT)**
There are a number of scoring systems for this test. The Alzheimer's disease cooperative scoring system is based on a score of five points:
- 1 point for the clock circle
- 1 point for all the numbers being in the correct order
- 1 point for the numbers being in the proper special order
- 1 point for the two hands of the clock
- 1 point for the correct time.

A normal score is four or five points.

**Test results**
The test can provide information about general cognitive and adaptive functioning such as memory, how people are able to process information and vision. A normal clock drawing almost always predicts that a person's cognitive abilities are within normal limits.

The Clock Drawing Test does offer specific clues about the area of change or damage.

Research varies on the ability of the Clock Drawing test to differentiate between, for example, vascular dementia and Alzheimer's disease.

Draw a clock and set the hands to show 10 minutes past 11.

Copy this clock below.
Appendix 2 -- Cornell Scale for Depression in Dementia (CSDD)

Ratings should be based on symptoms and signs occurring during the week before interview. No score should be given if symptoms result from physical disability or illness.

SCORING SYSTEM
a = Unable to evaluate 0 = Absent 1 = Mild to intermittent 2 – Severe

A. MOOD-RELATED SIGNS
1. Anxiety: anxious expression, rumination, worrying
2. Sadness: sad expression, sad voice, tearfulness
3. Lack of reaction to present events
4. Irritability: annoyed, short tempered

B. BEHAVIORAL DISTURBANCE
5. Agitation: restlessness, hand wringing, hair pulling
6. Retardation: slow movements, slow speech, slow reactions
7. Multiple physical complaints (score 0 if gastrointestinal symptoms only)
8. Loss of interest: less involved in usual activities (score only if change occurred acutely, i.e., in less than one month)

C. PHYSICAL SIGNS
9. Appetite loss: eating less than usual
10. Weight loss: (score 2 if greater than 5 pounds in one month)
11. Lack of energy: fatigues easily, unable to sustain activities

D. CYCLIC FUNCTIONS
12. Diurnal variation of mood: symptoms worse in the morning
13. Difficulty falling asleep: later than usual for this individual
14. Multiple awakening during sleep
15. Early morning awakening: earlier than usual for this individual

E. IDEATIONAL DISTURBANCE
16. Suicidal: feels life is not worthy living
17. Poor self-esteem: self-blame, self-depreciation, feelings of failure
18. Pessimism: anticipation of the worst
19. Mood congruent delusions: delusions of poverty, illness or loss
SCORE ______ Score greater than 12 = Probable depression

Notes/Current Medications:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Instructions for use:
1. The same worker should conduct the interview each time to assure consistency in response.
2. The assessment should be based on the client's normal weekly routine.
3. If uncertain of answers, questioning other caregivers may further define the answer.
4. Answer all questions by placing a check in the column under the appropriately numbered answer.
   (a = unable to evaluate, 0 = absent, 1 = mild to intermittent, 2 - severe)
5. Add the total score for all numbers checked for each question.
6. Place the total score in the "Score" box and record any subjective observation notes in the "Notes/Current Medications" section.
7. Scores totaling twelve (12) points or more indicate probable depression
Appendix C. Cognitive Assessment

This section provides an overview of cognitive functioning and neuropsychological assessment, and is based on information available in key clinical references and the consensus of the working group. This appendix is not intended as a comprehensive or exhaustive discussion of cognitive or neuropsychological testing.

Cognitive Screening

Cognitive screening tests are useful for giving a general level of overall cognitive impairment. They may be used as an overall screening to determine whether additional testing is needed. They may also be used for individuals with more severe levels of impairment who cannot complete other tests.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Screening Test Name</th>
<th>Screening Test Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIMC</td>
<td>Blessed Information Memory Concentration Test</td>
<td>33-point scale with subtests of orientation, personal information, current events, recall, and concentration. There is a short version with six items.</td>
</tr>
<tr>
<td>Cognistat</td>
<td>The Neurobehavioral Cognitive Status Examination</td>
<td>This screening test examines language, memory, arithmetic, attention, judgment, and reasoning.</td>
</tr>
<tr>
<td>MLDT</td>
<td>MacNeill Lichtenberg Decision Tree</td>
<td>This decision tree combines the use of brief screening measures (Benton’s Temporal Orientation Test and the Animal Naming test) with questions about environmental demand and a 3-item screen to rule out depression.</td>
</tr>
<tr>
<td>MMSE</td>
<td>Mini Mental State Examination</td>
<td>30-point screening instrument that assesses orientation, immediate registration of three words, attention and calculation, short-term recall of three words, language, and visual construction.</td>
</tr>
<tr>
<td>MoCA</td>
<td>Montreal Cognitive Assessment</td>
<td>30-point cognitive screening instrument that assesses visualspatial/executive, naming, memory, attention, language, abstraction, delayed recall, and orientation to time.  <a href="http://www.mocatest.org/">http://www.mocatest.org/</a></td>
</tr>
<tr>
<td>MSQ</td>
<td>Mental Status Questionnaire</td>
<td>10-item, 10-point scale assessing orientation to place, time, person, and current events. It has low to modest sensitivity for detecting neurological illness.</td>
</tr>
<tr>
<td>7MS</td>
<td>The Seven Minute Screen</td>
<td>This screening instrument combines four tests, each with separate scores of various ranges: recall, verbal fluency, orientation, and clock drawing.</td>
</tr>
<tr>
<td>SLUMS</td>
<td>The Saint Louis University Mental Status Examination</td>
<td>11-item scale to detect mild cognitive impairment and dementia includes orientation, word memory, arithmetic, naming, clock drawing, story memory.  <a href="http://medschool.slu.edu/agingsuccessfully/">http://medschool.slu.edu/agingsuccessfully/</a> pdfsurveys/slumseexam_05.pdf</td>
</tr>
<tr>
<td>SPMSQ</td>
<td>Short Portable Mental Status Questionnaire</td>
<td>10-point scale scored as a sum of errors on subtests of orientation, location, personal information, current events, and counting backwards. High scores (8-10) equals severe impairment. Race and age corrections to scores are available.</td>
</tr>
<tr>
<td>TICS</td>
<td>Telephone Interview for Cognitive Status</td>
<td>11-item scale developed for situations where in-person cognitive screening is impractical, although it can be administered face to face. Norms for English-speaking adults, ages 60-98 years.</td>
</tr>
</tbody>
</table>
Scoring for Clock Drawing
- Scoring system for Clock Drawing test (CDT)*
- 1 point for the clock circle
- 1 point for all the numbers being in the correct order
- 1 point for the numbers being in the proper spatial order
- 1 point for the two hands of the clock
- 1 point for the correct time.
- A normal score is four or five points.

*There are a number of scoring systems for this test. The Alzheimer’s disease cooperative scoring system is based on a score of five points.

MacNeill-Lichtenberg
Decision Tree for Older Adults
- Cognitive Indicators
- Psychosocial Indicators
- Emotional Factors

Activities of Daily Living
Functional Assessment Screening
- Instrumental - IADL's
  - Transportation
  - Financial Affairs
  - Taking Medications
  - Shopping
  - Preparing Food
  - Housework
  - Using Telephone
- ADL's
  - Bathing
  - Grooming
  - Dressing
  - Feeding
  - Continence
  - Ambulate/Transfer
Medication Issues

Learning Objective 2

Learning to recognize common medication problems and interactions.

Will changing his meds, clear his mind?

Slide 71

Medication Issues

- Adverse reactions
- Medication side effects
- Medication interactions
Meds

- Seniors represent just over 13% of the population, but consume 30-40% of prescription drugs and 35% of all over-the-counter drugs.
- On average, individuals 65 to 69 years old take nearly 14 prescriptions per year, individuals aged 80 to 84 take an average of 18 prescriptions per year.

Meds

- 15% to 25% of drug use in seniors is considered unnecessary or otherwise inappropriate.
- Adverse drug reactions and noncompliance are responsible for 28% of hospitalizations of the elderly.
- 36% of all reported adverse drug reactions involve an elderly individual.
- Each year 32,000 seniors suffer hip fractures caused by medication-related problems (FDA, 1996).

Risk Factors for Adverse Reactions

- Age: slowing down or deterioration of systems
- Weight/small stature
- Excessive # of meds
- Multiple illnesses
- Medications which affect brain
- Taking expired meds
- Changes in medication regimen
- Previous adverse reactions
- Malnutrition and dehydration
- Renal dysfunction
Slide # 75

How it goes wrong

• Unnecessary meds
• Unmet need for new or additional meds
• Wrong med (contraindicated, inappropriate)
• Dosage too low or too high
• Adverse drug reaction or event
• Nonadherence or noncompliance (cost, rx errors, not taking correctly)

Slide # 76

Medication Interactions

• Multiple medications
  - Both meds become ineffective
  - Combo make both meds stronger
  - One med makes the other stronger
  - Combined effect reduces/negates effects of other
• Medication interaction with food, disease, lab tests

Slide # 77

Medication Risks to the Elderly

- 2-7 daily prescription drugs increases risks of Noncompliance, Dosing Errors, Drug Interactions
- More sensitive to therapeutic/toxic effects
  - Increased sedation
  - Anticholinergic
  - Extrapyramidal
- Significant Changes in Pharmacokinetics
  - Decreased distribution
  - Slower metabolism
  - Slower clearance
What You Need to Know/Do

• Medication review: prescriptions, OTC, supplements
• Medical diagnosis
• Etiology and history of medical condition/medication regimen/substance abuse
• Client’s perception of problem in cultural context

Preferred Psychopharmacological Agents for Elderly

Start Low/ Go Slow

**Depression**
- Sertraline (zoloft)
- Mirtazapine (zemcel)
- Venlafaxine (effexor)
- Buproprion (wellbutrin)
- Citalopram (celexa)

**Anxiety**
- Lorazepam (ativan)
- Oxazepam (serax)
- Buspirone (buspar)

**Psychosis/Agitation**
- Olanzapine (zyprexia)
- Risperidone (risperdal)
- Quetiapine (seroquel)

Warning: FDA public health advisory: Treatment of behavioral disorders in elderly patients with dementia with these meds is associated with 1.65 fold increased mortality.

High Risk Situations

• Seeing multiple providers
• On multiple drugs
• Lives alone and/or has cognitive impairment
• Discharge from hospital or any change in venue
Slide # 81

Resources

http://www.umm.edu/adam/drug_checker.htm
  - Drug Checker

  - Beers List (see handout)

http://www.drugs.com/imprints.php
  - Pill Identifier

Slide # 82

Medication Exercise

Slide # 83

Substance Abuse

“Drug abuse among the elderly is an unforeseen epidemic, due largely to the ageing of baby boomers... researchers say the number of adults over 50 with substance abuse problems will double from 2.5 million in 1999 to 5 million in 2020.”

## Common Drugs and Their Side Effects

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Trade Name</th>
<th>Possible Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressants - Tricyclics</td>
<td>Elavil, Sinequan, Tofranil</td>
<td>Sedation, dizziness, dry mouth, blurred vision, weight gain, constipation, blood pressure changes, arrhythmias, sexual dysfunction</td>
</tr>
<tr>
<td>Antidepressants - SSRI</td>
<td>Prozac, Paxil, Zoloft</td>
<td>Mild agitation, restlessness, insomnia</td>
</tr>
<tr>
<td>Anti-Anxiety Medications</td>
<td>Ativan, Xanax, Valium</td>
<td>Drowsiness, slurred speech, lethargy, confusion May cause sudden excitement in elderly – if so, should be discontinued</td>
</tr>
<tr>
<td>Anti- Parkinson's Agents</td>
<td>Sinepet, Artane, Parlodel, Eldepryl, Symmetrel,Cogentin</td>
<td>Confusion, restlessness, excitement</td>
</tr>
<tr>
<td>Pain Medications</td>
<td>Percocet, Percodan, Darvon, Codeine</td>
<td>Dizziness, sedation, nausea, sweating, flushing, slow breathing</td>
</tr>
<tr>
<td>Sedatives, Sleep Aids (prescribed for anxiety)</td>
<td>Halcion, Restoril, Prosom</td>
<td>Drowsiness, lethargy, or confusion</td>
</tr>
<tr>
<td>Antacids and Ulcer Medications</td>
<td>Tagamet, Zantac</td>
<td>Diarrhea, constipation, Interaction with other meds, causing confusing leading to behavioral problems and falls</td>
</tr>
<tr>
<td>Anticoagulants</td>
<td>Coumadin, low-dose aspirin</td>
<td>Abnormal bleeding, excessive bruising</td>
</tr>
<tr>
<td>Cardiac: Antihypertensives</td>
<td>Cardura, Corgard Digoxin, Ineral, Sectral Lasix, Diuril Vasotec, Capopril, Zestril Nitroglycerin</td>
<td>Nausea, loss of appetite, fatigue, dizziness, headache, fainting, skin tingling, confusion, incontinence</td>
</tr>
<tr>
<td>Cardiac: Antiarrhythmics</td>
<td>Depakote, Phenobarbital</td>
<td>Lethargy, dizziness, rash, irritability</td>
</tr>
<tr>
<td>Cardiac: Diuretics</td>
<td>Glucophage</td>
<td>Low blood sugar</td>
</tr>
<tr>
<td>Cardiac: ACE Inhibitors</td>
<td>Mocronase, Glucotrol, Glucophage</td>
<td>Weight loss, reliance</td>
</tr>
<tr>
<td>Angina treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Slide # 84

Alcohol and Physiology

Age Factors
- Decrease in body water
- Decrease in metabolism

Comorbidities
- Increase risk of hypertension and heart problems
- Increased risk of hemorrhage
- Impaired immune system
- Liver disease
- Decreased bone density
- Internal bleeding
- Mental illness
- Sleep disturbances

Slide # 85

CAGE
- Have you ever felt you should cut down on your drinking?
- Have people annoyed you by criticizing your drinking?
- Have you ever felt bad or guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

Slide #86

Physical Symptom
- Sleep complaints
- Cognitive impairment
- Seizures, malnutrition, muscle wasting
- Persistent irritability
- Altered mood, depression, anxiety
- Somatic complaints
- Incontinence
- Blurred vision/dry mouth
- Unexplained nausea, gastrointestinal distress
- Tremor, shuffled gait
- Frequent falls
Behavioral Symptom Triggers

- Worrying if drugs are “really working”
- Worrying about having enough meds
- Self medicating
- Withdrawing from others
- Withdrawing from life-long practices
- Involvement in minor traffic accidents
- Changes in behavior

MAST-G

In the past year:
1. When talking with others, do you ever underestimate how much you actually drink?
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn’t feel hungry?
3. Does having a few drinks help decrease your shakiness or tremors?
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?
5. Do you usually take a drink to relax or calm your nerves?

MAST-G

In the past year:
6. Do you drink to take your mind off your problems?
7. Have you ever increased your drinking after experiencing a loss in your life?
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?
9. Have you ever made rules to manage your drinking?
10. When you feel lonely, does having a drink help?

Scoring: If the person answered “yes” to two or more questions, encourage a talk with the doctor.

Source: University of Michigan Alcohol Research Center, Michigan Alcohol Screening Test (MAST-G) © The Regents of the University of Michigan, 1991
ACTIVITY: Drug Search (No dogs required)

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen to the case introduction.</td>
<td>Review medication labels.</td>
<td>Record all the issues/problems you can identify.</td>
<td>Report out your group's findings.</td>
</tr>
</tbody>
</table>

Background for Drug Search:

"Mrs. Young is a 65 year old woman who has a history of mental health problems. Lately, her neighbors state that she has been unsteady on her feet and somewhat confused. Please review her medications (see handout) and see how many issues you can identify involving her medications? What would your next steps be?"
NOTE: Medications reviewed on 4/15/2010

<table>
<thead>
<tr>
<th>Brand</th>
<th>Contact Information</th>
<th>Prescription Details</th>
<th>Patient Name</th>
<th>Dosage</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savondrugs</td>
<td>8212 Riverside Dr, CA, 92504</td>
<td>Phone: (951) 781-0146</td>
<td>Rx # 289735</td>
<td>2 tabs/31/10</td>
<td>Morning and bedtime</td>
</tr>
<tr>
<td>Savondrugs</td>
<td>8212 Riverside Dr, CA, 92504</td>
<td>Phone: (951) 781-0146</td>
<td>Rx # 123567</td>
<td>2 tabs/31/10</td>
<td>Morning and bedtime</td>
</tr>
<tr>
<td>Savondrugs</td>
<td>8212 Riverside Dr, CA, 92504</td>
<td>Phone: (951) 781-0146</td>
<td>Rx # 888935</td>
<td>2 tabs/8/15/09</td>
<td>Morning and bedtime</td>
</tr>
<tr>
<td>Savondrugs</td>
<td>8212 Riverside Dr, CA, 92504</td>
<td>Phone: (951) 781-0146</td>
<td>Rx # 888932</td>
<td>2 tabs/5/11</td>
<td>Morning and bedtime</td>
</tr>
<tr>
<td>Savondrugs</td>
<td>8212 Riverside Dr, CA, 92504</td>
<td>Phone: (951) 781-0146</td>
<td>Rx # 89135468</td>
<td>2 tabs/5/11</td>
<td>Morning and bedtime</td>
</tr>
<tr>
<td>Savondrugs</td>
<td>5560 Central Ave, CA, 92504</td>
<td>Phone: (951) 358-4057</td>
<td>Rx # 78625566</td>
<td>2 tabs/8/3/09</td>
<td>Morning and bedtime</td>
</tr>
<tr>
<td>Savondrugs</td>
<td>5560 Central Ave, CA, 92504</td>
<td>Phone: (951) 358-4057</td>
<td>Rx # 559872</td>
<td>2 tabs/8/3/09</td>
<td>Morning and bedtime</td>
</tr>
</tbody>
</table>

*NOTE: This bottle contains a yellow and white pill.*
ACTIVITY: Case Studies

Step 1: Put your Trainee ID on all forms.

Step 2: Read the vignettes working independently.

Step 3: Respond to the questions on the evaluation.

Step 4: You have 30 minutes to complete this exercise.

For each of the following vignettes, please read each one and then answer Part 1 and Part 2 using the letters in the key below.

A. Dementia  M. Impaired arousal
B. Delirium    N. Disorientation
C. Depression  O. Visual hallucinations
D. Delirium superimposed on dementia  P. Cognitive screening normal
E. Dementia with depression  Q. Hopelessness
F. Delusional  R. Many "don't know" answers
G. Change from baseline  S. Withdrawal from usual activities
H. Impairment in short-term memory  T. Agitated
I. Impaired judgment  U. Possible untreated infection
J. Suspiciousness/paranoia  V. May be dehydrated, malnourished
K. Normal medical work up  W. Psychotic disorder
L. Impaired attention
I.) Case 1: Owen

Owen is an 86 year-old widower living in an apartment. His wife of 60 years died three years ago of cancer. They had no children. Owen is a WWII veteran who spent most of his working life as a chef in a hotel. His nephew, who lives across the country, called APS for a well-being check because he has not gotten any letters from his uncle (very unusual because he always sent holiday cards) and his uncle was not answering phone calls or messages left on the answering machine. The apartment manager says that he has seen half-eaten meals-on-wheels trays left outside the door and the meals-on-wheels worker says that Owen is around but that he is worried about him, “He just stopped talking and joking with me, we used to talk about the Giants.” When you visit him, Owen is malodorous, his hair is unwashed and his clothing stained. The apartment is tidy, however. When you ask Owen about how he is doing, he says, “How do you think I’m doing? My wife is gone and I’m old and I’m going to run out of money. I don’t know what the use is.” You try to ask him some screening questions and he repeatedly says, “I don’t know,” or “Why should you care?” After a great deal of urging, he agrees to sign a release of information for his primary care physician whom he last saw 3 months ago. His physician says that his he has arthritis, hypertension and diabetes but that his cognitive screening was normal for someone of his age and education.

Part 1: Based on the symptoms described above, a likely cause for his presentation is:

__________ (Insert letter corresponding to the correct disease/condition from the chart below)

Part 2: What symptoms from the above vignette support your answer to Part 1? (Circle correct letter or letters)

A. Dementia  M. Impaired arousal
B. Delirium  N. Disorientation
C. Depression  O. Visual hallucinations
D. Delirium superimposed on dementia  P. Cognitive screening normal
E. Dementia with depression  Q. Hopelessness
F. Delusional  R. Many “don’t know” answers
G. Change from baseline  S. Withdrawal from usual activities
H. Impairment in short-term memory  T. Agitated
I. Impaired judgment  U. Possible untreated infection
J. Suspiciousness/paranoia  V. May be dehydrated, malnourished
K. Normal medical work up  W. Psychotic disorder
L. Impaired attention
II.) Case 2: The Retired Teacher

A 70-year-old retired high school teacher lived with his wife in an active retirement community. Since retiring five years previously, he had been doing volunteer work and had enrolled in the local university's extension program. During the year, he and his wife noticed that he was forgetting names and losing things. On several occasions, he had angry outbursts and accused his wife of hiding his wallet and car keys and of having an affair with a neighbor. He had lost interest in his hobby (building model planes) and seemed lethargic. A week before his wife called APS, he became lost while driving home from the grocery store. His wife then discovered that he had opened several bank accounts and credit cards without her knowledge so that he could "play sweepstakes" something that he would never do earlier in his life. His wife estimates that he may have lost $20,000 although he continues to believe that he is about to get a payoff. He was healthy and usually drank two glasses of wine daily, and he took no medication. According to the primary care physician, his medical work up was unremarkable. He could draw a clock face with great difficulty, and when asked to set the time at "10 after 11," he placed the hands of the clock in the wrong position. He scored 24 out of 30 on the Folstein Mini Mental State Exam (MMSE) because he could not recall two of three objects; could not complete one component of a three-part directed task; and could not recall the current date, month, or year.

Part 1: Based on the symptoms described above, a likely cause for his presentation is:

__________ (Insert letter corresponding to the correct disease/condition from the chart below)

Part 2: What symptoms from the above vignette support your answer to Part 1? (Circle correct letter or letters)

A. Dementia  M. Impaired arousal
B. Delirium  N. Disorientation
C. Depression  O. Visual hallucinations
D. Delirium superimposed on dementia  P. Cognitive screening normal
E. Dementia with depression  Q. Hopelessness
F. Delusional  R. Many don't know answers
G. Change from baseline  S. Withdrawal from usual activities
H. Impairment in short-term memory  T. Agitated
I. Impaired judgment  U. Possible untreated infection
J. Suspiciousness/paranoia  V. May be dehydrated, malnourished
K. Normal medical work up  W. Psychotic disorder
L. Impaired attention
III.) Case 3: Elizabeth

Elizabeth is a 74-year-old woman you have seen several times for different reports of abuse in the past year (e.g. self-neglect, suspected financial abuse). According to her neighbors, she has had increasing memory problems during the past year, and has gotten lost while driving to many familiar places and has been brought home by the police on several occasions. She has also experienced increased difficulty in completing activities of daily living (e.g. has knocked on neighbors’ doors because she had no food). Her primary care physician gave her a diagnosis of mild dementia, although she has always been able to recognize you. Today when you visit, because neighbors were concerned that they had not seen her out of the house for several days and she reportedly fired her in-home caregivers last week, Elizabeth does not seem to notice when she is spoken to and is much sleepier than usual, and falls asleep while you try to assess her. She is disoriented to time and place, and does not recognize you at all. Although you encourage her, she will not eat or take her medicines. During most of the visit, she is staring at the wall as if something were moving there, and says, “that man up there keeps trying to get in.” There is a prominent smell of urine about her person.

Part 1: Based on the symptoms described above, a likely cause for her presentation is:

__________ (Insert letter corresponding to the correct disease/condition from the chart below)

Part 2: What symptoms from the above vignette support your answer to Part 1? (Circle correct letter or letters)

<table>
<thead>
<tr>
<th>A. Dementia</th>
<th>M. Impaired arousal</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Delirium</td>
<td>N. Disorientation</td>
</tr>
<tr>
<td>C. Depression</td>
<td>O. Visual hallucinations</td>
</tr>
<tr>
<td>D. Delirium superimposed on dementia</td>
<td>P. Cognitive screening normal</td>
</tr>
<tr>
<td>E. Dementia with depression</td>
<td>Q. Hopelessness</td>
</tr>
<tr>
<td>F. Delusional</td>
<td>R. Many don’t know answers</td>
</tr>
<tr>
<td>G. Change from baseline</td>
<td>S. Withdrawal from usual activities</td>
</tr>
<tr>
<td>H. Impairment in short-term memory</td>
<td>T. Agitated</td>
</tr>
<tr>
<td>I. Impaired judgment</td>
<td>U. Possible untreated infection</td>
</tr>
<tr>
<td>J. Suspiciousness/paranoia</td>
<td>V. May be dehydrated, malnourished</td>
</tr>
<tr>
<td>K. Normal medical work up</td>
<td>W. Psychotic disorder</td>
</tr>
<tr>
<td>L. Impaired attention</td>
<td></td>
</tr>
</tbody>
</table>
IV.) Case 4: Mavis

Mavis is a 79 year-old woman residing in her own home. You are called out by the post man who is concerned that her mail is piling up and there looks to be water that has been running out of her garage for two days. He can hear the television on. When you knock on the door, she yells for you to come in without asking who is there; the door is unlocked. She is lying on her couch in her dressing gown. Her hair is unkempt. The television is blaring. There are unopened bottles of water and Gatorade around her. There are cartons of yogurt where the foil is busted open; it smells of sour milk. She immediately starts telling you that it is her birthday today and that Larry King is taking her out to dinner. She restless, pulling at her clothes and to every question you ask, she says, “Darling, I am much too beautiful to answer that question, surely you know that.” You look on the table and see an unopened bottle of antibiotics (Cipro) was prescribed 3 days ago. Luckily, while you are taking this in, the phone rings and she answers the cordless handset on the coffee table and says, “I’m fine will you stop worrying!!! Of course I’m taking my medication. Here, talk to my agent” and hands you the phone. One the other end of the line, her daughter, who lives in another county, sounds scared that another person is there and explains that she took her mother to the doctor a few days ago for a urinary tract infection but had to get home to take care of her children. It is not, in fact, her birthday and they do not know Larry King.

Part 1: Based on the symptoms described above, a likely cause for her presentation is:

__________ (Insert letter corresponding to the correct disease/condition from the chart below)

Part 2: What symptoms from the above vignette support your answer to Part 1? (Circle correct letter or letters)

| A. Dementia | M. Impaired arousal |
| B. Delirium | N. Disorientation |
| C. Depression | O. Visual hallucinations |
| D. Delirium superimposed on dementia | P. Cognitive screening normal |
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| H. Impairment in short-term memory | T. Agitated |
| I. Impaired judgment | U. Possible untreated infection |
| J. Suspiciousness/paranoia | V. May be dehydrated, malnourished |
| K. Normal medical work up | W. Psychotic disorder |
| L. Impaired attention |   |
Mitigating the Need for Conservatorship

TIME ALLOCATED: 60 minutes

Slide # 92

Learning Objective 3

Recognize how social supports impact the effects of diminished capacity.

Does he have to be conserved?

Slide # 93

Eco-mapping Activity

- Diagrams client’s degree of connectedness with community, social support, and family
- Represents the nature of the relationships
- Opens door to information, especially when involving client.

Strong connection
Tenuous Connection
Stressful Connection
Interrupted or Broken Connection
Arrows show the direction of energy
Appendix F. Interventions to Address Diminished Capacity

The following list was based on a checklist of less restrictive alternatives to guardianship by Professor Joan O’Sullivan, University of Maryland School of Law. This list details a wide range of legal and social interventions that can be used to assist someone with functional or decisional compromise instead of guardianship.

If the person needs medical treatment, but is not able to consent:

☐ Health Care Advance Directive
Any written statement a competent individual has made concerning future health care decisions. The two typical forms of advance directive are the living will and the health care power of attorney.

☐ Surrogate decision making by an authorized legal representative, a relative, or a close friend
In many states, the next of kin are authorized to make some or all medical treatment decisions in the absence of a health care advance directive or appointed guardian.

If the problem involves litigation against or by the disabled person:

☐ Appointment of Guardian ad litem
The court in which litigation is proceeding has authority to appoint a guardian ad litem solely for the purpose of representing the best interests of the individual in the litigation.

If the problem involves a family dispute:

☐ Mediation
Referring a case to mediation before a hearing offers a personal, confidential, and less intimidating setting than the courtroom, as well as an opportunity for exploring underlying issues privately.

If the person needs help with financial issues:

☐ Bill paying services
Also called money management services, these assist persons with diminished capacity through check depositing, check writing, checkbook balancing, bill paying, insurance claim preparation and filing, tax and public benefit preparation, and counseling.

☐ Utility company third party notification
Most utility companies permit customers to designate a third party to be notified by the utility company if bills are not paid on time.

☐ Shared bank accounts (with family member)
The use of joint bank accounts is a common strategy for providing assistance with financial management needs. However, if the joint ownership arrangement reaches most of the individual’s income or assets, it also poses risk in its potential for theft, self-dealing, unintended survivorship, and exposure to the joint owner’s creditors. A more secure arrangement is a multiple-party account with the family member or friend designated as agent for purposes of access to the account.

☐ Durable Power of Attorney for finances
This legal tool enables a principal to give legal authority, as broadly or as narrowly as desired, to an agent or attorney in fact to act on behalf of the principal, commencing either upon incapacity or commencing immediately and continuing in the event of incapacity. Its creation requires sufficient capacity to understand and establish such an arrangement.

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Trusted

Trusts can be established to serve many purposes, but an important one is the lifetime management of property of one who is or who may become incapacitated. They are especially useful where there is a substantial amount of property at stake and professional management is desired. Special or supplemental needs trusts and pooled income trusts are recognized under federal Medicaid and Social Security laws as permissible vehicles for managing the funds of persons with disability who depend on government programs for their care needs.

Representative Payee

A person or organization authorized to receive and manage public benefits on behalf of an individual. Social Security, Supplemental Security Income (SSI), veterans’ benefits, civil service and railroad pensions, and some state programs provide for appointment of a “rep payee.” Each program has its own statutory authorization and rules for eligibility, implementation, and monitoring.

Adult protective services

The term protective services encompasses a broad range of services. It includes various social services voluntarily received by seniors in need of support (e.g., homemaker or chore services, nutrition programs). It also includes interventions for persons who may be abused, neglected, or exploited, and which may lead to some form of guardianship.

If the person is living in an unsafe environment:

Senior shared housing programs

In shared housing programs, several people live together in a group home or apartment with shared common areas. Congregate housing refers to complexes with separate apartments (including kitchen), some housekeeping services, and some shared meals. Many congregate care facilities are subsidized under federal housing programs. Personal care and health oversight are usually not part of the facility’s services, but they may be provided through other community social services.

Adult foster care

Adult foster care is a social service that places an older person, who is in need of a modest amount of daily assistance, into a family home. The program is similar to foster care programs for children. The cost varies and may be covered in part by the state social services program.

Community residential care

These are small supportive housing facilities that provide a room, meals, help with activities of daily living, and protective supervision to individuals who cannot live independently, but who do not need institutional care.

Assisted living

Assisted living facilities provide an apartment, meals, help with activities of daily living, and supervision to individuals who cannot live independently, but who do not need institutional care.

Nursing home

Nursing homes provide skilled nursing care and services for residents who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons.

Continuing Care Retirement Communities (CCRCs)

Continuing Care Retirement Communities, also called life care communities, usually require the payment of a large entry fee, plus monthly fees thereafter. The facility may be a single building or a campus with separate independent living, assisted living, and nursing care. Residents move from one housing choice to another as their needs change. While usually very expensive, many guarantee

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lifetime care with long-term contracts that detail the housing and care obligations, as well as its costs.

**If the person needs help with activities of daily living or supervision:**

- **Care management**
  
  This is provided by a social worker or health care professional, who evaluates, plans, locates, coordinates, and monitors services for an older person and the family.

- **Home health services**
  
  If the person needs medical care or professional therapy on a part-time or intermittent basis, a *visiting nurse* or *home health aide* from a *home health agency* may meet that need. Some services may be covered by Medicare or Medicaid, private insurance, or state programs.

- **Home care services**
  
  *Homemaker* or *chore services* can provide help with housework, laundry, ironing, and cooking. *Personal care attendants* or *personal assistants* may assist an impaired person in performing *activities of daily living*, (i.e., eating, dressing, bathing, toileting, and transferring), or with other activities instrumental to daily functioning.

- **Adult day care services**
  
  These are community-based group programs designed to meet the needs of functionally and/or cognitively impaired adults through an individual plan of care. Health, social, and other related support services are provided in a structured, protective setting, usually during normal business hours. Some programs may offer services in the evenings and on weekends.

- **Respite care programs**
  
  “Respite” refers to short-term, temporary care provided to people with disabilities in order that their families can take a break from the daily routine of caregiving. Services may involve overnight care for some period of time.

- **Meals on Wheels**
  
  Volunteers deliver nutritious lunchtime meals to the homes of people who can no longer prepare balanced meals for themselves. The volunteers also provide daily social contact with elders to ensure that everything is okay.

- **Transportation services**
  
  Because many elders cannot afford a special transit service, and are too frail to ride the bus, senior transportation services volunteers drive clients to and from medical, dental, or other necessary appointments, and remain with them throughout the visit.

- **Food and prescription drug deliveries**
  
  Either volunteer-based or commercially-based delivery services for food or prescription drugs, may assist those who are unable to leave their home regularly.

- **Medication reminder systems**
  
  This may include a weekly pill organizer box, or another pill distribution system, or telephone reminder calls.

- **Telephone reassurance programs**
  
  These services use volunteer to provide a daily telephone call to older persons living alone.

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Emergency call system ("lifeline")
Usually includes equipment added to the telephone line, plus a wireless signal button worn by the older adult. Trained responders provide emergency assistance in the event of a medical emergency in the home, such as a fall.

Home visitors and pets on wheels
Elder service agencies and other volunteer agencies may match elders with home visitors, including visiting pets, which provide social interaction and a form of monitoring.

Daily checks on the person by mail carriers
Many mail carriers, if notified that an elder at risk is living at an address, will monitor the home to insure that mail has been picked up daily, and if not, notify a designated individual.

Housing modification
A home may be modified or renovated to enhance safety and the use of technology in the home. For example, grab bars, ramps, night wandering alarms, medication prompt systems, and home-telehealth monitors may be added.

If the person has a psychological or medical condition impacting capacity

- Alcohol or other substances intoxication
  Detoxification; supplement diet or other intake needs.

- Altered blood pressure
  Treat underlying cause of blood pressure anomaly with medication or other treatment.

- Altered low blood sugar
  Management of blood sugar through diet or medication.

- Anxiety
  Treatment with medications and/or psychotherapy; support groups.

- Bereavement; Recent death of a spouse or loved one
  Support, counseling by therapist or clergy; support group; medications to assist in short-term problems (e.g., sleep, depression).

- Bipolar disorder
  Treatment with medications and/or psychotherapy; support groups.

- Brain tumor
  Medical treatment as indicated, such as surgery, radiation, and medication.

- Delirium
  Obtain standard labs; obtain brain scan if indicated; assess vitals; treat underlying cause; monitor and reassess over time.

- Dementia
  Treatment with medications for dementia; simplify environment; provide multiple clues within environment; use step-by-step communication.
□ Depression
   Treatment with medications and/or psychotherapy; add pleasurable activities to day; ECT if indicated
   support groups.

□ Developmental disability
   Education and training.

□ Head injury
   Treatments for acute effects (e.g., bleed, pressure, swelling) as necessary; monitoring over time; rehabilitative speech, physical, occupational therapies.

□ Infection (e.g., urinary, influenza, pneumonia, meningitis)
   Treat underlying infection with antibiotic or other treatment.

□ Insomnia
   Sleep hygiene practices (e.g., limit caffeine, light exercise, limit naps); medications.

□ Liver or kidney disease
   Treatment of underlying illness with medication, dialysis, surgery.

□ Loneliness
   Social and recreational activities; support groups.

□ Malnutrition or dehydration
   IV fluids; fluid/food by mouth; food supplements; possible food by feeding tube.

□ Mania
   Treatment with medications and/or psychotherapy; support groups.

□ Medications and sudden medication withdrawal
   Review of medications by clinical pharmacist or specialist; slow one-by-one tapers or changes of medications.

□ Poor heart or lung function (e.g., hypoxia)
   Treatment of underlying condition with medication, surgery, supplemental oxygen.

□ Post surgical confusion (usually related to anesthesia or pain medicines)
   Monitoring and reassessment over time; try alternative medications and treatments for pain management.

□ Depression and anxiety
   Psychotherapy, support, counseling by therapist or clergy; support group; medications to treat symptoms.

□ Schizophrenia; hallucinations or delusions
   Treatment with medications for schizophrenia; simplify environment; provide support.

□ Transfer trauma (a recent move that has the individual disoriented)
   Monitoring over time; re-orientation to environment.

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Transit ischemic attacks (TIA)
   Treatment of risk factors to prevent future recurrence.

Urinary or fecal retention
   Treat underlying cause of retention through medication or surgery.

Vitamin deficiency; Imbalances in electrolytes and blood levels
   Vitamin or electrolyte supplement; balanced diet; diet supplements.

If communication is difficult

Difficulty hearing
   Use hearing amplifiers; have hearing evaluated; provide hearing aids; write information down; repeat information; slow down speech; speak clearly and distinctly.

Difficulty seeing
   Use magnifying glass; have sight evaluated; provide glasses; provide spoken information; repeat information; ensure sufficient lighting; use large print; have access to Braille materials.

Difficulty understanding English
   Use translator.

Low educational or reading level; illiterate
   Provide information in simple language without "talking down"; provide information in multiple formats.

Religious, cultural, or ethnic background
   Sensitivity to religious, cultural, and ethnic traditions; inquire about views and needs; involve professional from similar background.
Look at the whole person

- View client's life in context
- Evaluate skills needed to sustain client's way of life – how he lives and how he wants to live
- Identify authentic incapacities
- Support and nurture capacities
- Client's quality of life depends on your assessment

Some final thoughts...

Primary Standards

1) Best Interests of Elder
2) Right of Self Determination
3) Freedom Over Safety
4) Optimize Functioning
5) Aging in Place

Least Intrusive, Disruptive, Restrictive Alternatives

Addressing Ethical Concerns

- Self awareness
- Openness to learn
- Covering all bases
- Using interdisciplinary approach
- Processing case with peers and supervisor
Code of Ethics

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Adult Protective Services Ethical Principles and Best Practice Guidelines

Dedicated to the memory of Rosalie Wolf

Adult Protective Services are those services provided to older people and people with disabilities who are, or are in danger of being mistreated or neglected, are unable to protect themselves, and have no one to assist them.

Interventions provided by Adult Protective Services include, but are not limited to, receiving reports of adult abuse, exploitation or neglect, investigating these reports, case planning, monitoring and evaluation. In addition to casework services, Adult Protection may provide or arrange for the provision of medical, social, economic, legal, housing, law enforcement or other protective, emergency or supportive services.

Values

Guiding Value: Every action taken by Adult Protective Services must balance the duty to protect the safety of the vulnerable adult with the adult's right to self-determination.

Secondary Value: Older people and people with disabilities who are victims of abuse, exploitation or neglect should be treated with honesty, caring and respect.
Principles

- Adults have the right to be safe.
- Adults retain all their civil and constitutional rights unless some of these rights have been restricted by court action.
- Adults have the right to make decisions that do not conform with societal norms as long as these decisions do not harm others.
- Adults are presumed to have decision-making capacity unless a court adjudicates otherwise.
- Adults have the right to accept or refuse services.

Practice Guidelines

- Recognize that the interests of the adult are the first concern of any intervention.
- Avoid imposing personal values on others.
- Seek informed consent from the adult before providing services.
- Respect the adult’s right to keep personal information confidential.
- Recognize individual differences such as cultural, historical and personal values.
- Honor the right of adults to receive information about their choices and options in a form or manner that they can understand.
- To the best of your ability, involve the adult as much as possible in developing the service plan.
- Focus on case planning that maximizes the vulnerable adult’s independence and choice to the extent possible based on the adult’s capacity.
- Use the least restrictive services first—community based services rather than institutionally based services whenever possible.
- Use family and informal support systems first as long as this is in the best interest of the adult.
- Maintain clear and appropriate professional boundaries.
- In the absence of an adult’s expressed wishes, support casework actions that are in the adult’s best interest.
- Use substituted judgment in case planning when historical knowledge of the adult’s values is available.
- Do no harm. Inadequate or inappropriate intervention may be worse than no intervention.
A quick word about documentation

- Clear, concise, and objective
- Direct quotes and observations
- Progress notes on home visits, phone calls to client and to and from others relating to client
- Scores on formal assessment tools used and dates given

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REFERENCES