fountain of health

Initiative for Optimal Aging

The Fountain of Health Initiative:

Seniors Mental Illness Assessment Toolkit

The Fountain of Health Seniors Mental Illness Assessment Toolkit:
Developed by Dalhousie University Geriatric Psychiatry Program
& Nova Scotia Seniors Mental Health Network

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Introduction

The **Fountain of Health Initiative for Optimal Aging** is a national effort to improve how well all Canadians age, offering reliable information about the science of healthy aging. The Fountain of Health offers tools to support Canadians in adopting an adaptive outlook and behaviours to promote health and happiness through: 1) mental and cognitive health promotion; 2) ageism and mental illness stigma reduction; and 3) advocating for equitable access to quality seniors mental health care service across Canada. For more details of the Fountain of Health, please visit www.fountainofhealth.ca. Clinical tools for mental health promotion of seniors can be found under "Clinicians' Corner".

A standardized approach to a comprehensive assessment is another important step toward quality assurance in the mental health care of seniors in order to treat common disorders, promote wellness and maximize quality of life. The following ***Seniors Mental Illness Assessment Toolkit*** is intended to be a helpful clinical tool or guide for a comprehensive Geriatric Psychiatry Assessment for use in clinical practice. The Fountain of Health Seniors Mental Illness Assessment Toolkit was developed through Dalhousie University's Department of Psychiatry in partnership with the Nova Scotia Seniors Mental Health Network and Department of Health and Wellness. The Seniors Mental Illness Assessment Toolkit will be relevant for:

- **FAMILY PHYSICIANS AND/OR NURSE PRACTITIONERS IN PRIMARY CARE (SERVING LONG TERM CARE AND COMMUNITY)**

Whether in the community or in long term care, family physicians and nurse practitioners are often the first line of contact for many seniors on common mental illnesses issues such as: depression, anxiety disorders, delirium, addiction disorders, dementia and common behavioural and psychological symptoms of dementia. The Fountain of Health Seniors Mental Illness Assessment Toolkit is intended to support primary care clinicians in assessing mild and moderate disorders in identifying more serious disorders that require additional services and in completing competency assessments.

- **SECONDARY CARE (COMMUNITY MENTAL HEALTH TEAMS)**

In secondary community adult mental health teams, quality mental health care of seniors is essential given the growing population size, and need to support primary care and need to build capacity in the system. The Seniors Mental Illness Assessment Toolkit can support the work of the secondary teams and their interface with tertiary services through standardized tools, language and assessment approach.

- **TERTIARY GERIATRIC PSYCHIATRY**

A major role of the tertiary resource is to provide education and training across all health disciplines in the area of geriatric psychiatry to prepare the next generation of service providers in the relevant region of practice. Ongoing capacity-building is also needed in a wide range of providers, from frontline care providers in long term care, to primary and secondary care and the community. The Seniors Mental Illness Assessment Toolkit is an educational resource for use by tertiary teams interfacing with local community teams and primary care.

Seniors Mental Health

Geriatric Psychiatry Assessment

Patient name: _____ HUN: _____

Date of referral: _____ Date seen: _____

Guardian / POA: _____ Phone: _____

Other contact people: _____ Phone: _____

_____ Phone: _____

Pharmacy: _____ Phone: _____

REASON FOR REFERRAL
(mental status, living arrangements)

_____

_____

_____

ALLERGIES

_____

_____

Name of medication	What happens?

MEDICATIONS

Patient currently on Pharmacare Y / N

Medications administered by: _____

Geriatric Psychiatry Assessment

Name of medication	Dose	Indication	How long

Individuals present during interview:

_____

_____

_____

Geriatric Psychiatry Assessment

HISTORY OF PRESENTING ILLNESS

PAST PSYCHIATRIC HISTORY

(psychiatrists, admissions, treatment including ECT, suicidality)

Personal history of :

Depression	Y / N	Psychosis	Y / N
Suicide Attempt	Y / N	Mania	Y / N
ECT	Y / N	Dementia	Y / N
Anxiety	Y / N		

Geriatric Psychiatry Assessment

Comprehensive Geriatric Assessment Form

WNL = Within Normal Limits ASST = Assisted
IND = Independent DEP = Dependant

Patient contact (Pt.): ☐ Inpatient ☐ Clinic ☐ GDH ☐ NH ☐ Outreach ☐ Home ☐ Assisted living ☐ ER ☐ Other

How many month since well?

○ **Cognitive Status** ☐ WNL ☐ CIND/MCI ☐ Dementia ☐ Delirium MMSE _____ FAST _____
Chief lifelong occupation: _____ Education: (years) _____

○ **Emotional** ☐ WNL ☐ ↓ Mood ☐ Depression ☐ Anxiety ☐ Fatigue ☐ Other

○ **Motivation** ☐ High ☐ Usual ☐ Low **Health Attitude** ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Couldn't say

○ **Communication** **Speech** ☐ WNL ☐ Impaired **Hearing** ☐ WNL ☐ Impaired **Vision** ☐ WNL ☐ Impaired

○ **Strength** ☐ WNL ☐ Weak Upper: PROXIMAL DISTAL Lower: PROXIMAL DISTAL

		BASELINE (two weeks ago)	CURRENT (today)	NOTES
○ **Mobility**	Transfers	IND ASST DEP	IND ASST DEP	
	Walking	IND SLOW ASST DEP	IND SLOW ASST DEP	
	Aid	_____	_____	
○ **Balance**	Balance	WNL Impaired	WNL Impaired	
	Falls	N Y Number_____	N Y Number_____	
○ **Elimination**	Bowel	CONT CONSTIP INCONT	CONSTIP CONT INCONT	
	Bladder	CONT CATHETER INCONT	CATHETER CONT INCONT	
○ **Nutrition**	Weight	GOOD UNDER OVER OBESE	STABLE LOSS GAIN	
	Appetite	WNL FAIR POOR	WNL FAIR POOR	
○ **ADLs**	Feeding	IND ASST DEP	IND ASST DEP	
	Bathing	IND ASST DEP	IND ASST DEP	
	Dressing	IND ASST DEP	IND ASST DEP	
	Toileting	IND ASST DEP	IND ASST DEP	
○ **IADLs**	Cooking	IND ASST DEP	IND ASST DEP	
	Cleaning	IND ASST DEP	IND ASST DEP	
	Shopping	IND ASST DEP	IND ASST DEP	
	Medications	IND ASST DEP	IND ASST DEP	
	Driving	IND ASST DEP	IND ASST DEP	
	Banking	IND ASST DEP	IND ASST DEP	

Current Frailty Score:

Scale	Pt.	CG
1. Very fit		
2. Well		
3. Well ∈ Rx'd co-morbid disease		
4. Apparently vulnerable		
5. Mildly frail		
6. Moderately frail		
7. Severely frail		
8. Very severely ill		
9. Terminally ill		

○ **Sleep** ☐ Normal ☐ Disrupted ☐ Daytime drowsiness **Socially Engaged** ☐ Freq ☐ Occ ☐ Not

○ **Social** ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Advance directive in place?

Lives ☐ Alone ☐ Spouse ☐ Other

Home ☐ House (Levels ___) ☐ Steps (Number___) ☐ Apartment ☐ Assisted living ☐ Nursing home ☐ Other

Supports ☐ Informal ☐ HCNS ☐ Other ☐ Req. more support ☐ None

Caregiver relationship ☐ Spouse ☐ Sibling ☐ Offspring ☐ Other

Caregiver Stress ☐ None ☐ Low ☐ Moderate ☐ High

Caregiver occupation: (CG) _____

○ **Code Status** ☐ Do not resuscitate ☐ Resuscitate

ACTION REQUIRED (check appropriate circles)

Problems:	Med adjust req.	Associated Medication: (*mark meds started in hospital with an asterisks)
1. RFR	○	
2.	○	
3.	○	
4.	○	
5.	○	
6.	○	
7.	○	
8.	○	
9.	○	
10.	○	
11.	○	

Assessor/Physician: _____ Date: _____
YYYY/MM/DD

Geriatric Psychiatry Assessment

MEDICAL HISTORY

- ☐ Diabetes
- ☐ Heart disease
- ☐ Stroke
- ☐ Thyroid
- ☐ Cancer
- ☐ Psychiatric illness
- ☐ Head Injury

OTHER CONDITION(S)

LABS

IMAGING

CT

MRI

Geriatric Psychiatry Assessment

Family supports _____

Family history _____

Current family

Agency supports _____

Pre-morbid personality/relationships _____

Coping skills _____

Education: type and level _____

Employment _____

Finances _____

Specific Diagnoses: Common Issues, Helpful Tips & Tools

a. Depression

Prevalence: 3% of general elderly community population has depression; 11-13% of elderly in medical settings; 15-25% of seniors in LTC; any medical illness doubles the risk for depression. (Luber 2000)

Assessment: Requires careful assessment including a comprehensive biopsychosocial assessment, and an interview that includes a review of symptoms (SIG E CAPS). Collateral is always required, to clarify the extent of functional change, and inquire about safety concerns. It is important to screen for memory and executive functions (MoCA or MMSE, and Clock drawing, at a minimum).

Diagnostic Criteria: To make a diagnosis of Major Depressive Disorder, a senior should have symptoms that include low mood or loss of interest and at least four other symptoms and lasts at least two weeks, and interfere with daily function:

S - Changes in sleep
I - Changes in interest/motivation
G - Guilt
E - Changes in energy
C - Changes in concentration
A - Changes in appetite
P - Psychomotor changes
S - Suicidal thoughts or plans

Differences in Late Life - seniors tend to present with more:

- Anxiety: Seniors can report more anxiety than sadness, referred to as "atypical depression"
- Somatic concerns/vegetative symptoms: Spending more time in bed, increased pain or other physical complaints
- Social withdrawal
- Psychosis: Specifically ask about the presence of delusions of poverty, somatic, persecution
- Cognitive impairment during the depression: Often resolves with treatment for the depression, but a risk factor for dementia onset within three years (should be monitored)
- Irritability or agitation
- Decreased life satisfaction
- Less likely to report suicidal ideation (so need to ask)
- Co-morbid medical conditions and frailty (and less physical reserve)

HELPFUL TIPS

Special presentations of depression in late life include:

- Agitated Depression: A severe form of "atypical" depression, in which the level of anxiety is extremely high, includes significant physical agitation, and can require urgent/aggressive treatment (such as ECT).

- Psychotic Depression: As above, much more common in seniors, often associated with delirium and usually requires ECT for more rapid treatment (i.e. if antidepressant + antipsychotic not working quickly enough).

- Depression Executive Dysfunction Syndrome (DED Syndrome): Depression which presents like an early dementia with prominent executive dysfunction, often with WMH on CT or vascular risks, apathy is common and treatment often requires the use of a stimulant (Modafanil, Wellbutrin or Methylphenidate–Ritalin, or ECT or Lithium augmentation).

Useful Assessment Tools:

1. **Geriatric Depression Scale (GDS):** Score of 5/15 is considered a sign of clinical depression.
2. **Cornell Depression in Dementia Scale:** Score of 10+ indicate a *probable* major depressive episode, score 18+ indicate a *definite* major depressive episode.

NOTE: For details on a clinician's guide to assessment and treatment of late life depression, and a patient/family handbook, please see the **CCSMH National Guidelines** at: http://www.ccsmh.ca/en/natlGuidelines/initiative.cfm

b. Anxiety

Prevalence: In community dwelling elders, prevalence is highest for Generalized Anxiety Disorder 7.3%, Phobias 3.1%, Panic Disorder 1.0%, Obsessive Compulsive Disorder 0.6%. Rates are higher in institutions, medically ill and hospitalized patients.

Assessment: Requires careful assessment including a comprehensive biopsychosocial assessment, and an interview that includes a review of symptoms (screening for all subtypes of anxiety since they can be co-morbid), a screening for depression, and for relevant medical problems. Collateral is always required, to clarify the extent of functional change, and inquire about safety concerns.

Diagnostic Criteria: Six different anxiety disorders share features of excessive anxiety (out of keeping with circumstances), with behavioural disturbances that impact on functioning. These disorders include (in order of prevalence): Generalized Anxiety Disorder, Specific Phobias, Social Anxiety Disorder, Panic Disorder, Obsessive Compulsive Disorder and Post Traumatic Stress Disorder. See DSM-V for full diagnostic criteria.

Differences in Late Life - seniors tend to present with more:

- Anxiety in the context of depression
- Generalized anxiety than younger patients
- Somatic symptoms
- Co-morbid medical conditions (Congestive Heart Failure, arrhythmias, asthma, Chronic Obstructive Pulmonary Disease)
- Fewer panic symptoms (patient might not meet full criteria)

HELPFUL TIPS

Special presentations of anxiety in late life include:

- Agitated Depression: A severe form of "atypical" depression in which the level of anxiety is extremely high, with significant physical agitation.

- New Onset Generalized Anxiety: In older adults new onset of anxiety symptoms is usually indicative of a depression (depression until otherwise proven) and treated accordingly.

- New Onset Panic or OCD: New onset often linked with an underlying medical condition exacerbating anxiety symptoms (asthma, Chronic Obstructive Pulmonary Disease, arrhythmia), or a neurological disorder.

Clinical Symptoms of Anxiety:

Emotional	**Cognitive**	**Behavioural**	**Somatic**
Keyed up	Intrusive thoughts	Hyper-vigilant	Perspiration
Fearful	Apprehension	Jumpy	Heart palpitations
On edge	Danger	Tremors	Fainting
Irritable	Contamination	Pacing	Dyspnea
Worried	Going crazy/dying	Avoidance behaviour	Nausea
Terrified	Irrational fears	Repetitive behaviours	Tingling
Nervous	Repetitive themes		Muscular tension
	Embarrassment		Shakiness
	Humiliation		Flushing
	Catastrophizing		Gastrointestinal disturbances
			Dizziness

Useful Assessment Tools:

1. **Beck Anxiety Scale:** Score over 36 is cut off for clinically significant anxiety.
2. **Hamilton Anxiety Scale:** Score of 17+ is mild severity, 18-24 is mild-moderate severity, 25-39 is moderate to severe.

c. Psychosis

Prevalence: Up to 23% of older adults will experience psychotic symptoms; psychotic symptoms appear in 40% of dementia cases: Dementia Lewy Body 78%; Vascular Dementia 54%; Alzheimer's Dementia 36%.

Assessment: New onset of psychotic symptoms needs to be carefully assessed and include a full medical work up to rule out underlying medical cause or delirium. When assessing for psychosis, inquire about both delusions (fixed false beliefs out of keeping with the patient's cultural context of beliefs) and hallucinations (sensory misperceptions in any of the five senses). Collateral is always needed since insight is often lacking, to clarify symptoms and safety concerns.

Diagnostic Criteria: Psychotic illnesses are heterogeneous and encompass disorders including: Delusional Disorder, Schizophrenia (including Late Onset), Schizoaffective Disorder and Major Depressive Disorder with psychotic features. Each has specific diagnostic criteria (see DSM-V); all include delusions and/or hallucinations.

Psychosis Subtypes with examples:

Delusions	***Hallucinations***
Paranoid	Hearing-> "auditory"
Grandiose	Seeing-> "visual"
Somatic	Feeling-> "tactile"
Infidelity	Tasting-> "gustatory"
Abandonment	Smelling-> "olfactory"

Differences in Late Life-Seniors with psychosis tend to present with more:

- Delirium: A common cause for new onset psychosis, especially hallucinations.
- Other Medical Conditions: Psychotic symptoms can occur as a part of a number of illnesses including Parkinsons Disease and Stroke.
- Cognitive Disorders: New psychosis can be in context of dementias (Lewy Body Dementia, Vascular Dementia or Alzheimer's Dementia).
- Co-morbid Depression: Psychosis in depression is more common in seniors than in younger patients (somatic, persecutory or poverty delusions).

HELPFUL TIPS

Special presentations of psychosis in late life include:

- Delusions in psychotic illnesses (i.e. Schizophrenia, Bipolar Disorder, Depression): Tend to be bizarre in schizophrenia (paranoid, religious); grandiose in mania' and somatic, persecutory or poverty in depression.

- Delusions that are more typical of dementia: Fragmentary and non-bizarre such as missing items are stolen or moved (forgetting where they put them); “people are entering my home”; “my house is not my home”; “people are plotting against me”; misidentifications (wife is a different person).

- Late onset isolated visual or auditory hallucinations: Correct perceptual impairments (loss of hearing or vision are risk factors), consider Charles-Bonnet Syndrome (in context of impaired vision) or strategic stroke or vascular risks as etiology.

Useful Assessment Tools:

1. **Brief Psychiatric Rating Scale**

d. Dementia

Prevalence: Overall prevalence estimates for dementia are approximately 1-2% at age 65 and as high as 30% by age 85.

Assessment: Assessment of dementia requires a complete history, physical, medical investigations, cognitive and functional testing. A thorough assessment can take up to two hours. Collateral is always needed to clarify cognitive and functional issues, and review safety concerns.

Diagnostic Criteria: Note that the criteria in DSM-5 are changed from DSM IV.

***MILD* Neurocognitive Disorder:** Evidence of modest cognitive decline from a previous level of performance in one or more cognitive domains (same as above), however the cognitive deficits do **NOT** interfere with the capacity for everyday activities (i.e. Instrumental Activities of Daily Living and Activities of Daily Living), (previously called "CIND"- Cognitive Impairment No Dementia, or "MCI"- Mild Cognitive Impairment).

***MAJOR* Neurocognitive Disorder:**

- Evidence of significant cognitive decline from previous level of functioning in one or more cognitive domains: complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition; aphasia, apraxia, agnosia or executive dysfunction.
- Cognitive deficits interfere with independence in everyday activities (Instrumental Activities of Daily Living/Activities of Daily Living).
- Cognitive deficits do not occur exclusively in the context of delirium, and are not better explained by another mental disorder.

Diagnostic Sub-Types of Dementia include (see DSM-5 for details):

Alzheimer's Disease
Vascular Cognitive Impairment
Lewy Body Disease
Frontolobar Degeneration or Fronto-Temporal Dementia
Dementia due to substance use
Dementia due to multiple etiologies (Mixed Dementia)
Other types of Dementia include:
Dementia due to Parkinson's Disease, Huntington's Disease, Traumatic Brain Injury

Differences in Late Life - seniors tend to present with more:

- Dementia in general: Age is a significant risk factor!
- The prevalence of Dementia doubles every 5 years after the age of 60 (increasing from 1-2% at 65 years, up to 30% at 85 years of age).

- Risk factors in younger adults include family history, head injury and Down's Syndrome, and Fronto-Temporal Dementia presents early (usually before 65 years).

HELPFUL TIPS

- Alzheimer's Disease: The most common dementia accounts for 50% of dementias. Prevalence doubles every five years after the age of 60. Hallmarks are slow insidious onset with progressive losses; short term memory impacted early; problems with instrumental activities of daily living progress to deficits in activities of daily living and eventually to global impairment; can be staged using Functional Assessment and Staging Tool (FAST) into 7+ stages depending on level of functional/cognitive impairment. Staging can be helpful in assisting others to understand the deficits and in developing appropriate care plans.

- Vascular Cognitive Impairment: 10-30% of dementias; clinically heterogeneous; can be slow, insidious onset due to small vessel vascular disease or sudden onset from a strategic stroke. Symptoms correlate with degree and area of damage. Can have early problems with gait, incontinence, hallucinations, and seizures. Stepwise deterioration with periods of stability between stages.

- Lewy Body Disease: 15-20% of dementias (under recognized); age of onset 50-83 years; characterized by fluctuations in cognition and function, Parkinsonism and hallucinations; early and prominent psychiatric symptoms including visual hallucinations and delusions. Can present with picture of cognitive impairment, or as above. Two thirds will present with hallucinations, 65% with delusions, and 70% with Parkinsonism.

- Fronto-Temporal Dementia (FTLD): 5-10% of dementias but up to 20% of early onset (second to Alzheimer's); onset often in 50's; Fronto-Temporal Dementia usually begins prior to age 65. As the disease progresses patients become globally impaired. There are varied clinical pictures but key features include: profound alteration in character and conduct with the changes in personality preceding dementia onset. There is a loss of insight and judgment, a decline in interpersonal conduct and behavioural disorders are common (shop lifting, urinating in public, sexual comments). Problems with language are also common with poor verbal fluency, anomia and perseveration. In some cases, patients can present with apathy, social withdrawal, depression or obsessive-compulsive type of behaviour. In terms of cognition, patients tend to have impaired executive skills with perseveration, poor shifting sets, poor verbal fluency, but relatively intact memory.

Useful Assessment Tools:

1. **Mini-Mental Status Exam (MMSE)**
2. **Montreal Cognitive Assessment (MoCA)**
3. **Frontal Assessment Battery (FAB)**
4. **Behavioural Neurology Diagnostic checklist**
5. **Clock drawing**
6. **Baycrest**

7. **Trails B**
8. **Lawton–Brody**
9. **Functional Assessment and Staging Tool (FAST)**

e. *Behavioural and Psychological Symptoms of Dementia (BPSD)*

Prevalence: 90% of patients with dementia will have some personality or behavioural change during the course of their illness - not all changes or behaviors are problematic.

Assessment: Behavioural and Psychological Symptoms of Dementia (BPSD) is an intrinsic part of the disease process, important to address and manage as the disease progresses.

Diagnosis: Behavioural symptoms include those symptoms that are inappropriate or excessive within the context of the situation/setting and are disturbing, disruptive or potentially harmful to the patient or others (see Canadian Coalition of Seniors Mental Health (CCSMH) Guidelines). BPSD also challenges caregiver/care provider's ability to understand and provide appropriate care. It is important to note that what challenges some will not challenge others. Therefore, BPSD are seen not just from the patient's perspective, but from the caregiver lens as well. This is why collateral is imperative in assessment of BPSD.

Behavioural Symptoms	**Psychological Symptoms**
Agitation*(50%)	Personality (90%)
Aggression* (20%)	Depression* (80%)
Screaming, cursing*	Delusions* (70%)
Restlessness*	Hallucinations* (50%)
Sexual disinhibition*	Apathy*
Insomnia*	Mania* (15%)
Wandering	Anxiety*
Hoarding	
Inappropriate urination/defecation	

Note: *= May respond to medications and (%) is prevalence

HELPFUL TIPS

- Individualize Care Plan: The foundation of treating BPSD is *nonpharmacologic*. Individuals with BPSD require an individualized assessment and treatment/care plan. The key to developing an appropriate treatment plan is understanding the behaviour as being related either to an unmet need or an attempt to communicate from a "broken brain".

- Use of Medications: If medications are used they are intended to treat 'target symptoms'. Using a psychobehavioural metaphor, choose the class of medications: If it seems "like a depression", try an antidepressant; if it "seems like a psychosis", try an antipsychotic; if it seems "like a mania", try a mood stabilizer. Cholinesterase inhibitors should also be considered as they have been shown to treat BPSD as well as stabilize cognition and improve function.

- Black Box warnings on Antipsychotics: Despite evidence of effectiveness to treat agitation and aggression in late life, all of the antipsychotics have warnings due to a slight increased risk of stroke or death compared to a placebo when used in seniors with dementia/vascular risks. These risks increase with increase dose and duration of treatment, so consider a shorter trial and a gradual taper once patient is stabilized. Patient/Substitute Decision Maker (SDM) informed consent must be sought and documented accordingly. In dementia, a "palliative" context might be appropriate, such as end-stage disease where safety is a concern or to alleviate patient distress. Alternatives to antipsychotics for agitation include cholinesterase inhibitors, Memantine and the antidepressants.

Useful Assessment Tools:

1. **MMSE**
2. **Lawton-Brody**
3. **FAST**
4. **Cohen-Mansfield Agitation Inventory**
5. **DOS (Dementia Observation Scale)**
6. **Behaviour Tracking Tool**
7. **NeuroPsychiatric Inventory-Nursing Home version (not included)**
8. **PIECES Training Manual (not included)**

NOTE: For more patient and family information on dementia of all types, please see the **Alzheimer's Society of Canada** website and its many resources at http://www.alzheimer.ca

f. Delirium

Prevalence: Delirium occurs in up to 50% of older adults admitted to acute care. Among older adults admitted to medicine or geriatric hospital units rates were 5-20%. Surgical patients had a 10-15% frequency with cardiac patients 25-35% and hip fracture/repair 40-50%.

In the community, non-demented elders, aged over 85 had a rate of 10% over a three year period. In those community dwelling seniors over age 65 with dementia, the rate increases to 13%. Residents of Long Term Care are a vulnerable population and there have been few studies in this group. Estimates are from 6-14% to 40% depending on the study. (CCSMH 2006)

Assessment: The initial history obtained from an elder thought to have delirium should include an evaluation of their current and past medical problems and treatments. Collateral is always required and information from chart, staff, family and friends may be used to help inform the assessment.

There should be a physical exam/lab work (and other tests as necessary) available for the clinicians' review.

Diagnostic Criteria: Disturbance in attention and cognition that develops quickly (hours to days) and is a change from the patient's usual level of awareness and cognition. Level of awareness and attention fluctuate within the course of a day. There is evidence from history, physical exam or lab findings that the disturbance is the consequence of a medical condition, substance use or withdrawal, exposure to a toxin or due to multiple etiologies. This includes medication use, withdrawal, infection or other physiologic problems (constipation, urinary retention, dental problems, and pain).

In up to 50% of elderly patients presenting with delirium, no direct cause is found.

Patients with an underlying neurocognitive disorder (dementia) are at greater risk of developing delirium due their fragile brains.

Differences in Late Life/Risk Factors:

The highest prevalence is among seniors with hip fracture, post-operative state, or with multiple medical problems. Seniors are more vulnerable due to having more of the risk factors. Risk factors include:

- Age
- Male
- Presence of dementia
- Hospital admission
- Severe medical illness
- Presence of depression
- Alcohol or substance use
- Hearing or visual impairment

HELPFUL TIPS

Special presentations of delirium include:

- Hypoactive Delirium: Can look like depression with decreased initiative, decreased interest, somnolence, decreased awareness of time/place/person, poor hydration/nutrition.

- Hyperactive Delirium: Presents with agitation, psychotic symptoms, confusion and distress.

- Treatment: Identify and treat the underlying cause. Resolution of underlying cause does not guarantee resolution of cognitive and functional deficits. Patients with underlying dementia may not return to previous level of function.

- Non-Pharmacological Approach: Includes a calm, supportive approach, consistent caregivers, use of light/dark to help orient to time, cues such as a calendar and clock, reduced white noise.

- Pharmacological Treatment: Usually for extreme agitation or psychosis. An antipsychotic such as Haldol or Risperidone is often used.

Useful Assessment Tool:

1. **Confusion Assessment Method (CAM)**

NOTE: For details on a clinician's guide to assessment and treatment of delirium, and a patient/ family guide, please see the **CCSMH National Guidelines** at

http://www.ccsmh.ca/en/natlGuidelines/initiative.cfm

Also see **National Delirium Website**, "This Is Not My Mom" at http://thisisnotmymom.ca/

g. Suicide

Prevalence: Men over 80 have highest rate of suicide (Canada) - 31/100,000; men over 65 - 23/100,000; women over 65 - 4.5/100,000; the lethal potential of self-harm behaviour increases with age.

Assessment: Suicide risk assessment should be part of any mental health assessment, and done in a respectful and sensitive manner. The suicide "ladder" or step wise approach is often used, contextualizing the question in a gradual way: "How does the future look to you?", "Does it ever seem life is not worth living?", "Do you ever have thoughts of suicide?"

Level of Risk: In the risk assessment, it is important to distinguish separately suicidal thoughts/ideation from a suicide plan (actual steps to carry out) and from an intent to carry a plan out (i.e. thoughts on their own are considered a lesser risk than having a plan with an intent).

Diagnostic Criteria: Not a specific disorder but "an end point to an individual's painful psychological process" (see CCSMH); usually seen in the context of severe Major Depressive Disorder.

Differences in Late Life/Risk Factors:

- Suicidal or self-harm behaviour including equivocal behaviour, such as accidental medication overdose and self-neglect.
- Expression of active or passive suicidal ideation or wish to die.
- Any mental illness: Major Depressive Disorder, any Mood Disorder, Psychotic Disorder, Substance Use Disorder.
- Medical illnesses: Visual impairment, malignancy, neurologic disorder, chronic lung disease, seizure disorder, moderate-severe pain.
- Negative life events and transitions: Being widowed, perceived physical illness, family discord, separation, recent financial difficulties, change in employment, the prospect of living with dementia.
- Personality factors: Personality Disorder, high neuroticism, emotional instability, psychological difficulties, low extroversion-social isolation or loneliness, low openness to experience, i.e. rigidity, restrictiveness, narcissism, and poor coping in the face of physical, emotional or social changes.
- Interpersonal factors: Loneliness, unmarried, living alone, lack of religious involvement.
- High levels of anxiety: Presence of panic disorder .
- Substance use/abuse.

HELPFUL TIPS

Special presentations of suicidality in late life include:

- Older adults may not report suicidal ideation: Older adults may downplay thoughts of suicide owing to guilt, stigma and fear of hospitalization, so it's important to ask carefully.

- Watch out for hopelessness: Research has linked late-life suicidal thoughts and behaviors with hopelessness and lack of perception of meaning and purpose in life (see CCSMH).

Useful Assessment Tools: (Not all included in this package)

1. **Beck Hopelessness Scale:** Not readily available to public institutions/must be purchased
2. **Geriatric Depression Scale:** Watch questions on hopelessness and uselessness
3. **Nova Scotia Suicide Assessment Tool:** Not specifically targeted for elderly population.

PLEASE NOTE: For details on a clinician's guide to assessment and treatment of suicide in late life, and a patient/family handbook, please see the CCSMH National Guidelines at:

http://www.ccsmh.ca/en/natlGuidelines/initiative.cfm

Also see The Canadian Mental Health Association initiative "Communities Addressing Suicide Together" or "CAST" at the following website: http://novascotia.cmha.ca/programs_services/cast/

h. Substance Use and Addictions

Prevalence: 6-10% of seniors use alcohol in a pattern suggestive of abuse, which is similar to other adult groups. Problems with gambling are thought to be less common in older adults than younger people. Canadian statistics show that 2.1% of older adults have gambling problems (extremely difficult to obtain Canadian statistics).

Diagnostic Criteria: Essential feature is a cluster of cognitive, behavioural and physiologic symptoms indicating that the individual continues using the substance despite significant substance related problems.

DSM-5 Criterion A: impaired control, social impairment, risky use and pharmacologic criteria.

Symptoms of tolerance and withdrawal occurring during appropriate medical treatment with prescribed medications (specifically opioid analgesics, sedatives, stimulants) are NOT counted when diagnosing a substance use disorder.

Broad range of severity from mild to severe depending on number of symptom criteria met - mild: 2-3 symptoms, moderate: 4-5 symptoms, severe: 6-7 symptoms.

A) Changes in behaviour
B) Changes in mental abilities

Differences in Late Life-Seniors tend to present with more:

- Gambling problems more than substances (watch for gaming, online purchasing, as well as casino gambling).
- Prescription drug misuse/addiction is more common, due to greater access (to pain meds and sedatives).
- Alcoholism is much more common than street drugs, compared to younger adults.
- Some cannabis use is starting to emerge.

HELPFUL TIPS

Special presentations of addiction in late life include:

- Presentations in context of dementia: Can be dementia due to alcoholism, or concurrent with other types of dementia, complicating the management.

- Changes in seniors' behavior that should raise a flag:

    - Falls
    - New issues with continence/not able to make it to the bathroom on time
    - Increased complaints of headaches/dizziness

- Diminished self-care
- Changes appetite and food preference
- Decreased socialization
- Thoughts of suicide
- Money/legal problems

- Changes in mental abilities that raise a flag:

  - Increased anxiety
  - Decreased memory
  - Decreased concentration/difficulties with decision making
  - Loss of interest in usual activities
  - Mood swings or feelings of sadness

Useful Assessment Tools:

1. **C.A.G.E. questionnaire**

   a. Do you feel you need to **Cut** down?
   b. Do you get **Annoyed** by others regarding your drinking?
   c. Do you feel **Guilty** about your drinking?
   d. Do you take an **Eye** Opener?

i. Capacity

Prevalence: The main reason for the need to assess capacity is a patient being at risk of harm due to psychiatric or cognitive issues that might interfere with decision-making. In Nova Scotia each person is presumed to have the capacity to make their own decisions. This includes decisions both for and against recommended treatment. Each province has provincial guidelines that should be referred to.

Criteria/Definition: Capacity is the ability to understand the facts and significance of own behaviour. Competency is the quality of being adequately or well qualified physically and intellectually. This refers to the minimal cognitive capacity required to perform a recognized act, including decision making.

Assessment: Clinicians working in mental health are often asked to assess capacity, however it is worth noting that under the current mental health law, any attending physician can assess capacity whether in hospital, or in the community. In the hospital a declaration of incapacity is written on the patient's chart, and appropriate form completed, but will only be upheld while the patient remains an inpatient. The form is not legal once the patient leaves. In the community capacity is officially determined by a judge, on the strength of two medical opinions.

Abilities needed to make an informed choice:

1. Ability to *express* a choice
2. Ability to *understand* information relevant to the decision
3. Ability to *appreciate* significance of that information
4. Ability to *reason* with relevant information

Use a methodical and organized approach:

1. Can the patient express a choice?
2. Can the patient repeat the relevant information? Describe his/her condition?
3. Can the patient describe the suggested treatment? Can they list an alternate treatment?
4. Can they describe the significance of the information? Can they describe pros/cons of each option?
5. Can they weigh the options? Evaluate the consequences and his/her reason for choosing one option over the others?

There are three main domains or spheres of competency to consider:

- Medical Treatment: Make decision about health care and treatments.
- Personal Care: Make decisions about staying at home, safety, and care for self.
- Financial: Make decisions about managing property, paying bills, making a will.

Note: A patient can be assessed for their capacity to do any specific thing. For example, they can be assessed for their capacity to take a plane on a trip, etc. However, other specific competencies more

often requested can includes competence to be a witness, to engage in sexual relationship, fitness to assign a Power of Attorney (PoA), or even capacity to marry.

HELPFUL TIPS

A key role of the mental health clinician can be to guide and support an attending physician in making a determination of capacity. Sharing the assessment checklists included here is a good way to support another clinician's work as it provides some clarity on the various domains and areas of consideration in deciding on capacity. For more complex cases, or ones that will be seen in court, there is often a need for a second opinion (perhaps a more appropriate use of skills for a mental health clinician).

Useful Assessment Tools:

1. **Assessment for Consent to Treatment**
2. **Assessment for Personal Care Competence**
3. **Assessment for Financial Competence**
4. **Form 1: Assessment of Capacity to make Decisions about a Personal Care Matter**

Appendix of Assessment Tools and Scales

PLEASE NOTE: This list of tools is not exhaustive. It contains a selection of tools most used by Seniors Mental Health.

A1. Anxiety

- Hamilton Anxiety Scale: Higher scores indicate greater anxiety
- Beck Anxiety Scale: Higher score suggests more concern - 0-21 very low anxiety; 22-35 indicates moderate anxiety; scores above 36 indicates potential cause for concern

A2. Depression

- Geriatric Depression Scale: scored out of 30, 15 or 5
- Cornell Scale for Depression in Dementia: score above 10 indicates *probable* major depressive episode, score above 18 indicates *definite* major depressive episode

A3. Suicide

- Nova Scotia Suicide Risk Assessment

A4. Psychosis

- Brief Psychiatric Rating Scale

A5. Substance Abuse and Addictions

- CAGE Questionnaire

A6. Dementia

- Mini Mental State Exam (MMSE): Scored out of 30 - 27-30 no impairment; 20-26 mild impairment; 10-19 moderate impairment; under 10 severe impairment
- Montreal Cognitive Assessment (MoCA): Scored out of 30
- Frontal Assessment Battery (FAB): Scored out of 18, lower score = more deficits
- Trail Making Test /Trails B
- Clock Drawing: Scored a variety of ways - we do 3 points: 1 for contour, 1 for correct number placement, 1 for correct hand placement
- Behavioral Neurology checklist
- Lawton-Brody Activities of Daily Living

A7. Behavioural Psychological Symptoms of Dementia (BPSD)

- Cohen-Mansfield Agitation Inventory
- Dementia Observation Scale

A8. Delirium

- Confusion Assessment Method “CAM”

A9. Capacity

- Assessment Checklists (3)
- Form 1: Assessment of Capacity to make Decisions about a Personal Care Matter

A1. Anxiety

Hamilton Anxiety Rating Scale

Patient's name:	Date of first report:
Diagnosis:	Date of this report:
Current therapy:	

INSTRUCTIONS *This checklist is to assist the physician in evaluating each patient with respect to degree of anxiety and pathological condition. Please fill in the appropriate rating*

0 None
1 Mild
2 Moderate
3 Severe
4 Severe, grossly disabling

Item		Rating	Item		Rating
Anxious mood	Worries, anticipation of the worst, fearful anticipation, irritability		Somatic (sensory)	Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, picking sensation	
Tension	Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax		Cardiovascular symptoms	Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat	
Fear	Of dark, of strangers, of being left alone, of animals, of traffic, of crowds		Respiratory symptoms	Pressure or constriction in chest, choking feelings, sighing, dyspnea	
Insomnia	Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors		Gastroin-testinal symptoms	Difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation	
Intellectual (cognitive)	Difficulty in concentration, poor memory		Genitourinary symptoms	Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence	
Depressed mood	Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing		Autonomic symptoms	Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair	
Behavior at interview	Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, belching, brisk tendon jerks, dilated pupils, exophthalmos		Somatic (muscular)	Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone	
				Total score:	

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Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____ .

Interpretation

A grand sum between **0 – 21** indicates very low anxiety. That is usually a good thing. However, it is possible that you might be unrealistic in either your assessment which would be denial or that you have learned to "mask" the symptoms commonly associated with anxiety. Too little "anxiety" could indicate that you are detached from yourself, others, or your environment.

A grand sum between ***22 – 35*** indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved. Clearly, it is not "panic" time but you want to find ways to manage the stress you feel.

A grand sum that **exceeds 36** is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a physician or counselor if the feelings persist.

A2. Depression

Geriatric Depression Scale

GERIATRIC DEPRESSION SCALE

CHOOSE THE BEST ANSWER FOR HOW YOU FELT THIS PAST WEEK – CIRCLE ONE

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

Total Score (Number of "depressed"/CAPITALIZED answers)	
Date (yyyy/mm/dd)	
Signature	

Key: Normal 0–6
Suggests Depression 6–15

* Yesavage J. A. J Psychiatric Research 1982; 17:37; Hoyl etal. JAGS 1999; 47; 873-8.

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Cornell Scale for Depression

Patient Name: _____ HUN: _____

Mood Related Signs

1. Anxiety - anxious expression, ruminations, worrying ☐
2. Sadness - sad expression, sad voice, tearfulness ☐
3. Lack of reactivity to pleasant events ☐
4. Irritability - easily annoyed, short tempered ☐

Behavioural Disturbance

5. Agitation - restlessness, hand-wringing, hair-pulling ☐
6. Retardation - slow movements, slow speech, slow reactions ☐
7. Multiple physical complaints (score 0 if GI symptoms only) ☐
8. Loss of interest - less involved in usual activities (score only if change occurred acutely, ie. less than one month) ☐

Physical Signs

9. Appetite loss - eating less than usual ☐
10. Weight loss (score 2 if greater than 5 lbs. in one month) ☐
11. Lack of energy - fatigues easily, unable to sustain activities (score only if change occurred acutely, ie. In less than one month) ☐

Cyclic Functions

12. Diurnal variation of mood symptoms worse in the morning ☐
13. Difficulty falling asleep - later than usual for this patient ☐
14. Multiple awakenings during sleep ☐
15. Early morning awakening - earlier than usual for this patient ☐

Ideational Disturbance

16. Suicide - feels life is not worth living, has suicidal wishes, or makes suicide attempt ☐
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 ☐

Scoring System:

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

0 = absent
1 = mild or intermittent
2 = severe
N/A = unable to evaluate

_____ Administered by

_____ Date

A3. Suicide

Nova Scotia Tool for Suicide Risk Assessment*©

Date: _____ Time: _____ Assessor: _____

Reason: ☐ MH Assessment ☐ Admission / Transfer / Discharge ☐ Acute Deterioration

Current diagnosis: _____

Interview Risk Profile:

- ☐ **Suicidal Ideation**: Expressing ideation about suicide, wish to die or death
- ☐ **Suicidal Intent**: seeking or has access to lethal means: pills, weapons or other
- ☐ **Suicide Plan**: evidence or expression of plan / intent or plan for after death (suicide note)
- ☐ **Hopelessness**
- ☐ **Intense Emotions:** rage, anger, agitation, humiliation, revenge, panic, severe anxiety
- ☐ **Unsolvable Problem**: expressing feelings of being trapped with no way out
- ☐ **Alcohol or Substance** intoxication or problematic use
- ☐ **Shut Down**: withdrawing from family, friends
- ☐ **Impaired Reasoning** / Judgment
- ☐ **Intolerable State:** expresses no reason for living / no sense of purpose in life
- ☐ **Clinical Intuition:** Assessor concerned
- ☐ **Recent Dramatic Change** in mood
- ☐ **Recent Crisis / Conflict / Loss**

Individual Risk Profile:

- ☐ Aboriginal, refugee
- ☐ Family history of suicide
- ☐ Past trauma: such as dom. violence / sexual abuse
- ☐ Poor self-control: Impulsive / violent
- ☐ Recent past suicide attempt
- ☐ Other past suicide attempts - Low rescue potential
- ☐ Mental illness / addiction
- ☐ Depression / schizophrenia
- ☐ Psychotic
- ☐ Command hallucinations
- ☐ Recent admission / discharge / ED visits
- ☐ Chronic medical illness
- ☐ Functional impairment
- ☐ Collateral information supports suicidal intent

Risk Buffers

These are included as an expectation of a complete assessment. They are not to be used to determine degree of risk.

- ☐ Has reason to live / hope
- ☐ Social support
- ☐ Responsibility for family/kids/pets
- ☐ Capacity to cooperate/resilience
- ☐ Religion / faith
- ☐ Internal or external strength for managing risk

Communication Plan

Letting others know of risk

- ☐ Verbal communication
  - Nurse: _____
  - Physician: Dr. _____
  - SDM: _____
  - Family: _____
  - Mobile Crisis: _____
  - _____
- ☐ Information faxed to _____
- ☐ Documentation in chart

Suicide Risk Management Plan

- ☐ Regular outpatient follow-up
- ☐ Urgent outpatient follow-up
- ☐ Admission to a psychiatric unit:
  - _____ Routine observation
  - _____ Close observation q 15 m
  - _____ Constant observation

Suicide Risk Level: Risk assessment is based on clinical judgement and not based on number of items checked. The checklist is intended to guide the clinical decision only.

☐ **High** ☐ **Moderate** ☐ **Low** Signature: _____

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Step II

Analysis of Risk, General Comments and Collateral Information:

Signature

Printed name / Designation

Developed by the Suicide Task Force of CDHA and IWK and adapted from: Tool for Assessment of Suicide Risk (TASR) in: Chehil S. Kutcher S. Suicide Risk Management: A Manual for Health Professionals. Wiley-Blackwell. 2012

A4. Psychosis

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Patient Name _____ Today's Date _____

Please enter the score for the term that best describes the patient's condition.

0 = Not assessed, 1 = Not present, 2 = Very mild, 3 = Mild, 4 = Moderate, 5 = Moderately severe, 6 = Severe, 7 = Extremely severe

Score		
☐	1.	SOMATIC CONCERN Preoccupation with physical health, fear of physical illness, hypochondriasis.
☐	2.	ANXIETY Worry, fear, over-concern for present or future, uneasiness.
☐	3.	EMOTIONAL WITHDRAWAL Lack of spontaneous interaction, isolation deficiency in relating to others.
☐	4.	CONCEPTUAL DISORGANIZATION Thought processes confused, disconnected, disorganized, disrupted.
☐	5.	GUILT FEELINGS Self-blame, shame, remorse for past behavior.
☐	6.	TENSION Physical and motor manifestations of nervousness, over-activation.
☐	7.	MANNERISMS AND POSTURING Peculiar, bizarre, unnatural motor behavior (not including tic).
☐	8.	GRANDIOSITY Exaggerated self-opinion, arrogance, conviction of unusual power or abilities.
☐	9.	DEPRESSIVE MOOD Sorrow, sadness, despondency, pessimism.
☐	10.	HOSTILITY Animosity, contempt, belligerence, disdain for others.
☐	11.	SUSPICIOUSNESS Mistrust, belief others harbor malicious or discriminatory intent.
☐	12.	HALLUCINATORY BEHAVIOR Perceptions without normal external stimulus correspondence.
☐	13.	MOTOR RETARDATION Slowed, weakened movements or speech, reduced body tone.
☐	14.	UNCOOPERATIVENESS Resistance, guardedness, rejection of authority.
☐	15.	UNUSUAL THOUGHT CONTENT Unusual, odd, strange, bizarre thought content.
☐	16.	BLUNTED AFFECT Reduced emotional tone, reduction in formal intensity of feelings, flatness.
☐	17.	EXCITEMENT Heightened emotional tone, agitation, increased reactivity.
☐	18.	DISORIENTATION Confusion or lack of proper association for person, place or time.

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Instructions for the Clinician:

The Brief Psychiatric Rating Scale (BPRS) is a widely used instrument for assessing the positive, negative, and affective symptoms of individuals who have psychotic disorders, especially schizophrenia. It has proven particularly valuable for documenting the efficacy of treatment in patients who have moderate to severe disease.

It should be administered by a clinician who is knowledgeable concerning psychotic disorders and able to interpret the constructs used in the assessment. Also considered is the individual's behavior over the previous 2-3 days and this can be reported by the patient's family.

The BPRS consists of 18 symptom constructs and takes 20-30 minutes for the interview and scoring. The rater should enter a number ranging from 1 (not present) to 7 (extremely severe). 0 is entered if the item is not assessed.

First published in 1962 as a 16-construct tool by Drs. John Overall and Donald Gorham, the developers added two additional items, resulting in the 18-item scale used widely today to assess the effectiveness of treatment.

BPRS Scoring Instructions:

Sum the scores from the 18 items. Record the total score and compare the total score from one evaluation to the next as the measure of response to treatment.

Overall, JE, Gorham DR: The Brief Psychiatric Rating Scale (BPRS): recent developments in ascertainment and scaling. *Psychopharmacology Bulletin* 24:97-99, 1988.

CAGE Questionnaire

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

Scoring:

Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

.....

Developed by Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Cahpel Hill, CAGE is an internationally used assessment instrument for identifying alcoholics. It is particularly popular with primary care givers. CAGE has been translated into several languages.

The CAGE questions can be used in the clinical setting using informal phrasing. It has been demonstrated that they are most effective when used as part of a general health history and should NOT be preceded by questions about how much or how frequently the patient drinks (see "Alcoholism: The Keys to the CAGE" by DL Steinweg and H Worth; American Journal of Medicine 94: 520-523, May 1993.

The exact wording that can be used in research studies can be found in: JA Ewing "Detecting Alcoholism: The CAGE Questionaire" JAMA 252: 1905-1907, 1984. Researchers and clinicians who are publishing studies using the CAGE Questionaire should cite the above reference. No other permission is necessary unless it is used in any profit-making endeavor in which case this Center would require to negotiate a payment.

.....

Source: *Dr. John Ewing, founding Director of the Bowles Center for Alcohol Studies, University of North Carolina at Chapel Hill*

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A6. Dementia

MINI-MENTAL STATE EXAMINATION

Education :_____ Date:_____ Score:_____

Occupation:_____ Examiner:_____

Write response next to each question. Ask each question a maximum of 3 times, ensuring that the question is heard. If no response, score 0. Do not give hints (e.g. head shaking, etc.)

1. ORIENTATION TO TIME **Score**

a. What year is this? _____ _____ (1)
Accept exact answer only.

b. What season is this? _____ _____ (1)
During the last month of the old season, or the first month of the new season, accept either season.

c. What month of the year is this? _____ _____ (1)
On the first day of new month, or last day of the previous month, accept either month.

d. What is today's date? _____ _____ (1)
Accept previous or next date, e.g. on the 7th accept 6th or 8th

e. What day of the week is this? _____ _____ (1)
Accept exact answer only.

2. ORIENTATION TO PLACE

a. What country are we in? _____ _____ (1)
Accept exact answer only.

b. What province are we in? _____ _____ (1)
Accept exact answer only.

c. What city are we in? _____ _____ (1)
Accept exact answer only.

d. What is the name of this hospital? _____ _____ (1)
Alternate: What is the street address of this house?

e. What floor are we on now? _____ _____ (1)
Alternate: What room of the house are we in?

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3. REGISTRATION

I am going to name 3 words. After I have said all 3 words, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes.

BALL CAR MAN

Please repeat the 3 items. _____ (3)

Score 1 point for each correct reply on the first attempt; if not correct, repeat all 3 items until they are learned (maximum of 5 times). Standardized alternatives: Bell, Jar, Fan / Bill, Tar, Can / Bull, War, Pan

4. CONCENTRATION/ATTENTION

Spell WORLD; now spell WORLD Backwards _____ (5)

Count the number of correct letters before the first mistake (e.g. DLORW =2).

5. RECALL

What were the 3 words? _____ _____ _____ _____ (3)

Score 1 point for each correct response regardless of order.

6. What is this called? _____ _____ (1)

Show wristwatch; accept wristwatch or watch, not clock, time, etc.

7. What is this called? _____ _____ (1)

Show pencil (pen); accept pencil (pen) only.

8. Repeat this phrase after me: "No ifs ands or buts" _____ (1)

Repetition must be exact.

9. Read the words on this page and do what it says _____ (1)

Show enlarged CLOSE YOUR EYES. If patient does not close eyes, repeat instructions up to 3 times. Score 1 point only if patient closes eyes.

10. COMPREHENSION _____ (3)

Ask if the patient is right or left handed; if the patient is right handed, say

"Take this piece of paper in your left hand, fold the paper in half with both hands, then put the paper on the floor"

Score 1 point for each instruction executed correctly.

11. Write a sentence _____ (1)

Score 1 point for a complete sentence that makes sense; ignore spelling errors/handwriting.

12. Copy this design _____ (1)

Score 1 point only if there are two 5-sided figures intersecting to create a 4-sided figure.

Write a sentence

Copy design

CLOSE YOUR EYES

References:

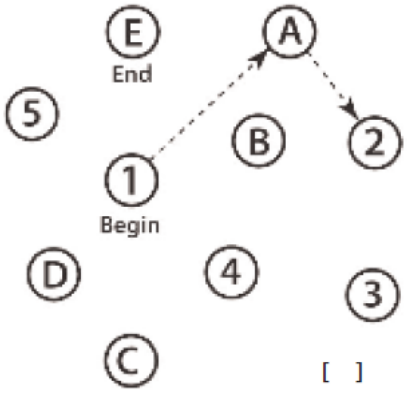
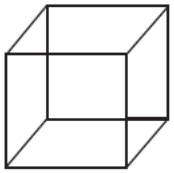
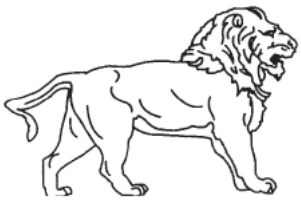
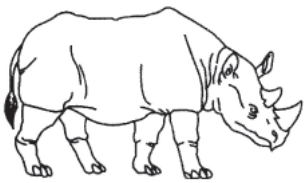
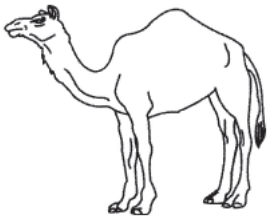
Folstein M., Folstein S., and McHugh P., *Mini-Mental State: A Practical Method for Grading the Cognitive State of Patients for the Clinician.* **Journal of Psychiatric Research** (1975) 12, 189-198.

Molloy D.W., Alemayehu E., and Roberts R., *Reliability of a Standardized Mini-Mental State Examination Compared With the Traditional Mini-Mental State Examination.* **Am J Psychiatry** (1991) 148, 102-105.

Montreal Cognitive Assessment (MoCA)

Name: _____ Date: _____

Date of birth: _____ Education: _____ Sex: _____

VISUOSPATIAL / EXECUTIVE	POINTS
 [ ]  Copy cube [ ]	/2
Draw CLOCK (Ten past eleven) (3 points) [ ] Contour [ ] Numbers [ ] Hands	/3
NAMING	
 [ ]  [ ]  [ ]	/3

MEMORY							
Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.		FACE	VELVET	CHURCH	DAISY	RED	No points
	1st trial						
	2nd trial						

ATTENTION	
Read list of digits (1 digit/sec). Subject has to repeat them in the forward order. 2 1 8 5 4 [ ] Subject has to repeat them in the backward order. 7 4 2 [ ]	/2
Read list of letters. Subject must tap with his hand at each letter A. No points if ≥ 2 errors. F B A C M N A A J K L B A F A K D E A A A J A M O F A A B [ ]	/1
Serial 7 subtraction starting at 100. [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65 4 or 5 correct subtractions: 3 pts, 2 or 3 correct 2 pts, 1 correct: 1 pt, 0 correct: 0 pt	/3

LANGUAGE	
Repeat: I only know that John is the one to help today. [ ] The cat always hid under the couch when dogs were in the room. [ ]	/2
Fluency: Name maximum number of words in 1 minute that begin with the letter F. _____ (N > 11 words)	/1

ABSTRACTION	
Similarity between eg. banana - orange = fruit. [ ] train - bicycle [ ] watch - ruler	/2

DELAYED RECALL								
Has to recall words WITH NO CUE		FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only	/5
OPTIONAL	Category cue							
	Multiple choice cue							

ORIENTATION	
[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City	/6

Normal ≥ 26/30

TOTAL _____ /30
Add 1 point if ≤ yr education

Frontal Assessment Battery (FAB)

Patient name: _____ Date: (YYYY/MM/DD) _____

Examiner: _____

1. Similarities

Ask *"in what way are they alike?"* In the event of failure with 1st item, help the patient by saying, *"both a banana and an orange are..."* but credit 0; do not help with the following two items.

		Score
Banana/orange	(fruits)	1
Table/chair	(furniture)	1
Tulip/rose/daisy	(flowers)	1

Tasks Tested

- self-organized
- cognitive strategies

2. Mental flexibility

"In the next 60 seconds, I would like you to please say as many words as you can beginning with the letter "s"; any words except surnames or proper nouns."

If no response 5 seconds, *"for instance, snake"*
If patient pauses, *"any word beginning with s"*

Greater than 9	3
6-9	2
3-5	1
Less than 3	0

- temporal organization
- execution

3. Motor series programming

Handedness does not change how the test is administered (i.e. left-handed and right-handed people do it the same way).

"Look carefully at what I am doing" – use left hand
(Luria: fist – edge – palm x 3)
"Now with your right hand do the same series, first with me, then alone"
(Examiner performs the entire sequence three times with patient)
"Now do it on your own"

Patient performs 6 complete sequences alone	3
Patient performs 3 or more complete sequences alone	2
Patient performs less than 3 sequences alone, but successfully copies examiner	1
Cannot perform with examiner	0

Frontal Assessment Battery (FAB)

4. Conflicting instructions

- self-regulation
- verbal conflicts with sensory
- echopraxia

"Tap twice when I tap once"
(Trial 1 – 1 – 1)
"Tap once when I tap twice"
(Trial 2 – 2 – 2)
Test: 1 – 1 – 2 – 1 – 2 – 2 – 2 – 1 – 1 – 2

No errors	3
1-2 errors	2
2< errors	1
Copies examiner x 4 consecutively	0

5. Go-No-Go (inhibitory control)

- ability to inhibit
- inappropriate responses
- must inhibit response previously given

"Tap once when I tap once"
(Trial 1 – 1 – 1)
"Do not tap when I tap twice"
(Trial 2 – 2 – 2)
Test: 1 – 1 – 2 – 1 – 2 – 2 – 2 – 1 – 1 – 2

No errors	3
1-2 errors	2
2< errors	1
Copies examiner x 4 consecutively	0

6. Environmental autonomy (prehension behavior)

- dependent on environmental cues
- imitation
- utilization behavior
- prehension behavior

Sit in front of patient.
Place patient's hands palm up on his/her knees.
*Bring hands close to patient's hands and touch palm of both – see if he/she will take them spontaneously.

If patient takes hands, *"Now, do not take my hands."*
Try again.

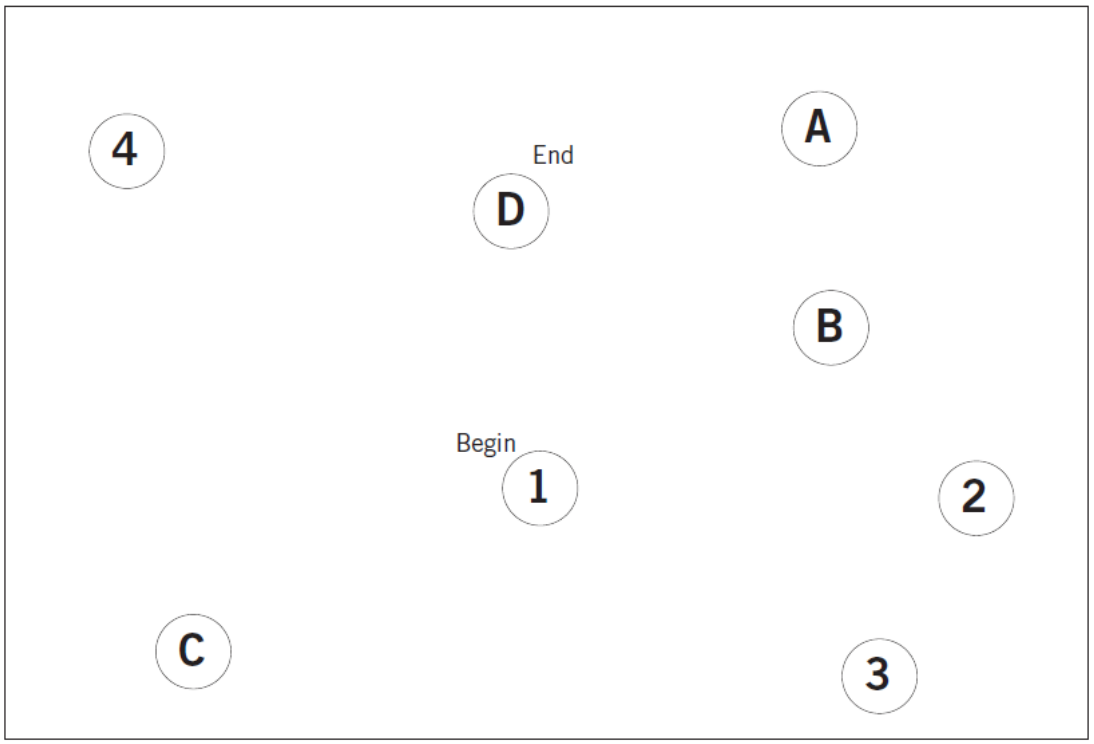
Patient does not take examiner hands	3
Patient hesitates and asks but does not take hands	2
Takes hands without hesitation	1
Takes hands even after told not to	0

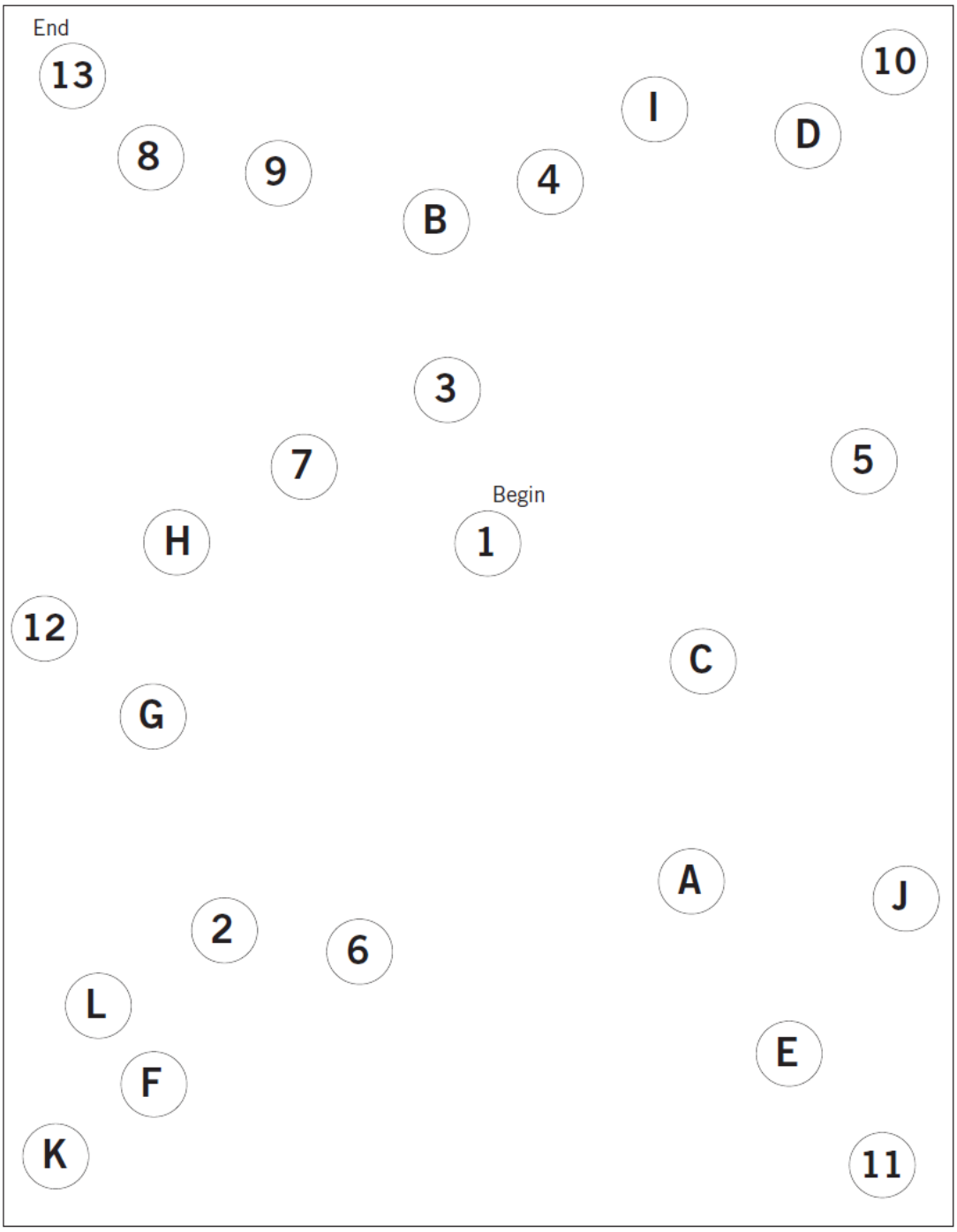
TOTAL SCORE: _____/18

Cut off = 12
(Slachevsky et al, Arch Neurology 2004)
Below 12 indicates significant frontal dysfunction

Trail Making Test

Patient name: _____ HUN: _____ Date: _____





CD1757MR_08_08

Page 2 of 2

Cognitive Assessment

NAME: _____

UNIT #: _____

CLOCK DRAWING SCORE: _____ Date: _____

Comments: _____

_____

Page 1 of 1

Behavioral Neurology
Diagnostic Criteria Checklist

Clinic Site_____

Patient Name_____ **Hospital ID**_____ **Date**_____

Probable Alzheimer's Disease (McKhann et al., 1984)

- ☐ Dementia established by clinical examination and and documented by tests such as the MMSE and confirmed by neuropsychological tests
- ☐ Deficits in 2 or more areas of cognition
- ☐ Progressive worsening of memory and other cognitive functions
- ☐ No disturbance of consciousness
- ☐ Onset between 40-90
- ☐ Absence of systemic disorders or other brain diseases that in and of themselves could account for the progressive deficits in memory and cognition.

Probable Vascular Dementia (Roman et al., 1993)

- ☐ Dementia (decline in memory and intellectual abilities that causes impaired functioning in daily living. The decline should be demonstrated by a loss of memory and deficits in at least two other domains)
- ☐ Cerebrovascular disease defined by presence of focal neurological signs consistent with stroke (with or without a history of stroke) and relevant CVD on CT or MRI
- ☐ Relation between dementia and CVD as shown by onset of dementia within 3 months following a recognized stroke, abrupt deterioration in cognitive functions, or fluctuating, stepwise progression of cognitive deficits.

Frontotemporal Dementia (Neary et al. 1998)

- ☐ NB Character change and disordered social conduct are the dominant features initially and throughout the disease course. Instrumental functions of perception, spatial skills, praxis, and memory are intact or relatively well preserved

- ☐ Insidious onset and gradual progression
- ☐ Early decline in social interpersonal conduct
- ☐ Early impairment in regulation of personal conduct
- ☐ Early emotional blunting
- ☐ Early loss of insight

Progressive Nonfluent Aphasia (Neary et al. 1998)

- ☐ NB Disorder of expressive language is the dominant feature initially and throughout the disease course. Other aspects of cognition are intact or relatively well preserved

- ☐ Insidious onset and gradual progression
- ☐ Nonfluent spontaneous speech with at least one of the following: agrammatism, phonemic paraphasias, anomia.

Semantic Dementia (Neary et al. 1998)

- ☐ NB Impaired understanding of word meaning and/or object identity is the dominant feature initially and throughout the disease course. Other aspects of cognition, including autobiographical memory, are intact or relatively well preserved.

- ☐ Insidious onset and gradual progression
- ☐ Language disorder characterized by
  1) Progressive, fluent, empty spontaneous speech
  2) Loss of word meaning, manifest by impaired naming and comprehension
  3) Semantic paraphasias and/or
- ☐ Perceptual disorder characterized by
  1) Prosopagnosia: impaired recognition of identity of familiar faces and /or
  2) Associative agnosia: impaired recognition of object identity
- ☐ Preserved perceptual matching and drawing reproduction
- ☐ Preserved ability to read aloud and write to dictation orthographically regular words

Dementia Lewy Bodies (McKeith et al. 1996, 2005)

- ☐ Dementia plus 2 of the following core features:
- ☐ Fluctuating cognition with pronounced variations in attention and alertness
- ☐ Recurrent visual hallucinations
- ☐ Spontaneous motor features of Parkinsonism

OR

- ☐ Dementia with one or more suggestive features plus one or more core features

Suggestive features are:

- ☐ REM sleep behavior disorder
- ☐ Severe neuroleptic sensitivity
- ☐ Low DA transporter uptake in basal ganglia on SPECT or PET

Mild Cognitive Impairment (Peterson et al. Arch. Neurol, 2001)

- ☐ Memory complaint, preferably corroborated by an informant
- ☐ Impaired memory function for age and education
- ☐ Preserved general cognitive function
- ☐ Intact activities of daily living
- ☐ Not demented

Preliminary Diagnosis_____

Final Diagnosis_____

Continued on next page

Page 2 "Possible" variations on diagnoses

Clin diagnosis of **possible AD**:

- ☐ Dementia syndrome in the absence o fother neurologic, psychiatric, or systemic disorders sufficient to cause dementia
  - ☐ Presence of variations in onset or presentation or clinical course
    OR
  - ☐ In the presence of a second systemic or brain disorder sufficient to produce dementia, which is not considered to be the cause of the dementia

***Possible* Dementia Lewy Bodies (McKeith et al. 1996, 2005)**

☐ Dementia plus 1 of the following core features:

- ☐ Fluctuating cognition with pronounced variations in attention and alertness
- ☐ Recurrent visual hallucinations
- ☐ Spontaneous motor features of Parkinsonism

The Physical Self-Maintenance Scale

A. Toilet

1. Cares for self at toilet completely, no incontinence.
2. Needs to be reminded, or needs help in cleaning self, or has rare (weekly at most) accidents.
3. Soiling or wetting while asleep more than once a week.
4. Soiling or wetting while awake more than once a week.
5. No control of bowels or bladder.

B. Feeding

1. Eats without assistance.
2. Eats with minor assistance at meal times and/or with special preparation of food, or help in cleaning up after meals.
3. Feeds self with moderate assistance and is untidy.
4. Requires extensive assistance for all meals.
5. Does not feed self at all and resist efforts of others to feed him.

C. Dressing

1. Dresses, undresses and selects clothes from own wardrobe.
2. Dresses and undresses self, with minor assistance.
3. Needs moderate assistance in dressing or selection of clothes.
4. Needs major assistance in dressing, but cooperates with efforts of others to help.
5. Completely unable to dress self and resist efforts of others to help.

D. Grooming (neatness, hair, nails, hands, face, clothing)

1. Always neatly dressed, well-groomed, without assistance.
2. Grooms self adequately with occasional minor assistance, eg. shaving.
3. Needs moderate and regular assistance or supervision in grooming.
4. Needs total grooming care, but can remain well-groomed after help from others.
5. Activity negates all efforts of others to maintain grooming.

E. Physical Ambulation

1. Goes about grounds or city.
2. Ambulates within residence or about one block distance.
3. Ambulates with assistance of (check one): a. ( ) another person b. ( ) railing c. ( ) cane d. ( ) walker e. ( ) wheelchair
4. Sits unsupported in chair or wheelchair, but cannot propel self without help.
5. Bedridden more than half the time.

F. Bathing

1. Bathes self (tub, shower, sponge bath) without help.
2. Bathes self with help in getting in and out of the tab.
3. Washes face and hands only, but cannot bath rest of body.
4. Does not wash self but is cooperative with those who bath him.
5. Does not try to wash self and resists efforts to keep him clean.

Activities of Daily Living Scale

A. Ability to use telephone
1. Operates telephone on own initiative–looks up and dials numbers, etc.
2. Dials a few well-known numbers.
3 . Answers telephone but does not dial.
4. Does not use telephone at all.

B. Shopping
1. Takes care of all shopping needs independently.
2. Shops independently for small purchases.
3. Needs to be accompanied on any shopping trip.
4. Completely unable to shop.

C. Food Preparation
1. Plans, prepares and serves adequate meals independently.
2. Prepares adequate meals if supplied with ingredients.
3. Heats and serves prepared meals, or prepares meals but does not maintain adequate diet.
4. Needs to have meals prepared and served.

D. Housekeeping
1. Maintains house alone or with occasional assistance (eg. "heavy work-domestic help").
2. Performs light daily tasks such as dish washing, bed making.
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness.
4. Needs help with all home maintenance tasks.
5. Does not participate in any housekeeping tasks.

E. Laundry
1. Does personal laundry completely.
2. Launders small items–rinses socks, stockings, etc.
3. All laundry must be done by others.

F. Mode of Transportation
1. Travels independently on public transportation or drives own car.
2. Arranges own travel via taxi, but does not otherwise use public transportation.
3. Travels on public transportation when assisted or accompanied by another.
4. Travel limited to taxi or automobile with assistance of other.
5. Does not travel at all.

G. Responsibility for own Medication
1. Is responsible for taking medication in correct dosages at correct time.
2. Takes responsibility if medication is prepared in advance in separate dosages.
3. Is not capable of dispensing own medication.

H. Ability to Handle Finances
1. Manages financial matters independently (budgets, write checks, pays rent, bills, goes to bank), collects and keeps track of income.
2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.
3. Incapable of handling money.

Date: _____ Completed by: _____

A7. Behavioural and Psychological Symptoms of Dementia (BPSD)

Cohen-Mansfield Agitation Inventory (CMAI)

Instructions: for each of the behaviors below, check the rating that indicates the average frequency of occurrence over the last 2 weeks.

	Never 1	Less than once a week 2	Once or twice a week 3	Several times a week 4	Once or twice a day 5	Several times a day 6	Several times an hour 7
Physical / Aggressive							
1. Hitting (including self)	1	2	3	4	5	6	7
2. Kicking	1	2	3	4	5	6	7
3. Grabbing onto people	1	2	3	4	5	6	7
4. Pushing	1	2	3	4	5	6	7
5. Throwing things	1	2	3	4	5	6	7
6. Biting	1	2	3	4	5	6	7
7. Scratching	1	2	3	4	5	6	7
8. Spitting	1	2	3	4	5	6	7
9. Hurt self or others	1	2	3	4	5	6	7
10. Tearing things or destroying property	1	2	3	4	5	6	7
11. Making physical sexual advances	1	2	3	4	5	6	7
Physical / Non-aggressive							
12. Pace, aimless wandering	1	2	3	4	5	6	7
13. Inappropriate dress or disrobing	1	2	3	4	5	6	7
14. Trying to get to a different place	1	2	3	4	5	6	7
15. Intentional falling	1	2	3	4	5	6	7
16. Eating/drinking inappropriate substances	1	2	3	4	5	6	7
17. Handling things inappropriately	1	2	3	4	5	6	7
18. Hiding things	1	2	3	4	5	6	7
19. Hoarding things	1	2	3	4	5	6	7
20. Performing rep mannerisms	1	2	3	4	5	6	7
21. General restlessness	1	2	3	4	5	6	7
Verbal / Aggressive							
22. Screaming	1	2	3	4	5	6	7
23. Making verbal sexual advances	1	2	3	4	5	6	7
24. Cursing or verbal aggression	1	2	3	4	5	6	7
Verbal / Non-aggressive							
25. Rep sentences or questions	1	2	3	4	5	6	7
26. Strange noises (weird laughter or crying)	1	2	3	4	5	6	7
27. Complaining	1	2	3	4	5	6	7
28. Negativism	1	2	3	4	5	6	7
29. Constant unwarranted request for attention or help	1	2	3	4	5	6	7

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Interior Health

Name: _____ Dates: From _____ to _____

Dementia Observational System (DOS) Tool[1]

Purpose: The DOS tool is used to assess a person's behaviour over a 24 hour cycle for up to 7 days to determine the occurrence, frequency, and duration of behaviours of concern.

When to use the DOS tool:

1. Upon admission for the first 7 days to establish a baseline behavioural profile.
2. Whenever there is a change or concern about the person's behaviours.
3. To evaluate the effectiveness of a planned intervention on the care-plan that is addressing specific target behaviours, e.g., has there been a change in the duration or frequency of the behaviour.

Directions:

1. Review behavioural key on the tool..Attach progress notes to the DOS.

2. Select the corresponding number from the behavioural key that best describes the person's behaviour within the time period and record in the ½ hour slot provided under the appropriate date.

3. Record the behaviour in 30 minute intervals for the duration of up to 7 days to determine trends.

4. Record behaviours of concern on the progress notes, using well-defined, neutral terms. Include:
   - **What** what behaviour was observed
   - **Where** where did the behaviour occur
   - **Why** what has happening just before the behaviour occurred
   - **How** what interventions were used – how were they implemented
   - **Outcome** how did the resident respond

5. To interpret results, use colour codes to assist in identifying patterns. Colour each 30 minute square for each 24 hour cycle with an assigned colour. Example of assigned colours:

Code	Colour	Behaviour
1 - 2	**Blue**	sleeping in bed/sleeping in chair
3	**Green**	awake/calm
4	**Yellow**	noisy
5	**Orange**	restless / pacing
6	**Brown**	exit seeking
7	**Pink**	aggressive - verbal
8	**Red**	aggressive - physical
9		other
10		other

6. For each 24 hour column, calculate the number of hours spent in sleep, calmness, restlessness, verbal aggression/agitation and physical aggression.

7. Summarize the analysis in the person' progress records with a note that describes the total number of days of the record, range of hours spent in each category of behaviour and any significant negatives.
   For example: Behavioural Summary for February 1st to 7th, 2010:

   "There have been 10 events of verbal aggression in the past 7 days which lasted approximately one hour each. On two of these occasions, verbal aggression was prolonged, about 2 hours in length, and immediately preceded two ½ hour events of physical aggression (hitting and pinching during care). Most events occurred between 1600 and 1930 hours".

[1] Adapted from the P.I.E.C.E.S. (2008) Resource Guide: A Model for Collaborative Care and Changing Practice, pages 88-92. For clinical and educational purposes only.

Interior Health

Name: _____ Dates: From _____ to _____

Use corresponding numbers to record behaviours in ½ hour intervals:

1. Sleeping in Bed
2. Sleeping in Chair
3. Awake/Calm
4. Noisy
5. Restless/Pacing
6. Exit Seeking
7. Aggressive – verbal
8. Aggressive – Physical
9. Other: _____
10. Other: _____

Dates:							
Time							
0730							
0800							
0830							
0900							
0930							
1000							
1030							
1100							
1130							
1200							
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0530							
0600							
0630							
0700							
0730							

2

A8. Delirium

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

1

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:

Inouye SK, van Dyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. *Ann Intern Med*. 1990;113(12):941-948.

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:

Inouye SK, van Dyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI. Clarifying confusion: the confusion assessment method. A new method for detection of delirium. *Ann Intern Med*. 1990;113(12):941-948.

A9. Capacity

Competency Checklist
Assessment for Consent to Treatment

Illness requiring treatment - risk if no treatment - perceived benefit of treatment	
Patient's understanding of this illness	
Patient's understanding of treatment	
Appreciation of risks and benefits of treatment	
Mental Status: - memory, concentration, orientation - delusions that interfere with capacity - judgment and insight - evidence cognitive impairment, delirium	
Diagnosis - medical - psychiatric	
Elements of consent ☐ evidence a choice ☐ factual understanding ☐ reasoning ☐ appreciation	
Competence ☐ yes ☐ no	

T. Chisholm-O.comp.cap to consent checklist
Hospitals Act, Nova Scotia
Jan 2000

Page 1 of 1

Competency Checklist
Assessment for Personal Care Competence

Name _____ Hospital # _____ Date _____

Assessor _____

Deficits in ability to care for self - PT, OT, RNs - Personal or health problems - ADLs (dress, feed, bathe) - IADLs (shopping, meals) - Incontinence	
Appreciation of one's strengths and weaknesses	
Willingness to make use of available resources (family or community)	
Evidence of impairment in judgement which resulted in danger to self or others	
Mental status: - evidence dementia, cognitive impairment + frontal deficits - delusions that interfere with capacity - judgment and insight	
Diagnosis - medical - psychiatric	
Elements of consent ☐ evidence a choice ☐ factual understanding ☐ reasoning ☐ appreciation	
Competence ☐ yes ☐ no	

T. Chisholm-O.cl.comp.pers care checklist
CPA guidelines, Can J Psychiatry 1989;34:829-832
Jan 2000

Page 1 of 1

Competency Checklist
Assessment for Financial Competence

Name _____ Hospital # _____ Date _____

Assessor _____

Patient's awareness of financial status - Assets, income, expenses, debt - daily financial tasks (calculations, bills, writing checks)	
Corroboration	
Appreciation of one's strengths and weaknesses with management of finances	
Understanding of POA (if necessary) Preference for estate management	
Willingness to make use of available resources (family or community)	
Evidence of impairment in judgement with respect to finances	
Implication to person and others should they exercise poor financial judgement	
Mental status: - memory, concentration, orientation - calculations - delusions that interfere with capacity - judgment and insight - evidence cognitive deficits	
Diagnosis - medical - psychiatric	
Elements of consent ☐ evidence a choice ☐ factual understanding ☐ reasoning ☐ appreciation	
Competence ☐ yes ☐ no	

T. Chisholm-O.comp.financialchecklist
CPA guidelines, Can J Psychiatry 1989:34:829-832
Jan 2000

Page 1 of 1

Form 1: Assessment of Capacity to make Decisions about a Personal Care Matter

(assessing capacity for Sections 10, 11 and 13 of the Personal Directives Act)

I, _____ *(full name and professional designation)*,
a physician, assessed _____ *(full name of person being assessed)*
of _____ *(address of person)* on _____/_____/_____ *(yyyy/mm/dd)*
at _____ a.m./p.m. at _____ *(location of assessment)*.

If the assessment is of a person delegated under a personal directive to make personal-care decisions for another, then skip items 1 and 2.

1) Personal directive made:

Check one:

☐ I am aware that _____ *(full name of person being assessed)* has made a personal directive.

☐ I do not know if _____ *(full name of person being assessed)* has made a personal directive.

2) Consultation under personal directive:
Subsection 10(1) of the Personal Directives Act states that a personal directive may name a person – by name, title, or position – with whom the person making an assessment of capacity of the maker is to consult in making the assessment.

Check one:

☐ I consulted with _____ *(full name of person named in personal directive)* in making this assessment of capacity.

☐ I have made reasonable efforts to consult with _____ *(full name of person named in personal directive)* in making this assessment of capacity.

☐ I am not aware that anyone has been named for consultation.

3) Capacity explained:
"Capacity" is defined in the Personal Directives Act to mean the ability to understand information that is relevant to the making of a personal-care decision and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

Before conducting the assessment of capacity, I explained to _____ *(full name of person being assessed)* the purpose of the assessment, the significance and effect of a finding of capacity or incapacity, and their right to refuse to be assessed.

4) Physician's opinion

It is my opinion that _____ *(full name of person being assessed)* has the capacity to make a personal-care decision regarding the following:

Personal Care Decision	Capacity	
• Health care _____	Yes ☐	No ☐

("health care" is defined for the Personal Directives Act to mean any examination, procedure, service or treatment for an individual that is done for a therapeutic, preventative, palliative, diagnostic or other health-related purpose, and includes a course of health care or a care plan)

- Placement in a continuing-care home Yes ☐ No ☐
- Provision of home-care services Yes ☐ No ☐
- Leaving the Province Yes ☐ No ☐
- Other personal care _____ Yes ☐ No ☐

("personal care" is defined in the Personal Directives Act to include, but is not limited to, health care, nutrition, hydration, shelter, residence, clothing, hygiene, safety, comfort, recreation, social activities, support services and any other personal matter that is prescribed by the regulations)

5) Supporting information:

The following information supports my opinion:

A) Observations from my assessment of the person being assessed:

_____

_____

_____

B) Information from other sources (please specify sources of information):

_____

_____

_____

Is there any additional supporting information or reports attached? Yes ☐ No ☐

_____ _____

(Date of signature) *(Signature)*

_____

(Printed name)

Notes:

1) This form must be completed by a physician. *(s. 5 of Personal Directives Regulations)*

2) This form is to be used:

   A) if any of the following request an assessment of the capacity of a person who has made a personal directive or a person on whose behalf personal care decisions will be made:
   - the person who made the personal directive or on whose behalf personal care decisions will be made
   - a delegate named in the personal directive
   - a statutory decision-maker
   - the nearest relative (as defined in the *Personal Directive Regulations*)
   - a health-care provider
   - a person in charge of the home-care services provider or continuing-care home where the person who made the personal directive or on whose behalf the personal care decisions will be made resides.

   (s. 10(2) and (3) of Personal Directives Act)

   B) for the assessment of capacity of a person who has made a personal directive after they have been prevented from leaving the Province *(s. 11 of Personal Directives Act)*

   C) for the assessment of capacity of a person delegated under a personal directive to make personal-care decisions *(s. 13 of Personal Directives Act)*

2) An assessment made under s. 11 of the Act after a person has been prevented from leaving the Province must be completed as soon as practicable. *(s. 11(2) of Personal Directives Act)*

Last updated: 11_2012