Cohen-Mansfield Agitation Inventory (CMAI)[1]

Background
The CMAI is a widely used tool to rate the frequency of agitated behaviors.

The following instructions are read to a caregiver who knows the person with dementia well:
I would like to ask you about certain specific behaviors sometimes seen in older persons. I do not expect that all of these behaviors apply to your relative (patient, resident). Rate behaviors as they occur on your shift (during the past 2 weeks). Do not include behaviors that are clearly explained by situational factors.

Caregivers rate the behavior using the following scoring scale:
1 = never
2 = less than once a week
3 = once or twice a week
4 = several times a week (3 or more)
5 = once or twice a day
6 = several times a day (3 or more)
7 = several times an hour (2 or more)
8 = would occur if not prevented
9 = not applicable (e.g., cannot pace because cannot walk or move wheelchair)

Behaviors on the scale include the following:

- Pacing and aimless wandering
- Inappropriate dressing or disrobing
- Spitting
- Cursing or verbal aggression
- Constant, unwarranted requests for attention or help
- Repetitive sentences or questions
- Hitting (including self)
- Kicking
- Grabbing onto other people
- Pushing
- Throwing things
- Making strange noises
- Screaming
- Biting
- Scratching
- Attempting to get to a different place
- Intentional falling
- Complaining
- Negativism
- Eating or drinking inappropriate substances
- Hurting self or others
- Handling things inappropriately
- Hiding things
- Hoarding things
- Tearing things or destroying property
- Performing repetitious mannerisms
- Making verbal sexual advances
- Making physical sexual advances or exposing self
- General restlessness
- Behaviors occurred most often in

___ Morning
___ Afternoon
___ Evening
___ No time more often than others
___ Different time for different behaviors

[1] Cohen-Mansfield, J. (1991). *Instruction Manual for the Cohen-Mansfield Agitation Inventory (CMAI)*. Rockville, MD: Research Institute of the Hebrew Home of Greater Washington.

Cornell Scale for Depression in Dementia (CSDD)[i]

Scoring System: U = unable to evaluate 0 = absent 1 = mild or intermittent 2 = severe

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

	U	Absent	Mild or Intermittent	Severe
A. Mood-Related Signs				
1. Anxiety – anxious expression, ruminations, worrying	U	0	1	2
2. Sadness – sad expression, sad voice, tearfulness	U	0	1	2
3. Lack of reactivity to pleasant events	U	0	1	2
4. Irritability – easily annoyed, short-tempered	U	0	1	2
B. Behavioral Disturbance				
5. Agitation – restlessness, hand wringing, hair pulling	U	0	1	2
6. Retardation – slow movements, slow speech, slow reactions	U	0	1	2
7. Multiple physical complaints (Score 0 if GI symptoms only)	U	0	1	2
8. Loss of interest – less involved in usual activities (Score only if change occurred acutely, i.e., in less than a month)	U	0	1	2
C. Physical Signs				
9. Appetite loss – eating less than usual	U	0	1	2
10. Weight loss (Score 2 if greater than 5 lbs in 1 month)	U	0	1	2
11. Lack of energy – fatigues easily, unable to sustain activities (Score only if change occurred acutely, i.e., in less than a month)	U	0	1	2
D. Cyclic Functions				
12. Diurnal variation in mood – symptoms worse in morning	U	0	1	2
13. Difficulty falling asleep – later than usual for this individual	U	0	1	2
14. Multiple awakening during sleep	U	0	1	2
15. Early morning awakening – earlier than usual for this individual	U	0	1	2
E. Ideational Disturbance				
16. Suicide – feels life is not worth living, has suicidal wishes, or makes suicidal attempt	U	0	1	2
17. Poor self-esteem – self-blame, self-depreciation, feelings of failure	U	0	1	2
18. Pessimism – anticipation of the worst	U	0	1	2
19. Mood-congruent delusions – delusions of poverty, illness, or loss	U	0	1	2
Total (38 possible)				

Cornell Scale for Depression in Dementia.

The Cornell is clinician-scored based on observation and interview, and collaborating information from a person who knows the older adult well and/or information in the chart. The Cornell includes 19 items that are scored 0 = absent, 1 = mild, and 2 = severe for a total score of 0 to 38 points.

Although the Cornell was developed for use with older adults who have dementia – and thus may not accurately report their symptoms of depression – it also is a reliable and valid scale for older people who are not cognitively impaired.

A cut-off score of 8 or greater indicates clinically significant depression that should be further assessed.

The main advantages of the Cornell include its ability to detect change in depression severity, wide use in clinical practice, and usability with older adults who may (or may not) have cognitive impairments that interfere with self-report of symptoms.

The disadvantage is that the Cornell requires more skill on the part of the clinician making the assessment, and relies on having access to a person who is familiar with the older person's usual habits and complaints.

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[i] Alexopoulos, G.S., Abrams, R.C., Young, R.C., & Shamoian, C.A. (1988). Cornell Scale for Depression in Dementia. *Biological Psychiatry, 23*(3), 271-284.

Alexopoulos, G.S., Abrams, R.C., Young, R.C., & Shamoian, C.A. (1988). Use of the Cornell scale in nondemented patients. *Journal of the American Geriatrics Society, 36*(3), 230-236.

The GAD-7 Anxiety Scale[i]

Name _____ Date _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Add columns: _____+ _____+ _____

Total: _____

8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all difficult ___

Somewhat difficult ___

Very difficult ___

Extremely difficult ___

Scoring instructions for the GAD-7 Anxiety Scale

Total score is 0 to 21

No anxiety:	0 to 4
Mild anxiety:	5 to 9
Moderate anxiety:	10 to 14
Severe anxiety:	15 to 21

Individuals who score 10 or greater should discuss their symptoms with their primary care provider or contact a mental health provider for further assessment and possible treatment.

One of the advantages of the GAD-7 is that it looks like, and is scored like the PHQ-9 – making it easy for the older person to transition from one scale to the other.

The disadvantage is that persons with cognitive impairment may not be able to accurately rate their symptoms.

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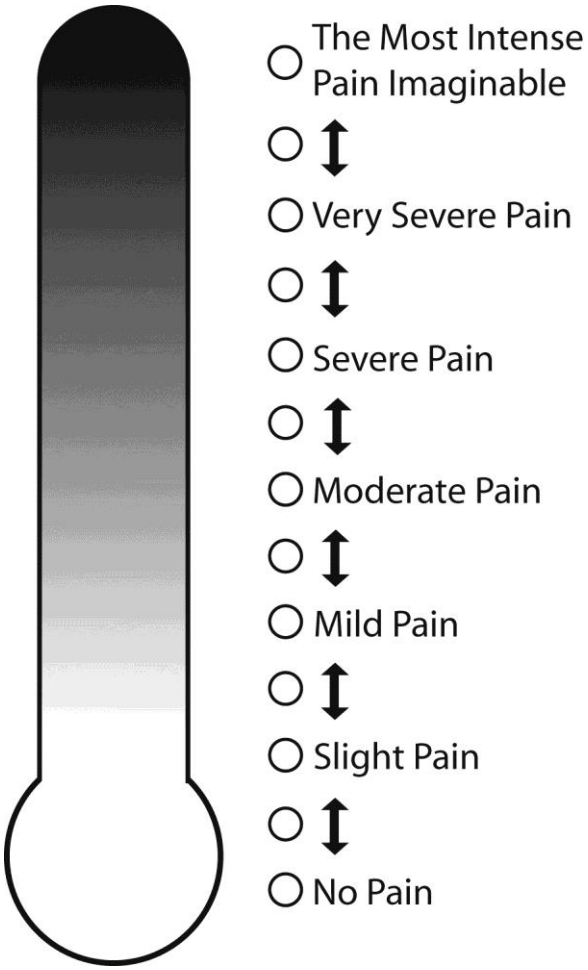
[i] Spitzer R.L., Kroenke, K., Williams, J.B., & Lowe, B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. *Archives of Internal Medicine, 166*(10), 1092-1097.

Iowa Pain Thermometer



Source: Herr, K.A., Spratt, K.F., Grand, L., & Li, L. (2007). Evaluation of the Iowa Pain Thermometer and other selected pain intensity scales in younger and older adult cohorts using controlled clinical pain: A preliminary study. *Pain Medicine*, page 3.

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Neuropsychiatric Inventory (NPI) Screening Questions[1]

The following 12 domains of the NPI are listed below, along with the screening question related to the topic. The full version of the NPI rates each area according to frequency of the symptoms, intensity of the symptoms, and the amount of distress the symptoms create for caregivers. The purpose of this handout is to provide a brief overview of common problems; it is not intended to be scored. For additional information about the NPI and its use, review the article noted in the footer or visit https://www.aafp.org/afp/2002/0601/p2263.html to review a modified version, the NPI-Q.

A. Delusions: Does (S) have beliefs that you know are not true? For example, insisting that people are trying to harm him/her or steal from him/her. Has he/she said that family members are not who they say they are or that the house is not their home? I'm not asking about mere suspiciousness, I am interested if (S) is convinced that these things are happening to him/her.	**Y**	**N**
B. Hallucinations: Does (S) have hallucinations such as false visions or voices? Does he/she seem to see, hear or experience things that are not present? By this question, we do not mean just mistaken beliefs such as stating that someone who had died is still alive; rather, we are asking if (S) actually has abnormal experiences of sounds and visions.	**Y**	**N**
C. Agitation/Aggression: Does (S) have periods when he/she refuses to cooperate or won't let people help him/her? Is he/she hard to handle?	**Y**	**N**
D. Depression/Dysphoria: Does (S) seem sad or depressed? Does he/she say that he/she fees sad or depressed?	**Y**	**N**
E. Anxiety: Is (S) very nervous, worried, or frightened for no apparent reason? Does he/she seem very tense or fidgety? Is (S) afraid to be apart from you?	**Y**	**N**
F. Elation/Euphoria: Does (S) seem too cheerful or too happy for no reason? I don't mean normal happiness that comes from seeing friends, receiving presents, or spending time with family. I am asking if (S) has a persistent and abnormally good mood or finds humor when others do not.	**Y**	**N**
G. Apathy/Indifference: Has (S) lost interest in the world around him/her? Has he/she lost interest in doing things or lack motivation for starting new activities? Is he/she more difficult to engage in conversation or in doing chores? Is (S) apathetic or indifferent?	**Y**	**N**
H. Disinhibition: Does (S) seem to act impulsively without thinking? Does he/she do or say things that are not usually done or said in public? Does he/she do things that are embarrassing to you?	**Y**	**N**
I. Irritability/Lability: Does (S) get irritated and easily disturbed? Are his/her moods very changeable? Is he/she abnormally impatient? We do not mean frustration over memory loss or inability to perform usual tasks; we are interested to know if (S) has abnormal irritability, impatience, or rapid emotional changes that are different from his/her usual self.	**Y**	**N**
J. Aberrant Motor Behavior: Does (S) pace, do things over and over such as opening closets or drawers, or repeatedly pick at things or wind string or threads?	**Y**	**N**
K. Sleep: Does (S) have difficulty sleeping (do not count as present if (S) simply gets up once or twice a night only to go to the bathroom and falls back to sleep immediately)? Is he/she up at night? Does he/she wander at night, get dressed, or disturb your sleep?	**Y**	**N**
L. Appetite and Eating Disorders: Has (S) had any change in appetite, weight, or eating habits? (Count as NA if (S) is incapacitated and has to be fed.) Has there been any change in the type of food he/she prefers?	**Y**	**N**

[1] Cummings, J.L., Mega, M., Gray, K., Rosenberg-Thompson, S., Carusi, D.A., & Gornbein, J. (1994). The Neuropsychiatric Inventory: comprehensive assessment of psychopathology in dementia. *Neurology, 44*(12), 2308-2314.

Six-Item Screener (SIS)[1]

Instructions for the patient:

I would like to ask you some questions that ask you to use your memory. I am going to name three objects. Please wait until I say all three words, and then repeat them. Remember what they are because I am going to ask you to name them again in a few minutes.

Please repeat these words for me: APPLE – TABLE – PENNY.

(May repeat names 3 times if necessary. Repetition is not scored.)

Did the patient correctly repeat all three words? ☐ Yes ☐ No

What year is this?	_____	(1)
What month is this?	_____	(1)
What is the day of the week?	_____	(1)
What are the three objects I asked you to remember?		
Apple	_____	(1)
Table	_____	(1)
Penny	_____	(1)
Total score:	**_____**	**(6)**

The Six-Item Screener follows the format of other mental status exams, including three orientation items and three recall items.

The total score is 6 points.

A score of ≤ 4 suggests cognitive impairment that should be assessed further.

The advantage of the SIS is that it is short and is highly correlated to scores on the MMSE.[1]

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[1] Callahan, C.M., Unverzagt, F.W., Hui, S.L., Perkins, A.J., & Hendrie, H.C. (2002). Six-item screener to identify cognitive impairment among potential subjects for clinical research. *Medical Care, 40*(9), 771-781.