

Integrating Neuropsychological Assessment into a Multidisciplinary Adult Protective Service Model

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Learning Objectives

- Attendees will gain an understanding of the County of Ventura's APS multidisciplinary team model, its creation, and day to day functioning.
- Attendees will learn how psychologists can contribute to APS assessment and intervention efforts.
- Attendees will learn what neuropsychological assessment is and how it can assist in decision making as part of APS assessment and intervention efforts.



Why is this important?



Increased Rates of Cognitive Impairment

- Prevalence of neurocognitive disorders will grow drastically over the next decades.
- These adults are at heightened risk for abuse and neglect.
- 5.7 Million
- 14 Million
- \$341,840
- 16.1 Million
- \$232 Billion
- \$277 Billion
- \$1.1 Trillion
- \$7.9 Trillion



Increase in APS Utilization and Case Complexity

- Case complexity is expected to increase as life expectancy increases
 - Greater medical comorbidities
 - Finances must stretch longer
 - Longer and more intensive caretaking
- There is and will be a great need for:
 - Effective multidisciplinary teams
 - Standardized practice
 - Evidence-informed practice
 - Objective screening and assessment
 - Integrated approaches to assessment and intervention
 - Culturally informed practice





COUNTY OF VENTURA

Ventura County APS



Ventura County Multidisciplinary Team

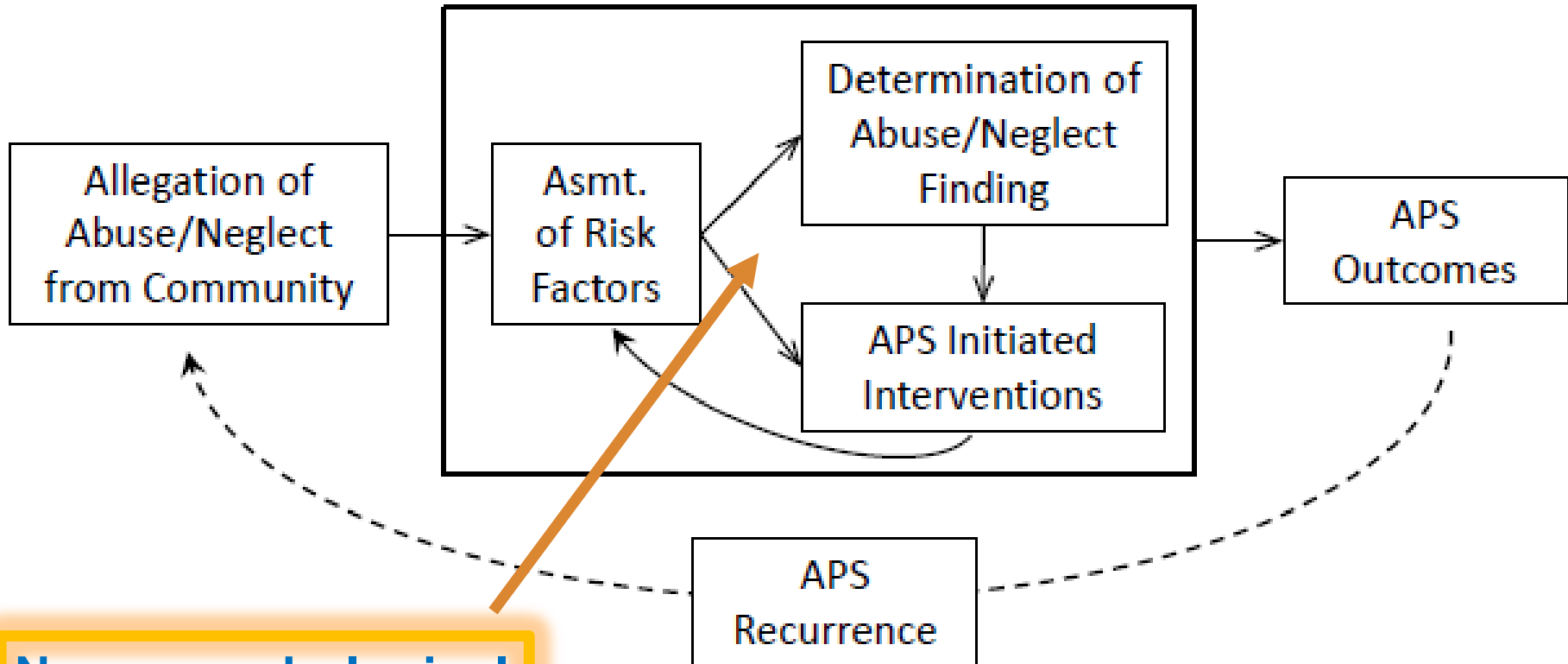
- Origin of the Ventura County Multidisciplinary Team/Rapid Response Expert Team
- Funding
- Team members
- Function of the team
- Culture of the team



Tool for Risk, Intervention, and Outcome (TRIO)



APS System Actions



**Neuropsychological
Evaluation**



What is Neuropsychology?

- A clinical neuropsychologist is a psychologist with special expertise in the applied science of brain-behavior relationships.
- Clinical neuropsychologists use this knowledge in the assessment, diagnosis, treatment, and/or rehabilitation of patients across the lifespan with neurological medical, neurodevelopmental, and psychiatric conditions, as well as other cognitive and learning disorders.



Some Questions

- How is this guy's cognition?
- Is this normal aging or dementia?
- Would you let him make medical decisions?
- Does he understand his will? He wants to change it.
- Should he live alone?
- Would you let him drive a car?
- Is this just depression?
- What impact did the stroke have?
- Why is he behaving so differently?
- Is this a reversible problem or not?
- How can we best improve his current functioning and independence?



MOOD

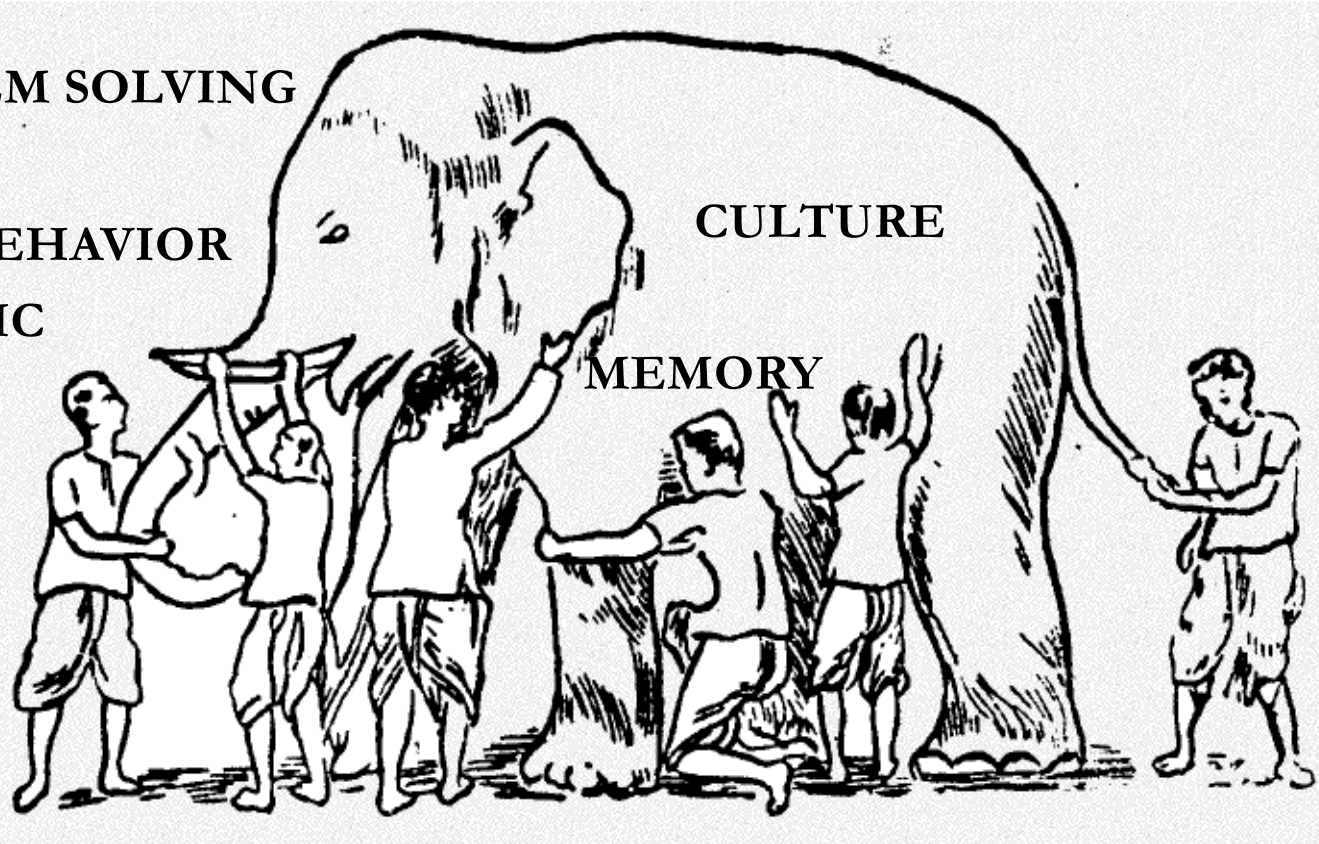
PROBLEM SOLVING

BEHAVIOR

CULTURE

**PSYCHIATRIC
SYMPTOMS**

MEMORY



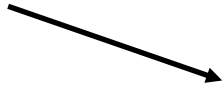
ENVIRONMENT/SOCIAL SUPPORT

SELF-AWARENESS



Assessment: Sources of Information

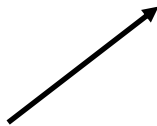
Collateral reports (family)



Provider's observations/
interview



Client Self-Report



Objective Personality &
Psychiatric Symptom
Assessment



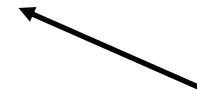
Objective
Behavior
Rating Scales



Medical Records



Objective Neuropsychological
Assessment

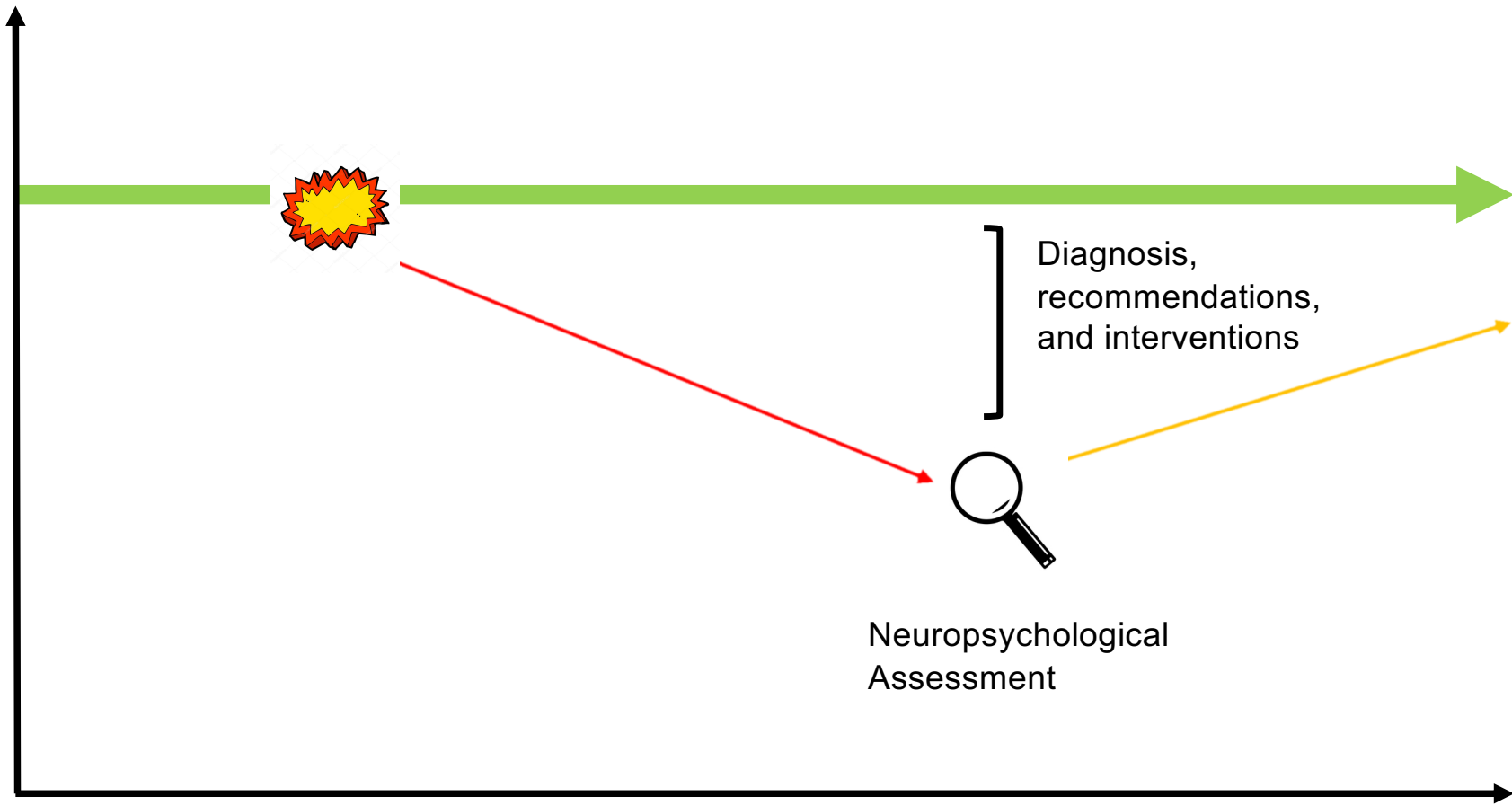


What is Neuropsychological Assessment?

- Starts with a referral question (why is Mr. Smith so forgetful?)
- Consists of an interview with the patient, family, medical/psych record review, and cognitive/psychological test administration
 - Testing is an objective and standardized measure of what you want to measure (e.g., learning, memory, problem solving)
 - Quantifies behavior or functioning compared to their peers
- Test data are combined with patient history, context, and observations
- Creates a cohesive and comprehensive understanding of a person (strengths and weaknesses)
- Diagnosis, prognosis, tailored recommendations, and referrals



Functioning



Time



Information to Act on

Severity of Cognitive Problems?

- No problems
- Normal aging
- Mild
- Major
- Problems not due to cognition

Course of Problems?

- Stable
- Progressive
- Reversible
- Improving



When to Contact Neuropsychology?



Cognitive Warning Signs/Red Flags

- Forgetfulness (appointments, misplacing objects, conversations)
- Asks the same questions over and over
- Tip-of-the-tongue moments
- Learning new information takes more effort
- Trouble following directions
- Personality changes
- Losing independence (managing medications or schedule)
- Increase in careless errors (forgetting to pay bills)
- Inappropriate and unusual behavior (e.g., not dressing for the weather, impulsivity)
- Unexplained weight loss
- Defer to others to answer questions



Functioning and Functional Impairment

- ADLS and IADLS
- Toileting and bathing
- Dressing and grooming
- Writing checks, paying bills, balancing check book
- Shopping alone for goods such as groceries
- Cooking. Turning on/off the stove
- Keeping track of appointments
- Managing medications
- Traveling via bus, car, etc. to various places such as the store and work
- Emergency procedures



DSM-5: Major Neurocognitive Disorder Diagnostic Criteria

- 1) Evidence of **significant** cognitive decline from a previous level of performance in one or more cognitive domains based on:
 - Concern of the individual, knowledgeable informant, or clinician that there has been a **significant** decline in cognitive function, and
 - A **substantial** impairment in cognitive performance, preferably documented by standardized neuropsychological testing
- 2) The cognitive deficits interfere with capacity for independence in everyday activities (paying bills, managing medications).



DSM-5: Mild Neurocognitive Disorder

Diagnostic Criteria

- 1) Evidence of *modest* cognitive decline from a previous level of performance in one or more cognitive domains based on:
 - Concern of the individual, knowledgeable informant, or clinician that there has been a *mild* decline in cognitive function, and
 - A *modest* impairment in cognitive performance, preferably documented by standardized neuropsychological testing
- 2) The cognitive deficits ***do not*** interfere with independence in everyday activities (paying bills, managing medications), ***but greater effort, compensatory strategies, or accommodation may be required.***



Causes of Neurocognitive Disorders

- Alzheimer's disease
- Frontotemporal lobar degeneration
- Lewy body disease
- Cerebrovascular disease
- Traumatic brain injury
- Substance/medication use
- HIV infection
- Prion disease
- Parkinson's disease
- Huntington's disease
- Another medical condition
- Multiple etiologies
- Unspecified



Causes that Can Mimic Dementia

- Medication Use
- B₁₂ deficiency
- Hypothyroidism
- Kidney/Liver problems
- Infections (e.g., UTI)
- Depression
- PTSD
- Sleep apnea
- Stress
- Alcohol and drug use



Delirium

- Acute decline in brain function
- A medical condition and emergency
 - Rapid onset
 - Reduced attention and concentration
 - Poor thinking
 - Waxing and waning mental status
 - Behavior changes
 - Emotional disturbance
- Reversible
- In older adults often due to medications, infection, medical procedure (anesthesia), metabolic imbalance, exposure to toxin



Depression

- Some subjective symptoms similar to dementia
 - Forgetfulness, poor concentration, inattentive, disoriented, slowed verbal and motor responses, sleep problems, appetite problems
- May appear sad, irritable, or worried, speech might be flat
- Often presents with nonspecific physical symptoms
- Depression is **not** a normal part of aging
- Unfortunately, only ~10% of older adults with depression receive treatment.
- Suicide rates are the highest among older adults
 - Especially men



Practice

- Depression?
- Delirium?
- Dementia?
- Normal Aging?
- Something Else?



Screening Tools for Older Adults

- Obtain quick sense of global function
 - Identify areas for formal cognitive evaluation
 - Identify mental health/social contributors
 - If repeated, can identify changes over time
- Cognition
- Depression
- Anxiety
- Alcohol Consumption





Useful Depression Screening Tools

- Screening Measures:
 - Patient Health Questionnaire (PHQ-2 or PHQ-9)
 - Geriatric Depression Scale (GDS) - Short Form
 - Beck Depression Inventory-II (BDI-II)
- **Tip: Use the patient's language**
 - Gender and age differences in symptom endorsement and language (depression is stigmatized)



Useful Anxiety Screening Tools

- Screening Measures:
 - Geriatric Anxiety Inventory (GAI)
 - Geriatric Anxiety Scale (GAS-10)
 - Beck Anxiety Inventory (BAI)

- **Tip: Sources of anxiety change with age**
 - Social → Work → Financial → Health → Family



Useful Anxiety Screening Questions

Use the patient's language (e.g., "nerves")

- Have you been concerned about/fretting over a number of things?
- Is there anything going on in your life that is causing you concern?
- Do you find that you have a hard time putting things out of your mind?

If the patient reports physical symptoms:

- What were you thinking about when you felt your heart start to race?
- When you can't sleep, what is usually going through your head?

Common areas of concern or worry

- Losing independence, becoming a burden on others
- Finances
- Falling
- Incontinence



Useful Alcohol Screening Tools

- Screening Measures
 - Short Michigan Alcohol Screening Test-Geriatric Version (S-MAST-G)
 - Cut-Annoyed-Guilty-Eye Opener (CAGE)
 - Alcohol Use Disorders Identification Test (AUDIT or AUDIT-C)
 - Drug Screening Questionnaire (DAST)

- **Tip: Do not assume your patient does not use/abuse**
 - Expect to be surprised from time to time (but don't act surprised/shocked)



Asking About Alcohol and Drug Use

- Use a **non-judgmental and non-confrontational** approach
- Ask **detailed questions about *quantity* and *frequency*** of drinking, medications, and illicit drugs (yes, cannabis too)
- **Give feedback** on screening – education on what constitutes low vs. high risk consumption
- Do not stigmatize or shame
- **Motivational Interviewing**
 - Discuss the **patient's reasons** for drinking, consequences of drinking, and the patient's reasons to cut down or quit
 - **Develop realistic goal** w/ patient



Assessment Considerations For All Professionals

- Use appropriate normative samples for objective comparison
- Interdisciplinary approach
- Understanding of how symptoms/disorders may present differently across the lifespan
- Attention to accommodations
- Length of assessment
- Time of day
- Setting
- Presence of others during assessment



Case Example 1



No Conservatorship Required

- Female in 70s, with a recent history of memory loss and poor judgment/self-neglect
- Concerns of opiate medication abuse
- At risk of losing housing as inadequate income

- Assessment sought to clarify diagnosis as attempting to help her find housing. Concerns dementia was contributing to difficulties.

- Findings (seen across several days):
 - impairment in attention, some executive functions, learning ability
 - Normal function in abstract reasoning skills, verbal comprehension, health and safety judgement, and money management
 - Primary issue likely depression and substance abuse



Case Example 2



Conservatorship Recommended

- Male in 90s, living independently, but recent episode of financial abuse
- Long history of supporting self by making personal loans to others
- At risk of ongoing financial abuse

- Assessment sought to clarify diagnosis and extent of impairment as intelligent and presents well, but has history of people taking advantage

- Findings:
 - Early dementia. Etiology unclear, subcortical in nature and may reflect conditions such as cerebrovascular disease.
 - Impaired attention, speed of information processing, executive functions, initial learning and memory retrieval, and on measures of health and safety judgement and financial management ability
 - Normal functioning in memory retention, abstract reasoning, language skills, and visuospatial skills



Initial Research Findings



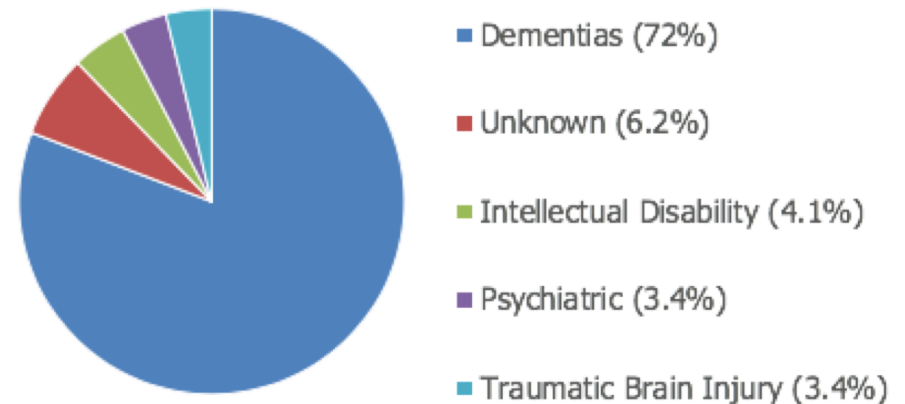
Characteristics and Prevalence Rates

- Those referred for neuropsychological assessment:
 - 86% were diagnosed with a neurocognitive disorder

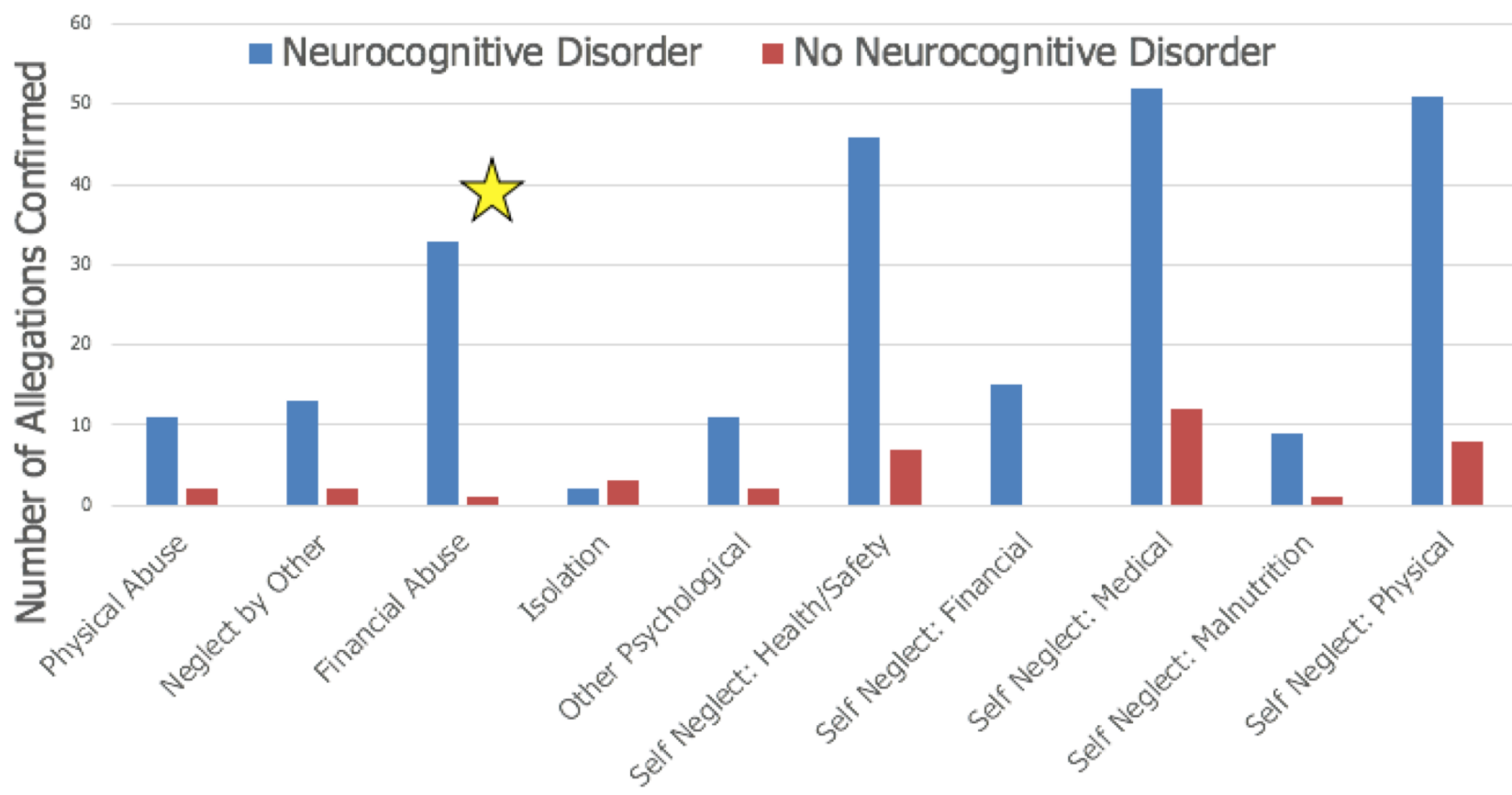
Those 86% with a Neurocognitive Disorder:

- Average 74 years of age
- 57% Female
- 73% White/Caucasian
- Average 12 years of education
- 9.7% given a co-occurring psychiatric disorder
- 1.6% given a co-occurring substance-related disorder

Primary Etiologies



Confirmed Allegations by Neurocognitive Disorder Status



Risk Factors, Interventions, and Outcome by Neurocognitive Disorder Status

Risk Factors

- **Precursors**
 - Live alone
 - Perceived as confused or with evidence of cognitive impairment
- **Biological Indicators**
 - Inadequate food/meal supplies
- **Social Indicators**
 - Neglect household finances
- **Psychological Indicators**
 - None found

Interventions

- Medical evaluation by a physician or nurse
- In home nursing assessment
- Tangible support was used to purchase necessary items

Outcome

- Demonstrated self-advocacy
- Sought conservatorship/guardianship
- Obtained conservatorship/guardianship
- APS protective issue reduced or eliminated



	No Neurocognitive Disorder	Neurocognitive Disorder
APS Protective Issue Unresolved	41.2%	11.9%
APS Protective Issue Reduced or Eliminated	58.8%	88.1%
Total	100%	100%



Neuropsychological Assessment's Contribution to APS Evaluation

- Neurocognitive disorders (given at neuropsychological assessment) were significantly predicative of client **health and safety** and **money management** abilities.
- TRIO variables were not predictive
 - Appear to be descriptive
- Neuropsychological assessment appears to add a unique contribution to understanding APS clients and their functioning.



Take Home Points

- Increasing number of older adults and cognitive impairment in the coming decades
- Expected increase in use of APS services & case complexity
- Need for effective multidisciplinary teams
- Need for assessment standardization and evidence-informed practice
- Neuropsychology is a specialty that can:
 - Improve objective understanding of a client's cognition
 - Assess decision making capacity
 - Clarify diagnosis
 - Inform prognosis
 - Improve biological, psychological, and social recommendations for intervention
- Initial research into our model demonstrates neuropsychological assessment provides a unique contribution to APS' understanding of clients



Any Questions?



*Please feel free to contact us
regarding any of our training presentations*

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