PART
2

Geriatric Assessment, Planning, and Care Monitoring

© Monkey Business Images/Shutterstock

9781284078985_CH03_Print.indd 33 10/7/15 8:47 PM

CHAPTER

3

Psychosocial Assessment in Care Management

Stephanie Swerdlow, Carmen L. Morano, and Barbara Morano

Introduction

The psychosocial assessment along with the functional assessment (discussed in Chapter 4) provides the foundation for all the care management that follows. Combined, the functional and the psychosocial assessments are not only critical to developing a relevant and appropriate care plan but in fact provide an in-depth perspective of the older adult's quality of life.[1]

A "good assessment" is not an end in itself. The assessment process provides the care manager an opportunity to begin to engage on a human level with the client and the family and is a first step in establishing the relationship that will be instrumental in helping the older adult and the family to navigate the aging process.

The goals of clinicians and researchers alike have moved from focusing on how long a particular intervention can extend an older adult's life to a more holistic approach that recognizes the importance of increasing the quality of the older adult's life.[1] (See Chapter 10 for a more complete discussion on quality of life.) Within the fields of social work and care management there has also been a shift from a focus on assessing client deficits (impairment or disease) to a broader perspective that focuses on the strengths of clients and their family systems.

The knowledge gained from a comprehensive psychosocial assessment provides objective, measurable information about the cognitive, social, psychological, spiritual, financial, and legal dimensions of the client system as well as important subjective information about the entire client system's coping mechanisms and relationships. There is no one model or approach to completing a psychosocial assessment or even a unified consensus on what specific dimensions (cognitive, psychological, financial, social, etc.) make up a comprehensive psychosocial assessment. The care manager must develop a psychosocial assessment that best meets the needs of the clients served, and one that helps to inform, guide, or contribute to making professional judgments about an appropriate care plan.[2]

In **Appendix 3A** at the end of this chapter, we include a sample psychosocial assessment designed and specially used by care managers for you to adapt or use. This chapter primarily focuses on the cognitive, psychological, economic, and social dimensions as well as on assessing the potential for substance abuse and elder maltreatment. Spiritual assessment is covered in Chapter 8. In **Appendix 3B** we include standardized assessment instruments that are available online.

"Underlying good care management is good assessment."[3] Although the psychosocial aspects of an assessment can be labeled the heart and soul of the comprehensive geriatric assessment, it is important that they represent

9781284078985_CH03_Print.indd 35 10/7/15 8:47 PM

dimensions of the assessment that can be understood only within the context of all other dimensions of a comprehensive assessment. The care manager takes a historical perspective that encompasses the individual, familial, and systemic perspectives. This understanding of the client's behavior, strengths, coping mechanisms, motivations, and the nature of relationships provides the foundation of the care plan. Once the assessment is completed, the care manager can engage the client more successfully as well as engage the entire client system in a collaborative working relationship.

The psychosocial assessment begins when a call is made to inquire about care management services for an older adult. Frequently, this call is precipitated by an unexpected trauma or crisis (e.g., hospitalization, sudden behavioral change, accident). Consequently, most practice models start with a family assessment on the phone or in person to obtain reliable information about the family system and to understand the problem more fully from the family perspective. During this initial call, the care manager inquires about the reason for the call at this particular time, rather than at some previous time, and the rationale for this call by this particular family member, rather than other family members or even the older adult. The information obtained during this initial call or visit is valuable for developing an approach for the initial engagement of the older adult as well as other family members who may be involved with the older adult.

Care management is unique in that there are frequently multiple clients, most notably spouses or life partners, adult children or step children, and their spouses, nieces, nephews, and grandchildren. Any member of the entire client system—most frequently the older adult—can be resistant to engaging a care manager let alone agreeing to an intervention. This resistance can be a function of a general denial of the problem, anger at family interference, fear of the unknown, inability to cope with the situation, or loss of control of one's self, family, or situation. By initiating the assessment process with the family, the care manager can begin to understand who the client is within a larger familial context and how to appropriately manage potential resistance from the initial engagement, through the assessment, and ultimately during the intervention.

This chapter delineates the essential elements of the psychosocial assessment. A comprehensive psychosocial assessment is time consuming and involves inquiring about sensitive and personal information that, for some families and cultures, can be intrusive. Therefore, it is not uncommon for the care manager to defer certain areas for subsequent visits when the care manager has established a relationship with the client and family members and can better gauge their comfort with some of the questions that will ultimately have to be asked. Because every care manager must initially assess for safety and risk factors in the client's day-to-day living situation, it is imperative that the cognitive, psychological, and support systems are assessed at the time of the first visit.

Demographic information about the client gathered during the initial family meeting is required to complete an assessment. Although a standardized tool does not exist, the following information about the older adult must be obtained:

- Birth date and place
- Nationality/history of immigration
- Religion: affiliation/importance
- Siblings: alive/deceased/relationships/health
- Childhood
- Education
- Military history
- Marital history/significant others
- Offspring: birth order/relationship to parent(s) and each other/current living arrangement/availability
- Occupation
- Hobbies/interests
- Legal and financial status
- Retirement

In addition, the care manager gathers information about each family member and can use it to construct a genogram (also called a family map) or an eco-map, which depicts connections

between family members (see **Figure 3-1** and **Figure 3-2**). We suggest using a genogram or eco-map to illustrate graphically who is part of the family system and each person's relationship (good, strained, distant, etc.) to the identified client. Additional information about the age and health status of each person can be included in the genogram. This enhances the basic genogram by providing a richer description of each of the members included.

More About Genograms and Eco-Maps

A genogram, or family map, shows all the living and deceased people who genetically, emotionally, and legally comprise a family. It may span three or more generations of relatives and several states, provinces, and continents, and it shows how each person "fits" in the group (how they are related).

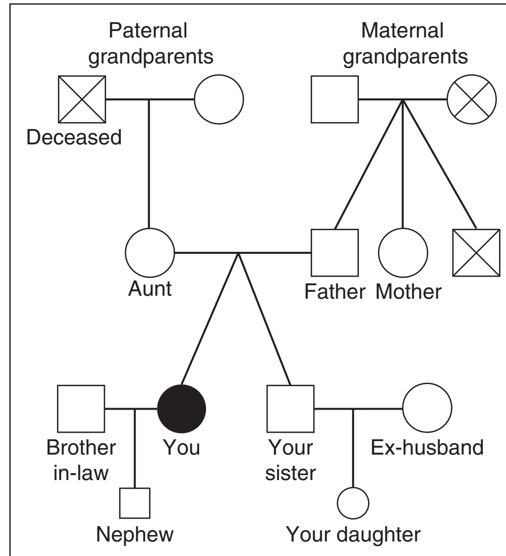

Figure 3-1 Genogram

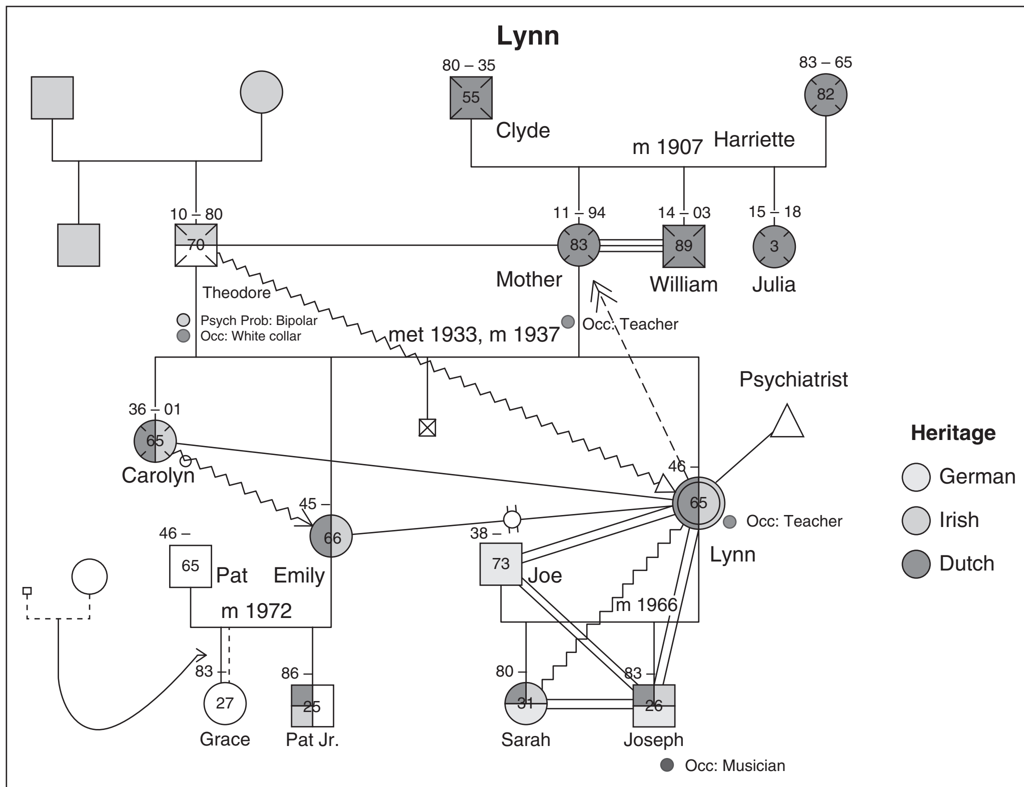

Figure 3-2 Eco-map

With extra notations and symbols, these maps can show family alliances, conflicts, relationship cutoffs, bonding strengths, and other important factors that help describe a family's structure and dynamics. Genograms can be especially helpful for new family members and kids who wonder "Who *are* we all now?" Genograms and eco-maps are useful visual tools to help understand and manage multigenerational families.

To start, view the sample genogram shown in Figure 3-1. Refer to it as you read the following suggestions.

Use circles for females and squares for males. Crosshatch or color these for extra-important people (important to whom?). Use dashed circles and squares or slashed or X symbols to represent dead, missing, or psychologically detached people. Option: Put the person's current age on the circle or square.

Horizontal solid lines show legal marriages, and dashed lines show committed unmarried primary relationships and important friendships, dependencies, heroes/heroines, and supporters. A horizontal line with a ----//---- or ----X---- can indicate a psychological or legal divorce.

Vertical or slanted solid lines show genetic connections. Dashed slanted lines can show adoptions, foster parents, or other special adult–child relationships. Option: Use double, triple, or colored lines to indicate the importance or relative strength of the bond between two people.

Zigzag, double, or wavy lines can symbolize strong emotional, legal, financial, or other kinds of current relationship connections, including lust, grief, anger, fear, and "hatred." If helpful, add symbols like + and – to show friendship, love, hostility, and fear.

As illustrated in Figure 3-2, the eco-map can be used to display all supports, both formal and informal, in a single document. The eco-map can be used to display supports that are in place at the time of the assessment as well as additional supports that might be indicated as part of the care plan. Arrows can be unidirectional or bidirectional and indicate whether the interactions between the client and support is positive or negative. Together, the genogram and eco-map are tools that the care manager can use to illustrate important information about the family system and current and future sources of formal and informal support. The process of conducting an assessment of formal and informal support provides important subjective and objective information that is critical to the development, and ultimately the success, of the care plan.

Cognitive Assessment

Cognitive assessment is an integral part of detecting dementia.[4] Because the incidence and prevalence of dementing disorders increases in later life, it is necessary to assess the older adult's cognitive status to determine whether the current living arrangement is appropriate and safe. Research has shown the failure of physicians to perform mental status testing routinely for older patients;[5] therefore, it is wise not to assume a cognitive assessment has been done. It is important for the care manager to understand that many persons with cognitive impairment can behave in a socially appropriate manner, and they might not be recognized as having any impairment without formal testing. Conversely, in some situations in which cognitive status has been accurately assessed and a diagnosis of mild to moderate dementia given, the client can demonstrate the capacity to make appropriate decisions within the home and other familiar environments.

Sometimes the most informative assessment could simply be to ask the older adult for an assessment of his or her own cognitive functioning. Regardless of the approach to the cognitive assessment, understanding the older adult's perception of his or her own functioning is especially useful to both the assessment and care plan. A lack of self-awareness

or denial of a cognitive problem must be addressed when the care plan is developed and implementation strategies explored with the family.

Care managers can also complete indirect assessment by conversing with family members or other close contacts. Family members can provide useful information because they have the historical context and can see change over time. "The caregiver is able to provide information regarding the mode of onset of cognitive dysfunction (abrupt vs. gradual), progression of symptoms (stepwise vs. continuous), and duration of symptoms."[4]

Assessment for mental capacity can be accomplished through both unstructured and structured processes using one or more screening tests. An unstructured form of cognitive assessment occurs throughout the entire evaluation process: On the basis of information provided by a family member, the care manager can ask the older adult many of the same questions initially asked of the family as a way to informally gauge memory and recall. Other ways to test memory are discussed in the following paragraphs.

The most commonly used and most thoroughly researched formal screening test for dementia is the Mini-Mental State Examination (MMSE) (**Exhibit 3-1**) developed by Folstein and colleagues.[6] Concentration, language, orientation, memory, and attention are tested in this short, usually 10-minute, 30-question test. A score of 23 or lower out of a possible 30 has been defined as indicating cognitive impairment. Shortcomings of the test include a wide variation of scoring and test administration styles, as well as inappropriateness for those with physical disability, sensory impairment, and poor command of the English language.

The Short Portable Mental Status Questionnaire (**Exhibit 3-2**) asks 10 questions with each error scored as 1 point.[7] Intact mental function is indicated by less than 2 errors, and severe mental impairment is indicated by 8 to 10 errors. The scoring is adjusted for educational level.

The Blessed Orientation-Memory-Concentration Test consists of all verbal questions, takes 3 to 6 minutes to administer, counts errors, and has a maximum score of 28, with a score of 10 indicating dementia.[8]

The Clock Drawing Test measures multiple cognitive and motor functions through a clock-drawing task.[9] The individual is given a piece of paper with a 4- to 6-inch circle drawn on it and is asked to write the numbers and draw the hands of the clock to show "10 past 11." Although many clinicians use a qualitative evaluation, there are scales to rank the drawing for completeness and correctness or to rate specific components of the clock drawn and combine the ratings into a score. The clock-drawing interpretation scale recommended by Mendez et al. falls into this latter category.

Exhibit 3-1 **MMSE Sample Items**

Orientation to Time

"What is the date?"

Registration

"Listen carefully. I am going to say three words. You say them back after I stop.

"Ready? Here they are …

"APPLE (pause), PENNY (pause), TABLE (pause). Now repeat those words back to me." [Repeat up to 5 times, but score only the first trial.]

Naming

"What is this?" [Point to a pencil or pen.]

Reading

"Please read this and do what it says." [Show examinee the words on the stimulus form.]

CLOSE YOUR EYES

Reproduced by special permission of the Publisher, Psychological Assessment Resources, Inc., 16204 North Florida Avenue, Lutz, FL 33549, from the Mini-Mental State Examination, by Marshal Folstein and Susan Folstein. Copyright 1975, 1998, 2001 by Mini Mental LLC, Inc. Published 2001 by Psychological Assessment Resources, Inc. Further reproduction is prohibited without permission of PAR, Inc. The MMSE can be purchased from PAR, Inc., by calling (813) 968-3003.

Exhibit 3-2 **Mini-Cog**

Pt. Name: ______________________ DOB: ______________________

Date: ______________________

Instructions

The MINI-COG

1. Instruct the patient to listen carefully and repeat the following:
   APPLE WATCH PENNY
2. Administer the Clock Drawing Test.
   Inside the circle draw the hours of a clock as a child would draw them.
   Place the hands of the clock to represent the time "forty five minutes past ten o'clock."
3. Ask the patient to repeat the three words given previously:

   ____

Scoring

Number of correct items recalled ____________ [if 3, then negative screen. STOP]

If answer is 1–2:

Is CDT Abnormal? No Yes

If No, then negative screen.

If Yes, then screen positive for cognitive impairment.

Scoring

1 point for each recalled word

Score clock drawing as Normal (the patient places the correct time and the clock appears grossly normal) or Abnormal

Score

0	Positive for cognitive impairment
1–2	Abnormal CDT then positive for cognitive impairment
1–2	Normal CDT then negative for cognitive impairment
3	Negative screen for dementia (no need to score CDT)

Borson S. The Mini-Cog: a cognitive "vitals signs" measure for dementia screening in multi-lingual elderly. *Int J Geriatr Psychiatry*. 2000;15(11):1021.

Although the use of standardized instruments to assess cognitive status is encouraged, it is important to keep in mind that the findings, regardless of the measure used, are understood within the larger context of an older person's ability to process cognitive information. The ability of the older person to function safely within his or her daily routine cannot always be measured by a single cognitive assessment instrument.

The Mini-Cog test is a 3-minute instrument used to screen for cognitive impairment in older adults in the primary care setting. (See Exhibit 3-2.) The Mini-Cog uses a three-item recall test for memory and a simply scored clock-drawing test (CDT). The latter serves as an "informative distractor," helping to clarify scores when the memory recall score is intermediate. The Mini-Cog was as effective as or better than established screening

tests in both an epidemiologic survey in a mainstream sample and a multiethnic, multilingual population composed of many individuals of low socioeconomic status and education level. In comparative tests, the Mini-Cog was at least twice as fast as the Mini-Mental State Examination. The Mini-Cog is less affected by the subject's ethnicity, language, and education, and it can detect a variety of dementias. Moreover, the Mini-Cog detects mild cognitive impairment (cognitive impairment too mild to meet diagnostic criteria for dementia).[10]

The Saint Louis University Mental Status (SLUMS) Examination is a brief oral/written exam given to people who are suspected to have dementia or Alzheimer's disease (see **Figure 3-3**). The exam serves as a tool to indicate whether a doctor should consider further testing to diagnose dementia. The SLUMS was created by the director of the Division of Geriatric Medicine at Saint Louis University. Early detection of dementia may lead to treatment that slows the disease. This exam is brief and easy to administer. The SLUMS is widely used by professionals.

Psychological Assessment

Older adults are hesitant to discuss psychological problems because of a fear of being labeled as crazy or because psychological problems may be perceived as a sign of weakness or something to be ashamed of.[5] With numerous somatic or physical complaints, older adults and their families might deny an additional diagnosis of depression. Frequently, sadness or anxiety is attributed to normal aging or to illness. The care manager is in a good position to differentially assess psychological compromise from personality traits or cognitive decline.

Through building an ongoing and trusting relationship with the care manager, the older adult may become more comfortable discussing personal problems and fears. Additionally, over time the care manager can assess the older adult's psychological functioning by observing him or her in different circumstances, performing various tasks, and relating to family, friends, and other professionals. Although standardized measures are valuable screening tools, they are not the definitive assessment; rather, they are used in conjunction with direct observation and interviews with the older adult and support system.[11]

Depression

According to the American Psychological Association, depression and suicide are significant public health issues for older adults. Depression is one of the most common mental disorders experienced by elders. Fortunately, it is treatable by a variety of means. Current cohorts of older adults in the United States evidence lower rates of major depression than younger cohorts, but they experience minor depression or significant subsyndromal depressive symptoms at rates equal to or greater than younger groups. Adults soon to enter later adulthood, most notably the so-called baby boom cohort, seem to be evidencing depressive disorders at significantly higher rates than previous groups did; this trend toward greater incidence of depression in subsequent cohorts seems steady. The reasons for these changes are the subject of much debate and are not clearly understood. Because depression tends to be a recurrent disorder, many older adults have experienced previous bouts of depression and are at increased risk for recurrence.[12]

Depression is significantly underdiagnosed and undertreated in older adults.[13] Yet, of every 100,000 people aged 65 years and older, 14.2 died by suicide. The rate of suicide among white non-Hispanic men was 48 per 100,000 compared to 10.9 per 100,000 in the general population.[14] Given that older adults represent approximately 13% of the general population but account for 18% of deaths resulting from suicide, the underdiagnosing and underreporting of depression are especially problematic.[15] Depression can affect performance on mental status tests

VAMC
SLUMS Examination

Questions about this assessment tool? E-mail aging@slu.edu.

Name ________________ Age ________________

Is patient alert? ________________ Level of education ________________

Department of Veterans Affairs

__/1 ① **1. What day of the week is it?**

__/1 ① **2. What is the year?**

__/1 ① **3. What state are we in?**

4. Please remember these five objects. I will ask you what they are later.

Apple Pen Tie House Car

5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.

① **How much did you spend?**

__/3 ② **How much do you have left?**

6. Please name as many animals as you can in one minute.

__/3 ⓪ 0-4 animals ① 5-9 animals ② 10-14 animals ③ 15+ animals

__/5 **7. What were the five objects I asked you to remember?** 1 point for each one correct.

8. I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say 42, you would say 24.

__/2 ⓪ 87 ① 649 ② 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.

② Hour markers okay

__/4 ② Time correct

__/2 ① **10. Please place an X in the triangle**

① **Which of the above figures is largest?**

11. I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

② **What was the female's name?**

② **What work did she do?**

__/8 ② **When did she go back to work?**

② **What state did she live in?**

______ **TOTAL SCORE**

Department of Veterans Affairs

SAINT LOUIS UNIVERSITY

AD MAIOREM DEI GLORIAM

AGING SUCCESSFULLY

SCORING		
HIGH SCHOOL EDUCATION		LESS THAN HIGH SCHOOL EDUCATION
27–30	Normal	25–30
21–26	MNCD*	20–24
1–20	Dementia	1–19

* Mild Neurocognitive Disorder

Figure 3-3 The SLUMs

SH Tariq, N Tumosa, JT Chibnall, HM Perry III, and JE Morely. The Saint Louis University Mental Status (SLUMS) Examination for Detecting Mild Cognitive Impariment and Dementia is more sensitive than the Mini-Mental Status Examination (MMSE) - A pilot study. *Am J Geriaatr Psychiatry* 14:900–910, 2006.

and should be considered when cognitive impairment is suspected. As discussed by Gallo and Wittink:

> The person with the appearance of cognitive impairment secondary to depression remains oriented and with coaxing can perform cognitive tests. Clues that dementia may be secondary to depression include recent onset and rapid progression, a family history of depressive disorders, a personal history of affective disorders, and onset of the disorder after the age of 60 years.[16]

The Geriatric Depression Scale (GDS) designed by Yesavage[17] was the first depression assessment scale explicitly for older adults, and it remains widely used because of its simplicity. The GDS is a 30-question survey that includes yes-or-no questions. A point is given for each answer that matches the answer in parentheses. A score of 10 or more usually suggests depression.

The Beck Depression Inventory is a 21-item self-rating report that assesses symptoms of depression and includes a broad range of questions.[18] Individual questions are scored as 0, 1, 2, or 3. A total score of greater than 11 is indicative of depression. This scale relies heavily on physical symptoms, making it less useful for older adults with physical impairment. It is also difficult to use with those who have cognitive impairment and those with communication and hearing problems.

The PHQ-9 is a nine-item instrument that is both brief and easy to use. Clients are asked a series of questions preceded by "How many days during the past 2 weeks...."[19] Sample questions include: Have you had little interest? Have you been down, depressed, or hopeless? The scoring is 0 = no days, 1 = several days, 2 = more than half the time, and 3 = nearly all the days. A response of "several days" or "more than half the time" for more than five questions is suggestive of needing treatment for depression. In addition to the brevity of this nine-item scale, the first two items can be used as a screen for suicidal ideation. This measure has also been used to objectively assess improvement or lack of improvement resulting from treatment. The complete instrument and scoring is available at http://www.depression-primarycare.org. http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf.

Anxiety

With community-living older adults, generalized anxiety, more commonly stated as worry, is the most frequently encountered disorder—it is even more prevalent than depression.[20] Anxiety and depression coexist and can overlap in older adults with symptoms stated as sleeplessness or fatigue. Other symptoms of anxiety can include fear, nervousness, dread, shortness of breath, and rapid heartbeat. All of these symptoms can be misdiagnosed as various medical conditions, such as cardiovascular problems, Parkinson's disease, Alzheimer's disease, or hormonal imbalances. Anxiety is easily confused with worry, which is an emotional reaction to health and safety concerns rather than a pathological response. Assessing an older adult's concerns during the assessment process is necessary to make this distinction.

The Beck Anxiety Inventory is a 21-item self-report questionnaire of common anxiety symptoms.[21] Respondents rate the intensity of each symptom as 0, 1, 2, or 3, with a score of 22 to 35 indicating moderate anxiety, and a score of more than 36 indicating severe anxiety. It should be noted that there are other anxiety instruments, none of which appear to be used frequently by care managers.

Social Support

Social support as presented in the context of this chapter and text refers to both formal and informal sources of support. Formal supports, such as home health care, custodial care, case management, and day care among others, are supportive services that are either purchased by the client or reimbursed through a third-party source (e.g., Medicare, Medicaid) or other local, state, or

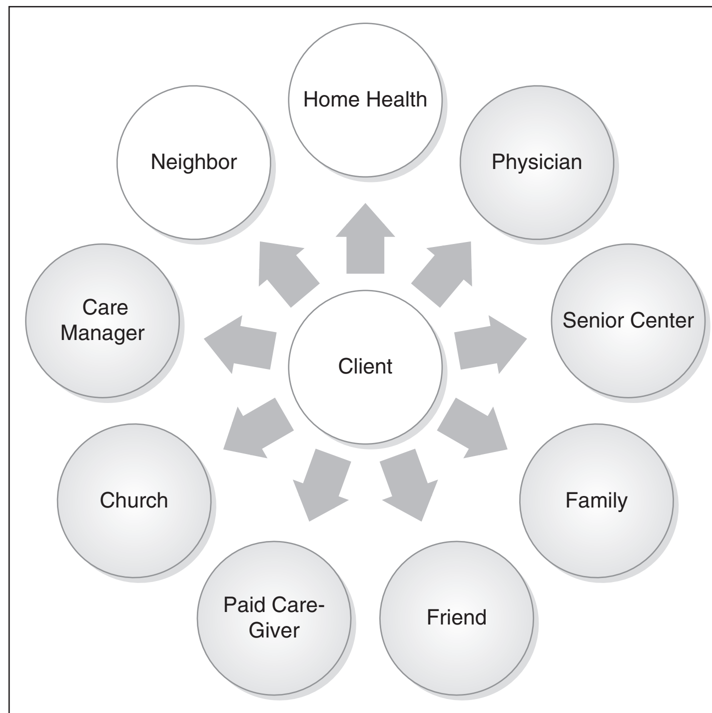

Figure 3-4 Eco-map

federal program. Informal support is provided by family members, extended kin, friends, or neighbors. Although this section focuses primarily on informal social support, the eco-map (see **Figure 3-4**) is an excellent tool that can be used to display all forms of social support, both formal and informal.

As issues of people who are lesbian, gay, bisexual, and transgender (LGBT) are being brought out into the open, the care manager must be sensitive to psychosocial issues as experienced by the LGBT community. The health, well-being, and social networks of the older LGBT population are understudied. As people age, for caregiving they rely on the informal supports in their network. In the United States most caregiving is provided by partners and children; LGBT older adults are more likely to live alone and less likely to have children than older heterosexuals do. Although significant numbers of LGBT individuals give and receive caregiving from their family of origin, some LGBT individuals have been ostracized by their family. Research suggests that LGBT persons are more likely to rely on friends—sometimes referred to as the family of choice—for caregiving, and this may prove problematic as friends in the network age and also require assistance. One study of LGBT older adults found that a third of those without partners did not know who would care for them if they needed assistance. Without traditional caregivers, these aging adults may rely increasingly on formal support services that may not be ready to meet the needs of LGBT older adults.[22]

Elder Mistreatment

Abuse and Neglect

The actual rate of elder mistreatment is probably much higher than is reported because secrecy and isolation, common in all forms of intimate abuse, prevent an accurate count. The National Elder Abuse Incidence Study calculated that for every case reported to

Adult Protective Services (APS), five additional cases were known to community agencies.[23] Furthermore, less than one-half of reported cases are substantiated.[24] Elders are vulnerable to abuse and neglect because they have a greater likelihood of suffering from physical and cognitive impairments and the resultant need to rely on caregivers and family members for basic physical care.[1]

For purposes of the psychosocial assessment, elder mistreatment is defined as physical, psychological or emotional, financial, or sexual abuse, as well as financial exploitation, use of undue influence, neglect, and self-neglect inflicted actively, passively, or unintentionally. All states have some form of protection and services for vulnerable older adults, yet at the time of this writing, four states do not have mandatory reporting (Colorado, New Jersey, New York, and North Dakota).

As with other areas of psychosocial assessment, elder mistreatment can be assessed both formally and informally. The care manager is directly involved with the older adult and his or her caregiver and can assess mistreatment by direct observation, interview, or report from others. An unexplainable sudden decline in the older adult's functional, cognitive, or psychological status can be an indicator of mistreatment. "The assessment of elder mistreatment begins when there is a suspicion that the elders' relationships are contributing to unnecessary suffering, or when elders hint at or directly report relationship problems."[25]

The instruments used to assess elder mistreatment are designed to assess the risk for abuse, cognitive ability, and functional status. The Elder Assessment Instrument (EAI) developed by Fulmer, Street, and Carr is a 46-item instrument that reviews signs, symptoms, and subjective complaints of elder abuse, neglect, exploitation, and abandonment.[26] There is no score, but this instrument is used as a guide for referral to APS if the following conditions exist:

- If there is any evidence of mistreatment without sufficient clinical explanation
- Whenever there is a subjective complaint by the elder of mistreatment
- Whenever the clinician believes there is a high risk of or probable abuse, neglect, exploitation, or abandonment[25]

The EAI has been in the literature since 1984.[26]

This instrument comprises seven sections that review signs, symptoms, and subjective complaints of elder abuse, neglect, exploitation, and abandonment.

Economic and Legal Assessment

Developing an appropriate care plan requires an accurate picture of the older adult's economic status. If the care plan is not affordable, or a particular community-based service is not accessible or available, the plan is inappropriate. A thorough financial assessment helps to screen for risk of financial exploitation and the unintentional and perhaps inappropriate dissipation of assets and facilitate access to future community-based or long-term care services. Unfortunately, many older adults are uncomfortable with this part of the assessment and hesitant to disclose the particulars of their finances to their own children or to the care manager. It is common for the adult child or children not to have a clear picture of the older adult's financial status and for them to be uncomfortable broaching the subject.

A complete financial assessment needs to include an evaluation of income and assets as well as health insurance and long-term care insurance. If the care manager senses any discomfort or resistance in this area, assessing the older adult's financial resources can be initiated by asking a few indirect questions to assess the individual's openness to discussing this especially sensitive area. Questions such as, "Do you worry about your finances?" "Have you ever delayed getting a prescription filled?" "Do you have sufficient healthy foods?" can help initiate discussion about finances. Because many older adults are living on a fixed income, unexpected expenses, such as for additional medications, special nutritional supplements, or home care or day care, can be difficult to manage.

Although Social Security frequently represents a significant percentage of monthly income, income from retirement pensions, annuities, interest, employment, or real estate must be accounted for. Information about the source of the income, as well as conditions attached to the income (taxable or tax free, time limited or for life, etc.), should also be obtained.

In addition to obtaining reliable information about income, it is important to include the older adult's assets as part of the financial assessment. Given the increased life span and years spent in retirement of elders today, what was once considered as adequate income and savings for retirement might turn out to be inadequate for meeting the older adult's future health and care needs. Additionally, most entitlement programs have specific income and asset qualifying limits. Therefore, just as with income, a complete and accurate assessment of assets must be obtained to determine the affordability of a care plan and eligibility for various entitlement programs. Accurate information about all assets (e.g., home, stocks, bonds, life insurance, property) must be accounted for. The care manager can consider referring the older adult to an elder law attorney or estate planner when there are considerable, or even reasonable, assets to plan for future care needs or to protect for a well spouse.

Many older adults, as well as their adult children, do not understand eligibility requirements for community-based entitlement programs and long-term care. False assumptions about what older adults are entitled to or not entitled to must be addressed. And although not every care management client will need to access an entitlement program, it is important that the care manager provides current and accurate information about any relevant entitlement programs and services. Care managers can use their knowledge of the various local programs and their expertise in navigating the bureaucracy to access these programs to increase the older adult's willingness to provide accurate information about finances.

In addition to income and assets, a comprehensive economic assessment should include an assessment of the older adult's insurance policies, including health, life, pharmaceutical, home, and long-term care insurance. It is especially important that the care manager confirm that all insurance policies are current and in effect and that they represent adequate and practical coverage. For example, some long-term care policies have long waiting periods (elimination days)—some as long as 90 days—before benefits can be accessed. Also, other restrictions can limit the policyholder's choice of provider, eligible diagnoses, or type of care.

A final dimension of the economic assessment includes an assessment of the older adult's legal affairs and advance directives (e.g., healthcare proxy, power of attorney, living will). This is another area in which the care manager is advised to confirm and verify the status of these documents. Although many older adults have some, or even all, of these documents, the documents may be outdated, not compliant with current law, executed in a state other than where the older adult is currently residing, or inappropriate as a result of the death or cognitive decline of the appointed agent. The care manager must be knowledgeable of the state's laws with respect to advance directives and must make an immediate referral to an appropriate elder law attorney to initiate or update these documents.

Substance Abuse

Substance abuse or dependence, including alcohol use, drug misuse, and nicotine use, can have severe negative physical, cognitive, and psychological consequences for the older adult. Screening for this is essential not only to detect the problem but also to identify potentially harmful interactions with other physical and mental conditions that could lead to high blood pressure, falls, or memory loss. Improper substance use can increase comorbidities and interfere with the treatment process and therefore increases medical complexity.[27]

9781284078985_CH03_Print.indd 46 10/7/15 8:47 PM

"Heavy drinking, even in the absence of abuse and dependence, can be detrimental to the care of older adults; however, moderate drinking may be associated with certain health benefits."[27p176] Having a clear definition of what constitutes problem drinking in the elderly is difficult, though. With younger adults, clear criteria are defined in the *Diagnostic and Statistical Manual of Mental Disorders* and include disruption of role function, financial instability, and decreasing social networks.[28] However, older adults without substance abuse problems can meet these criteria. Additionally, substance abuse problems are masked by other problems associated with aging, including falls, injury, confusion, self-neglect, depression, emotional liability, memory loss, sleep disturbance, and adverse drug interactions. Furthermore, an elder's tendency to use alcohol frequently or heavily is dismissed as "the only vice she has left" or "something to help him sleep."[1]

Even though the frequency of drinking and the amount consumed often decline with age, it is estimated that 49.4% of persons older than age 65 years drink alcohol at least on a semiregular basis compared to 73.1% of persons between the ages of 18 and 29 years. Approximately 10% of elders are defined as problem drinkers.[1] Of significance is the acceptance of and casual attitude toward alcohol consumption and drug use in the younger population, including the baby boomers, suggesting there will be a dramatic increase in substance abuse in the elderly in coming decades.

Formally assessing alcohol abuse in older adults is difficult because most screening instruments are not age specific and rely on self-report. The Short Michigan Alcoholism Screening Test–Geriatric Version was developed as the first short-form screening instrument for the elderly.[29] A score of two or more "Yes" responses suggests an alcohol problem. The goal of the screening is to identify an at-risk population of older adults who use alcohol on a regular basis.

More commonly used is the following CAGE screening questionnaire, a simple-to-administer, four-question instrument.[30] A positive response to any question indicates the need for further evaluation. The major drawback to the validity of this instrument is the reliance on self-report. The older adult may deny any problem when confronted with these questions.

The CAGE Questionnaire consists of these four questions:

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

The care manager must also rely on observation to detect alcohol use or abuse. Such indicators as deteriorating hygiene, increased number of falls, slurred speech, the smell of alcohol, and moodiness may indicate a potential problem with alcohol. As mentioned earlier, other physical and cognitive impairments must be ruled out first.

Drug dependency and misuse in the elderly population entail both the use of illicit drugs and the misuse of prescription medications. Drug dependency develops faster in this population because of older adults' slower metabolic processes. The kidneys and liver are not as efficient in removing substances from the bodies of older adults. Currently, a very small number of older adults have a lifelong history of illegal drug use. However, this number will rise dramatically as a result of the longer life expectancies and the widespread acceptance of recreational drug use of younger generations.[1]

The most common drug misuse among older adults is psychoactive medications for the treatment of depression, anxiety, and pain. These medications can cause both physical and psychological dependency. Women are more at risk for drug dependency because they are more likely to seek treatment for somatic complaints and other emotional problems. The care manager must pay close attention to all medications currently prescribed by the

older adult's physicians and must be aware of multiple pharmacies to prevent duplication that could potentially lead to lethal dosages.

Conclusion

Psychosocial assessment is important for both what it can accomplish and what can happen if it is not completed thoroughly and correctly. A comprehensive and accurate psychosocial assessment can better ensure the development of an appropriate intervention and successful care plan. The accurate and timely use of psychosocial assessment tools must be combined with good interviewing skills. The ability to develop and maintain relationships, knowledge of human behavior, understanding of family and caregiver dynamics, knowledge of the effects of aging and disability, and the awareness of community resources and services are critical to all that follows.[2] An assessment that is incomplete or that ignores good clinical and professional judgment can result in the failure to develop a healthy relationship between the care manager and older adult, which can only result in eventual failure of even the best care plan.

The Aging Life Care Association has developed a book of forms as a benefit for its members. Included in this comprehensive manual are many assessment forms a new care manager can use as well as a number of the assessment tools mentioned in this chapter (e.g., MMSE, GDS). As stated earlier, the care manager must adapt the psychosocial assessment to the population served to ensure appropriate and relevant information is obtained to develop the care plan. Care must be taken to use only those forms, or those sections of forms, that are reflective of the needs of the individual practice population.

References

1. McInnis-Dittrich K. *Social Work with Elders: A Biopsychosocial Approach*. 2nd ed. Boston, MA: Allyn & Bacon; 2005.
2. Geron D. *Guidelines for Case Management Practice across the Long-Term Care Continuum. Report of the National Advisory Committee on Long-Term Care Case Management*. Bristol, CT: Connecticut Community Care, Inc; 1994.
3. Aronson J. Assessment: the linchpin of geriatric care management. *Geriatr Care Manage*. 1998;*8*(1):11–14.
4. Langley LK. Cognitive assessment of older adults. In: Kane RL, Kane RA eds. *Assessing Older Persons: Measures, Meaning, and Practical Application*. New York, NY: Oxford University Press; 2002.
5. Gallo JJ. Cognitive assessment. In: Gallo JJ, Fulmer T, Paveza GJ, eds. *Handbook of Geriatric Assessment*. 4th ed. Burlington, MA: Jones & Bartlett Learning; 2006:46.
6. Folstein MF, Folstein SE, McHugh PR. Mini-Mental State: a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res*. 1975;12(3):189–198.
7. Pfeiffer E. A short portable mental status questionnaire for the assessment of organic brain deficit in elder patients. *J Am Geriatr Soc*. 1975;23:433–441.
8. Katzman R, Brown T, Fuld P, Peck A, Schechter R, Schimmel H. Validation of a short Orientation-Memory-Concentration Test of cognitive impairment. *Am J Psychiatry*. 1983; 140:734–739.
9. Mendez MF, Ala T, Underwood KL. Development of scoring criteria for the clock drawing task in Alzheimer's disease. *J Am Geriatr Soc*. 1992;40:1095–1099.
10. Borson S. The Mini-Cog: a cognitive "vitals signs" measure for dementia screening in multi-lingual elder. *Int J Geriatr Psychiatry* 2000; 15(11):1021.
11. Berkman BJ, Maramaldi P, Breon EA, Howe JL. Social work gerontological assessment revisited. *Gerontol Soc Work*. 2002;40(1/2):1–14.
12. Scogin F. Depression and Suicide in Older Adults Resource Guide. American Psychological Association. http://www.apa.org/pi/aging/resources/guides/depression.aspx. Accessed July 13, 2015.
13. Grann JD. Assessment of emotions in older adults: mood disorders, anxiety, psychological well-being, and hope. In: Kane RL, Kane RA, eds. *Assessing Older Persons: Measures, Meaning, and Practical Application*. New York, NY: Oxford University Press; 2000:129–169.

14. National Institute of Mental Health. 1999–2007 Trends in Suicide Rate. http://www.afsp.org/understanding-suicide/facts-and-figures. Accessed May 11, 2015.
15. Mitty E, Flores S. Suicide in late life. *J Geriatr Nurs*. 2008;29(3):160–165.
16. Gallo JW. Depression assessment. In: Gallo JJ, Fulmer T, Paveza GJ, eds. *Handbook of Geriatric Assessment*. Burlington, MA: Jones & Bartlett Learning; 2006:20.
17. Yesavage TL. Development and validation of a geriatric depression scale: a preliminary report. *J Psychiatr Res*. 1983;17:37–49.
18. Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J. An inventory for measuring depression. *Arch Gen Psychiatry*. 1961;4:561–571.
19. Spitzer RL, Kroenke K, Williams JB (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. *JAMA*. Nov 10;282(18):1737–44. PMID 10568646.
20. Gellis Z. Older adults with mental and emotional problems. In: Berkman B, ed. *Handbook of Social Work and Health in Aging*. New York, NY: Oxford University Press; 2006:10.
21. Beck AT, Epstein N, Brown G, Steer R. An inventory for measuring clinical anxiety: psychometric properties. *J Consult Clin Psychol*. 1988;*56*:893–897.
22. Met Life Mature Market Institute, Lesbian and Gay Aging Issues Network of the American Society on Aging, Zogby International. *Out and Aging: The MetLife Study of Lesbian and Gay Baby Boomers*. November 2006. https://www.metlife.com/assets/cao/mmi/publications/studies/mmi-out-aging-lesbian-gay-retirement.pdf. Accessed April 10, 2015.
23. Tomita S. Mistreated and neglected elders. In: Berkman B, ed. *Handbook of Social Work and Health in Aging*. New York, NY: Oxford University Press; 2006:219–230.
24. National Center on Elder Abuse. *The National Elder Abuse Incidence Study: Final Report: September 1998*. http://aoa.gov/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf. Accessed April 10, 2015.
25. Fulmer T, Street S, Carr K. Abuse of the elderly: screening and detection. *J Emerg Nurs*. 1984;*10*(3):131–140.
26. Fulmer T. Elder Mistreatment Assessment. *Try* This: Best Pract Nurs Care Older Adults. 2012;*15*: 1–2. New York, NY: The Hartford Institute for Geriatric Nursing, New York University, College of Nursing. http://consultgerirn.org/uploads/File/trythis/try_this_15.pdf. Accessed April 10, 2015.
27. Zanjani D. Substance use and abuse assessment In: Gallo JJ, Fulmer T, Paveza GJ, eds. *Handbook of Geriatric Assessment*. Burlington, MA: Jones & Bartlett Learning; 2006:175–192.
28. Fulmer T. and Wetle T. (1986). Elder abuse screening and intervention. *Nurse Practitioner*, *11*(5), 33–38.
29. American Psychiatric Association. *Diagnostic and Statistical Manual—Text Revision (DSM-TR)*. Washington, DC: American Psychiatric Association; 2000.
30. Blow FC, Gillespie BW, Barry KL, et al. Brief screening for alcohol problems in elder populations using the Short Michigan Alcoholism Screening Test–Geriatric Version (SMAST-G). *Alcohol Clin Exp Res*. 1998;22:13A.
31. Ewing JA. Detecting alcoholism: the CAGE Questionnaire. *JAMA*. 1984;252:1905–1907.

APPENDIX 3A
Psychosocial Assessment

Date: ______________

Client's Name: ______________________________________

Date of Birth/Age: ______________ SS#: ______________

Own/Rent Home: ______________

Address: ____

Condo: ______________ Apt #/Building #: ______

City: ______________________________________ State: ___________ Zip: __________

Phone: ( ) ______________

Marital Status: ______________ Date of Divorce or Widowhood: ______________

Spouse/Significant Other: ______________________________ Age: ______

Veteran (Y/N): ____________________ Army #: ______________________ branch of the services ____________________ date of service ___________________

Date of Initial Consult: ______________

Persons Involved in Consult: ________________

____

Date of Assessment: ________________ Persons Present at Assessment: ________________

Primary Contact Person:

Name: ______________________________________ Relationship: ________________

Address: ____

City: ______________ State: ______________ Zip: ______________

Contact Numbers: Work: ( ) ______________ Home: ( ) ______________

Cell: ( ) ______________ Email Address: _______________________

Fax: ______________________________ Other: ______________

9781284078985_CH03_Print.indd 50 10/7/15 8:47 PM

Responsible Party (Billing Person):

Name: ________________ Relationship: ________________

Address: ________________

City: ________ State: ________ Zip: ________

Contact #: Work: ( ) ________ Home: ( ) ________

Cell: ( ) ________ Fax: ( ) ________

Other Contacts:

____

____

Presenting Problem (major areas of concern; events leading up to request for help):

____

____

____

Legal/Financial Information:

Medicare Number: ________

Supplemental Insurance: ________ # ________

Health Maintenance Organization: ________ # ________

Long-Term Care Insurance: ________ # ________

Phone: ( ) ________

Funeral Arrangements:

Made (Y/N): ________ Contact Person: ________

Phone #: ( ) ________

Irrevocable Burial Trust (Y/N): ________

Financial Status:

Income (indicate source/amount for each)

Social Security $ ________

Pension $ ________

Annuity $ ________

Trust/Estate Income $ ________

Other: Veteran's Benefits | Interest/Dividends | Mortgage | Business Income | Income from Renters/Boarders | Salary $ ________

Fluid Cash

Checking: $ ____________________

Savings: $ ____________________

Money Market: $ ____________________

Stocks/Bonds: $ ____________________

CDs: $ ____________________

Other: $ ____________________

Assets/Valuable Personal Property: ____________________

____________________ $ __________

____________________ $ __________

____________________ $ __________

____________________ $ __________

Total

Receiving: ____

May Be Eligible: ____

Where is it kept? ____

Bank: ____________________

Name: ____________________

Address: ____

Comments: ____

____

Monthly Expenses

Rent/Mortgage $ ____________________

Gas/Electricity/Fuel $ ____________________

Telephone $ ____________________

Taxes $ ____________________

Health Insurance Premiums $ ____________________

Medical Expenses $ ____________________

Dependent Care $ ____________________

Other (specify on lines below)

$ ____________________

$ ____________________

$ ____________________

Total $ ____________________

Legal Information

Advance Directives:

Does Client Have a Living Will? Y/N ____________________

Does Client Have a Will? Y/N ____________________

Health Care Surrogate(s): ____________________

Does Client Have a Trustee? Y/N

Name of Person/Agent: ____________________

Phone: ( ) __________

Can the Patient Manage Finances Without Assistance? Y/N

(If No, give reason) ____________________

Name of Person Assisting ____________________

Phone: ( ) __________

Address: ____________________

City: __________ State: __________ Zip: __________

Is There a Substitute Payee, Guardian, Conservator of Estate, or Power of Attorney? Y/N

(If so, please indicate which): ____________________

If so, please indicate address: ____________________

____

Phone: __________

If so, Date Established: / /

Reason Established:

____

____

____

Is There a Conservatorship of Person or D.P.O.A. for H.C. Established?: Y/N

If so, who is the designated agent(s)?:

Agent(s) Phone: __________

Agent(s) Address: ____________________

When Was the Conservatorship/D.P.O.A. Established?: / /

Why Was It Established? ____________________

____

____

Is There a Do Not Resuscitate Order (DNR)? Y/N

Where do you keep a copy of DNR? ____________________

9781284078985_CH03_Print.indd 53 10/7/15 8:47 PM

Can we have a copy of the DNR? Y/N

If no, who will make the decisions on behalf of the client?

Name of person/agent: ____________________

Relationship: ____________________

Address: ____________________

Phone: ____________________

Medical History

____

____

____

Doctor's Name	Phone Number	Address	Specialty

Diagnoses: ____________________

____

____

____

Medications:

Name	Dose	Frequency	Reason Prescribed

Over-the-Counter/Herbal Medications:

____

____

Pharmacy:

Phone: ( ) ____________

Address: ____________

Allergies: ____________

Emergency Contact (name, address, phone number): ____________

____

Hospital of Choice: ____________

Hospitalization/Surgery History: ____________

Special Diet: ____________

Physical Functional Abilities:

ADLs	Self	Supervision	Assistance (who provides)
Dressing			
Eating			
Ambulating			
Gets in/out of bed			
Toileting day/night			
Hygiene (bathing, shaving, etc.)			

IADLs	Self	Supervision	Assistance (who provides)
Shopping			
Housework			
Food preparation			
Transportation			
Medication setup			
Home maintenance			
Money management			
Laundry			
Transferring			

Assistive Devices (walker, cane, etc.):

____

____

Home Care Services:

Name of Agency: ________________ Phone: ( ) ________________________

Contact Person: ____

Name of Caregiver: ____

Schedule: ____

Private Duty Caregiver (name, address, phone number): ______________________

____

Emergency Response System (name and contact number): ____________________

____

Spare Keys (name, location, phone number, and/or address): ___________________

____

Special Equipment (hospital bed, oxygen, Hoyer lift, bedside commode, feeding tube, etc.):

____

____

____

Sensory/Expressive Impairment (use of hearing aids, glasses, etc.): ______________

____

____

Auditory: ___________________________

Visual: ____________________________

Speech: ____________________________

Cognitive Functioning

Long-Term Memory: ____

____

Short-Term Memory: ____

Language Skills: ____

Visual/Spatial Skills: ____

Reasoning/Judgment: ____

Insight: ____

Executive Function: ____

Motor Skills: ____

Social Skills: ______________________________

Orientation (person, place, time): ______________________________

____

____

Psychological Functioning

Presentation/Appearance: ______________________________

____

____

Mood/Affect: ______________________________

____

____

Psychoses

Delusions: ______________________________

Hallucinations: ______________________________

Agitation: ______________________________

Paranoia/Suspicion: ______________________________

Suicidal Ideation: ______________________________

____

Additional Comments: ______________________________

____

Behavioral Disturbance (wandering, aggressive verbal/physical behaviors):

____

____

Psychiatric History/Substance Abuse: ______________________________

____

History of Personality: ______________________________

____

____

Psychosocial Summary

1. **Perception of Problem and Major Concerns of:**
   a. **Family:**

____

____

b. Client:

c. Spouse:

2. History of Problem:

3. Family of Origin (ethnicity/religion, socioeconomic background, siblings (alive and deceased):

4. Education/Hobbies/Occupation/Retirement (date and adjustment to retirement):

5. Marital History:

6. Relationship with Offspring (children and grandchildren; role as caregiver; dynamics/conflicts; supports to client):

7. **Other Family: Social Supports and/or Stressors:** ______________________

(Recent losses within family and/or close friendship structure)

____

____

Additional Observations:

____

____

____

____

Home Environment:

Own/Rent Home/Apartment/Other: ______________________

How long have they lived there? (Describe any recent changes):

____

____

Persons Living in Household:

____

Ability or Willingness to Help Client:

____

Additional Comments:

____

____

Home Safety Assessment:

Are pathways clear?	Clutter	
Throw rugs		
Are stairs safe?	Hand rails	
Adequate lighting		
Slippery floors		
Condition of floor surfaces		
Condition of carpeting		
Sturdy/stable chairs	Wheels	
Wiring or cords exposed		
Smoke detectors		
Fire extinguisher		
Accessible escape route (fire)		
Space heaters		

Condition of wires and plugs		
Does client smoke?	Safety issues	
Locks on doors and windows		
****EMERGENCY NUMBERS		
Accessible telephones	Audio and visual aids	
FIREARMS or weapons		
Pets		
Unsanitary conditions	Odors	
Functioning electricity		
Condition of appliances	Ovens, fridge, stoves	
Medication safety—properly marked and stored		
Air conditioning		
Kitchen safety		
Tub/shower		
Is there clutter or evidence of hoarding?		

Recommended Changes:

____

____

Technology Needs

Telehealth? Y/N

Product: ______________________________

Personal Electronic Health Records? Y/N

Product: ______________________________

Residential Monitoring System? Y/N

Product: ______________________________

Reminder System? Y/N

Product: ______________________________

Fall Detection? Y/N

Product: ______________________________

Medication Dispenser? Y/N

Product: ______________________________

Location Management? Y/N

Product: ______________________________

9781284078985_CH03_Print.indd 60 10/7/15 8:47 PM

Stove Use Detector? Y/N

Product: ______________________________

Programmable Thermostat? Y/N

Product: ______________________________

Computer for Social Networking? Y/N

Product: ______________________________

Social Networking without Computer? Y/N

Product: ______________________________

Videoconferencing? Y/N

Product: ______________________________

Cognitive Fitness? Y/N

Product: ______________________________

Physical Fitness? Y/N

Product: ______________________________

Digital Music Player? Y/N

Product: ______________________________

Electronic Book Reader: Y/N

Product: ______________________________

Television Viewing: Y/N

Product: ______________________________

Legacy Building? Y/N

Product: ______________________________

Calendaring System? Y/N

Product: ______________________________

APPENDIX

3B

Standardized Instruments Available Online

Geriatric Assessment Tools:
Iowa Geriatric Education Center http://www.healthcare.uiowa.edu/igec/tools/Default.asp

- Clock drawing test
- Katz-ADL
- Tinetti-Fall
- Caregiver Burden Inventory
- SPMSQ

Stroke Assessment Scales:
Internet Stroke Center, Washington University School of Medicine and UT Southwestern Medical Center http://www.strokecenter.org/trials/scales/bd_imct.html

- Blessed Memory Orientation

Louisiana State University Health Sciences Center: http://www.sh.lsuhsc.edu/fammed/OutpatientManual/Short%20MAST%2013.htm

- Short Michigan Alcoholism Screening Test–Geriatric Version

Carolinas HealthCare System
Family Practice Notebook: http://www.fpnotebook.com/Psych/Exam/BckDprsnInvntry.htm

- Beck Depression Inventory

Hartford Institute for Geriatric Nursing: http://www.hartfordign.org

- Geriatric Depression Scale
- Lawton Scale of Appraised Burden

9781284078985_CH03_Print.indd 62 10/7/15 8:47 PM