



# Brief Cognitive and Mood Assessments

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Clin-STAR 2022 Meeting  
San Diego, CA  
November 16, 2022

 @AJtheScientist



This presentation is 15 minutes long, so this brief assessment overview is going to be very brief.



Screening tools showcased here represent a selection from the literature rather than an exhaustive summary. Please don't get mad at me if I omitted your favorite tool.



I am a neuropsychologist. As you know, we like hours (rather than minutes) for assessments, so recommending brief tools is very painful for me.

# Cognitive Screening Tools

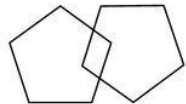
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# Mini-Mental State Examination (MMSE)

## Screening Tool: The Mini-Mental State Examination (MMSE)

Patient \_\_\_\_\_ Examiner \_\_\_\_\_ Date \_\_\_\_\_

Maximum	Score	
		<b>Orientation</b>
5		• What is the (year) (season) (date) (day) (month)?
5		• Where are we (state) (country) (town) (hospital) (floor)?
		<b>Registration</b>
3		• Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat until he/she learns all 3. Count trials and record. Trials _____
		<b>Attention and Calculation</b>
5		• Serial 7's. 1 point for each correct answer. Stop after 5 answers. Alternatively spell "world" backward.
		<b>Recall</b>
3		• Ask for the 3 objects repeated above. Give 1 point for each correct answer.
		<b>Language</b>
2		• Name a pencil and watch.
1		• Repeat the following "No ifs, ands or buts."
3		• Follow a 3-stage command: "Take a paper in your hand, fold it in half and put it on the floor."
1		• Read and obey the following CLOSE YOUR EYES.
1		• Write a sentence.
1		• Copy the design shown.



**Total Score**

ASSESS level of consciousness along a continuum \_\_\_\_\_

Alert Drowsy Stupor Coma

"Mini-Mental State." A Practical Method for Grading the Cognitive State of Patients for the Clinician, *Journal of Psychiatric Research*, 12(3): 189-198, 1975. Used with permission.

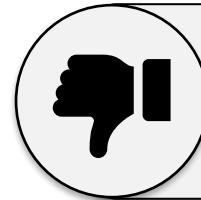
[more information on reverse](#) →



- 10 minute administration



- Probably the most widely used, studied, and validated tool out there



- Low sensitivity and specificity for detecting MCI
- Large age and education effects
- Now under copyright laws, no longer freely accessible (\$\$\$)



- MCI: 63% sensitivity, 65% specificity (using various cutoff scores between 25-27)<sup>1</sup>
- Dementia: 85% sensitivity, 90% specificity (using cutoff score of 24)<sup>2</sup>

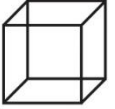
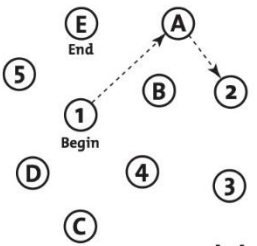
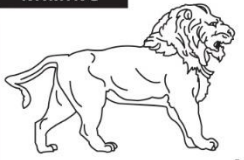
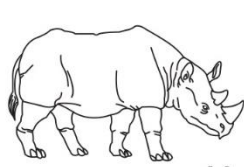
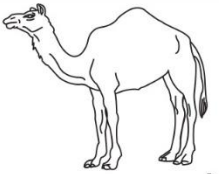
<sup>1</sup>Mitchell AJ. A meta-analysis of the accuracy of the Mini-Mental State Examination in the detection of dementia and mild cognitive impairment. *J Psychiatr Res*. 2009;43(4):411-431. doi:10.1016/j.jpsychires.2008.04.014

<sup>2</sup>Creavin ST, Wisniewski S, Noel-Storr AH, et al. Mini-Mental State Examination (MMSE) for the detection of dementia in clinically unevaluated people aged 65 and over in community and primary care populations. *Cochrane Database Syst Rev*. 2016;(1):CD011145. doi:10.1002/14651858.CD011145.pub2

# Montreal Cognitive Assessment (MoCA)

**MONTREAL COGNITIVE ASSESSMENT (MOCA)**

NAME : \_\_\_\_\_ Education : \_\_\_\_\_ Date of birth : \_\_\_\_\_  
 Sex : \_\_\_\_\_ DATE : \_\_\_\_\_

<b>VISUOSPATIAL / EXECUTIVE</b>		 Copy cube [ ]		Draw CLOCK (Ten past eleven) (3 points) [ ] [ ] [ ]		POINTS		
								
<b>NAMING</b>		 [ ]		 [ ]		 [ ]		
<b>MEMORY</b>		Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.		FACE	VELVET	CHURCH	DAISY	RED
		1st trial						
		2nd trial						
<b>ATTENTION</b>		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						No points
		Read list of letters. The 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						
		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						
<b>LANGUAGE</b>		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. [ ]						
		Fluency / Name maximum number of words in one minute that begin with the letter F [ ] ____ (N ≥ 11 words)						
<b>ABSTRACTION</b>		Similarity between e.g. banana - orange = fruit [ ] train - bicycle [ ] watch - ruler						
<b>DELAYED RECALL</b>		Has to recall words WITH NO CUE [ ] [ ] [ ] [ ] [ ] [ ]		FACE	VELVET	CHURCH	DAISY	RED
		Optional Category cue [ ] [ ] [ ] [ ] [ ] [ ]						
		Multiple choice cue [ ] [ ] [ ] [ ] [ ] [ ]						
<b>ORIENTATION</b>		[ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City						
		© Z.Nasreddine MD Version November 7, 2004 www.mocatest.org		Normal ≥ 26 / 30		<b>TOTAL</b> [ ] / 30 Add 1 point if ≤ 12 yr edu		



- 10 minute administration



- Available in 35 languages; adapted version for visual impairment
- Sensitive to detecting both MCI and dementia
- Formal training available



- Biased by education level
- May not distinguish between MCI and dementia very well
- Emphasizes memory impairment



- MCI: sensitivity 72%, specificity 75% (cutoff scores of 24)<sup>1</sup>
- Dementia: sensitivity 93%, specificity 96% (cutoff score of 20)<sup>1</sup>

<sup>1</sup>Cummings-Vaughn LA, Chavakula NN, Malmstrom TK, Tumosa N, Morley JE, Cruz-Oliver DM. Veterans Affairs Saint Louis University Mental Status Examination Compared with the Montreal Cognitive Assessment and the Short Test of Mental Status. *Journal of the American Geriatrics Society*. 2014;62(7):1341-1346. doi:10.1111/jgs.12874

## Mini-Cog™

### Instructions for Administration & Scoring

ID: \_\_\_\_\_ Date: \_\_\_\_\_

#### Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.<sup>1,9</sup> For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

#### Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test. Move to Step 3 if the clock is not complete within three minutes.

#### Step 3: Three Word Recall

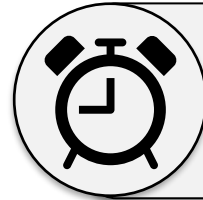
Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version: \_\_\_\_\_ Person's Answers: \_\_\_\_\_

#### Scoring

Word Recall: _____ (0-3 points)	1 point for each word spontaneously recalled without cueing.
Clock Draw: _____ (0 or 2 points)	Normal clock = 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor positions) with no missing or duplicate numbers. Hands are pointing to the 11 and 2 (11:10). Hand length is not scored. Inability or refusal to draw a clock (abnormal) = 0 points.
Total Score: _____ (0-5 points)	Total score = Word Recall score + Clock Draw score.  A cut point of <3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further evaluation of cognitive status.

Impairment is defined as 0 points on recall or 1-2 points on recall and abnormal clock



- 3 minute administration



- Easy administration (no special forms), requires minimal training
- Minimal influence of education on performance
- Alternate forms for 3-word registration/recall



- Limited to recall + clock drawing
- Scoring of clock is subjective
- Alternate forms for 3-word registration/recall may not be equivalent



- MCI: sensitivity 52%, specificity 80%<sup>1</sup>
- Dementia: sensitivity 76%, specificity 73%<sup>2</sup>


<sup>1</sup>Tran J, Nimojan T, Saripella A, et al. Rapid cognitive assessment tools for screening of mild cognitive impairment in the preoperative setting: A systematic review and meta-analysis. *Journal of Clinical Anesthesia*. 2022;78:110682. doi:10.1016/j.jclinane.2022.110682

<sup>2</sup>Seitz DP, Chan CC, Newton HT, et al. Mini-Cog for the detection of dementia within a primary care setting. *Cochrane Database of Systematic Reviews*. 2021;(7). doi:10.1002/14651858.CD011415.pub3

# Short Test of Mental Status (STMS)

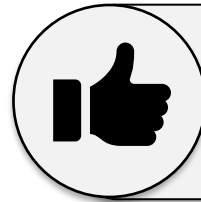
## Short Test of Mental Status (STMS)

"I would now like to examine your memory and related items. Please relax, pay attention to the questions I am asking, and answer them as best as you can."

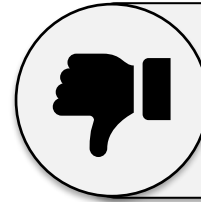
1. Orientation (8)	Name, address, current location (building), city, state, date (day), month, year	_____
2. Attention (7)	Digit span (present 1/sec; record longest correct span) 2-9-6-8-3, 5-7-1-9-4-6, 2-1-5-9-3-6-2	_____
3. Immediate recall(4)	Four unrelated words: "apple," "Mr. Johnson," "charity," "tunnel." Number of trials needed to learn all four:	_____
4. Calculation (4)	5 x 13; 65 - 7; 58/2; 29 + 11	_____
5. Abstraction (3)	Similarities: orange/banana, dog/horse, table/bookcase	_____
6. Construction (2)	Draw clock face showing 11:15	_____
Copy (2)		_____
7. Information (4)	President; first President; define an island; number of weeks per year	_____
8. Recall (4)	The four words: "apple," "Mr. Johnson," "charity," "tunnel"	_____
Total Score (38):	[Raw Score - (number of learning trials - 1)]	_____



- 5-10 minute administration



- Easily administered
- Good sensitivity and specificity for detecting MCI and dementia
- High correlation with more comprehensive measures



- Less widely used
- Less familiar score scale (38 max points)



- MCI: sensitivity 68%, specificity 76% (cutoff score of 32)<sup>1</sup>
- Dementia: sensitivity 93%, specificity 92% (cutoff score of 29)<sup>1</sup>

# Saint Louis University Mental Status (SLUMS)

**Saint Louis University  
Mental Status (SLUMS) Examination**

Name \_\_\_\_\_ Age \_\_\_\_\_  
Is patient alert? \_\_\_\_\_ Level of education \_\_\_\_\_

1. What day of the week is it? \_\_\_\_\_

2. What is the year? \_\_\_\_\_

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.  
How much did you spend?  
How much do you have left?

6. Please name as many animals as you can in one minute.  
1 0-4 animals 2 5-9 animals 3 10-14 animals 4 15+ animals

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.  
1 87 2 649 3 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  
2 Time correct

10. Please place an X in the triangle.  

11. 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?  
2 When did she go back to work? 2 What state did she live in?

TOTAL SCORE \_\_\_\_\_

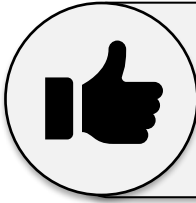
**Department of Veterans Affairs** SAINT LOUIS UNIVERSITY

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

\*MNCD=Mild neurocognitive disorder



- 7 minute administration



- Sensitive to MCI
- Includes tasks of executive functioning
- Available in >20 languages



- Limited research on reliability and validity
- Less sensitive than MMSE to cognitive changes over 1 year



- MCI: sensitivity 74%, specificity 65% (cutoff score of 26)<sup>1</sup>
- Dementia: sensitivity 93%, specificity 96% (cutoff score of 20)<sup>1</sup>

<sup>1</sup>Cummings-Vaughn LA, Chavakula NN, Malmstrom TK, Tumosa N, Morley JE, Cruz-Oliver DM. Veterans Affairs Saint Louis University Mental Status Examination Compared with the Montreal Cognitive Assessment and the Short Test of Mental Status. *Journal of the American Geriatrics Society*. 2014;62(7):1341-1346. doi:10.1111/jgs.12874

# Addenbrooke's Cognitive Examination-Revised (ACE-R)

**ADDENBROOKE'S COGNITIVE EXAMINATION - ACE-R**  
Final Revised Version C (May 2004) - Australian Version

Name : \_\_\_\_\_ Date of testing: ..... / ..... / .....  
 Date of birth : \_\_\_\_\_ Tester's name: .....  
 Hospital no. : \_\_\_\_\_ Age at leaving full-time education: .....  
 Occupation: .....  
 Handedness: .....

Addressograph

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**ORIENTATION**

Ask: What is the Day Date Month Year Season [Score 0-5]

Ask: Which Building Floor Town State Country [Score 0-5]

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**REGISTRATION**

Tell: 'I'm going to give you three words and I'd like you to repeat after me: lemon, key and ball.'  
 After subject repeats, say 'Try to remember them because I'm going to ask you later'. Score only the first trial (repeat 3 times if necessary).  
 Register number of trials .....

[Score 0-3]

---

**ATTENTION & CONCENTRATION**

Ask the subject: 'could you take 7 away from a 100? After the subject responds, ask him or her to take away another 7 to a total of 5 subtractions. If subject make a mistake, carry on and check the subsequent answer (i.e. 93, 86, 77, 70, 63 -score 4)  
 Stop after five subtractions (93, 86, 79, 72, 65) .....  
 (or the best performed task)

Ask: 'could you please spell **WORLD** for me? Then ask him/her to spell it backwards: .....

[Score 0-5]

---

**MEMORY - Recall**

Ask: 'Which 3 words did I ask you to repeat and remember? .....

[Score 0-3]

---

**MEMORY - Anterograde Memory**

Tell: 'I'm going to give you a name and address and I'd like you to repeat after me. We'll be doing that 3 times, so you have a chance to learn it. I'll be asking you later'  
 Score only the third trial

	1 <sup>st</sup> Trial	2 <sup>nd</sup> Trial	3 <sup>rd</sup> Trial
John Marshall	.....	.....	.....
24 Market Street	.....	.....	.....
Ballarat	.....	.....	.....
Victoria	.....	.....	.....

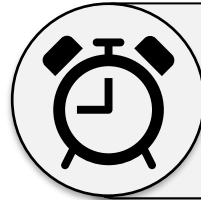
[Score 0-7]

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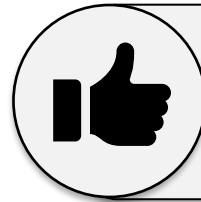
**MEMORY - Retrograde Memory**

Name of current Prime Minister .....  
 Name of the Premier of New South Wales .....  
 Name of the USA president .....  
 Name of the USA president who was assassinated in the 1960s .....

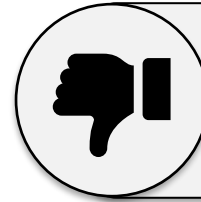
[Score 0-4]



- 15 minute administration



- Developed as an improvement over the MMSE + in 19 languages
- Provides subdomain scores
- Good sensitivity and specificity for detecting dementia



- Longer administration time than similar screening tests
- Heavily emphasizes memory domain



- MCI: sensitivity 68%, specificity 91% (cutoff score of 85.5)<sup>1</sup>
- Dementia: sensitivity 96%, specificity 88% (cutoff score varies from 80-88; 82 most accurate)<sup>2</sup>

<sup>1</sup>Lucza T, Ascherman Z, Kovács M, et al. Comparing Sensitivity and Specificity of Addenbrooke's Cognitive Examination-I, III and Mini-Addenbrooke's Cognitive Examination in Parkinson's Disease. Behav Neurol. 2018;2018:5932028. doi:10.1155/2018/5932028

<sup>2</sup>Larner AJ, Mitchell AJ. A meta-analysis of the accuracy of the Addenbrooke's Cognitive Examination (ACE) and the Addenbrooke's Cognitive Examination-Revised (ACE-R) in the detection of dementia. International Psychogeriatrics. 2014;26(4):555-563. doi:10.1017/S1041610213002329

# Cognitive Screening Tool Comparison

	<b>Admin Time (mins)</b>	<b>Age Range (years)</b>	<b>Score Range</b>	<b>Sensitivity for MCI (%)</b>	<b>Specificity for MCI (%)</b>	<b>Sensitivity for Dementia (%)</b>	<b>Specificity for Dementia (%)</b>
MMSE	10	18-85	0-30	63	65	85	90
MoCA	10	55-85	0-30	72	75	93	96
Mini-Cog	3	65+ (?)	0-5	52	80	76	73
STMS	10	65+ (?)	0-38	68	76	93	92
SLUMS	7	18+	0-30	74	65	93	96
ACE-R	15	50+	0-100	68	91	96	88

## Mood Screening Tools

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# Geriatric Depression Scale (GDS)

## Geriatric Depression Scale (GDS) Short Form

Choose the best answer for how you have felt over the past week:

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

Source: Sheikh, J.I., and Yesavage, J.A. Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. *Clinical Gerontologist* 5(1-2): 165-173, 1986.



- 2-5 minute (short form) or 3-7 minute (long form) administration



- Widely used
- Short-form available
- Specific to older adult population



- Does not directly assess suicidality



- Short Form: sensitivity 86%, specificity 79%<sup>1</sup>
- Long Form: sensitivity 82%, specificity 86%<sup>1</sup>

<sup>1</sup>Krishnamoorthy Y, Rajaa S, Rehman T. Diagnostic accuracy of various forms of geriatric depression scale for screening of depression among older adults: Systematic review and meta-analysis. *Archives of Gerontology and Geriatrics*. 2020;87:104002. doi:10.1016/j.archger.2019.104002

# Neuropsychiatric Inventory Questionnaire (NPI-Q)

Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems.

Rate the **SEVERITY** of each symptom (how it affects the patient) **IN THE LAST 30 DAYS**:

- 0 = No change (not noticed)
- 1 = Mild (noticeable, but not a significant change)
- 2 = Moderate (significant, but not a dramatic change)
- 3 = Severe (very marked or prominent, a dramatic change)

Please answer each question carefully. Ask for assistance if you have any questions.

## Delusions

Does the patient have false beliefs, such as thinking that others are stealing from him/her or planning to harm him/her in some way?

SEVERITY: 0 1 2 3

## Hallucinations

Does the patient have hallucinations such as false visions or voices? Does he or she seem to hear or see things that are not present?

SEVERITY: 0 1 2 3

## Agitation/Aggression

Is the patient resistive to help from others at times, or hard to handle?

SEVERITY: 0 1 2 3

## Depression/Dysphoria

Does the patient seem sad or say that he/she is depressed?

SEVERITY: 0 1 2 3

## Anxiety

Does the patient become upset when separated from you? Does he/she have any other signs of nervousness such as shortness of breath, sighing, being unable to relax, or feeling excessively tense?

SEVERITY: 0 1 2 3

## Elation/Euphoria

Does the appear to feel too good or act excessively happy?

SEVERITY: 0 1 2 3

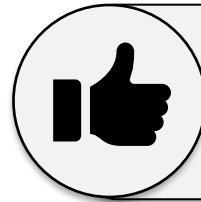
## Apathy/Indifference

Does the patient seem less interested in his/her usual activities or in the activities and plans of others?

SEVERITY: 0 1 2 3



- 5 minute administration



- Assesses numerous neuropsychiatric symptoms (i.e., delusions, hallucinations, agitation/aggression, depression/dysphoria, anxiety, elation/euphoria, apathy/indifference)



- Requires an informant
- Despite wide use, limited sensitivity/specificity data



- Limited evidence<sup>1</sup>

# Beck Depression Inventory-II (BDI-II)

**BDI-II** Date:

Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

**Instructions:** This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

<p><b>1. Sadness</b></p> <p>0 I do not feel sad.          1 I feel sad much of the time.          2 I am sad all the time.          3 I am so sad or unhappy that I can't stand it.</p> <p><b>2. Pessimism</b></p> <p>0 I am not discouraged about my future.          1 I feel more discouraged about my future than I used to be.          2 I do not expect things to work out for me.          3 I feel my future is hopeless and will only get worse.</p> <p><b>3. Past Failure</b></p> <p>0 I do not feel like a failure.          1 I have failed more than I should have.          2 As I look back, I see a lot of failures.          3 I feel I am a total failure as a person.</p> <p><b>4. Loss of Pleasure</b></p> <p>0 I get as much pleasure as I ever did from the things I enjoy.          1 I don't enjoy things as much as I used to.          2 I get very little pleasure from the things I used to enjoy.          3 I can't get any pleasure from the things I used to enjoy.</p> <p><b>5. Guilty Feelings</b></p> <p>0 I don't feel particularly guilty.          1 I feel guilty over many things I have done or should have done.          2 I feel quite guilty most of the time.          3 I feel guilty all of the time.</p>	<p><b>6. Punishment Feelings</b></p> <p>0 I don't feel I am being punished.          1 I feel I may be punished.          2 I expect to be punished.          3 I feel I am being punished.</p> <p><b>7. Self-Dislike</b></p> <p>0 I feel the same about myself as ever.          1 I have lost confidence in myself.          2 I am disappointed in myself.          3 I dislike myself.</p> <p><b>8. Self-Criticalness</b></p> <p>0 I don't criticize or blame myself more than usual.          1 I am more critical of myself than I used to be.          2 I criticize myself for all of my faults.          3 I blame myself for everything bad that happens.</p> <p><b>9. Suicidal Thoughts or Wishes</b></p> <p>0 I don't have any thoughts of killing myself.          1 I have thoughts of killing myself, but I would not carry them out.          2 I would like to kill myself.          3 I would kill myself if I had the chance.</p> <p><b>10. Crying</b></p> <p>0 I don't cry any more than I used to.          1 I cry more than I used to.          2 I cry over every little thing.          3 I feel like crying, but I can't.</p>
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Subtotal Page 1 Continued on Back



- 5-10 minute administration



- Widely used
- Assesses all diagnostic criteria for major depressive disorder
- Assesses suicidal ideation



- Not specifically developed for older adults (age 13-80)
- Less specific for depression in patients with various medical conditions



- Varies by sample, but sensitivity and specificity are generally >70%<sup>1</sup>

<sup>1</sup>Wang YP, Gorenstein C. Psychometric properties of the Beck Depression Inventory-II: a comprehensive review. Braz J Psychiatry. 2013;35:416-431. doi:10.1590/1516-4446-2012-1048

# Quick Inventory of Depressive Symptoms (QIDS)

## Quick Inventory of Depressive Symptomatology—Self-Report (QIDS-SR)

Please circle the one response to each item that best describes you for the past seven days.

1. Falling asleep:
  - 0 I never take longer than 30 minutes to fall asleep.
  - 1 I take at least 30 minutes to fall asleep, less than half the time.
  - 2 I take at least 30 minutes to fall asleep, more than half the time.
  - 3 I take more than 60 minutes to fall asleep, more than half the time.
2. Sleep during the night:
  - 0 I do not wake up at night.
  - 1 I have a restless, light sleep with a few brief awakenings each night.
  - 2 I wake up at least once a night, but I go back to sleep easily.
  - 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.
3. Waking up too early:
  - 0 Most of the time, I awaken no more than 30 minutes before I need to get up.
  - 1 More than half the time, I awaken more than 30 minutes before I need to get up.
  - 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
  - 3 I awaken at least one hour before I need to, and can't go back to sleep.
4. Sleeping too much:
  - 0 I sleep no longer than 7–8 hours/night, without napping during the day.
  - 1 I sleep no longer than 10 hours in a 24-hour period including naps.
  - 2 I sleep no longer than 12 hours in a 24-hour period including naps.
  - 3 I sleep longer than 12 hours in a 24-hour period including naps.
5. Feeling sad:
  - 0 I do not feel sad.
  - 1 I feel sad less than half the time.
  - 2 I feel sad more than half the time.
  - 3 I feel sad nearly all of the time.
6. Decreased appetite:
  - 0 There is no change in my usual appetite.
  - 1 I eat somewhat less often or lesser amounts of food than usual.
  - 2 I eat much less than usual and only with personal effort.
  - 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.



- 5-7 minute administration



- Validated in older adults
- Directly assesses suicidal ideation



- Heavily weighted towards physical symptoms (e.g., 4 of 16 items focused on sleep patterns)



- Sensitivity 86%, specificity 58%<sup>1</sup>

# Mood Screening Tool Comparison

	<b>Admin Time (mins)</b>	<b>Age Range (years)</b>	<b>Score Range</b>	<b>Sensitivity for Depression (%)</b>	<b>Specificity for Depression (%)</b>
GDS (short-form)	2-5	65+	0-15	82	86
GDS (long-form)	3-7	65+	0-30	86	79
NPI-Q	5	48-87	0-36	?	?
BDI-II	5-10	13-80	0-63	>70	>70
QIDS	5-7	13+	0-42	86	58

## Conclusions

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## Brief Cognitive and Depressed Mood Assessment Conclusions

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- There are many 'brief' cognitive screening tools available, but most require 7-10 minutes for administration
- The ACE-R offers an improvement over the MMSE, subdomain scores, and good sensitivity/specificity trade off, but it requires a longer administration time of 15 minutes
- The best sensitivity/specificity trade off among these cognitive screening tools is for the MoCA, which also has advantages of being freely accessible and available in 35 languages
- Subjective cognitive complaints (which I didn't cover today) remain a 'quick and dirty' screening method, especially if respondents find complaints 'concerning'
- Screening for mood issues can be accomplished in under 5 minutes and has the advantage of self administration
- The short-form GDS offers good sensitivity/specificity trade off for adults age 65 and older
- For patients in their 50s and early 60s, the BDI-II might offer a better solution (despite strong sensitivity, I wouldn't recommend the QIDS given the false positives that arise from sleep issues)





***Thank You for Your Attention***

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