The Assessment of Older People with dementia and depression of Culturally and Linguistically Diverse Backgrounds: A review of current practice and the development of guidelines for Victorian Aged Care Assessment Services

Final Report

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# Table of contents

1) Background .................................................................................................................. 2  
   1.1 Aims and Objectives ................................................................................................. 3  
2) Method ........................................................................................................................... 4  
3) ACAS Survey Results .................................................................................................. 6  
4) Focus Group Results .................................................................................................... 8  
5) Language and Tool Selection ....................................................................................... 10  
6) Good practice guidelines and web based resources .................................................... 14  
7) Conclusion .................................................................................................................... 15  
8) References ................................................................................................................... 16  
9) Attachments .................................................................................................................. 18  
    Attachment 1) ACAS CALD Survey ........................................................................ 18  
    Attachment 2): The Tip Sheets and Tools ................................................................. 22  
    Attachment 3) Tip Sheet 1 - Assessment and People from Culturally and Linguistically Diverse (CALD) Backgrounds ................................................................. 24  
    Attachment 4) Tip Sheet 2 – Working with Interpreters ............................................. 28  
    Attachment 5) Tip Sheet 3 – Cognitive assessment and people from Culturally and Linguistically Diverse (CALD) background ...................................................... 31  
    Attachment 6) Tip Sheet 4 – The Clock Drawing test (CDT) ....................................... 35  
    Attachment 7) Tip Sheet 5 – The IQCODE (Short Form) ............................................. 37  
    Attachment 8) Tip Sheet 6 – The Geriatric Depression Scale (GDS) - 15.41
1) Background

The cultural diversity within the Australian population has resulted in over 400 languages being spoken in the community (Australian Bureau of Statistics, 2007). According to the Australian Institute of Health and Welfare, 30.8% of Victoria’s older population are from Culturally and Linguistically Diverse (CALD) backgrounds (Australian Institute of Health and Welfare, 2006), and around one in six Victorians with dementia do not speak English at home (Access Economics Pty Limited, 2006).

It is well documented that those with dementia of CALD background may access services less and at a later stage of dementia (Black, Osborne, & Lindeman, 2004; Hassett, George, & Harrigan, 1999; Lister & Benson, 2006; LoGuidice, Hassett, Cook, Flicker, & Ames, 2001). Increasing understanding of the cultural reasons for this are being documented (Alzheimer’s Australia Victoria, 2008; Hill et al., 2007; Sims, Nguyen, LoGiudice, & Smith, 1999). However, once a referral is made it is crucial that an accurate and culturally appropriate assessment is completed to ensure adequate service provision and planning to enhance quality of life for the client and their families.

In a 2005 report, the most common primary health condition of Aged Care Assessment Service (ACAS) clients in Victoria was dementia (19.6%). It was more than twice as frequent as any other primary health condition (Victorian ACAP Evaluation Unit, 2006). In addition, a fifth of the clientele were from CALD backgrounds. Australia wide, in 2004-2005, 15.4% of all ACAS assessments were CALD clients (Communio, 2007).

Although referral rates of CALD clients have increased to ACAS, the numbers are still lower than represented in the general community. Of the assessments conducted by ACAS between July 1 2009 and June 30 2010, 24.5% were for people from a CALD background compared to the representative population of 29.6%. (Victorian ACAP Evaluation Unit, 2010). Even lower referrals are noted in rural regions (9.4% compared to 15.8% in the local population) (Victorian ACAP Evaluation Unit, 2010).

In terms of mental disorders, depression is one of the most common mental disorders among Australians. The 2007 National Survey of Mental Health and Wellbeing reports that one in seven Australian (14%) suffer from depression at some point in their lives (Australian Bureau of Statistics, 2008). There is limited Australian data on the prevalence of depression in older people from CALD backgrounds. However, there is some evidence that older people from other cultural backgrounds might be at greater risk of depression than the general community (Kuo, Chong, & Joseph, 2008).

To aid accurate assessment, it is important to ensure culturally appropriate assessments are undertaken with people with possible cognitive impairment and depression who come from CALD backgrounds. The Australian Dementia Outcomes Measurement Suite (DOMS) Project evaluated a number of cognitive assessment measures against pre-determined criteria and found that the Modified MMSE(3MS), RUDAS and GP-Cog\(^1\) were all suitable and valid tools in most health care settings (Sansoni, Marosszeky, & Sansoni, 2007). The authors cautioned, however, that “a further project is necessary to ensure a more comprehensive database...for CALD communities...where translated versions of the measures are further reviewed and made available where possible” (Sansoni et al., 2007, p. 28).

For older migrants with different linguistic, educational and cultural norms, it is not sufficient to translate a cognitive assessment tool from one language to another. Translation involves more than linguistics. Tools must be culturally equivalent. "It must be determined whether the use of a particular test format to assess cognitive skill of interest is equally valid in the language in which the test will be administered” (Manly &

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\(^1\) Modified Mini Mental State Examination (3MS), Rowland Universal Dementia Assessment Scale (RUDAS) and General Practitioner Assessment of Cognition (GP-Cog).
Espino, 2004, p. 105). The limitations of commonly used tests such as the MMSE (in less educated and CALD groups) are well documented (Anderson, Sachdev, Brodaty, Troller, & Andrews, 2007; Escobar et al., 1986). Many translations in different languages are available, but have not been assessed for suitability of use in various ethnic groups and in particular in CALD groups in Australia. Newer tools such as the RUDAS are developed to address such needs but require further community validation.

Similar concerns regarding the assessment of depression in CALD populations have been reported. For example, in relation to the Geriatric Depression Scale (Sansoni et al., 2007), a widely used tool, it was reported to contain items or terms that may be seen as “Western value judgments...” (p. 388). In addition, there was the issue that it may be culturally inappropriate to disclose such information to others (Sansoni et al., 2007).

Guidelines are available to aid clinicians in the screening and diagnostic assessment of people of CALD background with dementia (Hill et al., 2007), and other resources and networks aid in the dissemination of information relevant to this issue, e.g. National Cross Cultural Dementia Network (Alzheimer’s Australia, 2010). Resources such as Sensitive Assessments for Ethnic Elderly, NSW were published in 1999 (found at this website - http://dementia.uow.edu.au/understandingdementiacare/module6/principles_informationsheet1.html ) but little has been developed recently specific to the needs of ACAS.

### 1.1 Aims and Objectives

The aim of this project is to strengthen and improve the consistency of practice within ACAS in assessing CALD clients with depression and dementia. The specific objectives include:

i) To identify current ACAS practice in assessing CALD clients with dementia and depression and the assessment tools utilised.

ii) To identify cognitive assessment tools (including informant interviews) and tools to assess depression that are suitable for use with older CALD people based on recommendations of the Dementia Outcomes Measurement Suite (DOMS), National Tools Project (Sansoni, Marosszeky, Fleming, & Sansori, 2010) and other reviews, and to assess their usefulness within the ACAS context.

iii) To identify which of these tools have been translated into languages relevant to major CALD groups in Australia and ACAS clientele and determine their suitability based on their cultural and psychometric properties.

iv) To assess the cultural and psychometric properties of these translated tools based on published reports and/or on discussions with the tools’ authors. This will be guided against an established set of criteria.

v) To create a database of tools with recommendations for use by ACAS assessors and other clinicians.

vi) To identify gaps in the available literature regarding assessment tools and practices and make recommendations for the future.

vii) To develop best practice guidelines for ACAS in the approach to culturally appropriate assessment and utilisation of recommended tools.

viii) To provide professional development sessions on the findings and application of the recommended best practice guidelines.
2) Method

The purpose of this project is to improve the assessment practices of ACAS for CALD clients in relation to dementia and depression. The key components of the project include:

(i) Establishing a project steering committee that includes representatives from the Department of Health Victoria, ACAS, CALD groups, and the project advisors and the project team.

(ii) Engaging with, and informing Victorian ACAS managers and teams (there are 18 ACASs in Victoria) about the project, its aims and objectives and the participation required. This may include meetings, presenting the project plan to the ACAS Clinical Reference Group, attending ACAS Vic meetings or other relevant forums, and telephone discussions.

(iii) Identifying ACAS current practice in assessing CALD clients for dementia and depression through:
   (a) A web-based or paper-based survey of all Victorian ACASs (see 2.2).
   (b) Three focus groups to further understand how ACASs work with CALD clients currently, the challenges and issues they face and what they deem to be good practice in assessing dementia and depression in CALD clients.

(iv) Identify translated versions of cognitive assessment tools and tools to assess depression in the literature (Medline and grey literature), including the processes undertaken to determine cultural relevance. This may also involve contacting authors of the scales documented in the Dementia Outcomes Measurement suite, contacting service providers e.g. Cognitive Dementia and Memory Services (CDAMS) and other dementia service providers.

(v) Determine a set of criteria by which to assess the usefulness of the tools in the Australian context (e.g. is the tool translated only, which processes were undertaken for translation, were the tools validated and the robustness of the process of psychometric properties).

(vi) Liaise and consult with the Department of Health and the Department of Health & Ageing in regards to the National Tools Project.

(vii) Assess the usefulness of these tools in the ACAS context (see ix).

(viii) Develop good practice guidelines for ACAS for the assessment of dementia and depression and the use of the recommended tools (see ix).

(ix) A workshop or other consultation process will be undertaken to assist in activity (vi) and (vii) listed above.

(x) Provide a professional development session on the findings and application of the tools in the cognitive assessment of CALD clients (one session in the metropolitan area, all ACAS services with high CALD clientele will be invited to attend).

(xi) Determine recommendations for future translation and validation of tools, including which languages, and an ongoing process for this.

(xii) Document this information on the web for easy access by ACAS staff and other clinicians.

(xiii) Provide recommendations for future work in this area.
This project seeks to improve the accuracy of assessment of dementia and depression for those of CALD backgrounds. This report presents the findings from all project components: the ACAS surveys and focus groups, tools and literature review and professional development resources.
3) ACAS Survey Results

A survey was sent to all 18 Victorian ACASs asking staff to outline current assessment practices and use of standardised and validated tools for assessing cognitive status and depression in clients from a CALD background (see Attachment 1 for a copy of the survey). A total of 79 surveys were returned by 16 of the 18 ACASs in Victoria (response rate based on ACAS teams: 88.9%). The response rate by number of surveys sent and received is not available as it is unknown how many staff the ACAS managers distributed the survey to for completion.

Below is a summary of the survey findings. The findings are reported against the key themes that were explored:

**LANGUAGE -**
- The main languages other than English spoken by CALD clients were Italian, Greek and Polish.
- Most clinicians fluent in another language speak Greek followed by Cantonese.
- Most clinicians know which languages their clients commonly speak through their clinical work, followed by ACE data.
- Assistance with communication when interviewing clients of CALD backgrounds was mainly through the use of general interpreters and family members.
- Availability of interpreters was the main challenge involved in communication with CALD clients.

**TRAINING/EDUCATION -**
- Most participants indicated they had not had any specific training in working with clients from CALD backgrounds.
- Participants access information on working with CALD clients mainly from colleagues.
- Most participants stated that they are somewhat confident in assessing CALD clients.
- Most participants said their employer could best meet their educational needs for assessing CALD clients through workplace training.
- Respondents had knowledge of appropriate agencies to contact to obtain appropriate information and advice (such as Alzheimer’s Australia Victoria, CALD agencies, policy and government websites).
- Education regarding culturally specific training and education regarding tools was requested.
- Knowledge of, and linking with CALD agencies seemed strong.
- In-house training was a common means of staff education.

**GUIDELINES -**
- 64.6% of respondents were aware of guidelines for working with CALD clients; most were aware of general guidelines as compared to dementia guidelines and depression guidelines.
- Respondents indicated the main challenge to working effectively with clients from a CALD background is access to and use of interpreters; this included:
  - Client acceptance.
  - Loss of one on one relationship between the assessor and client at assessment.
  - Distance for interpreters to travel.
  - Difficulty arranging a time when interpreters, multiple service providers, and family members are all available.
  - Interpreters being heavily booked ahead of time (especially Russian) which delays assessment booking.
  - Non availability of interpreters for particular languages and late notification – requiring appointments with clients to be cancelled at the last minute.
ASESSMENT TOOLS -

- **Cognitive Screening tools** -
  - Most respondents never, or only sometimes, used cognitive screening tools when assessing CALD clients.
  - Of the tools that were used, the Clock Test, RUDAS, and MMSE were more commonly used.
  - There appeared to be more knowledge of the RUDAS amongst participants than other tools.

- **Comprehensive Dementia Tools** -
  - Most respondents stated they have “never” used any of the comprehensive dementia tools mentioned (on a scale of “always”, “sometimes”, “never”).

- **Depression Assessment Tools** -
  - Most respondents stated that they “always” or “sometimes” use the Geriatric Depression Scale when asked about how often they use certain depression tools.

SUMMARY -
The findings from this survey indicate that participants use interpreters as their main method of communicating with CALD clients. However a range of barriers and challenges were highlighted when using interpreters in undertaking complex assessments.

Findings highlighted knowledge of key CALD services and dementia services where information could be accessed. There were also requests from survey participants for culturally specific training, including training regarding use of appropriate assessment tools and dementia and depression guidelines.
4) Focus Group Results

Building on the findings of the current practice survey, focus groups were conducted to further understand how ACASs work with CALD clients. A total of 21 participants attended three focus groups:

- Group 1: 7 participants - four from rural ACASs/three from metropolitan ACASs.
- Group 2: 4 participants - all from metropolitan ACASs.
- Group 3: 10 participants - one from a rural ACAS/nine from metropolitan ACASs.

Participants were asked a series of questions:

- Where do you access information on working with clients from a CALD background?
- What training have you received on working with clients from a CALD background with dementia and/or depression and how is it best delivered?
- Can you tell us about the current practice in assessing dementia and depression in CALD clients? This included making comment about tools used, whether they are translated and how they communicate with CALD clients.
- We want to further explore the challenges to working effectively with clients from a CALD background. Can anyone comment on these?
- Can you describe examples of good practice with clients of CALD backgrounds?
- Are there any issues you would like to raise about assessing dementia and depression in CALD clients?

Below is a summary of the findings; findings are reported against key themes explored:

ACCESS TO INFORMATION –
Information on working with clients from a CALD background was accessed via:

- Cultural groups (e.g. ethno specific/ethnic organisations).
- Colleagues and in-house information (including hospital translation/language service).
- The internet.

TRAINING -
- Across all groups, participants had received training either on dementia, depression and/or tools but had not had training linking these topics to CALD population groups; and there was more training about dementia rather than depression.
- Training seemed to be ad hoc, little was provided regarding CALD groups or tools more generally and training in relation to tools (e.g. Geriatric Depression Scale) was identified as a gap.
- Rural participants were concerned that most training was held in the metropolitan area.
- Training was received via a range of methods: conferences, seminars, in-house, online.
- Effective approaches to training were described as those that were interactive.

CURRENT PRACTICE -
- Across all focus groups, participants stated that they use the Geriatric Depression Scale (GDS), RUDAS and MMSE; in one focus group, the Clock Test was also mentioned.
- Comments were made about the GDS and RUDAS questioning their appropriateness for CALD clients.
- Others said they had not had any training in how to use the GDS.
- There was mention in one focus group of using a Greek translated version of the MMSE and an Italian translated version. In this focus group, a participant made the recommendation that interpreters undergo training on how to interpret the MMSE and other tools.
- Other practice issues regarding tools were identified, including: all ACAS should use the same tools; the scoring on the MMSE may misclassify CALD clients; tools should not be used as a standalone assessment and that other sources of information about
the person are also important; tools appropriate to different cultures would be helpful in the assessment process.

CHALLENGES -
- Interpreters and issues around working with interpreters were identified as a challenge. This included balancing client preferences against good practice, skills of interpreters, skills of clinicians in working with interpreters and issues pertaining to specific cultures.
- Insufficient ethnic or ethno specific services.
- Knowing what the right tools to use are when assessing a specific client.
- Time limitations for assessors.
- Being a bi-lingual staff member or being of a different cultural background.
- Undertaking assessment when multiple family/friends are present (e.g. privacy issues).
- Many CALD clients do not want to go to CDAMS.
- Many CALD communities do not understand the different allied health services.

ACAS staff also took the opportunity to discuss issues related to Indigenous communities, particularly trying to engage the communities to use ACAS services.

GOOD PRACTICE EXAMPLES –
Examples of good practice when working with CALD clients included:
- Links with ethnic organisations promotes good practice.
- Having bi-lingual colleagues.
- Good interpreters who are well trained and do not interfere with the conversation.
- Patience and flexibility.
- Having effective tools is essential.
- Using useful resources from other organisations e.g. Eastern Health Transcultural Service.
- Organising clients who speak the same language to be assessed on the same day so that an interpreter is more likely to attend and stay for the whole day.
- Exposing all staff to a variety of cultural experiences and languages.

ASSESSING DEMENTIA AND DEPRESSION IN CALD CLIENTS –
Other issues raised related to the assessment of CALD clients included:
- The importance of understanding the issues for newer and emerging communities.
- Providing translated flyers for CALD clients is not always sufficient as clients need to be fluent in their own language to be able to read translated information.
- For a bi-lingual assessor, communicating with two generations (parents and children) was mentioned as a challenge when children are not fluent in the parent’s language.
- Considering the appropriateness (and limitations) of the use of technology to assist in the assessment process.
- The importance of providing community education.

SUMMARY -
The findings from the focus groups indicate that:
- Participants are aware of how to access information about CALD groups and have strong partnerships with cultural groups.
- General training regarding cultural groups and training about tools seems to be ad hoc. Requests were raised from participants for culturally specific training and training regarding use of tools.
- Barriers to working with interpreters were highlighted and some strategies and recommendations for addressing these were raised.
- Good practice examples and issues to consider when working with cultural groups were identified.
5) Language and Tool Selection

This section presents a summary of the findings of the assessment tool literature review, including language group selection, criteria used to assess the usefulness of the tools in the Australian context, links to the National Tools Project and assessing the usefulness of the tools in the ACAS context. Full details are available in a separate literature review report.

**LANGUAGE GROUPS** -

To select which languages were to be included in the literature review, the following data sources were reviewed:
- Previous, current and projected languages spoken by older people from CALD backgrounds (Gibson, Braun, Benham, & Mason, 2001);
- ACAS data on interpreter use;
- ACAS ACE database; and
- Survey results from the current study.

Taking into account the above data, Italian, Greek, Chinese (Cantonese and Mandarin), Vietnamese, Macedonian and Arabic were chosen as the languages most likely to be relevant to current and future ACAS assessments and therefore the review was restricted to tools relevant to these language groups.

**TOOL SELECTION** -

Findings from the 2010 Expert Clinical Reference Group (ECRG) report (Sansoni et al., 2010), results from the survey, and input from the Project Steering Committee were appraised to determine which tools should be included in this review. The ECRG report investigated tools suitable for use by ACATs in four functional domains: physical, social, psychological and behavioural, and cognitive (Sansoni et al., 2010). The report recommended the following appropriate tools for use nationally by ACATs:
- The Standardised Mini Mental State Examination (SMMSE) (Molloy & Standish, 1997) for assessing cognitive function.
- The Rowland Universal Dementia Assessment Scale (RUDAS) (Storey, Rowland, Basic, Conforti, & Dickson, 2004) for assessing cognitive function. The RUDAS was selected specifically for its use with people from CALD backgrounds making it appropriate to include in this project.
- The Geriatric Depression Scale (GDS) (Yesavage et al., 1983) for assessing behavioural and psychological function.

After considering the results of the ACAS staff surveys and focus groups, and the opinions of the Project Advisory Group, the Clock Drawing Test (CDT) was also included in the literature review. Further discussions with ACAS and the Department of Health resulted in the inclusion of the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE), an informant tool.

This resulted in the inclusion of four tools for assessing cognitive function (the SMMSE, RUDAS, CDT, and IQCODE) and one tool for assessing depression (the GDS) in older people of CALD backgrounds in the literature review.

**LITERATURE REVIEW** -

A literature review was conducted to identify studies validating versions of the RUDAS, SMMSE, CDT, IQCODE and GDS that have been translated into Italian, Greek, Chinese (Cantonese and Mandarin), Vietnamese, Macedonian, and Arabic.

A search was conducted using the name of each tool in combination with each language. In addition, search terms included a combination of the relevant tool name and the following terms: Translation; Language; Ethnic; Culture. Databases searched included: MEDLINE; CINAHL PLUS (EBSCO); PubMed; Scopus; PsychInfo; Google.
The reference lists of all included papers were also examined for additional articles, as were individual tool sites to obtain copies of translated tools and articles. Articles were included in the review where:

- There was an English abstract written in last 15 years;
- The tool was translated into the languages relevant to this project or used in a multicultural sample in a Western country; and
- Qualitative or quantitative data on the psychometric and/or transcultural properties of the tool were reported.

This criteria was based on Dementia Outcomes Measurement Suite Project Criteria.

Fifty nine articles were reviewed related to assessment tools used to assess dementia and depression in CALD older people; 40 related to cognitive assessment tools (the RUDAS, CDT, MMSE and IQCODE) and 19 to the GDS. There were no articles identified in the Vietnamese or Macedonian language (cognitive or depression tool). Twenty four articles were of studies conducted in a Western Country; nine with multicultural samples and eight with a specific ethnic group. There were no articles specifically looking at the SMMSE and therefore information detailing different translated versions of the MMSE was included in the review.

**Cognitive Assessment tools:** In summary, the RUDAS was validated in multicultural samples in Australia (with the one cut off score); its psychometric properties (AUC ranging from 0.92-0.94; and high reliability scores) were strong and scores did not appear influenced by education, CALD status/preferred language or gender.

The CDT articles showed variability in its ability to discriminate between those with/without dementia (sensitivity ranging from 60% to 98% and specificity ranging from 47% to 92%) even when using the same scoring system. Age and education were often reported to impact on scores.

The MMSE articles generally demonstrated good psychometric properties in studies involving Chinese, Greek and multicultural samples but different versions of the MMSE were used as well as different cut off scores (generally sensitivity ranged from 83.7% to 100%; specificity ranged from 72.9% to 95.6%; but two Chinese articles reported a sensitivity or specificity value below 70%). Age, education/literacy and CALD status/language/country were often reported to impact on scores. Most articles recommended different cut off scores based on age and/or education/literacy. There was insufficient information related to the Italian language (only one article), and for the Arabic language, no conclusions regarding the MMSE and appropriate cut off scores could be derived from the three identified articles.

There were only four articles related to the IQCODE and only the three Chinese language articles provided details of the translated version used. In relation to the Chinese language, sensitivity and specificity was high, over 78% or above, regardless of the version used, though the 26 item version and a cut of score of 3.4 provided better results (88% or above). The IQCODE was reported to be significantly correlated to the MMSE and education may have less of an influence on the IQCODE score.

**Geriatric Depression Scale:** The GDS has been validated in a range of languages, with Chinese languages receiving the most attention in the literature review time-frame. It should be noted that none of the reviewed articles included Australian immigrant samples.

Adequate to high reliability and the ability of the GDS to discriminate between depressed and non depressed older persons (sensitivity ranging from 71%-97% and specificity ranging from 70%-97%) have been reported for the various versions of the scale. While many of the articles did not compare depressive symptoms and demographic information, those that did reported mixed findings. The practical advantages of the shorter, screening versions of the tests, particularly for use with older persons, have also been noted in the literature. While the studies reviewed included a range of participants,
those with dementia were excluded from many of the studies, questioning its evidence base with a cognitively impaired population. Additionally, many of the studies reported that participants were illiterate and unable to complete the self-administered form, thus, the measure was verbally administered.

RECOMMENDATIONS -
Based on the findings of the literature review and the National Tools project the following is suggested:

- The RUDAS is used to assess CALD clients using the suggested cut off of 22 or less. To further assist ACAS staff, and aid the process of using interpreters, the Department may wish to consider contacting the developers of the tool to discuss having the RUDAS translated into the languages of interest: Greek, Italian, Macedonian, Arabic. NARI has already translated the RUDAS into Chinese and Vietnamese as part of a separate project (and versions are available on AAV website in Chinese and Italian at the following link) http://www.alzheimers.org.au/understanding-dementia/rowland-universal-dementia-assessment-scale.aspx

- The RUDAS should also be considered for use with all clients with lower levels of education and further considered for use with all clients as there are no copyright issues to address, and its performance was equal to the MMSE (and GPCOG) in the Australian studies.

- For staff wishing to use the MMSE with CALD clients, as an additional verification, the following translations should be considered:
  - Greek: Tsolaki et al (2000a) version using the cut off score of 23.
  - Italian: Frisoni et al (1993) version was the only Italian version identified in this review and no validity data was available.
  - Arabic: Wroble et al (2004) version using a cut off score of 22, however, there is insufficient evidence to support this cut off score, or the use of the MMSE (particularly in those with lower levels of education) in this cultural group.

- The IQCODE should be used to supplement the other patient administered tools, or used in situations where the patient is unable to complete the assessment. As there were only four articles involving a translated version of the IQCODE, and only the three Chinese articles outlined the version used, a recommendation can only be made in relation to the Chinese language. For other languages an interpreter should be used.

- There were various versions of the CDT and scoring methods used. Given the low specificity, 16% (with the Mendez method) to 58% (with the Wolf-Klein method) reported in the Australian setting using a multicultural sample and six different scoring methods (including the CERAD used in the Borson et al articles), it is not possible to recommend a scoring system based on the findings.

- In relation to the GDS, the 30- and 15-item versions received the most attention in the literature review. The practical benefits of using the shorter 15-item version with older participants was highlighted in many of the articles. Versions by language:
  - Italian: Two of the three Italian articles used the Pedrabissi & Santinello (1991) translation of the GDS-15 using a cut off score of ≥6.
  - Greek: The single Greek article by Fountoulakis et al. (1999) devised their own translation of the GDS-15 using a cut off of 6/7.
  - Arabic: The two Arabic articles conducted their own translation of the GDS-15 (cut off 7/8, (Chaaya et al., 2008)) and GDS-30 (cut off=11, (Wrobel & Farrag, 2006)).
Given the large number of translations and cutoff scores used in the Chinese articles, it is not possible to suggest a specific translation or cutoff score. In this case, it would be adviseable to continue using the cutoff scores suggested by the authors of the original English version of the scale (with scores of 6 for the GDS-15 and 11 for the GDS-30 indicating depression), until further studies conducted on local samples can provide more specific recommendations.

Refer to Attachment 2 for details of copyright and how to access tools.

**SUMMARY**
The review highlighted a need for further research validating all the tools in the Australian setting, not only in multicultural samples but in specific ethnic groups.
6) Good practice guidelines and web based resources

Two of the aims of this project were:

- To develop best practice guidelines for ACAS in the approach to culturally appropriate assessment and utilisation of recommended tools.
- To provide professional development sessions on the findings and application of the recommended best practice guidelines.

Best practice guidelines

The result of the findings from the literature review, survey and focus groups identified a range of areas where clinicians requested additional information and support. These included:

- Training about working with cultural specific groups;
- Challenges associated with the use of interpreters;
- Training regarding use of appropriate tools.

Participants also requested simple, practical, easy to use and easy to access resources (when asked what they would like developed as “best practice guidelines”). In response to this, and discussion with the project advisory group, a series of tip sheets were developed to address this aim and to respond to participant requests. The tips sheets are attached as Attachments 2-7 and cover the following areas:

- Tip Sheet 1 - Assessment and People from Culturally and Linguistically Diverse (CALD) Backgrounds
- Tip Sheet 2 - Working with Interpreters
- Tip Sheet 3 - Cognitive assessment and people from CALD background
- Tip Sheet 4 - The CDT
- Tip Sheet 5 - The IQCODE (Short Form)
- Tip Sheet 6 - The GDS-15

Rather than conducting an additional workshop with ACAS staff to assess the usefulness of the tip sheets, the tip sheets were presented at the ACAS State Training Reference Group (TRG) in May 2011. The tip sheets were discussed and feedback obtained from this session led to further refinement of the tip sheets.

Professional development sessions

It was envisaged that a professional development session/education session would be conducted with ACAS staff in the Melbourne metropolitan area (focusing on an area with a large CALD population). After further discussion with the project team and project advisory group (DH and ACAS representatives), it was agreed that the findings of the project are applicable to all ACAS’s (not just those located in metropolitan Melbourne) therefore, it was agreed that this component would be replaced by web-based resource materials, tip sheets, which were presented in draft form at the ACAS State Training Reference Group (TRG) in May 2011. In the TRG meeting it was agreed that a lesson plan, for use by ACAS Education Officers on the use of interpreters and culturally appropriate assessment of people from CALD backgrounds, would also be developed to support the web-based resources.

Web based resources

The final stage of the project is to make the information developed in this project available on the web for easy access by ACAS staff and other clinicians. It is proposed that the literature review, tip sheets with supporting material and this final project report will be available on the NARI website.
7) Conclusion

Key findings from the ACAS surveys, focus groups, and a literature review looking at translated assessment tools, informed the development of tip sheets and resource material to support the tip sheets. The tip sheets aim to address concerns related to the use of interpreters, assessing CALD clients and the appropriateness of the tools used to assess depression and dementia in CALD clients. It is proposed that these resources will be available from the NARI website for use by ACAS staff and other clinicians. They are also attached to this report.

The recommendations in this report supplement the National Tools Project recommendations. The findings from the report highlight the need for further research into appropriate assessment tools for CALD clients, particularly in the Australian setting.
8) References


ACAS current practice in assessing CALD clients for dementia and depression

The National Ageing Research Institute (NARI) has been engaged by the Victorian Government Department of Health to undertake a project which aims to: strengthen and improve the consistency of practice within ACAS in assessing clients from a Culturally and Linguistically Diverse (CALD) background with dementia and depression.

We are inviting you to complete the attached survey or pass it on to a relevant staff member or colleague in your organisation. The purpose of this survey is to identify ACAS current practice in assessing CALD clients for dementia and depression, identify assessment tools translated and validated for use in assessment of those from a CALD background with dementia living in Australia and assess the usefulness of these tools in the ACAS context.

Section One: Basic Information
1. Which ACAS do you work for? ________________________________________________

2. What is your role in the ACAS? ________________________________________________

3. How long have you worked in ACAS?
   - Less than 12 months
   - 1 – 5yrs
   - 6-10 yrs
   - 11+ yrs

4. What are the main languages other than English, spoken by your clients?
   __________________________________________________________________________
   __________________________________________________________________________

5. How do you know this (i.e. where do you get this information from)?
   - ACE
   - Clinical work
   - ABS
   - Local council
   - Interpreting service
   - Other (specify)____________________________________________________________________

6. Are you fluent bi/multilingual?
   - No (Go to Q9)
   - Yes (Answer Q7 and Q8)

7. What languages other than English, do you speak?
   __________________________________________________________________________
   __________________________________________________________________________

8. Do you only deal with clients from your language group?
   - No
   - Yes
   If yes what are the challenges and benefits of this?
   __________________________________________________________________________

9. Do you have any bi/multilingual colleagues?
   - No
   - Yes
10. What languages other than English, do your colleagues speak? 
________________________________________________________________________
________________________________________________________________________

11. When interviewing clients of CALD background, who assists you with communication? 
(Tick all that apply)

☐ Bi/multilingual colleagues    ☐ Interpreter (general)    ☐ Interpreter (medical)
☐ Family member                ☐ Other (specify) ________________________________

12. What are the challenges involved with using interpreter services? (Tick all that apply)

☐ Availability    ☐ Access    ☐ Quality of service    ☐ Cost
☐ Variability of service    ☐ Other (specify) ________________________________

Section Two: Knowledge and training
13. Have you had any specific training for working with clients from a CALD background with depression and/or dementia?

☐ No    ☐ Yes: describe_______________________________________________

14. Where do you access information on working with clients from a CALD background? 
(Tick all that apply)

☐ Colleagues    ☐ Internet    ☐ Ethno specific agencies
☐ I don’t    ☐ Other (specify) ________________________________

15. How confident do you feel about assessing clients of CALD background?

☐ Very confident    ☐ Somewhat confident    ☐ Somewhat unsure    ☐ Very unsure

16. How could your employer best meet your educational needs for assessing clients from a CALD background?

☐ Workplace training    ☐ Online learning    ☐ Guidelines
☐ Other (specify) ________________________________

Section Three: Guidelines
17. Are you aware of any guidelines for working with clients from a CALD background?

☐ General guidelines (specify) ________________________________
☐ Dementia specific (specify) ________________________________
☐ Depression specific (specify) ________________________________
18. If yes, do you use these guidelines in your work?
☐ No ☐ Yes (specify) __________________________________________

19. What are the main challenges to working effectively with clients from a CALD background? (Tick all that apply)
☐ Language ☐ Cultural factors ☐ Access to interpreters
☐ Translated resources ☐ Other (specify) ____________________________

Section Four: Assessment Tools
For the following tools please indicate if you always use them in assessing clients of CALD background, if you sometimes use them or if you never use the tool. Please indicate if you also use a translated version of the tool.

<table>
<thead>
<tr>
<th>Cognitive screening tools</th>
<th>Always</th>
<th>Sometimes</th>
<th>Never</th>
<th>Translated version</th>
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<tbody>
<tr>
<td>Standardized Mini Mental State Examination (SMMSE)</td>
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<td>Mini-Mental State Examination (MMSE)</td>
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<td>Abbreviated Mental Test Score (AMTS)</td>
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<td>Psychogeriatric Assessment Scales – Cognitive Impairment Scale</td>
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<td>Kimberley Indigenous Cognitive Assessment (KICA)</td>
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<td>Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)</td>
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<td>Rowland Universal Dementia Assessment Scale (RUDAS)</td>
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<td>The Montreal Cognitive Assessment (MOCA)</td>
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<td>The clock test</td>
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<td>Frontal Assessment Battery (FAB)</td>
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### Comprehensive Dementia tools

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<td>Cambridge Mental Disorders of the Elderly Examination (CAMDEX)</td>
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<td>Hierarchic Dementia Scale (HDS)</td>
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<td>Alzheimer’s Disease Assessment Scale (ADAS)</td>
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<td>Neuropsychiatry Unit Cognitive Assessment Tool (NUCOG)</td>
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### Depression assessment tools

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<tr>
<td>Geriatric Depression Scale (GDS)</td>
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<td>Brief Mental Health Inventory (BMHI)</td>
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<td>Cornell Scale for Depression (CSDD)</td>
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<td>Beck Depression Inventory</td>
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<td>Center for Epidemiological Studies Depression Scale (CES-D)</td>
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<td>Zung Self-Rating Depression Scale (Zung SDS)</td>
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<td>Preliminary Depression Scale</td>
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### Section Six: Other comments

Do you have any other comments on current practice in assessing CALD clients for dementia and depression?

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**Thank you very much** for completing this survey. Your time and effort are greatly appreciated. Please return the completed survey to k.ledgerwood@nari.unimelb.edu.au or fax it to 03 9387 4030 by Monday 25th October.
**Attachment 2): The Tip Sheets and Tools**

The tips sheets cover the following areas and can be accessed via Attachment 3-8:

- **Tip Sheet 1 - Assessment and People from Culturally and Linguistically Diverse (CALD) Backgrounds**
- **Tip Sheet 2 - Working with Interpreters**
- **Tip Sheet 3 - Cognitive assessment and people from CALD background**
- **Tip Sheet 4 - The CDT**
- **Tip Sheet 5 - The IQCODE (Short Form)**
- **Tip Sheet 6 - The GDS-15**

Some of the tools recommended in these tip sheets have copyright requirements and have also been obtained or are available in other languages as follows:

1. **The Standardised Mini Mental State Examination (SMMSE)**

   The SMMSE can be accessed via the following web link below:


   Permission to use/reproduce the SMMSE and acquire a copy of the guidelines can be obtained by contacting Dr D William Molloy (Published by New Grange Press).

   There are no formal translations known of the SMMSE, however the MMSE has similar questions to the SMMSE. The MMSE and its translations are copyrighted by Psychological Assessment Resources (PAR) and can be purchased at [www.parinc.com/](http://www.parinc.com/)

2. **Rowland Universal Dementia Assessment Scale (RUDAS)**

   The RUDAS can be accessed via the following web link at no cost:


   This website also contains translated versions of the tool in Chinese and Italian.

3. **The Clock Test (CDT)**

   This tool is appropriate in multiethnic populations due to the ‘universal’ nature of the clock. However, an appropriate CDT score system needs to be determined for the Australian setting. It is advised to use an interpreter when assessing people from CALD backgrounds.
4. Geriatric Depression Scale (GDS)

The GDS can be accessed at the following link at no cost:

http://www.stanford.edu/~yesavage/GDS.html

Although there are a number of translated (written) versions of the GDS on the above website, many have not been verified or validated in Australia. In the tip sheet, there is an Arabic, Greek and Italian version provided; the authors have provided permission for their inclusion on this webpage.

5. Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

The IQCODE can be accessed at the following link at no cost:

http://ageing.anu.edu.au/Iqcode/

Although there are a number of translated (written) versions of the IQCODE on the above website, many have not been verified or validated in Australia. In the tip sheet, there is a copy of the Chinese version of the IQCODE; the authors have provided permission for its inclusion on this webpage.
Attachment 3) Tip Sheet 1 - Assessment and People from Culturally and Linguistically Diverse (CALD) Backgrounds

Tip Sheet 1 - Assessment and People from Culturally and Linguistically Diverse (CALD) Backgrounds

Assessment
Assessment is a broad term that applies to the collection of information that allows for the identification of risks and diagnoses. A comprehensive assessment integrates details on all relevant issues, including function and medical history of an individual. Comprehensive assessments take a multidimensional, interdisciplinary approach to understanding a client and their family and carer’s needs (Department of Health Victoria, 2010).

For many older people, an ACAS professional is the first step to an official diagnosis of dementia or other aged care conditions, and entry into the service system. The use of standardised and validated assessment tools allow assessors to evaluate client abilities and help identify which services best meet their needs.

Person centred care and assessment
At all times during assessment, it is essential that a person-centred approach is used (The Best care for older people everywhere: the toolkit Department of Health Victoria, 2010). Person centred care is important for all assessments, not just those with people from a CALD background.

Person centred care is also known as:
- Client-centred care
- Client-focused practice
- Patient-centred care
- Person-centred health care
- Person-centred practice.

Person centred care involves a “collaborative and respectful partnership” where “the service provider respects the contribution the service user can make to their own health, such as their values, goals, past experience, and knowledge of their own health needs, and the service user respects the contribution the service provider can make, including their professional expertise and knowledge, information about the options available to the service user, and their values and experience” (Dow et al., 2006, pg. 1).

Person Centred Care involves:
- Getting to know the client
- Empowering the client by allowing them to make decisions which will affect their life and sharing power and responsibility over these decisions.
- Providing accessible and flexible services which respond to the changing needs of clients.
- Coordinating and integrating service provision to maximise outcomes.
- Providing an environment that is conducive to person-centred care when assessing clients (Dow et al., 2006).
Communication

A key aspect of effective assessment is communication.

Good communication involves:

- Using positive communication, for example active listening and allowing clients the time to express their needs.
- Reducing negative expectations by assuming capacity rather than incapacity.
- Trying to learn a few basic words in the language of your CALD clients.
- Checking your understanding of what the client has said.

(Tinney, 2006)

Good Practice/CALD clients

During all assessments – consider the following:

- Respect older people.
- Take a positive approach to care and promoting the client’s strengths.
- Help to maintain independence, if the client desires it.
- Ensure there are no distractions (e.g. avoid unnecessary noise, heat or glare).
- Help to maintain client privacy.
- Always use a qualified interpreter to conduct a cognitive assessment. However, consider client and family wishes if there is a preference not to use an interpreter.
- Consider referring clients to bilingual clinicians/services who speak the client’s language.
- Use culturally appropriate assessment tools (refer to Tip Sheet 3).
- Source information and advice from ethnic specific organizations.
- Be informed and seek advice and training in assessing people from different backgrounds.
- Provide written information in the client’s main language (sheets on depression and dementia can be found in a variety of languages from Alzheimer’s Australia www.alzheimers.org.au/ and beyondblue www.beyondblue.org.au/ websites).

Cognitive Assessment

Consider the following when undertaking a cognitive assessment:

- Scores in screening tools may not accurately reflect cognitive functioning. Age, language, culture and education can influence scores (See Tip sheets 3, 4, 5).
- Observation and clinical judgement are important when interpreting the scores. This is especially true for people of a CALD background due to cultural biases in assessment tools that have been primarily developed in Western countries and cut off scores that may not have been adequately validated in multicultural samples in an Australian setting.
- Record answers to questions rather than just if the answer was correct or not.
- Score with and without extra time or prompts.
- Examine where points have been lost and consider potential biases in these questions.
- Use multiple assessment tools to determine cognitive functioning (e.g.
functional and cognitive tools), supplemented by informant information).

- Record on the tool if it was interpreted informally (on the spot or without a physically translated tool) by an interpreter as each interpreter may interpret (say) a question slightly differently to another interpreter.
- Seek advice from bi-lingual colleagues or bi-lingual staff from organisations that specialise in working with people from CALD backgrounds.

(Source - refer to reference list below).

Things to be aware of

- It may take more time to complete cognitive assessments with people from a CALD background.
- Be aware of limitations of screening tools for people of CALD backgrounds.
- In some cultures there is stigma around dementia and depression; this can lead to uncomfortableness or unwillingness to discuss some topics. Be aware of this and be sensitive when discussing issues that may have cultural significance to your client.
- The RUDAS is the cognitive assessment tool recommended to use when assessing clients from CALD backgrounds (see Tip sheet 3). This tool has been developed to be “culture fair” and easily translated into other languages, and has been validated in multicultural samples in Australia.

Tips for bilingual assessors

- If you are not completely fluent in all the medical terms required for an assessment, you must use an interpreter.
- It may be appropriate for you to interpret basic information for clients if an interpreter cannot be accessed immediately.
- Consider becoming accredited with NAATI. For staff classified under the Victoria Public Service (VPS) you may be entitled to the VPS Language Allowance.
- Only interpret when you feel comfortable doing so.

Further Resources and References

Services

- beyondblue: www.beyondblue.org.au/
- Victorian Transcultural Psychiatry Unit: http://www.vtpu.org.au
  Usefull webpage for resources, programs, research and links. This page also contains a directory of bilingual mental health professionals.
- Centre for Culture, Diversity and Ageing: http://www.culturaldiversity.com.au
- Centre for Culture, Ethnicity and Health: http://www.ceh.org.au/
  81-85 Barry Street, Carlton VIC 3053
  Ph: +61 3 9342 9700; Fax: +61 3 9342 9799
  Email: enquiries@ceh.org.au
- Migrant Resource Centre (South Eastern Region): http://www.sermrc.org.au/
  Dandenong Office
  Level 1, 314 Thomas Street
  Dandenong 3175
  Ph: (03) 9706 8933; F: (03) 9706 8830
  E: sermrc@sermrc.org.au


St George’s Hospital, (2010). ‘Guidelines for interpreters in the cognitive, dementia and memory service at the St George’s Hospital campus of St Vincent’s (CDAMS)’. Interpreter Services, St George’s Hospital, Victoria.


Attachment 4) Tip Sheet 2 – Working with Interpreters

Tip Sheet 2 - Working with Interpreters

Introduction
When working with people from culturally and linguistically diverse (CALD) backgrounds, you may need to use an interpreter. Below are some tips for getting the most out of your assessment when working with interpreters.

Booking an interpreter
- Confirm if there is a specific language or dialect required with the client (this might include asking what region of a country a client is from) to avoid miscommunication.
- Consider religious, cultural or political issues and any gender preferences of the client.
- Request a Level 3 Professional Interpreter (preferably with mental health experience for dementia assessments) who is NAATTI accredited.

Access to interpreters
- If you live in a rural area, you may choose to book an interpreter for a day and undertake all assessments of that language group on the same day.
- For a preliminary assessment, consider using a telephone interpreter if an interpreter is not available to come out.

How to work with an interpreter
- Brief the interpreter before the session with the client. Identify what you would like to get out of the session and talk about culturally relevant issues that might arise. Mode of interpreting and seating position may also be discussed here.
- Clarify terms that will be used during the assessment such as dementia and depression with the interpreter.
- De-brief the interpreter after the session; discuss any issues that arose and how they might be dealt with in future.
- Explain the role of the interpreter to the client.
- Make sure the client is aware that the assessment is completely confidential and that the interpreter must also maintain confidentiality.
- Direct conversation towards the client, not the interpreter.
- Use non-technical language.
- Use short sentences and allow time for the interpreter to relay what you have just said.
- At the end of the assessment summarise the key points.
- Make sure the client is clear on any issues that need following up.

(Source: refer reference list below).
Things to be aware of

- Allow additional time for assessments.
- Do not use family members to interpret. They may have a conflict of interest. Family members are also not bound by the same confidentiality codes as a professional interpreter. Family members have an important role in supporting and advocating for the client.
- There is not always a direct translation from English into another language; concepts as well as words may need to be explained.
- Check client’s literacy and hearing; make sure client’s use hearing aids if required.
- Use a translated tool if available.

Do not leave the interpreter alone with the client. This is for safety and to help interpreters remain impartial.

What do I do if a client refuses an interpreter?

Using interpreters allows family members to fulfil their role as ‘family’ by providing support or information as required instead of thinking about interpreting concepts and giving themselves time to think about their own questions.

Clients have the right to refuse an interpreter, try to explain the benefits of an interpreter, but you must accept their final decision. Please note the decision in the case notes.

Reluctance to use an interpreter may be due to stigma surrounding various medical conditions or knowing the interpreter (particularly in small communities).

- Suggest using a telephone interpreter if the client is from a small community and has concerns about confidentiality.
- You might also suggest that the interpreter is as much for your benefit as the client and will ensure you understand all the issues for the client.
Further Information and References

Services
Australian Institute of Interpreters and Translators (AUSIT)
www.ausit.org

National Accreditation Authority for Translators and Interpreters (NAATI):
www.naati.com.au

Translating and Interpreting Service (telephone interpreting)
www.intnsi.gov.au/hts

Victorian Transcultural Psychiatry Unit:

References


- Translating and Interpreting Service. *Working with interpreters: Guidelines for staff providing services to people who require assistance in English*. ACT Office of Multicultural Affairs, ACT.


  http://www.alzheimers.org.au/commo

- St George's Hospital. (2010). "Guidelines for interpreters in the cognitive, dementia and memory service at the St George’s Hospital campus of St Vincent's (CDAMS)". Interpreter Services, St George's Hospital, Victoria.


Tip Sheet 3 - Cognitive assessment and people from Culturally and Linguistically Diverse (CALD) background

Cognitive assessments help determine the cognitive ability of an individual. A cognitive assessment should include assessment of function using standardised and validated assessment tools and information gathered from family or informant.

There are a range of cognitive assessment tools that have been developed. The RUDAS is a cognitive assessment tool which has been validated for use with people from CALD backgrounds and is the tool recommended by the 2010 Expert Clinical Reference Group (ECRG) (Sansoni et al., 2010) for use by ACAS staff.

Training: The RUDAS requires administrator’s to be trained in its use. An easy to access DVD (and guidelines) is available on the Alzheimer’s Australia website:


The RUDAS consists of a series of questions aimed at assessing memory, visuospatial orientation, praxs, visuoconstructual drawing, memory recall and language.

Cut off score: 22 or less (lower scores indicate greater impairment), 23-30 considered normal, and needs to be considered in the clinical context.

SMMSE

The Standardized Mini Mental State Examination (SMMSE) was the tool recommended for use with non-CALD clients by the 2010 Expert Clinical Reference Group (Sansoni et al., 2010). However, ACAS staff may wish to use the SMMSE to supplement the RUDAS with some CALD clients. Care should be taken when interpreting the SMMSE scores when used with people from CALD backgrounds.

What is the SMMSE? The SMMSE is an adaptation of the Mini Mental State Examination (MMSE). The MMSE is a cognitive screening tool that has commonly been reported to have cultural and educational biases (Basic et al. 2009; Rowland et al. 2006). The SMMSE was developed by Molloy and Standish in 2007.

The Assessment of Older People with Dementia and Depression of CALD Background: A review of current practice and the development of guidelines for Victorian AGS (undertaken by NARI, 2011). Funds for this project were provided by the Council of Australian Governments (COAG) as part of the COAG initiative to strengthen and improve the Aged Care Assessment Program (ACAP). The ACAP is an initiative of the Australian Government and is jointly funded by the Australian Government and the Government of Victoria.
to provide a systematic approach to the administration of the MMSE.

Benefits of the SMMSE: The SMMSE has detailed instructions with time limits on questions and takes approximately 10 minutes to administer.

Cut off score: Lower scores indicate greater impairment [range: 0-30]

Scoring guidelines for assessing cognitive impairment (Vertesi, Lever, & Molloy, 2001)

30 – No impairment;
26 – 30 – Considered normal;
20 – 25 = Mild;
10 – 19 = Moderate;
0 – 9 = Severe.

Things to be aware of

RUDAS:
Although the RUDAS has consistently been found to be free of cultural and educational bias in multicultural samples in Australia, one study in South India did find education impacted on the RUDAS score. Sansoni et al (2007) suggest that question 5 (judgement - traffic lights and busy street) may reflect a degree of acculturation to dominant Western and urban based cultures.

SMMSE
Questions most commonly modified in overseas studies to make the MMSE more culturally and linguistically relevant or relevant to those less educated include:

Culture:
• Repeating “no ifs, ands or buts” (replaced with a more common phrase/tongue twister).
• Orientation to time and place (replaced with regional names of places or terminology and accepting traditional calendar systems responses; and season removed or replaced with time of day).
• Accepting regional language differences in responses.

Education:
• Spelling word backward (replaced with days of the week backwards).
• Counting backward by 7s (replaced with a subtraction task).
• Writing a sentence (replaced with tell me something about...).

Translated Tools

RUDAS
The RUDAS seems likely to have less cultural and educational bias so it is easily interpreted by an interpreter during an assessment. Some translated (written) versions are available but are not validated.

SMMSE
There are no formal translations known of the SMMSE, however the MMSE has similar questions to the SMMSE. The MMSE and its translations are copyrighted by Psychological Assessment Resources (PAR) and can be purchased online www.parnic.com/.

Some studies which have translated the MMSE and provided psychometric properties are listed in the references below.
Further Resources and References

Cognitive Assessment
Victorian Transcultural Psychiatry Unit: www.vtpu.org.au/

References

RUDAS

The RUDAS can also be found on the Dementia Collaborative Research Centre website: http://www.dementia-assessment.com.au/measures.html

RUDAS References

SMME
International Psychogeriatric Association
This website contains administration guidelines and a copy of the SMME:
http://www.ipa-online.org/ıpaprograms/guidetoaddiagnos.aspx

Permission to use/reproduce the SMMSE and obtain a copy of the guidelines can be obtained by contacting Dr D William Molloy (Published by New Grange Press).

Psychological Assessment Resources (PAR):
To order copies of the MMSE and the various translations visit the following website: www.parinc.com/

SMME/MMSE References


• **Arabic MMSE:** Wrobel, N.H., & Farrag, M.F. (2004). Identification of dementia and mental health symptoms in an elderly Arab American sample: Final report. Wayne County Senior Citizens Services. Detroit. (Various tools, including the MMSE are included in Arabic as an appendix - education based cut off scores)

Attachment 6) Tip Sheet 4 – The Clock Drawing Test (CDT)

Tip Sheet 4 – The Clock Drawing Test (CDT)

What is the CDT? The Clock Drawing Test (CDT) is a measure of dementia severity. There are variations in the administration of the test including using a pre-drawn circle and a clock copying task. This tip sheet refers to the free drawn test where the client is presented with a blank piece of paper. Clients are asked to draw a clock face and mark in the hours and then draw in the hands to indicate a particular time (for example quarter to two – see below). Ten past eleven, or ten to two. The CDT assesses frontal and temporo-parietal functioning.

Benefits of the CDT: The way a client draws a clock face can provide an assessor with insight into the severity of dementia and it only takes two minutes to administer. It is also appropriate in multicultural populations due to the ‘universal’ nature of the clock.

The CDT can complement other screening tests, especially those which do not include an item to assess frontal lobe impairment.

Things to be aware of

A valid scoring method in a multicultural Australian population has not been demonstrated with the CDT. The one study in Australia using a multicultural sample demonstrated low specificity using five different scoring methods: between 42%–84% of cognitively intact people were incorrectly classified as having dementia.

The CDT could be used to supplement the recommended tools. Educational attainment can influence this test, so be aware when interpreting scores.

Consider physical impairment including any issues with muscles in the hand/arm or vision.

Remove/cover any clocks in the room and be aware if participants have a wrist watch on during this test.

It is advised to use an interpreter when assessing people from CALD backgrounds.

Scoring

There are a number of scoring systems used in the literature but no one scoring system shows superior predictive validity. The main aspects to consider are

(i) correct spacing with even spaces between numbers and correct placement of 12, 3, 6, and 9, and

(ii) correct placement of hands (e.g., 10 past 11)

(Brodsky et al. 2002). Much is gained by observation of the task, and scoring is descriptive.
Another more complicated scoring system is described if required:

- Sunderland et al. 1989 A PRIORI criteria for evaluating clock drawings. Cut off score = 5 or less indicates impairment.

10 - 6. Drawing of clock face with number and circle generally intact
10. Hands in correct position (i.e. Hours hand approaching 3 o’clock)
8. More noticeable errors in placement of hour and minute hands.
7. Placement of hands is significantly off course.
6. Inappropriate use of clock hands (i.e. use of digital display or circling numbers despite repeated instructions).
5 - 1. Drawing of clock face with circle and numbers is NOT intact
5. Crowding of numbers at one end of the clock or reversal of numbers. Hands may still be present in some fashion.
4. Further distortion of number sequence. Integrity of clock face is now gone (i.e. numbers missing or placed outside of boundaries of the clock face).
3. Numbers and clock face no longer obviously connected in the clock drawing. Hands are not present.
2. Drawing reveals some evidence of instructions being received but only vague representation of a clock.
1. Either no attempt or an uninterpretable effort is made.

Further Resources and References


Attachment 7) Tip Sheet 5 – The IQCODE (Short Form)

Tip Sheet 5 – The IQCODE (Short Form)

What is the IQCODE: Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) is a tool used to assess cognitive impairment in older people.

The tool requires an informant to rate cognitive change over time on a 5 point likert scale.

The IQCODE was developed by Jorm and Jacomb in 1988 and consisted of 25 questions; in 1994 a 16 item short version of the IQCODE was developed by Professor Anthony Jorm.

Information in this tip sheet will focus on the short version on this tool as it is quicker to administer, and therefore more practical to use during an ACAS assessment. It has also been recommended by the 2010 Expert Clinical Reference Group (ECRG) (Sansoni et al., 2010) at a national level.

The IQCODE should be used to supplement the other patient administered tools (e.g. the SMIMSE, to increase sensitivity and specificity (Flicker et al., 1997; Flicker, 2010), or used in situations where the patient is unable to complete the assessment.

Benefits of the IQCODE: The IQCODE takes approximately 10-15 minutes to administer and is filled out by an informant. It can be used for people with lower levels of education and for those who are illiterate.

Cut-off score: The cut-off scores are based on the total score divided by the number of questions (average item score range 1-5). Higher scores indicate greater impairment. A score below 3.00 indicates improvement, 3.00 indicates no change, 3.01 – 3.50 indicate slight decline; 3.51 - 4.00 indicates moderate decline; and 4.01 – 5.00 indicate severe decline.

Translated Tools

Translated versions of the IQCODE (both short and long forms) can be found at the website listed below (please note that the tools on this site may not have been validated).

http://ageing.anu.edu.au/iqcode/

In addition to these tools the following versions of the tool are also available:


Further Resources and References

The web page listed below provides copies of the tool in short and long form in various languages (including English) and information on how to score the tool.

http://ageing.anu.edu.au/iqcode/
References


IQCODE in Chinese

(1995). The Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) as a screening tool

Jorms & Korten 問卷 (IQCODE)

姓 名：
受訪者：

請大聲地讀給受訪者聽:

我希望您能記起先生(太太)十年前的情形，來和他現在的情形相比較。十年前是指民國 年，總共認識有 年。

首先，我要請教您先生(太太)記憶力方面的情形，包括他對現在的日常生活和以前所發生的事情的記憶力。請記住，我們主要是比較先生(太太)現在和他十年前的情況。所以，假如他在十年前就常常忘記東西放在那裏，而現在仍然如此，就請您回答“沒什麼變化”。

和十年前相比較，
先生(太太)現在：

<table>
<thead>
<tr>
<th></th>
<th>好多了</th>
<th>好一點</th>
<th>變化</th>
<th>差一點</th>
<th>差多了</th>
<th>不知道</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 認得出家人和朋友的面貌</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>2. 記得家人和朋友的名字</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>3. 記得家人和朋友的職業、生日、住址</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>4. 記得最近發生的事情</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>5. 記得幾天前發生的事情</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>6. 記得幾天前發生的事情</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>7. 記得住址和電話</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>8. 記得今天是星期幾，是幾月份</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>9. 記得東西放在什麼地方</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>10. 西西找得到東西</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

The Assessment of Older People with dementia and depression of CSCI Background: A review of current practice and the development of guidelines for Victorian AGS (undertaken by WAP, 2011). Funds for this project were provided by the Council of Australian governments (COAG) as part of the COAG initiative to strengthen and improve the Aged Care Assessment Program (ACAP). The ACAP is an initiative of the Australian Government and is jointly funded by the Australian Government and the Government of Victoria.
和十年前相比较,

<table>
<thead>
<tr>
<th>先生(太太)現在:</th>
<th>好多了/好一點</th>
<th>變化</th>
<th>差一點</th>
<th>差多了</th>
<th>不知道</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. 肢體在日常生活上的一些改變</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. 使用家常用具的能力 (如電視機, 燈泡等)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. 會學習使用新的家常用具</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. 會學習東西的能力</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. 電話使用及重疊語言</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. 電話使用上所學到的一些東西</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. 會一些不常用的字</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. 做報紙登載的文章</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. 達到書上所讀的書的知識</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. 寫信參議的能力</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. 知道一些重要的歷史事件</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22. 對日常生活事務自己會做決定</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23. 會使用設置東西</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24. 處理財務的能力 (如退休金,動銀行)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25. 處理日常生活上的數字問題如:知道要花多少食物;知道朋友或家人上一次來訪後已經有多久了</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>26. 了解发生了什麼事，並能想出適當的處理方式</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

總分：________________

Attachment 8) Tip Sheet 6 – The Geriatric Depression Scale (GDS) - 15

Tip Sheet 6 – The Geriatric Depression Scale (GDS)-15

What is the GDS: The Geriatric Depression Scale (GDS) (15 point version) is a depression assessment tool specifically designed for older people. This short form of the GDS was developed in 1986 by Sheikh and Yesavage. There are four ‘trigger’ questions that often alert a practitioner to complete the 15-item GDS. They are:

1. Are you basically satisfied with your life? Yes/No
2. Do you feel that your life is empty? YES/No
3. Are you afraid that something bad is going to happen to you? YES/No
4. Do you feel happy most of the time? Yes/No

The 15 score item should be completed whenever possible.

Benefits of the GDS: The GDS can be filled out by the client or administered by an interviewer. It comprises of 15 questions about how the client has felt over the past week. Questions require yes/no answers.

While this tool is commonly used with people who have dementia, most studies investigating the GDS have excluded participants with dementia. Alternatively, the Cornell Scale for Depression (Alexopoulos, et al., 1988) has been recommended for use with people in residential care (Sansoni et al., 2007), however training is required to use it.

Cut off: Higher scores indicate more depressive symptoms are present. A score of 6 or more suggests the presence of depression which indicates further medical/psychiatric assessment is required. A score of 11 or more usually always indicates depression with higher scores indicating more severe depression.

Things to be aware of:

It has been reported that a number of items in the GDS contain Western value judgments of optimism, happiness, stoicism and looking forward (Sansoni et al., 2007). These include:

- Do you prefer to stay at home, rather than going out and doing new things?
- Do you think it is wonderful to be alive now?
- Do you worry a lot about the past?
- Do you think that most people are better off than you are?

These items may not be appropriate at all times for all cultural groups. Also, it is important to note that clients from some cultural groups may not disclose such information.

Translated Tools:

Although there are a number of translated (written) versions of the GDS many have not been verified or validated in Australia. You may choose to use the English version of this tool with an interpreter or ask an interpreter to follow a translated version of the tool. Translated tools referred to in the literature with evidence of psychometric properties include:

Greek: GDS-15: Fountoulakis et al. (1999 – see below) using a cut off of 5/7.


Further Resources and References

The following web page contains copies of the tool, information on scoring and unverified translations of the tool:

http://www.stanford.edu/~yesavage/GDS.html

The GDS can also be found on the Dementia Collaborative Research Centre website:


References

GDS

من فضلك ضع دائرة حول أفضل إجابة تصف كيف تشعر خلال الأسبوع الماضي.

1) هل أنت راضٍ عن حيفك أساسًا؟
2) هل تتخلت عن كثير من أنشطتك واهتماماتك؟
3) هل تشعر بأن حياتك اليومية قاربت؟
4) هل كابرًا ما تشعر بالملل؟
5) هل تشعر بالألم نحو المستقبل؟
6) هل يضايقك التفكير في أمور لا تستطيع التخلص منها؟
7) هل أنت في روح معينة طيلة هذه الأيام؟
8) هل أنت حافز أن تنسي بسرعة ما يحدث لك؟
9) هل تشعر بالسعادة معًا؟
10) هل تشعر بالغضب معًا؟
11) هل كثير ما تشعر بالطهور وتنتبه كثير؟
12) هل تتغذى الأهم في البداية على الخروج وعمل أشياء جديدة؟
13) هل أنت ما تقلق حول المستقبل؟
14) هل تشعر بأن أدائك، مشاكليات في الذكاء أكثر من معظم الناس؟
15) هل تعتقد أن شيء رأت أن تكون حيا الآن؟
16) هل كثيرا ما تشعر بالإحباط والحزن؟
17) هل أنت ما تشعر بأنه لا قيمة لك حاليا؟
18) هل تتلقى كثيرا حول الماضي؟
19) هل تجد الحياة مشروعة إذا؟
20) هل من الصعب عليك أن تبدأ مشروبات جديدة؟
21) هل تشعر بذلك مثل الآخرين؟
22) هل تشعر بأن معرفتك ببعض الأشياء تتأثر؟
23) هل تشعر بأن معظم الناس أحسن حالًا مثلك؟
24) هل كثيرا ما تشعر بالإحباط والحزن؟
25) هل كثيرا ما تشعر بالقلق على وفتك الفكاهة؟
26) هل ألقاك جسدي في التركيز؟
27) هل تستمتع بالإستمتاع في الزمان؟
28) هل تفضل تجنب الاتصالات الاجتماعية؟
29) هل من المهم عليك التخلص من الأفكار؟
30) هل عناق نفس الوضوح الذي تعودت عليه؟
**Sds in Italian**


---

**Geriatric Depression Scale – M**

(Seguin & Deponte, Arch. Geront. Geriat., 2007)

<table>
<thead>
<tr>
<th>EBA</th>
<th>Scheda</th>
<th>Sesso</th>
<th>Data</th>
</tr>
</thead>
</table>

Scegliere la risposta in base a come vi sentite nei corsi dell’ultima settimana.

1. E stato attorno vuoto il soggiorno che conti?  
   - Sì  
   - No

2. Ha abbandonato molte delle cose che faceva?  
   - Sì  
   - No

3. La giornata in seduta?  
   - Sì  
   - No

4. Si sente annoiato?  
   - Sì  
   - No

5. Si attarda verso il futuro?  
   - Sì  
   - No

6. E’ intollerante ai problemi che non riesce a controllare?  
   - Sì  
   - No

7. E’ di buon umore per la maggior parte del tempo?  
   - Sì  
   - No

8. La passa che qualitative di livello alta per accadere?  
   - Sì  
   - No

9. Si sente annoiato per la maggior parte del tempo?  
   - Sì  
   - No

10. Si sente spesso indebolito?  
    - Sì  
    - No

11. Si sente spesso trauillato o agitato?  
    - Sì  
    - No

12. Si sente inatteso nella sua situazione?  
    - Sì  
    - No

13. Si sente inatteso nel suo stato?  
    - Sì  
    - No

14. Si sente inatteso nel suo stato?  
    - Sì  
    - No

15. Si sente inatteso nel suo stato?  
    - Sì  
    - No

16. Si sente inatteso nel suo stato?  
    - Sì  
    - No

17. Si sente inatteso nel suo stato?  
    - Sì  
    - No

18. Si sente inatteso nel suo stato?  
    - Sì  
    - No

19. Si sente inatteso nel suo stato?  
    - Sì  
    - No

20. Si sente inatteso nel suo stato?  
    - Sì  
    - No

21. Si sente inatteso nel suo stato?  
    - Sì  
    - No

22. Si sente inatteso nel suo stato?  
    - Sì  
    - No

23. Si sente inatteso nel suo stato?  
    - Sì  
    - No

24. Si sente inatteso nel suo stato?  
    - Sì  
    - No

25. Si sente inatteso nel suo stato?  
    - Sì  
    - No

26. Si sente inatteso nel suo stato?  
    - Sì  
    - No

27. Si sente inatteso nel suo stato?  
    - Sì  
    - No

28. Si sente inatteso nel suo stato?  
    - Sì  
    - No

29. Si sente inatteso nel suo stato?  
    - Sì  
    - No

30. Si sente inatteso nel suo stato?  
    - Sì  
    - No

**Punteggio Totale:**

---

*The Assessment of Older People with dementia and depression of OAD's Background: A review of current practice and the development of guidelines for Victorian AGA (undertaken by INP, 2011). Funds for this project were provided by the Council of Australian Governments (COAG) as part of the AGA initiative to strengthen and improve the Aged Care Assessment Program (ACAP). The ACAP is an initiative of the Australian Government and is jointly funded by the Australian Government and the Government of Victoria.*

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44
GDS in Greek


Web address for tool: [http://www.stanford.edu/~yesavage/GDS-Greek.html](http://www.stanford.edu/~yesavage/GDS-Greek.html)

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Are you basically satisfied with your life?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Have you dropped many of your activities and interests?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Do you feel that your life is empty?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>Are you often bored?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>Are you in good spirits most of the time?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>Are you afraid that something bad is going to happen to you?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Do you feel happy most of the time?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>Do you often feel helpless?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>Do you prefer to stay at home rather than go out and do new things?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>Do you feel you have more problems with your memory than most?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>Do you think it is wonderful to be alive now?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>12</td>
<td>Do you feel pretty worthless the way you are now?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>Do you feel full of energy?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td>Do you feel that your situation is hopeless?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>15</td>
<td>Do you think that most people are better than you are?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Πιστεύετε ότι είναι υπέροχο πράγμα που είστε ζωντανός τώρα;</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Αισθάνομαι όχι όμως είστε τέμπος;</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Αισθάνομαι γεμάτος ενέργεια;</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Αισθάνομαι ότι η κατάστασή μου είναι απελπιστική;</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Πιστεύετε ότι οι περισσότεροι ένθραπτοι είναι σε καλύτερη κατάσταση από εσάς;</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>