March 11, 2010 NAPSA-NCPEA Research to Practice Webinar
Dr. Jason Schillerstrom
Attendee Questions & Answers
March 11, 2010

The following questions were asked by attendees during the NAPSA-NCPEA Research to Practice Webinar presented by Dr. Schillerstrom on 3/31/10. Dr. Schillerstrom's responses are provided below:

Q: Can he share more about Exploitation comparison. What does this mean? I'm not sure I understand the graph. Thanks.

A: One of our hypotheses was that APS clients investigated for self-neglect would have worse cognitive performance than clients referred for other reasons (primarily exploitation). We found this hypothesis to be true. Subjects investigated for self-neglect had worse MMSE, EXIT25, CLOX1, and CLOX2 performance. The figure in the presentation shows the mean distribution of EXIT25 and CLOX1 scores for both self-neglectors and non-self-neglectors (primarily financial exploitation). This should not be interpreted that the financial exploitation is normal. They too had poor performance – just not as poor as those with self-neglect as a component of the referral.

Q: What are his thoughts about APS field reps doing the clock test? Should it only be used by health care professions?

A: I am a strong proponent of APS field specialists using valid and reliable cognitive screening instruments to inform their investigations and intervention plans. However, it is important to remember that the results need to be considered within the context of the entire encounter.

Q: If older adults ask for feedback about their clock, what is the best way to respond if it's a clear miss?

A: It is always best to be honest with clients. If they perform poorly, the right thing to do is to state that they scored below the cut-point suggesting that their problem solving abilities may not be as efficient as they once were. It is rare that clients with executive impairments ask for feedback and those that do usually agree that their thinking is not as efficient as it once was.

Q: Do you find that people do poorly on CLOX1 because the instructions are rather vague but then do well on CLOX22 because they are copying the caseworker?

A: CLOX1 is an executive function task that is sensitive to frontal lobe brain regions. CLOX2 is a visuospatial task sensitive to poster parietal regions. We always expect people will do better on CLOX2 than CLOX1 (hence the higher scoring bar for CLOX2). Clinically, CLOX1 and 2 performances assists with guiding the differential diagnosis. Subjects with Alzheimer's disease tend to fail both tasks because they have pan-cortical impairments. Subjects with vascular dementia, Parkinson's disease, and dementia secondary to vitamin or metabolic disturbances will fail CLOX1 but pass CLOX2 because they have isolated frontal systems impairment.

Q: Could it be clarified regarding whether a point is assigned if the client copies the outline of the circular clock face onto the area that bleeds through on back of the sheet?

A: The client misses the last point on the scoring system if they draw any part of their clock on the circle that "bleeds" through the page.

Q: For those clients who do refuse to participate with the testing, do you still render a conclusion/determination of capacity? If so, what are the subjective means to evaluate a noncompliant client??

A: Yes – provided they are willing to consent to the interview and the interview yields enough information to inform a clinical opinion. Neuropsychological testing informs the clinical interview, it does not replace it. Subjective considerations for decisional capacity include assessing the client's understanding of the concerns, their reasoning abilities, their ability to voice understanding of the risks of their situation, their ability to consider alternative solutions, and their overall ability to reason effectively.

Q: Is the doctor consulting on cases for potential court cases, or are the APIs in Texas routinely considered as experts in Court for capacity cases and can utilize the screening results as additional support of their opinion?

A: When APS workers in Texas suspect that the reason a client is suffering from neglect, exploitation, or abuse is because of decisional incapacity, the APS workers can request a decision making capacity assessment by a professional (physician, psychologist, neuropsychologist, nurse practitioner, licensed masters level social worker). These assessments then inform APS's decision of whether or not to refer the case for guardianship. All information gathered by APS can be considered by the court system.

Q: How does the CLOX test work when the elderly person may have only gone through the first or second grade, is now mid to late 90's. How does this factor in?

A: All neuropsychological tests are influenced by education. However, clock drawing tasks may be less influenced because of the non-verbal response elicited by the examinee.

Q: Is it possible to do this test if person has access to clock or watch?

A: Yes.

Q: Is the EXIT25 test available?

A: Dr. Donald Royall holds the copyright to the EXIT25 and he releases it free of charge to people who are trained to use it. However, the training is much more intense and is not amenable to a webinar format. APS offices interested in training their staff to use this instrument should contact me (schillerstr@uthscsa.edu) or Dr. Royall (royall@uthscsa.edu) to discuss arranging a training session. However, we do have to charge for travel expenses and time away from the university. In most cases CLOX is sufficient to guide APS decision trees which in most cases is deciding whether or not to request a medical decision making capacity assessment.

Q: Can these assessment tools be used for adults under age 60 who are disabled?

A: Yes. These instruments are sensitive to executive dysfunction which can occur across the age span in virtually every mental illness and many medical illnesses.

Q: Should the test/tests be administered if a client can complete only a portion of it? Would the responses be able to be evaluated accurately??

A: For any individual test, the client has to complete it for the test to be interpretable. However, when multiple tasks are presented to the client, the client does not have to do every test for the examiner to elicit useful information.

Q: You say to draw a clock with "hands" not "arrows", but some clocks do not have arrows or have circles at the end. Are arrows that relevant? If so what is the relevance?

A: There are a thousand ways to draw a clock. However, there is only one way that executively intact people draw clocks and their clocks tend to have arrows. Remember that this is just one item in the scoring system. If the client does everything else right they will get a 14/15 and still pass. Executive impairment is suggested when there are multiple errors (>4).

Q: How do you get past individuals with visual and hearing impairments, not to mention those with physical problems which will render them unable to perform Clox method? Would it then be fair to still ask them to rely on their frontal lobe?

A: It is pointless to administer a task that the client is unable to do because of physical limitations (vision, hearing, paralysis, etc…). Tasks other than clock drawing may be more informative in these situations .

Q: why not use a blank sheet to have subject draw clock instead of having circle show through and them using it?

A: Because that is not how this task is designed. The circle showing through is meant to capture stimulus bound, executively impaired subjects. Neuropsychological tests are not accidentally designed. Every single word in the instructions is meant to be there. Every single mark on the page is meant to be there. You are welcome to add your own “twists” if you are willing to accept that you have strayed from reliability, validity, accuracy, and interpretability.

Q: How is the clock able to measure this? Do clients have any insight as to whether their clocks look abnormal or not?

A: I am not certain about the intent of the first question. For the second part, some clients have insight and some don’t.

Q: Can CLOX be used reliably for people of different ethnicities? with non-English speaking clients?

A: Yes. There is a Spanish language translation of the CLOX. I suggest you email Dr. Royall (royall@uthscsa.edu) to request a copy as needed.

Q: If client asks questions before they start drawing, it's okay to answer?

A: It is ok to repeat the instructions before they start drawing. However, it is not ok to guide them beyond repeating the instructions or simply stating “It’s up to you”.

Q: On the CLOXI, what is the time limit for a client to complete the task?

A: There is no time limit. However, it is rare for this task to take longer than 5 minutes.

Q: How often can the CLOX 1 and CLOX 2 assessments/ evaluations be given to an individual? We often have Intakes on the same individuals within months and wondered if the tool became less effective with uses following the initial use?

A: Practice effects are always a concern in neuropsychological testing. There is no specific rule for CLOX. My experience, however, is that this test can be repeated in a meaningful way with a 1-2 week delay. I use it in my clinic on a monthly basis with many of my patients to track their responses to my medication interventions.
