

Measuring Psychosocial
Treatment Outcomes
with Older People

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Introduction

The British Psychological Society's (BPS) Centre for Outcomes Research and Effectiveness (CORE) is publishing a series of papers on the use of outcome measures in routine clinical practice. The first paper in the series (Sperlinger, 2002) outlined the context in which outcome measurement in the NHS needs to be considered and identified some general issues that should inform good practice in this area. Further papers in the series will concentrate on reviewing measures in relation to specific areas of clinical practice. The first area to be examined was outcome measures for drug misuse clients (Sperlinger *et al.*, 2003).

Scope and background of the current

The current project aimed to evaluate – and offer advice – on the use of outcome measures in relation to older adult clients being seen in the UK. By 'outcome measures' we mean 'the assessment during or after having received services, of behaviour, states or adjustment, which are significantly related to the reasons for the person having sought care' (Sperlinger, 2002, p.5) – thus, the ability to measure changes over time is a central element of such measures. This advice is particularly aimed at clinicians who are not working as part of a specialist older people's service and who may not be familiar with the measures that are available in this area, but who may be providing psychosocial services to an older person. It is hoped, however, that it may also be useful to clinicians working in specialist services for older people who wish to update their knowledge about outcome measures. The aim is to provide practical advice for clinicians. We have not

attempted to comprehensively review all measures that have been used with this client group, many of which may only have been used in a research setting. We have, therefore, concentrated on measures that are currently in use or are easily accessible to psychologists or other clinicians working in older people services in the UK. It is also not the intention that the project indicates measures that are approved or not approved by the BPS or CORE.

There have been a few other reviews that have examined areas that overlap to some degree with work reported in this paper (see, particularly, Bowling, 1991; Burns *et al.*, 2002; McDowell & Newell, 1996; Ramsay *et al.*, 1995; Salmon, 2000; Strydom & Hassiotis, 2003). However, none of these covers exactly the same area as the present project, with its focus on offering practical advice for clinicians providing psychosocial services in the NHS.

Method

In order to identify outcome measures currently being used in Older Peoples' services, particularly in the UK, a literature search was undertaken in September 2002 and discussions were held with practitioners working in the field who were linked to the Older People's Faculty of the BPS Division of Clinical Psychology (PSIGE). As the term 'older people' refers to the whole population above the age of 65 years, rather than to a specific problem area (such as drug misuse), the range of measures that might be relevant to this client group is potentially enormous. In theory, almost any outcome measure that might be used for adults of working age could be relevant to a specific older person. In order to make the project manageable it was decided, therefore, to focus on published measures which met at least two of the following criteria:

- a) the measure was specifically directed at older people, or focussed on problems (such as dementia) that are particularly prevalent in older people, or had norms for older people;
- b) the measure was primarily aimed at psychologists or others who were providing psychological therapies to older people;
- c) the measure was reasonably accessible to and was being used by UK clinicians.

Measures were excluded if they were mainly addressing activities of daily living or specific aspects of neuropsychological functioning, or were cognitive screening or needs assessment measures. There are significant problems in the use of cognitive screening measures in the assessment of outcomes; this point will be discussed further later in this paper. Measures specifically aimed at carers were also not included, but see Ramsay *et al.* (1995) for a review of outcome measures for community services for people with dementia, including caregiver measures available at that time.

Eighteen measures were evaluated. Information about the measures evaluated can be found in Appendix One. This includes: where information about the measure can be obtained; a short description of what it is designed to measure; and information on administration. The measures that were evaluated for the project – and the criteria for their inclusion - are indicated below:

A. Behaviour rating scales

1. Behavioural Assessment Scale of Later Life (BASOLL) (inclusion criteria a, b, c)
2. Challenging Behaviour Scale (CBS) (a,b,c)

B. Measures of mood

1. Beck Anxiety Inventory (BAI) (b, c)
2. Beck Depression Inventory-II (BDI) (b, c)
3. Beck Hopelessness Scale (BHS) (b, c)
4. Centre for Epidemiologic Studies Depression Scale (CES-D) (a, c)
5. Cornell Scale for Depression in Dementia (Cornell) (a, c)
6. Geriatric Depression Scale (GDS) (30 item version) (a, c)
7. Hospital Anxiety and Depression Scale (HADS) (a, c)
8. Rating Anxiety in Dementia (RAID) (a, c)
9. Selfcare (D) (a, b, c)

C. Quality of life/satisfaction measures

1. Life Satisfaction Index (LSI) (a, b, c)
2. Quality of Life in Alzheimer's Disease (QOL-AD) (a, b, c)
3. Quality of Life Assessment Schedule (QoLAS) (a, b, c)

D. Measures of overall functioning

1. Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE) (a, b, c)
2. Health of the Nation Scales for Older People (HoNOS 65+) (a, c)

E. Measures of behaviour/memory problems in people with dementia

1. Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) (16-item version) (a, b, c)
2. Revised Memory and Behavior Problems Checklist (RMBPC) (a, b, c)

Criteria had been developed for the paper on outcome measures in drug misuse services (Sperlinger *et al.*, 2003) against which those measures could be assessed. These criteria drew on other studies that have considered the evaluation of outcome measures in various areas of mental health (e.g. Andrews *et al.*, 1994; Fitzpatrick *et al.*, 1998; Slade *et al.*, 1999; Newman *et al.*, 1999). For the present paper these criteria were revised to take account

of the different nature of the client group and of experience using the criteria in the previous paper. The 18 criteria were grouped into five main areas:

1. *Practicality* (three criteria) – amount of time required for clinicians to familiarise themselves with the measure; cost of using the measure in clinical practice; and ease of availability.
2. *Feasibility* (six criteria) – acceptability for users; degree of discomfort for clinician in administering the test; difficulty of administration; ease of scoring; length of time required to complete; and ease of interpreting scores.
3. *UK relevance* (three criteria) – availability of UK norms/benchmarking data; extent of use clinically in the UK; and evidence of use cross culturally in the UK, with reported norms.
4. *Psychometric properties* (three criteria) – evidence of validity and of reliability; and the measure's sensitivity for measuring change; these were all rated in relation to the measures generally, not specifically in relation to their use with older people.
5. *Content of measure* (three criteria) – relevance to psychological work with older people; degree to which items in the measure are culturally appropriate; and the degree to which the language and content of the measure are consistent with person centred principles.

The 18 criteria were all rated on three-point scales. An evaluation form was developed for the project and three of the authors (LC, AC and NB) independently rated the 18 measures on the 18 criteria using this form.¹ Following this the ratings were discussed and, where possible, agreement was reached on a common rating; the three raters' final scores were then totalled to provide the final rating. The scores from the ratings for each of the five sections were totalled and were then transformed into a star rating system (from 0 to 3), in order to make the findings more accessible. Thus a minimum score in any section was assigned no stars and a maximum score was given three stars. The Table also shows the percentage of the potential maximum rating score (171) that each measure achieved.

¹ Copies of the rating form can be obtained from the first author

Findings

Table 1 summarises the final overall ratings. The shaded measures in the table received good ratings across all the five areas that were rated. None of the measures we evaluated performed poorly across all five sections of the criteria. The table provides a guide to the possible areas of strength and weakness of the different measures. Measures tended to be evaluated particularly poorly in relation to their UK relevance and to evidence of their psychometric properties. Nevertheless, for many users of

these measures in clinical practice, these tests will be practical and feasible to use and are often very relevant to work with older people. It is also likely that some of the measures that have come out relatively poorly on the ratings may, nevertheless, be of value to particular services because the content is especially relevant in that service context. Some further implications of the results are examined more fully in the Discussion section.

Table I. Overall rating for the measures

	Practicality	Feasibility	UK relevance	Psychometric properties	Contents of measure	Total score
MEASURE						
A. Behaviour rating scales						
BASOLL	**	***	*	*	**	77
CBS	*	**	*	*	*	68
B. Mood						
BAI	**	***		*	**	77
BDI	**	***	*	**	**	81
BHS	**	**		**	*	69
CES-D	***	***		*	**	77
CORNELL	***	**	*	*	**	73
GDS	***	***	**	**	**	89
HADS	**	***	**	**	**	86
RAID	**	**			**	68
SELFCARE (D)	***	***	*	*	**	83
C. Quality of life/satisfaction measure						
LSI	**	**		*	**	71
QoL - AD	***	***	*	*	**	82
QoL - AS	**	**		*	**	67
D. Overall functioning						
CORE	***	**	**	**	**	84
HoNoS 65+	**	**	*	**	*	64
E. Measure of behaviour/memory problems in people with dementia						
IQCODE	***	***		*	**	75
RMBPC	***	**		*	*	65

Star ratings are based on minimum score = no stars; maximum score = 3 stars and dividing the remaining scores up equally.

Total score = % of rating score of 171,

The shaded measures in the table received good ratings across all the five areas that were rated

Discussion

This paper set out to explore the practical utility for clinicians of a number of outcome measures relevant to psychological work with older people in the UK. Evaluation of psychological outcomes with older people is complicated for a number of reasons. Older people are a heterogeneous group in terms of age and life stage as well as health status and social context. Psychological work necessarily must take account of physical and cognitive factors as well as the social systems surrounding the individual, couple or family and the possible differing needs of family carers. For some older people, progressive cognitive changes may, over time, render particular measures no longer relevant. It cannot be assumed, therefore, that a given measure which is appropriate at one point in time will remain so indefinitely. The goal of intervention is not always one of improvement; where health-related difficulties are long-term or progressive, absence (or delay) of a decline in well-being may be an important outcome in itself. Thus, the question of what constitutes a good outcome in work with older people is not always straightforward, and there are numerous practical challenges associated with outcome evaluation. Whatever the goal of intervention, however, routine objective evaluation of clinical outcomes is important to help monitor efficacy of service provision and to encourage the application of best practice and evidence-based interventions within services for older people. The complexity of work with older people highlights a particular need for appropriate and sensitive measures. Measures are required that evaluate outcomes of psychological and psychosocial intervention for individual older people, for those who support them, and for service systems. The present paper focuses primarily on the first of these domains.

In considering outcome evaluation with older people, there is a need to acknowledge the possible damaging impact on older people of social stigma resulting from ageism, which may be replicated in service contexts. New developments in the field of social gerontology and dementia studies are helping to create a climate within which the well-being of older people may be more effectively supported. For example, the concept of person-centred care (Brooker, 2003; Kitwood, 1997) has

stimulated a more respectful and inclusive approach to the care of older people. This emphasis has been reflected in the present paper, with measures rated in terms of their use of person-centred language and concepts as well as their acceptability to service users and clinicians.

As noted above, the range of potentially relevant measures was large. However, many measures routinely used with older people are primarily designed and employed for purposes of assessment, rather than outcome evaluation. An example might be the neuropsychological tests employed to contribute to the process of determining a diagnosis of dementia. Since these evaluate impairment, rather than disability, there are significant problems with their use as outcome measures for psychosocial interventions, and therefore these particular instruments were deemed to be outside the scope of this paper. Probably the most commonly used measures of all with older people are screening tests for cognitive impairment, such as the Mini-Mental State Examination (Folstein *et al.*, 1975) – see, for example, the findings of a survey of the use of standardised scales by old age psychiatrists in England and Northern Ireland reported in Reilly *et al.* (2004). There are particular problems associated with the use of these for both assessment and outcome evaluation purposes (Clarke *et al.*, 1999). These measures were also excluded from the scope of the present paper. Instruments measuring functioning in relation to activities of daily living were also excluded, not because functional ability was considered unimportant, but because it was thought that these measures were not likely to be aimed primarily at practicing clinicians working psychologically. Needs assessment measures were excluded for similar reasons.

The measures selected for review fell into five groups. The first four of these, covering behaviour rating scales, measures of mood, quality of life/life satisfaction measures and measures of overall functioning, all include some measures intended for use with, or applicable to, older people who have dementia as well as those who do not. The remaining group, measures of behavioural/memory problems in people with dementia, comprises informant rating scales specifically designed to evaluate

functioning in people with cognitive impairments. Thus, taken together, these measures relate to a broad spectrum of psychological work with older people.

All the selected measures were evaluated in relation to five criteria: practicality, feasibility, UK relevance, psychometric properties, and content. All the included measures achieved acceptable scores overall, with particular strengths evident in relation to evaluation of mood and overall functioning. Most measures were rated highly on practicality and feasibility of use, and to some extent on content, supporting their application and acceptability in the everyday clinical setting. Scores in the categories of psychometric properties and relevance to the UK context were, in most cases, considerably less impressive. Some of the ratings on UK relevance may seem surprisingly low, but this reflects the fact that the data available about UK norms or the use of measures cross-culturally are often currently quite limited. While these issues do not preclude use of the measures concerned, it does of course have implications for the interpretation of scores and thus for evaluation of outcomes using these measures. There is clearly a need for fuller information about the psychometric properties of many measures used with older people, both in general terms and in terms of how this relates to the UK cultural and social context.

The present paper was intended to be directly relevant to and useful for practising clinicians working psychologically with older people. We have not attempted to produce a comprehensive systematic review of all possible outcome

measures. Instead, we have attempted to reflect current practice in the UK. While the selection and rating of measures was undertaken by a small group of clinical psychologists, efforts were made to access and incorporate the views and experience of a wider group of clinicians working with older people. This included liaison with members of the PSIGE national committee and the associated standing committee for clinical training, personal approaches to clinicians known to be involved in outcome evaluation, and an interactive poster presentation at the PSIGE national conference in 2003.

The review has highlighted a number of areas where further work may be useful. As noted above, measures that primarily evaluate outcomes for carers or at the level of service delivery have not been addressed here, and these may be the subject of a separate review. Given the breadth of psychological work being undertaken with older people, it may be useful in the future to review measures that are potentially relevant for specialised areas of work, such as psychotherapy or cognitive rehabilitation, that are increasingly being undertaken by clinical psychologists working in services for older people. There may also be scope for identifying measures that have potential for application to outcome evaluation with older people, but are not currently used in this way. Finally, there is an urgent need for clinical psychologists working with older people in the UK both to contribute to developing appropriate and sensitive measures and to help ensure that good-quality psychometric data are available to support the use of those measures that are suitable and acceptable for use in clinical settings.

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Appendix

The information below was obtained from published sources about the measures, such as articles describing the development of the measures, relevant websites or information generally available from publishers of the measures (where relevant).

Description of measures evaluated

1. Behavioural Assessment Scale of Later Life (BASOLL)

Description of measure

A broad-based instrument that is helpful in care planning with a diverse group of older clients. Comes in two versions: (i) Checklist – can be used by the key worker to assess behaviour within residential or daycare settings; (ii) Interview – can be used to assess the client from the perspective of a main caregiver (usually a family member). Consists of six scales: Self-care; Memory and orientation; Challenging behaviour; Mood; Sensory abilities; Mobility. The Checklist version can be completed by an experienced worker who knows the client well in less than 10 minutes and the Interview version takes about 45 minutes.

Original developers/obtaining the measure

Details of the development of the scale can be found in Brooker *et al.* (1993) and in the User Manual in Brooker (1997). The Manual and scale (and a computer disk from which hard copies of the forms can be printed) can be purchased from: Winslow, Telford Road, Bicester, Oxfordshire OX6 0TS.

2. Challenging Behaviour Scale (CBS)

Description of measure

A 25-item behavioural rating scale for resident behaviours that staff in care homes for older people find difficult to manage. It records staff reports of the incidence, frequency and management difficulty of resident behaviour and it can also identify 'challenging residents' through a computed score. It takes about 5 minutes to complete.

Original developers/obtaining the measure

The development of the scale is described in Moniz-Cook *et al.* (2001) and copies of the scale can be obtained from the author of that paper. No cost to use the measure in NHS clinical practice.

3. Beck Anxiety Inventory (BAI)

Description of measure

A 21-item measure that evaluates both physiological and cognitive symptoms of anxiety. It can be administered by a trained interviewer or self-administered. The measure takes 5–10 minutes to complete.

Original developers/obtaining the measure

The development of the scale is described in Beck *et al.* (1985). A manual and copies of the measure can be purchased from: The Psychological Corporation, 32 Jamestown Road, London NW1 7BY. The use of the BAI with older adult psychiatric outpatients has been reported in Kabacoff *et al.* (1997).

4. Beck Depression Inventory-II (BDI)

Description of measure

A 21-item measure that evaluates both physiological and cognitive symptoms of depression. It can be administered by a trained interviewer or self-administered. The measure takes 5–10 minutes to complete. This is a revised version of the original BDI. There is also a 13-item version, which may be particularly suitable for older people (see Scogin *et al.*, 1988).

Original developers/obtaining the measure

The development of the original scale is described in Beck and Steer (1993) and the revised version in Beck *et al.* (1996). A manual and copies of the measure can be purchased from: The Psychological Corporation, 32 Jamestown Road, London NW1 7BY. The use of the BDI-II with depressed geriatric inpatients has been reported in Steer *et al.* (2000).

5. Beck Hopelessness Scale (BHS)

Description of measure

A 20-item scale that measures three aspects of hopelessness: feelings about the future, loss of motivation and expectations. The measure takes up to 10 minutes to complete. The manual for the scale reports that BHS scores were only significantly related to age in one of their samples (and that correlation was rather small).

Original developers/ obtaining the measure

The development of the scale is described in Beck *et al.* (1985). A manual and copies of the measure can be

purchased from: The Psychological Corporation, 32 Jamestown Road, London NW1 7BY.

6. Centre for Epidemiologic Studies Depression Scale (CES-D)

Description of measure

The original version of the scale has 20 items and is a self-report measure of depressive symptoms. Shorter versions are also available. Useful especially as a screening measure. The measure takes 5–10 minutes to complete.

Original developers/obtaining the measure

Development of the scale is described in Radloff (1977) and details of the scale can be found in the original paper. A copy of the measure can also be found in Burns, Lawlor and Craig (1999). No cost to use the measure in NHS clinical practice.

7. Cornell Scale for Depression in Dementia (Cornell)

Description of measure

A 19-item interview-based scale for measuring depression in people with dementia, using a combination of observed and informant-based information. The measure takes 20 minutes to complete with the carer and 10 minutes with the client.

Original developers/obtaining the measure

Development of the scale is described in Alexopoulos *et al.* (1988) and details of the scale can be found in the original paper. A copy of the measure can also be found in Burns, Lawlor and Craig (1999). No cost to use the measure in NHS clinical practice.

8. Geriatric Depression Scale (GDS)

Description of measure

A 30-item scale specifically designed for use with older people. Each item has a yes/no answer, with the scoring dependent on the answer given. The measure takes about 5–10 minutes to complete. A review of the use of the GDS can be found in Scogin *et al.* (2000). There are also shorter 15-item and 4-item versions, which may be more useful with older people, but the use of the 1-item version appears to be problematic (Howe *et al.*, 2000). The 15-item version has been used in one study with UK older African-Caribbean people (Abas *et al.*, 1998).

Original developers/obtaining the measure

Development of the scale is described in Yesavage *et al.* (1983) and details of the scale can be found in the original paper. A copy of the measure can also be found in Burns, Lawlor and Craig (1999). The 15-item version is described in Sheikh and Yesavage (1986) and results have been reported from a large-scale sample of people aged over 75 in the UK (Osborn *et al.*, 2002). No cost to use the measure in NHS clinical practice.

9. Hospital Anxiety and Depression Scale (HADS)

Description of measure

Consists of two 7-item subscales, one measuring anxiety and the other depression. The two subscales are scored separately. The measure takes about 5 minutes to complete. Results from a UK study comparing the Selfcare (D) and the HADS can be found in Upadhyaya and Stanley (1997).

Original developers/obtaining the measure

The development of the scale is described in Zigmond and Snaith (1983). A manual and copies of the measure can be purchased from: nferNelson, The Chiswick Centre, 414 Chiswick High Road, London W4 5TF.

10. Rating Anxiety in Dementia (RAID)

Description of measure

An interview-based 18-item measure specifically for measuring anxiety in people with dementia, with items grouped in four subscales: worry; apprehension and vigilance; motor tension; and autonomic hypersensitivity.

Original developers/obtaining the measure

The development of the measure is described in Shankar *et al.* (1999) and details of the scale can be found in the original paper. No cost to use the measure in NHS clinical practice.

11. Selfcare (D)

Description of measure

A 12-item questionnaire derived from an interview form for older people, using items known to discriminate between people with and without depression. Results from a UK study comparing the Selfcare (D) and the HADS can be found in Upadhyaya and Stanley (1997) and

Appendix (cont.)

Banerjee *et al.* (1998) report on its use with people receiving local authority home care in the UK.

Original developers/obtaining the measure

A copy of the measure and preliminary results from older people in some UK GP patients can be found in Bird *et al.* (1987).

12. Life Satisfaction Index (LSI)

Description of measure

A 20-item self-report measure of life satisfaction, with five subscales: zest for life; resolution and fortitude; congruence between desired and achieved goals; self-concept; and mood tone. Its use with an ageing and retired UK population has been described by Bigot (1974). The original measure takes about 10 minutes to complete. A 13-item version has been described by Wood *et al.* (1969) and has been used in a large research project with older people in Wales (Windle & Woods, 2004).

Original developers/obtaining the measure

The development of the scale is described in Neugarten *et al.* (1961). The original version of the scale is given in Bigot (1974) and a 13-item version in Wood *et al.* (1969). No cost to use the measure in NHS clinical practice.

13. Quality of Life in Alzheimer's Disease (QOL-AD)

Description of measure

A 13-item measure of quality of life, which has self and caregiver versions. The items cover areas such as physical health, mood, memory, family, and ability to do chores around the house. It is possible to derive a weighted composite score using both versions of the measure. The measure takes about 10 minutes to complete. The validity and reliability of the measure in a UK sample is described in Thorgrimsen *et al.* (2003).

Original developers/obtaining the measure

The development of the scale is described in Logsdon *et al.* (1999) and details of the scale can be found in the original paper. A more recent review of the use of the QOL-AD with older adults with cognitive impairment can be found in Logsdon *et al.* (2002). Its use in the UK is described in Selai, Vaughan *et al.* (2001). A copy of the measure can also be found in Burns, Lawlor and Craig (1999). No cost to use the measure in NHS clinical practice.

14. Quality of Life Assessment Schedule (QoLAS)

Description of measure

Ten 'constructs' are elicited from each client by an interviewer for each of the following domains of quality of life: physical, psychological, social/family, daily activities, and cognitive functioning (or well-being). The client then rates how much of a problem each of these is now on a six-point scale.

Original developers/obtaining the measure

The development of the scale is described in Selai *et al.* (2000) and details of how the scale is administered can be found in the original paper. The measure has been validated in a UK study with people with dementia (Selai *et al.*, 2000; Selai, Trimble *et al.*, 2001). No cost to use the measure in NHS clinical practice.

15. Clinical Outcomes in Routine Evaluation – Outcome Measure (Older adult version) (CORE)

Description of measure

The CORE Outcomes Measure (Evans *et al.*, 2000) is aimed primarily at adults of working age, but it can be used with older people with some small procedural adaptations and norms for this group are now available (Barkham *et al.*, in press). There are 34 items, grouped into four subscales: subjective well being; symptoms; functioning; and risk. The measure takes about 10 minutes to complete.

Original developers/obtaining the measure

The development of the scale is described in Evans *et al.* (2000). Copies of the original CORE scale are available free of charge from: Psychological Therapies Research Centre, School of Psychology, University of Leeds, 17 Blenheim Terrace, Leeds LS2 9JT and can be downloaded from: www.psyc.leeds.ac.uk/ptrc/research.htm. No cost to use the measure in NHS clinical practice.

16. Health of the Nation Scales for Older People (HoNOS 65+)

Description of measure

An interview-rated measure covering 12 areas (such as aggression, self-harm, cognitive problems, depression and relationships). Each scale is rated on a 5-point scale. This version is an adaptation for older people of a measure for younger people with mental health problems.

The measure takes 5–10 minutes to complete by a professional who knows the patient and 30 minutes in a semi-structured interview. (The use of HoNoS in measuring outcomes in older people's mental health services has recently been reviewed by Turner, 2004.)

Original developers/obtaining the measure

The development of the original HoNOS scale is described in Wing *et al.* (1998) and the adaptation for older people in Burns, Beevor *et al.* (1999). A copy of the measure can also be found in Burns, Lawlor and Craig (1999). There is no cost to use the measure in NHS clinical practice but it is required that professionals undergo appropriate training in administering the measure before it is used.

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

Description of measure

An interviewer-administered questionnaire aiming to assess changes in the everyday cognitive functioning of older people and to assess cognitive decline independent of pre-morbid level of functioning. The measure is based on an interview with an informant who has known the person for some time and asks them to compare how well the older person is able to do various cognitive tasks compared to 10 years ago. The version assessed here was the shorter 16-item

version, which has been found to perform as well as the original longer version. The measure takes about 10–15 minutes to complete.

Original developers/obtaining the measure

The development of the measure is described in Jorm and Jacomb (1989). The development of the 16-item measure is described in Jorm (1994) and the items used are also described in that paper. A copy of the measure can also be found in Burns, Lawlor and Craig (1999). There is no cost to use the measure in NHS clinical practice.

18. Revised Memory and Behavior Problems Checklist (RMBPC)

Description of measure

A 24-item checklist, based on interview with a caregiver. The scale has three subscores for: memory related, depression and disruptive behaviours. The items are rated both for their frequency and in terms of the caregiver's reactions to them. The scale takes about 20 minutes to complete.

Original developers/obtaining the measure

The development of the measure is described in Teri *et al.* (1992) and details of the scale can be found in the original paper. A copy of the measure can also be found in Burns, Lawlor and Craig (1999). There is no cost to use the measure in NHS clinical practice.

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