

ECAS FAQs

1. At what point in a patient's care can an ECAS be administered?

An ECAS can be administered at any point in the course of patient care. It is recommended that an ECAS is administered early in the course of the disease. This early assessment highlights potential problems so that early intervention can be initiated and appropriate support can be provided.

Early assessment may highlight changes not identified by clinical judgement alone. In cases where cognition and behaviour is within the 'normal' range at the time of assessment, a baseline measure may be used for reference if changes are suspected later in the course of the disease.

2. How much insight do affected patients have about their cognitive/behavioural changes?

This depends on the individual patient. Some patients who experience cognitive changes may be aware that they are having difficulty with certain kinds of tasks but may not be able to identify the reason for their difficulties. In some cases, for example, people may claim their memory isn't what it used to be; however, an ECAS may show that they are having difficulty with executive functions. Patients with frontotemporal dementia (FTD) have less awareness of the changes others may notice.

3. A patient doesn't seem to be making an effort to answer the ECAS questions. What should I do?

It is critical that patients are motivated when undertaking a neuropsychological assessment. If a patient is not engaged, seems uninterested, or seems not to be making an effort then this will affect the results of the assessment. If a patient does not seem to be making an effort, it may be best to stop the assessment. You could still carry out the behaviour interview with a carer, if the patient gives permission. The behaviour interview alone may provide useful information. The cognitive part of the assessment could be attempted on another day if the patient is willing and motivated.

4. A patient doesn't seem to understand the instructions for a particular ECAS task. Can I repeat/reword the instructions?

You may repeat any instructions using the exact wording written on the ECAS form. It is important that you do not try to re-word the instructions.

5. Is the ECAS a capacity assessment?

The ECAS is not a capacity assessment. The results from an ECAS cannot be used as the only source of information regarding a person's capacity to make a decision. Results from an ECAS may contribute towards an evaluation of a person's capacity to make a decision.

6. Who can administer the ECAS? Do they need to attend an official training event?

Neuropsychologists can administer the ECAS. Other health professionals may also administer the ECAS (e.g. neurologists, speech and language therapists, occupational therapists, specialist nurses) however, it is recommended that they seek supervision from a neuropsychologist for interpretation of the results.

7. A patient doesn't want a family member to complete the behaviour screen. What should I do?

You need a patient's permission to conduct the behaviour interview with a carer or family member. The behaviour interview should not be conducted without the patient's permission.

8. A patient's family member cannot be present in person to complete the behaviour screen. Can the behaviour screen be completed over the telephone?

The behaviour interview can be conducted over the telephone; however, it is advised that health professionals seek to conduct the interview face-to-face if at all possible.

9. A patient had problems learning to read and write at school. They may have dyslexia or another type of learning difficulty. How can I take this into account when scoring the ECAS?

Patients who have a learning difficulty may fall below the cut-off of 105 even though their cognitive abilities are the same as before the onset of their disease. Patients who received very little formal education in their lifetime may also fall below the cut-off even though their cognitive functioning has not changed since the onset of their disease. In such cases, it is essential that a clinical psychologist or neuropsychologist is consulted as they have the expertise to assess such patients.

10. Why do non-neuropsychologists need supervision from a neuropsychologist when interpreting the ECAS? Can a health professional administer and interpret an ECAS without supervision from a neuropsychologist?

A health professional can administer the ECAS however, ideally, they will receive some supervision from a clinical neuropsychologist or clinical psychologist.

Clinical neuropsychologists/clinical psychologists have expertise in interpreting the results of cognitive tests and will be able to provide the care team with more information about a patient's strengths and support needs. They may also be able to offer a more detailed/holistic assessment of a patient and may even offer advice on appropriate interventions.

If access to a clinical neuropsychologist/clinical psychologist is not possible, results of the ECAS should always be discussed within a multidisciplinary team.

11. How are the final scores of the ECAS interpreted? What do these scores mean?

The ALS-specific score is out of a total of 100. The ALS-non-specific score is out of a total of 36. You can also produce an ECAS total score by summing these scores together to produce a maximum score of 136. Assessing whether someone has an abnormal score is determined from normative data. The cut-offs for 'normal' scores can be found in the guidelines. In the UK, the cut-off for the ECAS total is 105. A score AT or BELOW 105 suggests that a person may have cognitive impairment.

For the behaviour interview, a positive response by the carer on the apathy domain or at least two of the five domains suggests that the person may have behavioural impairment.

12. Can you administer an ECAS to the same person more than once?

You may wish to carry out an ECAS more than once on a patient to see if they have experienced changes in cognition or behaviour over a certain period of time. If using ECAS A, you should wait around 6 months before using this version a subsequent time on the same patient. Waiting 6 months should limit 'practice effects' (i.e. patients performing better because they have been tested with the same version of the ECAS on a previous occasion).

Two more versions of the ECAS (B, C) will be released soon and may be used to avoid practice effects.