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"Transforming Psychological Science: the 2030 agenda"

Abstracts

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Selecting cut-offs in tests: lessons learnt from the Lithuanian Addenbrooke's Cognitive Examination – III (ACE-III) adaptation study

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ACE-III is a popular dementia screening instrument, translated into many languages. However, each adaptation uses a different threshold value that ranges from 62 to 89 (out of 100) for dementia and 71-89 for MCI, meaning similar performances can be classified as healthy in one country and dementia in another. The single-threshold approach ignores the effects of cognitive reserve on performance, highlighting the need for individualized cut-offs.

Our study aimed to create Lithuanian ACE-III's population-level norms based on age and education that could be used as individualized cut-offs for clinical decisions. We collected data from 319 healthy controls aged 45+ and produced performance percentiles, stratified through 5 age groups by decades and 3 education levels (school/undergraduate/ graduate or higher). We then used data from 61 patients for ROC analysis to identify cut-offs for MCI and dementia.

We found that ACE-III performance scores of healthy controls were affected by their age and education levels. These relationships increased with participants' age, highlighting the need for a more scaled approach when calculating clinical cut-offs for ACE-III. The ROC analysis yielded cut-offs of 75 points for dementia and 84 for MCI.

When compared to 23 other ACE-III adaptation studies, our control sample was one of the largest and most representative, allowing us to create individualized norms for each age and education group. However, it was limited to literate Lithuanians, fluent in the national language. Additional research is needed to identify individual test and task-specific cut-offs for non-native speakers and socially deprived individuals.

Nowadays, increasing emphasis is placed on quantitative test scores in dementia screening, using cut-off values to determine health benefits and service availability. This approach doesn't consider an individual's cognitive reserve, leading to type I and type II errors in clinical decisions. We propose researchers to replicate our method in future test adaptations.