Mental health screening for women age 50 Years and older

By Beth Kelsey, EdD, APRN, WHNP-BC, FAANP

Our mental health includes emotional, psychological, and social well-being. Mental and physical health are intertwined. Mental illness increases the risk for many types of physical problems, and the presence of chronic physical conditions can increase the risk for mental illness.[1] Mental illnesses include many different conditions that vary in degree of severity. In the United States, the overall prevalence of mental illness for women is 22.3%.[1] The two most common categories of mental illness experienced by adult women are anxiety and depression.[1] Alcohol and substance misuse and interpersonal violence are also critical mental health issues for women. When mental illness and mental health issues are unidentified and untreated, the consequences can include significant impairment in everyday functioning, lowered quality of life, and potential for life-shortening comorbidities.

Mental health screening is an important component of routine preventive healthcare for all women. Nurse practitioners (NPs) providing healthcare for women from adolescence through adulthood have an opportunity to provide mental health screening and early diagnosis to promote treatment. Screening also identifies patients with risk factors for mental illness so that preventive interventions can be implemented. Mental health screening should take place in a clinical setting with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

This article highlights mental health screening specifically for women age 50 years and older based on recommendations from the Women's Preventive Services Initiative (WPSI). WPSI is led by an expert advisory panel representing the American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, and the National Association of Nurse Practitioners in Women's Health. The panel developed and annually updates a well-woman chart and a clinical summary table with recommended preventive services based on age, health status, and risk factors. WPSI recommendations serve as the basis for insurance coverage at no cost sharing to patients for a comprehensive set of preventive services.[2]

WPSI recommendations for women age 50 years and older are divided into three groups: age 50 to 64, 65 to 75, and older than 75 years. The mental health screening recommendations for each of these groups are the same. WPSI mental health screening recommendations encompass alcohol use, depression, anxiety, substance use, and interpersonal violence.[2] These recommendations complement, build on, and fill gaps in existing guidelines provided by the US Preventive Services Task Force (USPSTF).[2]

Alcohol use screening and counseling

Approximately 52% of women age 45 to 64 years and 37% of women age 65 years and older report having consumed any alcohol in the past 30 days.[3] In the 45- to 64-year age group, 13.0% report binge drinking in the past 30 days, and in the 65 years and older age group, 4.7% report it. Among women in these age groups reporting binge drinking, the average number of binges was 4 days in the past 30 days.[3] Binge drinking for women is consuming four or more alcoholic drinks on the same occasion or within a couple of hours of each other. Heavy alcohol use is binge drinking on 5 or more days in the past

month.[4] Long-term heavy alcohol use can lead to serious health consequences. Women may be more susceptible than men to some of these health consequences that include liver damage, heart disease, and brain damage even though they may consume less alcohol.[5]

WPSI and the USPSTF recommend screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adult women.[2,6] Unhealthy alcohol use is any use that increases the risk or likelihood of health consequences or has already led to health consequences.[6] Several screening tools are available to assess for unhealthy alcohol use with acceptable sensitivity and specificity in the primary care setting. The USPSTF has determined that 1-item to 3-item screening tools have the best accuracy for use with adults. Examples of these brief screening tools are the AUDIT-C [Alcohol Use Disorders Identification Test-Consumption] with 3 questions and the SASQ [Single Alcohol Screening Question].[6] When a patient screens positive using one of the brief screening tools, the NP should follow up with a more in-depth risk assessment to confirm unhealthy alcohol use and determine the next steps for intervention. The NP also should offer a brief behavioral counseling intervention for patients identified as engaged in unhealthy alcohol use.[6] Patients who demonstrate a maladaptive pattern of alcohol use that meets *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, criteria for alcohol use disorder should be offered referrals for further evaluation and treatment.

Depression screening

Major depressive disorder (MDD) is one of the most common mental health conditions in the United States. It occurs as a single or recurrent episode and ranges from mild to severe in relation to level of impairment. Moderate and severe MDD is associated with significant effects on quality of life and the ability to carry out usual life activities.[7] It is a leading cause of disability, associated with increased mortality due to suicide, and can impair ability to manage other health issues.[8]

In the age group 50 to 64 years, 7% to 8% of women have experienced an MDD episode during the previous year. For women age 65 years and older, the prevalence is lower at 3.5%.[9] It is significant to note that identifying depression in older adults may be complicated because it can manifest as somatic complaints such as fatigue, insomnia, poor concentration, appetite change, and weight loss that may be mistaken for some of the physical ailments common in this age group. In older adults, depression is also more likely to coexist with other medical conditions including cardiovascular disease, cancer, neurologic impairment, and arthritis.[8]

Both WPSI and the USPSTF recommend routine screening for depression for patients age 13 years and older.[2,10] A variety of validated screening tools have been developed for use with adult patients in primary care settings. The Patient Health Questionnaire 2 (PHQ-2) is popular because it is brief and highly sensitive. The expanded PHQ-9 is also commonly used.[8] WPSI and the USPSTF recommend that depression screening should take place with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.[2,10]

Anxiety screening

Anxiety disorders include generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, posttraumatic stress disorder, social anxiety disorder, and other specific types. All anxiety disorders share the features of excessive, uncontrollable anxiety or worry and related behavioral disturbances. Anxiety disorders can impair performance of daily activities and work responsibilities as well as adversely affect sense of well-being and social relationships.[11] Anxiety increases the risk for major depression.[11]

An estimated 21% of women in the United States age 45 to 59 years and 9% of those 65 years and older have had an anxiety disorder in the past year.[12] WPSI recommends screening females age 13 and older for anxiety.[2] The USPSTF has a screening recommendation update in progress for depression, anxiety, and suicide risk in adults.[13] Screening has the potential to identify previously unrecognized anxiety disorder, initiate individualized treatment, and prevent progression and impairment.[11] Several screening tools that demonstrate moderate-to-high accuracy in identifying anxiety disorders are available for use in the primary care setting. One is the GAD-7 [Generalized Anxiety Disorder 7-item] scale. Because of the frequent co-occurrence of anxiety and depressive disorders, the NP can use validated tools that screen simultaneously for both disorders such as the PHQ-4.[2] When screening suggests the presence of anxiety, the NP should provide or refer for further evaluation to establish the diagnosis and determine appropriate treatment.

Substance use assessment

Unhealthy drug use is defined as the use of substances (not including alcohol or tobacco products) that are illegally obtained or the nonmedical use of prescrip-

tion psychoactive medications.[14] Although cannabis is legal in some localities, it is included in this definition. The adverse effects of unhealthy drug use are variable depending on the category (eg, opioids, cocaine, sedatives, cannabis), amount, and frequency of use. All categories can impair daily functioning and negatively affect interpersonal relationships. Illegal drug use is associated with violence, criminal activity, incarceration, and other social and legal problems.[14]

In the United States, approximately 6% of adults age 50 to 64 years and 4% of those age 65 years and older have used one or more illicit drugs in the past 30 days. Data specifically for women are not available for use in these age groups. The overall prevalence of illicit drug use for all adult women, however, is close to 10%.[9] For older adults, biologic changes of aging can increase the effect of illicit drugs. Comorbidities and other medication use can exacerbate adverse health effects.[15]

WPSI recommends screening, and appropriate counseling as needed, for individuals age 13 through 21 years for the use of illicit drugs, but this recommendation does not include adults older than age 21 years.[2] In June 2020, the USPSTF finalized an updated recommendation to screen for unhealthy drug use in adults age 18 years or older.[14] Several accepted screening tools are available for use in the primary care setting. Some combine screening for alcohol, tobacco, and illicit drugs. The National Institute on Drug Use Quick Screen asks four questions. ASSIST [the Alcohol, Smoking, and Substance Involvement Screening Test] has eight items.[14] The NP can also use the SBIRT [substance use (including alcohol), brief intervention, and/or the referral to treatment] approach recommended by the Substance Abuse and Mental Health Services Administration.[14]

Interpersonal violence

Interpersonal or intimate partner violence (IPV) is common in the United States but often remains undetected. IPV includes physical and sexual violence, stalking, and psychological harm by a current or former partner or spouse.[16] The immediate effects of IPV are injury or death, but there are often long-term health effects. Among these long-term effects are mental health conditions such as anxiety disorders, depression, substance use, and suicidal behavior.[17]

In the United States, over 1 in 3 (36%) of women have experienced IPV during their lifetime and an estimated 1 in 18 (5.5%) have experienced IPV in the past year.[16] Based on age categories reported by the Centers for Disease Control and Prevention, the incidence of IPV for women age 45 and older is lower than that for reproductive-age women. Approximately 4% of women age 45 to 54 years and 1% of women 55 years or older have experienced IPV in the past year.[16]

WPSI recommends that adolescent and adult females be screened annually for IPV.[2] The USPSTF recommends screening for IPV in women of reproductive age and providing or referring women who screen positive to ongoing support services.[17] This recommendation is limited to reproductive-age women because the evidence for benefits of ongoing support services has come primarily from studies of pregnant and postpartum women and then been extrapolated to women of reproductive age. The USPSTF does not recommend routine screening for elder abuse, stating inadequate evidence that it reduces exposure to abuse, harm, or mortality and that valid, reliable screening tools to identify elder abuse are not available.[17] Several validated IPV screening tools are available for use in the primary care setting. Examples include HARK [Humiliation, Afraid, Rape, Kick], HITS [Hurt, Insult, Threaten, Scream], and WAST [Woman Abuse Screening Tool].[17]

Conclusion

Older women benefit when NPs provide evidence-based mental health screening with preventive counseling and referrals as needed for diagnosis and treatment. NPs can become familiar with the various screening tools and choose those that best fit their clinical setting and patient population. As always, it is critical to use clinical judgment to provide individualized, patient-centered care.

Beth Kelsey is Editor-in-Chief of *Women's Healthcare: A Clinical Journal for NPs*, Director of Publications for the *National Association of Nurse Practitioners in Women's Health* in Washington, DC, and Assistant Professor in the School of Nursing at Ball State University in Muncie, Indiana.

References

1. Centers for Disease Control and Prevention. Learn about mental health. 2018. https://www.cdc.gov/mentalhealth/learn/index.htm.
2. Women's Preventive Services Initiative. https://www.womenspreventivehealth.org.
3. White A, Castle I-J P, Chen CM, et al. Converging patterns of alcohol use and related outcomes among females and males in the United States, 2002-2012. *Alcohol Clin Exp Res*. 2015;39(9):1712-1726.
4. National Institute on Alcohol Abuse and Alcoholism.

(continued on page 42)

prepared to care for women and their families for the next crisis.

Postscript

As Megan's lead faculty member, I (Randee Masciola) can attest to the significant stress that the students endured in the final semester of their WHNP program, which continues through the examination and job search. The students positively responded to frequent communication, authenticity, and honesty when we did not know the answers to their major life-changing questions. This was an incredibly stressful time for faculty, as policies and procedures were changing daily and sometimes hourly at the national, state, and organizational level. This was frustrating to students trying to cope with a global pandemic, financial constraints, academic and graduation uncertainty, and the fear of getting ill. Faculty were working overtime to create online content, develop telehealth education and clinical opportunities, and create clinical simulation experiences while they themselves were also living through a pandemic, with their own family and child care issues, financial constraints, and fear of budget cuts. Our college implemented many free wellness and mental health resources and programs for our faculty, staff, and students and created an atmosphere of patience, grace, kindness, and flexibility. This was essential for the success of our students like Megan and brought us closer together as a college, faculty, and in our relationship with our students. We will never forget the bonds that tie us together at this point in time.

Megan Dorsey is a recent graduate of the women's health nurse practitioner (WHNP) specialization track at The Ohio State University, College of Nursing, in Columbus, Ohio. Randee L. Masciola is Assistant Professor of Clinical Nursing at The Ohio State University, College of Nursing, and serves on the editorial advisory board for *Women's Healthcare: A Clinical Journal for NPs*. The authors state that they do not have a financial interest in or other relationship with any commercial product named in this article.

(continued from page 33)

Drinking levels defined. https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/moderate-binge-drinking.

5. National Institute on Alcohol Abuse and Alcoholism. Women and alcohol. 2019. https://www.niaaa.nih.gov/sites/default/files/women-and-alcohol-fact-sheet.pdf.
6. US Preventive Services Task Force; Curry SJ, Krist AH, Owens DK, et al. Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2018;320(18):1899-1909.
7. National Institute of Mental Health. Major depression. 2019. https://www.nimh.nih.gov/health/statistics/major-depression.shtml.
8. Smithson S, Pignone MP. Screening adults for depression in primary care. *Med Clin N Am*. 2017;101(4):807-821.
9. Substance Abuse and Mental Health Services Administration. 2018 NSDUH detailed tables. 2019. https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables.
10. Siu AL, US Preventive Services Task Force; Bibbins-Domingo K, Grossman DC, Baumann LC, et al. Screening for depression in adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2016;315(4):380-387.
11. Nelson HD, Cantor A, Pappas M, Weeks C. Screening for anxiety in adolescent and adult women: systematic review for the Women's Preventive Services Initiative. 2020:1-63. https://www.womenspreventivehealth.org/wp-content/uploads/Screening-for-Anxiety-Report.pdf.
12. National Institute of Mental Health. Any anxiety disorder. 2017. https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder.shtml.
13. US Preventive Services Task Force. Screening for depression, anxiety, and suicide risk in adults. 2020. https://www.uspreventiveservicestaskforce.org/uspstf/draft-update-summary/screening-depression-anxiety-suicide-risk-adults-july-2022.
14. US Preventive Services Task Force; Krist AH, Davidson KW, Mangione CM, et al. Screening for unhealthy drug use: US Preventive Services Task Force recommendation statement. *JAMA*. 2020;323(22):2301-2309.
15. Han BH, Moore AA. Prevention and screening of unhealthy substance use by older adults. *Clin Geriatr Med*. 2018;34(1):117-129.
16. Smith SG, Zhang X, Basile KC, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 data brief – updated release. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. 2018.
17. US Preventive Services Task Force; Curry SJ, Krist AH, Owens DK, et al. Screening for intimate partner violence, elder abuse, and abuse of vulnerable adults: US Preventive Services Task Force final recommendation statement. *JAMA*. 2018;320(16):1678-1687.