



Tailoring the mental health assessment to older adults

Abstract: This article discusses selected considerations for mental health assessment in older adults. Adopting a biopsychosocial model and trauma-informed approach to care creates a safe structure for a more comprehensive assessment. Selecting appropriate tools to improve diagnostic reasoning sets the foundation for further workup and tailored interventions.

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The older adult (OA) population is increasing. According to the US Census Bureau, over the next 30 years, the number of adults age 65 and older in America is expected to increase from 48 to 88 million, and by 2050, the life expectancy is expected to increase by 8 years.¹ This means that there will be a greater demand on the healthcare system to competently address the mental health needs of this population.

Because of the uneven distribution of specialty mental health providers in the US, many OAs receive care from generalists who may have limited training/background in geriatric mental health.² Sixty percent of visits in which a mental health condition was diagnosed and 77% of visits in which a psychotropic

medication was prescribed were to a primary care provider (PCP).³ This has prompted initiatives to further integrate behavioral health into primary care.⁴ This article provides clinical pearls on the approach to the geriatric mental health assessment, highlighting interviewing considerations and selection and use of various tools as recommended by clinical guidelines to facilitate this process and screen for conditions such as depression, trauma history, and bipolar disorder (BD).⁵

■ Assessment framework

OAs often present with atypical or ambiguous symptoms, high medical complexity, and susceptibility to cognitive and behavioral health problems and adverse reactions to medical treatments. These factors, coupled with increased

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Main components of a biopsychosocial mental health assessment^{7,8}

- Presenting complaints and history of the current illness
- Past psychiatric and medical history
- Medication history
- Family structure
- Family psychiatric and medical history
- Personal history (trauma/adverse experiences, habits, nutrition, and lifestyle factors such as finances, social connectedness, support systems, and environment including food/housing security)
- Premorbid personality and coping styles
- Mental status exam
- Goals

likelihood of social isolation and decreased functioning in activities of daily living, increase the risk of institutionalization and can contribute negatively to well-being.⁶ Competent assessment and care of OAs' mental health must extend beyond the biomedical model, which focuses primarily on identifying and treating pathologic diseases, to include the individual's unique contextual meaning of their quality of life (social connectedness, environmental factors, and functioning). The biopsychosocial model is a valid, widely referenced framework that has evolved since the 1970s; however, healthcare's adoption of this approach has been slow outside of mental health and rehabilitation in part due to reimbursement models based upon pathologic diagnoses and level of disability structures.⁷ Important components of this model include biological (illnesses and risk factors), psychological (values, behavior, and quality of life), and social (economic status, class, relationships, religion, and culture) factors. These components should be incorporated into an assessment (see *Main components of a biopsychosocial mental health assessment*). This framework provides a more holistic mental health assessment to illustrate the connectedness of a person's problems. A biopsychosocial approach fosters interdisciplinary collaboration and comprehensive treatment planning.

■ Key assessment considerations

The mental health assessment serves multiple purposes: it commences the process of therapeutic interaction while gathering history and conducting a mental status exam.⁸ Establishing rapport is necessary to provide a safe space for an open dialog. Ensuring that patients have their sensory appliances can facilitate

their ability to actively participate in the assessment. Key interviewing skills include allowing the patient time to process information and to answer questions without feeling rushed.⁹ Explaining the purpose at the beginning and summarizing this information at the end of each part of the assessment helps to reduce confusion and anxiety.¹⁰

A comprehensive assessment necessitates reviewing pertinent health records to obtain a complete medical and prior psychiatric treatment history. It is essential to begin a mental health assessment by ascertaining the motivation to seek care.¹¹ Determining whether the patient is presenting of their own accord; at the behest of a spouse, family member, or caregiver; or as a referral from an agency or healthcare professional from the outset provides some indication of whether the patient has insight into the purpose of the evaluation and the extent to which involvement of others is needed. Additionally, it can help provide more information regarding issues of informed consent and intended use of the assessment. If the OA is accompanied by key informants, beginning the interview with everyone together helps to determine these parameters. The clinician should obtain releases to visit with knowledgeable parties if there are identified concerns about the OA's ability to provide a detailed history. It is also essential to provide an opportunity for the OA and other informants to be interviewed separately to allow for sharing without inhibition and to assess for maltreatment/self-neglect situations. Allowing sufficient time to interview the OA and other informants separately assists with the practitioner's development of rapport with all parties and demonstrates a desire to listen actively and ensure everyone feels heard.¹¹ An important part of the assessment involves eliciting concerns regarding caregiver burden if the OA is relying on others for care.⁹

Compared with younger adults, OAs are more likely to present with and focus on physical complaints, such as pain, difficulty sleeping, or gastrointestinal and cognitive concerns, or they may report "stress" rather than describing emotional problems such as anxiety or depression.¹² This may require moving from open-ended questions to more structured questions and defined time frames to understand the pattern of symptoms.⁸ It is important not to focus solely on symptom counts but also to determine their impact on functioning. Changes in social connectedness and activities of daily living are two key areas that are helpful in assessing the

level of functional impairment in the context of a geriatric mental health assessment. The onset of these changes can help differentiate diagnoses, determine severity, and guide interventions. For example, providers may ask whether functional changes predated the onset of mental health symptoms or began after. Gathering such information can help focus the exploration of potential psychosocial or environmental problems in concert with medical and psychiatric symptoms.

Obtaining a prior psychiatric symptom experience and treatment history can be helpful in diagnosing psychiatric disorders. Many OAs grew up during a time when there was much more stigma around mental health issues and fewer treatment options. They may have experienced symptoms but never sought help to receive a diagnosis, or different terms may have been used to describe psychological distress, such as “nervous breakdown.”⁹ Evaluating the severity and symptom pattern of previous episodes helps determine differential diagnosis; understanding treatment engagement, adherence, and response informs prognosis. Response to previous treatment can also help in understanding apprehensiveness to seek further care.

Obtaining a family history of at least first-degree relatives including parents, siblings, and children assists in identifying possible psychiatric disorders. Additionally, if the patient is a caregiver for a family member or friend, it is important to assess for caregiver burden.

Family members involved in the care of the OA may need to be assessed for caregiver burden as well to determine if additional family system interventions may be needed. The Zarit Burden Interview 6-item version, an efficient tool to help assess the perceived burden of dementia caregivers, was found to identify probable depression in caregivers and have comparable correlation with the original 22-item version.¹³

■ Adopt a trauma-informed approach

Approximately 70% to 90% of adults age 65 and older have experienced at least one traumatic event in their lifetime.¹⁴ The cumulative effect of traumatic experiences has been shown to be an underlying factor in the development and severity of behavioral and physical health problems in later life, yet these connections are often missed in the primary care setting as screening for traumatic exposures and assessment of psychosocial factors is rarely included as part of routine healthcare for OAs.^{15,16}

A long lifespan increases the likelihood of exposure to various traumas. As described by Ogle et al., research has shown there is a cumulative, dose-response relationship between the number of adversities experienced throughout life and posttraumatic stress disorder (PTSD) symptom severity.¹⁵ Specific event categories such as exposure to childhood violence and adulthood physical assaults are most strongly associated with PTSD symptom severity in older adulthood. OAs have

Select tools for mental health assessment in OAs

Zarit Burden Interview (table with all versions)	https://doi.org/10.1080/13607863.2018.1450841
Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)	https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp
Patient Health Questionnaire-2 (PHQ-2) and Patient Health Questionnaire-9 (PHQ-9)	www.phqscreeners.com/
Geriatric Depression Scale (GDS)	https://emedicine.medscape.com/article/286759-workup#c8
Cornell Scale for Depression in Dementia	https://emedicine.medscape.com/article/286759-workup#c8
Folstein Mini-Mental State Exam (MMSE)	www.researchgate.net/figure/Mini-mental-state-examination-questionnaire-Note-Figure-1-shows-MMSE-test-a-30-point_fig1_351948858
Montreal Cognitive Assessment (MoCA)	www.mocatest.org/training-certification/
Young Mania Rating Scale	https://psychology-tools.com/test/young-mania-rating-scale
Columbia-Suicide Severity Rating Scale (C-SSRS) ; several versions available, including those tailored for the initial and subsequent assessments and the setting, as well as shorter versions)	https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english

an increased vulnerability to negative posttraumatic outcomes due to cumulative traumatic experiences with aging including unexpected deaths of friends and family, retirement, and age-related changes in health status and mobility, all of which can contribute to the secondary effect of reducing social support networks, further compounding severity of trauma-related symptoms. PTSD may manifest differently in OAs than in those under age 65, with, for example, increased reporting of poor health, chronic pain, cognitive impairment, and a decreased ability to connect past events to current symptoms.¹²

Potentially triggering stimuli in healthcare settings can lead to trauma reexperiencing. A trauma-informed approach to care involves recognizing that trauma is prevalent in society and that modification of interactions within the healthcare system can facilitate healing and minimize retraumatization.¹⁷ Changing perspective from wondering what is “wrong” with a person to wondering what happened to a person can help guide more trauma-sensitive care.¹⁸ Using validated instruments is an important part of trauma-informed care.¹⁹ The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) is a 5-item screening assessment designed to identify individuals with probable PTSD. This screening tool is related to specific traumatic experiences for a diagnosis of PTSD; however, it is still important to recognize that there are other traumatic experiences that can contribute to psychological distress.¹⁵ The emotional salience of the event for the individual determines whether an experience is traumatic to them.¹⁷

■ Sorting out the 3 D’s: Delirium, depression, dementia, and beyond

In 2018, prior to the start of the COVID-19 pandemic, prevalence of depression and anxiety among OAs was reported at 11%. By August 2020, the incidence had increased to 24%.²⁰ Research from prior to the pandemic found that up to 50% of long-term care facility residents



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may be depressed.²¹ Overlapping issues may include other psychiatric disorders, diseases, medication effects and adverse reactions, and substance use. Depression,

dementia, and delirium are often concurrently present and can be risk factors for developing or exacerbating each other. In the context of an assessment for relatively abrupt onset of a mental status change, it can be helpful to remember the phrase “delirium until proven otherwise.”²² There are several resources available that review the key differences of these disorders, which can be distinguished from one another based on eight major features.^{23,24} These features follow:

1. Rapidity of onset
2. Duration/course
3. Cause
4. Level of consciousness
5. Orientation
6. Affective symptoms
7. Language
8. Executive functions

After delirium has been ruled out, because of the many confounding factors that make depression screening and diagnosis more challenging in later life, it is helpful to consider the utility of the common screening tools available for the OA population (see *Select tools for mental health assessment in OAs*). When selecting screening tools, providers need to consider the reliability and sensitivity of the tools, the OA’s capacity to participate and tolerate their use, and whether the tool contributes to the efficiency of the visit.

Depression screening. The most widely used depression screening tools are the Patient Health Questionnaire (PHQ)-2 and the PHQ-9. While the PHQ-2 is sensitive and efficient with only two questions, it is not as specific as the full nine-item version, the PHQ-9.²¹ However, it is thought that tools that include somatic items may interfere with diagnosis, as OAs often have multiple physical complaints associated with medical conditions, which can inflate scores. Therefore, an assessment tool such as the self-report Geriatric Depression Scale (GDS) may be better suited for assessing depression in OAs, as it does not include somatic items. The 15-question version

(GDS-15) is designed with Yes/No responses that can be completed in approximately 5 to 7 minutes.²⁵ Studies have revealed that the GDS-15 has adequate diagnostic value and superior accuracy to the 30-item version, with an 8% increase in case detection.

²⁶ However, a few studies suggest no significant difference between the GDS or the PHQ-9 for detecting depression in OAs without dementia.^{27,28}

Late-life onset of anxiety and depression as potential diagnostic clues for dementia. The onset of a first episode of major depression and/or anxiety in later life has been identified as a risk factor for developing dementia.^{29,30} Among OAs with mild cognitive impairment (MCI), depression and anxiety are among the most common neuropsychiatric symptoms. OAs with MCI have a 10%-15% risk per year of developing dementia compared with a 1%-2% risk per year for the general population. Incidence of later-life anxiety disorders is low, as 95% of all anxiety complaints have already manifested by the age of 51 years and 99% are identified by the age of 65 years.³⁰ OAs with dementia are more likely to experience longer and more severe major depressive episodes. In vascular dementia and Alzheimer disease, the incidence of depression may be 30%, and in Parkinson and Huntington disease-related dementias, it may be 40%. Confounding signs and symptoms between dementia and major depression include social withdrawal, lack of interest in oneself or others, low initiative, and poor motivation. Apathy is a shared sign that increases diagnostic difficulty.²⁹ Detecting depression in dementia can be facilitated by using the Cornell Scale for Depression in Dementia.³¹ It is a reliable and valid clinician-rated tool completed by eliciting responses from the OA and an informant, such as the patient's caregiver. It has also been found to be reliable and valid for use in OAs without dementia.³²

OAs with dementia. Treatment for dementia has been found to be most effective for preserving cognitive function when initiated early in the disease process, improving chances of the OA remaining in the community longer. The Folstein Mini-Mental State Exam (MMSE) is the most widely used screening tool for cognitive impairment. However, the MMSE was found to have some limitations in identifying cognitive impairment depending on educational level. Another tool is the Montreal Cognitive Assessment (MoCA), which includes other testing elements such as pattern tracing, a clock draw test, and other concentration and recall tasks. The MoCA requires certification to use; the training can be done online, takes about an hour, and may require a fee. Once familiar with it, administering the MoCA takes approximately 10 minutes. While both tests are accurate in detecting

Alzheimer disease, the MoCA has been shown to be superior to the MMSE in identifying MCI and in tracking changes over time.³³

■ Screen for manic symptoms

In any mental health assessment, screening for a history of manic symptoms is vital, as treatment for BD is different than for unipolar depressive disorders; inaccurate diagnosis can lead to poor outcomes. Approximately 70% of people with bipolar I disorder are first misdiagnosed with a 5- to 10-year average delay from illness onset to diagnosis.³⁴ There is limited scientific literature on BD in OAs. Among patients with

BD can be more difficult to detect in OAs because it may present atypically, with less euphoria and more dysphoria, cognitive symptoms, and somatic complaints.



BD, approximately 25% are age 60 or older, and of those patients, 70% are female. Five to ten percent of patients with BD experienced their first manic episode at age 50 years or older. About 19% of OAs with BD will develop dementia.³⁵ BD can be more difficult to detect in OAs because it may present atypically, with less euphoria and more dysphoria, cognitive symptoms, and somatic complaints.^{9,36}

One major contributing factor that can cause a delay in diagnosis is the cyclical pattern of BD. A person may experience years of stability between manic-depressive cycles. Depressive episodes may predominate many episodes and are the most unpleasant and therefore the most memorable. However, it is the discrete episodes of manic or hypomanic symptoms that include uncharacteristic changes in mood, impulsive behavior, and decreased need for sleep that are the most difficult to elicit from patients due to poor insight and recall. Poor impulse control may be the prominent feature of a manic episode in an OA and can also be associated with an agitated delirium.⁹

Screening tools can be helpful but should not be considered definitive for diagnosis, as a significant number of people who have been diagnosed with BD do not have it.³⁴ The clinician-administered Young Mania Rating Scale has been shown to be reliable and valid to detect BD in OAs and should be utilized when there is diagnostic uncertainty or a mixed-symptom

presentation that fails to respond to standard treatment for unipolar depressive disorders.³⁷ Structured clinical interviews and observation are necessary to accurately diagnose BD, which requires extra diligence and time.³⁴ Interviewing persons with knowledge of the OAs' longitudinal behavior patterns is often necessary to assist with detection of manic and hypomanic symptoms.

■ Assessing for suicide risk in OAs

Several tools for depression also assess for suicidal ideation. Understanding the nuances of the tools can help in their selection for use with the OA population. Suicidal ideation is often a symptom of depression



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and is a significant sign of distress, regardless of level of imminent danger of self-harm. It can occur in people without a diagnosis of depression. Research has shown that for people who died by suicide, 45% saw their PCP and 20% saw a mental health provider within a month prior to their death. Fifty percent had received healthcare services within the past month, and 83% had within the prior year.³⁸ Adult males over 75 years of age are more likely to complete suicide by selecting lethal means. OAs are less likely than younger people to spontaneously report suicidal ideation. Therefore, it is important to ask about suicidal ideation as a routine part of a mental health assessment. Screening for suicidal ideation has not been shown to induce or worsen suicidal thoughts, and failure to identify it is a potentially tragic missed opportunity to intervene. Suicidal ideation is generally conceptualized into two main risk severity categories including “passive” thoughts, which include fantasizing about dying without formulating a specific plan, and “active” thoughts with more formulated suicide plans. It is important to remember that the goal of a suicide risk assessment is not to predict whether an OA will attempt or die by suicide but to determine interventions to keep the person safe.³⁸

The PHQ-2 and PHQ-9 scales have potential limitations in assessing for depression among the OA population. Another limitation is with suicide screening. A PHQ-2 cut-off score of 3 is often used to trigger

completion of the PHQ-9, which includes a question about suicidal ideation; however, this cut-off may fail to detect half of individuals with suicidal ideation. Another limitation is that the PHQ-9 screens for symptoms that have occurred only in the previous 2 weeks. A more comprehensive initial suicide risk assessment involves obtaining a lifetime history of suicidal behavior patterns. The Columbia-Suicide Severity Rating Scale (C-SSRS), which consists of 18 items, has been shown to predict suicide attempts in both people contemplating suicide and those not contemplating suicide.³⁹

Another relevant tool used as part of a comprehensive population-specific suicide risk assessment is the Geriatric Suicide Ideation Scale (GSIS). Monitoring changes in suicide risk across the course of treatment is a useful feature of this tool. This scale includes a set of variables associated

significantly with the likelihood of dying by suicide among OAs. It includes some of the same elements as the C-SSRS, such as the presence of suicidal ideation and/or history of suicidal behavior. It also assesses for the presence of mental disorders; extreme personality traits or disorders; medical illness and pain; difficulty adjusting to losses, transitions, and other psychosocial difficulties; and experienced or anticipated reduction in cognitive and/or physical functioning.⁶ To obtain a copy of the GSIS requires permission from the authors. The GDS was also found to have some questions that were sensitive to detecting suicidal ideation, even though it does not directly ask about suicidal ideation. Some OAs may be more likely to express their suicidal thinking as symptoms of hopelessness and worthlessness and feeling as though life is empty.³⁹

■ Implications for practice, education, and research

Although the importance of conducting mental health assessments to detect disorders is recognized, the most appropriate tools based on age and setting are often not consistently used. Additionally, tools are often not used to determine or improve quality of life. Implications for practice include the need for further investigation into understanding and selecting appropriate tools to improve diagnosis, treatment selection, and evaluation of efficacy as well as for

practice management, coding/billing, and revenue. Implications for nursing education include creating a standardized assessment package for advanced practice registered nurses to enhance selection, understanding, and use of the tools to improve screening, diagnosis, treatment, and referral if indicated. Three essential areas for research include incorporation of tools into the primary care setting, exploration of content in existing primary care curricula, and use of assessment tools and diagnoses related to patient outcomes and quality of life.

Conclusion

As the OA population increases, the demand for mental health care will also rise. The uneven distribution of mental health providers creates an opportunity for advanced practice registered nurses to meet this need. Adopting a biopsychosocial model and a trauma-informed approach to care creates a safe structure for a more comprehensive geriatric mental health assessment. Selecting the appropriate tools to improve the efficiency and accuracy of diagnostic reasoning sets the foundation for further workup and tailored interventions. PCPs will be better positioned to determine when referrals are indicated, such as when there is diagnostic uncertainty, multiple psychiatric complaints, medical complexity, or failure to respond to treatment or remit symptoms. Sending and receiving records including progress notes, diagnostics/lab results, and medication histories are all vitally important for coordination of care and understanding the reason for referral or consultation. Future directions for geriatric mental health assessment include discussion around and investigation into the level of long-term care facility involvement in the mental health assessment, treatment planning, evaluation of the effectiveness of treatment, trauma-informed care environments, and the effects on the behavioral and psychiatric symptoms of people with and without dementia. 

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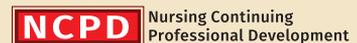
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INSTRUCTIONS

Tailoring the mental health assessment to older adults

TEST INSTRUCTIONS

- Read the article. The test for this CE activity is to be taken online at www.nursingcenter.com/CE/NP. Tests can no longer be mailed or faxed.
- You'll need to create (it's free!) and log in to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Professional Development online CE activities for you.
- There's only one correct answer for each question. A passing score for this test is 7 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Professional Development: 1-800-787-8985.
- Registration deadline is December 5, 2025.

PROVIDER ACCREDITATION

Lippincott Professional Development will award 2.0 contact hours for this continuing nursing education activity.

Lippincott Professional Development is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 2.0 contact hours. Lippincott Professional Development is also an approved provider of continuing nursing education by the District of Columbia, Georgia, West Virginia, New Mexico, South Carolina, and Florida, CE Broker #50-1223. Your certificate is valid in all states.

Payment: The registration fee for this test is \$21.95.