Position Statement: Consensus Statement on Improving the Quality of Mental Health Care in U.S. Nursing Homes: Management of Depression and Behavioral Symptoms Associated with Dementia

Approved by the Board of Trustees, December 2003

"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – APA Operations Manual.

The Board of Trustees voted to endorse the AGS/AAGP Consensus Statement on Quality of Care in Nursing Homes with the caveat that the APA does not necessarily support specific policy recommendations included in the statement.

BACKGROUND

This document presents the recommendations of an interdisciplinary expert panel assembled to identify effective approaches to addressing the mental health care needs of older persons with depression and behavioral symptoms associated with dementia who reside in nursing homes. An extensive literature review, which appears in this issue, was conducted as an integral component of the panel’s activities. (1) This review was used to rate the scientific evidence that supports the panel’s consensus statements, but the panel’s recommendations were not based solely on the evidence rankings. During its deliberations the panel recognized the critical role played by specific health policies and therefore the importance of policy recommendations in any effort to improve the availability and quality of mental health care in nursing homes. A subgroup of the panel drafted recommendations for changes in mental health policy in long-term care; these were expanded into a set of official, joint public policy recommendations of the American Geriatrics Society (AGS) and American Association for Geriatric Psychiatry (AAGP), which also appear in this issue (2).

The following organizations were represented on the expert panel and have reviewed and endorsed* the consensus statement: American Association for Geriatric Psychiatry, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Geriatrics Society, American Health Care Association, American Society on Aging, American Society of Consultant Pharmacists, Gerontological Society of America, National Association of Directors of Nursing Administration in Long-Term Care, National Conference of Gerontological Nurse Practitioners.

The following organizations were also represented on the expert panel and reviewed and commented on the consensus statement: Alzheimer’s Association, American Medical Directors Association, American Psychiatric Association: Council on Aging, American Psychological Association, National Citizen’s Coalition for Nursing Home Reform.

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*Endorsement of this consensus statement does not indicate review or endorsement of any policy recommendations emanating from the deliberations of the expert panel that developed this consensus statement.

Note: Review and endorsement of some organizations still pending / 5-06-03

This project was initiated during the review and development of a response to the changes in the State Operations Manual Interpretive Guidelines for nursing facilities proposed by the Centers for Medicare and Medicaid Services (CMS) and circulated for review and comment in December 2000. The CMS guidelines devoted considerable attention to the use and monitoring of antipsychotics and other medications considered to be “chemical restraints.” In an effort to inform the proposed changes, the AGS and the AAGP organized an expert panel to create a process for making specific recommendations to improve the quality of mental health care in U.S. nursing homes.

Rather than focus narrowly on antipsychotics and “chemical restraints,” the panel chose to focus more broadly on two conditions in nursing home residents: depression and behavioral symptoms associated with dementia. These conditions were selected because of the prevalence and morbidity of depression in the nursing home population, and because of the prominence given to behavioral symptoms in the proposed CMS guidelines. Moreover, these conditions were considered to be appropriate topics for a consensus process in light of the increase in evidence-based literature specific to nursing homes and a relative lack of consensus on how to choose among multiple treatment strategies. A prior long-term-care initiative of the AAGP had identified these two conditions as prime candidates for further research and the development of improved treatment and policy recommendations. (3) From the outset, the panel expressed interest in basing its statements on the existing evidence base and in addressing both nonpharmacologic and pharmacologic treatment approaches.

Numerous stakeholder organizations were contacted, and each was asked to nominate experts who would represent the organization on the panel. These collaborating organizations were informed that they would have an opportunity to review and endorse the panel’s statements. Panel members were selected by the expert panel co-chairs on the basis of nominating organizations’ letters of recommendation and nominees’ curricula vitae,

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and with an eye to achieving interdisciplinary representation. A writer-researcher was selected from applicants responding to an announcement from the AGS to geriatric medicine academic programs.

GOALS

At the panel’s initial meeting in December 2001, several goals were articulated. The panel wanted to create statements that would be clinically useful to the wide variety of practitioners working in nursing homes. Toward this end, panel members were encouraged to make choices among management strategies and prioritize them, but were asked to avoid endorsing all the possible treatments, since practitioners must often make choices among them. The panel also intended to develop statements that would be helpful to nursing home leadership in their quality improvement activities. Consideration was given to broadening the focus of the statements to include assisted-living facilities, but because of the variability in definitions of these facilities and the relative lack of evidence-based literature, the panel ultimately agreed to focus solely on nursing homes. The panel also envisioned statements that would be helpful to CMS and other policy makers. Though interested in pursuing this goal, the panel recognized the potential risk of the premature use of statements in policy mandates or regulatory language. Therefore, in some areas, the panel avoided stating exactly who, when, or how some aspects of care should be accomplished, in order to allow flexibility in the care process. The statements are intended to encourage further dialogue about the revision of regulatory language relating to these conditions in nursing homes, not to be directly adopted into regulatory language.

CONTEXTUAL ISSUES

The panel first established a series of overarching principles that would provide both a context for its own discussions and a guide for improving policy and practice in caring for nursing homes residents with mental health needs. These principles follow:

1. High quality mental health care in nursing homes is possible only where overall care is of high quality.
2. If mental health care of nursing home residents is to improve, the tendency to overemphasize and regulate only the assessment process must change. For those with mental health disorders, assessment must be followed by treatment.
3. The providers who are qualified and able to provide important and necessary assessments and treatments for mental health conditions in nursing homes must be reimbursed for delivering them.
4. The institution must be committed at all levels, including its administrative leadership and medical direction, to maintaining a high quality of life for its residents. The nursing home culture, i.e., the way people live and work together and the type of environment they create, must foster good mental health care. The ways staff and residents interact need to be characterized by trusting relationships that build a sense of community, support residents so that they can contribute to the life around them, and acknowledge and respect resident choice and decision making in areas such as time to arise, times to perform other daily activities, and whether to be alone or with others.
5. Adequate staffing is essential to providing good mental health care to nursing home residents. It facilitates strengthening of staff-resident relationships through permanent staff assignments. It also enables nursing assistants to be important participants in interdisciplinary care planning and conferencing, and allows for closer staff observation of resident preferences and more staff interaction with residents’ families and friends.
6. A homelike physical environment—for example, the spontaneity that is generated by the presence of children, pets, and plants—is a necessary ingredient of a high quality of life and of success in managing depression and behavioral symptoms.
7. The panel also recognized that a thorough assessment of the potential underlying causes and factors contributing to depression and behavioral symptoms should encompass multiple domains if the care of residents with depression and behavioral symptoms is to be comprehensive. These domains include the identification and treatment of pain and sensory deficits, the recognition and minimization of drug side effects, the identification and treatment of psychosis related to dementia and other psychiatric conditions common in nursing homes, appropriate evaluation and diagnosis of dementia, and appropriate diagnosis and treatment of delirium.

A myriad of terms have been used in the literature on the assessment and treatment of behavioral symptoms associated with dementia. General terms such as agitation or behavioral problems are commonly used, even though specific types of behaviors can be characterized with precision (e.g., physically aggressive, physically nonaggressive, verbal, wandering, hiding, hoarding). Since the vast majority of studies in the literature do not focus on a specific type of behavioral symptom, the panel chose to use the relatively nonspecific term behavioral symptoms. Although the term is free of assumptions about the cause or fault, the panel recommends that in the future greater attention be paid to specific types of dementia-related behavioral symptoms in intervention research and policy. In addition, the panel recommends that future research define optimal treatment of specifically defined syndromes, such as “psychosis in dementia,” rather than the more nonspecific “behavioral symptoms in dementia.” Most of the existing literature does not make these distinctions. (1)

METHODS

The writer-researcher for the panel conducted an extensive review of the data-based literature on the assessment and management of the two conditions. This review focused on studies done in nursing home residents and excluded studies done in other settings (see the literature review in this issue (1) for details on the review method). The preliminary results of the review were presented to the panel in December 2001 at its first meeting, along with presentations by experts in depression and behavioral symptoms in nursing home residents. Panel members discussed several sample statements that

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The accuracy of the items on depression of the Minimum Data Set (MDS) as it is routinely performed was a concern of the panel, which believes that the MDS is inadequate by itself for screening for depression.

Residents with suicidal ideation, with or without verbalization of a plan to harm themselves, should be considered for immediate referral to a mental health professional for consideration of treatment. (The determination of the need for immediate referral should be based on the particular circumstances, including intent, likelihood of harm to self, and the availability of staff for observation.)
Residents who have depression with psychotic features or who have not responded to 6 or more weeks of treatment should be referred to a mental health professional. [Note: With regard to referrals, the panel recognizes that access to qualified mental health professionals may be limited for some facilities. Qualified primary health care providers may be able to perform such services when mental health providers are not available.]

The use of nonpharmacologic interventions in combination with antidepressant medications for treating major depression is supported by the panel.

For residents with minor depression, treatment alternatives include nonpharmacologic interventions, antidepressants, and watchful waiting. The choice among them depends upon factors such as severity, previous history, and preferences of the resident, family (if resident desires), or legal representative.

Psychotherapeutic modalities, including group and individual cognitive-behavioral psychotherapy, may be helpful in treating selected residents. Other nonpharmacologic interventions supported by the panel include increasing social activities and providing meaningful activities, such as sheltered workshop, volunteering, religious activities, or activities that maintain residents’ past roles.

First-line treatment of major depression should include antidepressant medications.

Once a decision has been made to use an antidepressant, of the classes of agents currently available, selective serotonin reuptake inhibitors (SSRIs) are the most appropriate for first-line treatment of depression in nursing home residents. (Evidence currently exists for the effectiveness of SSRIs for depression in nursing home residents, but other classes of nontricyclic antidepressants [e.g., non-SSRIs] may also be appropriate for first-line treatment of depression in nursing home residents.)

Antidepressants that should be avoided include amitriptyline, doxepin, monoamine oxidase inhibitors, and clomipramine.

**Recommendations on Behavioral Symptoms Associated with Dementia**

The panel’s recommendations of primary clinical importance that have the potential to improve the management of behavioral symptoms associated with dementia in nursing home residents include:

- Education and training of mental health professionals working in nursing homes and of nursing home staff in the recognition, assessment, treatment, and monitoring of behavioral symptoms in nursing home residents is essential.
- The MDS is not adequate in identifying all residents with behavioral symptoms. Verbal, nonverbal, and physical behavioral symptoms should be described and quantified.
- Residents with new onset of or changes in behavioral symptoms should be assessed for disorders such as psychosis, depression, anxiety, sleep disorders, other neurological conditions, adverse drug reactions and interactions, and substance abuse or medication abuse or withdrawal. Environmental, situational, social, and psychological factors should also be assessed.
- Residents with new onset of or change in behavioral symptoms should have vital signs taken and be evaluated for adverse medication effects, infections, dehydration, pain or discomfort, delirium, fecal impaction, and injury.
- The assessment and treatment of behavioral symptoms should be interdisciplinary, and development of individualized care plans should involve families and include information about residents obtained from both staff and family members.
- Residents who threaten or attempt harm to self or others, with or without inflicting actual harm, should be considered for immediate referral to a mental health professional for consideration of treatment. (The determination of need for immediate referral should be based on the particular circumstances, including likelihood of harm to self or others and the availability of staff for observation.)
- Residents being treated with nonpharmacologic interventions and/or drug treatment for behavioral symptoms who show minimal or no improvement in 30 days should be referred to a mental health professional. [Note: With regard to referrals, the panel recognizes that access to qualified mental health professionals may be limited for some facilities. Qualified primary health care providers may be able to perform such services when mental health providers are not available.]
- After associated medical conditions are assessed and treated, the initial treatment of behavioral symptoms should be nonpharmacologic when there are no psychotic features and when there is no immediate danger to the resident or others.
- Appropriate nonpharmacologic interventions should be delivered by trained professionals or trained nursing home staff and include sensory therapy, activities therapy, modification of activities of daily living care to meet individuals’ needs, environmental modifications, behavioral theory treatments, and social contact interventions.
- Appropriate first-line pharmacologic treatment of residents with severe behavioral symptoms with psychotic features, such as hallucinations and delusions that are causing distress, consists of atypical antipsychotics.
- Combination pharmacotherapy for severe behavioral symptoms and psychotic features can be considered following two different trials with two different classes of agents at sufficient doses.
- Pharmacologic treatments, when used only for dementia-related behavioral symptoms, should be evaluated for tapering or discontinuation not more than 6 months after symptoms are stabilized, followed by attempts at tapering or discontinuation thereafter every 6 months.

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DISCUSSION

This consensus panel, which broadly represents provider, professional, and other stakeholder organizations, differs from consensus panels that present expert opinions based on the concerns of a specific discipline (e.g., medicine, nursing, psychology, social work, pharmacy), and its recommendations likewise differ from those of individual organizations (e.g., professional societies, researcher organizations, consumer advocacy organizations). Because of the diversity of panel members and their perspectives, the panel’s recommendations constitute a strong indication of the areas in which consensus is emerging. One strength of this inclusive process is its ability to highlight positions about providing quality mental health care in nursing homes for which there is clear and broad-based support from multiple constituencies. For example, in addressing behavioral symptoms in dementia, the panel found broad acceptance among its members of the importance of a thorough medical assessment and of the effectiveness of environmental and behavioral interventions.

At the same time, the panel’s deliberations confirm the persistence of controversies over the value of particular interventions, despite the existence of a growing research base. For example, there was considerable variation in ratings of the value of specific pharmacologic interventions for behavioral symptoms in dementia.

Given the diversity of the panelists, it is understandable that some individuals would not feel qualified to rank certain statements, especially those relating to pharmacologic treatments, and would thus abstain. When the number of abstentions for an item amounted to nearly half of the panel, the strength of the consensus process for that item is limited. For example, the panel endorsed using a specific depression screening instrument, but the rankings for that item ranged from 1 to 9. Tighter consensus might have been achieved, and some statements with borderline rankings of 4 or 6 might have been endorsed, if the process had incorporated an opportunity for panelists to discuss the rationale behind their rankings before they made their final ranking.

All panel members were provided a summary of the evidence-based literature to help inform their final rankings of statements. The panel’s rankings were generally, though not uniformly, in line with the literature review evidence ratings. In some areas, the final consensus statements directly correspond to the literature in rating the strength of support. However, in others, there was a divergence on the relative value of various assessment and treatment strategies, as indicated by a number of items with a level of evidence rating of IV. For example, in the depression statements, the panel endorsed the efficacy of nonpharmacologic and pharmacologic interventions in accord with randomized controlled trials of each type of intervention. However, the panel could not reach consensus on using either treatment modality alone for residents with major depression. The implication is that pharmacologic and nonpharmacologic interventions should be employed simultaneously as first-line treatment, even though there are currently no data from randomized controlled trials in nursing homes to support this combined approach.

Individual panelists also differed strongly in ranking the effectiveness of pharmacologic treatment of behavioral symptoms when psychosis is not clearly present. Rankings ranged from a 1, indicating nonagreement, to an 8, supporting treatment effectiveness. Thus, the panel did not reach consensus supporting the use of drugs of any class for behavioral symptoms in the absence of psychotic features, even though there are several well-conducted placebo-controlled randomized trials suggesting at least modest efficacy of antipsychotics, and some positive trials for anticonvulsants and antidepressants. (1) Conversely, the panel chose to endorse (with rankings ranging from 5 to 9) the use of nonpharmacologic treatments for behavioral symptoms, such as sensory therapy, treatments based on behavioral theory, environmental modifications, and social contact interventions, even in the absence of randomized controlled trials for these interventions.

CONCLUSIONS

The interdisciplinary panel of experts representing numerous organizations reached consensus on a broad spectrum of statements regarding the assessment and treatment of depression and dementia-related behavioral symptoms in nursing home residents. The process, though different from the process used by consensus panels who consider only the evaluation of peer-reviewed evidence, produced similar results in several areas and enabled the panel to address many areas that research has yet to investigate. Moreover, the professional breadth of the panel adds validity to the areas where consensus reaches beyond a single discipline. The breadth and relatively small size of the panel, particularly in cases where several panel members abstained from voting, limited the depth of interventions that were endorsed. Thus, areas in which the practitioner must choose among several treatment options, or choose a second- or third-line treatment, could not be addressed in detail. In the real world of caring for nursing home residents, management may appropriately include assessment and interventions on which this panel could not achieve consensus. The statements upon which the panel did reach consensus should provide a useful guide to clinicians. However, clinical judgment and the consideration of the unique aspects of individual residents and their situations, will be necessary for the optimal treatment and assessment of depression and dementia-related behavioral symptoms in the nursing home population.
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Note: The organization the panel member represented is noted in parenthesis.

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Centre for Evidence-Based Medicine Web site, funded by University of Toronto Health Network and Mt. Sinai Hospital:(http://www.cebm.utoronto.ca/intro/whatis.htm)