

Use of Antidepressants in Nursing Home Residents

A Joint Statement of the Members of the Long Term Care Professional Leadership Council (LTCPLC)

SUMMARY

The LTCPLC wishes to provide information and comment regarding the appropriate use and considerations for using antidepressants in the nursing home.

- Normal human emotions such as sadness and anxiety should not be confused with disease.
- The diagnosis of depression should be made carefully, based on established guidelines.
- Treatment of mood disorders, including depression, should be broad-based.
- Antidepressants are sometimes initiated under questionable circumstances.
- As with all other medications, antidepressants have both benefits and risks.
- The CMS Quality Indicator for depression must be interpreted cautiously.
- The F329 Unnecessary Drug guidance encourages judicious decision making.
- It is reasonable to promote the careful use and periodic reconsideration of the need for antidepressants.

DISCUSSION

In December, 2006, the Centers for Medicare & Medicaid Services (CMS) released an update of its “F329 - Unnecessary Drugs” guidelines for surveyors. Among other things, these guidelines include additional categories of psychopharmacological medications—including antidepressants—to be considered for tapering.

This section of the surveyor guidance has elicited concerns from facilities, surveyors, and practitioners. Some believe that it is unreasonable to expect that tapering of such medications be considered.

Arguments include the following:

- for many years, it has been stated that depression is under-diagnosed and under-treated
- the alleged standard of care is to keep people on antidepressants indefinitely, not to taper them
- because CMS has a quality indicator related to the number of people in the facility with symptoms of depression on the MDS who are not receiving antidepressants, failure to treat these people with antidepressants may put the facility at risk for a survey deficiency.

The LTCPLC wishes to provide information and comment on this issue.

Normal human emotions such as sadness and anxiety should not be confused with disease.

Sadness and anxiety are normal human emotions. Crying is a normal human expression of sadness. Emotions can become problematic when they become so extreme or overpowering that they interfere with normal function. Sometimes, medical conditions can cause extreme emotions.

Depression is a mood disorder. It is important not to confuse normal human emotions with disease needing medical treatment.

The diagnosis of depression should be made carefully, based on established guidelines.

The diagnosis of depression always requires more than just identification of symptoms. Although the diagnosis of depression is sometimes unclear, and empirical treatment is sometimes indicated, there are specific criteria for the diagnosis.

There is a spectrum of mood disturbances and disorders. No one symptom defines depression. There is not a distinct cutoff between normal and depressed. Therefore, it is always important to look at the whole individual and the symptoms in the proper context.

For example, it is normal for people to express dismay or sadness as a result of personal loss, serious illness, or other difficult situations. Statements such as “I don’t want to live” may deserve additional investigation, but do not by themselves mean that someone is depressed or has a condition or illness that warrants a medication.

Nursing home regulations and related materials and documents (including the Minimum Data Set [MDS] and RAPs [Resident Assessment Protocols]) do not provide enough information or guidance to permit the diagnosis of depression. Therefore, the conclusion that someone is depressed requires additional evaluation and careful review of all pertinent information.

Concerns have been raised repeatedly about possible over-diagnosis and over-treatment of mood and behavioral symptoms, and the confusion of normal emotions of everyday life with treatable medical illnesses. Since screening checklists do not provide enough information to diagnose depression, results must be interpreted in the proper context. [Wakefield JC, Schlitz MF, First MB, Horowitz AV. Extending the bereavement exclusion for major depression to other losses: Evidence from the national comorbidity survey. Arch Gen Psychiatry. 2007;64:433-440]. Although this study covers younger individuals, the concerns about inappropriate diagnosis and inadequate context to interpret information apply to any age group.

In addition, symptoms that could reflect depression can also result from other significant conditions that may look like, or be totally unrelated to, depression. For example, diseases and medications can cause lethargy, weakness, or apathy. These may appear to be caused by depression, but they are due to other conditions. [Landes AM, Sperry SD, Strauss ME, Geldmacher DS. Apathy in Alzheimer's Disease. J Amer Geriatr Soc 2001; 49:1700-1707.] Careful assessment is needed to identify the cause of such symptoms. Appropriate interventions depend on the cause of such symptoms.

Symptoms of depression may range from major (severe symptoms, significant complications) to minor and/or uncomplicated. Any mood disturbance, including depression, may be enduring or limited.

Treatment of mood disorders, including depression, should be broad-based.

There is ample evidence that nonpharmacologic interventions are often successful in individuals with mood disturbances including anxiety and depression, especially in individuals with less complicated courses and intermittent symptoms. [American Medical Directors Association. Depression Clinical Practice Guideline. AMDA: Columbia, MD, 2003.] Use of nonpharmacologic interventions should be considered in treatment of mood disorders, either alone or in combination with medications.

Antidepressants are sometimes initiated under questionable circumstances.

Antidepressants are used legitimately to treat various conditions. In many individuals with depression, medication is essential.

However, antidepressants are sometimes initiated for questionable indications, with little or no evidence of efforts to consider alternative explanations for, or root causes (such as medication side effects) of symptoms. This may occur when treatment is based on speculation or misinterpretation of symptoms. Although properly trained psychiatrists and other clinicians are often helpful, not all psychiatric consultations in nursing homes are done by adequately trained and knowledgeable clinicians.

For example, it is often assumed that people who aren't eating should receive an antidepressant as an "appetite stimulant." However, the reputation of antidepressants as "appetite stimulants" has been exaggerated. Using them routinely is not good practice.

Anorexia is common, and sometimes is a symptom accompanying depression. Many other medications that residents already take (including some antidepressants) may suppress appetite, directly or indirectly (by causing lethargy, confusion, dry mouth, etc.). There are many medical and medication-related causes of decreased appetite that should be investigated and can be corrected. Just putting someone on an antidepressant because they are not eating well is not good practice.

Only qualified individuals who are capable of evaluating the whole picture including possible alternative explanations for symptoms, and who understand the relative benefits and potential adverse consequences of medications, should attempt to diagnose depression and/or prescribe antidepressants. This does not necessarily require a psychiatrist, as primary care practitioners who perform an appropriate assessment and refer to relevant criteria can potentially diagnose and manage uncomplicated situations.

Since many individuals have other, often reversible underlying causes for not eating, it is often inappropriate to use an antidepressant as a first line intervention. Even when such medication is prescribed appropriately, it is important to evaluate whether it is helpful, and to discontinue it if not effective. Even when used successfully, it is often appropriate to try to taper such medication subsequently.

As with all other medications, antidepressants have both benefits and risks.

Overall, antidepressants have a relatively good safety profile. But, they also carry significant risks. Under certain circumstances, including use in combination with other medications, they can be related to serious, if not fatal, adverse consequences.

While newer antidepressants may have fewer side effects overall than older ones, some risks are comparable. For example, the incidence of falls as an adverse consequence related to newer antidepressants is not appreciably different than with older ones.

Many antidepressants increase a chemical in the brain called serotonin. But other medications can also affect serotonin levels in the brain. If a person is receiving too many medications, or too high of a dose of medications, which affect serotonin levels, they can get a dangerous condition called “serotonin syndrome.” This condition may masquerade as a viral or flu-like illness, cardiac disease, anxiety, neurologic disorder, or worsening of prior psychiatric symptoms [Lantz MS. Serotonin syndrome in the older adult. Clin Geriatr 2006; 14:13-16. Sternbach H. The serotonin syndrome. Am J Psychiatry 1991;148(6):705-713; LoCurto MJ. The serotonin syndrome. Emerg Med Clin North Am 1997;15(3):665-675; Boyer EW, Shannon M. The serotonin syndrome. N Engl J Med 2005;352(11):1112-1120.]

Adverse consequences of antidepressants may not be identified when they are not sought or are not believed when they are seen. When adverse consequences are suspected, further appropriate action (such as tapering to see if there may have been an adverse consequence) may not be taken.

The CMS Quality Indicator for depression must be interpreted cautiously.

Application of the CMS Quality Indicator (QI) related to depression is flawed. Having a symptom of depression does not represent a diagnosis. No one symptom proves that an individual is depressed or should receive a medication.

The MDS QI was developed as a screen at the facility level to evaluate whether individuals with depression are being identified and treated. However, it has been misinterpreted by some to imply that appropriate practice is to initiate antidepressant medications for anyone who triggers with a symptom that could represent depression.

Based on diagnostic considerations mentioned above, the MDS cannot diagnose depression, but only lists symptoms. Therefore, it is not appropriate to judge the quality of care simply based on the number of individuals who are (or are not) receiving antidepressants, without also evaluating whether the other important considerations mentioned herein have been addressed.

The F329 Unnecessary Drug guidance encourages judicious decision making.

The guidance for F-329 asks facilities to consider whether continued use of an antidepressant is indicated and whether a dose reduction might be appropriate. That is a reasonable expectation.

Although some individuals will not be candidates for attempted tapering, others may not need antidepressants indefinitely, or may do well on a lesser dose. There is a significant difference between individuals who are clearly diagnosed with clinical depression and others for whom an antidepressant is begun based on nonspecific symptoms, or when given for pain management or anorexia. Judicious clinical assessment and decision making help to distinguish appropriate situations, and minimize the risks of having significant symptoms return. In addition, tapering does not necessarily mean abrupt discontinuation.

Our conclusion: It is reasonable to promote the careful use of antidepressants and periodic reconsideration of the need for their continued use.

- The use of antidepressants should be governed by the facts, not by existing myths and misconceptions.
- Facilities, nursing home staff, survey agencies, physicians, consultant pharmacists, and others should recognize the myths and realities about antidepressants, including their relative benefits and risks.
- There are good reasons to expect careful consideration of indications, dosage, and duration of antidepressants, as with other categories of medications.
- Sometimes, antidepressants must be continued indefinitely. But there are various situations where antidepressants can be safely tapered, and sometimes discontinued.
- Valid practice guidelines do not suggest that antidepressants should never be considered for tapering or discontinuation.
- A key component of clinical judgment is to be able to identify situations where treatment may not be warranted or can be discontinued; indiscriminate “cookbook” approaches do not necessarily reflect real judgment or skill, and do not represent personalized care.

The Council also recommends the following:

1. State survey agencies should help surveyors understand that the expected review of antidepressants as recommended in the surveyor guidance is reasonable. Surveyors should be given information to help them understand legitimate indications for antidepressant use and clinical contraindications to tapering.
2. Nursing home staff and practitioners should be given adequate information about the appropriate use of antidepressants and their potential—alone or combined with other medications—to cause significant adverse consequences.
3. The practice of using antidepressants routinely or indiscriminately as empirical appetite stimulants should be reconsidered. Individuals with anorexia or weight loss should be assessed appropriately for causes of those symptoms, including adverse consequences due to other medications. Interventions for anorexia and weight loss should be targeted to those causes.
4. Appropriate clinical practice guidelines should be used to guide diagnosis and management of depression.
5. Research on the subject of depression and its treatment in nursing homes should be more balanced.

Research about depression management in nursing homes appears to be based primarily on the hypothesis that depression remains widely under-diagnosed and untreated. Undoubtedly, there are individuals for whom this is true. But the use of antidepressants has increased from 28.8 percent of nursing home residents in 1998 to 47 percent in 2007, according to CMS data. Therefore, it is puzzling how under-treatment can still be described as common or widespread. A careful review of the basis for diagnoses of depression and the rationale

for treating it in individual nursing home residents is needed to determine whether appropriate criteria for diagnosis and treatment are being met. Research should also look for the broader impact of antidepressants on individuals, including possible undetected or unmanaged adverse consequences.

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