

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

American Geriatrics Society and American Association for Geriatric Psychiatry

The American Geriatrics Society and American Association for Geriatric Psychiatry Expert Panel on Quality Mental Health Care in Nursing Homes developed this consensus statement.

The following organizations were represented on the expert panel and have reviewed and endorsed* the consensus statement:

Alzheimer's Association, 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 Medical Directors 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 Citizen's Coalition for Nursing Home Reform, National Conference of Gerontological Nurse Practitioners.

The following organizations were also represented on the expert panel and reviewed and commented on the consensus statement:

American Psychiatric Association: Council on Aging, American Psychological Association. *J Am Geriatr Soc* 51:1287-1298, 2003.

Key words: behavioral symptoms; clinical recommendations; dementia; depression; nursing homes

This document presents the recommendations of an interdisciplinary expert panel assembled to identify effective approaches to addressing the mental healthcare 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 ratings. During its deliberations, the panel recognized the critical role played by specific health policies and therefore understood 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 participating organizations' endorsement of this consensus statement does not imply endorsement of the AGS/AAGP public policy recommendations.

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 that are 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 attention paid 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-

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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.

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based literature specific to nursing homes and a relative lack of consensus on how to choose from 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 and in addressing nonpharmacological and pharmacological 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. The expert panel coauthors selected panel members based on nominating organizations' letters of recommendation, nominees' curricula vitae, and interdisciplinary representation. A writer-researcher was selected from among 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 from among management strategies and prioritize them, but were asked to avoid endorsing all the possible treatments, because practitioners must often make choices among them. The panel also intended to develop statements that would help 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 assisted living 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. Although 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, 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 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 are:

1. Persons in nursing homes are primarily people who need to be allowed to lead their lives in the most autonomous and pleasant way possible. The regulations and the

institution's organization, both, should reflect this goal rather than interfere with it.

2. High-quality mental health care in nursing homes is possible only where overall care is of high quality.
3. 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, treatment must follow assessment.
4. 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.
5. 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 (the way people live and work together and the type of environment they create) must foster good mental health care. 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 rise, times to perform other daily activities, and whether to be alone or with others need to characterize the ways staff and residents interact.
6. 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.
7. A homelike physical environment (e.g., 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.

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 these conditions 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.

Many terms have been used in the literature to discuss 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). Because 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 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 less-specific "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 on the assessment and treatment of the two conditions. This review focused on studies conducted in nursing homes and excluded studies conducted in other settings.¹ 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 were based on these presentations. A summary of the completed literature review and sample consensus statements were subsequently distributed, and the panel members submitted written comments and additional statements for consideration. At its second meeting, in April 2002, the panel added statements and edited each statement in preparation for ranking. The writer-researcher gave each statement an evidence-based rating that indicated the strength of the relevant literature; the ratings were based on those used for other evidence-based consensus statements.^{1,4,5}

The panel did not attempt to reach consensus on the level of evidence for each statement. Thus, statements with negative studies and studies with mixed results were marked "–" and "+/–," respectively. The statements developed by the panel differ from some evidence-based consensus statements in that they were not included, excluded, or ranked solely on the strength of evidence. This approach allowed the panel to address areas not examined by the current research literature and allowed the individual panel members' beliefs and interpretations of the literature to affect the rankings. The process used to develop the statements (reviewing the literature, using expert opinion from a multidisciplinary panel, and involving advocacy groups representing nursing home residents) is in keeping with the definition of evidence-based medicine as the integration of best research evidence with clinical expertise and patient values.⁶

Statements with the evidence ratings were mailed to panelists for ranking. Panel members were asked to use a 9-point scale (0 = abstain, 1–3 = do not agree, 4–6 = somewhat agree, 7–9 = agree) to rank each statement in two domains: the strength of their agreement or disagreement with the statement and the clinical value or importance of the statement. Results of the rankings were tabulated, and an average was calculated for each statement (excluding the zeroes for abstentions). The statements were then sent back to each panelist for a second ranking, with knowledge of the average ranking for each statement and the panelist's prior ranking, so that panelists who wished to change their ranking could do so. After the second round of ranking, statements obtaining a median ranking of 7 or greater were identified as agreement, those with a median ranking of 3 or

less were identified as disagreement, and those with a median ranking of 4 to 6 were identified as no consensus.

RESULTS

The panel was able to reach consensus on a wide variety of statements concerning the screening, assessment, referral, and treatment of residents with depression and behavioral symptoms associated with dementia. For depression, the panel reached consensus on 89 of the 131 (68%) statements ranked (Table 1). For behavioral symptoms associated with dementia, the panel reached consensus on 105 of the 139 (76%) statements ranked (Table 2). The median rankings of clinical value or importance were nearly identical to the rankings of agreement and are therefore not presented. The range of the rankings (highest ranking from a panelist minus lowest ranking) was examined and found to vary from 1 to 7 across all items. The average range of the rankings for the depression and behavioral items were 4.6 and 4.3, respectively.

Between four (23%) and eight (47%) of the 17 panel members abstained from ranking the 26 depression items and 77 behavior symptoms items involving judgments about specific medications. Thus, rankings of statements related to individual drugs are not included in the tables. The panel agreed that, when antidepressants are prescribed in this population, selective serotonin-reuptake inhibitors (SSRIs) are the most appropriate first-line treatment. The panel also agreed that some antidepressants should generally be avoided in treating nursing home residents, including strong anticholinergics, such as amitriptyline and doxepin, and monoamine oxidase inhibitors. For behavioral symptoms associated with dementia, the panel endorsed atypical antipsychotics for first-line treatment of severe symptoms associated with psychotic features. The panel also agreed that the risks may outweigh the benefits of using certain drugs, including thioridazine and clozapine, in treating nursing home residents.

The panel did not take cost considerations into account in its rankings of statements regarding medication use, although the panel recognizes that there are severe cost constraints in most Medicaid and capitated programs on the use of the newer, more expensive drugs.

The panel's consensus on a broad range of statements resulted in many recommendations on the assessment and treatment of depression and behavioral symptoms associated with dementia. These recommendations are summarized in the following sections.

Recommendations on Depression

The panel's recommendations of primary clinical importance that have the potential to improve the management of depression in nursing home residents include the following:

1. Screening for depression should be conducted 2 to 4 weeks after admission and repeated at least every 6 months. In addition, the new onset or worsening of depressive symptoms should prompt an assessment that includes psychological, situational, and medical evaluations.

2. Depression screening instruments should be used for the identification and assessment of depressed residents and evaluation of treatment effectiveness. Self-report scales

Table 1. Management of Depression in Nursing Home Residents: Consensus Statements on Which the Panel Reached Agreement

	Statement	Evidence Rating*
Identification and screening		
1.	The Minimum Data Set alone, as routinely used, is NOT an adequate tool for screening nursing home residents for depression.	III
2.	Depression screening in nursing home residents should be accomplished using an additional instrument beyond the Minimum Data Set.	II (+/-)
3.	Depression scales that rely on self-report (e.g., Geriatric Depression Scale, Beck Depression Inventory) should NOT be used for residents with more than MILD cognitive impairment.	II
4.	Depression scales that rely on self-report should NOT be used for residents with SEVERE cognitive impairment.	II
5.	Interviewer-rated scales should be used for residents with moderate or severe dementia by a clinician trained in their use.	III
6.	Screening for depression in nursing home residents should be conducted:	
	a) In newly admitted residents after allowing 2 to 4 weeks to adjust to nursing home placement	IV
	b) In all residents at least every 6 months	III
Assessment and diagnosis		
7.	Diagnosis of depression should NOT be determined solely on the basis of severity score ratings of validated depression scales.	IV
8.	When a resident is identified as having depressive symptoms, initial evaluation of the resident should include assessment with:	
	a) Interviewer-rated scales used by a clinician trained in their use, particularly for residents with moderate or severe dementia (e.g., Cornell Scale for Depression in Dementia)	II
	b) Self-report scales for residents with no more than mild to moderate cognitive impairment (e.g., Geriatric Depression Scale)	II
9.	When a resident is identified as having depressive symptoms, physical, environmental, social, and spiritual issues should be evaluated.	III
10.	Residents with new-onset depression or worsening of depressive symptoms should receive an evaluation focusing on:	
	a) Past history of depression symptoms and treatment	III
	b) Current response to treatment of depression	III
	c) Symptoms constituting a diagnosis of mood disorder	III
	d) Suicidal ideation	III
	e) Changes in cognitive function	III
	f) Changes in social or family situation	III
	g) New stressors or situational factors such as changes in staff	III
	h) Availability of social and meaningful activities	III
	i) Availability of positive (reinforcing) experiences	II
	j) Unmet needs	III
11.	Residents with new-onset depression or worsening of depressive symptoms should receive a medical evaluation by a physician, nurse practitioner, or physician assistant, including a history and physical examination that focuses on:	
	a) Assessment of pain	III
	b) Nutritional status	III
	c) Worsening of chronic medical conditions	III
	d) Recent onset of new medical condition	III
	e) Medications that have the potential to alter cognition or mood	II
12.	Unless recent results are available, residents with new-onset depression or worsening of depressive symptoms should be considered for laboratory and diagnostic testing as determined by the findings of the history and physical examination:	IV
	a) Hemoglobin	III
	b) Thyroid function	III
	c) Electrolytes	III
	d) Vitamin B ₁₂ level	III
	e) Serum drug levels that may play a role in presentation of depression in this population	III
	f) Complete blood cell count	III
Referral to (or evaluation by) mental health professional†		
13.	Residents with suicidal ideation but WITHOUT demonstrated behavior or verbalization of a plan to harm themselves should be monitored and referred to a qualified mental health professional for evaluation.	IV

continued

Table 1. (continued)

	Statement	Evidence Rating*
14.	Residents with suicidal ideation AND with demonstrated behavior or verbalization of a plan to harm themselves should be closely supervised until a qualified mental health professional evaluates them.	IV
15.	Residents with suicidal ideation WITH or WITHOUT demonstrated or verbalization of a plan to harm themselves should be immediately referred to a mental health professional for consideration of treatment.	IV
16.	Residents with depressive symptoms AND with coexistent psychotic symptoms should be referred to a mental health professional.	III
17.	Residents with minimal or no significant improvement in depressive symptoms AFTER 6 WEEKS of treatment:	
	a) Should have their treatment adjusted, changed, or augmented	III
	b) Should be referred to a mental health professional if they have not seen one	IV
18.	Residents with minimal or no significant improvement in depressive symptoms AFTER 8 WEEKS of treatment:	
	a) Should have their treatment adjusted, changed, or augmented	IV
	b) Should be referred to a mental health specialist if they have not seen one	IV
19.	Residents with minimal or no significant improvement in depressive symptoms AFTER 12 WEEKS of treatment:	
	a) Should have their treatment adjusted, changed, or augmented	III
	b) Should be referred to a mental health specialist if they have not seen one	IV
Treatment [†]		
20.	The need for, type, or intensity of treatment should not be determined SOLELY based on severity score ratings of validated depression scales.	IV
21.	Nonpharmacological interventions are effective in treating depressive symptoms in nursing home residents with major depression.	I
22.	Pharmacological interventions are effective in treating depressive symptoms in nursing home residents with major depression.	I
23.	For residents who meet criteria for MINOR depression, observation of the resident for up to 2 months WITHOUT specific treatment may be appropriate.	III
24.	For residents who meet criteria for MINOR depression, alternatives for treatment include nonpharmacological interventions, antidepressants, and watchful waiting; the choice among them depends upon factors such as severity, previous history, and patient or family preference.	IV
25.	First-line treatment for residents who meet criteria for MINOR depression includes:	
	a) Nonpharmacological interventions to be delivered by trained geriatric professionals or trained nursing home staff	I
	b) Specialized psychotherapies to be delivered by a trained mental health professional	I
26.	Nonpharmacological interventions are effective in treating depressive symptoms in nursing home residents who meet diagnostic criteria for MINOR depression.	I
27.	The following nonpharmacological interventions delivered or facilitated by a trained geriatrics professional or trained nursing home staff are appropriate for treatment of MAJOR depression:	
	a) Provision of meaningful activities, such as sheltered workshop, volunteering, religious activities, or activities that maintain residents' past roles	I
	b) Social contact intervention	I
28.	The following nonpharmacological interventions delivered by a mental health professional are appropriate for treatment of MAJOR depression for residents WITHOUT moderate or severe cognitive impairment:	
	a) Group cognitive behavioral psychotherapy	I
	b) Individual cognitive behavioral psychotherapy	IV
29.	The following nonpharmacological interventions delivered or facilitated by a trained geriatrics professional or trained nursing home staff are appropriate for treatment of MINOR depression:	
	a) Provision of meaningful activities, such as sheltered workshop, volunteering, religious activities, or activities that maintain residents' past roles	IV
	b) Social contact intervention	IV
30.	First-line treatment for residents who do NOT meet criteria for MAJOR depression but who have significant symptoms of depression, dysthymia, or minor depression includes:	
	a) Nonpharmacological interventions to be delivered by trained geriatrics professionals or trained nursing home staff	IV
	b) Specialized psychotherapies to be delivered by a trained mental health professional	IV
31.	First-line treatment for residents who meet criteria for MAJOR depression WITHOUT psychotic features should include an antidepressant.	I (+/-)

continued

Table 1. (continued)

	Statement	Evidence Rating*
32.	For residents with major depression WITH psychotic features, a combination of antidepressant and antipsychotic medications is appropriate.	III
33.	Residents with a first or second episode of MAJOR depression responding well to antidepressant treatment should be continued on full-dose treatment for at least 6 months after significant improvement is noted.	III
34.	Selection of an appropriate antidepressant agent for nursing home residents should be based on:	
	a) Previous history	III
	b) Other affective features	III
	c) Other medical comorbidities	III
	d) Side-effect profiles of the antidepressants	III
	e) Potential drug-drug interactions	III
35.	Once a decision has been made to use an antidepressant, of the classes of agents currently available, the most appropriate for first-line treatment of depression in nursing home residents are selective serotonin-reuptake inhibitors.	IV
36.	Tertiary tricyclics and psychostimulants are NOT FIRST-LINE treatment.	IV
	Monitoring	
37.	Monitoring of the effectiveness of pharmacological and nonpharmacological treatment for depression should include a history and assessment of change in target symptoms.	IV
38.	Monitoring of the effectiveness of pharmacological and nonpharmacological treatment for depression should include severity score ratings from validated depression instruments.	IV
39.	Assessment of the effectiveness of pharmacological and nonpharmacological treatment for depression should occur at approximately 6 weeks and 12 weeks of treatment, using:	
	a) Interviewer-rated scales (e.g., Cornell Scale for Depression in Dementia) when used by a clinician trained in their use, particularly for residents with moderate or severe dementia	IV
	b) Self-reported scales (e.g., Geriatric Depression Scale, Beck Depression Inventory) for residents with no more than mild to moderate cognitive impairment	IV
	c) The same depression rating scale used for initial evaluation	IV

Note: One hundred thirty-one individual items were rated. The panel reached agreement on 89 (68%) of these items. Some of the individual items have been combined into the statements in the table. See the section on methods in the text for definition of agreement.

*Evidence ratings are as follows:

I Evidence provided by one or more well-designed randomized, controlled clinical trials, including overviews (meta-analyses) of such trials.

II Evidence provided by well-designed observational studies with concurrent controls (e.g., case-control or cohort studies).

III Evidence provided by expert opinion, case series, case reports, and studies with historical controls.

IV Statements suggested by panel members without data-based evidence to support or refute the statement.

Unless otherwise indicated, studies rated I, II, or III were positive (– = negative study; +/– = mixed results).

[†]The panel recognizes that access to qualified mental health professionals may be limited for some facilities. Qualified primary healthcare providers may be able to perform such services when mental health providers are not available.

[‡]See text regarding panel ratings on individual drugs.

such as the Geriatric Depression Scale or Beck Depression Inventory are indicated only for residents with no more than mild to moderate impairment, whereas observer-rated scales such as the Cornell Scale for Depression in Dementia are indicated for residents with moderate to severe dementia.

3. 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.

4. 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.)

5. 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. (The panel recognizes that access to qualified mental health professionals may be limited for some facilities. Qualified primary healthcare providers may be able to perform such services when mental health providers are not available.)

6. The panel supports the use of nonpharmacological interventions in combination with antidepressant medications for treating major depression.

7. For residents with minor depression, treatment alternatives include nonpharmacological 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.

8. Psychotherapeutic modalities, including group and individual cognitive-behavioral psychotherapy, may

Table 2. Management of Behavioral Symptoms Associated with Dementia in Nursing Home Residents: Consensus Statements on Which the Panel Reached Agreement

	Statement	Evidence Rating*
1.	All nursing home staff should be educated to observe and report ongoing changes in residents' behaviors.	IV
2.	Health professionals who provide mental health services to nursing homes should be educated about the unique and individualized manifestations of and strategies for addressing behavioral symptoms in nursing home settings.	IV
3.	The nursing home should have an interdisciplinary process to design, implement, and maintain strategies to prevent and address behavioral symptoms. These strategies should include the recognition, assessment, treatment, and monitoring of the effect of interventions.	IV
4.	Nursing home staff should have education about the unique and individualized manifestations of and strategies for addressing behavioral symptoms in nursing home settings.	I (+/-)
5.	The importance and value of families in the care of residents with behavioral symptoms should be recognized by:	
	a) Involving the family in regular resident care planning	IV
	b) Educating nursing home staff about the importance of family involvement in resident care	IV
	c) Educating the family about mental health assessment and treatment	IV
Identification and Screening		
6.	Behavioral symptoms should be described in terms that identify and quantify observable verbal, nonverbal, and physical behaviors.	III
7.	Nursing home staff should be observant for and report changes in resident behaviors.	III
8.	Nursing homes should assess residents with behavioral symptoms for hearing and vision problems, and adaptive devices and other interventions should be considered whenever there is a potential for reduced sensory loss.	III
9.	The Minimum Data Set, as routinely used, is inadequate to identify all residents with behavioral symptoms.	II (+/-)
Assessment and Diagnosis		
10.	Residents with the new onset of behavioral symptoms should be initially evaluated for possible contributing medical conditions as soon as feasible.	IV
11.	Residents with new onset of or change in behavioral symptoms should have vital signs taken and be evaluated for the following medical conditions:	
	a) Constipation or fecal impaction	II
	b) Adverse medication effects	III
	c) Infections	IV
	d) Dehydration	IV
	e) Pain or discomfort	III
	f) Delirium	III
	g) Injury	IV
12.	Residents with new onset of or changes in behavioral symptoms should be assessed for:	
	a) Antecedents to the agitated behavior, including time, place, and events preceding agitated behavior	III
	b) Verbal and nonverbal communication of unmet needs such as hunger, thirst, exercise, warmth, sleep, touch, and intimacy	III
	c) Adequacy of social contacts with family, residents, staff, and others	III
	d) Disruptive changes in caregivers	III
	e) Engagement in meaningful or appropriate activities	IV
	f) Actual, attempted, or threatened harm to self or others	III
	g) Deviations from normal life patterns, preferences, and autonomy	III
	h) Environmental factors, such as a change in room	III
13.	Residents with new onset of or changes in behavioral symptoms should have laboratory or diagnostic imaging testing determined by history and physical assessment findings.	III
14.	Residents with new onset of or changes in behavioral symptoms should be assessed for psychiatric disorders such as:	
	a) Psychosis	III
	b) Depression	III
	c) Anxiety disorders	III
	d) Sleep disorders	III
	e) Substance or medication abuse or withdrawal	III

Table 2. (continued)

	Statement	Evidence Rating*
Referral to Mental Health Professional[†]		
15.	Residents being treated for behavioral symptoms and showing minimal or no significant improvement in 30 days should:	
	a) Have their treatment adjusted, changed, or augmented	IV
	b) Be referred to a mental health specialist	IV
16.	Residents who have threatened harm to self or others WITHOUT actual or attempted harmful behavior should be monitored and referred to a qualified mental health professional for evaluation.	IV
17.	Residents who HAVE attempted to harm or actually HAVE harmed self or others should be supervised closely until they receive evaluation by a qualified mental health professional.	IV
18.	Residents who HAVE threatened harm to self or others WITH or WITHOUT actual or attempted harmful behavior should be immediately referred to a mental health professional for consideration of treatment.	III
Treatment[‡]		
19.	Residents with new onset of or changes in behavioral symptoms but WITHOUT immediately dangerous behaviors or known causes (e.g., delirium, psychosis, environmental changes) may be appropriate candidates for a brief observation and evaluation period without implementation of specialized treatment.	III
20.	Interventions for behavioral symptoms should be individualized based on a careful interdisciplinary assessment to address specific etiologies and the resident's past and present preferences, habits, and abilities.	IV
21.	In addition to assessment and treatment of medical conditions, the initial approach to behavioral symptoms that do NOT present immediate danger to the resident or others should be nonpharmaceutical.	IV
22.	In addition to assessment and treatment of medical conditions, the initial approach to behavioral symptoms WITHOUT psychotic features such as delusions and hallucinations should be nonpharmaceutical.	IV
23.	In addition to assessment and treatment of medical conditions, the initial approach to behavioral symptoms WITHOUT psychotic features and that do not present immediate danger to the resident or others should be nonpharmaceutical.	IV
24.	Appropriate nonpharmaceutical interventions to be delivered by trained geriatrics professionals or trained nursing home staff include:	
	a) Sensory therapy	II (+/-)
	b) Activities therapy	I (+/-)
	c) Modification of activities of daily living care to meet individual needs	I (-)
	d) Environmental modifications	II
	e) Behavioral theory treatments	II (+/-)
	f) Social contact intervention	IV
25.	Appropriate first-line pharmaceutical treatment of residents with severe behavioral symptoms WITH psychotic features such as hallucinations and delusions includes atypical antipsychotics.	I
26.	Appropriate first-line pharmaceutical treatment of residents with severe behavioral symptoms WITH psychotic features such as hallucinations and delusions does NOT include:	
	a) Conventional antipsychotics	I (-)
	b) Anticonvulsants	I (+/-)
	c) Selective serotonin-reuptake inhibitors	I (-)
	d) Short- and intermediate-acting benzodiazepines.	II (+/-)
26.	Combination pharmaceutical therapy for residents with severe behavioral symptoms can be considered after sufficient dose and duration of monotherapy with two different classes of agents have been tried.	IV
Monitoring		
27.	The effectiveness of specific interventions in residents with behavioral symptoms should be reassessed at regular intervals using:	
	a) A validated scale	II
	b) A quantitative count of agitated behaviors	III
	c) Global clinical impression of a geriatrics or mental health specialist or trained nursing home staff	III
28.	Residents with behavioral symptoms for whom an intervention is initiated should be monitored at intervals appropriate to the symptom and the intervention.	IV
29.	Residents receiving pharmaceutical treatments for behavioral symptoms should be monitored for adverse drug effects, particularly neuromotor effects such as drug-induced parkinsonism from antipsychotics or ataxia from anticonvulsants.	IV
30.	Pharmaceutical treatments, when being used ONLY for dementia-related behavioral symptoms, should be evaluated for tapering or discontinuation or medication:	

continued

Table 2. (continued)

	Statement	Evidence Rating*
	a) At regular intervals	IV
	b) Not more than 6 months after symptoms are stabilized	IV
31.	Repeated, periodic attempts at tapering or discontinuation of medication for dementia-related behavioral symptoms should be made every 6 months.	IV

Note: One hundred thirty-nine individual items were rated. The panel reached agreement on 105 (76%) of these items. Some of the individual items have been combined into the statements in the table.

*Evidence ratings are as follows:

I Evidence provided by one or more well-designed randomized controlled clinical trials, including overviews (meta-analyses) of such trials.

II Evidence provided by well-designed observational studies with concurrent controls (e.g., case-control or cohort studies).

III Evidence provided by expert opinion, case series, case reports, and studies with historical controls.

IV Statements suggested by panel members without data-based evidence to support or refute the statement.

Unless otherwise indicated, studies rated I, II, or III were positive (– = negative study; +/- = mixed results).

[†]The panel recognizes that access to qualified mental health professionals may be limited for some facilities. Qualified primary healthcare providers may be able to perform such services when mental health providers are not available.

[‡]See text regarding panel ratings on individual drugs.

be helpful in treating selected residents. Other nonpharmacological interventions supported by the panel include increasing social activities and providing meaningful activities, such as sheltered workshops, volunteering, religious activities, or activities that maintain residents' past roles.

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

10. Once a decision has been made to use an antidepressant, of the classes of agents currently available, 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.)

11. 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 the following:

1. 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.

2. The MDS cannot adequately identify all residents with behavioral symptoms. Verbal, nonverbal, and physical behavioral symptoms should be described and quantified.

3. 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.

4. Residents with new onset of or changes 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.

5. 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 staff and family members.

6. 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.)

7. Residents being treated with nonpharmacological interventions or drug treatment for behavioral symptoms who show minimal or no improvement in 30 days should be referred to a mental health professional. (The panel recognizes that access to qualified mental health professionals may be limited for some facilities. Qualified primary healthcare providers may be able to perform such services when mental health providers are not available.)

8. After associated medical conditions are assessed and treated, the initial treatment of behavioral symptoms should be nonpharmacological when there are no psychotic features and when there is no immediate danger to the resident or others.

9. Trained professionals or trained nursing home staff should administer appropriate nonpharmacological interventions, which 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.

10. Appropriate first-line pharmacological treatment of residents with severe behavioral symptoms with psychotic features, such as hallucinations and delusions that are causing distress, consists of atypical antipsychotics.

11. Combination pharmacotherapy for severe behavioral symptoms and psychotic features can be considered after two different trials with two different classes of agents at sufficient doses.

12. Pharmacological 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.

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. A 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 pharmacological 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 pharmacological treatments, and would thus abstain. When the number of abstentions for an item amounts 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 screening instrument for depression, 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, although not uniformly, consistent with the literature review evidence ratings. In some areas, the final consensus statements directly correspond to the literature in rating the strength of support, but 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 (Tables 1 and 2). For example, in the depression statements, the panel endorsed the efficacy of nonpharmacological and pharmacological interventions in

accord with randomized controlled trials of each type of intervention, but the panel could not reach consensus on using either treatment modality alone for residents with major depression. The implication is that pharmacological and nonpharmacological 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 pharmacological treatment of behavioral symptoms when psychosis is not clearly present. Rankings ranged from 1 (nonagreement) to 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 nonpharmacological 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, although different from the process used by consensus panels that 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 in which 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 from 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 reached consensus should provide a useful guide to clinicians, but 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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Panel Members and Affiliations

Note: The organization the panel member represented is noted in parenthesis.

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