Scandinavian Journal of Primary Health Care, 2011; 29: 252–256

informa
healthcare

ORIGINAL ARTICLE

Treatment decisions on antidepressants in nursing homes: A qualitative study

KRISTINA RIIS IDEN[1], STEFAN HJØRLEIFSSON[2] & SABINE RUTHS[1,2]

[1]*Research Unit for General Practice, Uni Health, Bergen, Norway, and* [2]*Department of Public Health and Primary Health Care, University of Bergen, Norway*

Abstract

Objective. To explore decision-making on treatment with antidepressants among doctors and nurses in nursing homes. *Design and subjects*. A qualitative study based on interviews with three focus groups comprising eight physicians engaged full time, eight physicians engaged part time, and eight registered nurses, respectively. The interview guide comprised questions on initiating, evaluating, and withdrawing treatment with antidepressants. The interviews were audio-recorded, transcribed, and analysed by systematic text condensation. *Results*. The first theme was the diagnostic process. The informants expressed difficulty in differentiating between depression and sorrow resulting from loss in old age. Further, the doctors reported that they relied on nurses' observations and rarely carried out systematic diagnostic work and follow-up of patients with depression. The second theme was treatment. Antidepressants were usually the only type of treatment provided, and patients were kept on medication even though staff felt uncertain whether this was effective. The third theme was who really determines the treatment. Registered nurses reported that unskilled and auxiliary nursing staff requested drug treatment, and doctors felt some pressure from the nurses to prescribe antidepressants. *Conclusions*. This study suggests that the quality of diagnosis and treatment for depression in nursing homes needs to be improved in Norway. Doctors should be more available and take responsibility and leadership in medical decisions.

Key Words: *Antidepressants, nurses, nursing homes, physicians, qualitative study, treatment decisions*

Introduction

The prevalence of depression increases with age. A review of epidemiological studies revealed that depression affects 32% of nursing home patients and 13% of community-dwelling older people [1]. Depression impairs quality of life and increases morbidity and mortality among older nursing home patients [2]. Awareness of the condition is a prerequisite for providing appropriate diagnosis and treatment for people with depression.

Norway's national guidelines for diagnosing and treating depression among adults recommend that nursing home patients be diagnosed based on systematic work, including diagnostic tests such as the Cornell Scale for Depression in Dementia; patients with depression should be offered both treatment with antidepressants and environmental therapy [3]. However, studies suggest that depression is commonly inadequately diagnosed and treated in nursing homes [2]. This may at least partly be explained by coexisting dementia, impairing patients' ability to communicate with staff and compounding the diagnostic and therapeutic process.

The overall use of antidepressants in nursing homes in Scandinavia has nearly doubled since selective serotonin-reuptake inhibitors were introduced in the early 1990s [4,5]. Recent nursing home studies revealed a 37% prevalence of antidepressant use in Norway and 51% in Sweden [6,7], with great variation between institutions [8,9]. However, little evidence supports the efficacy of antidepressants for patients with mild or moderate depression and for those with depression and coexisting dementia [10]. Further, nursing home patients are at particular risk of adverse drug reactions and drug–drug interactions due to age-related pharmacokinetic and pharmacodynamic changes, complex health problems, and the use of multiple medications.

Correspondence: Kristina Riis Iden, Research Unit for General Practice, Uni Health, Bergen, Norway. E-mail: kristina.iden@gmail.com.

(Received 14 October 2010; accepted 4 September 2011)

ISSN 0281-3432 print/ISSN 1502-7724 online
DOI: 10.3109/02813432.2011.628240

Antidepressants are prescribed to many nursing home patients, but knowledge is sparse regarding the factors determining doctors' treatment decisions.

- Doctors reported that they relied on nurses' observations and rarely carried out systematic diagnostic work and follow-up of patients with depression.
- Antidepressants were usually the sole treatment provided, and patients were kept on medication even though staff members were not certain whether the antidepressants were effective.
- Registered nurses reported that auxiliary nursing staff requested drug treatment, and doctors felt some pressure to prescribe antidepressants.

The question therefore arises as to whether the increased use of antidepressants in nursing homes reflects improved care or uncritical overprescribing [11]. Staff members' knowledge, skills, and attitudes are presumably important prerequisites for appropriate prescribing of antidepressants, but knowledge is sparse regarding the factors that determine doctors' treatment decisions. We therefore performed this study to examine decision-making among doctors and nurses in nursing homes on the treatment of patients with depression using antidepressants.

Material and methods

General practitioners under part-time contract most commonly provide health services in Norway's nursing homes, although some larger institutions have employed doctors in full-time positions. We hypothesized that the continuity and stability of health care provided by doctors working full time might positively influence the quality of decisions on the treatment of patients with depression. We therefore included doctors engaged both full time and part time.

We conducted a qualitative study in 2009–2010 in Rogaland County, Norway based on three focus-group interviews. We recruited doctors through professional meetings and e-mail and nurses through phone calls to nursing homes. We included a purposeful sample of 24 informants working in 23 nursing homes, with broad diversity regarding age (30–70 years), gender, profession, clinical experience (1–40 years), and position. The first focus group comprised eight nursing home doctors engaged full time (four women), the second group eight registered nurses (seven women), and the third eight doctors working part time in nursing homes (seven women).

Each interview lasted 90 minutes. The first author moderated, and the second author acted as secretarial assistant. The interview guide comprised three questions on the informants' experience and considerations regarding initiating, evaluating, and withdrawing antidepressants. Based on preliminary analysis of two focus-group interviews, two questions about how nurses influence treatment decisions and challenges regarding patients with concurrent dementia and depression were included in the final interview with doctors engaged part time.

The first author audio-recorded and transcribed the focus-group interviews, and all three authors analysed them in collaboration by systematic text condensation in accordance with Malterud [12]: (1) reading the transcripts to obtain an overall impression and bracketing the authors' preconceptions as far as possible; (2) identifying units of meaning representing different aspects of the use of antidepressants in nursing homes and coding for these; (3) condensing and summarizing the content of each coded group; and (4) generalizing the descriptions and concepts regarding treatment decisions related to antidepressants in nursing homes.

The first author has long experience as a nursing home doctor and is concerned about improving health care in nursing homes. All three authors are specialists in family medicine and experienced general practitioners.

Results

The interviews elicited three main themes. Doctors and nurses sometimes expressed different opinions, but full-time doctors and part-time doctors generally shared similar ideas.

Depressed or just tired of life?

The doctors had difficulty in differentiating between sorrow resulting from losses in old age and depression. Although doctors were afraid of mistaking depression for dementia, most did not perform systematic diagnostic work. Instead, they based their conclusions on observations reported by trusted nurses. However, the nurses said that their ability to differentiate depression from sorrow might be poor.

> Nurse: We are not skilled in differentiating between these conditions. If they cry, we call it depression and give them antidepressants. And that's it.

The nurses lamented the limited time physicians had, suggesting that doctors being more available

would improve discussions and reflection during pre-round case conferences.

To treat or not to treat with antidepressants?

Antidepressants were usually the only form of treatment provided if a patient was considered depressed. The informants reported that nursing staff members were pressed for time, and antidepressants might emerge as a simple solution. Some informants thought that sorrow warrants drug treatment, whereas others considered sorrow to be a natural part of old age and were more reluctant to start medication.

Although both doctors and nurses expressed great uncertainty about whether the medication was effective, they admitted that they commonly maintained patients on antidepressants because they feared that withdrawing drugs might upset a delicate balance.

> Nurse: You don't know what might happen if you withdraw these medications. They may suffer from side effects of the drugs, and you may be unsure whether they need the treatment; but you know what you have, and you don't know what you'll get.

Several doctors said that the patients commonly received long-term drug treatment without follow-up; few doctors said that they conducted annual general check-ups of current health status and medication reviews to evaluate the effectiveness of treatment. Most doctors relied mainly on registered nurses' opinions on treatment response.

The informants stressed being aware of the beneficial effects of environmental therapy but stated that this option was seldom used due to financial constraints, conservative treatment traditions and staff attitudes. The nurses said that they spent relatively much time on basic nursing care, including washing and feeding, leaving less time to talk with the patients. Further, they maintained that increasing the emphasis on social aspects would probably reduce the need for pills.

Who determines the treatment?

The registered nurses said that they spend much energy dealing with unskilled and auxiliary nursing personnel asking for patients to be treated with antidepressants. Several nurses commented that doctors were not eager to discuss or question their observations; instead, doctors would simply initiate treatment with antidepressants. Doctors, especially those working part time in nursing homes, explained that they would select reliable registered nurses and trust their evaluations. However, several comments and examples indicated that the nurses might dominate this relationship or at least that doctors felt some pressure to prescribe antidepressants.

> Doctor: They called me on the carpet to tell me that withdrawing antidepressants was not a clever thing to do because the patient became angrier and resisted care. They therefore demanded that I reinstate medication.

Discussion

Our findings suggest that doctors seldom conduct systematic diagnosis of nursing home patients presumed to have depression. Antidepressants were the predominant treatment method, and doctors were reluctant to dispute nurses' opinions regarding the indications for and effectiveness of drug treatment.

Strengths and limitations

Focus-group interviews are preferable to individual interviews, particularly in seeking information on attitudes, viewpoints, and personal experiences in environments in which people cooperate [13]. The purposeful sample represented rich variation in age, gender, working experience, position, and institutions. Voluntary study participation may have caused selection bias towards informants with a special interest in geriatric psychiatry and with idealistic attitudes. A certain recall bias cannot be excluded either. However, the informants reported a discrepancy between their clinical practices and what they regarded to be best practices, such as environmental therapy, for depression. We therefore believe that the informants were stating their honest opinions, which might even have evolved as a result of their mutual reflection during the focus groups, without excessive concern about making a favourable impression.

The diagnostic process

Our findings suggest a scarcity of systematic diagnostic work, in accordance with a nursing home study in Sweden reporting that doctors usually treat patients with depression based on information obtained from nursing staff and medical records without talking to the patients [14]. This should raise concern, because nurses frequently fail to recognize depression or over-recognize the condition among non-depressed patients [15,16]. The lack of diagnostic work and follow-up probably leads to unnecessary drug treatment for some patients, whereas others do not receive potentially beneficial medications [2].

Old age is usually accompanied by loss of functional ability, health, close relations, and even dignity. Although this may lead to sorrow, the relationship between sorrow and depression as a mental disorder requiring treatment is complex. Unfortunately, modern research on older people seems to neglect the phenomena of sorrow and despair, and few studies seek to clarify how sorrow, despair, and depression relate to each other [17].

Treatment

A recent study demonstrated high persistence of depression among nursing home patients, regardless of whether they received antidepressants [18]. In another study, antidepressants were successfully withdrawn from about half the patients receiving long-term treatment [19]. Nevertheless, since they are effective in some cases, antidepressants may be proposed for various symptoms and types of behaviour and thus replace psychosocial interventions. If the main reason for doctors' reluctance to withdraw antidepressants was actually fear of exposing vulnerable patients to treatment changes, it is remarkable that they did not act on this concern when they considered starting drug treatment.

Although staff members were aware of the importance of therapeutic conversations with depressed patients, medications may emerge as a quick and easy solution. Studies suggest that barriers to non-pharmaceutical treatment in nursing homes include excessive reliance on antidepressant medication and conservative staff attitudes [20]. Johnson emphasizes the need to change nursing home culture, pleading for a resident-centred approach to improve residents' quality of life [21]. Treatment should be based on individual considerations; however, comparative studies of drug treatment and environmental therapy for depression in nursing homes are not available to guide treatment decisions.

Decision-making

This study suggests that doctors accept basing their diagnostic and therapeutic conclusions on nurses' observations and opinions. These findings support a study in the United Kingdom demonstrating that psychiatrists accepted "pressure" from nursing staff to prescribe psychotropic drugs for treating behavioural and psychiatric symptoms of dementia, despite being aware of limited efficacy and potentially serious side effects [22]. Schmidt et al. have demonstrated that high-quality multidisciplinary teamwork in nursing homes can improve psychotropic drug prescribing according to clinical guidelines [23]. Although multiple professions work in nursing homes in Norway, cooperation appears to be unsatisfactory. The doctors are responsible for basing their treatment decisions on sound evidence. When clear leadership is lacking, other professions will take initiatives. Registered nurses have key positions regarding care for patients but may feel caught between doctors and auxiliary staff.

Implications for clinical practice

Experience from the Netherlands indicates that postgraduate education leading to a formal medical specialty has substantially improved the quality of nursing home medicine [24]. Improving the quality of diagnosis and treatment of patients with depression in nursing homes in Norway requires that doctors be more available and take clear responsibility for health care decisions. In addition, formal postgraduate education programmes should be initiated.

Acknowledgement

The authors would like to thank thank all informants who participated in the focus-group interviews.

Ethics

The Western Regional Committee for Medical and Health Research Ethics and the Norwegian Data Inspectorate approved the study.

Source of funding

Norwegian Medical Association.

Conflict of interest

All authors declare that there are no competing interests.

References

[1] Rosenvinge BH, Rosenvinge JH. [Occurrence of depression in the elderly – a systematic review of 55 prevalence studies from 1990 to 2001]. Tidsskr Nor Laegeforen 2003; 123:928–9.

[2] Barca ML, Selbaek G, Laks J, Engedal K. Factors associated with depression in Norwegian nursing homes. Int J Geriatr Psychiatry 2009;24:417–25.

[3] Norwegian Directorate of Health. Nasjonale retningslinjer for diagnostikk og behandling av voksne med depresjon i primær- og spesialisthelsetjenesten [National guidelines for the diagnosis and treatment of adults with depression in primary and secondary health care in Norway]. IS-1561. Oslo: Norwegian Directorate of Health; 2009.

[4] Nygaard HA, Ruths S, Straand J, Naik M. Not less but different: Psychotropic drug utilization trends in Norwegian nursing homes during a 12-year period. The Bergen District Nursing Home (BEDNURS) Study. Aging Clin Exp Res 2004;16:277–82.
[5] Løvheim H, Sandman PO, Karlsson S, Gustafson Y. Changes between 1982 and 2000 in the prevalence of behavioral symptoms and psychotropic drug treatment among old people with cognitive impairment in geriatric care. Int Psychogeriatr 2009;21:941–8.
[6] Kirkevold Ø, Engedal K. Is covert medication in Norwegian nursing homes still a problem? A cross sectional study. Drugs Aging 2009;26:333–44.
[7] Bergman Å, Olsson J, Carlsten A, Waern M, Fastbom J. Evaluation of the quality of drug therapy among elderly patients in nursing homes. Scand J Prim Health Care 2007;25:9–14.
[8] Ruths S, Straand J, Nygaard HA. Psychotropic drug use in nursing homes: Diagnostic indications and variations between institutions. Eur J Clin Pharmacol 2001;57:523–8.
[9] Lapane KL, Hughes CM. Which organizational characteristics are associated with increased management of depression using antidepressants in US nursing homes? Med Care 2004;42:992–1000.
[10] Bains J, Birks J, Dening T. Antidepressants for treating depression in dementia. Cochrane Database Syst Rev 2002(4);CD003944.
[11] Gaboda D, Lucas J, Siegel M, Kalay E, Crystal S. No longer undertreated? Depression diagnosis and antidepressant therapy in elderly long-stay nursing home residents. J Am Geriatr Soc 2011; DOI:10.1111/j.1532-5415.2011.03322.x
[12] Malterud K. Shared understanding of the qualitative research process: Guidelines for the medical researcher. Fam Pract 1993;10:201–6.
[13] Morgan DL. Focus groups as qualitative research. 2nd ed. Thousand Oaks, CA: Sage Publications; 1997.
[14] Fastbom J, Schmidt I. [Deficiencies in the treatment of depression of the elderly in nursing homes in Stockholm. Diagnosis is based on flimsy grounds and follow-up performed early]. Läkartidningen 2004;46:3683–8.
[15] Brühl KG, Luijendijk HJ, Muller MT. Nurses' and nursing assistants' recognition of depression in elderly who depend on long-term care. J Am Med Dir Assoc 2007;8:441–5.
[16] Ayalon L, Arean P, Bornfield H. Correlates of knowledge and beliefs about depression among long-term care staff. Int J Geriatr Psychiatry 2008;23:356–63.
[17] Guttmann D. Finding meaning in life, at midlife and beyond: Wisdom and spirit from logotherapy. New York: Praeger; 2008.
[18] Barca ML, Engedal K, Laks J, Selbaek G. A 12 months follow-up study of depression among nursing-home patients in Norway. J Affect Disord 2010;120:141–8.
[19] Lindström K, Ekedahl A, Carlsten A, Mårtensson J, Mölstad S. Can selective serotonin inhibitor drugs in elderly patients in nursing homes be reduced? Scand J Prim Health Care 2007;25:3–8.
[20] Choi NG, Wyllie RJ, Ramson S. Risk factors and intervention programs for depression in nursing home residents: Nursing homes staff interview findings. J Gerontol Soc Work 2009;52: 668–85.
[21] Johnson MA. Changing the culture of nursing homes. Arch Intern Med 2010;170:407–9.
[22] Wood-Mitchell A, James IA, Waterworth A, Swann A, Ballard C. Factors influencing the prescribing of medications by old age psychiatrists for behavioural and psychological symptoms of dementia: A qualitative study. Age Ageing 2008;37:547–52.
[23] Schmidt IK, Claesson CB, Westerholm B, Nilsson LG, Svarstad BL. The impact of multidisciplinary team interventions on psychotropic prescribing in Swedish nursing homes. J Am Geriatr Soc 1998;46:77–82.
[24] Hoek JF, Ribbe MW, Hertogh CM, van der Vleuten CP. The role of the specialist physician in nursing homes: The Netherlands' experience. Int J Geriatr Psychiatry 2003;18:244–9.