Trial HALTs unnecessary use of antipsychotics

Preliminary results from the HALT Project show that the majority of people with dementia in aged care homes who are prescribed antipsychotic medications to control BPSD do not need them. Tiffany Jessop reports.

The Halting Antipsychotic Use in Long Term Care (HALT) Project is an Australian study, running since 2014, aiming to reduce the use of antipsychotic medication in long-term care residents with behavioural and psychological symptoms associated with dementia (BPSD).

Inappropriate prescribing of antipsychotics for people with dementia is common, particularly for those living in care homes where multiple residents may present with distressed behaviour. As a result, GPs and geriatricians may feel pressure to prescribe psychotropic medications, including antipsychotics, in response to BPSD in care home residents – despite best practice guidelines suggesting non-pharmacological approaches should be tried before resorting to medication and then only for three months before reviewing.

The tight regulations around the use of these medications are due to the significant risks and side effects associated with their use in older people. These include dizziness, accelerated cognitive decline, falls, pneumonia, stroke and death. The modest potential benefit of these medications needs to be weighed carefully against these risks in each individual and they should be prescribed with caution.

One antipsychotic, Risperidone, is currently indicated for psychotic symptoms, or persistent agitation or aggression in Alzheimer’s disease but not other dementias. Despite this, we still see antipsychotics administered in response to behaviours for which there is no evidence of benefit such as wandering, calling out and delirium, in residents with comorbid vascular conditions or other forms of dementia, and for long periods without review. Until the HALT intervention, participants had been taking their current course of antipsychotics for an average of two years.

We are now heading into the final three months of the trial, involving 140 residents across 23 NSW care facilities. Preliminary results indicate that the HALT deprescribing intervention successfully eliminated antipsychotic medications from the treatment plan in the majority of participants.

Initially, over 90% of study participants ceased antipsychotic medication, but not all remained off the medication during the follow-up period. Fourteen recommended regular antipsychotic medication within three months, and a further 10 within six months and two (to date) before the final visit at 12 months (a total of 21% of the sample who originally ceased the antipsychotic medication).

Importantly, preliminary analyses show behavioural and psychological symptoms remain stable up to six and 12 months after deprescribing for all participants, regardless of whether an antipsychotic was restarted or never ceased after deprescribing commenced.

We have almost completed 12-month follow-up data collection from participating residents and final results will be available at the end of this year.

**Controlled deprescribing**

The reduction in antipsychotic use was achieved through controlled deprescribing involving community pharmacists, facility staff, participants’ GPs and family members. Long-term care facility nurses (HALT champions) were also trained to recognise potential causes of BPSD and encourage the use of non-pharmacological and person-centred approaches, including environmental modifications, to manage symptoms.

Participants were assessed for neuropsychiatric symptoms, agitation, cognition, activities of daily living and quality of life twice before deprescribing and then three months, six months and 12 months after deprescribing started.

**Feedback from HALT champions**

The research team has also spent a substantial amount of time talking with the HALT champions to understand how the project was received by staff and management and what, if any, sustainable impact it has had on the residents as well as the facilities. The HALT champions are a critical component of the project. These champions are, for the most part,
registered nurses (RNs) appointed in each facility to drive the education, awareness and implementation of non-pharmacological behaviour management strategies to support deprescribing.

**Education**

While we are still evaluating the project, one issue has been consistently highlighted by the champions: the need for ongoing and consistent education about dementia, dementia care and person-centred care.

Many of the facilities involved in the trial have, at the same time, also been participating in capacity-building initiatives focused on person-centred care which have complemented the HALT project. However, this education is still predominantly targeted at AINs and may not filter through to care workers, management and allied health professionals. Champions indicated that particular attention needs to be paid to ensuring education is provided to AINs / care staff who make up the majority of workers providing hands-on care to residents. This is even more important as policy around the requirement for RNs remains controversial.

Continuing training can be supported at the organisational level, however there is a real need to engage with tertiary institutions offering formal aged care qualifications and review the curriculum to ensure they provide solid foundations in dementia, BPSD and dementia care.

**Management support**

Champions have recognised the need to embed the person-centred philosophy of care into organisational policy and be specific about what this means for residents and staff alike. One champion said that her facility now makes person-centred care part of the mandatory training undertaken by all staff on an annual basis. While this is a positive step, she also said this approach and the organisational values underpinning it need to be consistently reinforced by management and supported at the organisational level to ensure resources are available to meet the changing environment.

Ultimately this needs to be reflected in government policy and accreditation standards which will encourage organisations lacking direction in this area to get on board.

**Awareness and confidence**

Overall, the feedback from champions has been positive even if, at the outset, they or other staff members were concerned that taking residents off antipsychotic medications would lead to an increased burden on staff and ‘unmanageable’ residents.

The majority of champions have said that participating in the HALT trial has definitely created more awareness among staff about antipsychotics and the alternatives they can try first instead of jumping straight on the phone and asking a GP to prescribe these medications.

The majority of champions identified pain management as one of the most effective strategies for responding to challenging behaviours. This feedback from champions clearly confirms the well-known fact that pain is underdiagnosed and undertreated in people with dementia.

The HALT Project has also empowered staff to evaluate and question the need for antipsychotic medications in newly admitted residents. As one champion said: “They [new residents] come to us on a stack of medications, but being on the project has just made us more aware that we can speak up about it because we know more about it and we can make more informed decision and say to the doctors, ‘let them get settled and then see if they really still need to be on that’.”

This increased awareness and confidence to challenge the appropriateness of antipsychotic use in some residents is a positive outcome and has the potential to have a powerful impact on people with dementia.

A recent study has provided updated data on the risk of mortality with different antipsychotics compared to non-use and with alternative psychotropics (anti-depressants and valproic acid), and the findings are concerning (Maust et al 2015).

**Number Needed to Harm**

The phrase ‘Number Needed to Harm’ is used to describe how many people need to be exposed to a risky treatment for one person to be harmed. Previous conservative findings suggested the number needed to harm for haloperidol, a typical antipsychotic, was 100 (Schneider et al 2006).

However Maust and colleagues’ updated estimate is 26, with Risperidone, an atypical and commonly used antipsychotic, very closely following at 27. This means that on average, for every 27 people taking Risperidone, one person will be negatively impacted by one of the many associated risks.

This study also demonstrated that risk of mortality correlates with dose: higher dose equals higher risk of mortality. This means that in the absence of a relevant mental health condition, it is crucial to regularly review the need for antipsychotic medications for people with BPSD, as even a dose reduction is a positive outcome if cessation cannot be achieved.

**Lack of consent**

The HALT Project has brought many systemic issues to light; one that is particularly concerning is the number of cases where medication is being prescribed without consent. NSW law requires that written informed consent is obtained before prescribing drugs that act on the nervous system, such as antipsychotics. Consent is required from either the individual or their ‘person responsible’ if they lack capacity.

In our study sample, participants’ current course of antipsychotic medication was commonly prescribed outside these guidelines and, in the majority of cases, without informed consent, and continued without change for lengthy periods until the HALT intervention. Only one case out of 139 followed the proper consent procedures. In another 21 cases we saw comments in the residents’ files indicating verbal consent, however whether this was truly ‘informed consent’ is questionable, especially considering our conversations with family members revealed their general lack of knowledge of risks associated with antipsychotic use.

Education is the key to tackling this long-standing problem of over-prescribing of antipsychotics in aged care, and the qualitative feedback from the HALT champions emphasises this point. The critical need for education and training doesn’t end with aged care staff. It involves GPs, specialist clinicians and allied health personnel.

Importantly, families, when faced with the distress of a loved one experiencing BPSD, also need to be involved in the conversation and understand the potential risks and benefits of antipsychotic medications so they can make an informed decision about their loved one’s treatment and well-being. Equally important, families should be made aware of non-pharmacological alternatives and the vital role they (the family) can play in successfully implementing person-centred strategies for their loved one living with dementia.

**Building on HALT success**

The results of this project will be used to encourage the development of a nationally applicable and sustainable approach to the care of people with BPSD in long-term residential facilities. This will require significant investment from the government and the sector and will not happen overnight. However, the results of this project should empower
prescribers and aged care workers to make positive changes to the way they approach BPSD right now.

Families also have a role to play in facilitating this change. Managing expectations of family members is a challenge for residential care staff and often individualised approaches to care are compromised to meet these expectations. Good information for families and people with dementia is needed to help understand the complexities of the issues surrounding BPSD.

Finally, the HALT Project team has developed targeted, evidence-based training materials to up-skill GPs and aged care home staff in this area, as well as in the quality use of medicines. It is hoped that future funding will be available to promote and circulate these resources to clinicians and aged care facilities.

For more information about accessing the HALT resources, contact Dr Tiffany Jessop at t.holmes@unsw.edu.au.

An educational webinar to educate GPs about antipsychotics and BPSD, as part of the HALT Project, is also available on the DCRCs’ DementiaKT Hub website at dementiakt.com.au/resource/webinar-halt-bpds. The webinar, ‘How you can understand, prevent, and remedy Behavioural and Psychological Symptoms of Dementia (BPDS), is presented by Professor Henry Brodaty and Dr Allan Shell.

Acknowledgments

The HALT Project is funded by the Australian Department of Health through the Aged Care Service Improvement and Healthy Ageing Grants Fund. The HALT team comprises Professor Henry Brodaty, Dr Tiffany Jessop, Dr Allan Shell, Fleur Harrison, Monica Cations, Linda Nattrass and Professor Lynn Chertoweth.

Dr Tiffany Jessop is HALT Project research coordinator with the Dementia Collaborative Research Centre: Assessment and Better Care, UNSW Australia. Contact her at: t.holmes@unsw.edu.au

References


CST guide designed for Australian use

Daniella Kanareck, Natalie Narunsky and Brian Draper have developed an Australian guide to complement the Cognitive Stimulation Therapy (CST) manuals used in residential and community care settings in the UK.

Cognitive Stimulation Therapy (CST) is a program of multisensory stimulation for people with mild to moderate dementia aimed at improving cognition and social functioning. Developed in the UK by Dr Aimee Spector, Professor Martin Orrell and Professor Bob Woods, it has been endorsed by the UK’s National Institute for Health and Care Excellence as an evidence-based and cost-effective intervention. It aims to improve cognition and social functioning by focusing and building on a person’s retained abilities and strengths.

CST typically runs twice weekly in a structured group setting. It involves 14 sessions of themed activities such as current affairs, art discussion, categorising objects, life history, physical activities, number and word games. This is followed by longer-term, or ‘maintenance CST’. Sessions aim to actively stimulate and engage people with dementia, whilst providing an optimal learning environment plus the social benefits of a group. Participation in CST is reported to show results comparable to the effects of dementia-specific medications currently prescribed (see www.cst dementia.com/page/the-evidence-base).

CST manuals’ provide user-friendly instructions for multidisciplinary team members to facilitate the program. Care workers, diversional therapists, occupational therapists, social workers, nurses, psychologists etc can deliver CST in a range of settings such as residential aged care, hospitals, day centres and community venues.

Australian prompts

In 2015 our team of multidisciplinary clinicians at the Aged Care Psychiatry Service (ACPS), Eastern Suburbs Mental Health Service, Sydney, developed an Australian guidebook called 1 2 3 Australian CST (Kanareck et al 2015) to assist CST facilitators who plan to incorporate Australian prompts in their group sessions. The guidebook is a compendium of Australian content to complement the CST training manuals* Making a difference (Spector et al 2006) and Making a difference 2 (Aguirre et al 2012).

1 2 3 Australian CST is available for free download from the Dementia Collaborative Research Centres’ new DementiaKT Hub website (www.dementiakt.com.au). Along with an explanation of CST, the guidebook includes Australian historical facts and dates, well-known personalities, iconic landmarks, popular culture, brands, television shows and detailed outlines of 24 activity sessions which reinforce the CST key principles (see box p43). There are also links to online information and video content and easily accessed economical, everyday equipment, such as household objects, that are relevant to Australian participants and can be used to trigger reminiscence and discussion.

The guide suggests topics for discussion and tips for facilitators to be cautious of when planning sessions, such as emotional triggers and activities that might be confrontational. For example, in the ‘Current Affairs’ session, facilitators are advised to “be mindful of headlines that...”