The HALT Project
Halting Antipsychotic use in Long Term care

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Impact of BPSD in LTC
- Increase rate of institutionalisation
- >90% of PWD during course of disease
- Distress to PWD, fellow residents and staff
- Higher rate of complications in hospital
- Faster rate of decline
- Associated with increased mortality
Interventions for BPSD

- Treat cause eg UTI, pain
- Behaviour as communication
- Understand the person behind the behaviour

BPSD: Psychosocial Interventions

- First line
- Increasingly strong evidence
- Person centred care, humour therapy, individual engagement, music, massage, etc
- No side effects

Pharmacotherapy for BPSD

- Recommended as 2nd line therapy or if urgent
  - Atypical / typical antipsychotics
  - Antidepressants eg citalopram
  - Cholinesterase inhibitors
  - Memantine
  - Anticonvulsants
- Limited evidence of efficacy
Polypharmacy in the elderly

- Older people more likely to be prescribed multiple medications at once (polypharmacy)
- Inappropriate prescribing (Steinman, 2006)
- ≈ 43.8% of residents prescribed ≥ 1 inappropriate medicine (Stafford, 2011)

Strong evidence to support deprescribing in NH residents

- Review of 20 trials including 4 in NHs deprescribing is feasible, variably effective but often poorly evaluated
- 332 different drugs in 119 patients in six geriatric nursing hospital departments discontinued → ↓mortality and ↓costs

Garfinkel D and Magin D (Arch Int Med 2010; 170:1648-50)

Antipsychotics

- 28% of NH residents on antipsychotics
- Antipsychotic use associated with AEs:
  - Parkinsonism
  - Falls
  - Anticholinergic effects
  - Hospitalisation
  - Greater cognitive decline
  - Stroke
  - Death

1 Snowdon J, 2011
Continuing vs stopping neuroleptics in dementia patients?

- 12 months RCT
- Continuous use of neuroleptics vs placebo
- Most AD pts withdrew without detriment
- Continuers – worse verbal fluency (p<.002)
- Subgroup of pts with more severe symptoms (NPI ≥ 15) might benefit from continuous Rx

Ballard et al 2008 PLOS Medicine, 5:587-599

DART-AD – mortality associated with continuous Rx

- Modified intention-to-treat (mITT) population
- Placebo
- Continuous treatment

Psicotropic medication for patients with dementia¹,²

- 633 NH residents with dementia followed 1 yr¹
  – Persistent psychotropic use very common
  – No difference in users vs non-users re BPSD
- Cochrane: aim to discontinue antipsychotics ²

² Declercq T et al, Cochrane Review, 2013
Summary so far

• BPSD common
• Drug treatments limited efficacy
• Side effects of concern esp. antipsychotics
• Psychosocial treatments effective but limited uptake

The HALT Project

• Evidence for feasibility of deprescribing antipsychotics in people with dementia (Declercq, 2013)
• Develop and test a model for deprescribing in residential aged care
  • reduce the use of antipsychotics without an associated rise in alternative prescriptions or problem behaviours.

Steering Committee

• Dementia Collaborative Research Centre, UNSW
• Centre for Healthy Brain Ageing, UNSW
• Prince of Wales Hospital, Sydney
• Medicare Locals – East and South West Sydney
• NSW Health
• National Prescribing Service
• Dementia Behaviour Management Advisory Service
• Alzheimer’s Australia NSW
• Universities of Sydney and of Tasmania
• Neuroscience Research Australia
Protocol
- Single arm longitudinal study; (RCT not allowed)
- 18 LTC homes within Sydney area
- Recruitment target 200 residents, >1 month in NH
- Resident selection:
  - regular antipsychotics for > 3 months
  - ≥ 60 yrs
  - consent / assent
  - GP agreement
  - No primary mental health diagnosis
  - NPI scores: total < 50, aggression/agitation < 12

Protocol
- Recruit NHs and 1-2 RN champions per NH
- Identify dispensing pharmacies
- Identify residents on antipsychotics 3m+
- Consent residents, families and GPs
- Academic detailing to GPs and pharmacies
- Assess residents 2 months before intervention
- Assess residents at baseline
- 12 weeks of training for nurses in psychosocial management of behaviours, then ….
- 12 weeks - GPs deprescribe antipsychotics

Intervention
- Gradually withdraw antipsychotics
- 50% dose reduction every 2 weeks
- Monitor for effects of withdrawal and re-emergence of behaviour
- Avoid replacement with other drugs such as benzodiazepines
**Education**

- Develop HALT training packages
  - Awareness about risks of antipsychotics
  - Benefits of reducing antipsychotics
  - Non-pharm management of BPSD
- Champions train LTC staff
- Info to families and residents
- Academic GP trains GPs
- Community pharmacist detail pharmacists
- Continuing education points for all

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**LTC staff - HALT Champions**

- Training
  - 3 day workshop
    - Prof Lynn Chenoweth
  - Person-centred care
  - Non-pharmacological behaviour management
  - “Train-the-trainer”
  - Ongoing tutorials for care staff

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**Education - GPs**

- Category 1 Clinical Audit activity
- Continuing Professional Development points from RACGP
- Pre-activity survey
- Academic detailing
- Reinforcement activities – evening workshop
- Evaluate impact
Outcome measures

• Data collection:
  ➢ Pre-baseline (2 months before)
  ➢ Baseline
  ➢ Post – 3 months after
  ➢ Follow up (1) – 6 months
  ➢ Follow up (2) - 12 months

Outcome measures

• Primary outcomes
  ➢ Reduced rate of antipsychotics without substitute medication use
  ➢ Behaviours - NPI-NH score
• Secondary outcomes
  – Cognition, Function, Quality of Life
  – Side effects, falls, hospitalisations, deaths
• Co-variates: age, cognition, function, NPI, agitation, quality of life, comorbidities and non-antipsychotic medications

Challenges

• “Selling” project to RACFs (time poor, limited resources, managers not open to change)
• Finding suitable “Champions” willing to commit to project activities
• RACFs responsible for identification of potential participants
• Reliance on HALT Champions prioritising research activities
• Quarantining time for HALT activities
• Arranging backfill
Challenges

- Complex ethics process
- Two interventions – deprescribing & education
- Arm’s length recruitment, privacy issues have delayed consenting process
- Families wanting immediate withdrawal of medication – issue for study design
- Family members resistant to change in care
- GPs start deprescribing immediately
- Variance in rates of antipsychotic use

Conclusion

- HALT study underway
- Results → end 2015
- Wish us luck

Thank you

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The HALT Project

- Facilitate KT
  Education for RACF staff, GPs and pharmacists in best practice approaches
- Build the evidence
  Reduce the use of antipsychotics without increasing alternative prescriptions or BPSD

  Develop generalisable model for implementation
Education

- Develop HALT training packages
  - Awareness about risks of antipsychotics
  - Benefits of reducing antipsychotics
  - Non-pharm management of BPSD
- Champions/RACF staff - train-the-trainer
- Info to families and residents
- RACGP activity for GPs
- CPD modules for pharmacists

Progress so far

- 55 assessed for eligibility and invited
- Declined (23)
- Agreed (32)
- Withdrew (10)
- Total recruited (n= 22)

Resident enrolment

- Eligible and assent to contact person responsible participation = 132
- Ineligible = 44
- Consent from person or proxy = 88
- Pre-baseline assessment = 62
- Baseline assessment = 39
**How to seal the deal?**

How to make good care 'practice as usual'?  
- Incentives for owners, managers, staff  
- Accreditation standards  
- Drive demand - families, residents  
- Show cost effectiveness  
- Publicise, communicate  
- Leadership, training

**Summary**

- BPSD common  
- Prevent BPSD, PCC, titrate stimulation, environment, staff training  
- Drugs have limited effects and AEs  
- Psychosocial treatments have evidence  
- Problem is implementation

**Summary**

- So why are nursing homes not engaging more?  
- *Practical* suggestions for working with facilities  
- Need *policy recognition* too – accreditation standards, government policy, research support