HALT UPDATE

A big welcome for 2015 from the HALT team. Haven’t we hit the ground running? Our HALT research psychologists, Fleur and Monica, are flat out visiting all participating facilities around Sydney and we again thank all of the nursing home managers and staff for their wonderful help and support during these visits.

For the first round of participants enrolled in the study, we have just begun our 6 month follow up assessments and pleased to see that so many of these residents remain off their antipsychotic medication. We are beginning to put together a picture of the sample of participants we have involved in HALT and a snapshot of these demographics is below. Fleur and Monica will travel to Perth in April to present these plus other interesting preliminary results at the prestigious Alzheimer’s Disease International (ADI) conference. This year the ADI conference - Care, Cure and the Dementia Experience - A Global Challenge has partnered with Alzheimer’s Australia to deliver what is sure to be a stimulating program of international speakers working in the dementia field. You can visit http://www.alzint.org/ for more details about this conference.

<table>
<thead>
<tr>
<th>Characteristic (n*)</th>
<th>% (n) or x ± SD (range)</th>
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<tbody>
<tr>
<td><strong>SOCIODEMOGRAPHICS</strong></td>
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<tr>
<td>Age (78)</td>
<td>86.9 ± 7.0 (65.7 – 101.8)</td>
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<tr>
<td>Female gender (78)</td>
<td>70.5 (55)</td>
</tr>
<tr>
<td>Marital status (77)</td>
<td></td>
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<tr>
<td>Single, never married</td>
<td>5.2 (4)</td>
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<tr>
<td>Separated /divorced /widowed</td>
<td>63.6 (49)</td>
</tr>
<tr>
<td>Married/de facto</td>
<td>31.2 (24)</td>
</tr>
<tr>
<td>Born in Australia (78)</td>
<td>52.6 (41)</td>
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<tr>
<td><strong>RESIDENTIAL CARE</strong></td>
<td></td>
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<tr>
<td>Years since admitted to facility (77)</td>
<td>3.0 ± 1.8 (0.5 – 8.0)</td>
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<tr>
<td><strong>MEDICATION USE</strong></td>
<td></td>
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<tr>
<td>Duration of course of antipsychotic medication (years) (72)</td>
<td>2.2 ± 1.6 (0.2 – 8.0)</td>
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*Total number of participants for whom this specific information was available

FOR MORE INFORMATION ON THE HALT PROJECT, CONTACT
HALT@UNSW.EDU.AU

Best wishes,

Tiffany
Tiffany Jessop
(HALT Project Coordinator)
FOCUS ON DELUSIONS

During our interviews with staff members across the 24 HALT facilities we have noted that it is often challenging for staff to identify and explain the psychotic symptoms residents may experience, particularly delusions. Below is information about what a delusion is, how it may present in a person with dementia and ways to try and maintain a state of well-being for a person experiencing delusions. This information was taken from the “Behaviour Management: A Guide to Good Practice” in-service materials developed by the DCRC http://www.dementiaresearch.org.au/BPSDGuide.

What is a delusion?

Delusions are one of two psychotic symptoms of dementia, the other being hallucinations. Delusions are strong, unshakeable false beliefs that are resistant to logic and not shared by others. In people with dementia these delusions are often of a persecutory or paranoid nature and associated with a significant emotional response, e.g. fear or anger. It is important to realise that these feelings of fear or anger are very real, even if the belief is not, and so should be treated with empathy and kindness and not dismissed as ‘silly’.

How might a delusion be experienced by a person with dementia?

As mentioned above, often people with dementia will experience persecutory or paranoid delusions. The purple text provides some ideas for thinking about these things from the perspective of a person with dementia. The person may believe that:

- People are stealing their things – can lead to angry accusations, hiding or hoarding items or wearing multiple layers of clothing. _Staff come and go from residents rooms at all times of day, other residents wander and due to cognitive impairment people with dementia may misplace their things easily._

- Someone is trying to harm them – can lead to refusal to leave their room or to let care staff enter, resident being resistive during personal care or refusing food or medications. _There are new staff at the nursing home or the resident doesn’t remember the faces of all of the staff. They come and get the resident out of their bed and try to shower/dress/feed them and give them medications that sometimes make them feel dizzy or sick or sleepy._

- One’s house is not one’s home – the resident may wander in an attempt to “get home”. _Even after many years residing at a nursing home, a person may never feel that it is their ‘home’ and always want to return to their family home. They see their spouse or children visit and then leave back to “home”. Why am I here and they are there?_

- Their spouse is an imposter – can also be classified as misidentification and can cause distress to both the resident as well as the spouse who may end up on the receiving end of anger and aggression from the person with dementia. _A person with dementia may remember their spouse as they were when they were first married and not associate an older person as being their partner._
• They are being abandoned – this may manifest as actual feelings of abandonment or a paranoid belief that there is a conspiracy to have them institutionalised. In cases where people with dementia retain some insight into their condition, this can come from feelings of being a burden on caregivers which feeds this delusion. It is important to use clinical judgement as many of these beliefs may actually be true, for example valuables being stolen, abandonment by family and friends and that their house is not their home, in which case these would not be false beliefs and so would not be delusions.

**How do we approach care for a person experiencing delusions?**

Delusions can have a negative impact on a person’s quality of life, place additional burden on caregivers and can be associated with physical aggression. For all of these reasons it is important to approach the care of a delusional person in an appropriate and sensitive way.

• Using a person centred approach, gather as much information about the person as possible.
• As with any BPSD it is important to first rule out a medical problem that may be the underlying cause such as a delirium, infection, pain or other physical cause.
• Using a person centred approach, gather as much information about the person as possible.
• Develop psychosocial strategies and interventions and trial these before resorting to medication.
• Make sure that the person and other around them are not at risk of harm and provide assurance to the person experiencing the delusion that they are safe and cared for.
• If a delusion is NOT distressing to the person experiencing it, intervention may not be necessary!

**Delusion or Illusion?**

A delusion is a belief that has no foundation in logic. An illusion is a misperception or misinterpretation. It is important to try and distinguish between these 2 things as misperception in dementia is not a psychotic symptom however can lead to similar behaviours. One common scenario we have come across is when doll therapy is used. People with dementia will often believe that the baby doll is real and care for it as such. This should be considered an illusion as there is some rationale to this belief.

**Principles of psychosocial responses to BPSD**

- Targeted & individualise
- Gentle approach
- Safety
- Engagement
- Empathy
- Simplify environment
- Check accuracy of information
- Distraction
- Clear communication
- Reassurance
- Acceptance
- Reduce fear
- Targeted & individualise
- Check accuracy of information
- Safety
- Distraction
- Reassurance
- Acceptance
- Reduce fear

**Supported by the Dementia Collaborative Research Centre – Assessment and Better Care, UNSW Australia. The views expressed in this work are the views of its author/s and not necessarily those of the Australian Government.**
SPOTLIGHT - GPs

HALT GP Dr Allan Shell spoke with one of the GPs participating in the HALT project, Dr Andrew Hollo, from the Eastern Suburbs of Sydney.

What were your initial thoughts of the HALT project?

Right from the start I was very favourably inclined towards this because I think a lot of elderly people especially those in nursing homes are just “zonked” too much, sometimes in fact the for convenience of the staff rather than benefit of the patient. Certainly there are lots of behavioural problems and I think there are much better ways of coping with and treating them.

The HALT project is trying to encourage the “appropriate” use of antipsychotics but there are times when the medications are necessary, aren’t there?

Yes, there are still occasions where you can’t avoid using medications, even if it is only briefly.

Staff skills and education in this area have been a challenge for GPs previously. Have you seen a change in the nursing home you visit before and after the HALT project commenced?

Yes I think there has been a noticeable difference in staff knowledge before and after HALT. They are not pushing as much as they used to, they are less likely to ask you to prescribe antipsychotics and are much happier to try behavioural therapies and other interventions with the patients. Having the nursing home staff upskilled in this area is excellent, in other nursing homes that I visit that don’t have the HALT training, I have tried to initiate deprescribing. I’ve found it much easier, I’m better able to convince the RNs and other staff to get on board using the knowledge and information I’ve gained by being involved in the project. There is still resistance but I’ve found they’re even happier to call in DBMAS to help which is great reinforcement.

What about the attitudes of patients’ families?

Families are also sometimes quite demanding in this sort of way but when you talk to them and show them the difference, for example their ga-ga parent compared to their not so “ga-ga” parent then they become happier about it as well.

What changes have you noticed in your patient’s involved in the HALT project since they have had their antipsychotic medication reduced or ceased?

Overall very positive and there are some of my other patients that aren’t involved in the project that I have also been reviewing and making changes with at other nursing homes. I think that HALT has encouraged me to look more positively on deprescribing generally for patients that have been on the same medication for a long period of time, not just antipsychotics.

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