A successful approach to reducing antipsychotic medications in long-term care: The HALT project

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Why are BPSD important?

- Ubiquitous, >90% of PWD during Δ course
- Distress to PWD and to caregivers
- Increase rate of institutionalisation
- Higher rate of complications in hospital
- Associated with faster decline & ↑ mortality

Antipsychotics for BPSD

Meta-analysis from 13 studies[1]

- Mean ES in Rx = 0.45
- Mean ES in placebo = 0.32

Side effects

- Sedation
- Dizziness
- Falls
- Orthostatic hypotension
- Anticholinergic
- Weight gain
- Stroke[2]
- Death[3]

[1] Yury C & Fisher J, Psychotherapy and Psychosomatics 2007
[2] Brodaty H et al, J Clin Psychiatry 2003
[3] Schneider L, 2005

Continuing vs stopping antipsychotics in people with dementia?

Ballard 2008: 12 m RCT, continuous use vs PBO

- For most AD pts, withdrawal → no detriment
- Continuers: ↓ verbal fluency ($p<.002$); ↑ mortality
- Subgroup, more severe symptoms Rx benefit

Devanand 2012

- Responders for psychosis or agitation, & no AEs
- Discontinuation → higher rate of relapse

The HALT study

Halting Antipsychotic use in Long-Term care

A single-arm 12-month longitudinal study in 23 aged care facilities of at least 60 beds in urban and rural NSW

Resident participants assessed

- **≈4 wks & 1wk prior to deprescribing (T1 & T2)**
- **Re-assessed 3, 6 &12 months later (T3–T5)**

Pre-baseline → **Baseline** → **3 months** → **6 months** → **12 months**

HALT protocol

Education

- GPs (academic detailing)
- Train the trainer model, 3-day workshop for nurse champions who trained residential care staff

Recruitment

- Nurse champions identified residents…
- … & approached families for consent
- If √, GP asked for consent

HALT measures

- Sociodemographics, health
- Medications
    - Antipsychotics: regular, PRN
    - Sedatives
    - Others
- BPSD
    - NPI-NH
    - CMAI

HALT participants

SOCIODEMOGRAPHICS (n = 139)	% (n) or $\bar{x}$ ± SD (range)
Age	85.6 ± 7.5 (59.5 – 101.8)
Female gender	66.2% (92)
Marital status ~	
Single, never married	5.1% (7)
Separated /divorced /widowed	57.2% (79)
Married/de facto	37.7% (52)
Born in Australia	46.8% (65)
Preferred language of English	68.3% (95)
Education ^	Higher 45%, Lower 55%

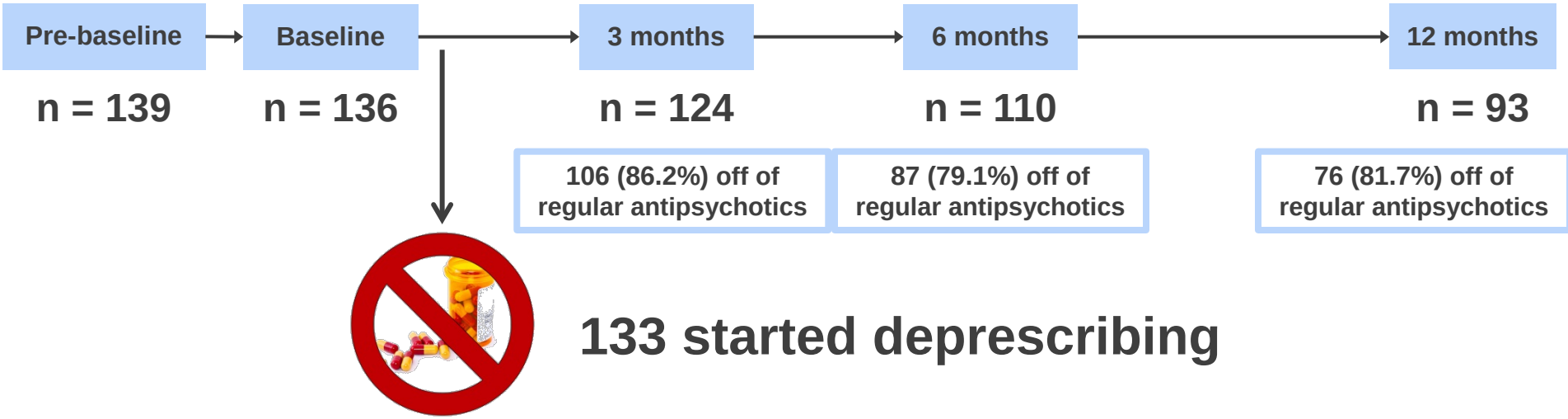
Missing data ~ 1 missing; ^ 20 missing

Medical diagnoses (139)	% (n) or $\bar{x}$ ± SD (range)
Dementia	93.5% (130)
Not otherwise specified	30.0% (39)
Alzheimer's disease	31.5% (41)
Vascular dementia	15.4% (20)
Mixed dementia	10.8% (14)
Frontotemporal dementia	4.6% (6)
Dementia with Lewy bodies	3.8% (5)
Dementia in Parkinson's disease	2.3% (3)
Younger onset AD	1.5% (2)
Depression	58.3% (81)
Parkinson's disease	6.5% (9)
Stroke	26.6% (37)

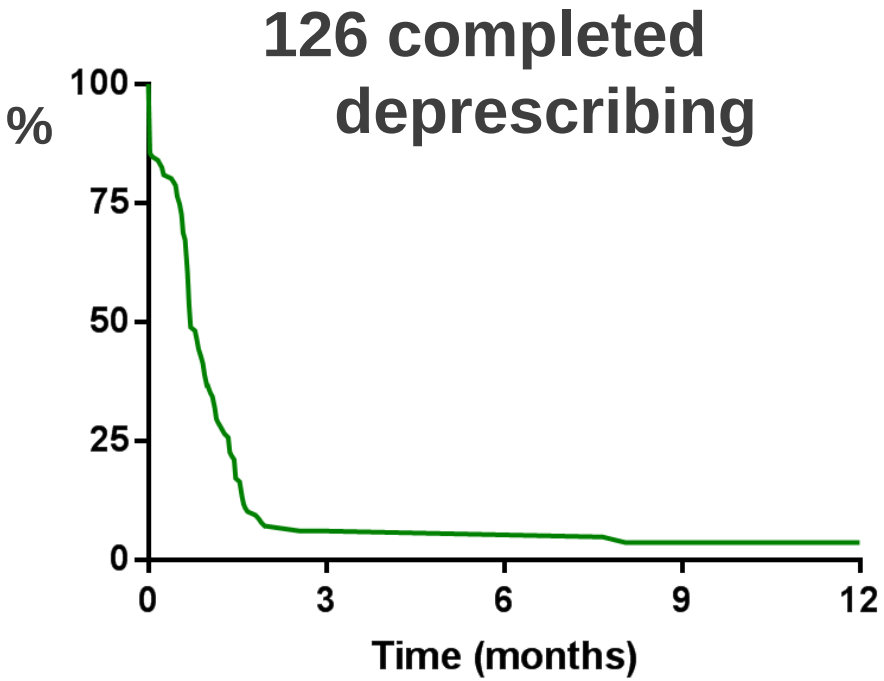
MEDICATIONS (n = 139)	% (n) or $\bar{x}$ ± SD (range)
Number of current psychotropic medications	2.4 ± 1.1 (1 – 5)
Number of current non-psychotropic medications	9.0 ± 4.1 (2 – 23)
Regular antipsychotic medication	
Olanzapine	12.9% (18)
Quetiapine	18.0% (25)
Risperidone	61.2% (85)
Haloperidol	10.1% (14)
Duration of current course of antipsychotic (years)	2.2 ± 1.8 (0.1 – 8.1)
Duration of current dose of antipsychotic (years)	1.4 ± 1.3 (0.1 – 6.7)

Setting of antipsychotic initiation (139)	% (n) or $\bar{x} \pm$ SD (range)
During hospitalisation	20.1 (28)
Since admission to RACF	57.6 (80)
Living in community	10.8 (15)
Unknown/other	11.5 (16)
Informed consent?	
No or unknown	84.1 (117)
Yes – verbal/ written	15.1 (21)/ 0.7 (1)
Prior regular antipsychotic	21.6 (30) (n = 138)
Prior recommend review a'psychotic	61.7 (79) (n = 128)

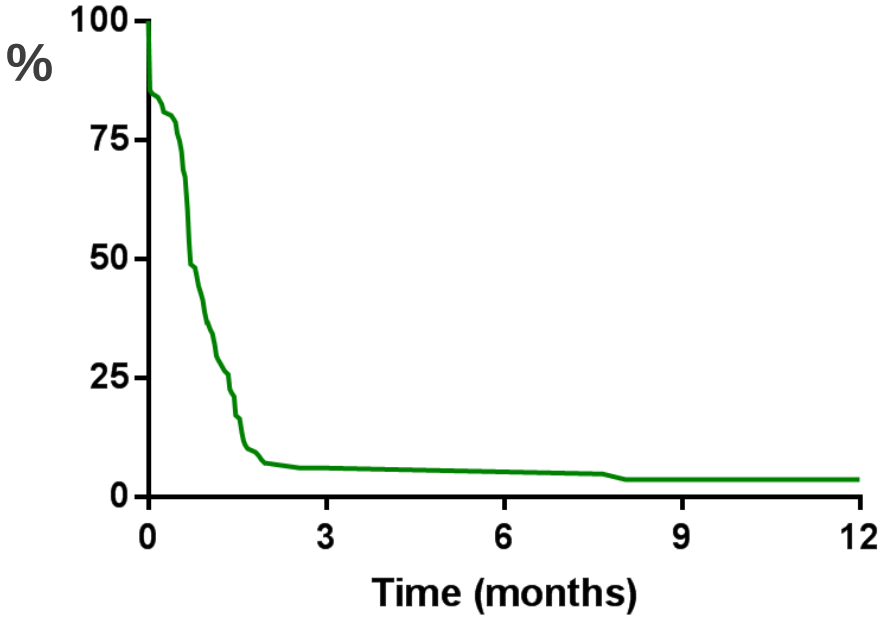
Resident flow



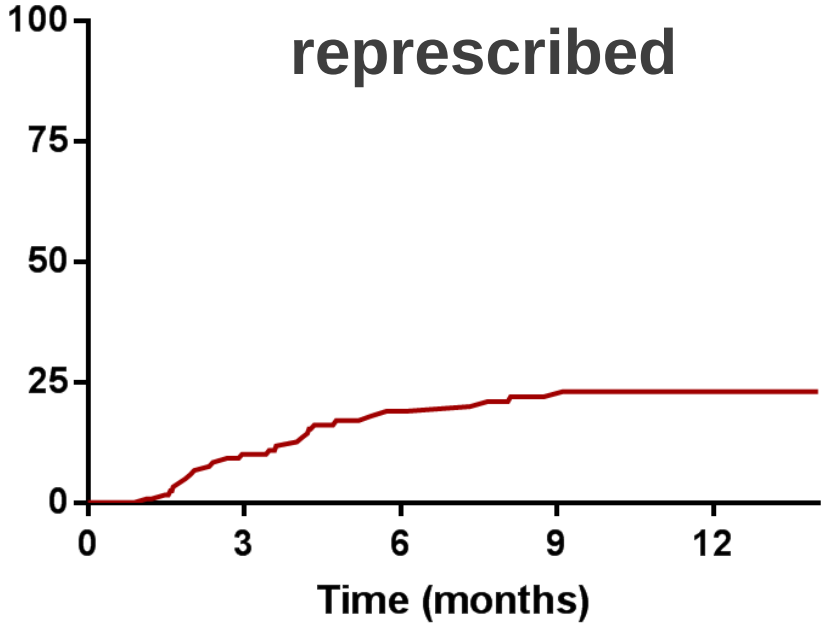
Deprescribing



Deprescribing & represcribing

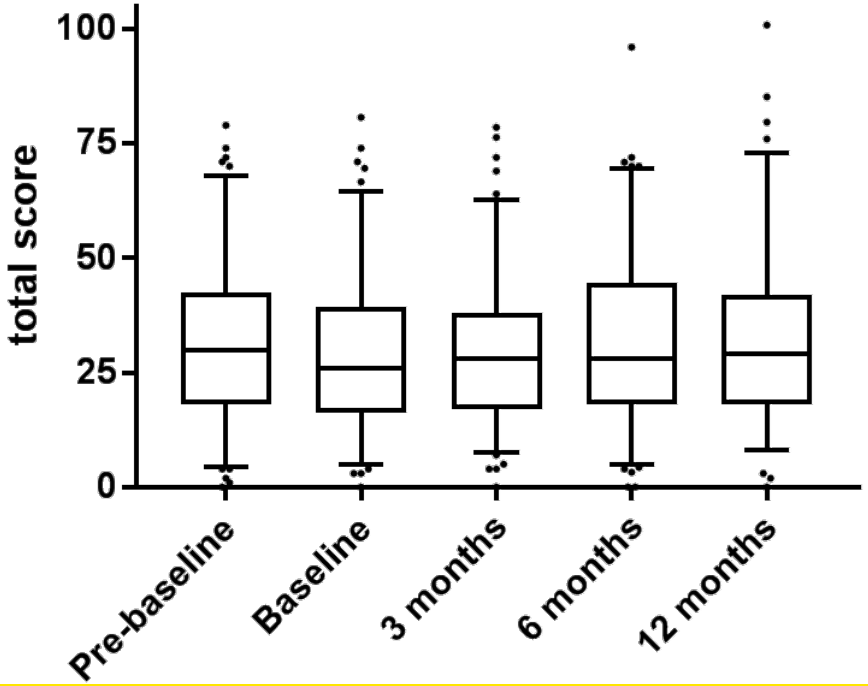


26 were represcribed



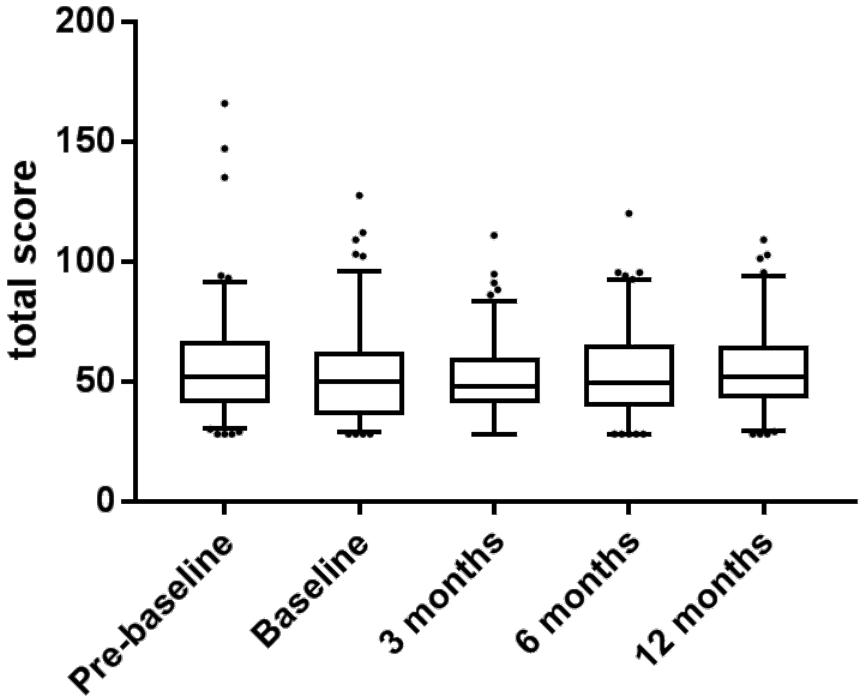
Neuropsychiatric symptoms

No change in total NPI score over time

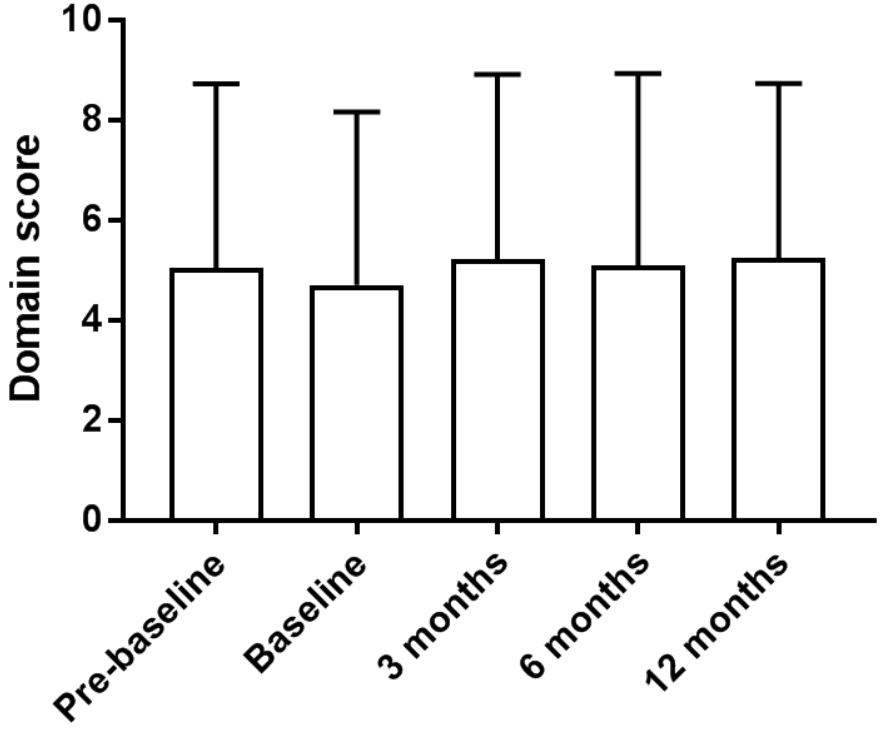


Agitation / Agression

No change in total CMAI score over time



Agitation/aggression (NPI)



Challenges

- Difficult to recruit: NHs, GPs, families
- Lack of education re BPSD for care staff, GPs, families
- Task orientated nursing care, change process to implementing PCC, family expectations
- Presence of “nurse led” prescribing of antipsychotics
- Lack of information for GPs, care staff and families adds to fear of deprescribing

Limitations

Selection bias

- **23/58 of NHs approached joined study**
- **Incomplete list of residents on antipsychotics**
- **241 assent → 157 proxy consent → 139 trial**

Not RCT but no change in antipsychotic use in prior month

No evidence of regular drug substitution eg BDZ; increase in BDZ prn; infrequent and low doses

Emerging Issues

Inappropriate use of antipsychotics is an story – why are we still talking about it?

We have the knowledge, it's time to build the foundations for practice change

Informed consent processes lacking, no accountability

Models of improving PCC in residential care

Needs top down support, bottom up engaged

Next steps

How to make good care *Practice As Usual?*

Top ↓

Incentives for owners, managers, staff

- **Accreditation standards, education**
- **Leadership, training**

Bottom ↑

Drive demand: families, residents

- **Publicise, communicate**

Conclusions

Deprescribing antipsychotics is feasible

- **Without re-emergence of behaviours**
- **Without substitution regular medication**

Subgroup of 20-25% may benefit from Rx

Questions remain about identifying who benefits from continuing antipsychotics

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