The HALT Project
Halting Antipsychotic use in Long Term care

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Public Health Advisory: Deaths with Antipsychotics in Elderly Patients with Behavioral Disturbances

The issues described in this communication have been addressed in product labeling (see Drugs@FDA).
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)
- \( \uparrow \) inappropriate prescribing (Steinman, 2006)
- \( \approx 43.8\% \) of residents prescribed \( \geq 1 \) 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

- Garfinkel & Magin discontinued 332 different drugs in 119 patients in six geriatric nursing hospital depts → ↓mortality and ↓costs

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

• 28% of NH residents on antipsychotics\(^1\)

• 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

![Graph showing cumulative survival rates for Placebo and Continue treatment groups.]

- **Modified intention-to-treat (mITT) population**
  - **Placebo**
  - **Continue treatment**

<table>
<thead>
<tr>
<th>Number at risk (deaths)</th>
<th>Continue treatment</th>
<th>Placebo</th>
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<tbody>
<tr>
<td></td>
<td>64 (19)</td>
<td>64 (15)</td>
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<tr>
<td></td>
<td>45 (13)</td>
<td>49 (3)</td>
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<td></td>
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<td>29 (6)</td>
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<td></td>
<td>9 (1)</td>
<td>19 (2)</td>
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<td>4 (0)</td>
<td>8 (1)</td>
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**HR 0.58 (95% CI 0.35 to 0.95); Log-rank p=0.03**

Psychotropic medication for patients with dementia\textsuperscript{1,2}

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

\textsuperscript{1} Selbæk et al (2008): Am J Geriatr Psychiatry, 16:7, 528-536
\textsuperscript{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)
- 14 LTC homes within Sydney area
- Recruitment target 200 residents
- Resident selection:
  - regular antipsychotics for > 3 months
  - ≥ 60 yrs
  - consent / assent
  - GP agreement
  - No primary mental health diagnosis
  - NPI scores – total < 25, aggression/ agitation < 9
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
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
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\(^1\) 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
- Variance in rates of antipsychotic use
Conclusion

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

Thank you

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