I am Robert Nikkel, MSW, a mental health and addictions professional since 1978 and from 2003 to 2008 the director of the state's Addictions and Mental Health Division. For the past 3 years I have served as the executive director of an international psychiatric on-line continuing education project. I work closely with the Boston medical journalist Robert Whitaker who has specialized knowledge of the unbiased research literature on the effects and side effects of psychiatric medications.

I am pleased to provide this testimony in support of HB 3262. a bill that I believe has great merit and deserves careful consideration in Oregon. It highlights an issue of great concern across this country and many others--the use and overuse of psychotropic medications in physically, cognitively and emotionally vulnerable people, those over 65 living in 3 categories of residential settings as well as adults of any age with a disability who live in foster care and other residential facilities. These Oregonians are quite commonly prescribed medications from the entire range of psychiatric drugs.

The bill's definition of psychotropic medications is appropriately broad and comes from the Oregon statute that is protective of another population vulnerable to overuse of psychiatric medications, children in foster care.

Psychotropic medication means medication the prescribed intent of which is to affect or alter thought processes, mood or behavior, including but not limited to antipsychotic, antidepressant and anxiolytic medication and behavior medications. The classification of a medication depends upon its stated intended effect when prescribed, because it may have many different effects.

For seniors, the issue has been receiving attention and study at the federal level for a number of years. The Food and Drug Administration has expressed concern that antipsychotic drugs are often associated with an increased risk of death when used to treat older adults with dementia especially where psychosis is involved. There is also an increased incidence of cerebrovascular incidents in older individuals.

To give a sense of the magnitude of the problem, a 2013 article in the Journal of Public Mental Health by Mavrodaris and Philip, "Reducing antipsychotic prescriptions in primary care: a healthcare perspective", Journal of Public Mental Health reported in its survey that 25% of seniors with dementia were being prescribed antipsychotics.

Oregonians with disabilities, especially those on disability for psychiatric conditions, are also regularly prescribed medications of all the classes defined in this bill. Those in group homes are especially likely to be prescribed and over-prescribed. I have reliable information that some residents in licensed group homes are on as many as 12 different medications.

An extremely positive aspect of this bill is that it would result in a much better assessment of medication prescribing practices in Oregon, something that as far as I know has never been attempted. If it turns out that Oregon has a much lower prescription rate of using psychotropic medications, the impact of this bill would be relatively minor. But if we are prescribing at a higher rate, then the bill is all the more necessary to implement.

I believe that the rules required to be adopted by the passage of HB 3262 are justified on the basis of the risks involved in over prescribing psychotropic medications alone. But there is also a financial aspect to the problem. These medications are expensive and to the degree that they would be prescribed less over time and more appropriately, there would be cost savings to the Oregon Health Plan for those under 65 with psychiatric disabilities and to the federal government for Medicare savings.

These likely savings would not be immediate nor should they be. Reducing dosages of psychiatric medications cannot safely be done unless it is gradual and with great care to avoid withdrawal syndromes. These are not what are normally seen in addictive drug detoxification (except for the benzodiazepines) but can nevertheless result in the return of certain psychiatric symptoms.

The other precaution that needs to be taken is to review the kinds of non-pharmacological interventions that would be needed to replace the inappropriate prescription of psychotropic drugs. Some savings could be applied to additional staff and training necessary to fulfill the intent of this bill.

It is possible that many primary care physicians will have some discomfort with reviewing the use of psychiatric medications, especially in seniors and possibly with persons disabled due to psychiatric problems. Here again, some increased information, training and consultation would be advisable depending on primary care physicians' assessment of their comfort level with a more supervisory role than they may have heretofore performed. To the extent that the integration of physical and mental health care has been realized by the CCOs, this may be a larger or smaller problem to consider.

This bill deserves passage if for no other reason than that it brings a problem into the open for review that has had some but far too little recognition and even less action. Along with children, persons over 65 and those with disabilities are among the most vulnerable to medications that have a much higher risk profile than is customarily recognized. Oregon owes it to these individuals to assure that prescribing standards meet the highest levels of unbiased research findings and evidence-based practice.

If I can be of any service to Oregon in the implementation of this bill if passed into law, I would be happy to make myself available