Oregon
Kate Brown, Governor

Department of Human Services
Aging and People with Disabilities
500 Summer St. NE, E-02
Salem, OR 97301
Voice: 503-947-5476
Fax: 503-373-7823

March 16, 2017

DHS
Oregon Department of Human Services

Chair Keny-Guyer
Vice-Chair Olson
Vice-Chair Sanchez
Members of House Human Services and Housing

Re: Ann McQueen, Ph.D Testimony, HB 3262, March 16, 2017

Good morning, Chair Keny-Guyer, Vice Chairs Olson and Sanchez, and Members of the Committee. My name is Ann McQueen, and I have a Ph.D. in gerontology with specialty work related to Alzheimer's and Dementia. I am the administrator of the Safety, Oversight and Quality Unit of Aging and People with Disabilities with DHS. Our unit is the licensing and regulatory body for long term care facilities throughout the state, and we have an unwavering commitment to the safety, independence, choice and dignity of the vulnerable older adults living in Oregon's licensed long term care settings.

Although the agency is neutral on this bill, we have been happy to provide information to Representative Nathanson related to House Bill 3262. I would like to share some of that information with you today.

To offer some context, *antipsychotics* are one family of drugs under the larger umbrella of a class of drugs called *psychotropics*. There are two classes of antipsychotics:

- Typical antipsychotics (sometimes referred to as first generation antipsychotics, are a class of antipsychotic drugs first developed in the 1950s and used to treat psychosis (in particular, schizophrenia).
- Atypical antipsychotics are a group of antipsychotic drugs more recently developed to treat psychiatric conditions such as schizophrenia, bipolar disorder, and autism. Atypicals are less likely to cause motor control disabilities, such as body rigidity, involuntary tremors, and unsteady Parkinson's disease-type movements.

In numerous studies, drugs within both groups of antipsychotics have been shown to have dangerous side effects for older adults, including strokes, fractures, kidney injury, and mortality. Older adults with dementia, in particular, face an increased risk of death from these medications. This is such a serious problem that the FDA placed its most serious warning, called a black box warning, on the *off label or unapproved* use of these drugs to treat dementia-related behaviors.

Despite these known risks, recent research funded by the National Institute of Mental Health, which is part of the National Institutes of Health, showed that the percentage of people receiving an antipsychotic prescription *increased* with age after age 65. In their study, the percentage of older people with an antipsychotic prescription was approximately twice as high among people 80 to 84 as among those age 65 to 69. (https://www.nimh.nih.gov/news/science-news/2015/antipsychotics-use-among-older-adults-increases-with-age.shtml)

Researchers conducting this study stated unequivocally, “The results of the study suggest a need to focus on new ways to treat the underlying causes of agitation and confusion in the elderly. The public health community needs to give greater

attention to targeted environmental and behavioral treatments rather than medications."

Unfortunately, our society does not do a very good job communicating and connecting with people who have Alzheimer's disease and other forms of dementia. When a person receives a diagnosis of dementia, we often assume they are no longer able to communicate meaningfully and that they have little or no capacity to experience emotions. This is simply untrue. People with dementia experience a variety of losses, including the ability to find words or to express themselves verbally. Thus, they often attempt to express what they need or how they feel through behavior, some of which may be challenging, aggressive, or seemingly inappropriate. Unfortunately, rather than take the time to figure out *what* a person may be trying to communicate through his or her behavior, we focus on trying to immediately stop unsettling behaviors with medications like antipsychotics. In doing so, we effectively suffocate the human emotions people with dementia still possess because we fail to take the time needed to listen and to try to understand the basic human needs they are attempting to express.

Medication should never be the first or only line of defense in addressing dementia-related behaviors, and there are a variety of evidence-based, non-pharmacological approaches that have been shown to reduce or eliminate the need for antipsychotics in many older people living with dementia. I don't have time to share them today, but I would be happy to do so for anyone who is interested in learning more.

I'd like to close with a quote from James Thomas, a man who lived with Alzheimer's disease for eight years before he died at age 70:

“I am hungry for the life that is being taken away from me. I am a human being. I still exist. I have a family. I hunger for friendship, happiness, and the touch of a loved hand. What I ask for is that what is left of my life shall have some meaning. Give me something to die for! Help me to be strong and free until my self no longer exists."

Thank you, Chair Keny-Guyer, Vice Chairs Olson and Sanchez, and members of the Committee for the opportunity to speak with you this morning.

Sincerely,

Ann McQueen
Safety, Oversight and Quality Administrator
Aging & People with Disabilities
Department of Human Services