Alzheimer's & Dementia Alliance
OF WISCONSIN

Legal Interventions for Persons with Alzheimer's Disease and Related Dementias
Special Study Committee
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Good morning,

I would like to thank the committee members for taking the time to address this important and somewhat complicated issue.

The position of the Alzheimer's and Dementia Alliance of Wisconsin is that the legislature should consider modifying the statutes to allow the involuntary commitment process to be used for people with dementia, either by opening up Chapter 51 or creating a mechanism under Chapter 55, however we would also suggest some modifications to the process and changes to definitions

Under Chapter 51 section 51.20 we suggest including people with a degenerative brain disorder who could benefit from psychiatric treatment. I've read over the testimony from the Dane County Corporation Council and we generally agree with the recommendations outlined in that testimony, however, we urge caution in loosening any standards allowing for administration of psychotropic medications.

Administration of psychotropic medications to address behavioral issues should be a last resort. The Wisconsin Legislature acknowledged the dangers of prescribing psychotropic medications when it created Wisconsin Act 281 requiring written informed consent from the nursing home resident or the person action on behalf of the resident before administering psychotropic medications with black box warnings.

One of the most commonly prescribed psychotropic medications is Risperdal which has a black box warning and I just want to read to you the warning so you understand what these are all about.

"IMPORTANT SAFETY INFORMATION FOR RISPERDAL ®
Elderly Patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. RISPERDAL ® (risperidone) is not approved for the treatment of patients with dementia-related psychosis."

Atypical antipsychotics (AAP) (also known as second generation antipsychotics) are a group of antipsychotic tranquilizing drugs used to treat psychiatric conditions. Both generations of medication tend to block receptors in the brain's dopamine pathways, but atypical medications differ from typical antipsychotics in that they are less likely to cause motor control disabilities in patients, such as Parkinson's disease-type movements, body rigidity and involuntary tremors. These abnormal body movements can become permanent even after medication is stopped. Basically the atypical psychotics are considered safer than the older generation of medications, however for people with dementia we do not believe any are truly safe and should always be administered as a last resort. In fact Wisconsin Act 281 was a direct response to deaths in Wisconsin of Alzheimer's patients who had been prescribed psychotropic medications.

While psychotropic medications are on some occasions necessary, we believe they are widely overused in the dementia population.

From the perspective of the Alzheimer's and Dementia Alliance of Wisconsin, more emphasis should be placed on avoiding or heading off difficult behaviors that often lead to stays in psychiatric units. Increased training and collaboration with organizations like ours would help to avoid Chapter 51 placements and would reduce reliance upon behavior modification medications.

I can give you a real world example of this which I believe is fairly powerful. Our Dementia Support Team became aware of a man, a retired doctor, who had been confined to Mendota Mental Institute for 2 ½ years. Our team went in and was able to transition this man into a CBRF within four weeks. He spent the remainder of his life in the CBRF without any issues. Not only was this a benefit to this man but it also resulted in considerable cost savings. It costs approximately $1,200.00 per day to treat a person in Mendota.

With that being said, we realize that situations will occur where behavior issues rise to a level which facility staff cannot adequately address. We also recognize that facilities have an obligation to protect all residents from harm and have a duty to protect staff as well. Situations will arise where a person with dementia will need to be removed, hopefully for a brief period of time, to address behavioral issues.

In some cases a geriatric psychiatric unit is going to be the best place to address those issues, especially when they involve medications. I think it's important to note that on average an Alzheimer's patient has three to four accompanying conditions, all of which may require medications. Sometimes behavior problems arise as a result of not one medication or a lack of medications but because of interactions between medications. The best place to sort that out is often a geriatric psych unit. The psychiatric units are also in a good position to deal with and potentially adjust medications as interactions between different medications occur. It may not be ideal but that is the reality.

Unfortunately, Chapter 55 does not allow for involuntary commitment to a geriatric psych unit, in fact it specifically prohibits it. So, again, we would suggest that creating a

mechanism to allow for involuntary commitment to psychiatric facilities is in the best interests of people with dementia, however, we believe that modifications should be made to the system to better address the unique circumstances faced by this population.

1. Handcuffing

Police departments often have policies in place mandating that anyone who is in custody or is placed into a police car be handcuffed. Families do not like having their loved ones with dementia handcuffed and taken to a psychiatric unit in a police car. Handcuffing someone with dementia is not appropriate and will likely make the situation worse.

We suggest using ambulance services for transport. A police officer could ride along in the ambulance if necessary, or could follow the ambulance if there was a concern. I have discussed this with law enforcement personnel and they seemed to think this would work.

2. Psychiatric unit environmental issues

A person with dementia is an easy victim for predators. It is essential that people with dementia are protected from other patients when committed to psychiatric units. It is not appropriate to house a person with Alzheimer's disease with a person who has a diagnosis of Schizophrenia for example. This also causes problems with development of the personal care plan for the person with dementia. We don't get a good sense of how an individual treatment plan is going if the person is agitated by other patients with other types of conditions and this can cause an increased length of stay. This is a problem our Dementia Support Team has faced in the past.

We suggest the legislature require people with dementia to be housed separately from people with other mental health conditions.

3. Commitment criteria

Placing an individual with Alzheimer's disease in a psychiatric unit should be a last resort. We believe it would be beneficial to create a specific definition regarding behaviors that would qualify for psychiatric commitment for people with dementia and ideally include strategies aimed at addressing the behavior that would have to be attempted before a commitment could be initiated.

4. Length of stay and discharge criteria

Define in the statutes how long a person with dementia may be committed to a psychiatric unit before an attempt has to be made to place the person back in the community. I would point you to the example I used earlier of the man who had been in Mendota for 2 ½ years as evidence that this would be sound public policy.

5. Staff training / determination of behavior catalyst / strategies to cope with behavior / methods to avoid commitments

This last piece will be explained further by our training expert, Mary Salzieder, when she speaks later today.

We would like to see the committee look at how we train professional caregivers and what opportunities in this area are available. Obviously training professional caregivers isn't going to address those cases where the individual is still living in the community where family and friends are acting as the caregivers but most of the cases I've been made aware of involve individuals who are in some sort of an assisted living facility, whether that's a CBRF for a nursing home.

I thank you for your time and consideration.