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A GENERATION AT RISK: BREAKING THE CYCLE OF SENIOR SUICIDE

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BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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A GENERATION AT RISK: BREAKING THE CYCLE OF SENIOR SUICIDE

THURSDAY, SEPTEMBER 14, 2006

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 10:02 a.m., in room SD–562, Dirksen Senate Office Building, Hon. Gordon H. Smith (chairman of the committee) presiding.

Present: Senators Smith and Kohl.

OPENING STATEMENT OF SENATOR GORDON H. SMITH, CHAIRMAN

The CHAIRMAN. Good morning, ladies and gentlemen, and thank you for your attendance here at this Committee hearing of the Senate Special Committee on Aging. This is a topic that tugs at the heart strings, but is very important. We have entitled it "A Generation at Risk: Breaking the Cycle of Senior Suicide."

Today's hearing focuses on an issue that is of particular importance to me, that of mental illness and suicide prevention. Since suffering a family tragedy, I have felt a personal call to action to shed light on the struggle of millions of Americans coping with a mental illness. As my wife and I became involved in the issue of suicide prevention, we were overwhelmed by personal stories of those battling mental illness. Sharon and I now share in a fraternity of sorrow with those who have lost loved ones to this killer.

Though it is not a common perception, seniors are at a much higher risk for suicide than those of other age groups. While those over the age of 65 account for only 13 percent of the U.S. population, they account for 20 percent of the Nation's suicides. The problem only worsens with age. Compared with suicide rates of younger men, suicide rates of men over the age of 85 are two to three times higher. Statistics such as these are alarming, and that is why this hearing is so important. It is critical that we raise public awareness of this issue and discuss ways to reduce these startling and tragic statistics.

Suicide across the age spectrum is becoming an epidemic. There is work being done at the Federal level, but we still have a very long way to go. The Aging Committee has served as a forum to examine the needs of seniors, all kinds of needs, and to highlight better ways to serve them. This Committee was the first to bring this important issue to light with a hearing in 1996, and I hope today's work will serve as a call to action.

It is a sad irony that as medical technology evolves to extend lives, seniors are choosing to end theirs. Retirement should be a time to relax, travel, and spend time with grandchildren. Unfortunately, seniors often are exposed to circumstances that can lead to depression, such as social isolation, physical illness, and the death of loved ones. I think it is very important that we understand that depression is neither a weakness nor a normal part of aging. Depression at any age is a very real disease. No one should suffer in silence.

What many fail to realize is that suicide is entirely preventable. The senior population, however, presents unique challenges. As a generation, seniors are less likely to talk about their symptoms or to seek help. More than any age group, seniors suffer from the stigma associated with mental illness, and many are unaware of or are too ashamed to pursue treatment options.

Fortunately, there are ways to help seniors in dealing with these issues. Studies show that 77 percent of seniors saw their primary care physician within one year of their suicide and 58 percent saw their primary care physician within one month. Clearly, the primary care setting is the critical component of suicide prevention and intervention.

This hearing will examine the quality of mental health care given to seniors and will look for ways to improve upon the ability of primary care doctors to recognize the signs of depression among their senior patients. Today, we will hear the results of a groundbreaking study that demonstrates the effectiveness of serving the mental health needs of seniors in a primary care setting.

As one of Oregon's Senators, I am very pleased that my home State has a particularly innovative model of suicide prevention. It has this, I suppose, in spite of and maybe because of the assisted suicide law in our State. It is the only State to implement a comprehensive suicide prevention plan for seniors. I am looking forward to learning more about their efforts today and those of several other experts in the field of suicide prevention. It is a pleasure to have all of you here and I truly appreciate your sharing your experiences with us today.

There is a vote scheduled at 11, so we are going to try to be expeditious and give sufficient time to each of our witnesses. What you have prepared to share is important to us and will help us better understand how we in the Federal Government can help you to prevent suicide among seniors and among all people.

With that, I turn to my colleague, Senator Kohl, for his opening remarks.

OPENING STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Thank you, Mr. Chairman, for holding this important hearing. We all admire your steadfast leadership and commitment to helping our Nation's families prevent tragic cases of suicide. We look forward to today's discussion of how to make sure seniors who suffer from depression find the help that they need.

Our Nation is slowly making progress in removing the stigma of mental illness, but today too many seniors still fall prey to depression. Some are ashamed, some believe it is just a fact of life in old age, and some don't know where to turn for help. In fact, a survey of seniors found that only 38 percent believe depression is a health problem and more than half responded that it was just a normal part of aging. But depression, as we all know, is not a normal part of aging and it is treatable. Yet, too often seniors are left untreated and suicidal.

Seniors make up 13 percent of our population, but account for close to 20 percent of all suicides. In fact, 75 percent of older people who commit suicide have seen their primary care doctor within the last month of their lives, as our Chairman has pointed out, and our health care system has failed them. So we must do more.

Doctors must be trained to recognize and respond when their senior patients are depressed. We also need more geriatric specialists to manage the care of older patients who face multiple health problems. Today, there are only 5 geriatricians and 1.4 geriatric psychiatrists for every 10,000 seniors. We have pushed for funding for the Federal geriatrician training program to address these shortages and we hope that that program will be restored.

As the Nation prepares for the retirement wave of 77 million baby-boomers, we need to rethink the way mental health care is provided to seniors. Today, we will hear from two panels of distinguished experts who will explain the problem of senior suicide and suggest creative models to prevent it. I am very pleased that Dr. Art Walaszek, a leader in this field in Wisconsin, is here to share his experience and his work.

Again, we thank you, Senator Smith, for organizing this hearing.

The CHAIRMAN. Thank you very much, Senator Kohl.

Our first panel consists of Dr. David Steffens. He is a professor of psychiatry and medicine, and head of the Division of Geriatric Psychiatry at Duke University Medical Center. Dr. Steffens is also a chief investigator on the IMPACT study and will discuss publicly the findings of this ground-breaking study today.

Thank you for coming, Dr. Steffens.

STATEMENT OF DAVID CARL STEFFENS, M.D., M.H.S., PROFESSOR OF PSYCHIATRY AND MEDICINE, AND HEAD, DIVISION OF GERIATRIC PSYCHIATRY, DUKE UNIVERSITY MEDICAL CENTER, DURHAM, NC

Dr. STEFFENS. Senator Smith and Senator Kohl, I want to thank you for inviting me to give testimony about suicide, an important public health matter that affects Americans across the age spectrum, but as we have heard, has a disproportionate effect on older Americans.

As a geriatric psychiatrist, when I look at the CDC statistics, the take-home message for me is the alarming suicide rate for white men 85 and over. The large majority of these victims used a firearm to kill themselves. I want to shift my testimony, however, in a positive direction and talk about solutions. Both the NIH and private foundations are helping to develop an evidence base for prevention of suicide in older adults. One example is the NIMH-funded PROSPECT trial. Completed in 2003, PROSPECT showed a positive result when a collaborative team involving a depression care manager and physicians working in primary care practices came together to treat depression. Intervention participants showed significant reductions in suicidal ideation at 4 and 8 months when compared with the treatment-as-usual group.

I will now focus on the IMPACT study. In 1998, the John A. Hartford Foundation took the lead in supporting the study "Improving Mood-Promoting Access to Collaborative Treatment," or IMPACT. Dr. Jurgen Unutzer, now at the University of Washington, is the IMPACT principal investigator.

IMPACT focused on treatment of major depression and dysthymia in the elderly. Patients were drawn from 18 primary care clinics, from 8 health care organizations in 5 States, and were randomized to working with depression clinical specialists in the primary care clinic versus receiving usual care for depression in primary care. Depression clinical specialists were trained to use an anti-depressant medication algorithm and they also received special training for delivering problem-solving therapy, a six- to eight-session brief, structured psychotherapy for depression. We found a powerful effect for the intervention in treating depression.

More recently, we analyzed the IMPACT data to determine the effect of the intervention on reducing suicidal ideation specifically. At baseline, just to give you an idea, 15 percent of intervention patients and 13 percent of treatment-as-usual patients reported thoughts of suicide. At 6 months and 12 months, intervention subjects had significantly lower rates of suicidal ideation than those in the comparison group. Remarkably, after the 1-year intervention was over, we still found an effect at 18 months and 24 months. There were no completed suicides in the study. Our findings will be published in the Journal of the American Geriatric Society.

I served as an IMPACT study psychiatrist at the Duke general internal medicine site. In that capacity, I met each week with the two depression clinical specialists to review the new and returning cases they had seen that week. We made specific written recommendations to the primary care physician, who had to sign off on them before they could be implemented.

Thus, the main thrust of our collaborative work was two-fold: first, keeping the primary care physician in charge of the final treatment decision and, second, striving to keep the care of the depressed patient in the primary care setting. Occasionally, I would need to see patients largely to evaluate treatment refractory patients or to assess suicide risk.

I am happy to report to you that at the Duke site, this collaborative care model did not end when the IMPACT study ended. As you might imagine, the primary care physicians in the practice came to value highly their work with the depression clinical specialists. As the IMPACT study wound down, we moved to implement the model as a clinical service in primary care. Now, I work with a master's-level clinical nurse specialist who functions as a care manager in primary care. We have also expanded the patient population to include adults ages 18 and above. In the past 4 years, the care manager has seen 478 referred patients in over 3,000 visits, including 171 older adults and 129 older adults with depression.

The Hartford Foundation is currently supporting efforts aimed at implementation of the IMPACT model, including care manager training seminars and development of educational materials to help clinic managers incorporate the model into primary care practices. In sum, IMPACT provides a good model for tackling the problem for suicide in the elderly. It focuses on management of depression, the condition most commonly associated with suicide.

Its other key feature, provision of care in the primary care setting, is appealing for several reasons. For one, older adults may perceive stigma of mental illness more than other age groups and thus may be more reluctant to go to a separate psychiatric clinic. Second, most older adults have primary care doctor, but they may not have access to a psychiatrist, let alone a geriatric psychiatrist. Third, the IMPACT study has shown that most depressions can be treated in the primary care setting.

It has been both personally and professionally satisfying to me to be able to implement in the clinical setting an intervention that I know works in the research setting. I look forward to hearing your thoughts and questions about suicide and suicide prevention, about the IMPACT study, and about ways we might be able to make changes in our health care system that will make a real difference in addressing the alarming suicide rates experienced by our greatest generation of older Americans.

Thank you.

The CHAIRMAN. Thank you, Doctor. My question really comes out of a conversation I had recently with one of my colleagues, who happens to be a baby doc deliverer, Senator Coburn, of Oklahoma, who indicated to me that fully half of his practice was psychiatrist counseling. I don't speak for him, but I believe he represented to me a view that he felt mental health teaching parity is vitally needed in our medical schools.

When I talk to medical school folks, they say, oh, no, everything is fine, we cover that. Yet, I am not sure I have talked to a doctor who says to me—they are not psychiatrists, but they say, you know, I got a little bit, but I really didn't know it sufficiently to

treat it in a primary care setting. I am wondering if you can comment on the notion of mental health teaching parity.

Dr. STEFFENS. Thank you, Senator. We certainly have experienced that at Duke University and I think our school is not alone in this. As technology advances, there is a temptation to become quite enamored of it in medical school teaching, to be at the cutting edge, and there is only so much time that is left for teaching. We find particularly when teaching psychiatry and managing mental illness that the formal amount of time that is set aside for psychiatry rotations is lessened. That tends to, I think, give the impression that these illnesses are less important.

Unfortunately, it is a sad reality in many teaching institutions that other specialties and an emphasis on technology may be more prominent, and therefore you get not only short shrift in terms of the time spent, but the overall message it sends to our future workforce of doctors about the importance of mental illness is worrisome to me as well.

The CHAIRMAN. So you think some emphasis perhaps from Congress on mental health care teaching——

Dr. STEFFENS. Yes, sir.

The CHAIRMAN. You think we ought to do that?

Dr. STEFFENS. Yes, sir. Any incentives that can be provided in terms of mental health teaching, involvement more of faculty with expertise and, in fact, teaching about models like the IMPACT model about the importance of collaborative care are important.

The CHAIRMAN. You would agree, I suppose, given your background, that if a person has physical health but not mental health, they don't have health.

Dr. STEFFENS. It is a matter of quality of life and I certainly agree with that, Senator.

The CHAIRMAN. As you consider the primary care industry system, how would you grade it in our country right now in terms of mental health?

Dr. STEFFENS. In terms of mental health, it is hard because just thinking about the——

The CHAIRMAN. When you look at your model and how effective it is, how many have those models?

Dr. STEFFENS. It is something that is sorely needed. It is certainly a vast minority of practices that have the ability right now to incorporate this model. So anything that you all can do to help with that——

The CHAIRMAN. You are a teacher. You grade papers, don't you? How would you grade primary care as to mental health? Would you give them a D?

Dr. STEFFENS. I want to be more encouraging to them, so I will give them a C——

The CHAIRMAN. OK, they got a C.

Dr. STEFFENS [continuing]. In part because I think there is a recognition of the importance of depression. It is now a matter of what tools can we do, given how busy primary care physicians are, to help them then effectively treat depression in the primary care setting.

The CHAIRMAN. Would you agree with me that Tom Cruise is a great actor?

Dr. STEFFENS. He is a fantastic actor, yes, sir.

The CHAIRMAN. What kind of a mental health physician do you think he is?

Dr. STEFFENS. I think that——

The CHAIRMAN. Let me ask you a better question.

Dr. STEFFENS. Yes, yes. [Laughter.]

Is post-partum depression real? Is it a legitimate medical condition?

Yes, sir.

The CHAIRMAN. I agree. Is bipolar condition a real condition?

Dr. STEFFENS. Yes, sir.

The CHAIRMAN. How about schizophrenia?

Dr. STEFFENS. Yes, sir.

The CHAIRMAN. They are identifiable medical conditions?

Dr. STEFFENS. They are.

The CHAIRMAN. You know what they are and there are treatments for those that actually work?

Dr. STEFFENS. Very effective treatments, yes, sir.

The CHAIRMAN. I wanted that on the record.

Dr. STEFFENS. Yes.

The CHAIRMAN. I wonder, as you consider the primary care system, what can we in Congress do to help improve it? What specific things would you——

Dr. STEFFENS. Well, I know that, for example, Senator Kohl has mentioned the reauthorization of the training for geriatricians under Title VII. We are hopeful that that is something in terms of just the pipeline and access aspect. There are other things, including making the Centers for Medicare and Medicaid Services—suggesting that they include a suicide assessment for individuals with mental illness as a quality indicator for care.

There are some issues around the donut hole in Medicare Part D in terms of we do have effective treatments particularly on the pharmacology side, but they do have an expense and sometimes people will choose to drop their depression treatment as opposed to their diabetes or other types of treatments, unfortunately, at their own peril. So those are some aspects.

The CHAIRMAN. We actually don't have pharmacology parity, do we, in Federal law as relates to mental health?

Dr. STEFFENS. Right, and we don't have mental health parity more broadly, and it seems to me that this is one area, given that our focus is primary care, where perhaps a CPT code could be developed for this type of collaborative model that would, in fact, be reimbursed more at the 80-percent level than at just the 50-percent level. That may make it more attractive to primary care business managers to think about incorporating this if they see that they can get sufficient reimbursement such that it definitely adds the quality. But will it be either a revenue-neutral or a minor revenue-losing or a slightly revenue-producing enterprise?

The CHAIRMAN. But if mental health care is legitimate, shouldn't it be equal to physical?

Dr. STEFFENS. Absolutely.

The CHAIRMAN. OK, that is my point. Probably the most important thing we could do in a short-term, tangible way would be medicine parity for mental health.

Dr. STEFFENS. Absolutely.

The CHAIRMAN. Anything else you can identify? We have got teaching parity, pharmacological parity. Anything else?

Dr. STEFFENS. I think we have covered most of the bases.

The CHAIRMAN. Senator Kohl.

Senator KOHL. Dr. Steffens, as you well know, primary care doctors who see patients with multiple chronic disease often don't have the time to also do a full assessment of the patient's mental state. In your program, they are on the front lines and very involved. Do you think that most doctors might be willing to take on this challenge?

Dr. STEFFENS. I think that there will be a willingness, Senator, but I think that the truth is that right now the incentives are for spending very little time, in general, seeing patients both in terms of the reimbursement that one gets from third-party payers, but even clinic managers sometimes will give bonuses if people can keep their volume up. So, certainly, there are very few incentives.

So I think that primary care physicians now understand the importance of treating depression, but they have, I think, one of the toughest jobs out there in terms of trying to balance all of the patient's problems, treating the patient as a whole and trying to incorporate time to deal with depression.

This is one model, Senator, that I think would be very helpful to the primary care doc because it keeps physicians not only in the loop, but at least the way we have implemented it, they have to sign off on the recommendations that the care manager makes after consultation with me. So this is something that I think they would find very appealing because it is not, well, we will just refer it out and maybe I will get a note about it every once in a while. That is not the way that this works. This is something that intimately involves the primary care physician and I think that they would be open to it.

Senator KOHL. Well, data from your program show that patients had fewer suicidal thoughts after 6 months of therapy and medication. If this is a successful model, then how should we encourage more doctors and health care systems to use it?

Dr. STEFFENS. I think that, one, the financial incentives, changes to the system that we have talked about in terms of mental health parity; improving access that they have to geriatricians by increasing the pool of geriatricians; making people aware through meetings like this about resources that are available, for example, through the American Association for Geriatric Psychiatry, through the John A. Hartford Foundation that sponsored the original study.

They are now moving into what is called IMPACT II, which is actually the dissemination of information and production of tool kits for primary care physicians and managers to describe how they can best incorporate this model.

Senator KOHL. Primary care physicians who deal with chronic diseases in the elderly are not trained or qualified in many cases to deal with the mental aspect of it. To the extent that this is true or, as you pointed out, they don't have the time to pursue this, how do we get beyond this? If we don't get beyond this, it seems to me, we are not going to deal with the problem.

Dr. STEFFENS. I think that certainly now there is a recognition. If you look at the journals in primary care, as well as the conferences that are sponsored, depression and mental illness are now incorporated. So I think the message is trying to get out there that mental disorders are just like other physical conditions and should be part of what primary care physicians can deal with.

The sad truth is that most depressions can be managed in the primary care setting if appropriate time is allotted. So I think again that the willingness is there. It is a matter of managing time, of providing the incentives, for example, through changes in Medicare, providing certain CPT codes that would actually allow for them to spend the time or to work in the collaborative model as well.

Senator KOHL. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Doctor, thank you very much. We appreciate your contribution this morning. It has been very helpful.

Dr. STEFFENS. Thank you, sir.

The CHAIRMAN. We honor your work and we just need to get it out on a larger basis.

Dr. STEFFENS. Thank you, sir.

[The prepared statement of Dr. Steffens follows:]

United States Senate Special Committee on Aging

Testimony of

David Carl Steffens, M.D., M.H.S.

Professor of Psychiatry and Medicine

Duke University Medical Center

September 14, 2006

1 Senator Smith, Senator Kohl, and members of this Special Committee on Aging:
2 My name is David Steffens, and I am a geriatric psychiatrist at Duke University Medical Center
3 in Durham, North Carolina. I want to thank the committee for inviting me to give testimony
4 about suicide, an important public heath matter that affects Americans across the age spectrum,
5 but has a disproportionate effect on older Americans particularly. I come here as someone who
6 has devoted his career to date to the care and scientific understanding of older depressed adults.
7 Because the focus today is on suicide prevention, I will confine my remarks to completed suicide
8 rather than non-lethal suicide attempts.
9
10 An older man comes home to find his wife of 53 years in their bathtub, dead of an intentional
11 overdose of her heart medication. A daughter, stopping by her parents' home to check on her
12 widowed father, is horrified to discover him with a self-inflicted shotgun blast through his heart.
13
14 These two cases illustrate the tragedy that is suicide. It is hard to get oneself into the mindset
15 that would make suicide the only viable option for someone. Suicide leaves a grieving family,
16 full of questions and a mixture of emotions – anger, guilt, shock, sadness and even shame.
17 Family members and friends are forever left with a sense that a life has been snuffed out
18 prematurely yet are often too ashamed to discuss the loss and get the solace they need because of
19 the stigma associated with suicide particularly and mental disorders more broadly.
20
21 Sadly, these are not rare events. Very briefly, I wanted to review for the Committee some of the
22 statistics regarding suicide both in older adults and across the age spectrum. I include more
23 comprehensive reports (tables and figures) from the CDC in the Appendix. In 2003, the most

1 recent year we have statistics on suicide, 31,484 Americans committed suicide, making it the
2 11th leading cause of death in the U.S. It is the 18th leading cause of death in the elderly. By
3 way of comparison, suicide is the third leading cause of death in young people ages 15 to 24 and
4 the second leading cause of death in people aged 25 to 34.
5
6 Rates of completed suicide are highest among older men. In 2003, 4,453 men aged 65 or older
7 committed suicide. Death rates are reported per 100,000 people. For men in the older age
8 brackets, we see a steady increase in suicide with increasing age. The suicide rate in the 65 to 69
9 age group is about 21 per 100,000. This increases to about 32 per 100,000 in the group of men
10 aged 75 to 79. It is in the oldest group, men 85 and older, where we see the rate skyrocket to
11 nearly 48 per 100,000, more than double the rate during the years 18 to 65.
12
13 At the other end of the age spectrum, for males, suicide is fairly uncommon below the age of 15.
14 However, in 2003, 1,222 young men aged 15 to 19 and 2,159 men in the 20 to 24 year old group
15 committed suicide, corresponding rates of about 12 and 20 per 100,000 respectively.
16
17 When we focus on race, suicide appears to be a common cause of death for young men in all
18 racial groups. However, in older men we start to see a predominance of suicide among whites
19 compared to other groups. Most striking, and perhaps the "take-home" message for the suicide
20 statistics, is the suicide rate for white men 85 and over. In 2003, 672 men in this oldest group
21 killed themselves, for a rate of 51 per 100,000 (see also figure 1, CDC 2001).
22

The pattern of rates for completed suicide rates for women is different from men. The peak period for women committing suicide is in the mid-to-late 40s, at nearly 8 per 100,000. Among women 65 and older, the rate varies from 3.3 to 4 per 100,000 across the five-year age groups. When thinking about race and suicide among women, rates tend to be somewhat higher for whites, Native Americans, and Asian women than for African-American women, though there is considerable fluctuation across age groups.

When we focus on causes of death for older Americans who commit suicide, it is clear that firearms play the largest role in completed suicide in this age group (see Figure 2, CDC 2003). Over 73% of older adults who killed themselves in 2003 used firearms. Use of firearms as a means of suicide overshadowed suffocation and poisoning (each at about 10%) and other causes.

Nationally, there are also some regional differences in rates of suicide. For example, suicide rates are generally higher than the national average in the western states and lower in the eastern and Midwestern states (see Figure 3, CDC 2001). There is no clear explanation for these regional differences.

Ninety percent of suicides that take place in the United States are associated with mental illness, including disorders involving the abuse of alcohol and other drugs (1). Fifty percent of those who die by suicide were afflicted with major depression, and the suicide rate of people with major depression is eight times that of the general population (2). Besides major depression, other risk factors for completed suicide in the elderly include presence of hopelessness, more rigid thinking, presence of serious medical illness, bereavement, family discord, and presence of

1 a handgun in the home (3, 4). Psychosis and alcoholism contribute to suicide in the elderly to a
2 lesser degree than in the young and middle-aged populations.
3
4 I want to end my prepared testimony on a positive note and talk about solutions. Both at the
5 Federal Government and Private Foundation levels, attempts have been made to develop an
6 evidence base for prevention of suicide in older adults. In 1997, the National Institute of Mental
7 Health issued the Request for Applications (RFA), "Prevention of Suicidal Behavior in Older
8 Primary Care Patients." The RFA requested applicants to test of models of depression and
9 suicidality recognition and treatment. The outcome of the RFA was the funding of a three-site
10 study called "**P**revention **O**f **S**uicide in **P**rimary care **E**lderly: **C**ollaborative **T**rial," or
11 PROSPECT. This trial, which was completed in 2003, tested how the "collaborative care" model
12 improves depression treatment through physician and patient education and follow-up. In
13 PROSPECT, the collaborative team involved a depression care manager, usually a specially
14 trained nurse or social worker, working with physicians in primary care practices. The
15 depression care manager provided education to patients and families about depression, identified
16 comorbid physical or psychiatric conditions that might affect treatment, monitored adherence to
17 treatment recommendations, managed treatment-related side effects, and evaluated mood state to
18 determine if the current treatment was effective of if it needed to be modified. The patients who
19 participated in the program showed significant reductions in suicidal ideation at 4- and 8-month
20 retesting when compared with the treatment-as-usual group. This result was greater for those
21 diagnosed with major depression than for those diagnosed with minor depression (5).
22

1 I will now focus on the IMPACT project, sponsored chiefly by the John A. Hartford Foundation.
2 The Hartford Foundation has long been interested in issues related to aging, mental health and
3 well-being. In 1998, the Hartford Foundation took the lead on supporting the study, "**I**mproving
4 **M**ood – **P**romoting **A**ccess to **C**ollaborative **T**reatment" (IMPACT). Shortly thereafter, other
5 foundations joined Hartford in supporting the study, including the California Healthcare
6 Foundation, the Hogg Foundation, and the Robert Wood Johnson Foundation. The study's
7 Principal Investigator is Dr. Jurgen Unützer, who is now at the University of Washington. The
8 study was focused mainly on treatment of serious depressive disorders in the elderly, specifically
9 Major Depression and Dysthymia. Subjects were drawn from 18 primary care clinics from 8
10 health care organizations in five states. Patients were randomized to working with a Depression
11 Clinical Specialist in the Primary Care clinic versus receiving Usual Care for depression in the
12 primary care setting. Depression Clinical Specialists were trained on the recommended
13 medication algorithm and also received special training on delivering Problem Solving Therapy,
14 a 6- to 8-session brief structured psychotherapy for depression. Thus Depression Clinical
15 Specialists were especially well equipped to help depressed patients manage their depressive
16 symptoms through education about the illness and about medications as well as providing
17 psychotherapy. After 12 months, 45% of intervention patients had a 50% or greater reduction in
18 depressive symptoms from baseline compared with 19% of usual care participants. These
19 findings were reported in 2002 in the Journal of the American Medical Association (6).
20
21 I served as the Study Psychiatrist at the Duke General Internal Medicine site. In that capacity, I
22 met each week with two of our Depression Clinical Specialists to review the new and returning
23 cases they had seen that week. We focused on specific depression symptoms, factors that may

1 have lead to or exacerbated the depression and comorbid psychiatrist or physical illness that may
2 influence our choice of depression treatment. When we had decided on a treatment plan to
3 recommend, I would write out the plan on a primary care contact route sheet and sign it. This
4 route sheet would be placed in the primary care physician's In-box. He or she would either sign
5 off on the recommendation or contact the Depression Clinical Specialist or me with any
6 questions or concerns about the plan. The main thrust of our collaborative work was two-fold: 1)
7 keep the primary care physician in charge of the final treatment decision; and 2) strive to keep
8 the care of the depressed patient in the primary care setting. Occasionally I would need to see
9 patients, either to clarify the extent or severity of depression symptoms, to educate the patient
10 further about depression and the need for treatment, or to evaluate suicide risk. I ended up
11 seeing just under 10% of the patients in the intervention arm.
12
13 More recently, we have analyzed the IMPACT data to determine the effect of the intervention on
14 reducing suicidal ideation. At baseline, 139 (15.3%) intervention subjects and 119 (13.3%)
15 controls reported thoughts of suicide. Intervention subjects had significantly lower rates of
16 suicidal ideation than controls at 6 months (7.5% vs. 12.1%) and 12 months (9.8% vs. 15.5%)
17 and even after intervention resources were no longer available at 18 months (8.0% vs. 13.3%)
18 and 24 months (10.1% vs. 13.9%). There were no completed suicides in either group. We
19 concluded that primary care-based collaborative care programs for depression represent one
20 strategy to reduce suicidal ideation and potentially the risk of suicide in older primary care
21 patients. Our findings are due to be published soon in the Journal of American Geriatrics
22 Society.
23

1 I am happy to report to you that at the Duke site, this collaborative care model for care of
2 depressed patients did not end when the main study ended. As you can imagine, the primary
3 care physicians in the Duke General Internal Medicine Clinics came to value highly their work
4 with the Depression Clinical Specialist. As a result, over a couple of years we moved to
5 implement the model as a clinical service in the Primary Care Clinics. There were several
6 hurdles to overcome. Internally, the Depression Clinical Specialist needed to be credentialed at
7 Duke for outpatient practice, placed on managed care panels, and hired full time by the Practice.
8 Risk management had to review the process of my making treatment recommendations on
9 patients that I had not physically seen. Ultimately we agreed that there was a conjoint risk
10 among myself, Ms. Carol Saur, the Depression Clinical Specialist, and the primary care
11 physician. After a couple of years of working on these logistics as the IMPACT study was
12 winding down, we were successful in setting up the model. As a Clinical Nurse Specialist, Ms.
13 Saur can obtain her own Medicare code for billing purposes. In general she bills using the
14 following Medicare-acceptable Current Procedural Terminology (CPT) codes:

15 • Individual psychotherapy (CPT Code 90804 for 20-30 minutes, CPT Code 90806 for 45-
16 50 minutes, or CPT Code 90808 for 75-80 minutes)
17 • Family psychotherapy (CPT Code 90846 without the patient present or CPT Code 90847
18 with the patient present)
19 • Group psychotherapy (CPT Code 90853)
20 • In collaboration with the patient's PCP, provide psychotherapy with medical evaluation
21 and management services (CPT Code 90805 for 20-30 minutes, CPT Code 90807 for 45-
22 50 minutes, and CPT Code 90809 for 75-80 minutes).

1 We have also expanded the patient population to include adults ages 18 and above. In the past
2 four years, Ms. Saur has seen 478 patients in 3,325 visits, including 171 older adults and 129
3 older adults with depression.
4
5 Thus far, we have had no difficulty in billing Medicare and receiving reimbursement. There
6 have been some difficulties with private insurance, often related to the fact that the entity
7 managing the patient's visit to the primary care doctor is different from the entity managing the
8 patient's mental health benefit. At this juncture, we are close to the break even point on covering
9 her salary – although part of her salary is still supported by the Hartford Foundation. A trickier
10 question in terms of expanding this model is covering the time of the psychiatrist. Thus far, we
11 have not found an acceptable way to cover my services. There is a CPT code (99361) which is a
12 Medical Conference by a physician with interdisciplinary team of health professionals or
13 representatives of community agencies to coordinate activities of patient care (patient not
14 present). It specifies a time frame of approximately 30 minutes. Neither the description of the
15 activity nor the time specification captures sufficiently what we do as a team. Besides, the
16 perception is that Medicare usually will not reimburse this code (i.e., patient not present).
17
18 We have found that patients report a high degree of satisfaction with this model of care. They
19 like the fact that they can see someone in the same clinic where they see their primary care
20 doctor. They like that Ms. Saur is a nurse who not only focuses on care for depression but also
21 integrates depression treatment with care for their other medical problems. They like that there
22 is a psychiatric expert involved in their care, and will often ask Ms. Saur to "please ask Dr.
23 Steffens about…."

1

2 In sum, IMPACT provides a good model for tackling the problem of suicide in the elderly. It
3 focuses on management of depression symptoms in primary care. Both the depression focus and
4 the primary care focus are key elements when the goal is suicide prevention in the elderly. With
5 most suicide being related to depression, a focus on depression is crucial in reducing suicide in
6 the elderly. Having the care provided in the primary care setting is also very important for
7 several reasons: 1) Older adults often perceive the stigma of mental illness more than other age
8 groups and may thus be more reluctant to go to another clinic to see a mental health specialist; 2)
9 Most older adults have a primary care physician who manages the bulk of their medical
10 problems; 3) There is a shortage of psychiatrists, and especially geriatric psychiatrists to whom
11 primary care clinicians can refer their patients; and 4) the IMPACT model has shown that most
12 clinical depressions can be treated in the primary care setting.
13
14 There are a number of challenges to implementing a similar collaborative care model more
15 widely. Primary care physicians and clinical business managers have to buy into the idea that
16 such care is important and affordable for the practice. A force of Depression Clinical Specialists
17 needs to be developed to deliver the care. There is a need for clinics to have access to
18 psychiatrists who can support the process by providing treatment recommendations and being
19 available to see difficult cases. Fortunately, the Hartford Foundation has emphasized their
20 commitment not only to supporting research that treats depression and suicidality, but in
21 following through with support for implementation of good practices. Dr. Jurgen Unützer at the
22 University of Seattle, Principal Investigator of the main IMPACT study, is now leading
23 "IMPACT-II," a project seeking to promote efforts at implementation. We at Duke are pleased

1 to be part of this effort as well. This new phase, IMPACT-II, involves publishing and
2 disseminating results of the study, putting together regional training sessions for future
3 Depression Clinical Specialists, and developing practical implementation packets for primary
4 care providers and clinic managers.
5
6 There are some specific actions that you as legislators can consider taking as well.
7 1) Help ensure that Medicare will cover collaborative care in a manner consistent with
8 overall medical care for older adults in the primary care setting. This may require some
9 degree of innovation, but one recommendation would involve develop legislation
10 focusing on reimbursing Clinical Nurse Specialists or other master's level clinicians
11 working in primary care clinics at the 80% level for providing mental care health care.
12 This would go a long way toward making this program acceptable to the primary care
13 community. Similarly, if the Clinical Depression Specialist documents time spent
14 discussing the case with a psychiatrist or other mental health professional and if that
15 professional documents the recommendation, then some more straightforward way to pay
16 for that consultative service could be developed.
17 2) Support programs that train medical students and nurses in the area of suicide assessment
18 and prevention.
19 3) Support programs that train master's level clinicians in this collaborative care model who
20 agree to see patients in the primary care setting.
21 4) Provide loan forgiveness for master's level clinicians and psychiatrists who agree to
22 participate in collaborative care models.

5) Increase the number of geriatric psychiatrists who are available to consult with primary care practices, either in person or through telemedicine, by reauthorizing the Title VII funding that supports training of geriatric physicians through the Health Resources and Services Administration's Bureau of Health Professions.
6) Ensure that seniors have access to affordable antidepressant medications. Some seniors encounter the "doughnut hole" in Medicare Part D and find that they can no longer afford their medications. If it comes down to a choice about which medications to take and which to stop taking, sometimes they choose to stop their antidepressant medication.
7) Encourage the Centers for Medicare and Medicaid Services (CMS) to include suicide assessment for individuals with mental illness as a Quality Indicator for care.

It has been both personally and professionally satisfying to me to be able to implement in the clinical setting an intervention that we know works in the research setting. I look forward to hearing your thoughts and questions about suicide and suicide prevention, about the IMPACT study, and about ways we might be able to make changes in our health care system that will make a real difference in addressing the alarming suicide rates experienced by our greatest generation of older Americans.

Respectfully submitted,

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Appendix

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Other supplementary material

1. Slide set: IMPACT study and suicide
2. Slide set: Overview of IMPACT study
3. Core components of Evidence-based Depression Care
4. Registry of Evidence-Based Suicide Prevention Programs: PROSPECT. Suicide Prevention Resource Center.
5. Article: "Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: a randomized controlled trial." JAMA. 2004 Mar 3;291(9):1081-1091.
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Table 1. 2003, United States
Suicide Injury Deaths and Rates per 100,000
All races, Both Sexes, Ages 0 to 85+ (racial data not shown)
ICD-10 Codes: X60-X84, Y87.0,*U03

Sex	Age Group	Number of Deaths	Population	Crude Rate
Males	00-04	0*	10,105,415	0.00*
	05-09	6*	10,119,907	0.06*
	10-14	188	10,856,749	1.73
	15-19	1,222	10,518,680	11.62
	20-24	2,159	10,663,922	20.25
	25-29	1,901	9,772,711	19.45
	30-34	2,255	10,449,775	21.58
	35-39	2,347	10,726,548	21.88
	40-44	2,791	11,407,111	24.47
	45-49	2,616	10,730,879	24.38
	50-54	2,271	9,312,777	24.39
	55-59	1,771	7,660,724	23.12
	60-64	1,216	5,763,600	21.10
	65-69	958	4,525,541	21.17
	70-74	996	3,823,820	26.05
	75-79	985	3,098,962	31.78
	80-84	824	2,055,245	40.09
	85+	690	1,444,924	47.75

Females	00-04	[illegible]	9,663,864	[illegible]
	05-09	[illegible]	9,655,369	[illegible]
	10-14	56	10,336,612	0.54
	15-19	265	9,959,789	2.66
	20-24	342	10,063,772	3.40
	25-29	375	9,395,243	3.99
	30-34	534	10,254,869	5.21
	35-39	611	10,681,456	5.72
	40-44	853	11,555,479	7.38
	45-49	869	11,030,309	7.88
	50-54	725	9,730,634	7.45
	55-59	543	8,133,326	6.68
	60-64	313	6,342,086	4.94
	65-69	209	5,220,542	4.00
	70-74	172	4,767,141	3.61
	75-79	174	4,353,631	4.00
	80-84	132	3,360,834	3.93
	85+	108	3,268,543	3.30
		6,281	**147,773,499**	**4.25**
Total		**31,477**	**290,810,789**	**10.82**

*** Rates based on 20 or fewer deaths may be unstable. Use with caution. Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC**

Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates.

Table 2. 2003, United States

Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 0 to 85+ (with racial data)
ICD-10 Codes: X60-X84, Y87.0,*U03

Sex	Age Group	Race	Number of Deaths	Population	Crude Rate
Males	00-04	White	[illegible]	7,889,666	[illegible]
		Black	[illegible]	1,637,210	[illegible]
		Am Indian/AK Native	[illegible]	117,395	[illegible]
		Asian/Pac Islander	[illegible]	461,144	[illegible]
			[illegible]	**10,105,415**	[illegible]
	05-09	White	[illegible]	7,887,082	[illegible]
		Black	[illegible]	1,640,152	[illegible]
		Am Indian/AK Native	[illegible]	138,699	[illegible]
		Asian/Pac Islander	[illegible]	453,974	[illegible]
			[illegible]	**10,119,907**	[illegible]
	10-14	White	147	8,435,323	1.74
		Black	34	1,804,333	1.88
		Am Indian/AK Native	[illegible]	154,547	[illegible]
		Asian/Pac Islander	[illegible]	462,546	[illegible]
			188	**10,856,749**	**1.73**
	15-19	White	1,047	8,275,292	12.65
		Black	107	1,632,697	6.55
		Am Indian/AK	37	150,102	24.65

		Native			
		Asian/Pac Islander	31	460,589	6.73
			1,222	**10,518,680**	**11.62**
	20-24	White	1,781	8,450,770	21.08
		Black	278	1,547,308	17.97
		Am Indian/AK Native	43	143,788	29.91
		Asian/Pac Islander	57	522,056	10.92
			2,159	**10,663,922**	**20.25**
	25-29	White	1,580	7,784,835	20.30
		Black	224	1,289,611	17.37
		Am Indian/AK Native	38	122,223	31.09
		Asian/Pac Islander	59	576,042	10.24
			1,901	**9,772,711**	**19.45**
	30-34	White	1,950	8,374,007	23.29
		Black	208	1,323,274	15.72
		Am Indian/AK Native	38	117,422	32.36
		Asian/Pac Islander	59	635,072	9.29
			2,255	**10,449,775**	**21.58**
	35-39	White	2,080	8,714,212	23.87
		Black	173	1,339,996	12.91
		Am Indian/AK Native	36	115,453	31.18

		Asian/Pac Islander	58	556,887	10.42
			2,347	**10,726,548**	**21.88**
	40-44	White	2,571	9,414,670	27.31
		Black	156	1,365,312	11.43
		Am Indian/AK Native	30	116,429	25.77
		Asian/Pac Islander	34	510,700	6.66
			2,791	**11,407,111**	**24.47**
	45-49	White	2,447	8,949,574	27.34
		Black	109	1,226,834	8.88
		Am Indian/AK Native	[illegible]	103,075	[illegible]
		Asian/Pac Islander	49	451,396	10.86
			2,616	**10,730,879**	**24.38**
	50-54	White	2,141	7,857,280	27.25
		Black	93	990,815	9.39
		Am Indian/AK Native	[illegible]	83,706	[illegible]
		Asian/Pac Islander	29	380,976	7.61
			2,271	**9,312,777**	**24.39**
	55-59	White	1,673	6,598,781	25.35
		Black	57	712,977	7.99
		Am Indian/AK Native	[illegible]	63,206	[illegible]
		Asian/Pac Islander	37	285,760	12.95

			1,771	**7,660,724**	**23.12**
	60-64	White	1,143	4,990,925	22.90
		Black	50	518,640	9.64
		Am Indian/AK Native	5*	44,131	11.34
		Asian/Pac Islander	15*	209,904	7.14
			1,216	**5,763,600**	**21.10**
	65-69	White	901	3,928,400	22.94
		Black	32	406,144	7.88
		Am Indian/AK Native	3*	31,125	9.64
		Asian/Pac Islander	22	159,872	13.76
			958	**4,525,541**	**21.17**
	70-74	White	944	3,379,699	27.93
		Black	27	304,446	8.87
		Am Indian/AK Native	2*	22,108	9.05
		Asian/Pac Islander	23	117,567	19.56
			996	**3,823,820**	**26.05**
	75-79	White	944	2,779,916	33.96
		Black	24	219,081	10.95
		Am Indian/AK Native	3*	14,860	20.19
		Asian/Pac Islander	14*	85,105	16.45
			985	**3,098,962**	**31.78**

	80-84	White	797	1,857,912	42.90
		Black	16	135,452	11.81
		Am Indian/AK Native	0*	8,654	0.00
		Asian/Pac Islander	11	53,227	20.67
			824	**2,055,245**	**40.09**
	85+	White	672	1,306,751	51.43
		Black	3	95,911	3.13
		Am Indian/AK Native	1*	6,031	16.58
		Asian/Pac Islander	9	36,231	24.84
			690	**1,444,924**	**47.75**
Females	00-04	White	0*	7,523,300	0.00
		Black	0*	1,583,938	0.00
		Am Indian/AK Native	0*	113,637	0.00
		Asian/Pac Islander	0*	442,989	0.00
			0*	**9,663,864**	**0.00**
	05-09	White	0*	7,487,677	0.00
		Black	0*	1,587,289	0.00
		Am Indian/AK Native	0*	134,828	0.00
		Asian/Pac Islander	0*	445,575	0.00
			0*	**9,655,369**	**0.00**
	10-14	White	41	8,000,163	0.51

		Black	[illegible]	1,749,239	[illegible]
		Am Indian/AK Native	[illegible]	150,708	[illegible]
		Asian/Pac Islander	[illegible]	436,502	[illegible]
			56	**10,336,612**	**0.54**
	15-19	White	227	7,795,394	2.91
		Black	[illegible]	1,583,322	[illegible]
		Am Indian/AK Native	[illegible]	144,926	[illegible]
		Asian/Pac Islander	[illegible]	436,147	[illegible]
			265	**9,959,789**	**2.66**
	20-24	White	263	7,862,961	3.34
		Black	48	1,556,595	3.08
		Am Indian/AK Native	[illegible]	133,130	[illegible]
		Asian/Pac Islander	21	511,086	4.11
			342	**10,063,772**	**3.40**
	25-29	White	315	7,294,715	4.32
		Black	31	1,394,320	2.22
		Am Indian/AK Native	[illegible]	112,534	[illegible]
		Asian/Pac Islander	23	593,674	3.87
			375	**9,395,243**	**3.99**
	30-34	White	460	8,015,352	5.74
		Black	46	1,467,416	3.13

		Am Indian/AK Native	7*	111,871	3.58*
		Asian/Pac Islander	24	660,230	3.64
			534	**10,254,869**	**5.21**
	35-39	White	549	8,478,198	6.48
		Black	39	1,503,136	2.59
		Am Indian/AK Native	10*	114,337	8.75*
		Asian/Pac Islander	13*	585,785	2.22*
			611	**10,681,456**	**5.72**
	40-44	White	783	9,335,125	8.39
		Black	48	1,549,254	3.10
		Am Indian/AK Native	5*	120,340	4.15*
		Asian/Pac Islander	17*	550,760	3.09*
			853	**11,555,479**	**7.38**
	45-49	White	807	9,005,159	8.96
		Black	32	1,408,560	2.27
		Am Indian/AK Native	3*	108,883	2.75*
		Asian/Pac Islander	26	507,707	5.12
			869	**11,030,309**	**7.88**
	50-54	White	669	8,028,569	8.33
		Black	35	1,170,892	2.99
		Am Indian/AK Native	3*	89,277	3.36*

		Asian/Pac Islander	13	441,896	2.97
			725	**9,730,634**	**7.45**
	55-59	White	508	6,871,244	7.39
		Black	32	866,646	3.69
		Am Indian/AK Native	1	67,401	1.48
		Asian/Pac Islander	12	328,035	3.66
			543	**8,133,326**	**6.68**
	60-64	White	294	5,392,244	5.45
		Black	15	664,773	2.26
		Am Indian/AK Native	2	48,008	4.16
		Asian/Pac Islander	12	237,061	5.06
			313	**6,342,086**	**4.94**
	65-69	White	191	4,445,652	4.30
		Black	14	547,197	2.56
		Am Indian/AK Native	1	35,400	2.82
		Asian/Pac Islander	3	192,293	1.56
			209	**5,220,542**	**4.00**
	70-74	White	162	4,129,856	3.92
		Black	7	451,388	1.55
		Am Indian/AK Native	0	26,857	0.00
		Asian/Pac Islander	3	159,040	1.89

			172	**4,767,141**	**3.61**
	75-79	White	163	3,844,813	4.24
		Black	2*	368,591	0.54*
		Am Indian/AK Native	1*	19,940	5.02*
		Asian/Pac Islander	3*	120,287	2.49*
			174	**4,353,631**	**4.00**
	80-84	White	125	3,013,756	4.15
		Black	3*	258,504	1.16*
		Am Indian/AK Native	0*	13,208	0.00*
		Asian/Pac Islander	4*	75,366	5.30*
			132	**3,360,834**	**3.93**
	85+	White	98	2,950,147	3.32
		Black	4*	246,859	1.62*
		Am Indian/AK Native	0*	12,828	0.00*
		Asian/Pac Islander	6*	58,709	10.22*
			108	**3,268,543**	**3.30**
Total			**31,477**	**290,810,789**	**10.82**

*** Rates based on 20 or fewer deaths may be unstable. Use with caution.**

Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC
Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates.

Table 3. 2003, United States
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 65 to 85+ (without racial data)
ICD-10 Codes: X60-X84, Y87.0,*U03

Sex	Age Group	Number of Deaths	Population	Crude Rate
Males	65-69	958	4,525,541	21.17
	70-74	996	3,823,820	26.05
	75-79	985	3,098,962	31.78
	80-84	824	2,055,245	40.09
	85+	690	1,444,924	47.75
		4,453	**14,948,492**	**29.79**
Females	65-69	209	5,220,542	4.00
	70-74	172	4,767,141	3.61
	75-79	174	4,353,631	4.00
	80-84	132	3,360,834	3.93
	85+	108	3,268,543	3.30
		795	**20,970,691**	**3.79**
Total		**5,248**	**35,919,183**	**14.61**

*** Rates based on 20 or fewer deaths may be unstable. Use with caution.**

Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC
Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates.

Table 4. 2003, United States
Suicide Injury Deaths and Rates per 100,000
All Races, Both Sexes, Ages 65 to 85+ (with racial data)
ICD-10 Codes: X60-X84, Y87.0,*U03

Sex	Age Group	Race	Number of Deaths	Population	Crude Rate
Males	65-69	White	901	3,928,400	22.94
		Black	32	406,144	7.88
		Am Indian/AK Native	[illegible]	31,125	[illegible]
		Asian/Pac Islander	22	159,872	13.76
			958	**4,525,541**	**21.17**
	70-74	White	944	3,379,699	27.93
		Black	27	304,446	8.87
		Am Indian/AK Native	[illegible]	22,108	[illegible]
		Asian/Pac Islander	23	117,567	19.56
			996	**3,823,820**	**26.05**
	75-79	White	944	2,779,916	33.96
		Black	24	219,081	10.95
		Am Indian/AK Native	[illegible]	14,860	[illegible]
		Asian/Pac Islander	[illegible]	85,105	[illegible]
			985	**3,098,962**	**31.78**
	80-84	White	797	1,857,912	42.90
		Black	[illegible]	135,452	[illegible]

		Am Indian/AK Native	0	8,654	0.00
		Asian/Pac Islander	115	53,227	216.07
			824	**2,055,245**	**40.09**
	85+	White	672	1,306,751	51.43
		Black	3	95,911	3.13
		Am Indian/AK Native	0	6,031	16.58
		Asian/Pac Islander	2	36,231	24.04
			690	**1,444,924**	**47.75**
Females	65-69	White	191	4,445,652	4.30
		Black	11	547,197	2.01
		Am Indian/AK Native	1	35,400	2.82
		Asian/Pac Islander	6	192,293	3.12
			209	**5,220,542**	**4.00**
	70-74	White	162	4,129,856	3.92
		Black	7	451,388	1.55
		Am Indian/AK Native	0	26,857	0.00
		Asian/Pac Islander	3	159,040	1.89
			172	**4,767,141**	**3.61**
	75-79	White	163	3,844,813	4.24
		Black	7	368,591	1.90
		Am Indian/AK Native	1	19,940	5.02

		Asian/Pac Islander	[illegible]	120,287	[illegible]
			174	**4,353,631**	**4.00**
	80-84	White	125	3,013,756	4.15
		Black	[illegible]	258,504	[illegible]
		Am Indian/AK Native	[illegible]	13,208	[illegible]
		Asian/Pac Islander	[illegible]	75,366	[illegible]
			132	**3,360,834**	**3.93**
	85+	White	98	2,950,147	3.32
		Black	[illegible]	246,859	[illegible]
		Am Indian/AK Native	[illegible]	12,828	[illegible]
		Asian/Pac Islander	[illegible]	58,709	[illegible]
			108	**3,268,543**	**3.30**
Total			**5,248**	**35,919,183**	**14.61**

*** Rates based on 20 or fewer deaths may be unstable. Use with caution.**

Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC
Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates.

Table 5. 20 Leading Causes of Death, United States
2003, All Races, Both Sexes

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 5,621	Unintentional Injury 1,717	Unintentional Injury 1,096	Unintentional Injury 1,522	Unintentional Injury 15,272	Unintentional Injury 12,541	Unintentional Injury 16,766	Malignant Neoplasms 49,843	Malignant Neoplasms 95,692	Heart Disease 563,390	Heart Disease 685,089
2	Short Gestation 4,849	Congenital Anomalies 541	Malignant Neoplasms 516	Malignant Neoplasms 560	Homicide 5,368	Suicide 5,065	Malignant Neoplasms 15,509	Heart Disease 37,732	Heart Disease 65,060	Malignant Neoplasms 388,911	Malignant Neoplasms 556,902
3	SIDS 2,162	Malignant Neoplasms 392	Congenital Anomalies 180	Suicide 244	Suicide 3,988	Homicide 4,516	Heart Disease 13,600	Unintentional Injury 15,837	Chronic Low. Respiratory Disease 12,077	Cerebro-vascular 138,134	Cerebro-vascular 157,689
4	Maternal Pregnancy Comp. 1,710	Homicide 376	Homicide 122	Congenital Anomalies 206	Malignant Neoplasms 1,651	Malignant Neoplasms 3,741	Suicide 6,602	Liver Disease 7,466	Diabetes Mellitus 10,731	Chronic Low. Respiratory Disease 109,139	Chronic Low. Respiratory Disease 126,382
5	Placenta Cord Membranes 1,099	Heart Disease 186	Heart Disease 104	Homicide 202	Heart Disease 1,133	Heart Disease 3,250	HIV 5,340	Suicide 6,481	Cerebro-vascular 9,946	Alzheimer's Disease 62,814	Unintentional Injury 109,277
6	Unintentional Injury 945	Influenza & Pneumonia 163	Influenza & Pneumonia 75	Heart Disease 160	Congenital Anomalies 451	HIV 1,588	Homicide 3,110	Cerebro-vascular 6,127	Unintentional Injury 9,170	Influenza & Pneumonia 57,670	Diabetes Mellitus 74,219
7	Respiratory Distress 831	Septicemia 85	Septicemia 39	Chronic Low. Respiratory Disease 81	Influenza & Pneumonia 224	Diabetes Mellitus 657	Liver Disease 3,020	Diabetes Mellitus 5,658	Liver Disease 6,428	Diabetes Mellitus 54,919	Influenza & Pneumonia 65,163
8	Bacterial Sepsis 772	Perinatal Period 79	Benign Neoplasms 38	Influenza & Pneumonia 72	Cerebro-vascular 221	Cerebro-vascular 583	Cerebro-vascular 2,460	HIV 4,442	Suicide 3,843	Nephritis 35,254	Alzheimer's Disease 63,457
9	Neonatal Hemorrhage 649	Chronic Low. Respiratory Disease 55	Chronic Low. Respiratory Disease 37	Benign Neoplasms 41	Chronic Low. Respiratory Disease 191	Congenital Anomalies 426	Diabetes Mellitus 2,049	Chronic Low. Respiratory Disease 3,537	Nephritis 3,806	Unintentional Injury 34,335	Nephritis 42,453
10	Circulatory System Disease 591	Benign Neoplasms 51	Cerebro-vascular 29	Cerebro-vascular 40	HIV 178	Influenza & Pneumonia 373	Influenza & Pneumonia 992	Viral Hepatitis 2,259	Septicemia 3,651	Septicemia 26,445	Septicemia 34,069
11	Intrauterine Hypoxia 558	Cerebro-vascular 46	Anemias 16	Septicemia 38	Diabetes Mellitus 160	Liver Disease 358	Chronic Low. Respiratory Disease 950	Septicemia 2,157	Influenza & Pneumonia 3,130	Hypertension 18,657	Suicide 31,484

12	Atelectasis 441	Acute Bronchititis 27	HIV 15	Anemias 31	Septicemia 154	Septicemia 309	Septicemia 910	Influenza & Pneumonia 2,140	Hypertension 1,755	Parkinson's Disease 17,566	Liver Disease 27,503
13	Necrotizing Enterocolitis 405	Anemias 24	Diabetes Mellitus 10	Diabetes Mellitus 21	Complicated Pregnancy 116	Chronic Low. Respiratory Disease 282	Nephritis 796	Homicide 2,017	HIV 1,517	Pneumonitis 15,850	Hypertension 21,940
14	Homicide 341	Meningitis 24	Meningitis 10	HIV 21	Anemias 105	Nephritis 282	Viral Hepatitis 652	Nephritis 2,001	Aortic Aneurysm 1,477	Athero-sclerosis 12,336	Parkinson's Disease 17,997
15	Influenza & Pneumonia 322	Meningo-coccal Infection 18	Perinatal Period 10	Nephritis 15	Benign Neoplasms 96	Complicated Pregnancy 229	Congenital Anomalies 564	Hypertension 1,031	Benign Neoplasms 1,238	Aortic Aneurysm 12,040	Homicide 17,732
16	Gastritis 310	Nephritis 14	Nephritis 7	Pneumonitis 12	Nephritis 95	Benign Neoplasms 178	Hypertension 372	Aortic Aneurysm 820	Viral Hepatitis 1,085	Benign Neoplasms 10,838	Pneumonitis 17,335
17	Septicemia 278	Pneumonitis 10	Diseases Of Appendix 6	Meningo-coccal Infection 9	Pneumonitis 46	Anemias 157	Benign Neoplasms 339	Benign Neoplasms 682	Homicide 786	Liver Disease 10,210	Aortic Aneurysm 14,810
18	Chronic Respiratory Disease 262	Diabetes Mellitus 8	Suicide 6	Perinatal Period 9	Aortic Aneurysm 41	Aortic Aneurysm 112	Aortic Aneurysm 316	Congenital Anomalies 667	Pneumonitis 773	Suicide 5,248	Perinatal Period 14,378
19	Hydrops Fetalis 188	Hernia 6	Hernia 4	Meningitis 7	Meningo-coccal Infection 39	Hypertension 98	Anemias 183	Pneumonitis 392	Congenital Anomalies 666	Anemias 3,539	HIV 13,658
20	Renal Failure 170	Diseases Of Appendix 5	Pneumonitis 4	Diseases Of Appendix 5	Meningitis 37	Pneumonitis 69	Two Tied 166	Peptic Ulcer 281	Alzheimer's Disease 554	Peptic Ulcer 3,110	Benign Neoplasms 13,563

WISQARS™ **Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention**

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Figure 1. Graphical display of U.S. Suicide rate across the age spectrum

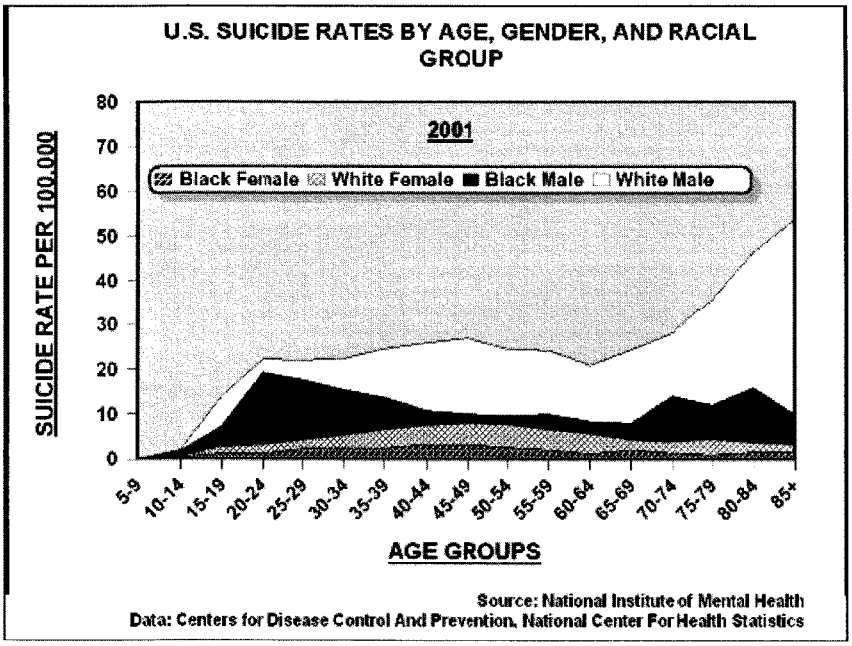
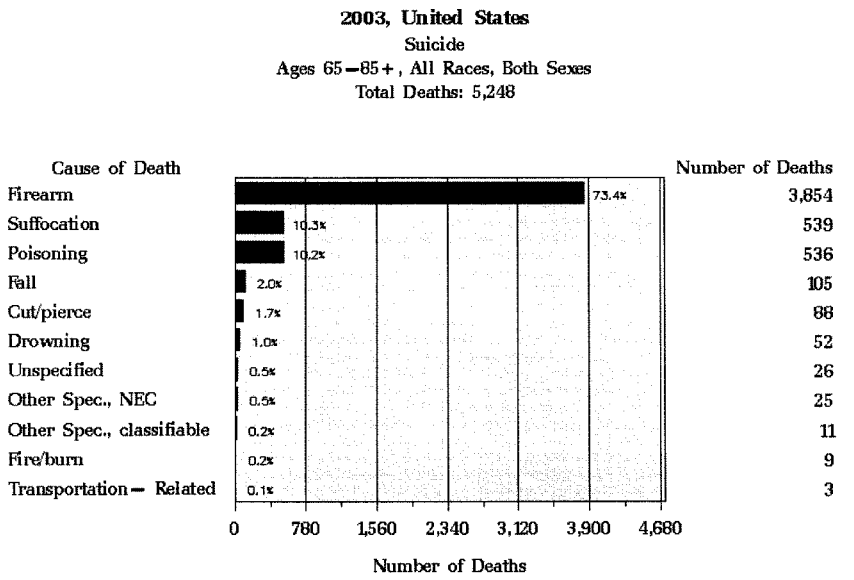


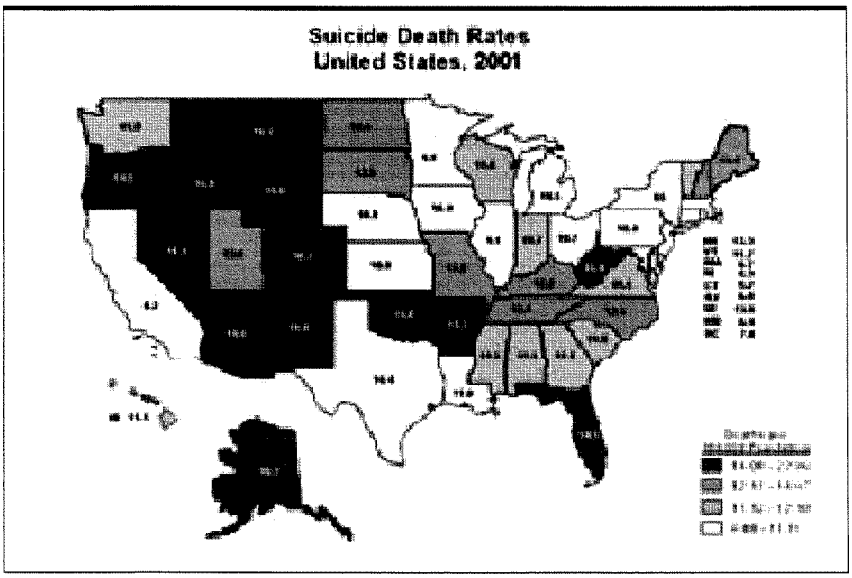
Figure 2. Suicide in the elderly: causes of death, 2003



NEC means Not Elsewhere Classifiable.

WISQARS™ Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Figure 3. Regional variations in suicide death rates, United States, 2001



The CHAIRMAN. Our second panel will consist of Dr. Richard Colenda. He serves as the dean of the Texas A&M Health Sciences Center in the College of Medicine and is the current president of the Association of Geriatric Psychiatry. Dr. Colenda will provide an overview of current mental health curricula in medical academia and discuss specific efforts needed to improve mental health services for seniors.

He will be followed by my constituent, Dr. Mel Kohn, who is State epidemiologist and administrator for the Office of Disease Prevention and Epidemiology in the Oregon Department of Human Services. Dr. Kohn will discuss Oregon's innovative efforts to combat elder suicide on a statewide level.

Senator Kohl has already introduced his constituent, Art Walaszek, who is a geriatric psychiatrist and the residency training director at the University of Wisconsin School of Medicine and Public Health. As a clinician, Dr. Walaszek will present his personal experience treating seniors with mental health illnesses and discuss solutions to some of the barriers confronting seniors as they seek help.

Finally, we will hear from Dr. David Shern, who is the president and CEO of the National Association of Mental Health. Dr. Shern brings with him a long history of advocacy and expertise in the area of mental health. His testimony will focus on current programs in place to reduce the rate of suicide in seniors.

Thanks to all of you for coming. Dr. Colenda, take it away.

STATEMENT OF CHRISTOPHER C. COLENDA, M.D., M.P.H., THE JEAN AND THOMAS McMULLIN DEAN OF MEDICINE, TEXAS A&M UNIVERSITY, COLLEGE STATION, TEXAS, AND PRESIDENT, AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY

Dr. COLENDA. Good morning, sir. Mr. Chairman and members of the Committee, I am Chris Colenda. I am dean of Medicine at the Texas A&M Health Science Center, and also president of the American Association for Geriatric Psychiatry. My testimony this morning reflects both my work in academic medicine, which involves the education and preparation of the next generations of physicians, as well as my own clinical and research practice which is in geriatric psychiatry.

As heard earlier, the toll of mental illness among older adults, those age 65 and older, is stunning. Suicide is the horrible outcome of late-life mental illness, especially those with depression, and older men have the highest rates of suicide in the Nation. One-third of older adults who die from suicide have seen their primary care physician in the week before their deaths, and 70 percent have seen their physicians within the last month of life.

Mr. Chairman, depression is not a normal part of aging. Depression is an illness that can be successfully treated at any age that it strikes. The symptoms that a practitioner, either a generalist or a mental health specialist, needs to recognize often vary according to age and culture, but depression is real and treatable.

How can we improve the quality of health care delivered to the elderly and thus prevent or ameliorate the tragic outcomes for seniors such as suicide and reduced quality of life? As you heard ear-

lier, we know a lot and we know what works, but I offer three main strategies from the perspective of a dean of a medical school.

The first is to improve the content of geriatric curriculum and core competencies throughout the continuum of medical education from medical school, through residency, through continuing medical education. This education should include late-life psychiatric disorders.

We must also have sufficient numbers of geriatric mental health specialists to lead the field in research, education and treatment. We must move to integrated longitudinal systems of care that bring together multiple health care disciplines—primary care, mental health care and rehabilitation—with the goal of promoting functional independence and quality of life.

Academic medicine must increase its commitment to these aspects of professional training, but what makes this issue so striking is that in the hyper-competitive environment of academic medicine, we are not getting the necessary resources to make sure that these programs are in place. Competition for time and resources in training is a huge factor in both mental health and primary care specialties.

Mental health is complicated and stigmatized, and so is old age. The two together lead to a collective set of negative attitudes that lead to significant disincentives both in terms of financial reimbursement for services at medical schools as well as the intangibles derived from the long-held and deeply ingrained dual stigma of mental illness and fragile old age.

In my written testimony, I have suggested a number of specific steps that the Federal Government should take to begin to address this problem. First, we need a solid study commissioned by the Institute of Medicine to determine the geriatric medicine and geriatric mental health and geriatric psychiatry workforce needs to serve the next generation of patients coming through the pipeline.

We need to summarize the best practices for programs delivering mental health services such as what you heard earlier today in primary care and community settings. We need to incorporate tool sets to provide best educational and training practices to enhance geriatric core competencies and promote inter-professional education.

We need to fund the geriatric health professions education programs such as those that were under Title VII. We need geriatric loan forgiveness programs to encourage practitioners to specialize in geriatrics and the requirements for inclusion of older adults in clinical trials. We need the NIMH to dedicate more research time and more research resources for mental health and psychiatric illnesses in older adults.

Finally, sir, the financing of our health care systems, especially for the elderly and especially those with late-life mental disorders, requires a fresh look. Today's system of reimbursement for primary care, preventive and mental health services does not foster integration and compassionate longitudinal care. It fragments care either through volume or through technology. Our current financing system rewards technology, and in so doing provides strong incentives for young physicians to pursue careers where the money is, as op-

posed to the rewarding careers of primary care, psychiatry, geriatric medicine and geriatric psychiatry.

Without fundamental financial reform, we will not recruit the best and the brightest into the field. In my lifetime, without fundamental financial reform and because of the demographic imperatives of the baby-boom generation, the health care system will simply collapse. Academic medicine has a steep hill to climb in developing and implementing adequate training for practitioners who care for the elderly. The scope and the size of the task are going to increase sharply over the next two decades.

Mr. Chairman, academic medicine and the field of geriatric psychiatry and geriatric medicine welcome this Committee's active concern about this issue and we look forward to working with you to help increase the public's awareness and to combine public and private resources to help find remedies for this issue.

[The prepared statement of Dr. Colenda follows:]

Testimony of Christopher C. Colenda, MD, MPH
Before the Special Committee on Aging
United States Senate
On the Prevalence of Suicide Among Older Adults
September 14, 2006

Mr. Chairman and Members of the Committee:

I am Christopher Colenda, the Jean and Thomas McMullin Dean of Medicine at Texas A&M University, and President of the American Association for Geriatric Psychiatry. My testimony this morning reflects both my work in academia, which involves the education and preparation of the new generations of physicians, and in my own medical specialty, which is geriatric psychiatry.

I appreciate having the opportunity to speak to you this morning on an issue that is largely hidden but nonetheless devastating, and it takes a terrible toll in our society. The toll of suicide among older adults – those who are 65 years of age and older – is stunning. Older men have the highest rates of suicide in the nation. One-third of older adults who die from suicide have seen their primary care physician in the week before their deaths, and seventy percent have seen their doctors within the prior month. My colleague at Texas A&M, Ming Tai-Seale, PhD, MPH, conducted a study of late-life mental health treatment in primary care settings that demonstrated that, due to time restrains and inadequate training, primary care practitioners infrequently conduct formal mental health assessments, have poor knowledge of psychopharmacology, and cannot adequately deal with suicide prevention.

The President's New Freedom Commission on Mental Health
The Interim Report of the President's New Freedom Commission on Mental Health noted the high risk of suicide among older adults and went on to say:

> "Older adults (age 65 or above) manifest depression in different ways than do younger adults, and they are reluctant to get care from specialists (DHHS, 1999). Instead, older people feel more comfortable going to their primary care doctor. Still, they are often more sensitive to the stigma of mental illness, and do not readily bring up their sadness and despair, their feelings of hopelessness and loss. If they acknowledge problems, they are more likely than young people to describe physical symptoms. Primary care doctors may see their suffering as 'natural' aging, or treat their reported physical distress instead of the underlying mental disorder. What is often missed is the deep impact of depression on older persons' capacity to function in ways that are seemingly effortless for others."

Mr. Chairman, depression is NOT a normal part of aging. That statement is almost a mantra among geriatric psychiatrists. Depression is an illness that can be successfully treated at any age that it may strike. The symptoms that a practitioner, either a generalist or a mental health specialist, needs to recognize often vary according to age or cultural

differences. But the disease is as real and as treatable in the very old as in any other population.

But that reality of treatable disease is contradicted by virtually everything our society tells older people: You are old, you are sick, you have lost your spouse, you don't have productive work, your memory isn't what it used to be, your mind is not so sharp, it's hard for you to live alone, your children have their own full lives to lead, your friends are dying, you yourself will die soon. Of course you're depressed.

Mr. Chairman, with that message and the consequent inattention paid to this disease among older adults, it is no wonder that we are faced with the stunning suicide rates I have cited.

The Geriatrics Workforce
That lamentable – even tragic – attitude of our society is reflected in the medical community, as well. And, speaking as a medical school dean, I know that it affects our efforts to train future generations of physicians.

Effectively combating this tragic loss of life will require a two-pronged approach. We must have sufficient numbers of geriatric mental health specialists to lead the field in research, education, and treatment. And we must ensure that primary care practitioners have the tools and knowledge to identify, treat, and, when necessary, refer vulnerable patients so that their suicides may be prevented.

Academic medicine must increase its commitment to both aspects of professional training – but the hard reality is that the remedy for this situation must take place in an atmosphere in which, like most important areas of American endeavor, there is fierce competition for time, resources, energy, and attention. What makes this issue – of caring for frail, old persons coming to the end of their lives – so hard to address is that the vulnerable folk in our society are the least able to fight for their needs in the hyper-competitive arena that is academic medicine. Geriatric medicine – as you surely know – is a small medical specialty. Geriatric psychiatry is smaller still. In the field of psychiatric training alone, there is little dedicated time for residents to learn what they need to know about geriatric patients, even as we are faced with the tsunami of the demographic changes that will be brought about by the aging of baby boom generation.

For medical generalists, the rotations of family practice and internal medicine residents are inadequate for geriatric medicine and inadequate nearly to the point of non-existence for geriatric psychiatry. The same kind of competition for time and resources in training is a huge factor in primary care specialties – mental health is complicated and stigmatized. And so, too, is old age. The two together lead to a collective set of negative attitudes – can't, won't, don't know how, doesn't much matter. There are massive disincentives both in terms of reimbursement and in the intangibles derived from long-held, deeply ingrained stigma associated with mental illness and fragile old age.

This landscape is bleak. But there are indications that we can develop and implement the tools to remedy our problems both in our society and in academic settings. The fact that this distinguished committee is holding this hearing is hugely important in bringing public policy and public attention to the fore.

An indication that the American public is sometimes well ahead of American policy is found in the actions of delegates to the White House Conference on Aging, which was held in December 2005. It was my privilege to serve as one of 1200 delegates to the conference, a truly representative group of American citizens from every state and Congressional district concerned about issues affecting older adults in our society. The delegates voted on more than 75 resolutions, choosing those that are most critical to be addressed as the Baby Boom generation enters late life. As this Committee well knows, that generation will begin turning age 65 five years from now, and by 2030 older adults will comprise 20% of the population of our nation. The statutory charge to the delegates was to focus on the needs of that generation. No previous White House Conference on Aging had given serious consideration to mental health issues. At this one, however, three resolutions central to the problem of suicide among older adults were voted among the top ten recommendations to the President and the Congress. These are, numbered by voting rank:

6. Support geriatric education and training for all healthcare professionals, paraprofessionals, health profession students, and direct care workers.
8. Improve recognition, assessment, and treatment of mental illness and depression among older Americans.
9. Attain adequate numbers of healthcare personnel in all professions who are skilled, culturally competent, and specialized in geriatrics.

These resolutions demonstrate that the reality of the tragic toll of late life mental illness is apparent to those who are involved day-to-day in aging issues. We are, in fact, on the cusp of a public health crisis, and there will be a terrible price to pay if it is neglected. Already, the numbers of geriatric specialists are inadequate: the national mean of geriatricians per 10,000 older adults is 5.5; for geriatric psychiatrists, that number is 1.4. The numbers of these specialists is decreasing even as the older population is beginning the greatest growth spurt in our history.

The Challenge for Academic Medicine

Geriatric mental health research must be strengthened, so that there will continue to be a body of knowledge to impart to health care practitioners, the expertise to teach it, the stimulation of advancement of the field, and assurance to researchers in the field that the research enterprise values the importance of their contributions to the public health of our nation. The NIH and the FDA both require research scientists to justify exclusion of children, minorities, and women from their studies. It is much easier to do research on healthy 35-year-old Caucasian men, but we have learned that those limited studies are woefully inadequate in telling us what we need to know about the broader reaches of our society. It is time to focus similar attention on older adults, because neither disease nor

appropriate treatment of disease is the same for a frail, 85-year-old woman as for a 35-year-old man.

We must address the disincentives for health care professionals to specialize in geriatric mental health professions and for generalists to receive adequate training in the field. From the discrimination inherent in Medicare's required 50% copayment for outpatient mental health services to the termination this year of all geriatric health professions education programs under Title VII of the Public Health Service Act, our government reinforces the neglect of these disciplines and the patients they serve. The Association of Directors of Geriatric Academic Programs (ADGAP) in a survey of obstacles to achieving goals of geriatric programs found that poor clinical reimbursement for patient care was a major issue at 65.2 percent of the schools.

The training of medical students in geriatric medicine and geriatric psychiatry is inadequate from virtually every standpoint. ADGAP notes that less than two percent of graduating physicians will seek a career in geriatric medicine or geriatric psychiatry, but nearly all of them, except pediatricians, will treat large numbers of older adults. Furthermore, while elective geriatric medicine courses are common, few medical schools have any required clinical courses in geriatric and the elective courses are rarely selected by medical students. In an ADGAP study published in October 2003, only five percent of medical schools surveyed reported a required rotation on a geriatric psychiatry clinical unit for third and fourth year medical students. And these were schools that had already demonstrated some expertise and interest in improving their geriatrics curriculum. In comparison, all medical schools in the United States require four to eight weeks of clinical training in pediatrics, although the majority of medical school graduates do not provide medical care to children. The ADGAP survey on obstacles for geriatric programs found major problems in a lack of senior research faculty (70.7 percent), lack of research fellows (61.4 percent), lack of junior faculty (57.8 percent), and lack of institutional financial support (53.4 percent).

Academic medicine – like other aspects of university life – responds to monetary resources. Universities are all looking at which scientific endeavors attract the funds that will support them. It is difficult for me, as dean, divert the resources of my medical school to programs that are underfunded, that the government has no interest in, and that the private sector sees as unprofitable. It will require the concerted efforts of private industry, private philanthropy, organizations devoted to advancing public health, and the government at every level to force change. Two important initiatives in recent years could provide a basis for the change in emphasis that is needed: The Association of American Medical Colleges (AAMC), with funding from the John A. Hartford Foundation, has provided grants to forty medical schools to enhance their geriatric curricula. Secondly, the Donald W. Reynolds Foundation has provided grants to twenty schools to strengthen physicians' geriatric training.

Recommendations for Federal action.

- **IOM study**. Congress should consider requesting a study by the Institute of Medicine of the National Academy of Sciences (IOM) to determine the multi-disciplinary mental health workforce needed to serve older adults. The study should provide a thorough analysis of the forces that shape the mental health care workforce, including education, training, modes of practice, and reimbursement. A clear blueprint of the geriatric mental health workforce needs that would be afforded by an IOM study would be an important step forward in assuring appropriate research, prevention, and treatment for the future. Although the IOM is already prepared to undertake a broad study of the geriatric workforce, we strongly recommend funding for a complementary study of the geriatric mental health workforce.

- **Mental health services in primary care and community settings.** There is promising research – such as the IMPACT study Dr. Steffens is describing this morning – that demonstrates important ways to reach patients in primary care settings. We need to make those evidence based practices available to more of our seniors, until they become the norm. Senators Clinton and Collins have introduced the Positive Aging Act, S. 1116, which is designed to make mental health services an integral part of primary care services in community settings and to extend them to other settings where seniors reside and receive services, through projects administered by the Administration on Aging (AOA) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

- **Title VII funding.** The geriatrics health professions program under Title VII of the Public Health Service Act has supported three important initiatives. The Geriatric Faculty Fellowship trained faculty in geriatric medicine, dentistry, and psychiatry. The Geriatric Academic Career Award program encouraged newly trained geriatric specialists to move into academic medicine. The Geriatric Education Center (GEC) program provided grants to support collaborative arrangements that provide training in the diagnosis, treatment, and prevention of disease. In Fiscal Year (FY) 2005, these programs were funded at $31.5 million, but, while they were funded in the Senate Appropriations bill for FY 2006, the final legislation followed the House version, which eliminated funding for them.

- **Research on mental illness in older adults.** Given the impact of mental illness in an increasing segment of our society, it is important that funding for research related to geriatric mental health be increased at the National Institute of Mental Health (NIMH) as well as other institutes that address issues relevant to mental health and aging, including the National Institute of Aging (NIA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute of Neurological Disorders and Stroke.

- **Geriatricians Loan Forgiveness.** A legislative initiative to relieve the disincentives for entering geriatric specialties would include each year of fellowship training in geriatric medicine or geriatric psychiatry as a year of

obligated service under the National Health Service Corps Loan Repayment Program, forgiving $35,000 of education debt incurred by medical students who enter the National Health Service Corps for each year of advanced training required to obtain a certificate of added qualifications in geriatric medicine or psychiatry. This proposal was initiated several years ago by the then chair and ranking members of this committee, and a version of it has been included in the Elder Justice Act.

- **Clinical Trials.** In recent years, the federally funded research and clinical trials for drug approvals have been to include women, children, and minorities when appropriate. These studies should also be required to apply to older adults. Especially in the area of the safety and efficacy of FDA-approved drugs, there is little available scientific information with respect to older adults.

Conclusion

Academic medicine has a steep hill to climb in developing and implementing adequate training for practitioners who must be prepared to help prevent suicide among older adults. The scope and size of the task are going to increase sharply in the next few years. Mr. Chairman, academic medicine and the field of geriatric psychiatry welcome this Committee's active concern about the devastating illnesses that result in tragic death for far too many of our seniors. We look forward to working with you in focusing public and private resources on finding a remedy for them.

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The CHAIRMAN. Thank you. Those are excellent suggestions.

I think in the interest of time, before the vote comes up, we will ask questions after, Senator Kohl.

Dr. Kohn.

STATEMENT OF MELVIN KOHN, M.D., M.P.H., STATE EPIDEMIOLOGIST, PUBLIC HEALTH DIVISION, OREGON DEPARTMENT OF HUMAN SERVICES, SALEM, OR

Dr. KOHN. Mr. Chairman, Senator Kohl, thank you very much for inviting me to speak with you today. For the record, I am Dr. Mel Kohn. I am the State Epidemiologist in the Public Health Division at the Oregon Department of Human Services. In that capacity, I oversee a wide variety of public health programs, including communicable disease control, chronic disease control, and injury prevention, and it is in the latter capacity that I have gotten involved with the suicide prevention work that we have been doing.

Today is actually my 47th birthday, and thank you; it is really a very nice birthday present to be able to come and speak about something that I feel very passionately about and I think is really, really important.

The CHAIRMAN. I could actually think of better places to be on your birthday, but we are glad you are here. [Laughter.]

Dr. KOHN. Senator Smith, I also really want to thank you and your wife for the courageous leadership that you have provided for suicide prevention efforts.

When I talk about suicide, one of the first places I like to start is with how big a problem this is. I think most people are surprised to learn that every year in the United States we have roughly 20,000 homicides that occur. We all agree that is a huge problem, but we have over 30,000 suicides that occur every year.

In my State of Oregon, almost three-quarters of our violent deaths are due to suicide. In 2003, almost 600 Oregonians died from suicide, and that is more than the number of Oregonians who died in motor vehicle crashes.

The CHAIRMAN. Give me that number again.

Dr. KOHN. Almost 600 Oregonians in 2003.

As folks have already alluded to, the rate of suicide increases dramatically with age. In recent years, in Oregon, the rate of suicide among those age 65 was three times the rate among those age 10 to 24. I should say this is not unique to Oregon. For all States, the age group with the highest suicide rate is older adults.

Now, because of this huge toll that suicide is taking, our injury prevention program, together with other partners from our human services agency working in mental health and in senior services, convened a statewide planning process to create an older adult suicide prevention plan. I did bring a few copies with me and I will share those with you afterwards. They are also available on our website.

The CHAIRMAN. When did you produce that?

Dr. KOHN. This was launched, I believe, last year. It is fairly recent.

Through a grant from the Centers for Disease Control, we convened a multidisciplinary work group that reviewed available data and research literature and interviewed experts in the field, as well

as service providers and older adults. With this information, we developed a prevention framework. We then held six community forums around the State to gather public input on the proposed framework, which also served to raise awareness about what a huge problem this is. Based on what we learned, we wrote our plan.

For this process, we were very fortunate that we had funding from the Centers for Disease Control for the National Violent Death Reporting System. That data source allowed us to learn many more details about the circumstances of older adult suicide in Oregon that were useful for crafting our prevention approach.

For example, almost 50 percent of the men and 60 percent of the women above age 65 who died by suicide were reported to have a depressed mood before death—perhaps not surprising. However, only a small proportion of those depressed people, 14 percent of the men and 29 percent of the women, were under treatment for their depression, suggesting that screening and treatment for depression might have saved many of these lives.

Ninety-three percent of the decedents had a chronic illness and over a third of them had visited a physician in the last 30 days of their life, suggesting, as has already been discussed, that primary care office visits are a very feasible opportunity for intervention.

Similarly, more than a third of the decedents were reported to be very socially isolated or living alone, suggesting that providing some social supports might have been helpful. There are some papers in the research literature to suggest that with some fairly low-cost kinds of interventions to address that social isolation issue, we can make a real difference in people's lives.

But there isn't really a single intervention that is going to fix this problem. There is no pill that we are going to give out that is going to solve this whole thing. We really need a multi-faceted approach, and I think in accord with what we learned from our Oregon data, our plan is divided into two main groups of strategies—clinically based suicide prevention activities and community-based suicide prevention.

Some of the examples of clinically based suicide prevention you have already heard about, but in the community-based area, programs to increase public awareness about the problem, reduce social isolation and provide social services to help older adults cope with challenges they may be facing. This kind of multidisciplinary collaboration is really critical.

So while this may seem like a sad topic, I want to tell you that it has been incredibly invigorating and exciting for our group to be working on this. The need is enormous out there. People recognize this, and the response from the community and from health care and social service providers has been tremendous.

So I want to ask both of you to continue to call attention to this problem, as you are doing today, and to integrate your awareness of this problem with the other aspects of services to seniors that you might hear about in this Committee. Of course, all of this work takes resources and I hope that you will continue supporting funding for efforts to address this problem particularly at the State and local level.

Thank you.

[The prepared statement of Dr. Kohn follows:]

Submitted Testimony by Melvin Kohn, MD MPH
State Epidemiologist
Public Health Division, Oregon Department of Human Services

Before the Senate Special Committee on Aging
September 14, 2006

Mr. Chair and members of the Committee, for the record I am Dr. Mel Kohn, State Epidemiologist in the Public Health Division at the Oregon Department of Human Services. In that capacity I oversee a wide variety of public health programs including communicable disease control, chronic disease prevention and injury prevention.

Thank you for inviting me to speak with you today about the work a group of us in Oregon are doing in older adult suicide prevention. I especially want to thank Senator Smith and his wife for the courageous leadership they have provided for suicide prevention.

Most people are surprised to learn how big a problem suicide is. Every year in the US there are about 20,000 homicides, but about 30,000 suicides. In Oregon almost three quarters of our violent deaths are suicides. In 2003 almost 600 Oregonians died from suicide, and that's more than the number that died from car crashes.

The rate of suicide increases dramatically with age (Figure 1). In recent years in Oregon the rate of suicide among those above age 65 was three times the rate for those aged 10-24. This is not unique to Oregon: for all states the age group with the highest suicide rate is older adults.

Because of the large toll from older adult suicide in Oregon our injury prevention program, together with partners from our agency working in mental health and in senior services, convened a statewide planning process to create an Older Adult Suicide Prevention Plan. I have provided each of you with a copy, in addition it is available on our website (http://egov.oregon.gov/DHS/ph/ipe/esp/docs/plan.pdf). Through a grant from the Centers for Disease Control we convened a multidisciplinary workgroup that reviewed available data and the research literature, and interviewed experts in the field, as well as service providers and older adults. With this information we developed a prevention framework. We then held six community forums around the state to gather public input on the proposed framework. Based on what we learned during this process we wrote the Plan.

For this process we were fortunate that Oregon had been funded by the Centers for Disease Control for the National Violent Death Reporting System. That data source allowed us to learn many details about the circumstances of older adult suicides in Oregon that were useful for crafting our prevention approach. For example, almost 50% of men and 60% of women above age 65 who died by suicide were reported to have a depressed mood before death. However, only a small proportion of these depressed people – 14% of the men and 29% of the women – were under treatment for their depression, suggesting that screening and treatment for depression might have saved lives. Ninety three percent of decedents had a chronic illness, and over a third of decedents had visited a physician in the last 30 days of their life, suggesting that primary care office visits might be a feasible opportunity for intervention. Similarly, more than a third of decedents were isolated or lived alone, suggesting that providing some social supports might have been helpful.

However, no single intervention or program will fix this problem. A multi-faceted approach is needed. In accord with what we learned from our Oregon data, our plan has two main strategies: clinically based suicide prevention, and community-based suicide prevention. Some examples of clinically based activities in the plan are promoting screening, assessment and treatment for depression by primary care providers, and overcoming barriers to care. Some of the community-based activities in the plan include programs to increase public awareness about the problem, reduce social isolation and provide social services to help older adults cope with difficult challenges they may face. As this list of activities makes clear, multidisciplinary collaboration is the key to success in addressing this problem.

While older adult suicide might seem like a sad topic, our experience with this planning process was extremely positive. Healthcare providers, social service providers and community members recognized the enormous need and the potential for prevention related to this issue, and were eager to collaborate. We have also been fortunate to receive a small grant from the Substance Abuse and Mental Health Services Administration to begin to implement the plan. With those funds we are developing and implementing training for physicians on screening and assessment for suicide risk in the primary care setting. In addition we are using these funds to conduct community forums in 13 regions of Oregon and assist these areas in implementing the physician training and other aspects of the plan in their area. The plan will be implemented primarily through existing service delivery systems as resources allow.

In closing I want to ask all of you to continue to call attention to this problem, as you've done with this hearing today, and to integrate your awareness of this problem in with other efforts you undertake to help older Americans. Of course all this work takes resources, and I hope that you will support funding for efforts to address this problem, particularly at the state and local level.

Thank you for your attention.

The CHAIRMAN. Thank you.
Dr. Walaszek.

STATEMENT OF ART WALASZEK, M.D., ASSISTANT PROFESSOR OF PSYCHIATRY AND DIRECTOR OF PSYCHIATRY RESIDENCY TRAINING, UNIVERSITY OF WISCONSIN SCHOOL OF MEDICINE AND PUBLIC HEALTH, MADISON, WI

Dr. WALASZEK. Mr. Chairman, Ranking Member Kohl and members of the Committee, thank you for the invitation to testify before the Committee this morning.

I would like to share my experiences as a physician working on the front lines of geriatric mental health care. I work on a daily basis with older adults who are suffering from depression and suicidal thinking. I work with their family members, who must watch as their loved ones struggle with depression, a devastating and potentially lethal disease. I work with medical students and residents, in other words, with the doctors who will soon be taking care of older adults. I would like to share my concerns based on these various experiences and my concerns about our ability to address late-life depression and break the cycle of senior suicide.

First, my patients face a number of barriers as they seek care for depression. I would like to illustrate this by presenting a typical clinical scenario. A 70-year-old married retired gentleman has lost interest in activities, is sad everyday and has withdrawn from his wife, children and grandchildren. In the face of a number of medical problems—heart disease, high blood pressure, chronic pain—he has become hopeless and even harbored thoughts that life isn't worth living. He has clinical depression and clearly is at risk of suicide. How does he, in fact, get help?

First, he will have to overcome a double stigma: stigma about aging and stigma about mental illness. Our society tells him that decline and depression are a part of aging. He may have his own internal beliefs that he is not ill, that he doesn't need treatment, and his low energy, low motivation and low interest—all symptoms of depression—may prevent him from talking to someone about depression.

Second, once he has made the step to seek care, perhaps with the help of family members, he will need to get diagnosed. How will that happen? Well, as you have heard, primary care may be the best site to identify older adults who are at risk of suicide. My 70-year-old patient goes to his primary care provider, who may have the best intentions to provide high-quality care. But it turns out that during his visit, they have to talk about heart disease, high blood pressure, medications for pain, exercise, eating right, losing weight, stopping smoking, and all in 15 minutes. So it wouldn't be surprising if depression didn't come up, and that would be an awful missed opportunity to possibly save this gentleman's life.

Third, let's say he has been diagnosed as having depression. The next barrier is treatment. Anti-depressant medications are safe and effective treatments for depression. The Medicare prescription drug plan has helped some of my patients afford medications they couldn't before, but as you have heard, some of them are now heading into the "donut hole". Furthermore, the complexity of the system can vex older adults suffering from depression, which affects

their concentration, their memory and their ability to make decisions.

Finally, psychotherapy or talking therapy is an evidence-based treatment for depression and was incorporated into the IMPACT model that Dr. Steffens described. It works and it reduces suicidal thoughts. Yet, Medicare's fee structure, whereby only 50 percent of mental health services are covered, poses a financial barrier to my patient, who may be on a fixed income and has other rising costs and makes the decision not to seek psychotherapy as a type of treatment.

Furthermore, qualified therapists who must themselves raise their own families and run their own businesses may not seek Medicare patients because the reimbursement is too low. So there may be a double barrier in terms of my patient being able to get what is a standard of care, psychotherapy, for depression.

We are soon going to face an even bigger barrier. Although the number of older adults needing medical care is going up, the number of clinicians who can treat them is going down. I have seen this myself from the time when I was in medical school when the focus was on getting medical students into primary care, to now, where a minority of medical students are going to eventually end up in primary care. At this rate, I don't see how we are going to have anywhere close to the number of clinicians treating older adults that we need.

The CHAIRMAN. If they do go into primary care, are they going to know how to treat them?

Dr. WALASZEK. That is an additional question, absolutely.

In closing, I thank the Committee for addressing the issue of late-life suicide. Without immediate intervention on many fronts, my patients will face growing barriers to treating depression and reducing the risk of suicide. I worry about them and I worry about my practice, my ability to provide high-quality medical care and thereby fulfill my duty to alleviate the suffering of older adults.

Thank you.

[The prepared statement of Dr. Walaszek follows:]

Art Walaszek, M.D.
University of Wisconsin School of Medicine and Public Health
Testimony before the United States Senate Special Committee on Aging
"A Generation at Risk: Breaking the Cycle of Senior Suicide"
September 14, 2006

Mr. Chairman, Ranking Member Kohl, and Members of the Committee:

I am Art Walaszek, Assistant Professor of Psychiatry and Director of Psychiatry Residency Training at the University of Wisconsin School of Medicine and Public Health. As a board-certified geriatric psychiatrist, I have worked directly with hundreds of older adults suffering from mental illness and their families.

Thank you for the invitation to testify before this Committee on suicide, a devastating yet preventable outcome of depression. I would like to share my perspective as a physician on the "front lines" of geriatric mental health and as an educator concerned about the supply of physicians willing and able to identify and treat older adults at risk of suicide.

First, I will discuss the practical barriers my patients face in seeking adequate mental health care. Next, I will outline the challenges of training the next generation of clinicians to address the mental health needs of the next generation of older Americans, who will be arriving shortly. Finally, I will point out that, since we have the tools to identify older adults at risk of suicide and to treat late-life depression, breaking the cycle of senior suicide should be within our reach.

Suicide is disproportionately a killer of older adults, especially older men. The risk of suicide climbs steadily for men after age 65; men over 85 years old are 5 times more likely to kill themselves than the average American. Medical problems such as chronic pain, psychological problems such as loneliness and grief, and social problems such as loss of loved ones and financial hardship contribute to this high risk of suicide. Older adults are more likely than younger adults to use a gun to commit suicide. Even when they attempt using a less violent method, older adults are less likely to survive because of their age and medical condition.

Clinical depression is present in over 80% of older adults who commit suicide, and so any investigation into breaking the cycle of late-life suicide must include discussion of depression. Depression is a disorder that affects up to 20% of older adults. Those who suffer from depression lose interest, motivation, hope and the capacity to feel joy. They withdraw from friends and family and are less likely to take care of themselves. In time, they can get caught in a spiral of depression and disability that can lead to death. Between 2 and 9% of people who suffer from major depression eventually commit suicide.

My patients who suffer from late-life depression face a number of barriers to getting help:

- Because of stigma and stereotypes about aging, older adults may not view depression as a condition that requires medical attention. Our culture presents late life as a time of loss and decline, with depression viewed as almost inevitable. Those suffering from depression may think it is "normal." Guilt, loss of interest, worthlessness, helplessness, hopelessness and low energy – all symptoms of depression – serve as "internal" barriers to seeking medical care.

- Many of my depressed patients are caregivers, especially wives caring for ill husbands. Caregiving can be a very stressful, 24-hour-a-day labor of love. Caregivers may feel guilty about taking care of themselves – exercising, eating well, seeking medical help – since they may see these things as detracting from the care of their loved one. Such patients may not seek mental health care until they are burnt out and desperate.

- Most older adults who commit suicide visit a physician within the last month of their lives. So, primary care providers are in a good position to identify and treat late-life depression and to prevent suicide. But, the typical older adult may suffer from various chronic medical conditions (such as arthritis, high blood pressure, high cholesterol, diabetes, heart disease, cancer, stroke and chronic lung disease). It has been estimated that it would take the average primary care physician 18 hours per day just to provide all recommended treatment for chronic conditions and to implement all preventative care recommendations. Screening for depression can begin with two simple questions, followed by a more thorough review of other key symptoms of mental illness – but this requires additional time and attention.

- Once diagnosed with depression, an older adult can be prescribed an antidepressant medication or recommended to see a therapist for talk therapy, or both. Selecting a safe antidepressant medication can be challenging because older adults are often on many other medications and have other medical problems. Paying for medications is another matter. Though the Medicare Prescription Drug Plan has successfully extended drug coverage to millions of older adults, its complexity can be daunting for older adults who, because of depression, have troubles with attention, motivation and decision-making.

- Talk therapy is an effective treatment for late-life depression and can decrease suicidal thoughts. The personal connection between a therapist and a patient can be instrumental in alleviating depression and in preventing suicide. But Medicare's current system of reimbursement for mental health services, which requires a 50% co-pay, presents two obstacles. Older adults are less likely to seek such services because of the expense involved and mental health workers, getting better reimbursement from insurers other than Medicare, are less likely to provide psychotherapy to older adults.

Addressing these issues will be necessary to successfully reduce the risk of suicide among older adults. Suffering from depression takes a considerable toll on patients, their families and the medical system, which I would like to illustrate.

A patient of mine (whom I will call Mr. Jones) is a World War II veteran who had never been depressed until three years ago. He was an active and vital man until medical problems started catching up with him. He no longer found pleasure in life, he stopped socializing and he decided to retire. Despite encouragement from his wife, he became hopeless and felt that life wasn't worth living. Ashamed and guilty, he did not seek mental health care until two years into his illness.

Despite treatment with antidepressants, Mr. Jones' depression worsened and, one morning last winter, he awoke with the thought of killing himself. With his wife's support, he agreed to be admitted to a psychiatry unit. There, the staff adjusted his medication regimen, talked with him about coping with the changes in his physical health and convinced him to become more active and volunteer in the community. Mr. Jones developed hope and his depression improved. Many people spent untold hours working with Mr. Jones, using the power of personal relationships, and thereby saving his life.

As an educator, I try to instill in future physicians a passion for helping older adults overcome depression. I work closely with psychiatry residents and with medical students who will enter a variety of medical fields. I have several concerns about our ability to adequately prepare future physicians for the swelling geriatric population:

- Most geriatric mental health care occurs in primary care and the most opportunities for preventing suicide are in primary care. But, the number of U.S. medical students entering primary care has plummeted. Family medicine residencies have seen a 50% drop in U.S. medical students from 1997 to 2005; only 20% of internal medicine residents now go into traditional primary care. In the last 5 years, the number of physicians entering geriatric medicine has not increased and the number entering geriatric psychiatry has actually decreased.

- Students are quite aware of the discrepancy between reimbursement for procedures (for example, surgery or angioplasty), of which there are very few in geriatric primary care, and reimbursement for office-based care, especially by Medicare. The average income for specialist physicians is now almost twice that of primary care physicians. Decreasing Medicare reimbursements for physicians and increasing medical student debt has led to less interest in working with older adults.

- Treating late-life depression requires patience, attention and time. These seem to be in increasingly short supply. Our medical system is fragmented and includes harsh time constraints. If we are not careful, we will end up producing not doctors, but technicians – well versed in tests and procedures, but unable to talk and connect with patients and appreciate the complexity of their lives.

I became a geriatric psychiatrist primarily for two reasons: I had outstanding mentorship and I witnessed that older adults with mental illness can get better. My teachers were deeply committed to ensuring that their patients received outstanding care and to teaching other physicians how to provide that care. In turn, I have tried to be such a teacher to my own students and residents, including Dr. Brown.

Dr. Brown is a senior resident in our training program. She is a compassionate, thoughtful and intelligent physician who will be quite ready for practice when she graduates next year. Yet, Dr. Brown has decided to seek additional training, either in geriatric psychiatry or in the emerging field of psychosomatic medicine, which addresses the needs of people with both medical and mental health problems.

I believe that Dr. Brown's training with many committed mentors helped lead to her decision. In our geriatric psychiatry clinic, Dr. Brown and I take the time to thoroughly discuss patient care prior to, during and after each visit; we have comprehensive visits with patients and their family members; we take great pains to work with the many other doctors treating our patients; we investigate and implement the latest advances in geriatric care. This is what it takes to inspire the next generation of physicians caring for older adults.

I have hope that we can break the cycle of senior suicide. We can do so both by working with future doctors one at a time and by making system-wide changes. We must devote adequate resources to training and retaining physicians skilled in the care of older adults.

- Funding for geriatric health professions under Title VII of the Public Health Service Act should be restored to prior levels. Restoring the Geriatric Academic Career Awards and Geriatric Training for Physicians, Dentists, and Behavioral/Mental Health Professionals would help alleviate the shortage of geriatric educators.

We must implement best practices in late-life depression care – routine screening for depression in older adults, collaborative care models of treating depression and access to medications and psychotherapy.

- Mental health services should be covered under Medicare on a par with general medical care. This would eliminate an important barrier to accessing the services necessary to treat depression and reduce the risk of suicide.
- Funding should be increased at NIMH and SAMHSA for research involving the translation of advances in scientific knowledge into clinical care, specifically the dissemination of best practices.

And, with the first baby boomers due to turn 65 in less than five years, we must do so now.

Thank you for the opportunity to testify before you.

The CHAIRMAN. Thank you very much.

Dr. Shern.

STATEMENT OF DAVID SHERN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NATIONAL MENTAL HEALTH ASSOCIATION, ALEXANDRIA, VA

Mr. SHERN. Chairman Smith, Senator Kohl, thank you so much. It is wonderful to be here today, and happy birthday. I am the president of the National Mental Health Association and have held this position now for 10 days. So I am learning an awful lot about the Mental Health Association and about Washington traffic. I had just a delightful drive in this morning down 395.

The CHAIRMAN. Would you say that contributes to mental health difficulties? [Laughter.]

Mr. SHERN. I have an enormous sense of wellness right now, having sat in traffic and being late for my first-ever opportunity to testify to a Senate committee. It is a great honor to be here.

Senator Smith, I have had the opportunity to meet you and your wife on other occasions, and the kind of inspirational leadership that you have in taking the horrible thing that happened to you in your life and making it into something that changes other people's lives is an inspiration to all of us and it makes an enormous difference.

The panel has done a spectacular job of summarizing the issues, that we need to confront. The biggest issue is taking our considerable research base—we need more work—and figuring out how to get it in action. Prior to joining the NMHA, I was also a dean. So I am a dean in early stages of recovery. I chose to leave academia, which was an extremely difficult decision for me because I felt that this opportunity at the National Mental Health Association would give me a direct chance to try to move research into action through public education and policy advocacy.

There is no area where the issues are clearer than in the integration of general health and mental health within a single concept, and taking our considerable research base and putting it in place. As everybody has mentioned this morning, mental health problems are not trivial problems; they are fatal problems. These problems kill lots of people every year. We could characterize the situation as really a national embarrassment. That we continue, with the technology and information we have, to allow 30,000 people a year to die by suicide should be shameful for us as a society.

One of the mental health themes that we always talk about is stigma, ignorance and discrimination. In fact, it is so important that we are launching a national public information campaign today. At exactly this same moment, at the National Press Club, we're announcing the "Depression Is Real" campaign, and this campaign reflects a seven-member coalition, including the National Mental Health Association, the National Alliance on Mental Illness, the American Psychiatric Foundation, the Depression and Bipolar Support Alliance, the Urban League, LULAC, and the National Medical Association, each of which is committed to drilling this message to the general public that depression is real, it is identifiable, it is treatable, and that we waste an enormous amount of our human capital by not effectively recognizing and treating de-

pression, which would have direct effects on driving down the suicide rate.

The groups that the National Mental Health Association is collaborating with on this particular initiative, reflect minority groups in important measure. As you all know, if we look at people of color in this Nation, we find great disparities in terms of their access to health care and mental health care, and we find great disparities in terms of their health status. They don't do as well. That lack of access causes problems.

Older adults, with regard to mental health care, would fall right into that category. There are enormous disparities with regard to their access to care; there have been for years. The demographic comparative everybody has been talking about is as clear as it can possibly be. The baby-boomers, and I consider myself among them, are marching toward our older years and unless we develop more effective strategies to deal with these issues, we are going to be in big trouble.

People today have highlighted several of the models that are available. We have a model at the Florida Mental Health Institute FMHI which we developed for alcohol and substance abuse treatment that works with elders in the settings in which they show up, rather than trying to get them to go to specialty settings. It doesn't focus on primary care. It focuses on aging centers and other areas where elders congregate. It is very low-intensity, inexpensive to try to recognize and treat alcoholism and prescription drug abuse, which you know are also real problems in elders.

Our colleagues at Cornell are developing programs to use natural helpers, people like home visitors, Meals on Wheels, to try to get some new systems of care in place utilizing a broader base of workforce and non-traditional settings to reach out to people who have traditionally not chosen to participate in care.

I will end by bringing us back to parity because it is fundamental. It fundamentally reflects in our statutes, in our policies, in our State regulations the discrimination against these disorders. As the Surgeon General said, health is fundamental. Mental health is fundamental to health; they are not separate things. We cannot deal with them separately and we cannot continue to tolerate this discrimination statutorily built into our programs. One I will point out is the Medicare program, where there is a $50 co-pay for specialty mental health services, as opposed to a $20 co-pay for general health services. That is not acceptable.

It has been a great honor to be here. This is a huge problem. I am committed, and all of our allies are, to making a difference in this area and I am confident, with your leadership, we will be able to really move the needle on this issue.

[The prepared statement of Mr. Shern follows:]

STATEMENT

of

DAVID SHERN, Ph. D., PRESIDENT AND CEO
NATIONAL MENTAL HEALTH ASSOCIATION

before the

Special Committee on Aging

United States Senate

Suicide among Older Americans

September 14, 2006

Mr. Chairman and Members of the Committee:

It is a privilege for me to appear before you today as President and CEO of the National Mental Health Association (NMHA). This is only my tenth day on board full-time with NMHA. But I have dedicated my 30-year professional career to advancing mental health service-delivery, principally in translating research into practice and policy. Until very recently, I served as dean of the Louis de la Parte Florida Mental Health Institute at the University of South Florida, one of the largest research and training institutes in behavioral health in the country.

NMHA is the nation's oldest and largest advocacy organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, we work to improve the mental health of all Americans through advocacy, education, research, and service.

My move from the more reflective world of academia to lead the National Mental Health Association has everything to do with the theme of this important hearing. It is very much about reducing dramatically the often profound gap between science – what we

know – and service – what we actually do in communities across the country. In the area of mental illness, that gap can be fatal, as Dr. Kay Redfield Jamison has observed.

As you know, Mr. Chairman, mental illnesses affect a very large segment of older Americans. Yet few receive the treatment they need. According to the Surgeon General's 1999 Report on Mental Health, some 20 percent of those 55 and older experience specific mental disorders that are not part of normal aging, including phobias, obsessive-compulsive disorder, and depression. Major depression is particularly prevalent among older Americans: in primary care settings, 37 percent of seniors display symptoms of depression.

All too often, however, seniors struggle with mental illness alone and without treatment and support. It is estimated that only half of older adults who acknowledge mental health problems actually are treated. A very small percentage of older adults – less than 3 % - report seeing mental health professionals for treatment. This lack of care has tragic consequences as illustrated by the fact that Americans 65 and older have the highest rate of suicide in the country, accounting for 20 percent of suicide deaths.

I share the widely held view that suicide is a major public health problem and that it is preventable. Where do we start?

My background takes me to the science, and to acknowledging the important investment Congress has made in mental health research. Certainly, our commitment to preventing suicide must draw on that body of work. We know that mental health and substance-use disorders are implicated in 90 percent of the suicides in this country. We know that these disorders are real, that they are readily diagnosable and that there are a range of effective treatments. Further, our research investment has yielded numerous studies indicating that prevention and early intervention services for seniors result in improved mental health conditions, positive behavioral changes, and decreased use of inpatient care.

As we seek to apply that knowledge to confront the epidemic of suicide among older Americans, we cannot ignore the barriers in our path, from the continued stigma surrounding mental illness to the cost of care, barriers that help explain the alarming numbers of people with diagnosable mental disorders who do not receive treatment.

Stigma, of course, finds its roots in ignorance and misunderstanding, and we are late as a society in understanding fully that mental health is central to overall health. We must still undo a sad legacy of viewing mental illness and mental health as separate from other aspects of health and wellness. And we have yet to achieve substantial coordination and integration of mental health delivery into general health care.

The historic anomaly of separating mental health care from other health care delivery likely contributes to a too-frequent failure in our primary health care system to recognize mental health problems, even in high-risk patient populations. As the Institute of Medicine noted in its 2002 report, *Reducing Suicide: A National Imperative*, primary care has become a critical setting for detecting the two most common risk factors for suicide,

depression and alcoholism. Yet only 30 to 50 percent of adults with diagnosable depression are accurately diagnosed by primary care physicians. Surely, those who provide services to populations like the elderly should routinely employ age- and culturally-appropriate screening tools to detect mental health and substance-use problems.

Clinical practices must change. Provider education and training must change. But we must also look beyond medicine and acknowledge that reducing the toll of suicide generally, and suicide among older Americans in particular, is a challenge that must be embraced across many areas of society. It is not simply an issue for the mental health "system" or for medicine alone. Suicide prevention must be integrated into a broad spectrum of the community, from health and human service settings to the workplace to faith and worship facilities and other institutions.

The Surgeon General, the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention and other agencies, have in collaboration with many other stakeholders played a vital part in crafting national strategies for suicide prevention and calls to action. It is a call that must be renewed and reinvigorated, and I applaud the Committee for embracing it.

We do know much about risk factors and protective factors for suicide. But our investment in risk reduction and enhancing protective factors is pitiable in relation to the toll of this epidemic. We do have a rich research base, but the research funds needed to mount long-term studies to understand and prevent suicide remain under pressure.

Your successful leadership in winning increased funding for suicide prevention has been a source of inspiration to many, Mr. Chairman. There is much more work to be done – in public education, in community, in medical education and training, in research, in the business community. The National Mental Health Association – in concert with our affiliate field -- is committed to continuing to play a central role in that work, both at the national level and in communities across the country.

Certainly your engagement on this issue, Mr. Chairman, and that of this Committee, go a long way to address the hard-hitting view of the New Freedom Commission on Mental Health in its *Interim Report to the President* that the nation's failure to make suicide prevention a national priority is a national tragedy. We pledge to work with you in any way we can.

I would be pleased to answer any questions that you or other Members of the panel might have.

The CHAIRMAN. David, I think your point—and all of you have made it, I believe—about the discrimination that exists in American law, Medicare, Medicaid, when it comes to mental health is truly beyond absurd; it is now an embarrassment. There really should be no higher issue of priority for us in Congress when we take up health care than to fix this. Please know that is No. 1 on my list.

Mr. SHERN. I think it is in our enlightened self-interest to do that. I think ultimately we will get healthier, more productive communities.

The CHAIRMAN. Yes.

Mr. SHERN. Depression is, by 2010, going to be the most disabling illness, period, of all illnesses, according to the World Health Organization. If we continue to leave it untreated, we are just wasting enormous amounts of human capital. Those kinds of estimates need to be factored into these cost equations. We can't simply look at revenue expenditure.

The CHAIRMAN. In addition to pharmaceutical parity, you would add teaching parity, and how about research parity?

Mr. SHERN. Absolutely, all of those things.

The CHAIRMAN. Insurance parity is another issue, but we have not been able to get that through the bicameral system here. But we would add that as well along with insurance, research, pharmaceutical and teaching parity—if we are really going to be serious about addressing this issue.

Mr. SHERN. I agree.

The CHAIRMAN. I guess that is our job. We have got to march in order, Senator Kohl.

David, you talk about this being a national embarrassment. Are there other nations, in your experience, in research that are doing this well?

Mr. SHERN. You know, it is very interesting. Let's talk about schizophrenia for a second rather than depression. The World Health Organization has done an international study of people with schizophrenia and one of the most surprising results from that study is that persons who have schizophrenia—and this is again using a standardized diagnostic technique culturally appropriate, so they have done the science all right.

One of the most surprising findings from this international study is that people who have schizophrenia in Third World nations, in developing nations, actually have a much better course than people who have schizophrenia in First World nations. Now, we are not sure exactly why that is, and like all scientific findings, there are some nuances that I am glossing over a bit, but it is a main effect; we find it.

Some people feel that it is because in Third World nations we can't marginalize people from our communities. Everybody's labor has to be involved if the community and the family is going to be successful, whereas in First World nations we have systems of disability that require people essentially to make public declarations that they are no longer able to contribute to their community or to their society in order to get basic health care and a basic below-subsistence income.

So it could be that as we look at some of the counterintuitive effects that we have with well-intentioned policies like the Social Security disability program, which is extraordinarily important. We need to think about somehow aligning these incentives differently so that we no longer marginalize people with severe disorders so they can engage productively in their community. There are other international differences, but I think for me that is a really important theme.

The CHAIRMAN. It sounds to me like you are saying it is not just a national embarrassment, it is a worldwide embarrassment that we are not doing better.

Mr. SHERN. Yes.

The CHAIRMAN. Dr. Colenda, the four points you made—I have made note of those and we are going to add those others that I didn't mention to David; we are going to add those to our priority list as well.

In my dealings with seniors, when you have occasion to go and look in their medicine cabinet, it is just astonishing how many medicines they are taking. I wonder from your scientific perspective, is there like a pharmacological brew that has unintended effects on people's mental health? Is the understanding of mental health well enough known so that as doctors are prescribing all these other things for various aches and pains, they may be fueling depression?

Dr. COLENDA. Yes. I think that as I used to say to my residents and fellows, less is best. One of the things that we try to train our folks on is that pharmacology in late life is a complicated management issue for physicians to become familiar with. Quite frankly, many physicians do not understand the nuances of pharmacology for elders.

I can give a personal example. My father was on a medication prior to his death that was given at the same dose that one would give to a 45-year-old healthy person, and he was 88 and he got toxic from it. Not being a quiet, retiring individual, I went thermonuclear with his primary care physician. That primary care physician was well-trained. He went to my medical school, and I was astounded that he was using a dose for a 45-year-old in an 88-year-old.

So there is a tremendous gap between knowledge and practice, between what we know how to do and what we do in pharmacology. Certainly multiple medications can lead to things, not only to depression, but also to cognitive impairment, because many of the drugs that are prescribed have effects on brain functioning.

The CHAIRMAN. Senator Kohl may need to leave shortly and I am going to follow with a second round because I have more questions.

Senator Kohl, please.

Senator KOHL. Thank you, Mr. Chairman.

Gentlemen, listening to you all, you point out the fact that most people or a majority of those who commit suicide have seen a physician within a month or 2 months before they committed suicide. You have talked about physicians who are knowledgeable with respect to high blood pressure and all the other chronic diseases that our seniors face, but isn't it true that if they were sufficiently knowledgeable and empowered to do the same kind of an analysis

and examination of their psychiatric health, this problem, while never being eliminated, would be reduced significantly? Isn't this going to have to happen in order for us to get to an alleviation of the problem of senior suicide? I mean, isn't that a must that we need to be sure that our physicians are qualified, capable and interested in diagnosing and treating the problem just as they do with heart problems? Isn't that right?

Dr. COLENDA. Yes, sir, Senator Kohl, and it starts from day one of medical school and it needs to continue through continuing medical education. Fortunately, in medicine today we are going toward what we call competency-based education, demonstrating that a physician knows what he or she needs to know for that particular series of illnesses.

As you heard from Dr. Steffens, primary care physicians are the front lines of health care in this country, and when they are scheduled for basically 7- to 8-minute office visits, trying to discover significant mental health issues in late life takes time, and time is of the essence for them in terms of running their busy practices. So we have looked toward collaborative care models to help with providing experts that assist primary care physicians to do the right thing.

They want to do the right thing. They are dedicated health care professionals. But time is a major problem, and there are two ways to get reimbursed in Medicare right now—volume or technology. The only way that you can do volume is shorter and shorter periods of time.

Senator KOHL. So it is not the seniors' fault, it is our fault. Isn't that right?

Dr. COLENDA. Well, there is a whole body of literature on breast cancer research that has looked at how to help breast cancer patients be actively involved in the decision for their treatment. It is decision support programs for patients. In terms of dissemination of this, we need to be publicly and actively destigmatize mental illness in late life and say it is OK to go in to your doctor and say, you know, I am not feeling really good and it may be that I am sad and depressed, which keys the physician to do what he or she knows how to do.

Dr. WALASZEK. We have devoted a lot of resources to teaching people about the signs of heart disease, having a heart attack, looking for those signs of chest pain, and that has been a tremendous investment and it has saved a lot of lives. I think we can do something similar to teach people and their family members about recognizing the warning signs of depression and suicide, and again to break down that stigma to make it easier to approach someone's primary care provider not just because they are in pain or they are feeling nauseous or they need a refill of their medications, but because, in fact, they have been feeling sad and down and thinking about ending their lives recently.

Mr. SHERN. Could I just add a couple of quick thoughts, one follows on Chris's notion about picking up on the continuing medical education. We need to do that in a fundamentally different way than we have done it in the past. You know, we use methodologies that are oftentimes called spray and pray. You spray training on people and you pray some of it sticks.

We need more systematic ways to follow up and support people in their practices. Hopefully we are rapidly developing the kind of electronic medical record systems that we need in this country. I am sure you all have thought a lot about that because it is a huge problem. It is amazing that I can go to Hong Kong and stick in my ATM card and get Hong Kong money and get my checkbook balance. But when I go to the doctor, I fill out, typically, an old blue form. The disconnect there is enormous.

When we start to make that kind of data available, we can support people in making better decisions. We can prompt primary care physicians so they don't have to try to remember everything. We can prompt them and help them look at the risk factors for a particular patient in a much more efficient way.

The other thing we are learning, which I think is dramatic and I hope is really going to start to change this conversation, is the importance of comorbidities, of people who have more than one condition. We now know that if you have cardiac disease and depression, having the depression will predict dramatically different outcomes for you. You are much more likely to die if you have cardiac disease and depression than a person who only has cardiac disease.

As we start to appreciate the complexity of the whole person, Senator Kohl, this will also give a chance to better integrate our thinking and destigmatize these illnesses, when you start to see what happens when you add them concurrently to a condition that no one would question in terms of its legitimacy. I think that will also help us improve practice.

Senator KOHL. Thank you very much, and thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kohl.

I have got a bunch of additional questions and apparently the vote isn't going to be immediately, probably 15 minutes or so, so I would like to take advantage of your being here.

Dr. Colenda, in addition to the four things you asked us to look at, I am interested in your—and, Art, you may have a comment on this, too. You are both in medical schools right now. What are the minimum psychiatric requirements for someone going into general practice today?

Dr. COLENDA. If you look at the Liaison Committee for Medical Education Requirements, for medical schools—the requirement is that students must have "adequate experience in psychiatry," as defined by general competencies; that is, diagnosing mental illness, being able to conduct an interview and learning fundamentals of treatments.

The average experience in psychiatry in medical schools in the country is about 5 weeks. That is compared to 12 weeks in medicine, 12 weeks in surgery. The competition for time in the curriculum is such that with the explosion in technology and genetics and molecular medicine, there has been an increasing compression of time on things like psychiatry, neurology and other types of specialties that have historically had larger amounts of time in the curriculum.

In primary care residencies, in family medicine, there is no required psychiatry rotation, but they do have to have certain general competencies met as part of their requirements for completion

of residencies. It is similar to the spray-and-pray concept. We are trying to move from a fixed amount of time in the curriculum to demonstrating that Chris Colenda as a third-year medical student knows how to conduct an interview, knows how to diagnose major illnesses. Then Chris Colenda as a resident in primary care knows how to manage depression in a community setting, and that competency is then reinforced throughout time. We have the tools to do that, but it has been incredibly slow to try to move that forward because of the competition for time in our training programs, whether it is medical school or residency training.

The CHAIRMAN. As Art pointed out, we have got a baby-boom generation about to become seniors, and you have pointed out the economics aren't there in mental health. Assuming the Federal Government can purge the discrimination from the various policies we have, it seems to me that it is imperative that medical schools understand where the puck is going, where the ball is going, and the ball has got to be going in your direction. We have to get our policies in line with where the economics are going to be, and there are going to be in the geriatric field and in the mental health field.

So I wonder if you have a comment, Art, about that.

Dr. WALASZEK. Senator, I would like to make a comment about fragmentation of the medical system and how that is actually in parallel with how medical training occurs. You commented on all the different medications that you find in the prescription cabinet, and that is often because someone sees a cardiologist who prescribes three medications, a primary care doctor who is in charge of a couple of more, and a pulmonologist who adds a couple more.

Just practicing on a daily basis, it is very hard to keep track of all of that, to keep all these folks in sync with each other and making sure that their medications are not interacting with each other and causing problems. You see that in medical training. These tend to be block experiences in the third and fourth year. You do your time in surgery, you do your time in medicine, you do your time in pediatrics, without getting a sense of what it is actually like to practice, which is that you are juggling many different things at the same time.

So as a dean, I don't know how realistic, Dr. Colenda, it is to see if that is going to change any, but it would seem that that would need to be a fundamental change in medical training.

Dr. COLENDA. Medical education is under going reform. The last major reform was at the beginning of the 20th century. My hope is that the next major reform will be at the beginning of the 21st century. Hospital systems have gone to service lines, where it is integrated care. If you go into a hospital today, for heart disease at a major academic medical center, you get admitted to it is the cardiovascular service line. So you have cardiovascular surgeons, the cardiologist, the rehabilitation folks all working together to provide a continuity of care within a particular service line.

We still are in the mode of, as Art says, 12 weeks of medicine, 12 weeks of surgery. We need to move toward an integrated system of care because that is how docs are going to practice in the future. Now, as a dean, you would think that I have some control over the curriculum. I have a thousand points of "no" and they are called faculty.

The CHAIRMAN. So you are in politics, too. [Laughter.]

Dr. COLENDA. Yes, sir, and it is persuasion and guile and bribery and all the good things that my mother said I should not do as a physician. At Texas A&M Health Sciences Center, I am proud that we are making substantial changes in our curriculum that are pointing people toward the 21st century practice of medicine and not the 20th century practice of medicine.

The CHAIRMAN. Mel, I have a hard question for you. First of all, happy birthday.

Dr. KOHN. Thank you.

The CHAIRMAN. You and I come from, I think, the best of the 50 States, but we also have a law that allows physicians to assist in suicide. Now, let me be very careful to say for the record that that is the will of the people of Oregon, and that will has been affirmed by the United States Supreme Court and Congress is not going to change that.

Given that law, how does that affect your work to prevent what we make legal?

Dr. KOHN. Well, Senator Smith, I guess I would say one of the main ways it affects my work is that every time we talk about suicide, as somebody from Oregon, this issue gets raised. I think in many ways it is unfortunate that the two issues get mixed together because we are talking about in my mind two things, two patterns of behavior that really are very different.

The CHAIRMAN. But you find anecdotally it is mixed all the time, and I do in every town hall where the issue comes up.

Dr. KOHN. In terms of our data, by law, according to the Oregon law, deaths under Oregon's Death With Dignity Act are not counted as suicides. So the numbers I gave to you before or any of the numbers that you see reported in either our data or the national data that come from our data—those deaths are not included in our counts for suicide.

The CHAIRMAN. Yet without those numbers, we are the fourth highest in the Nation for senior suicide.

Dr. KOHN. It is an enormous problem for us.

The CHAIRMAN. There is an old maxim in lawmaking that whatever you legalize, you normalize and incentivize. Is that a problem in your work?

Dr. KOHN. Well, when we look at the rates of suicide in Oregon over time, there has essentially been no change in the rates with the enactment of the Death With Dignity Act in Oregon. So I wish that the rates were dropping precipitously in Oregon, but they have continued to be high in Oregon both with and without the law.

The CHAIRMAN. I appreciate your answer to that. It is a very difficult issue. They are apples-and-oranges issues, but I know in politics perception is reality, and that is how it is perceived not just in Oregon, but around the country, that we are sort of at cross-purposes.

I am aware that SAMHSA awarded Oregon $100,000 in recognition of your and your agency's leadership in the area of suicide prevention. I wonder if you can tell us how you will use the money. Has it helped?

Dr. KOHN. Thank you, Senator. Yes, we did get that grant from SAMHSA and we have been using it in two ways. The first is along

the lines of the discussion that we have already had in the Committee this morning to put together a training program for Oregon physicians, particularly primary care physicians, around this issue, and we are in the process of developing and launching that.

The other thing that we have been doing is working on disseminating the plan more widely, and by that I mean getting more people engaged on this issue. We are going to be holding a series of community forums around the State. One of the things that I think is very clear to us is that this is an issue that needs to be addressed not just by the medical community, but by all of the service networks that we have that touch seniors' lives.

Dr. Shern referred to some of the other folks who come in contract with seniors who can be important gatekeepers and encouragers of people getting the treatment that they need. So part of the work that we are doing with communities around the State is to get these other networks of providers on board and engaged and using their resources to address this problem as well.

The CHAIRMAN. Well, we appreciate so much what you are doing in this area. Suicide is just such a tragic outcome, particularly when it is entirely, utterly preventable. This hearing this morning has identified a lot of concrete things we can do at the Federal level, what you are doing at the State level, and certainly what we need to do at the university level, because this problem is not going away. It is going to get bigger as this population gets bigger, and we have got to have a better program and better answers than we are currently providing at every level of medicine and government.

So I simply want to express to each of you how much I value your work and honor your profession. You are on the side of the angels as far as I am concerned. Whether it is a senior at 85 or a teenager at 18, we have got to do a better job.

To David's point earlier, we have a societal interest in this. I mean, some of the greatest people and leaders in history have been manic depressives. Abraham Lincoln comes to mind. Meriwether Lewis, of the Lewis and Clark expedition, was undoubtedly a manic depressive who at the end of the journey blew his brains out—actually, he shot himself in the heart, but tragic; I mean, a very gifted and bright man. Winston Churchill used to speak of it as his black dog. So there are a lot of bright lights we need to keep on running brightly, and you are on the front lines.

So we thank you for spending your time with us. You have given us specific things to do and we will do our best to do them. Parity is an issue that is on my mind every time I get up in the morning. At the research, the medicine cabinet, the teaching and the insurance levels, we need to change our policies in the Federal Government, and count on you guys to change the medical schools and fight that political battle. I don't know which is harder, in higher ed or in Washington, DC, but it is politics of the first order. But it is a life-and-death issue that you have to win and also one that we have to win here on the Hill.

So with that, I would again express our genuine thanks, and happy birthday, Mel. So Chris, Mel, Art, David, physicians and doctors all, thank you, and we are adjourned.

[Whereupon, at 11:18 a.m., the Committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR KEN SALAZAR

I thank Chairman Smith and Ranking Member Kohl for holding these hearings—to address the troubling suicides rates among America's seniors, and learn more about what we can do to reverse them.

Recent studies continue to highlight disturbing trends in the suicide rates for older Americans. Loneliness, a loss of autonomy and independence, and anxiety about mounting bills and financial obligations contribute to the sense of hopelessness that ultimately drive seniors to end their lives. These are deeply personal matters, and many seniors are reluctant to express their thoughts and ask for help.

However, as policy makers, I do not believe that we are powerless to help mitigate these effects. In the 1930's, with the implementation of New Deal programs designed to provide a financial safety net for Americans as they reach retirement, America saw a dramatic down turn in the rates of senior suicides. This trend has continued through the past decades with the creation of the Medicare program and the Older Americans Act.

These important programs have helped to provide seniors with invaluable aid as they retire, assistance to receive the medications they need—and communicates a message that they are not alone, and America will not abandon the promises it has made to care for them and see that they age with dignity.

The Senior Community Service and Employment Program—under the Older Americans Act—has been a great example in my home state of Colorado, and throughout the country, of the value of such senior programs. The SCSEP program not only helps low-income seniors develop the necessary skills to re-enter the workforce, it also helps to renew the individual's sense of self worth. These factors decrease the risk of depression among seniors—and lower the risk of suicide.

We have a duty to continue the legacy of these programs and honor the promises our generation has made to generations before us. The fact that the American population continues to age with the baby boomer generation implies that these programs are more important than ever, and we must strengthen our resolve to protect and enhance them.

Community organizations at the local and national level have played an important role in preventing suicide, educating the public, and bringing the issue of suicide prevention to the forefront. Activity within my home state of Colorado on this front has been tremendous—and I am pleased to see that the Suicide Prevention Resource Center is holding their annual conference for many western states in Colorado this October.

However, despite these important advances, suicide rates among senior citizens, particularly white males, continue to be much greater than the suicide rates of every other age group.

At the personal level, early identification of suicide risk factors is key to mitigating and preventing elder suicides. Identifying these risk factors is shared by many parties—from primary care physicians, and long term care providers—to family members and community care organizations.

Increasing the accessibility of seniors to affordable healthcare and prescription drugs, combined with greater access to mental health services will continue to be critical in identifying these factors, as well as increasing help seeking behavior.

I look forward to the testimony and insight from today's panel of expert witnesses on these fronts to further illuminate this problem, and discuss what steps we can take to reverse this current trend.

Thank you again.