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SENIOR DEPRESSION: LIFE-SAVING MENTAL HEALTH TREATMENTS FOR OLDER AMERICANS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

WASHINGTON, DC

JULY 28, 2003

Serial No. 108–17

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

90–051 PDF WASHINGTON : 2003

For sale by the Superintendent of Documents, U.S. Government Printing Office
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SENIOR DEPRESSION: LIFE-SAVING MENTAL HEALTH TREATMENTS FOR OLDER AMERICANS

MONDAY, JULY 28, 2003

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

The committee met, pursuant to notice, at 2:03 p.m., in room SD–628, Dirksen Senate Office Building, Hon. John Breaux, presiding.

Present: Senators Breaux, Dole, and Reid.

OPENING STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. The committee will please come to order.

Good afternoon, everyone. I thank all of you for being with us. This is a very important subject, and I would like to thank all of the witnesses who have come before us to testify today. Your testimony will be very important to our committee as we continue to address some of the most important issues that face older Americans in our country. Our Nation truly stands at a crossroads as we prepare for the pending wave of some 77 million baby boomers. Our responsibility in the Congress is to help this country rethink and also redefine how we age.

A few months ago, I chaired an Aging Committee hearing that looked at ageism in our Nation's health care system. We learned that medical ageism is pervasive. It can be found in the use of preventative screenings, clinical trials for valuable treatments, the treatment of hospital-borne infections, and in the way mental health care is provided to seniors.

Outdated thinking about aging leads to outdated public policies and also public health risks. We must certainly rethink our attitudes and our policies toward the elderly and eliminate any form of discrimination against them.

Though much progress has been made to eradicate the stigma and the shame of mental illness, seniors have been left behind in this area. By the year 2030, it is expected that close to 15 million seniors will suffer from some form of depression. Many seniors and health professionals assume that the symptoms of depression are a part of the normal aging process. In fact, a survey of adults older than 65 found that only 38 percent believed that depression is a health problem, and more than half responded that it was a normal part of aging.

Older Americans have the highest suicide rate in America, a rate that is 4 times the national average. Even more disturbing, 75 percent of the suicide victims saw their doctor within one month of their suicide, but were not treated or not referred for treatment for their depression. Our health care system simply failed them.

We can no longer continue to fail our Nation's seniors. Depression and suicide are not a normal part of aging. Those who need care must be properly diagnosed and properly treated.

Today, I am very pleased to announce that I will be introducing the Positive Aging Act of 2003. This legislation will help seniors receive the mental health care that they need. The Positive Aging Act will provide grants for demonstration projects to integrate mental health services for seniors into the primary care settings. It will also provide the opportunity for community-based mental health providers to team up with other professionals to create outreach teams to better screen and diagnose our Nation's seniors.

I am very excited by the opportunity to work with my colleagues to get this very important legislation adopted. The bill that I am introducing and today's hearing are important steps toward ensuring that depression and suicide in the elderly are no longer ignored to the extent that they are ignored today. We still have a great deal to do, and I look forward to hearing and learning from and working with the experts who are assembled before us this afternoon.

I would like to recognize our distinguished Democratic leader, Senator Harry Reid of Nevada, for any comments that Harry might have. Senator Reid.

STATEMENT OF SENATOR HARRY REID

Senator REID. Senator Breaux, thank you very much. I always enjoy these hearings. I served on the Aging Committee in the House under the great Claude Pepper and then under Chairman Roybal, and it has been a pleasure to work in the Senate.

First, I want to thank you, Senator Breaux, for your advocacy and for arranging this hearing. We have not had such a hearing since 1996, which was the first of its kind then. But the issues we will be discussing here are still as relevant as they were back then.

In 1996, the committee, chaired by the Defense Secretary, Bill Cohen—who became Secretary of Defense, was chairman of this committee. It was called a hearing on mental illness among the elderly. At that hearing, Mike Wallace, the anchor for "60 Minutes," came forward to testify about his depression and feelings of suicide.

I was so impressed by this man's courage—Mike Wallace—coming forward and exposing his soul to us, his ability to speak publicly about a problem he had and the treatment he had received, I at that time commended him for speaking about a condition that may people associate with weakness, a stigma that still persists some 8 years later.

It was during this hearing that I learned that unmanaged depression results in suicide on many occasions. For the first time, I found the courage to share with my colleagues in the Senate that my father had killed himself when he was in his 50's. He killed himself when he was in his 50's.

I requested there right at the time that the hearing was going that Chairman Cohen hold a special hearing on suicide in the elderly, which, of course, is a population at risk. This hearing took place just a short time later in 1996. At that hearing I spoke about my Dad's suicide. By that time I also realized that suicide was a national problem. More than 30,000 people kill themselves in this country each year, and the problem is particularly bad in Nevada. It is worse in Nevada than any other State. So I came to the understanding that my father was not alone, and neither was I as a survivor.

Following these hearings, I was contacted by people from Georgia—Marietta, GA—Elsie and Jerry Weyrauch. They had lost their orthopedic surgeon daughter with suicide. It was heartbreaking for them, to say the least. They founded an organization called the Suicide Provision Advocacy Network to raise awareness about this issue. That organization and we generally have made great strides since then.

With their encouragement and the assistance of my then-staff member, a man by the name of Jerry Reed, who is now the Executive Director of SPAN, I proposed Senate Resolution 84, which declares suicide to be a national problem and sought to make suicide prevention a national priority. The resolution passed. It was followed by a similar resolution in the House led by others, but mainly by John Lewis, the great Representative from the State of Georgia.

The importance of Senate Resolution 84 was its recognition that suicide is not just an individual's health problem. In fact, every time someone commits suicide, we all lose in many different ways.

After former Surgeon General David Satcher was confirmed, I invited him to approach suicide as a national health issue, and he did. In 1998, he convened a conference in Reno, NV. The Reno conference brought together experts from all over the country to address the problem of suicide. By the time they were finished, they had come up with a national strategy for suicide prevention.

In 1999, Dr. Satcher issued what he called "A Call to Action to Prevent Suicide," which introduced a blueprint for addressing suicide. The plan called for awareness, intervention, and methodology. This gave the issue momentum.

I requested the Subcommittee on Appropriations on Labor, Health and Human Services to hold a hearing on suicide awareness and prevention. Dr. Satcher and others testified at that hearing in February of 2000. This was another opportunity for me to talk about my being a survivor of suicide, part of a family of people all over this country who have suffered this unique yet preventable in many instances loss.

Since the hearing before the Appropriations Committee, Federal dollars backed up the Surgeon's call to action, and the results have been tangible. In 2001, the Department published its National Strategy for Suicide Prevention which outlines 11 goals and 68 objectives for action to prevent suicide using a public health approach. In 2002, the Institute of Medicine published its report, "Reducing Suicide: A National Imperative." Now we have suicide research centers, suicide hotlines, and, most recently, the National Suicide Prevention Resource Center. This center is designed to pro-

vide States and communities with evidence-based strategies for suicide prevention. There are websites, bibliographies. There are a lot of different things we did not have just a short time ago.

No one wanted to talk about it in 1996. Now you even see ads for antidepressant medication on TV. We have come a long way. It is amazing what a few congressional hearings can do to bring needed attention to such an important hearing.

Again, Senator Breaux, thank you very much, and I extend my appreciation to Senator Craig also.

I have just a few more things. I am sorry to take so long, but I wanted to outline this in a little more detail.

There is a lot more we can do. As of the year 2000, suicide was still on of the leading causes of death in my age group, John, our age group, Senator Dole, our age group, age 55 through 64. All pathways that lead to suicide—biological, physiological, psychological—affect senior citizens. If you are not a senior now, you soon will be. It is not normal for seniors to be depressed. As a group called SAVE has put it, "Treating depression is preventing suicide." The rate of suicide among seniors is proportionally higher than any other age group. In addition to continuing to work on reducing the stigma of mental illness, we need to train primary health care providers, including nurses and aides, to recognize the signs of depression in all age groups, especially the elderly. We also need to promote the training of geriatric specialists, including geriatric psychiatrists. We need to do more regarding mental health parity in insurance coverage. We need to value our seniors and keep them involved in our communities. We need to continue to talk about these issues.

Senator Breaux, I have looked at these statements. I am tremendously impressed with Diana Waugh's statement. Suicide does run in families. I have a friend in Las Vegas, a charming young woman, who confided in me after a television interview we had that she had lost her father and her brother. Six months later, I received a telephone call from her that her sister committed suicide.

You, Hikmah Gardiner, you do a lot in outlining the fact that the cost of drugs is a problem, and the fact that people simply cannot afford drugs has caused suicides.

So I apologize for coming and leaving, but the Senate floor is left bare, and I have got to go. We have an energy bill there today, and I have to be there to take care of some of the problems that exist on that.

So, Senator Breaux, thank you so very much for doing this hearing and keeping this issue in the forefront of medical problems in America today.

Senator BREAUX. Well, Senator Reid, thank you so much for sharing your thoughts, your personal experiences. That is very important. I think as you said, the more we are able to get leaders in the political field to talk about this, the more we can get Congress to focus in on it, the more we can encourage our health professionals to do more about it, the quicker we will find solutions to this national problem. That is what we are trying to do here today, and certainly, Senator Reid, your testimony and your commitment in this area goes a very long way to helping us reach the

goals that we all are attempting to do so, and we appreciate very much your statement.

Now we will hear any comments Senator Dole might have.

STATEMENT OF SENATOR ELIZABETH DOLE

Senator DOLE. Thank you, Senator Breaux and Senator Reid.

This is a very important topic, and I am grateful to all of those who are here today to share their personal stories of how depression and suicide have affected their lives. It is essential that we come together to discuss depression—young, middle-aged, seniors—because when a person suffers from depression, it affects the whole family. A child who does not receive the intervention of a school psychologist or outreach services may grow into an adult who finds it increasingly difficult to cope, and then a senior who battles depression and ultimately takes his or her own life.

A key step to making sure this scenario does not happen is having open discussions of the problems of depression and removing the social stigma of mental illness. We as lawmakers and as a society must ensure that we do not create nor perpetuate a system that isolates those who suffer from mental illness. We absolutely must remove barriers to access and deterrence to treatment and ensure that those in need of help receive it.

I am very interested in the testimony of our researchers on areas that are quite disturbing, including homicide-suicide in the elderly, and the high prevalence of suicide among elderly men. There are gender differences that I want to explore.

I also want to learn more about the interventions, the treatments, and the solutions to address depression and mental health in the elderly. I have worked with Mike Faenza, who is head of the National Mental Health Association, when I served as president of the American Red Cross. We had started a program in 1992, mental health counseling for those who had been victims of disasters such as earthquakes or hurricanes or the terrible tragedy of September 11th. We found that this help with mental health counseling dealing with traumas was very important for those workers as well who were trying to address the problems.

So I want to thank all of you who do research and work in this area for your tireless efforts on behalf of the seniors in our country and all our citizens. I certainly want to thank you, Senator Breaux, for organizing this hearing, for the legislation which you have written, which I certainly look forward to pursuing.

Thank you very much.

Senator BREAUX. Thank you very much, Senator Dole, for your work on our Aging Committee. It is outstanding and we appreciate your being with us.

The first two witnesses this afternoon will be individuals who have personal experience with both depression and suicide. The first witness will be Diana Waugh, who is from Spring Valley, CA. We thank you for coming all the way out here to be with us on the other coast. She is also a volunteer coordinator for the National Association of Mental Illness, where she continues her work as a volunteer. We thank you very much, Ms. Waugh, and we will take your testimony first.

STATEMENT OF DIANA WAUGH, SPRING VALLEY, CA

Ms. WAUGH. Well, thanks. I really appreciate the opportunity to tell you about my personal experiences with this most vicious killer of seniors: clinical depression and suicide.

As he said, I am Diana Waugh. I live in San Diego County, CA. I have three grandchildren, and I am 60 years old.

Stigma and ignorance about depression killed both my parents and almost killed me.

My mother killed herself at age 50. There were several events in a row that should have been a clue that she was in trouble. However, the family didn't see it. She was in menopause and seemed worried about getting old. She quit a job she loved and moved with my father from California to Montana in the middle of winter. My father shortly thereafter asked her for a divorce. Her beloved dog died, she had no job or friends since she was 20 miles away from her nearest neighbor. My normally happy and vivacious mother thought her life was over. She took a gun, put it in her mouth, and pulled the trigger. The family was shocked, grief stricken, angry, and ashamed. Suicide was considered an act of cowardice and not talked about.

It is estimated that 4.4 million Americans suffer the loss of a loved one to suicide. Suicide is like terrorism in a family. The result is devastating.

My father was never the same after mother's suicide. He killed himself 25 years later at age 79, also with a gun. He complained a lot about getting old. He had various aches and pains, was irritable and cranky and listless. He could not concentrate to read. He was having trouble sleeping. He didn't want to do anything. He gave up the loves of his life—hunting and fishing. The family just accepted that this was part of getting old. He continuously complained about his symptoms to his doctor up until the week he pulled the trigger.

I know Dad would have thought it a weakness to talk about his feelings. He had been taught that a man should be strong. Even though he exhibited all the physical signs of depression, he was never diagnosed or treated for it.

I suffered from post-traumatic stress disorder and went into a deep depression after Dad's suicide. I was 52. I had been a dynamic, energetic person, with a successful career for a government contractor, who could no longer concentrate and my job suffered. I was irritable, negative, and listless. I didn't want to do anything. I ached all over. I felt like my legs were encased in cement. Eventually I couldn't get out of bed and even do the simplest things to take care of myself. I lost my job and I was isolated from everyone. My life was empty and gray. I was ashamed, afraid, and hopeless.

I wanted to kill myself, but I remembered the pain and suffering I had gone through after my parents' suicides, and I didn't want my family to suffer the same. I asked for help.

My sister took me to a psychiatrist who diagnosed me with clinical major depression. He explained that I had a brain disorder and, just like a diabetic, would probably have to take medication for the rest of my life. I was relieved. It wasn't that I was weak or had a character defect. I had a disease of the brain.

My ignorance, fear, guilt, and shame prevented me from getting treatment earlier. As a result, I lost my job, my home, and suffered health and dental problems that could have been avoided had I known more about my illness.

I still suffer from depression, but medication and therapy have helped me regain clearer thinking, a purpose and joy in my life again.

I have just been hired by NAMI San Diego, an affiliate of the National Alliance for the Mentally Ill. NAMI's goal is to erase the stigma attached to mental illness and to improve the lives of the mentally ill and those affected by it.

Many seniors live at poverty level. Low incomes and limitations on health care insurance coverage severely impacts access to mental health care. The Medicare system only pays 50 percent of mental health services and no prescription drug coverage. Private insurances also discriminate against mental health by allowing a less dollar amount or number of visits allowed than for any other disease.

Psychiatric drugs are often expensive, as you said, and if there is a choice between taking a heart medicine and a medicine for depression, seniors will often take the medicine for their heart, not realizing that the medication for depression also is imperative to their lives.

Primary care physicians must be trained to recognize and treat depression. I suggest that depression screenings be routinely a part of any doctor visit.

I ask this committee to support the recommendations from the President's study on mental illness to allocate funds for education, to stop stigma, as well as funds for research to put an end to this killer disease. Also, Medicare must have parity and prescription drug coverage as well as private insurance parity be implemented throughout the country.

I hope that my experiences have opened your eyes and hearts about depression and suicide in older adults.

We can no longer remain ignorant and apathetic about depression. The attitude that "everyone gets depressed, just get over it" helps seniors take the overdose of pills, slit their wrists, put their necks in a noose, put the plastic bag over the heads, or pull the trigger.

Help stop this vicious killer. Depression does not have to be a part of growing old.

Thank you.

[The prepared statement of Ms. Waugh follows:]

Testimony for Senate Hearing on Aging

My name is Diana Waugh. I reside in San Diego County, California. I am 60 years old.

I am here today to tell you about my personal experiences with the most viscous killer of Seniors- Clinical Depression and Suicide.

Stigma and ignorance about depression killed both my parents and almost killed me.

My mother killed herself at age 50. There were several events that happened in a row that should have been a clue that she was in trouble. However, the family didn't see it.
She was in menopause and seemed worried about getting old. She quit a job she loved and moved with my father from California to Montana in the middle of winter. My father shortly thereafter asked her for a divorce. Her beloved dog died, she had no job or friends since she was 20 miles away from her nearest neighbor. My normally happy and vivacious mother thought her life was over. She took a gun, put it in her mouth and pulled the trigger. The family was grief stricken, angry and ashamed. Suicide was considered an act of cowardice and not talked about.

It is estimated that 4.4 million Americans suffer the loss of a loved one to suicide. Suicide is like terrorism in a family- the result is devastating.

My father was never the same after mother's suicide. He killed himself twenty-five years later at age 79, also with a gun. He complained a lot about getting old. He had various aches and pains, was irritable and "cranky" and listless. He could not concentrate and was having trouble sleeping. He did not want to do anything. He quit the loves of his life, hunting and fishing. The family just accepted that this was part of getting old. He continuously complained about his symptoms to his doctor up until the week he pulled the trigger.

I know Dad would have thought it a weakness to talk about his feelings. He'd been taught that men should be strong. Even though he exhibited all the physical signs of depression, he was never diagnosed or treated for it.

I suffered from Post Traumatic Stress Disorder and went into a deep depression after my father's suicide. I was 52. I had been a dynamic energetic person with a successful career who could no longer concentrate and my job suffered. I was irritable, negative and listless. I did not want to do anything. I ached all over. I felt like my legs were encased in cement. Eventually I could not get out of bed or do even basic things to take care of myself. I lost my job and isolated from everyone. My life was empty and gray. I was ashamed, afraid and hopeless.

I wanted to kill myself but I remembered the pain and suffering I had gone through after both my parent's suicides and I did not want my family to suffer the same. I asked for help.

My sister took to me to a psychiatrist who diagnosed me with clinical major depression. He explained I had a brain disorder, and just like a diabetic, would probably need to take medication for the rest of my life. I was relieved. It wasn't that I was weak or had a moral defect; I had a disease of the brain.

My ignorance, fear, guilt and shame prevented me getting treatment earlier, As a result, I lost my job, my home and suffered health and dental problems that could have been avoided if I'd known more about my illness.

I still suffer from depression, but medication and therapy have helped me regain clearer thinking, a purpose and joy in my life again.

I now work for NAMI San Diego, an affiliate of the National Alliance for the Mentally Ill. Our goal is to erase the stigma attached to mental illness and to improve the lives of the mentally ill and those affected by it.

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Many Seniors live at poverty level. Low fixed incomes and limitations on health care insurance coverage severely impacts access to mental health care for Seniors. The Medicare system only pays 50% of mental health services and has no Prescription drug coverage. Private insurances also discriminate against mental health coverage by allowing less dollar amount or number of visits than for any other disease.

Psychiatric drugs are often expensive and if a there is a choice between taking a heart medicine or a drug to prevent depression, Seniors will often choose the heart medicine, not realizing the drug for depression is just as necessary to their lives.

I ask this committee to support the recommendations from the President's study on mental illness, allocate funds for education to stop stigma as well a research to put an end to this killer disease. Also Medicare must have Prescription drug coverage and insurance Parity implemented throughout the country.

Primary care physicians must be trained to recognize and treat depression. I suggest that depression screenings be done routinely as part of Doctors visits for people over 55.

I hope that my experiences have opened your eyes and hearts about depression and suicide in older adults.

We can no longer remain ignorant and apathetic about depression. The attitude that "everyone gets depressed -just get over it" helps Seniors take the pill overdose, slit their wrists, put their necks in a noose, put the plastic bag over their heads or pull the trigger.

Help us stop this vicious killer. Depression does not have to be part of growing old.

Senator BREAUX. Thank you so very much, Ms. Waugh, for a very eloquent statement and a very important statement and for your work in this area.

Our next witness this afternoon will be Ms. Hikmah Gardiner, who has come to us from Philadelphia. She is very active with the Older Adult Consumer Mental Health Alliance, has been President of the Senior Advocacy Team of the Mental Health Association of Southeastern Pennsylvania, also on the board of the Pennsylvania Protection and Advocacy Committee, where she is very active. We are delighted to have you with us and appreciate your statement.

STATEMENT OF HIKMAH GARDINER, SENIOR ADVOCATE, MENTAL HEALTH ASSOCIATION OF SOUTHEASTERN PENNSYLVANIA, PHILADELPHIA, PA

Ms. GARDINER. Thank you very much kindly, Senator. Good afternoon, everyone, and thank you for allowing me this time to speak to you about depression.

First of all, before I forget, I want to thank you and Senator Reid, who had to leave us, and Senator Dole. This is very dear to me, very, very dear, and very personal. I don't know too many people in high places, if I may say, that would take the time to do what you are doing. I will remember you for the rest of my life. That is a promise. Now that I know who you are, you will hear from me, too, for the rest of my life. [Laughter.]

Anyhow, depression has been my unwanted companion for at least 60 years. We know each other very well. This adversarial relationship has taken me to the very bowels of Hell, which includes several attempts at suicide, my children being taken from me for a time, two failed marriages, a serious bout of alcoholism, which I thought would cure my mental illness, a loss of self-esteem and personal dignity, and relationships with my siblings.

However, I am slowly being restored to sanity and sobriety through treatment and loving family and friends. You know what? Treatment works.

Senator BREAUX. Ms. Gardiner, I want to hear you. Would you pull the mike just a little closer?

Ms. GARDINER. Sure. Treatment works. There are those among us who would gainsay me, but treatment works. The researchers, such as Dr. Katz sitting over there, can tell you that. His research work proves that treatment works.

I heard so many people say that, "You are getting old. We expect you to be depressed." That ain't necessarily so. That ain't necessarily so. Treatment works.

But in many cases, it costs so much. As my lady here on the right said, as Diana said—really, I thought she was reading from my paper. We are both saying the same thing, and she is on the west coast and I am on the east coast. So there has got to be something going on. She is saying the same thing that I have written down here.

I get real angry when I think about how seniors are treated in this country. I get real angry. We are at the bottom of the budget. It should not be. There are some things in place for seniors in the mental health arena, sure, but nowhere near enough. Nowhere near enough.

We have to pay too much for medication, and now that most of us are no longer working—we are living on Medicare or some pension or something—we can't afford those outrageous prices for medication. We just can't afford them. As Diana said, "We make some decisions: Am I going to pay my rent? Am I going to take my medication? Am I going to buy food?" This is horrible.

This is America. We live in America, where, God knows, there is a lot to be done. But this is the best country in the world.

I know many seniors who have worked, including myself, 50 or 60 years, honest labor. This is my reward? No.

But I will tell you something, and that is not what I have on this paper, either. I was born in 1929, and people in my age bracket were taught to be quiet. You weren't allowed to speak out. You dare not. So that is the way we grew up.

Fortunately, I was able to get out of it, obviously, whatever. So the old folk don't say anything. We are just satisfied with the status quo.

Now, you baby boomers and you folk who are younger have a whole heap to say. So you call attention to what is going on, and people come to you to see what you want. But because we, the old timers, don't say anything, you know, if you don't say anything, people will go on believing that it is OK.

I believe in the squeaky-wheel theory, and I am sure, Senators, you know what that is. So here I am today to make some noise.

You know, speaking of medication, if I were taking Prozac today—and thank God I am not—it would cost me about $213 a month. Old timers take three, four, five medications. Now, that is a whole lot of money out of a possible $600 or $700 check a month. No wonder they have to make such decisions.

I consider myself fortunate. I am still able to work. I am very, very blessed. Very blessed. So things are not as hard for me as they could be. Then I have got a bunch of kids who stay around me, won't let me alone. They stay around me all the time. We have done some role reversal kind of thing now. They are telling Mom what to do. But, anyhow, I have it a tad easier than many of my peers do. But I know what that suffering is because it was not always that way.

I also had trouble with alcohol. I thought I found a perfect cure—perfect—alcohol. Initially it was. It took away those God-awful feelings that I had about myself, about anybody, about anything, about my children. The alcohol initially took those feelings away. But eventually it caught up with me, and I reached the stage where I could not deal with my mental illness. I could not deal with my alcoholism, so there was only one thing to do. Go out of the window. Thank God I failed, or I wouldn't have the pleasure of sitting here in front of you today.

I tried the pills and that failed, and once again, I am very grateful that I couldn't even do a wrong right, as my children used to tell me. I am very grateful for that.

I have come to you today with a lot of challenges, and I realize it. As, once again, Diana said, talking about Medicare, something has got to be done about Medicare. It is not a thing of maybe, perhaps. Something—something positive, let me add that—has got to be done about Medicare. It is only a matter of time. I know that

something will be done. I realize that. But I hope Medicare remembers that it is put there for those of us who can no longer do as we have done for ourselves.

I don't consider Medicare a friend of mine anymore. I don't. Neither does anybody else, any of the senior citizens who have mental health problems, who have to make all these decisions. Medicare is no longer a user-friendly program. That shouldn't be. That shouldn't be. That is not what it was designed for.

You know, we have so many—we are so sophisticated today. We know how to do all these things and go to outer space and have all this equipment. Look at all this stuff here. We have got to remember—I have such a passion for this. I can barely talk, which is unusual for me. But we need to remember that but for the grace of God, it would be one of you. We need to remember that. We need to remember that—I believe Senator Breaux said that coming in back of me is a whole heap of old timers, you baby boomers around here, and you are coming right in back of me. We need to remember that. We need to do something about this mental health system.

The President's—what is it?—Freedom Commission, I went to speak. They invited me to come and speak for the old timers, and I got that report. Frankly, I was disappointed. There was very little talk there about seniors. You have to point us out. We are thrown into a pile with adults. When it gets down to the seniors, all the money is gone. The children in the mental health system have a separate part, and the adults have a separate part, and the old folks should have a separate part. That is what I say.

Additionally, I believe if you have problems, you need to come with some solutions, and I have some suggestions. Once again, work on the Medicare decision and get rid of the unfairness of copay in the physical versus mental. Medicare folks have to pay 50 percent for mental health care, but I only have to pay 20 percent for physical care. It should be the same 20 percent.

We should support outreach programs for the old timers. I am not going to go to the mental health center down the corner from me. I am just not going to go. I am just not. First of all, I don't want to be seen there. A lot of young people are there, and they have all those problems and use those drugs and drink that alcohol. I am not going down there. I don't want my neighbors to see me. I don't want my minister to know that is where I go. Bring something to me. Do some outreach. Once again, medicine, lowering the cost of medicine or help seniors pay for their medication.

This is another one of my bugs. I wouldn't let my primary physician give me a sugar pill for my mental illness. I wouldn't. No. I have a therapist. That is who knows about my brain, and that is who I want to go see.

Many of us—"us" meaning senior citizens—go undiagnosed with depression with primary care physicians. That is not their training. I am not criticizing them nor am I blaming. That is simply not their training. If we are going to use primary care physicians, then they should be trained to recognize mental illness, especially depression, and to treat it, not to overdiagnose or overmedicate. That is not the right way.

My hostess told me when I saw a red light, it was time for me to wind down, and I just remembered that.

Senator BREAUX. We are going to ask you some questions, too, and continue this.

Ms. GARDINER. Once again, I really appreciate this opportunity, and I certainly will be here for questions. Thank you.

[The prepared statement of Ms. Gardiner follows:]

Statements of Hikmah Gardiner
Senior Advocate
Mental Health Association of Southeastern Pennsylvania
Philadelphia, PA

Good Afternoon everyone, and thank you for allowing me the time to speak to you about depression.

Depression has been my unwanted companion for at least 60 odd years. We know each other very well. This adversarial relationship has taken me to the very bowels of Hell, which includes several attempts of suicide, my children being taken away from me, two failed marriages, a serious bout of alcoholism, a great low self esteem and personal dignity, and lost relationships with my siblings.

However, I am slowly being restored to sanity and sobriety through treatment and loving family and friends. "Treatment does work", however it can be very costly. Prozac (considered to be an excellent medication for depression) can cost $212.99 per month, consider, if you will that senior citizens take at least 3 or 4 other medications daily for chronic ailments. There are elders who must decide whether to take medicines, buy food or pay rent. Something is wrong with this equation. My work takes me to places where senior citizens live in nursing homes, personal care boarding homes, senior citizens high rises, and apartments. And I can tell you that I am not a happy camper talking to many of these folks.

And what of Ageism? Will out society continue to look upon our elders as a drain on the local, regional, and national budgets? And lastly, but certainly not least, what is to be done about the undiagnosed, under medicated, the over medicated? Research has shown that too many of our senior citizens are <u>not</u> getting proper treatment for depression. Most of the senior citizens prefer going to their primary care physicians for treatment for depression, yet these doctors know very little about depression, that is not apart of their training.

I have come to you today with a lot of challenges and yes some possible solutions. And if you really want to help us than the following are a few things that are within your power to do:

A) Work on the Medicare decision.
B) Get rid of the unfairness of co-pay in physical vs. mental. Medicare folks have to pay 50% for mental care but only have to pay 20% for physical care. They should be the same, 20% (yeah!)
C) Support out reach programs for senior citizens, as many are too feeble to come to Mental Health Centers, and many are ashamed to do so.
D) Medicine costs too much (use Medicare to lower the price of prescriptions).
E) Train primary care physicians on how to treat senior citizens who have depression/ or to make proper referrals.

Senator BREAUX. Thank you very much, Ms. Gardiner.

Next we will hear from three other panelists who are experts in this area. First, Dr. Donna Cohen. Dr. Cohen is an Internationally Distinguished Scientist and Educator, a Clinician, a Humanist, in the field of aging and mental health and long-term care and violence—it seems like all of the subjects that this committee deals with—from the University of South Florida. We are delighted to have you here.

STATEMENT OF DONNA COHEN, PH.D., PROFESSOR, DEPARTMENT OF AGING AND MENTAL HEALTH, LOUIS DE LA PARTE FLORIDA MENTAL HEALTH INSTITUTE, UNIVERSITY OF SOUTH FLORIDA, TAMPA, FL

Dr. COHEN. Thank you, Senator Breaux, Senator Reid—who has left us—Senator Dole, and other members of the committee.

Senator BREAUX. Get that mike right in front of you. It will pick it up better.

Dr. COHEN. I thank other members of the committee who I know will read the testimony or may have already read it.

I echo what the panelists said, thanking you for your leadership. Albert Einstein said that you cannot solve a problem with the same consciousness you bring to the problem, and your history with the elder justice bill and now the successful aging bill, followed by the activities that will come from this hearing will have a dramatic impact on the problems of older people.

Older people are the children of yesterday, and we are dealing also with children, who will be the aged of tomorrow. So your actions here, will make a difference. The beautiful testimony given by Diana and Hikmah—I am so sorry that one of my colleagues, a covictim of homicide-suicide, was not able to be here today, suffering great pain and still in depression, recovering from his parents' homicide-suicide 12 years ago. His testimony, I dare say, will bring a tear.

We have in our choir here, the ability to repeat what you have said admirably in your statements, both you and Senator Reid. I do want to highlight a few things that are important. There is a great deal of other material in my testimony.

Depression is a devastating illness, said brilliantly and beautifully and poignantly. It can be lethal. Older people have more intent. They are thinking about this. It is not a precipitous act. They think about it for a long time. Older people use guns 72 percent of the time, compared to 57 percent of the time in the general U.S. population. These are statistics analyzed by the National Institute of Mental Health.

Older people don't attempt it as much. Younger people attempt it 100 to 200 times for every completed suicide, older people one in four. Careful planning, physical vulnerabilities, depression, isolation, hopelessness and desperation lead to suicide. Pacts are rare, but a suicide pact that occurred in Fort Lauderdale, FL, this past New Year's Eve, shows the desperation of older suicides. The Spivacks—and this picture is provided by the niece who wanted her aunt and uncle to be shown—crawled to their deaths. Their method is unusual. They had told the condominium handyman they wanted him to remove the screens, so they could feel the

breeze. Within hours, they had crawled from their walkers to the window. Mrs. Spivack helped push her husband over before she followed. This is an unusual method, but the antecedent circumstances—incapacitating illness, unrecognized depression, and a suicide note—are not.

I am going to focus my comments on depression in people with Alzheimer's disease and related disorders, the impact on family caregivers, and then on the lethal consequences of homicide-suicide, a phenomenon we also pushed under the rug until 10 to 12 years ago.

Alzheimer patients number roughly 4 million. They will increase to 9 million by the year 2030. Roughly—and Dr. Katz probably has the better stats—30 percent or more of Alzheimer patients, maybe 50 percent, have depression which goes unrecognized and undetected it leads to behavioral problems, unnecessary use of psychotropic medications, and a premature deterioration, and an ultimate indignity.

We know very little about the risk factors for suicide, and also homicide-suicide, in dementia patients. David Cohen—no relation—3 years ago wanted to commit suicide in Naples. He didn't want his wife to die, so he closed the bedroom door hoping that this would protect her. He set himself on fire, panicked, left the house, and, unfortunately, his wife died from breathing in the fumes. This man was thrown in jail and put on a suicide watch. It took our Governor and a series of mental health advocates to get him into a residential facility that would be able to meet his needs.

These violent deaths are preventable, but we have to learn a lot more about prediction, what my colleagues and I are serious about.

The high prevalence of depression in family members is extremely well documented. Older spouses have the highest levels. It can be as high as 60 percent in older women caring for their spouses with Alzheimer's disease, 40 percent in men, and roughly a third of daughters and daughters-in-law. This depression goes unrecognized despite the fact that older people are being seen in medical care system. Men don't like to admit they are depressed, and I congratulate the NIMH for having a new special initiative on men and depression, something that needs continued support.

Depressed caregivers also do violent things. With the support of an NIH-supported grant, we saw that 17 percent of family members caring for a relative with Alzheimer's disease at home were involved in severe violence—kicking, hitting, stabbing, beating. Six percent of this was interactive violence, undetected, untreated.

Thank you for your interest in homicide-suicide, Senator Dole. In the old days, up until probably 1990, we assumed that these are just two old people, who were sick, old, and they deserved to die rather than go on living. We are finding that the portrait of homicide-suicide mirrors the portrait of depression. These are men, who almost always kill their wives, who are usually 4 to 6 years younger than they are. In the Hispanic community, it is 20 years. These are men who are depressed. Our study using—medical examiner reports showed that none of these men are on antidepressants, and in some other studies in New York and elsewhere, maybe one or two were on an antidepressant. They are on other kinds of medica-

tion, inappropriate medications again, emphasizing the importance of the primary care community.

Charlie Woods has been affected by depression. His brother tried to commit suicide. Families suffer. For every one completed suicide, there are roughly six family members who were affected. In the homicide-suicide literature, we are finding the same thing.

I will wrap up by saying that some people don't succeed, and if you could just pull the—this chart simply shows that Florida does lead the country in the rate of homicide-suicide.

Leo Visco took care of his wife for 5 years. He was depressed. He was taking his wife to six different doctors, but they never screened him. He killed her. He was taken into a court of law. This was a situation where a man did commit a killing, but the mitigating circumstances were undetected depression. Leo is now with his family in New York, serving probation.

You have seen the many reports that have been published by the Office of the Surgeon General, the CDC, and the Institute of Medicine. We know what will work. We have got the recommendations. We cannot afford to not meet these recommendations. As Walt Kelly said through Pogo's mouth: "We've met the enemy and they is us." We have met the aged, and they is us.

Thank you.

[The prepared statement of Dr. Cohen follows:]

DEPRESSION AND VIOLENT DEATHS IN OLDER AMERICANS:

AN EMERGENT PUBLIC MENTAL HEALTH CHALLENGE

STATEMENT OF

DONNA COHEN, PH.D.

PROFESSOR AND HEAD
VIOLENCE AND INJURY PREVENTION PROGRAM
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UNIVERSITY OF SOUTH FLORIDA

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

A HEARING ON

SENIOR DEPRESSION: LIFE-SAVING MENTAL HEALTH TREATMENTS FOR OLDER AMERICANS

JULY 28, 2003

Chairman Craig, Ranking Member Breaux, and Members of the Committee:

My name is Donna Cohen. I am a professor in the Department of Aging and Mental Health and Head of the Violence and Injury Prevention Program in the Louis de la Parte Florida Mental Health Institute at the University of South Florida. I am also a professor in the Departments of Psychiatry and Behavioral Sciences, Psychology, and Gerontology at the University of South Florida.

Thank you for convening this important hearing. In this era where there are so many compelling issues competing for your time and attention, my colleagues and I appreciate your focus on depression and ways to enhance mental health, vitality, and a meaningful existence for our rapidly aging and changing population. What comes from this hearing and collateral activities will not only affect the aged of today, but our children, who are the aged of tomorrow.

Thank you also for inviting me to testify on the critical public mental health challenges of depression in older Americans and its potential lethal consequences—suicide, homicide, and homicide-suicide. The lack of recognition, diagnosis, and treatment of depression in Americans of all ages, but especially older Americans, is unacceptable since depressive disorders are treatable illnesses. Depression goes undetected in half of the general population, and 80% of the older population.

The bad news is that this is due, in part, to the crippling forces of ageism and fatalism, the inadequate training of service providers, and the shortage of geriatric mental health specialists. The good news is that there are many research, clinical, educational, and community strategies to improve geriatric mental health care, which if successfully implemented will not only decrease unnecessary human suffering, but will also improve the well-being and productivity of our older population.

Depression, coupled with other risk factors, can be lethal. Older persons in the United States and around the world have the highest suicide rates compared to other age groups. However, in the United States older men commit 80% of suicides, whereas in other countries older men and women appear to be equally likely to commit suicide. Older persons show a greater degree of premeditation and lethality of intent compared to younger persons. As seen in Figure 1, from Dr. Jane Pearson, who also is participating in this panel, 72% of older persons use firearms compared to 57% for the general population. The aged are less likely to attempt suicide, with an average of 4 attempts for every completed suicide, compared to 100-200 attempts for every completed suicide in younger populations. Careful planning, increased vulnerabilities, physical health problems, and relative isolation all contribute to increased lethality in older persons.

Suicides are acts mediated by mental health problems, hopelessness, and desperation. Suicide pacts are very rare, but the suicide pact of an older couple in south Florida this past New Year's Eve illustrates the unquiet desperation and what Roger Maris has called a *"bankruptcy of hope and resources"*. The method of death is unusual, but the antecedent circumstances—incapacitating illness, depression, and a suicide note—are not.

> MS, age 85, and ES, age 80, had planned to die on New Year's Eve. They asked the condominium maintenance man to remove their bedroom screens, complaining that they blocked the ocean breeze. He removed them, and several hours later the couple committed suicide. The results of the medical examiner's investigation showed that MS and ES had crawled across the bedroom floor to the window and fell 17 floors to their death. Both relied on walkers to get around their home. ES appeared to have helped her husband, who was weak and frail from emphysema, by pushing him out the window first before she followed. A note was tape to the telephone; ES had a note in her blouse pocket.

I am going to focus my comments today on three key points:

- Depression, which is prominent in 30-50% of patients with Alzheimer's disease and related disorders, goes unrecognized in acute care and long term care settings. Death wishes or suicidal ideation occur in as many as 50% of patients, at least 15% are at significant risk and 3% complete suicide.

- Depression can be harmful to older caregivers and their patients. It is the most common negative consequence in family caregivers, especially older spouses. Unrecognized and untreated, affected family caregivers are less able to care for their relative and are at risk for a compromised immune system and health problems as well as premature death. The presence of depression in Alzheimer caregivers also increases the risk for elder abuse and severe violence, e.g., kicking, stabbing, and beating.

- Depression can be lethal. Unrecognized and untreated, depressed older persons are at high risk for violent, tragic, and unnecessary deaths—suicide, homicide, and homicide-suicide. Older persons not only have higher suicide rates compared to all other age groups, our research indicates that older persons also have higher homicide-suicide rates than younger persons. Homicide-suicides, where an older person (usually a man) kills one or more persons before committing suicide, are increasing in the older population.

Depression and Violent Deaths in Alzheimer's Disease and Related Disorders

Caring and the value of human life are woven into our society's moral fabric. With the increasing numbers of individuals with Alzheimer's Disease in our older population (from 4 million in 2000 to a projected 9 million in 2030), a group already believed by many to be a drain on the productive growth of our society, the pressure to reexamine our

ethical responsibilities and moral contract with the aged has become an issue of international concern. Alzheimer's disease has become a metaphor for aging, challenging us to appreciate the inalienable dignity of living and dying.

Depression co-exists with Alzheimer's disease in about 30% of patients, and the prevalence is higher in vascular dementias. Depression is most easily recognized early in the disease when individuals can communicate their thoughts and feelings to others, but detection is more difficult in later stages. Left untreated, depression and other psychiatric problems lead to disruptive behavioral problems, inappropriate use of psychotropic drugs, and premature deterioration. On the other hand, accurate diagnosis and interventions can significantly enhance functioning and emotional well-being throughout the course of illness, what one patient described as *"an oasis of hope in a dust bowl of despair."*

Little is known about the prevalence, causes, and risk factors for suicide and homicide in the dementia population, important information to prevent suicide and other violent deaths. It is estimated that about 10% of patients may be at high risk for suicide (400,000 persons) and that 3% (120,000 persons) commit suicide. Suicidal ideation, depression, physical illness, and other psychological problems are prominent, and these patients are capable of killing themselves, often in painful and unusual ways. The methods of death, e.g., ingesting poisons or glass or other agents, drowning, jumping, and hanging, are different than seen in non-dementia populations, where guns are most frequently used.

Homicides and homicide-suicides are rare in the dementia population, but they do occur. A 76-year old husband with dementia stabs his wife in the head with a pick-ax, killing her. A 62-year old daughter shoots her 90-year old mother before turning the gun on herself. An 80-year old husband beats his wife to death with a telephone and cane. An 85-year old man stuffs plastic in the mouth of a bedridden assisted living resident and smothers her with a pillow. The presence of psychotic depression, paranoia, and co-existing vascular dementia appear to be predisposing factors. Random circumstances may escalate into violent deaths at home and in long term care residences when residents have catastrophic reactions, over-react, or misinterpret the words or actions of others.

These violent deaths are largely preventable, but prevention is predicated on prediction, and we are not very good at prediction. Research is key to improving our ability to prevent suicide, homicide, and homicide-suicide in this at-risk population of patients. Not only will the numbers escalate because of increasing life expectancy, proportionally more will have mild and severe dementia as a result of improved early detection and better health care over the course of the illness. The result will be more patients who are not only living longer but also taking longer to die, and families will be coping with what one daughter called *"the death of the mind, the worst death imaginable."*

Depression Can Be Harmful to Older Persons and Family Caregivers

The high prevalence of depression in family members dealing with the stress and strain of caregiving is well documented, especially in Alzheimer families. Older spouses have the highest prevalence of depression, likely reflecting the responsibilities, values, and commitments of marital loyalties. Depression occurs in more than 60% of wives, 40% of husbands, 40% of daughters and daughter-in-laws, 25% of sons, and 25% of other relatives caring for relatives with dementia at home.

Despite frequent medical care visits, usually for the patient, depression in family members goes unrecognized. Even when caregivers know they are having emotional problems, they are usually reluctant or unwilling to admit it and reach out to family members or professionals for help. This is especially true for men, who also manifest depression differently than women, an issue that has been targeted by a new NIMH initiative.

Depressed caregivers are not only less able to care for the patient as well as their own health, they are also at an increased risk to harm their relative or themselves. The overall prevalence of severe violence, e.g., kicking, hitting, stabbing, in family members caring for relatives with dementia at home is 17%. About 6% are cases where caregivers are violent towards patients, 15% are circumstances where patients are violent towards caregivers, and 4% are situations of mutually interactive violence. The presence of significant depression in the caregiver was associated with a three-fold increased risk of severe violence. However, caregiver depression coupled with a living arrangement where the patient lived with family members but without their spouse, was associated with a nine-fold increased risk for severe violence.

Depression Can Be Lethal: Violent Deaths

Homicide-suicides are rare, compared to suicides and homicides, but they are an emerging public health problem, especially in the population age 55 and older. It is estimated that they account for 1,500-2,500 deaths a year, similar to the mortality count for deaths due to meningitis, viral hepatitis, or pulmonary pneumonia. It is important to emphasize that homicide-suicides are not crimes, but rather public health concerns that require our attention in the continuum of violent, unnecessary deaths.

Until recently, there were no studies of the prevalence or clinical patterns of homicide-suicide in older persons. They were assumed to be primarily violent acts involving younger persons who were mentally ill, angry, and jealous of spouses and intimates. When older people were involved they were presumed to be suicide pacts between old, sick husbands and wives or altruistic deaths where sick, older men killed their sick wives before committing suicide. However, these are myths. Homicide-suicide in the aged is much more complicated.

Available data indicate that homicide-suicides in the older population are predominantly spousal/consortial, where the husband, who is usually 4-10 years older, kills a spouse or

girlfriend. However, older perpetrators also kill other family members, children, and nonfamily members. Table 1 compares the characteristics of homicide-suicides in the U.S. population by age.

Although the CDC is developing a National Violent Death Reporting System, there are presently no national data on the prevalence of homicide-suicide. Several national newspaper surveillance studies suggest that older persons account for 500-900 of the estimated 1,500-2,500 total homicide-suicide deaths in the United States each year. In addition to the impact on family members, entire communities are dramatically affected by these tragedies.

Statewide epidemiological studies in Florida have shown that 40% of all homicide-suicides occur in the population age 55 and older, and the rates per 100,000 persons are at least twice as high as seen in the population under age 55. Furthermore, the state incidence rates are increasing in the older population but remaining constant in the younger population.

The results of a national newspaper surveillance study, presented in Table 2, shows that seven states in the United States, with 43% of the U.S. population and 43% of the population age 55 and older, have the most homicide-suicides. Florida not only has the most homicide-suicides, but also the highest rates per 100,000. Florida is followed by California and Texas, tied in second place, and then Pennsylvania, New York, Ohio, and Virginia. These are likely to be underestimates.

Depression, unrecognized and untreated, is a core characteristic of older homicide-suicide perpetrators, who are predominantly men. Analyses of medical examiner post-mortem data show that almost none are being treated with antidepressants. These older men also appear to be making the decision unilaterally, and women are unknowing victims. Furthermore, most of the perpetrators have seen a physician within a week or month of committing the homicide-suicide. These patterns mirror findings about older suicides.

The motivations for spousal homicide-suicides are complex. In addition to depression and other types of psychopathology in the older perpetrator, relationship variables play a role, such as caregiving stress, a strong attachment to the victim, domestic conflict, a pending separation, and other life stressors. Although the risk factors overlap with those for older suicides, there appear to be differences: many homicide-suicide perpetrators are caregivers, while older suicides are care recipients. There are at least three types of spousal/consortial homicide-suicides in the aged. Fifty percent are known as "Dependent-Protective" where the older husband is caring for a wife who is sick or whom he believes is sick; 30% involve domestic violence; and 20% are "Symbiotic," where both have been known to express a desire to be dead, but there is no clear evidence of a pact.

Depression also plays a critical role in older homicides, often referred to as "mercy killings." Older persons rarely kill. National data show that 5% of all homicide offenders are age 55 and older, and 17% involve a spouse, usually male, killing a spouse. There are

several common characteristics of the perpetrator and victim as well as the nature of the killing in this narrow band of spousal homicides. The couple has been married a long time and has enjoyed an intimate, fulfilling relationship. There is almost never evidence of physical or psychological abuse, domestic conflict, financial exploitation and gain, or violence. The older man is almost always caring for a wife who has been sick a long time, and is either suffering from disabling conditions or is terminally ill. The older man is usually severely depressed, exhausted from the stress of caregiving, and the depression has gone undetected despite many medical care visits. The man has also been intimately involved in his wife's care and has done everything possible to secure appropriate services, often lacking.

There is great prosecutorial and judicial discretion in the way these older men are treated in the criminal justice system. Sentences range from jail time served and probation to life in prison. Most spend 1-2 years in prison. Killing is not to be socially sanctioned. However, it is important to examine mitigating issues, including the lack of community resources, the undetected depression, and the severe shortage of physicians and other clinicians trained in geriatric care and palliative care.

Concluding Comments

In addition to continued support for clinical research, interventions need to be developed, tested, and implemented to improve detection, intervention, prevention of suicide and other violent deaths in our older population. Comprehensive recommendations targeting suicides have been identified in recent volumes: the 1999 and 2001 reports from the Office of the Surgeon General's report, the 2002 Institute of Medicine report, and the 2002 Centers for Disease Control report. The blueprint is well-defined. We now need to move forward. We cannot afford not to.

Thank you for listening to me. I am happy to answer any questions.

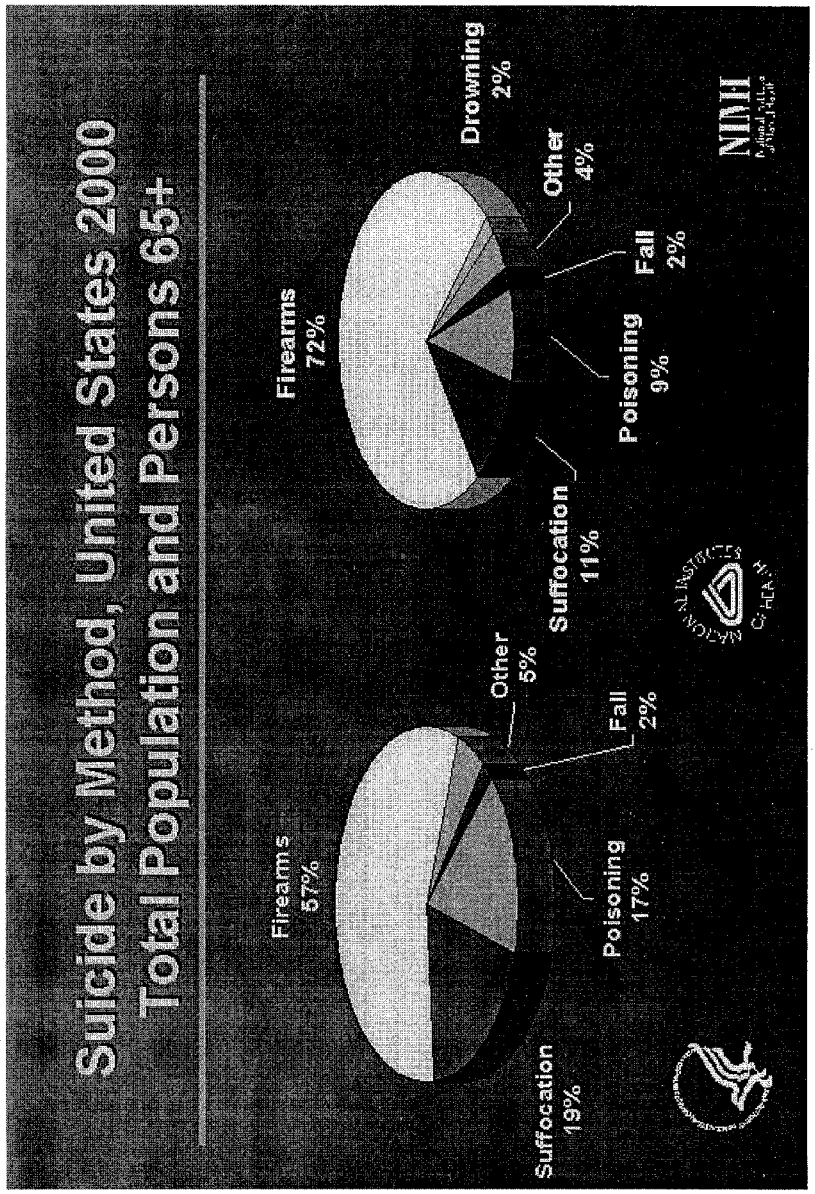
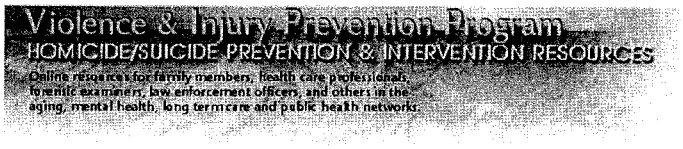

Suicide by Method, United States 2000
Total Population and Persons 65+
Firearms 57%
Suffocation 19%
Poisoning 17%
Fall 2%
Other 5%
Firearms 72%
Suffocation 11%
Poisoning 9%
Fall 2%
Other 4%
Drowning 2%
NIH

TABLE 1. COMPARISON OF CHARACTERISTICS OF YOUNGER AND OLDER HOMICIDE-SUICIDES ***(Cohen, Brock, Eisdorfer, Putney, in press)***

	Young	Old
Suicides		
N (%)	223 (79.4)	58 (20)
Age Range (yr)	20-54	55-90
Gender		
Male	202 (90.6)	52 (89.7)
Female	21 (9.4)	6 (10.3)
Homicides		
N (%)	268 (80.7)	64 (19.3)
Age Range (yr)	<1-84	11-89
Gender		
Male	78 (28.2)	14 (21.5)
Female	199 (71.8)	51 (78.5)
Subtype	n (%)	n (%)
Spousal/consortial	158 (73.5)	41 (71.9)
Familial	17 (7.9)	6 (10.5)
Infanticide/pedicide	14 (6.5)	3 (5.3)
Extrafamilial	22 (10.2)	6 (10.5)
Mass murder/Workplace killings	4 (1.9)	1 (1.8)
Method of death		
Firearm	195 (87.4)	49 (84.6)
More than 1 weapon/method used, but at least one gun	16 (7.2)	5 (8.6)
More than 1 weapon/method used, neither or none a gun	5 (2.2)	1 (1.7)
Asphyxiation	1 (0.5)	2 (3.4)
Knife	2 (0.9)	0 (0.0)
Other	4 (1.8)	1 (1.7)

TABLE 2. ESTIMATED ANNUAL HOMICIDE-SUICIDE RATES PER 100,000 POPULATION IN SEVEN STATES WITH THE MOST HOMICIDE-SUICIDES IN 2001 ***(Cohen, Brock, Eisdorfer, Putney, in press)***

State	Homicide-Suicide Rate		
	Young	**Old**	**Total**
Florida	0.31	0.72	0.41
California	0.17	0.20	0.17
Texas	0.26	0.22	0.25
Pennsylvania	0.26	0.13	0.23
New York	0.13	0.30	0.14
Ohio	0.20	0.16	0.20
Virginia	0.34	0.29	0.33



Homicide-Suicide in Older Persons:
How You Can Help Prevent a Tragedy

Written by

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Background

Homicide-suicides are tragedies that appear to be occurring more frequently in the U.S. than ever before. In these circumstances, a perpetrator, usually a man, kills a victim, usually a wife or intimate, and then commits suicide shortly thereafter. Almost all homicide-suicides in older persons involve a husband who kills his wife before killing himself.

Older adults have homicide-suicide rates that are twice as high as younger adults. Each year more than 500 homicide-suicides or 1,000 deaths occur in persons 55 years and older, which means that nearly 20 older Americans die each week in a homicide-suicide.

Although these events are relatively rare, they have a traumatic impact on surviving family members as well as neighbors and friends in the communities where they occur. The motivations for homicide-suicide are complex. These lethal actions result from many factors. They are not impulsive actions. The older perpetrator has usually thought about the act for several months and sometimes years. This means that you have a window of opportunity to help prevent a homicide-suicide.

Types of Homicide-Suicide

Homicide-suicides in older persons are not suicide pacts. Homicide-

from family, friends and social activities.
- The older couple has been arguing or there is talk of divorce or a history of estrangement.
- Since the husband is usually the perpetrator, look for the following signs.
    - changes in eating or sleeping
    - crying for no apparent reason
    - inability to feel good about the future
    - talk of feeling helpless or hopeless
    - talk that the future is bleak
    - talk that there is nothing they can do
    - threats to harm the wife
    - loss of interest in activities that used to give pleasure
    - anxiety and agitation
    - giving things away that are important to them
    - making plans to give someone a key to the home

If your spouse is showing these changes, or if you are an adult child or relative and you see these changes in a parent, talk to them. Do not ignore these signs.

What to Do if You See Signs

- Do not be afraid to ask if the older person has thought about suicide or homicide-suicide. You will not be giving them new ideas.
- Do not act surprised or shocked. This will make them withdraw from you. Continue talking and ask how you can help.
- Offer hope that alternatives are available. Do not offer glib reassurance. It may make the person believe that you do not understand.
- Get involved. Become available. Show interest and support. If you cannot do this, find someone who can, such as a neighbor or a minister, priest, or rabbi.
- Ask whether there are guns in the house. Ask the person what plans they have to die. The more detailed the plan, the higher the risk.
- Remove guns and other methods to kill.
- Do not be sworn to secrecy. Get help from persons or agencies that specialize in crisis intervention.
- Call a crisis hotline in your area or seek the help of a geriatric specialist. Do not try to do things by yourself.

Finding Help

There is help in the community. If you believe there is a risk for homicide-suicide, contact a professional immediately. Call a suicide crisis center, a crisis hotline, a family physician, a psychiatric or medical emergency room, or a community mental health center listed in the yellow pages of your phone book.

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from family, friends and social activities.
- The older couple has been arguing or there is talk of divorce or a history of estrangement.
- Since the husband is usually the perpetrator, look for the following signs.
    - changes in eating or sleeping
    - crying for no apparent reason
    - inability to feel good about the future
    - talk of feeling helpless or hopeless
    - talk that the future is bleak
    - talk that there is nothing they can do
    - threats to harm the wife
    - loss of interest in activities that used to give pleasure
    - anxiety and agitation
    - giving things away that are important to them
    - making plans to give someone a key to the home

If your spouse is showing these changes, or if you are an adult child or relative and you see these changes in a parent, talk to them. Do not ignore these signs.

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ANNOUNCING

The Violence and Injury Prevention Project is pleased to announce some major changes in our web site!

http://www.fmhi.usf.edu/amh/homicide-suicide/index.html

The Violence and Injury Prevention (VIP) Program is a multi-dimensional program developed to meet the needs of several groups impacted by homicide-suicide.

Violence & Injury Prevention Program

HOMICIDE/SUICIDE PREVENTION & INTERVENTION RESOURCES

Online resources for family members, health care professionals, forensic examiners, law enforcement officers, and others in the aging, mental health, long term care and public health network. For further information please contact Dr. Donna Cohen at (813)974-4665.

Senator BREAUX. Dr. Cohen, thank you so very much. A very powerful statement.

You mentioned Charlie Woods of Tampa, FL, and he was going to be a witness this afternoon. He became ill and cannot join us. He has a very eloquent statement describing that homicide-suicide of his parents, and that will be made part of our record.

[The prepared statement of Mr. Woods follows:]

STATEMENT OF CHARLIE WOODS
BEFORE THE
SPECIAL COMMITTEE ON AGING

July 28, 2003

Mr. Chairman, Senator Breaux, and other members of the committee,

I have been invited to speak to you today regarding some of the personal experiences my family and I have had with depression. For us as with many others, it has had some painful and lasting consequences. I am sharing these experiences with you in the hope that through these I might contribute, even in some small way, to this vital area of need, which your committee is investigating.

In the fall of 1988, fifteen years ago next month, my wife of 27 years, Kimberly, and I were living in Dallas, Texas where I was in my final semester of studies at Dallas Seminary. We were full of hope and excitement about the future and possible ministries after graduation.

One bright Sunday morning in August of that year, we had just returned from church services to our seminary apartment on campus in downtown Dallas, when we were met at the door by two uniformed police officers. They informed me that I had an urgent message to call the Leon County Sheriff's Department back home in Tallahassee, Florida. A few panic stricken minutes later as I spoke with a detective by phone, I was told that my father, Ray age 55, and mother Myrna, age 53, were both dead, victims of a murder / suicide. Sometime in the early morning hours of Sunday, August the 13th my father had broken into the house where my mother was living. With a hand-gun had purchased during the weeks prior he fatally shot her and then sat on the floor of the hallway and shot himself.

It would be impossible to tell you, in the few brief moments I have with you here, how painfully this impacted our lives or to show you all of the struggles that led up to that day. My parents had been having trouble in their marriage. A lifetime of inner turmoil and personal problems that were never addressed adequately had intensified with the progression of age. Married at ages 17 and 15 they had stayed together through nearly 37 years of marriage chiefly because of my mother's tolerance.

My mother, a warm hearted and devoted Christian, left the indelible mark of her loving kindness and faith on my life and many others. If not for her, my father, an alcoholic who had physically abused my mother as well as his three children would certainly have had a far greater and lasting impact on my life.

Because of my own abuse, twenty years earlier, at the age of fourteen, I had been taken from the home by the State of Florida, made of a ward of the State and placed in the care of my grandmother. Though only a teenager, I accomplished this with my own initiative

after hearing a social worker, visiting my junior high school class; explain what she did for a living. A short time later, that same year, I attempted to take my own life. I narrowly survived after being found comatose beside a suicide note I had written. I still recall the painful loneliness I felt during this early encounter with depression.

In the years just prior to my parent's deaths, as they entered their golden years, my father's health began to grow worse and my father especially grew increasingly depressed. Along with an increase in his drinking, the physical violence returned.

My mother now had finally made the decision that I had made so many years earlier, to leave, and to seek her own peace and happiness. She filed for divorce. During the final month of their lives, as I struggled with my studies, I struggled to keep in contact with both mom and dad. Mother was living a court injunction and for threats of violence coming from dad. We spoke often over the phone. The night before her death, I spoke with mother long-distance and we prayed together. She cried and shared her anguish about the situation. After her death I tried many ways to work through the painful sorrow of losing the mother I loved so dearly. In one instance, I gathered all the letters we had written to each other and made a book of them. Reading through them, especially her last expression, it is clear to see that the mother I always saw with a smile and a cheerfulness that was contagious was truly despondent. She was in a depression that left her without answers. In one final letter to Kim and I she wrote, "I hurt so badly. I want a sharing love. I feel hollow. I don't know what is wrong. I know my redeemer is in me and He keeps me but even Jesus wept.
Love,
Mom"

I also tried to keep in touch with my father. In the months prior to his death, my father began to speak to me about suicide. Even though I was a minister in training, I felt helpless to know how to help. I prayed with him. I tried to encourage him and tell him things would get better. It was difficult after he died not to feel I should have done more. While mother's infectious friendliness had made her hundreds of friends at both her job and the church she faithfully attended, my father was virtually alone. He had no real friends and now he had been cut off from the last person who had accepted him unconditionally. Shortly after my father's death we recovered some items from a small apartment he had taken. Among the very few items was a Bible dad had been given recently at a church where he had gone trying to find help? In the Bible, pressed between the pages was a promissory note for ten thousand dollars from the clinic where dad had rehabbed briefly. The clinic had closed for financial reasons weeks before his death. This had left him without professional help. On the outside of the note dad had scrawled a Bible passage reference for Psalms 102. It reads in part:

"Hear my prayer, O Lord; let my cry for help come too you.
Do not hide your face from me when I am in distress.
Turn your ear to me; when I call answer me quickly.
For my days vanish like smoke; my bones burn like glowing embers.
My heart is blighted and withered like grass.

As I read the Psalm I was moved to tears for a man whose end was a desolate picture of a lonely and desperately depressed failure. Even though he had come there on his own accord, I could only feel pity, sorrow and empathy for my father.

After mom and dad's deaths I began to slide into a deep depression. Though my life until then had not been free from difficulties, I had no experienced this kind of depression. As my own thoughts became increasingly suicidal, I realized I needed help. I would eventually seek professional help and counseling which would reveal that I was clinically depressed. In other words, I had a depth of depression which required professional in clinic help. With the help of an organization called 'Rapha', an in-patient care with group therapy, I was able too realize the blame I was assigning myself for my parent's deaths, and I was able to forgive my father. As a result of this experience I have a strong personal understanding of the need to be able to point people to a place where they can get professional help with depression, in addition to faith, fellowship and prayer.

The year that followed was a difficult, and often painful, journey that affected all of my relationships and changed each member of my surviving family. Me, my wife Kim, my younger brother Michael, and sister Kathy, each were reshaped in some way by the violent deaths of our parents. Our lives moved on propelled by the forces of grief. Not realizing that sorrow would one day visit us again, in an untimely season.

Kim and I eventually moved to Europe the year after my parents died. Living and teaching in Holland in 1989 through 1990. We both experienced a catharsis of sorts as we watched Europe and the world change around us as the wall came down. It was almost a metaphor for what was happening to me personally.

Soon home would call again as we had to move back to Florida, this time to care for my aging Grandmother who eventually needed to be moved to an assisted care facility. Soon Granny who had been like a mother to me passed on and once again we moved away. But, once again as time passed on, family duty called when my brother Michael, went on a number of years later to contract the AIDS virus. Kim and I, once again living and teaching in Texas, would return home to Florida to care for Michael. I fully believe that my brother's own depression and unresolved grief over losing his mother and lack of relationship with his father, contributed to his failing health. In 2001 at the age of 47, Michael died, here in our home with those who loved him. This happened only a matter of weeks after a failed suicide. I still miss him terribly. I still wear his Air-Force dog-tags around my neck each day to remind me of him and his final suffering. The night he died at about 3 in the morning I went into his room where he was being watched by a hospice worker. He looked like a holocaust victim, his body barely bones and swollen from failing organs. In his eyes all that night I could see the haunting stare of the grip of death trying to pull him away. I put my arms around him and said I love you brother. "I love you too", was his reply. Those were our final words. The best you could have. The following morning we found him in his bed, eyes shut, having passed away during the night.

I have been thinking lately about my own life. Next year I will be the age my mother was when she 'went on to be with the Lord'. I find I am thinking more about death and as I move toward that certainty, thinking more about what I have done with my life; about my health and preparing for the future. Here in my 'Golden Years', with more focus of the end of my life than on the present I find I get the 'blues' more often. But I do so with the faith and love my mother left me, with company of a wife who loves me, and with the knowledge that there is help and that there is nothing wrong in asking for it.

A favorite scriptural refuge of mine is in the Apostle Paul's letter to the church at Rome where he wrote that, "...we rejoice in our suffering, because we know that suffering produces perseverance; perseverance character; and character hope..." It seems like God has allowed me to gain a lot of hope through my life. Each time things grow dark and I feel bound I think back over the times that he has brought me through. And I feel that I have hope that the sun will shine and I will rise again.

Senator BREAUX. Next we will hear from Dr. Ira Katz, who is Professor of Psychiatry and Director of the Section of Geriatric Psychiatry at the University of Pennsylvania, and also the Director of the Mental Illness Research, Education and Clinical Center, Philadelphia VA Medical Center.

Dr. Katz, very glad to have you.

STATEMENT OF IRA R. KATZ, M.D., PROFESSOR OF PSYCHIATRY, DIRECTOR, SECTION OF GERIATRIC PSYCHIATRY, UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE, AND DIRECTOR, MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CENTER, PHILADELPHIA VA MEDICAL CENTER, PHILADELPHIA, PA

Dr. KATZ. Thank you. Thank you for giving us the opportunity to testify.

I am here before you as a geriatric psychiatrist and an investigator on the NIMH-supported PROSPECT study on the treatment of depression and the prevention of suicide. I am proud to recall testifying in this room in 1996, when witnesses emphasized a number of points that you have outlined: first, older people, especially older men, who are at the highest risk for suicide; second, the vast majority of these suicides are due to depression; third, although depression is treatable, depressions in late life are only rarely diagnosed and treated appropriately; and, fourth, about 75 percent of older people who commit suicide have seen their primary care doctors within a month. Therefore, there are major opportunities for preventing suicide by improving the recognition and treatment of depression in the elderly.

At the hearing in 1996, I was privileged to hear Senator Reid emphasize the importance of these issues. I want to thank him and the committee as a whole for all you have done.

Since the time of the hearing, there have been significant advances in the treatment of depression in the elderly, including the increased availability of newer and safer antidepressant medicines and evidence that specific forms of psychotherapy are effective. However, many cases of depression still go unrecognized, and treatment that is long enough and intensive enough to work is rarely given.

Late-life depression is still a fatal illness. As will be emphasized by Dr. Pearson, suicide rates remain high. In addition, there is increased evidence that depression in older adults is associated with increased mortality from natural causes in the overall population and in people with heart disease, lung disease, and stroke.

Primary care remains an important setting. As shown in the first figure, our research in the MIRECC at the Philadelphia VA has shown that the older veterans who have committed suicide had, by and large, never had treatment for mental health problems. More than for younger veterans, the initial recognition and diagnosis of depression is the key to prevention. This has led us to develop interventions to improve screening. However, we know this isn't enough. In addition, it is important to make sure that adequate and effective care is provided.

In this context, converging findings from the NIMH-supported PROSPECT and the Hartford Foundation-supports IMPACT stud-

ies are highly promising. Both tested interventions that were designed following models developed for disease management and other medical illnesses.

Actually, could we go to the next one and then come back?

Key elements in these interventions include: augmenting primary care practices with nurses or others who assist the doctor in managing patients; providing help with case recognition; following guidelines for first-line treatments and for sequences or combinations to use when patients don't respond; educating patients and families; and assisting the doctors in keeping treatment on target.

The findings shown there demonstrate that these programs work. Although there were substantial rates of antidepressant prescribing for the patients receiving usual care, the chart shows that the PROSPECT and IMPACT interventions worked to increase response rates. There we demonstrate that the PROSPECT intervention worked across all of the three settings in which it was delivered, and the IMPACT intervention works over time.

In both studies, however, improved outcomes are robust and demonstrable across a number of analyses. Moreover, as shown in that third slide, the PROSPECT findings demonstrate that the intervention decreases the frequency of suicidal thoughts in older people. Thus, treatment works. But only when it is good treatment of adequate duration and intensity and when it is modified or augmented for those who don't respond to first-line approaches. However, even though we know how to provide effective care for late-life depression, we most often cannot deliver it to those in need.

As suggested by the President's new Freedom Commission and all of my colleagues here today, barriers include stigma, high copayments for mental health care in Medicare, and system difficulties in integrating mental health with other components of care. The answer to preventing suicide in late life is to make high-quality mental health care available to America's elderly. However, there are a number of starting points where we can begin to address these gaps more immediately.

I urge you to consider a number of beginning steps. One is augmented funding for NIMH that specifically targets intervention and services research on the mental disorders of late life. Another is direction to the Center for Medicare and Medicaid Services to implement a Medicare demonstration project evaluating primary care-based care management for late-life depression.

Thank you for giving me the opportunity to testify before you.

[The prepared statement of Dr. Katz follows:]

Statement of Ira R. Katz, MD, PhD
Professor of Psychiatry
Director, Section of Geriatric Psychiatry
University of Pennsylvania
Director, Mental Illness Research Education and Clinical Center
Philadelphia VA Medical Center

I am pleased to have the opportunity to appear before you to address the topic of this hearing, "Senior Depression and Life-Saving Mental Health Treatments for Older Americans." I am speaking as a Geriatric Psychiatrist, and as a part of the research team that includes Drs. George Alexopoulos and Martha Bruce from Cornell University, Charles F. Reynolds, III from the University of Pittsburgh, and others, who conducted the NIMH-supported **Pr**evention **O**f **S**uicide in **P**rimary care **E**lderly: **C**ollaborative **T**rial (PROSPECT).

As I sit here, I am proud to recall testifying before this Committee in 1996 at the hearing on "Treatment of Mental Disorders in the Elderly: Reducing Health and Human Costs". At that time, witnesses emphasized a number of key points about depression and suicide in late life, namely:

- Elderly males, especially white males, are the people at highest risk for suicide in America.
- The vast majority of these suicides are consequences of depression. When other mental disorders such as alcoholism make a contribution, it is primarily in patients who also have depression.
- Although these depressions are treatable, they are only rarely recognized, diagnosed, and treated appropriately.
- Approximately 70% of older people who committed suicide have seen their primary care doctors within a month of their deaths. Therefore, there are major opportunities for preventing suicide by improving the recognition and treatment of depression in the primary care setting.

At that hearing, I was privileged to see Senator Reid rise to speak to emphasize the importance of these issues. His role as a champion for NIMH research targeting the treatment of depression and the prevention of suicide in older people led to the PROSPECT study and the scientific findings I will discuss today. For this, all of us are grateful to him, and to the Committee as a whole.

Since that time, a body of research has strengthened the evidence that late life depression is a fatal illness. As Dr. Pearson indicates, suicide rates remain high. In addition, evidence is accumulating that depression in older adults is associated with increased mortality from natural causes in community populations and in elderly people with

medical conditions such as heart disease, chronic obstructive pulmonary disease, and stroke. Research shows that these deaths can be due to the biological effects of depression, as well as to its impact on behaviors such as treatment adherence and self-care.

Since the time of the hearing, there have been significant changes in the care of depression, including the increased availability of newer and safer antidepressant medications, and evidence that specific forms of psychotherapy are effective in the elderly. However, there are still major barriers to the effective treatment of late life depression. There is still a high degree of stigma associated with the diagnosis of depression. In addition, high co-payments for mental health services in the traditional Medicare program remain, and the proportion of managed care expenditures devoted to mental health care has actually decreased.

Recent evidence that what happens in primary care is critical for the recognition and treatment of depression comes from several sources:

- Research conducted at the Philadelphia VA Medical Center by the Mental Illness Research Education and Clinical Center (MIRECC) that I direct shows that there are significant differences in the pattern of suicide across the lifespan (Figure 1). Among the elderly veterans who killed themselves, a large majority were seen in primary and medical specialty settings and had never received psychiatric care.

- The Substance Abuse and Mental Health Services Administration- (SAMHSA) and VA-supported **P**rimary Care **R**esearch on **S**ubstance Abuse and **M**ental **H**ealth in the **E**lderly (PRISME) study evaluated engagement in treatment for older primary care patients with depression who were offered treatment in the primary care setting compared to those who referred elsewhere for mental health services. 75% or more of those randomized to receive services in primary care, but only 50% or less of those referred to behavioral health settings engaged in treatment.

Primary care is a critical site for the recognition and treatment of depression. However, high quality care is rare. Although antidepressant prescribing is frequent, usual care is most often inadequate in terms of the doses of medications, the availability of psychotherapy, the duration of treatment, the monitoring of outcomes, and the adjustment of treatment when patients do not respond to first line approaches.

In this context, recent findings from the NIMH-supported PROSPECT study as well as the Hartford Foundation-supported **Im**proving **Ca**re for Late Life Depression-**C**linical **T**rial (IMPACT) are highly promising. The interventions in these studies were designed following concepts and models developed for the management of chronic disease and found to be effective in other medical illnesses in late life including diabetes and heart failure. Key elements include:

- Identifying late life depression in "real-life" patients in "real-life" primary care practices.

- Developing evidence-based guidelines that define initial first line treatments for depression (medications or, when appropriate, highly structured psychotherapies), as well as sequences or combinations of treatment to be used when patients do not respond.

- Augmenting the primary care practices with a nurse or other professional staff member who works with the patient's doctor in educating and activating patients, implementing treatment, monitoring side effects and therapeutic outcomes, and modifying therapy when needed.

- Involving families as partners to deliver patient-focused, family-centered care.

- Providing an information system to allow tracking of patients and cueing both assessments, and any modifications in care that are needed to follow the treatment guidelines.

Findings from these studies (Figure 2) demonstrate that these programs work. In both studies, the proportion of patients who responded to the program's intervention was greater than that for enhanced usual care. Moreover, the programs are efficient. The program-related costs associated with the PROSPECT intervention are substantially less than those for the medications.

Because the PROSPECT study was designed to determine whether improving primary care treatment for depression can reduce the risk of suicide, it also evaluated the effects of treatment on risk factors. The findings demonstrate that the intervention decreases the frequency of significant suicidal thoughts (Figure 3). Thus, the results of this research confirm the value of primary care treatment for improving the outcomes of treatment for depression, and in decreasing a measure of risk for suicide.

Since 1996, we have learned that treatment works in late life depression when it follows evidence-based guidelines. However, we have also learned that usual care is, most often, inadequate. As a field, Geriatric Psychiatry now has effective treatments for late life depression. We also have programs that make it possible for us to reach those patients who are at high risk for depression and its fatal consequences in the medical care settings where they receive the rest of their care. However, we cannot sustain these programs in the absence of research support. As a result, we cannot deliver the care that we know is effective to most of those who need it.

The information I reviewed clearly demonstrates the value of the intervention research on the mental disorders of late life depression that is supported through NIMH. However, there are still gaps in our knowledge that can be filled by targeted research:

- Despite advances in antidepressant drugs and psychotherapy, 20% of elders fail to respond and another 20-30% improve only partially. We need to work to understand the reasons for treatment resistance and find ways to overcome them.

- PROSPECT and other related studies showed that systems of care can be devised to improve the treatment of depression in the primary care setting. However, many depressed older people live in isolation, do not see physicians on a regular basis, and are never identified. Moreover, many of the most severely ill of older adults are treated in home care, nursing homes, rehabilitation facilities, and other institutional settings. With appropriately focused research, we can develop models to increase the access of these patients to treatment and improve their care.

- Effective models of care are only adopted by the health care system if appropriate financial and non-financial incentives are made available. The process of setting incentives can be scientifically investigated for both their ability to improve care and their cost efficiency.

To address these gaps, I must urge you to consider augmented funding for NIMH that specifically targets intervention research on the mental disorders of aging. In addition, to apply the knowledge that we have gained and to make effect, life-saving care available to older Americans, I hope you will consider directing the Center for Medicare and Medicaid Services to implement a demonstration project evaluating Medicare funding for primary care-based care management for late life depression.

Thank you for giving me the opportunity to testify before you.

Figure 1.

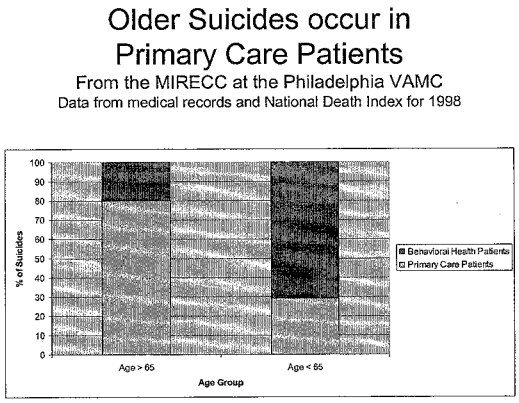


Figure 2.

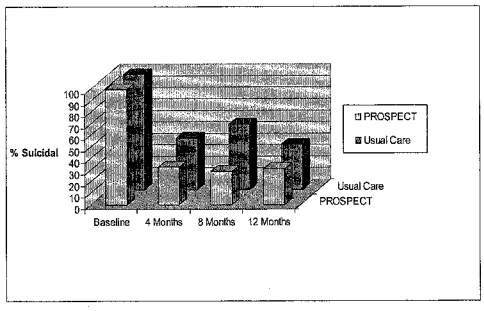
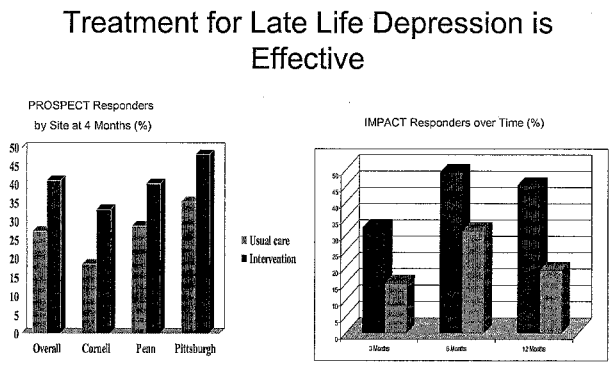


Figure 3.


Treatment for Late Life Depression is Effective
PROSPECT Responders by Site at 4 Months (%)
50
45
40
35
30
25
20
15
10
5
0
Overall
Cornell
Pean
Pittsburgh
Usual care
Intervention
IMPACT Responders over Time (%)

Senator BREAUX. Thank you very much, Dr. Katz.

Next we will hear from Dr. Jane Pearson, who is Associate Director for Preventive Interventions, Chair of the National Institute of Mental Health Suicide Research Consortium at the National Institute of Mental Health with NIH. Thank you so much for being with us.

STATEMENT OF JANE L. PEARSON, PH.D., ASSOCIATE DIRECTOR FOR PREVENTIVE INTERVENTIONS, DIVISION OF SERVICES AND INTERVENTION RESEARCH, NATIONAL INSTITUTE OF MENTAL HEALTH, BETHESDA, MD

Ms. PEARSON. Thank you for the opportunity to highlight the research of the National Institute of Mental Health.

As highlighted in the recently released President's new Freedom Commission on Mental Health, suicide is the most distressing and preventable consequence of undiagnosed and untreated mental disorders. Ninety percent of people who kill themselves have a mental disorder or substance abuse disorder.

We at NIMH are very concerned about the alarming numbers of older adults who suffer from depression and thoughts of suicide, and because they are often undiagnosed and untreated, may go on to take their own lives. We understand the heartbreak that the tragedy of suicide causes to families, and we want to pursue answers so families don't have to go through this and we don't lose more lives. We want to prevent suicide and the hopelessness that precedes it.

In 2000, which is the most recent year we have statistics available on suicide, over 29,000 Americans took their own lives. U.S. suicide deaths outnumber homicides by 5 to 3. In 2000, over 5,000 persons aged 65 and older died by suicide. The elderly account for 18 percent of all suicides even though they are only 13 percent of the population.

I apologize. I don't have Figure 1 up here on the board, but if you have your handout, there is a figure—I don't know if the audience has this or not. But in this figure, it is pretty clear that older adults have the highest suicide rates. If you look at the breakout by different ethnicities, you will see that it is older white males that have the highest rate. They comprise 81 percent of all elderly suicides. This is a rate that is 6 times the national average.

This graph also illustrates variation in suicide rates, among whites and African Americans. The direction of these differences are quite surprising given what we know about health care disparities. Where we would expect ethnic minorities to have lower access, there are many ethnic minorities who are protected against suicide. Since 1996, when I was last here to talk to you about elderly suicide, we now have more investigators examining protective factors, such as religious beliefs and social supports that seem to help certain cultural groups.

In 1996, we described how late-onset depression was the most common medical condition among elderly suicides. As several of you have noted already in your press releases, over 70 percent of older adults have been to their primary care provider in the month which they die.

More research has confirmed this since, but we also now know, as Dr. Katz just said, "that depression detection and treatment is woefully inadequate in those settings." More research is needed to figure out how to improve detection and treatment in late-life depression in the primary care setting.

In 1997, the NIMH set aside funds to test models of depression and suicidality recognition and treatment among older adults in the primary care setting. The outcome of this was the request for the support of the three-site study that Dr. Katz referred to, the PROSPECT study. This is the most directly targeted NIMH research investment in terms of reducing elderly suicide. But the investment in studies of aging and suicide have also doubled over time in the past 7 years. In fact, the NIMH portfolio on aging and suicide research has outpaced overall NIMH funding increases.

NIMH aging research has also shown that late-life depression can be deadly in other ways. Persons with heart attacks and depression, and persons with hip fractures, and depression are more likely to die than their non-depressed counterparts.

We have also learned more about a particular type of late-life depression that is due to small strokes called vascular depression. New research is acknowledging and, more importantly, preventing depression among persons threatened with blindness due to macular degeneration, and we are trying to figure out how to best prevent and treat depression in these conditions.

The prevention of depression in these conditions hopefully will allow people to function better in their day-to-day lives, and either maintain or improve their emotional well-being.

While there are many terrible outcomes from depression in later life, suicidality probably signals the greatest distress with regard to hopelessness and despair. Since 1996, we have substantially increased the number of funded treatment studies focusing on two important areas: one is reducing suicidal thoughts and behaviors specifically, and another area is expanding studies of treatments for mental illnesses to better reduce the suicide risk.

The second figure, illustrates that we are trying to increase the study's focus specifically on reducing suicide. This shows a dramatic 10-fold increase in those studies. What we have learned so far is that treatments focused specifically on targeting suicidal thoughts and behaviors suggest that that is a necessary step to reduce the risk.

The NIMH, along with the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, will likely soon announce a new research opportunity to create some developing centers to expand interventions for suicide prevention. This is in response to the IOM report, which Senator Reid mentioned, "Reducing Suicide: A National Imperative." We are hoping that this request will speed intervention research by promoting networks across centers, and this initiative could promote partnerships with community providers and organizations and provide infrastructure for career development for young investigators.

In closing, I want to emphasize that NIMH collaborates with other HHS agencies. That includes CDC, SAMHSA, IHS, FDA, HRSA, as well as with the Department of Veterans Affairs and Department of Defense, to work toward building additional scientif-

ically proven practices for preventing suicide. NIMH is also providing technical support to the Administration on Aging for their upcoming national summit conference in September. I am optimistic that we will soon have additional treatments to guide practice. But we need to work to see that these effective treatments are utilized. Depression and suicidality in later life are not normal features of aging.

Thank you for the opportunity, and I would be happy to answer questions.

[The prepared statement of Ms. Pearson follows:]

Testimony
Before the Special Committee on Aging
United States Senate

NIMH Research on Geriatric Depression and Suicide

Statement of
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For Release on Delivery
Expected at 2:00 PM on
Tuesday, July 28, 2003

I am pleased to have the opportunity to appear before you to discuss the National Institute of Mental Health's (NIMH) research efforts in the areas of geriatric depression and suicide. We at NIMH are very concerned about the alarming numbers of older adults who suffer from depression and thoughts of suicide, and—because they are too often undiagnosed and untreated—may go on to take their own lives. We understand the heartbreak that the tragedy of suicide causes families, and we want to pursue answers that we can use to prevent suicide and the hopelessness that precedes it. The NIMH Aging Consortium brings together relevant staff from across the Institute specifically to oversee NIMH's aging research portfolio, and to coordinate and strengthen overall efforts in this area. In addition, I chair the NIMH Suicide Research Consortium that oversees the suicide research portfolio.

In 2000, the most recent year national suicide statistics are available, 29,350 Americans took their own lives. U.S. suicide deaths outnumbered homicides (16,765) by more than 5 to 3, and there were twice as many deaths due to suicide than deaths due to HIV/AIDS (14,478).

In 2000, 5,306 persons aged 65 and older died by suicide. This was 18% of all suicides, even though the elderly only comprise 13% of the U.S. population. In the U.S. and other industrialized nations, older males have the highest rates of suicide. See Figure 1, which illustrates suicide rates by age and gender for Whites and African Americans. In this country, it is older *White* males with the highest rate, comprising 81% of all elderly suicides. White men age 80 and older have a suicide rate 6 times (59/100,000) the national average (10.6/100,000).

Here is what we have learned from analyzing death certificates. In addition to illustrating the high rate of elderly suicide, Figure 1 highlights the substantial difference in rates among older African Americans and White Americans. African American rates, particularly for females, are much lower. Consider how powerful this effect is given what we know about overall health care disparities between Whites and African Americans. Since 1996 when I was last here to talk to you about elderly suicide, we have more investigators examining protective factors among certain cultural groups. There is growing evidence to suggest that religious beliefs and social supports provide protection against suicidal thoughts.

In 1996 we described how late onset depression is the most common medical condition among older suicides, and that 70% of older adults have seen a primary care provider in the month before they die. Research conducted since then has confirmed these findings and has also indicated that older adults use methods that are more lethal. Dr. Donna Cohen, one of your expert panelists, will be describing these patterns in more detail. Recent reviews examining patterns of service use before suicide indicate that only about 10% of persons 55 and older had contact with a mental health care provider within a month of their suicide death.

Early indications of these patterns led NIMH in 1997 to issue the Request for Applications (RFA) [1], "Prevention of Suicidal Behavior in Older Primary Care Patients." The RFA requested applicants to test of models of depression and suicidality recognition and treatment. The

[1] A Request for Applications (RFA) is a formal statement that invites grant or cooperative agreement applications in a well-defined scientific area to accomplish specific program objectives. The RFA indicates the estimated amount of funds set aside for the competition, the estimated number of awards to be made, and the application receipt date(s). Applications submitted in response to an RFA usually receive a special review by an initial review group convened by the Institute that issued the RFA.

outcome of the RFA was the funding of a three-site study called **P**revention **O**f **S**uicide in **P**rimary care **E**lderly: **C**ollaborative **T**rial, or PROSPECT. This trial tests how the "collaborative care" model—typically a team approach involving nurses or social workers with physicians in primary care practices working to better manage chronic conditions—improves depression treatment through physician and patient education and follow-up.

About the same time PROSPECT was being fielded, several other studies of depressed elderly in primary care were also in the field, supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the Veterans Administration, and the Hartford Foundation. Dr. Ira Katz, who helped lead several of these efforts, is one of your expert panelists today, and he can describe these studies in more detail.

While PROSPECT remains the most directly targeted research investment in reducing elderly suicide, the NIMH portfolio on aging and suicide research has kept pace with overall NIMH funding increases. In 1996, NIMH spent $641,000 for support of studies of suicide in the elderly and $52 million in aging research. In 2002, NIMH spent $2.3 million for support of studies of suicide in the elderly, and $106 million in aging research, representing approximately a doubling of dollars in those 7 years.

In addition to studies focused on elderly suicide, we have learned from studies of medical illnesses and depression that late life depression can be deadly in other ways. There is now irrefutable evidence that persons with myocardial infarction and depression and persons with hip fractures who suffer depression are at significantly increased risk for death as opposed to their nondepressed counterparts. The potency of the effects of depression for increased risk for death is just as strong as smoking, obesity, or hypertension. We have also learned a great deal more about vascular depression, a subtype of late-life depression that was just beginning to be recognized in 1996. Vascular depression occurs in later life, and appears to be due to small but numerous cerebrovascular accidents (or "small strokes") that can occur in the parts of the brain responsible for mood regulation. Like other types of late-life depression, including those in people who have had depressive episodes earlier in their life, we now know that vascular depression responds to treatment with the same anti-depressant medications used with younger adults.

We are now beginning to fund research that is testing approaches to *preventing* depression among stroke victims, as well as persons threatened with blindness because of macular degeneration. Investigators are fairly certain that by preventing depression in these conditions, older persons will be able to function more fully in their day-to-day lives as well as having improved emotional well-being. Other advances in late-life depression research have come from powerful new technologies that have been developed to study the brain. For instance, researchers have used neuroimaging to identify brain receptors for serotonin, a neurotransmitter for mood regulation whose activity is increased by anti-depressant medications; also, as I mentioned above, the discovery of vascular depression depended on high-resolution magnetic resonance imaging (MRI) scans of the vascular structure of the brain. These and other new directions are described in NIMH's Strategic Plan for Mood Disorders called "**Breaking Ground, Breaking Through.**" While we still have far to go on decreasing stigma about

mental disorders in later life, the 1999 Surgeon General's report on Mental Health was a milestone in informing the public that good mental health is a fundamental part of health for all age groups.

Many of these depression and aging research advances came from NIMH centers focused on neuroscience or intervention and services research. These centers are important resources for "pilot testing" new research ideas, "hubs" that can link investigators in collaborative studies with other academic as well as community sites, and they provide rich training opportunities for both established investigators who are "re-tooling" and for new investigators.

Since 1996, we have substantially increased the number of funded treatment studies focused specifically on reducing suicidality. These include studies of treatments to reduce thoughts of suicide in the context of mental illnesses, as well as preventing another suicide attempt. Figure 2 illustrates an over 10-fold increase in funds awarded between 1996 and 2002. Early success with treatments that were focused specifically on targeting suicidal thoughts and behaviors suggests that this may be a necessary step to prevent future suicide risk, in addition to providing individuals adequate treatment for their mental or substance use disorder. To investigate this possibility further, NIMH, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) are collaborating on a soon to be released RFA on "Developing Centers on Intervention for the Prevention of Suicide." This RFA builds on recommendations from a 2002 Institute of Medicine report, **Reducing Suicide: A National Imperative**, which highlighted the limited evidence-based approaches for treating suicidal individuals, including older adults at risk. With NIMH, NIDA and NIAAA are also soon issuing a Program Announcement (PA), "Research on the Reduction and Prevention of Suicidality." This PA signals to the field needed areas of suicide research in risk, protection, and services, in addition to intervention research.

Other NIMH steps underway to increase knowledge in suicide prevention include efforts to: network neuroscience researchers who study postmortem tissue to share tissue samples and findings to understand more about the biological underpinning of suicide; gather information on how to more safely and fairly design and carry out trials with persons at risk for suicide (instead of excluding them as industry trials usually do); determine how best to help family members who have lost someone to suicide; and help States evaluate their public message campaigns on suicide prevention.

In closing, I want to emphasize that NIMH collaborates with the other Public Health Service agencies within the Department of Health and Human Services (HHS), as well as with the Department of Veterans Affairs and the Department of Defense, to build more evidence-based practices for suicide prevention generally. With regard to suicide prevention in the elderly, we are participating with the HHS Administration on Aging on providing technical assistance at an upcoming National Summit conference this September regarding recognition and treatment of depression, anxiety, and substance use in the elderly. I am very optimistic that the depression and suicide prevention research supported by NIH will soon be allowing us to make evidence-based practice recommendations. But that will not be enough. We will still need to overcome ageism and stigma around suicide and mental illness in later life; otherwise, these effective treatments will continue to be tragically underutilized. Hearings such as this help practitioners,

researchers, policy makers, and the public understand that depression and suicidality in late life are NOT a normal part of aging. Thank you for this opportunity. I would be happy to answer any questions you may have.

Figure 1.

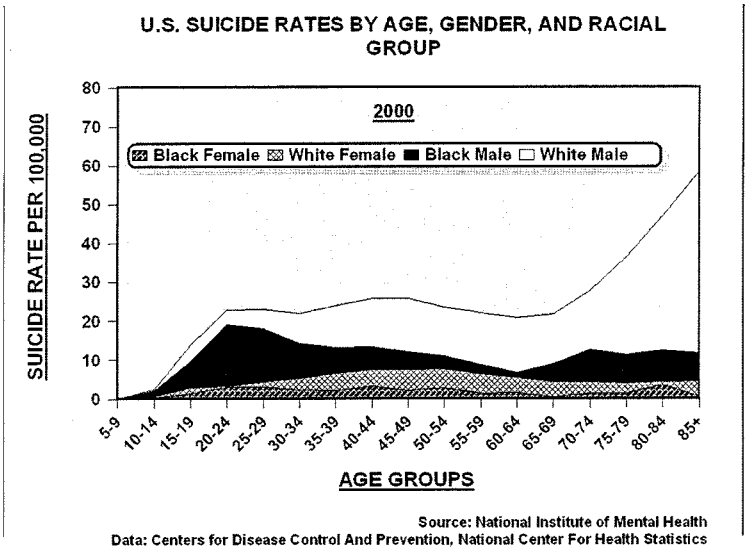
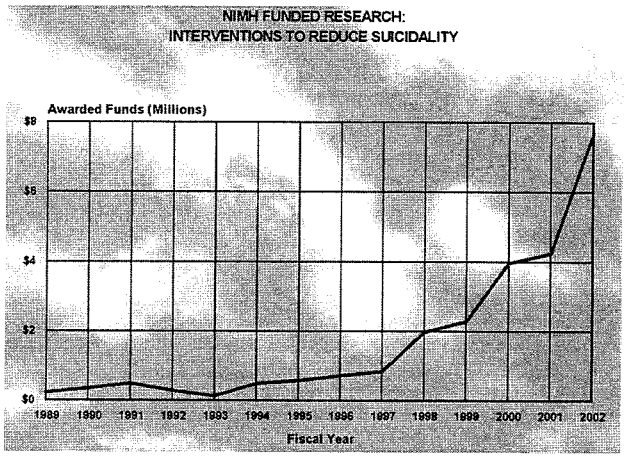

U.S. SUICIDE RATES BY AGE, GENDER, AND RACIAL GROUP
2000
Black Female
White Female
Black Male
White Male
SUICIDE RATE PER 100,000
80
70
60
50
40
30
20
10
0
5-9
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85+
AGE GROUPS
Source: National Institute of Mental Health
Data: Centers for Disease Control And Prevention, National Center For Health Statistics

Figure 2.


NIMH FUNDED RESEARCH:
INTERVENTIONS TO REDUCE SUICIDALITY
Awarded Funds (Millions)
$8
$6
$4
$2
$0
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
Fiscal Year

Senator BREAUX. Thank you very much, Dr. Pearson, and indeed, I thank everyone on the panel. We have had a good mixture of people, I would say, in the real world and in the professional world dealing with this important issue.

Can anyone give me a definition of depression? You want to try it? What is depression? What I am trying to find out: Is depression always an illness? Is it a state of mind that gets worse and becomes an illness? Is it an emotion? I mean, what is depression?

Ms. WAUGH. Can I answer that personally?

Senator BREAUX. Let me get them, then I will see how it applies to you guys.

Dr. COHEN. Depression has many faces. We all know what it is like to be lonely and sad. But depression is a disease of the brain, as has been stated here. We have consensus criteria for diagnosing depression, major depression, characterized by a lack of ability to feel pleasure. Older people often feel empty, lonely. There are bodily changes—gain of weight, loss of weight. In men, you can see more agitation. There are a series of criteria for the diagnosis major depressive disorders.

Senator BREAUX. Is it a physical condition?

Dr. COHEN. It is a physical condition. It is a disease of the brain. Just as a heart attack is a disease of the heart, depression is a disease of the brain Ira, do you want to talk about this.

Dr. KATZ. Yes, it is interesting. We can talk about the biology of depression, and there is a very powerful biology developing. But depression is also a disease of the mind and spirit as well as the brain.

The central question I think is: What is the difference between depression as an illness and normal sadness? What we like to teach about this is that anyone can get sad and anyone can get exhausted. But if we get stuck in a state of sadness and cannot get out of it, and if we get stuck in a state of exhaustion and no longer enjoy the things we usually do, then that is an illness.

Also, when that is disabling and when it leads to restriction of life space or decrease in acceptance of needed medical care, when it leads to disability and impairment, it really has to urgently be evaluated as a medical illness because it can be a fatal one.

Senator BREAUX. Anything to add, Dr. Pearson?

Ms. PEARSON. I think that is well said, and I also think that in late-life suicide, we are facing the challenge of figuring out when it is normal for older people think about death. As people reach the end of their lives, they do think about death. But the difference is taking your own life and feeling distress and despair about that.

So we are trying to figure out better ways of measuring that and helping physicians think that through and figure out ways of talking about that with older adults. So it is very important to understand how that works in a professional setting to make sure people aren't mis-alarmed about some things that are actually normal. I think Dr. Katz's point about when it starts interfering with the older person's functioning, it is a problem to address.

Senator BREAUX. Does anyone attempt suicide or commit suicide who is not mentally ill?

Ms. PEARSON. It is very rare. When I mentioned the 90 percent of people who die by suicide have a mental illness or substance

abuse, it can happen that there is no disorder, but it is often a precipitating event that distresses somebody, embarrasses them. They might impulsively act on it. It is unusual.

Senator BREAUX. Ms. Waugh, you had a comment on it from your perspective.

Ms. WAUGH. Well, you know, I think everyone suffers, you know, some depressed time. There is situational depression, and I have had it in my own life. But like the doctor said, when it continues, you know, like over 2 weeks, that becomes some kind of chemical imbalance, a brain disorder that needs to have some kind of treatment. It requires more than just a pill. It requires therapy. It requires change in lifestyle. Recovery is living the best possible lifestyle while you have the disease.

I said I still suffer depression, and that means that the symptoms still come up. I don't have to be afraid of them anymore. I still have suicidal ideation. But I know I don't have to act on it, I don't have to be afraid of it, because I have gotten tools about how to deal with my disease.

Senator BREAUX. One more question, and then I will let Senator Dole ask questions.

How treatable or how successful is treatment for depression, a proper regime, which I take it includes pharmaceuticals as well as other type of life adjustments? How successful is treatment of depression if it is done in a proper fashion? Anybody?

Dr. KATZ. Yes, I think our current evidence is that about 50 percent of patients remit, get better, with good treatment; and another 30 percent have a large degree of response for whom treatment makes a real difference.

Of the more severe depressions, there are still people that really are not helped yet, and that is why we need more research. One thing that we are learning, though, these are the results I am talking about for a course of treatment. The number of people that are helped from the first treatment, the first medicine or the first course of therapy, is really much smaller. One of the things we really have to learn is the importance of doctors, psychologists, other providers following patients, seeing those who get better and seeing those who do not, and if the treatment does not work, changing it.

Let me tell a story about my daughter. She is a nursing home administrator, and she talked about going on rounds in her facility and saying to some of the other people on the staff, "Hey, isn't Mrs. Greene depressed?" One of the nurses said, "Well, don't worry. Mrs. Greene is on an antidepressant. Let's go along and talk about Mrs. Harris." My daughter, bless her, said, "Hey, wait a minute, if Mrs. Greene is still depressed and she is on an antidepressant, we shouldn't move on. We should be talking about what else we should do for her." That is a message that we really have to deliver more and more.

Senator BREAUX. Senator Dole, questions?

Senator DOLE. Thank you, Mr. Chairman.

We are told that women experience chronic depression at about a 5:1 ratio to men, and, of course, that 80 percent of the suicides in the elderly are committed by men.

Help me understand these gender differences. How do services and interventions need to be altered to address the different ways that men and women handle depression?

Dr. COHEN. The gender difference, by the way, is unique to the United States. A World Health Organization survey of the world, there are questions about the accuracy of the reporting, reported for the year 2000, there were 1.6 million deaths, violent deaths. Almost 900,000 were suicides. Suicides accounted for more deaths than homicide and war put together.

In other countries, the rate is still highest for the population over age 60, but the available data indicate that there is no gender difference. So in the United States, I think your question is really well targeted. Women will talk more about their symptoms, will talk to their friends more. Men hold it in. Men will get anxious and talk about giving things away. They will not admit to their symptoms.

I think that across the panel you have heard that the issue really is accessibility of mental health services and having enough services to provide the care. Depression is treatable, Senator Breaux, but there are personal issues, compliance issues, in terms of the patient complying with these things. There are gender differences in the way men and women will accept services.

We also have a bias within the mental health system 3 percent of older people go to outpatient mental health centers. So we really have to deal with this ageism and this fatalism and the stigmatism in the broad community through education as well as through targeted research about these gender differences.

Senator DOLE. Any other comments on the gender difference?

Ms. PEARSON. Sure. Part of it is also the overall difference due to methods, where men are more likely to use firearms. But that difference is actually less in late life. There are more older women who use firearms than there are younger women. I also think Dr. Cohen is right. The whole help-seeking paradigm is very gender-specific, so the NIMH has a campaign to tell men it takes courage to go get help. It is a strategy consistent with the culture to go get help. So we are trying that, hoping that it is going to get the message out.

Senator DOLE. To those who—and thank you very much for sharing your personal experiences with us today. I would like to ask the two of you if you would just elaborate more on the signs that could have been recognized so that those around you might know that there was a need for help and intervention. There has been some mention in reading the materials of panic attacks. What exactly is this? What triggers of depression led you to attempt suicide? Help us to understand more about those signs.

Ms. GARDINER. I am trying to think about what led me to suicide. Everything and nothing—which does not make too much sense, but neither does suicide, really.

I had nothing to live for. My parents were dead. I was divorced. I had at that time two children. The world was just one big ball of slime. I could look in the mirror and not see anything. My family had long since disassociated itself from me. They did not understand mental illness.

I just did not have anything to live for, did not want to live, had nothing to live for, not my children nor—it was just nothing, absolutely nothing. My mental illness hurt me. Right in the middle of my belly, I envisioned a hole. I envisioned myself sinking in this hole. Sometimes the feet would come up and the head would meet, and they would sink in this whole, and I would be a big ball. Then I would have to be taken to a hospital. Just one of the most horrible things I have ever experienced in my life.

What led up to that? I wish I could tell you, Senator Dole. I really do.

Ms. WAUGH. Well, first of all, mental illness means we do not have a clear thinking, and hopelessness literally means that you feel totally alone and negativity is beyond anything that normal thinking would have negativity. It is like running a tape of every possible scenario of everything you did wrong, all the mistakes you have ever made, a lot of self-hatred happens with depression.

So fear and a lot of shame and anxiety, like you said, panic attacks, not being——

Senator DOLE. What is a panic attack?

Ms. WAUGH. OK. A panic attack is simply not being able to cope at the moment. The heart starts racing. I would get sweats. I would be afraid to leave the house. I can remember walking back and forth at the front door wringing my hands. I remember at one point calling a friend and saying—crying. I said, "I have to clean the bathroom, and I don't remember how." She literally walked me through it: Put some bleach in the toilet, call me back. Dah, dah, dah, call me back.

So, for me, panic attack wasn't about anybody else. It wasn't about crowds. It was just total overwhelm and not being able to think rationally.

Senator DOLE. Dr. Pearson, let me ask you if you would expand on a little bit on your written testimony, and you mentioned also here social supports, religious beliefs as a means to provide protection against depression and suicide.

Ms. PEARSON. Right.

Senator DOLE. I wonder, too, as people grow older, about the need to continue to feel relevant.

Ms. PEARSON. Absolutely.

Senator DOLE. In other words, to be involved in something bigger than yourself.

Ms. PEARSON. Right.

Senator DOLE. To feel you continue to contribute, and I think of organizations like Foster Grandparents and RSVP. I remember President Carter's mother, you know, joining the Peace Corps in her early 70's, I think. My mother, who is 102 years old, she has this heart for helping young people. So they will come and sit with her for 3 or 4 hours, and she is like a grandparent to a lot of these kids.

To what extent does this sort of continuing involvement help with the kinds of problems we are talking about here?

Ms. PEARSON. I think we are just beginning to understand that. We have had these statistics for years that showed this high risk distribution of older white males who we thought were isolated. Actually, about a third of them are still married when they kill them-

selves. But it is the style of being so independent and not wanting to rely on others, where I think women are more likely to be more interdependent, and you can translate that into different cultural groups where it is still very important to be a part of your community and feel like you are still needed and still essential.

With regard to what you heard here in terms of what precipitated thinking about suicide, some of the interventions we are funding at this point are trying to get people to think about why they should stay around and why they do belong, among are some protective factors, and trying to make that type of thinking at least equal or exceed why I should be gone. I think we could translate that into interventions in different cultural groups that is consistent with the culture, not to change the culture necessarily, but to say, OK, what is important within older men's culture that makes them feel like they belong, still think well of themselves, not say that it is bad to be interdependent, for example.

Durkheim, the French sociologist, talked about integration in society being a protective factor many, many years ago, but we just have not thought about it in terms of a clinical intervention, until recently. So we are finally looking at that.

Senator DOLE. Good. Dr. Cohen, to what extent are seniors included in clinical trials for new treatments and drug therapies for depression?

Dr. COHEN. I believe the overall inclusion of older people in clinical trials is only about 20 percent. It may be higher——

Ms. PEARSON. I don't think so.

Dr. COHEN. The nice thing about colleagues, they are there for you to back you up when the future looks pretty bleak.

We also, until recently, did not include women, older women——

Senator DOLE. Why not?

Dr. COHEN [continuing]. With the Women's Health Initiative. So it is critical to look at older people in these clinical trials because, you know, we are prescribing medications and older people use more medications than any other age group, and their bodies are changing.

Senator DOLE. Yes, I think it was Bernadine Healy who really, when she was head of NIH, did a great deal to get women included in clinical trials that particularly involved women, if it is osteoporosis or chronic depression. Women were not in the trials. Now that has changed. We need to see the same thing happen where our seniors are concerned.

Thank you, Mr. Chairman.

Senator BREAUX. Thank you, Senator Dole.

Is depression more common among any particular age category of citizens? Is there a difference in the amount of depression among older Americans versus middle-aged Americans versus teenagers?

Dr. KATZ. You know, there are really interesting findings that the current generation of older people is less vulnerable to depression than people in my generation and less vulnerable than my children's generation. This isn't true only right now, but if you follow suicide rates through the trajectories of these different cohorts of generations, you have seen it over time.

What this means is that our society and country is going to face a sort of double jeopardy, that as baby boomers age, there are going

to be more and more older people who are more and more vulnerable to depression facing the chronic medical and neurological illnesses of late life that are the major risk factors for depression. That is why we have to learn to deal with this problem now, or else we are really going to be in trouble when my generation begins to experience these problems.

Senator BREAUX. If depression is a physical mental illness, then can cultural interventions cure it? It would seem to me that if it is a mental disorder of the brain that something is out of whack, then you can have all the cultural interventions you want, but you are not going to cure the illness. It is still going to be there.

Ms. PEARSON. Well, like a lot of other mental illnesses and physical illnesses, sometimes you might have a genetic predisposition, but it is a certain environment where that gets expressed. So some prevention efforts, especially in young adults or in childhood, try to get more protective factors for children so they are not exposed to the stressful events that would lead to the illness exposing itself.

Senator BREAUX. But, I mean, does the environment cause it? I mean, a person who has just a terrible life situation, a family that is non-existent, abuse, et cetera, is that person more likely to have clinical depression which is a physical disorder than someone who is not?

Ms. PEARSON. I think they are probably more likely, but they are not destined to, and that is what scientists are beginning to understand now in terms of how the environment and genetics play at together. That is actually a very powerful model now to figure out what does happen to certain sub-groups; what might be unique about them in terms of their constitution, what made them more vulnerable, and then looking at people who seem to be so resilient who suffer all these stresses. What makes them different and what makes them more resilient.

So I think we are beginning to understand some of those clues. We are getting a little bit of information on what areas of genetics to explore but we still have a long ways to go.

Senator BREAUX. Let's talk about how easy it is to diagnose it. One of the things we are going to do with Medicare, which is not required now, is to require that anyone who comes into the Medicare program, as a prerequisite to getting in on Medicare, has to have a complete physical. Many people come on Medicare and don't ever see a doctor over the next 5 years, when they really should have at least a baseline study on who they are, what they are, what their conditions are when they start the program. They should have it a lot sooner than that. We just don't have a way of requiring it, but we can at least require it on the Medicare program.

But how difficult is it to diagnose it for a person who may not be a specialist in depression? I take it that if we require every senior to go to a general practitioner for a baseline physical before going into the Medicare program, that is not going to catch a lot of depression.

Dr. COHEN. Currently, in the primary care system, 80 percent of depression is missed in the old, and it is 50 percent for all age groups. One of the key issues that my colleagues have brought up is the issue of training in the primary care community. Since so

many older people see a primary care practitioner before they commit suicide, there are data showing that if physicians do screening in their offices, you can increase the detection of depression. But we also have to teach them proper treatments and the complexities that are involved.

We also have to get older people to talk about their depression, because they are a partner in this dialog.

Senator BREAUX. Is it easier to diagnose in a younger person or a middle-aged person versus an older American?

Dr. COHEN. Depression—and let my other colleagues address this as well. There are standards for diagnosing depression. They can be taught. You can improve detection and improve treatment. This is not something that requires, you know, technological imaging studies, although that is essential to some of the research.

Dr. KATZ. Yet the statistics are that if you do the test, i.e., if you ask the person, "Are you depressed?" and "What have you enjoyed doing lately?" the diagnosis of depression can be made just as well as the diagnosis of hypertension or diabetes.

The issue is that the test is a conversation, and it takes time. As you know, the current medical system is biased against the low-tech of this sort of conversation towards a high-tech of blood tests and machines and all. One of the things that will have to be done to improve the recognition is to incent in some financial or non-financial way doctors' spending time with patients to be able to know.

Senator BREAUX. I take it that a CT scan or an MRI cannot identify depression.

Dr. KATZ. Right.

Ms. PEARSON. Right.

Senator BREAUX. Because if you have heart disease or diabetes or any other disease that is prevalent among seniors, I take it even Alzheimer's to a certain extent, you can find out through clinical testing, but I guess with depression you cannot.

Dr. KATZ. Not yet.

Senator BREAUX. Is there a standard form of treatment that is now available? Or is it just open shop on what you want to try?

Ms. PEARSON. There are treatments and part of the PROSPECT study used an algorithm that used the best treatments known. As people have already referred to this, I think Dr. Katz was saying you really have to think through—try your first-line treatment. You probably want to minimize side effects. Then you go to the next-line treatment if that does not work. I think it——

Senator BREAUX. What is the first line of treatment?

Ms. PEARSON. It is probably a type of serotonin reuptake inhibitor because it minimizes side effects, and there are different ones that have different types of side effects.

Senator BREAUX. Say that again, because I want to make sure she gets it down for the record.

Ms. PEARSON. Sure. It is a serotonin reuptake inhibitor.

Dr. KATZ. Or a brief psychotherapy.

Ms. PEARSON. It could be psychotherapy as well.

Dr. KATZ. Depending on the severity of depression and the patient and family preference.

Senator BREAUX. How effective is the proper utilization of drugs to treat depression?

Dr. COHEN. They are very effective if they are used appropriately. There are 40 to 50 antidepressant medications.

Senator BREAUX. How many?

Dr. COHEN. Over 40 or 50 antidepressant medications. We mentioned the SSRIs, the serotonin reuptake inhibitors, which, as Dr. Pearson said, don't cause the serious side effects which affect compliance. But we are getting, you know, good information on the efficacy of psychotherapy with depression. In minor depression, self-help books have been shown to improve depressive symptoms.

The issue really comes down to, again, the training of the primary care community and the lack of manpower. All these antidepressants probably are about equally effective, but we just don't know who they are equally effective with. So we have to play around with the medications and start off, and if the treatment does not work——

Senator BREAUX. Well, there is a huge lack of geriatric training among all of our doctors. We have only got—what?—two or three medical schools that even require geriatric training or offer degrees in geriatrics. It is just a huge problem.

Let me ask Ms. Waugh and Ms. Gardiner, what was the best treatment that you had? Was it the drugs that they may have put you on, or was it any clinics that you went to?

Ms. WAUGH. It is a combination of both, but I have to tell you that we are trial and error with most of our psychiatrists, even, and it depends on what particular drug they have been given to try.

Senator BREAUX. Did you try several before you found one that was more——

Ms. WAUGH. Yes. My psychiatrist gets a rep coming who says, "Try this," and so he says, "Let's try this." I mean, I was on ten particular antidepressants before we found something without horrible side effects for me. I gained 50 pounds on one. I was totally nauseated all the time on another. I was agitated on another. I mean, I could go on.

Luckily, I did not have a lot of other physical problems that prohibited me from having the strength to go through this. I cannot even imagine what it would be like to be on six or seven other medications that probably have some contraindicative side effects and have an insurance company that allowed me maybe 6 minutes with my doctor, and during that time I had to tell him about my knee, about my heart problem, about maybe inactive kidneys or whatever. So I am not going to have time to deal with the other, so I will probably stop taking these medications that make me feel so terrible.

Senator BREAUX. But you finally found one that was effective?

Ms. WAUGH. Absolutely. I am so grateful. But we are talking over a 3-year period.

Senator BREAUX. Ms. Gardiner, what was the most effective for you?

Ms. GARDINER. I went through pretty much the same thing as Diana did, plus I was drinking. There was no therapy involved. I

just went and talked to this guy, a doctor, and he gave me some pills. I went to State store and bought some booze.

Intervention in my life came, truly came when I met some folk who really cared about me, the 12-step group. They let me be among them to see how they did things. There was a psychiatrist in this 12-step group who had been sober for some time, and he took me aside. Between the medication he gave me and the therapy and the 12-step group, here I am today.

Senator BREAUX. Is that a pretty common story as far as treatment? There has got to be a little bit of everything, right?

Dr. KATZ. Yes. You know, we talk about integrating mental health and medical care as an important issue. Two other very separate systems are mental health and alcohol or substance abuse care. So if I as a middle-aged person get a heart attack, get depressed over it, and try to treat my depression by drinking, I will have to go to three separate systems in order to get care. It just cannot be done.

Senator BREAUX. Well, all of this——

Ms. WAUGH. I just wanted to say that for me it is a combination of three things: I go to individual therapy; I am in a group so that those people can help me gauge when I am starting to slip, and they can always recognize it sooner than I can; plus I have medication and I see my psychiatrist for med checks monthly.

Senator BREAUX. Well, all of you have been very helpful. I particularly thank Ms. Gardiner and Ms. Waugh for giving us your personal experiences. There are millions that I think have probably had the same experiences to an extent as you have described here today. So your testimony really has the potential to affect many millions of Americans, and we thank you for telling your story. It is very important that you did this.

To our professionals, we thank you for the work that all of you do. It is incredibly important. This is a problem that is enormous, and with the baby-boom generation soon to become eligible for all of our senior programs, it is going to even be a greater challenge in the future. We thank you for your help and your assistance.

With that, this hearing will be concluded, and we will stand adjourned until the further call of the Chair.

[Whereupon, at 3:29 p.m., the committee was adjourned.]

APPENDIX

Statement of Mark Pope, Ed. D.
President, American Counseling Association

Before the Special Committee on Aging
United States Senate

Hearing on
Senior Depression and Suicide
Monday, July 28, 2003

Chairman Craig, Ranking Member Breaux, and members of the Committee, on behalf of the American Counseling Association (ACA), the nation's largest non-profit membership organization representing the counseling profession, thank you for the opportunity to submit a statement for the record on this important hearing. ACA is committed to improving Americans' access to high quality mental health services, including for older Americans. All too often, mental health services are an afterthought for this highly at-risk population.

To explain who we are, licensed professional counselors (LPCs) are master's or doctoral level mental health providers, licensed or certified as mental health professionals in 47 states and the District of Columbia. Under the typical standards required for licensure, counselors must complete a master's degree in counseling, accumulate two years and 3,000 hours of post-master's supervised clinical experience, and pass a national examination. Licensed professional counselors practice in a variety of settings, including private practice, clinics, community and rural health centers, agencies, health plans, hospitals, and group practices.

We commend Senator Breaux for calling today's hearing. Too often the issue of mental illness among our country's aging population is swept under the rug as the statistics continue to worsen. Members of this committee must recognize that mental illness is real, diagnosable, and treatable. The 1999 Surgeon General's Report on Mental Health estimated that 20 percent of all seniors and 37 percent of those who seek medical care suffer from depression[1]. This staggering figure leads to increases in costs of medical care, strain on family and caregivers, and risk of suicide. According to testimony presented before this committee in 1996, Medicare enrollees with untreated severe

[1] *Mental Health: A Report of the Surgeon General*, 1999. Rockville, MD: U.S. Department of Health and Human Services.

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depression experience general health care costs roughly 91 percent greater than those without depression, and it is estimated that if only 25 percent of Medicare enrollees with depression were effectively treated, the system would save about $500 million per year.[2]

Seniors are not getting the treatment they need for mental health, and they are quite literally dying as a result: those over age 65 are more likely to commit suicide than any other age group[3]. Of the elderly who commit suicide, more than 70 percent had visited a primary care physician within the month before their suicide, and 20 percent had done so the same day[4]. Physicians often do not have the training to recognize the symptoms of depression and other mental disorders among seniors, and if they do, often have only limited knowledge of psychotropic medications and their proper use. It is very important that older Americans and all Medicare beneficiaries have coverage for prescription drugs, including psychotropic medications. However, psychotropic drugs are not always the best course of treatment, and often have unpleasant and unexpected side effects which make them unattractive as treatment options. The use of such drugs in place of or without being accompanied by outpatient therapy may become an increasing concern among older Americans.

Despite significant advances over the past few years in both outpatient psychotherapies and psychotropic drugs, Medicare's mental health benefit has hardly changed since it was first implemented a generation ago, and consequently there are significant shortcomings in Medicare's mental health benefit. Medicare requires beneficiaries to pay 50 percent of the cost of outpatient mental health treatment, as compared to the 20 percent copayment required for all other outpatient services. As a result of its meager benefit package, over 80 percent of Medicare mental health spending goes to inpatient treatment.

As importantly, Medicare does not cover the services of licensed professional counselors or marriage and family therapists, two core mental health providers with education and training similar to clinical social workers, a group that has been covered by Medicare since 1989. Failing to reimburse licensed professional counselors for services provided to Medicare beneficiaries deprives seniors of the services of over 80,000 counselors licensed nationwide. Medicare's limited list of mental health providers presents another obstacle for seniors to overcome before they can access mental health treatment. Less than three percent of older Americans report seeing mental health professionals for treatment, the smallest percentage of any age group[5]. In many counties, licensed professional counselors are the only mental health providers available, but due to Medicare's policies, seniors have to drive long distances to access treatment, pay a counselor out-of-pocket, or go without treatment.

This is an acute problem in America's rural and underserved areas, especially when seniors have limited access to reliable transportation. According to the recently released report by the President's New Freedom Commission on Mental Health, "Virtually all of the rural counties in this country have a shortage of practicing psychiatrists, psychologists, and social workers. These professional shortage problems are even worse for children and older adults"[6]

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[2] Senate Committee, *Treatment of Mental Disorders in the Elderly*, 78.
[3] Senate Committee, *Treatment of Mental Disorders in the Elderly*, 2.
[4] National Institute of Mental Health. *Older Adults: Depression and Suicide Facts*, 2001. NIH Publication No. 01-4593.
[5] U.S. Administration on Aging. *Older Adults and Mental Health: Issues and Opportunities*, 2001, 11.
[6] President's New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America*, 2003, 51.

Patient choice of provider is important in all forms of health care, but perhaps is most important in the area of mental health treatment. Under current Medicare law beneficiaries are precluded from seeing licensed professional counselors, even though an LPC may be the beneficiary's first choice of provider. Anecdotal evidence suggests that many older Americans feel more comfortable seeing a counselor than a psychiatrist or a psychologist, or than confiding highly personal mental or emotional problems in his or her primary care physician. In many cases, counselors with good working relationships with primary care or other physicians have older patients referred to them by the physician, and must inform the patient that counselors' services are not covered by Medicare. This fact usually comes as a surprise to the physician.

ACA strongly supports legislation introduced by Senators Craig Thomas (R-WY) and Blanche Lincoln (D-AR)—S. 310, the "Seniors Mental Health Access Improvement Act"—as a cost-effective way of improving beneficiaries' access to care. The legislation would establish Medicare coverage of state-licensed professional counselors and state-licensed marriage and family therapists for medically necessary outpatient mental health services. The legislation was recently included as part of the Medicare prescription drug coverage and reform legislation passed by the Senate, S.1.

Coverage of LPCs under Medicare would not represent the addition of a new type of benefit. Counselors provide the same types of psychotherapy and counseling currently provided under the program by psychologists and clinical social workers, and under S. 1, Medicare would only reimburse LPCs for those services that are deemed medically necessary. The legislation would reimburse LPCs and marriage and family therapists at the same rate as clinical social workers, which is less than the rate charged by psychologists and physicians.

As Congress considers ways to modernize Medicare's medical benefit, it should also do so in the area of mental health care by establishing coverage of state-licensed professional counselors. Medicare beneficiaries deserve the same choice of provider and access to high-quality services as is enjoyed by those with private insurance. Current Medicare policy is not meeting the mental health needs of its enrollees.

We thank the committee for its attention to this important issue. We look forward to working with Congress to improve older Americans' access to high-quality clinical mental health services. Licensed professional counselors are an as yet untapped resource in helping care for America's aging population.

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