Art Walaszek, M.D.
University of Wisconsin School of Medicine and Public Health
Testimony before the United States Senate Special Committee on Aging
"A Generation at Risk: Breaking the Cycle of Senior Suicide"
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Mr. Chairman, Ranking Member Kohl, and Members of the Committee:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you for the opportunity to testify before you.