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

Mr. Chairman and Members of the Committee:

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

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

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

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

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

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

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

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

The Geriatrics Workforce

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

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

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

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

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

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

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

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

The Challenge for Academic Medicine

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

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

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

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

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

Recommendations for Federal action.

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

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

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

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

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

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

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

Conclusion

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

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