STATEMENT

of

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before the

Special Committee on Aging

United States Senate

Suicide among Older Americans

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Mr. Chairman and Members of the Committee:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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