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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.

Older Suicides occur in Primary Care Patients

From the MIRECC at the Philadelphia VAMC
Data from medical records and National Death Index for 1998

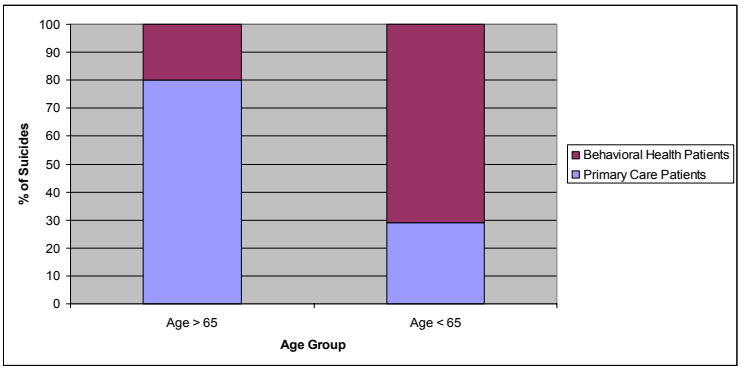


Figure 2.

Treatment Decreases Suicidality

Effect of PROSPECT on Suicidal Thoughts

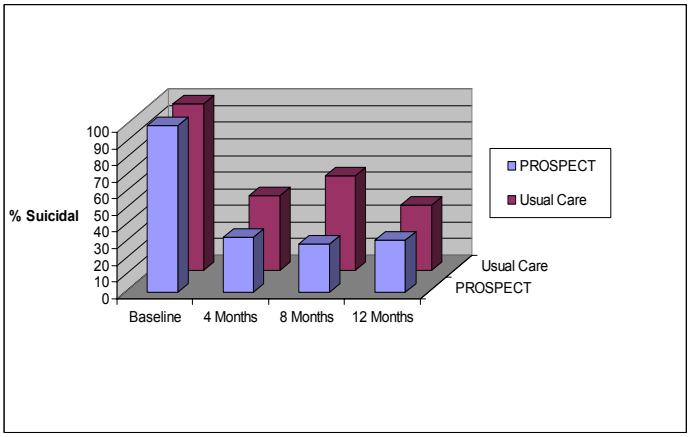
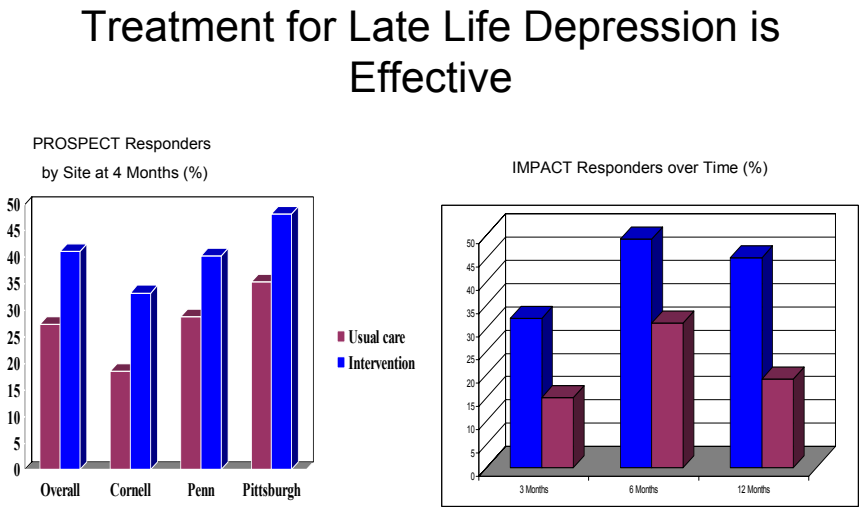


Figure 3.


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
Penn
Pittsburgh
Usual care
Intervention
IMPACT Responders over Time (%)
3 Months
6 Months
12 Months