

PROGRESS

Excerpt from PROGRESS – Summer, 2009

Interview with Dr. Harold Schwartz regarding The Depression Initiative

With the help of philanthropy, Hartford Hospital has launched the Depression Initiative – a groundbreaking effort aimed at enabling people with depression, bipolar disorder or anxiety disorders to achieve not just improvement, but full, functional recovery. In the following interview, Harold (Hank) Schwartz, M.D., Vice President, Behavioral Health and Psychiatrist-in-Chief at the Institute of Living (IOL), talks about the program and why the IOL is well positioned to take the lead on such an initiative.

Q. Why the Depression Initiative and why now?

A. Depression is one of the most pervasive and disabling disorders experienced by people with mental illness. The World Health Organization has determined that depression is the single greatest cause of disability, affecting the well-being of people around the world and the economies of all nations. This is the time to focus on depression. Years ago, the Institute came together around the Schizophrenia Initiative, creating a philanthropic base that enabled us to build off skill sets we had in place and to develop new skill sets. This effort led to the creation of the Olin Neuropsychiatry Research Center and multiple programs for individuals with schizophrenia, including the Family Resource Center and the Schizophrenia Rehabilitation Program. That really has made us a national leader in schizophrenia research and services. What we're doing with the Depression Initiative is capitalizing on the same kind of process. We are saying to the philanthropic community, with your help we can do in depression what we have done with schizophrenia and become a national leader in the development of research and clinical programs in depression, bipolar and anxiety disorders.



*Harold I. Schwartz, MD
Psychiatrist-in-chief and Vice
President of Behavioral Health,
Hartford Hospital / The Institute
of Living; Director, Department
of Psychiatry*

With our research processes and a very sophisticated and world renowned group of researchers, we're very well positioned to put our time, effort and energy into a very significant expansion to build a research enterprise in depression.

Q. What strengths enable the Institute of Living to take the lead on such a bold initiative?

A. The Institute has four well-developed research centers. The Burlingame Center for Psychiatric Research and Education and the Braceland Center for Mental Health and Aging, both

established with endowments in the 1980s, have provided the bedrock for our research over the past 20 years in many areas – psychometrics, depression, and health services research are examples. The Braceland Center is currently engaged in a major program following patients with dementing illness as their condition progresses into Alzheimer’s disease over time. In the last decade, we have established the Anxiety Disorders Center and then the Olin Neuropsychiatry Research Center, both created with significant support from philanthropy. In the Olin Center, we combine sophisticated brain imaging using the state’s first 3 Tesla MRI high resolution research scanner with advanced genetic techniques. There, under the direction of Dr. Godfrey Pearlson, we also have a group of exceedingly sophisticated researchers in place doing a range of work in schizophrenia, autism, dementing illness, substance abuse, and affective disorders. In the Anxiety Disorders Center, under the direction of Dr. David Tolin, we have a smaller but very sophisticated and effective research group studying the effectiveness of Cognitive Behavioral Therapy in various disorders.

We have the infrastructure and a group of sophisticated researchers who have developed the information systems for cataloging and collecting data and the protocols for recruiting patients, and who are able to mentor others in terms of the development of research protocols and grant submissions. That is an enormous strength that positions us to grow and move into other areas. We’ve done research into depressive disorders for many years, but we’re talking now about taking the next step into very large-scale, federally-funded projects. We can do that by expanding our research infrastructure, including new facilities and new equipment, and developing a clearinghouse using new hardware, software and personnel to track every patient and every patient treatment plan in order to maximize the integration of research and clinical programs.

Q. Is there an education component within the Depression Initiative that will help diminish the stigma surrounding these mental health issues?

A. Absolutely. One goal of the Schizophrenia Initiative was education and stigma reduction. From the philanthropic dollars, we created the Family Resource Center, which provides a service that is purely educational to family and friends of individuals with mental illness, helping them to understand and cope with the illnesses of their loved ones. Our hope is to expand the concept through the Depression Initiative to have an equivalent focus on individuals and families dealing with depression, bipolar and anxiety disorders.

One of the programmatic developments of the Depression Initiative will be the establishment of a Cognitive Behavioral Therapy Institute. Cognitive behavioral therapy (CBT) is probably the most evidence-based psychotherapy in practice today, with more sophisticated research examining its processes, techniques and outcomes than is the case for any other type of therapy. The science is quite clear – this type of therapy is unquestionably effective and efficient in terms of ongoing results. We are regional leaders in terms of providing cognitive behavioral therapy within the Anxiety Disorders Center, where it is a primary therapeutic tool and the subject of research.

We want to take the skills we have and expand them – we’re already doing that now, providing an annual ongoing symposium in CBT to train our staff to ensure it spreads out to the entire campus. We want to create an institute to provide training to the community and region at large, which will be a significant educational enhancement. As we move forward, we’d like to find donors who have an interest in community education and work with them to establish the kind of

initiative that would really highlight for the public the presence and the prevalence of depression and the availability of effective treatment.

Q. Five years from now, how will things be different for those suffering from depression, bipolar and anxiety disorders? What role will the IOL have played in that?

A. In just the next few years, the treatment for depression is going to look very different, starting with pharmacotherapy. Through our collaboration with Genomas and Dr. Gualberto Ruano, we have become leaders in the movement to bring in genetic assessment of appropriate pharmacotherapy for patients with depression. We have moved into the era of DNA-guided personalized medicine, able to determine which medication is most appropriate for which patient on the basis of genetic predisposition. Until recently, treatment for depression essentially required guesswork regarding which medication to use. One patient might take a medication but, having a genetic insufficiency of the enzymes necessary to metabolize the drug, would suffer troubling side effects. Another patient might be a rapid metabolizer and have virtually no therapeutic effect because it is broken down in the system so quickly. Within the past few years, with the application of personalized medicine through genetic testing, we have increasingly been able to avoid the consequences that result from either case by developing better choices of medication tailored to individual patients.

In addition, we're seeing a transition to newer technologies that hold great promise. As part of the Depression Initiative, we have established the first hospital-based transcranial magnetic stimulation (TMS) service in the state. This painless procedure utilizes electromagnetic radiation to induce an electrical current in the cerebral cortex that produces significant improvement in depressive symptomology for patients who fail to respond to a prior course of medication. This is a very significant development. I think it is inevitable that if TMS proves to be as effective as we believe it is, it will be used as a first line treatment by those whose preference is for treatment not requiring a pharmaceutical agent. And given the extremely low incidence of side effects and adverse events reported with TMS, ultimately it may become very widely selected by many patients struggling with depression.

Unfortunately TMS is an expensive procedure which is so new that it is not yet being reimbursed by most insurers. Enhancing access to treatment is another goal of this initiative. While we are encouraged that ultimately insurers will reimburse us, as with all new technologies it can take years to reach that goal. Our hope is to attract donors who would like to see this service be available over the next year or two through scholarships to people who could not otherwise afford it.

Another new program will be our Depression Evaluation Service. Most psychiatrists are good at treating routine depression, but by the time someone has failed to respond to two, three or four courses of medication, the cost in terms of pain to the patient and family, morbidity, impact on the community and, sometimes, even suicide is enormous. And the knowledge base necessary to evaluate what the next step ought to be is fairly significant. We're already a leader in this area, but we want to create a focus on consultation for treatment-resistant depression that would look at a variety of ways of assessing the patient that haven't worked their way into routine practice. This ranges from psychological testing and, when necessary, neuropsychological testing to a variety of complex medical assessments, to the use of genetic testing, brain imaging and consultation with a variety of colleagues in all the mental health disciplines. This is a level of assessment that, again, is not routinely provided and not routinely reimbursed, but which we feel

is a necessary component to establishing a full continuum of care for people suffering from depression.

Q. What role has philanthropy played in establishing The Institute of Living as a center of excellence, and what role will it play for the Depression Initiative?

A. The research enterprise at the IOL has always been supported by philanthropy. We wouldn't have the Braceland Center and the Burlingame Center, our two building blocks, were it not for the significant endowments that underlie their establishment and ongoing operations. Without philanthropy, we wouldn't have the Olin Neuropsychiatry Research Center or the Anxiety Disorders Center – research enterprises that in less than 10 years have generated over \$30 million in federal funding. We wouldn't have the Memory Disorders Center, an outstanding clinical assessment program within the Braceland Center or the cognitive behavioral therapy that is available in the Anxiety Disorders Center. We wouldn't have cutting-edge programs like the Schizophrenia Rehabilitation Program, which evolved directly from the findings of our pilot research studies about the role of attention, concentration and short-term memory in schizophrenia. We would not have any of these without the philanthropy generated by the Schizophrenia Initiative and the fund development that preceded it over many years. We could not have the learning, scholarly, research environment that is moving the science of psychiatric treatments forward and advancing our treatment programs. Without philanthropy we wouldn't have become one of only a handful of centers in the nation where genetic testing is moving into routine practice.

And without all of these developments we certainly would not have been recognized by *US News and World Report* for the third year in a row as one of America's top psychiatric hospitals.

People who come to the IOL – patients, families, employees, trainees – realize that this is a learning institution, an environment in which we pursue and employ new knowledge and hold ourselves to the standard of being leaders, at the cutting edge of everything we do. We could not do that without philanthropy and we are very grateful for the generosity our community has shown us. We believe that's the kind of behavioral health institution that Hartford Hospital and our community deserve; and, indeed, if that's the kind of IOL that our community would like to see, that's the kind of IOL we believe our community must support.

*Choose a Hartford Hospital Doctor
It could be the most important decision of your life.*



PROGRESS