



# PROSPECT

## Program Description

The Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) intervention combines treatment guidelines for community-dwelling elderly populations with care management for patients diagnosed as depressed. Guidelines consist of a clinical algorithm for treating geriatric depression in a primary care setting, with citalopram being the first-line recommendation for pharmacotherapy. Care management is conducted by a “depression care manager” who works with the primary care physician (PCP) and a supervising psychiatrist. As described in the PROSPECT protocols:

“In PROSPECT, a specially trained master-level clinician works in close collaboration with a depressed patient’s PCP to implement a comprehensive disease management program. When a patient had been diagnosed with a depressive syndrome that requires treatment, PROSPECT health specialists implement the various clinical tasks necessary for a successful treatment outcome, including educating older depressed patients and their family about depression, identifying and addressing comorbid physical and psychiatric conditions interfering with antidepressant treatment, monitoring adherence, managing treatment-emergent adverse effects and regularly assessing change in depressive symptoms to evaluate whether the current treatment is effective or whether it needs to be modified” (Mulsant et al., 2001, p. 586).

## Evaluation Design & Outcomes

Bruce et al. (2004) used a 2-group randomized controlled trial design to examine the impact of the PROSPECT program. Primary care practices were the unit of randomization. Outcomes included the following:

- Program participants demonstrated statistically significant reductions in suicidal ideation at 4- and 8-month retesting when compared with the treatment-as-usual group. This result was greater for those diagnosed with major depression than for those diagnosed with minor depression.
- Program participants also demonstrated statistically significant reductions in depression at 4-, 8-, and 12-month retesting when compared with the treatment-as-usual group. Differences were most pronounced at the 4-month follow-up and for those diagnosed with major depression.

The authors conclude that “The principal finding of this multisite, randomized primary care trial is that suicidal ideation resolved more quickly in patients from practices randomly assigned to receive the intervention compared with patients receiving usual care...The impact of the intervention on depressive symptoms was greater among patients with major depression than for patients with mild depression unless suicidal ideation was also present” (Bruce et al., 2004, p. 1088).

## SPRC Classification

Effective

<b>Program Characteristics</b>
Intervention Type <b>Treatment</b>
Target Age <b>60 +</b>
Gender <b>Female &amp; Male</b>
Ethnicity <b>Multiple</b>
IOM Category <b>Universal Selective Indicated</b>

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## **Generalizability**

The study sample (n = 598) was comprised of 428 women (72%) and 194 ethnic minorities (27% African-American, 3% Hispanic, 1% Asian, and 2% other). Four percent of the sample fell below the poverty line.

## **Implementation Essentials**

Implementation essentials include standardized treatment protocols, adequately trained depression case-managers, and a supervising psychiatrist.

## **Targeted Protective and Risk Factors**

The PROSPECT intervention impacts the following risk and protective factors that have been targeted by the *National Strategy for Suicide Prevention* for the reduction of suicide in the United States.

### ***Increased Protective Factors***

Effective clinical care for mental, physical, and substance abuse disorders  
Easy access to a variety of clinical interventions and support for help-seeking

### ***Decreased Risk Factors***

Barriers to accessing health care, especially mental health and substance abuse treatment  
Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders

## **Program Costs**

An analysis indicated that the average direct cost per patient of the care manager's time was \$156 for a 16-week program, excluding research tasks (Post, 2003, p. S39). This does not include any expense of the supervising psychiatrist's effort nor does it model any possible cost savings of reduced primary care physician time. Program costs undoubtedly will vary across settings.

## **Program Contact Information**

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## **References & Support Materials**

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