# Collaborative Care Helps Reduce Suicidal Ideation

BY DOUG BRUNK
*San Diego Bureau*

SAN DIEGO — Older adults with depression who received collaborative care from a primary care physician and a care manager had significantly less suicidal ideation compared with their counterparts who received usual care, results from a 2-year study have demonstrated.

The finding supports the use of collaborative care to reduce the risk of suicide in elderly patients, Jürgen Unützer, M.D., said at the annual meeting of the American Association for Geriatric Psychiatry.

Less than 10% of older adults with depression see a mental health professional. And when a primary care physician refers an older adult to a mental health professional, only about half follow through on the referral, said Dr. Unützer, professor and vice-chair of the department of psychiatry and behavioral health sciences at the University of Washington, Seattle.

In a randomized study, Project IMPACT (Improving Mood: Promoting Access to Collaborative Care), Dr. Unützer and his associates enrolled 1,801 older adults with a Structured Clinical Interview for DSM-III-R diagnosis of major depression and/or dysthymia to receive collaborative care for depression or usual care as recommended by their primary physicians. The 2-year study took place at 18 primary care clinics in five states.

Overall, 895 patients received usual care and 906 received collaborative stepped care at their primary care clinics. All patients were observed at baseline and at 3, 6, 12, 18, and 24 months. Patients in the usual care arm were told, "We're going to observe you, but you can do what you would normally do" for your depression, he said.

Patients in the collaborative care arm were encouraged to choose treatment in consultation with their primary care physicians. Care managers—usually a nurse or a psychologist—helped physicians follow and manage these patients by providing patient education, monitoring symptoms via interviews, and administering the Patient Health Questionnaire–9. They also helped with treatment such as behavior activation, support of prescribed antidepressant medication, and brief psychotherapy.

**When a primary care physician refers an older adult to a mental health professional, only about half follow through on the referral.**

"We also added a consulting psychiatrist who would come to the clinic once a week for 1-2 hours and go over the caseload of all the patients these care managers were following and provide feedback on the care and, if needed, see a patient in consultation," Dr. Unützer added.

Overall, about 17% of patients in the study met criteria for major depression, 32% met criteria for dysthymia, and 53% met criteria for both. "This is a pretty depressed group of older adults," he said.

At 1 year, the percentage of patients in the usual care group who reported thoughts of suicide had risen from 13% to 16%, compared with a decrease from 15% to 10% in the collaborative care group. The rates were similar at 2 years: 14% for usual care and 10% for collaborative care.

In addition, between baseline and 1 year, the number of patients in the usual care group who reported having any bothersome thoughts about death or dying slightly improved from 58% to 51%, while patients in the collaborative care group greatly improved from 56% to 32%.

In surveys conducted 2 years after baseline, there was little change in the rate for patients in the usual care group (50%), but a higher number of patients in the collaborative care group reported having thoughts about death or dying (42%).

Dr. Unützer and his associates intervened 135 times for 108 patients whom they deemed at high risk for suicide. Of these, 89 times were for patients in the usual care group, while 49 times were for patients in the collaborative care group. There were no completed suicides.

Patient characteristics that were significantly associated with the rate of suicidal ideation at 1 and 2 years were advancing age, male gender, number of comorbid medical conditions, baseline anxiety status, baseline depression severity, and baseline overall quality of life. ■



**REFERENCES: 1.** Data on file. Pfizer Inc., New York, NY. **2.** Keck PE, Versiani M, Potkin S, West SA, Giller E, Ice K, and the Ziprasidone in Mania Study Group. Ziprasidone in the treatment of acute bipolar mania: a three-week, placebo-controlled, double-blind, randomized trial. *Am J Psychiatry.* 2003;160:741-748.