



Older Adults and Depression



Selecting EBPs

Understanding Permanent Supportive Housing

Selecting EBPs for Treatment of Depression in Older Adults describes what an evidence-based practice (EBP) is and presents factors to consider when choosing an EBP.

It also identifies which EBPs are available for older adults with depression and describes the available training resources. If implemented correctly, these interventions are more likely to reduce depressive symptoms in older adults than other interventions. These treatments have been developed, tested, and delivered in mental health, aging, and general medical health systems. Effective treatments include psychotherapy interventions, antidepressant medications, outreach services, and collaborative and integrated mental and physical health care.

This booklet will help you select EBPs from a range of different effective depression interventions to address the needs of your agency's or community's population of older adults. This booklet is relevant to:

- older adults and their families or caregivers,
- practitioners who care for older adults with depression,
- agency administrators and program leaders, and
- mental health, aging, and general medical health authorities.

What are Evidence-Based Practices (EBPs) for Depression in Older Adults?

Depression is one of the leading causes of world-wide disability. Untreated depression can lead to unnecessary suffering, poor health outcomes, high health care costs, and suicide.

Effective treatments can reduce the severity of depression in up to 80 percent of older adults. EBPs for treating depression in older adults include: psychotherapy interventions, antidepressant medications, multidisciplinary geriatric mental health outreach services, and collaborative and integrated mental and physical health care.

EBPs are interventions that have strong scientific proof that they produce positive outcomes for certain types of disorders. Other interventions – sometimes labeled promising practices – may also produce good outcomes, but research has not been conducted at a level to say that there is strong evidence for those practices.

EBPs for older adults with depression are important because their use can:

- reduce symptoms of depression,
- improve health, and
- improve functioning.

The selection of an EBP depends on the older adult's problems, the outcomes desired, and his or her treatment preferences. For example, both antidepressant medications and psychotherapy interventions are effective in the treatment of depression in older adults. The choice of one of these interventions over the other may vary with respect to the nature and severity of depression, prior history of effective treatments, the presence of other health conditions or medications, tolerability of side effects or required effort, and the preferences and personal values of the older adult regarding these treatment characteristics.

Definition of Evidence-based Practice

Evidence-based practice is the integration of the best research evidence with clinical expertise and patient values (Institute of Medicine, 2001).

This definition has been modified by others, but all focus on the ideas of *scientific proof or evidence* and on the use and principles of evidence-based practice.

Informed choice and shared decision making are a central goal of providing evidence-based mental health care. In order to meet this goal, practitioners should have information that describes the evidence for different interventions and should recommend them based on the individual needs and preferences of the older adult. Based on this information, the practitioner and the older adult can decide together which intervention to select.

Although many EBPs exist for older adults with depression, the extent of their availability varies across the country. Program managers and funders often are operating under severe resource constraints. This KIT provides guidance on selecting EBPs that will address the needs of older adults with depression and fit the context of provider agencies.

Levels of Evidence

Interventions that are considered EBPs have been established as effective through scientific research according to a set of explicit criteria (Bartels and Drake, 2005; Drake and colleagues, 2001). The level of evidence for an intervention depends on the way that research studies are designed and conducted.

When a study measures the effectiveness of an intervention, it is important to ensure that older adults who received the intervention did not improve for some other reason. Research designs do this by controlling for variables that could

contribute to the older adult's improvement. If the study was not designed well, it might seem that the intervention made people better when other factors may have affected the outcomes.

Some research designs compare one group of older adults who received the intervention (the experimental group) with another group that did not (the control group). If most of the older adults in the experimental group improved while those in the control group did not, one conclusion might be that the intervention is effective. However, significant differences between the two groups in age, sex, ethnicity, or other characteristics could affect the outcome. Researchers use specific designs called *randomized controlled trials* to control for such variables and address alternative explanations.

A randomized controlled trial is the gold standard for assessing the effectiveness of an intervention. As defined by Webster's New World Medical Dictionary (2003), a randomized controlled trial is "a study in which people are allocated at random (by chance alone) to receive one of several clinical interventions. One of these interventions is the standard of comparison or control."

Randomized controlled trials provide stronger proof of the effectiveness of the intervention than other types of studies. And when many such studies are conducted – in different locations, by different researchers, in settings that resemble the real world – the evidence builds up and is increasingly corroborated.

Quasi-experimental studies are defined similarly to the randomized controlled trial, except there are no random assignments to the different groups. This type of study is still useful in suggesting the potential effectiveness of an intervention, but the evidence is not as strong as in a randomized controlled trial. Without random assignment to the treatment and control groups, it is likely that differences in outcomes will be due to a variety of factors or "selection bias," in addition to actual differences that might be due to the treatment being evaluated. Studies which do not have a control group or random assignment have lower levels of evidence.

Levels of evidence are based on the study designs and the number of times the interventions have been evaluated. Different schemes exist to describe such levels of evidence. The American Psychological Association (APA) (Yon and Scogin, 2007) and the American Medical Association (AMA) (Guyatt and Rennie, 2002) have methods for identifying effective treatments or EBPs. The APA and AMA criteria were used when selecting EBPs to be included in this KIT. These are described later in this booklet in the sections on Psychotherapy Interventions and Antidepressant Medications.

The Substance Abuse and Mental Health Services Administration (SAMHSA) also classifies and describes effective programs in the National Registry of Effective Programs and Practices (NREPP). You can access NREPP at <http://www.nrepp.samhsa.gov>.

EBPs for Older Adults with Depression

Four types of EBPs for treating older adults with depression have been systematically evaluated using randomized controlled trials.

- **Psychotherapy Interventions:** Psychotherapy is a general term for a method of treating mental disorders by talking about mental health problems and related issues with a mental health practitioner. It's also known as talk therapy, counseling, psychosocial therapy or, simply, therapy or counseling. This KIT describes six psychotherapy EBPs, including cognitive behavioral therapy, behavioral therapy, problem solving treatment, interpersonal psychotherapy, reminiscence therapy, and cognitive bibliotherapy.
- **Antidepressant Medications:** Antidepressant medications are used to treat the symptoms of depression. Antidepressant medications act on chemical substances found in the brain, called neurotransmitters, which are deficient or out of balance in persons with depression.
- **Multidisciplinary Geriatric Mental Health Outreach Services:** Outreach services provide depression treatment in the homes of older adults or in the locations where older adults frequently spend time, instead of a clinic or office. These services often involve practitioners with different training and skill sets, such as psychiatrists, psychologists, social workers, nurses, or professional counselors. This KIT highlights two models of outreach services, including Psychogeriatric Assessment and Treatment in City Housing (PATCH) and the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS).
- **Collaborative and Integrated Mental and Physical Health Care Services:** These programs provide mental health care in the primary health care setting. Programs include collaboration between mental health and physical health care practitioners. This KIT highlights two models of collaborative care, including Improving Mood, Promoting Access to Collaborative Treatment (IMPACT) and Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT).

EBPs for Older Adults with Depression

- Psychotherapy Interventions
 - Cognitive Behavioral Therapy
 - Behavioral Therapy
 - Problem Solving Treatment
 - Interpersonal Psychotherapy
 - Reminiscence Therapy
 - Cognitive Bibliotherapy
- Antidepressant Medications
- Multidisciplinary Geriatric Mental Health Outreach Services
- Collaborative and Integrated Mental and Physical Health Care

Psychotherapy interventions and antidepressant medications are specific clinical interventions. Mental health outreach services and collaborative and integrated mental and physical health care are proven service delivery models.

These EBPs are neither independent nor competing strategies. They can be used alone or in combination. Psychotherapy interventions and antidepressant medications are both effective treatments for depression. In some cases, these EBPs are more effective when they are provided together.

In some cases, an EBP clinical intervention can be a component of a broader EBP service delivery model. For example, psychotherapy interventions and antidepressant medications can be provided within specific approaches to outreach services and collaborative and integrated mental and physical health care.

The criteria used to identify EBPs are different for each of these four types of treatments. The specific criteria are described in the EBP summaries that follow. They are based on the criteria of the American Psychological Association and the American Medical Association.

Promising Practices

Scientists continue to develop and test different treatments for older adults with depression. Aside from EBPs, there are other treatments for depression that may be effective for older adults. Several treatments show promise, but have not been evaluated in more than one study with older adults, or have not been compared to a control group or another type of treatment. These treatments may prove to be effective for older adults. They also may help to answer some of the questions that remain for established EBPs.

An example of such a promising practice is the Healthy IDEAS program (Identifying Depression, Empowering Activities for Seniors). In this program, practitioners provide older adults with screening and assessment for depression, education, referral and linkage to treatment services, and behavioral activation. These components are embedded into the ongoing assessment and care planning of community case management programs. Components emphasize the active role of older adults with depressive symptoms in learning how to partner with practitioners and make changes to feel better. A study found that older adults who participated in Healthy IDEAS had a decrease in their symptoms of depression and were more knowledgeable about accessing treatment services (Quijano and colleagues, 2007).

Evidence suggests that the different components of the Healthy IDEAS program are individually effective. However, this intervention has not been compared to a control group and therefore does not meet criteria for an EBP. Research is now underway to clarify the impact of this program on older adults with depression. More research is necessary to clarify whether this and other promising practices are effective for older adults with depression.

Deciding to Move Forward with EBP Implementation

The decision to move forward with implementation of EBPs for older adults with depression consists of three stages:

- Deciding to implement an EBP for older adults with depression (based on need, priority, and general organizational readiness),
- Selecting the EBP, and
- Assessing the capacity of your organization and preparing to move forward with implementation of the specific EBP.

This process is not necessarily linear, and may involve interaction among the stages. An overview of these stages is provided below.

The **first stage** in moving forward with EBP implementation is to *make the decision to implement an EBP*. During this stage, you should determine whether there is a sufficient need – or rationale – for moving forward with EBP implementation in your particular setting, and whether EBP implementation is a priority for your organization.

The need for an EBP is usually related to a specific identified problem. Your need may be based on the lack of recognition and treatment of depression in older adults, or, if interventions are already in place for older adults with depression, they may not be producing the desired outcomes. Clearly defining the problem that you hope to address will help you rationalize the EBP implementation initiative at different levels and will help inform your selection process.

It is important to establish that the need for an EBP is a policy priority for your organization. Many mental health, aging service, and general medical health organizations have limited resources and competing priorities. A statement from senior leadership defining EBPs as a priority is helpful in leading the effort toward a full-scale adoption.

You also will need to assess the readiness of your organization to adopt and implement EBPs. This is addressed in greater detail in the *Guide for Agency Administrators and Program Leaders*. An assessment of organizational readiness will address several factors, including commitment from the administrative leadership, organizational capacity and limitations, and financial readiness.

For instance, some options should exist as to the source of funding of start-up and ongoing implementation of the EBP, the availability of staff to support the implementation effort, and resources for training and education of practitioners, supervisors, older adults, and family members or caregivers.

These aspects are critical for EBP implementation. If these elements are unclear, a plan should be developed to define them. This assessment of readiness will need to be increasingly refined as the choice of potential EBPs becomes narrower.

To some extent, readiness factors may shape the selection of EBPs. At the same time, the EBPs selected may determine the next steps that need to occur to prepare the organization for EBP implementation.

The actions that relate to these areas are briefly discussed in the following section of this booklet. More detail is available in the *Guide for Agency Administrators and Program Leaders*, as well as the *Leadership Guide for Mental Health, Aging, and General Medical Health Authorities*.

The **second stage** involves *selecting which EBP to implement*. During this stage, you should consider how the available EBPs match with the needs of your organization. Factors that you need to consider in selecting an EBP include:

- diagnoses of your target population of older adults,
- desired treatment outcomes,
- setting in which the EBP will be implemented, and
- “fit” of the evidence with your specific setting and target population.

Further information related to each of these factors is described within this booklet.

The **third stage** of moving forward with EBP implementation involves *assessing your organization’s capacity to implement a specific EBP*. In determining readiness, you may consider several factors, including:

- “fit” of the specific EBP with the organization’s function, priorities, and mission,
- acceptability to older adults and their family members or caregivers,
- acceptability to practitioners and other stakeholders, and
- the availability of training and implementation resources.

The decision to move forward with EBP implementation involves attention to all of these steps. This booklet provides guidance for this process.

Factors to Consider in Selecting an EBP

Prior to implementing an EBP, you should consider the match between the EBP, treatment setting, practitioners, and older adults who receive services.

Selecting a specific intervention occurs at different levels. At one level, mental health, aging, and general medical health authorities, agency administrators, and program leaders have to decide whether a particular intervention will be part of the services they provide. For example, a primary care program may need to decide whether to develop a model of collaborative and integrated mental and physical health care to address the mental health needs of older adults. This decision will depend on several factors, including:

- the prevalence and urgency of mental health needs in the target population,
- competing priorities,
- practitioner availability,
- caseload size,
- resources for training, and
- reimbursement for service provision.

At another level, the practitioner has to decide with the older adult and his or her family members or caregivers whether psychotherapy interventions or antidepressant medications or both are needed. This type of decision involves a different set of criteria, including:

- the older adult's diagnosis,
- desired outcomes,
- side effects and contraindications,
- preferences of older adults and their families or caregivers,
- insurance coverage, and
- the availability of trained practitioners to provide the service.

There is overlap of decision-making factors at these different levels. The selection process in this KIT focuses on the selection of an EBP for implementation at the agency program level, rather than the selection of an EBP for a specific older adult.

This section provides a guide for narrowing your search for an EBP. Tables that follow provide summary information about each EBP. This allows you to scan major features of the EBPs that can be considered in the selection process.

When selecting which EBPs to add to the array of services in your community or agency, the first set of factors to consider includes:

- the severity of depression of the older adults in your target population
- outcomes affected,
- service delivery settings,
- timeframe of service delivery, and
- practitioner qualifications and requirements.

Table 1 summarizes these key features of specific EBPs for older adults with depression. You can use this information to help select the most appropriate EBP for your setting.

These factors may help shape the initial set of EBPs that you select for consideration. For example, a major factor in shaping the selection process is the type of problem to be addressed. Some EBPs target older adults with major depression, while others target older adults with minor depression or dysthymia. The outcomes to be achieved are another determinant. While all the EBPs reduce symptoms of depression, some EBPs also improve access to depression treatment. The setting in which EBPs are provided is also a factor for consideration. For example, some EBPs are specifically tailored for primary care settings. The timeframe of service delivery and practitioner qualifications can help you determine if the EBP will fit within the framework of your organization.

More information is provided about these factors following Table 1.

Table 1: Factors to Consider in Selecting an EBP. Does the intervention fit with the needs and capacities of your organization?					
	Type of Depression Included in Studies	Outcomes Affected ¹	Service Delivery Settings	Timeframe	Practitioner Qualifications and Requirements
Psychotherapy					
Cognitive Behavioral Therapy	Major depression Minor depression Dysthymia Depression symptoms Sub-clinical depression	Depression symptoms, Coping strategies, Quality of life	Home, Outpatient mental health, Primary care	Up to 20 sessions	Mental health practitioners with an advanced degree
Behavioral Therapy	Major depression Minor depression Depression symptoms	Depression symptoms, Coping strategies, Quality of life	Inpatient physical health, Outpatient mental health	Up to 18 sessions	Mental health practitioners with an advanced degree
Problem Solving Treatment	Major depression Minor depression Dysthymia Depression symptoms	Depression symptoms, Functional impairment, Quality of life, Problem-solving skills	Home, Nursing home, Outpatient mental health, Primary care	Up to 12 sessions	Mental health practitioners with a Bachelors degree or higher
Interpersonal Psychotherapy	Major depression Minor depression Sub-clinical depression	Depression symptoms	Outpatient mental health, Primary care	Up to 16 sessions	Mental health practitioners with an advanced degree
Reminiscence Therapy	Major depression Depression symptoms	Depression symptoms, Hopelessness, Functional impairment, Life satisfaction	Long-term care, Retirement apartments, Senior community center	Usually 3 to 16 sessions	Physical or mental health practitioner with an advanced degree
Cognitive Bibliotherapy	Major depression Minor depression Dysthymia Depression symptoms	Depression symptoms	Home	Discretion of older adults	Self-administered, with at least minimal contact from a mental health practitioner with experience providing cognitive therapy
Antidepressant Medications	Major depression Minor depression Dysthymia	Depression symptoms, Prevention of relapse and recurrence of depression	Home, Inpatient mental or physical health, Outpatient mental or physical health	Acute treatment typically lasts 12-16 weeks	Physical or mental health practitioner with prescribing authority

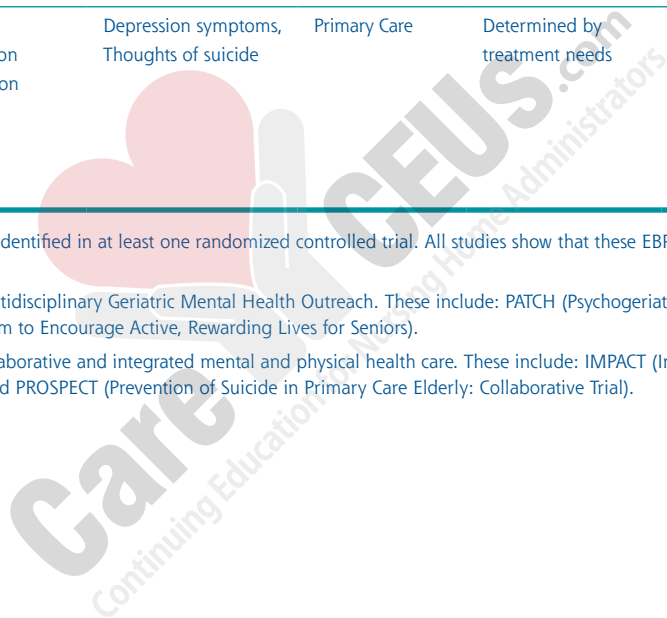
Table 1: Factors to Consider in Selecting an EBP. Does the intervention fit with the needs and capacities of your organization?

	Type of Depression Included in Studies	Outcomes Affected ¹	Service Delivery Settings	Timeframe	Practitioner Qualifications and Requirements
Multidisciplinary Geriatric Mental Health Outreach Programs²	PATCH: All types of depression	Depression symptoms, Psychiatric symptoms, Length of time living independently	Home / Senior public housing	Determined by treatment needs	Multiple practitioners involved, including: psychiatrist; nurse; case manager
	PEARLS: Minor depression Dysthymia	Depression symptoms, Functional and emotional well-being, Access to care	Home	Determined by treatment needs	Multiple practitioners involved, including: psychiatrist; primary care practitioner; social worker
Collaborative and Integrated Mental and Physical Health Care³	IMPACT: Major depression Dysthymia	Depression symptoms, Functional impairment, Quality of life, Access to care	Primary Care	Determined by treatment needs	Multiple practitioners involved, including: primary care practitioner, psychiatrist, depression care manager (e.g., nurse, social worker, psychologist)
	PROSPECT: Major depression Minor depression	Depression symptoms, Thoughts of suicide	Primary Care	Determined by treatment needs	Multiple practitioners involved, including: primary care practitioner, psychiatrist, depression care manager (e.g., nurse, social worker, psychologist)

1 The outcomes listed here have been identified in at least one randomized controlled trial. All studies show that these EBPs reduce the symptoms of depression in older adults.

2 This KIT describes two models of Multidisciplinary Geriatric Mental Health Outreach. These include: PATCH (Psychogeriatric Assessment and Treatment in City Housing) and PEARLS (Program to Encourage Active, Rewarding Lives for Seniors).

3 This KIT describes two models of collaborative and integrated mental and physical health care. These include: IMPACT (Improving Mood, Promoting Access to Collaborative Treatment) and PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial).



Type of Depression

Your selection of an EBP should consider the nature and severity of depression in your older adult population. Although most of these EBPs can be used for older adults with any type of depression, the majority of the scientific evidence has been collected from older adults with major depression or a specific level of depression severity.

All of the EBPs in Table 1 have been shown to be effective for older adults with major depression. The sole exception is the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS). PEARLS is an outreach service model that is specifically designed for older adults with minor depression or dysthymia.

Beyond their efficacy for treating major depression, EBPs for providing multidisciplinary mental health outreach services, collaborative and integrated mental and physical health care, and antidepressant medications also have been found to be effective for older adults with minor depression and dysthymia. The psychotherapy EBPs are less thoroughly evaluated in older adults with minor depression or dysthymia.

Outcomes Targeted for Older Adults

When choosing which EBP to implement, you should compare the benefits and effectiveness of different practices. While all of the identified EBPs reduce depressive symptoms in older adults, some also are particularly useful in helping older adults access appropriate services.

Common outcomes that are desired by older adults with depression include the following:

- remission or recovery from depression,
- decreased symptoms of depression and thoughts of suicide,
- increased coping behaviors,
- increased self care skills,

- increased energy,
- increased social connectedness,
- improved overall daily functioning,
- an ability to live in the least restrictive setting, and
- access to appropriate treatment services.

You can help select an EBP by identifying those practices that best match the needs of your older adult population. You can review the effectiveness of each EBP in the detailed descriptions at the end of this booklet.

How Does the EBP Fit your Organization?

Adding an EBP to existing services requires that you choose a practice that fits your:

- function, priorities, and mission,
- setting,
- practitioners, and
- older adults' treatment preferences.

Choose EBPs that Match the Function of your Organization

Consider how the different EBPs fit with the function, priorities, and mission of your organization. It is easier to integrate a new practice into existing services if the practice matches your mission and values.

- Mental health organizations typically focus on problems associated with mental disorders.
- General medical health care organizations, including systems of health care and public health authorities, focus on assuring good health and providing adequate and appropriate health care.
- Aging services organizations prioritize a range of services that allow older adults to function in the community for as long as possible.

It might be more feasible for a general medical health care organization to implement collaborative and integrated mental health services, while cognitive behavioral therapy might be more feasible for a mental health organization to implement. Joint implementation of some EBPs may be ideal. For instance, aging service organizations and mental health organizations may jointly implement outreach services and draw upon the strengths and missions of both of these organizations and their practitioners.

Your decision to implement a specific EBP may be influenced by the match between your service delivery system and those settings in which the EBPs are typically provided.

Along with the function of your organization, you should consider whether financing the EBP is feasible within your organization. Some interventions may fit within the array of services offered by your organization. Grants and other funding sources also may promote the use of a specific EBP. This could be a defining factor in your selection process.

The financing of psychotherapy is likely to fit within existing structures of a mental health organization. In contrast, physical health and aging service organizations may need to develop creative methods for financing this service.

Collaborative and integrated mental and physical health care are more easily financed in settings that have capitated financing arrangements (e.g., payment for each older adult served, rather than by service provided).

Successfully financed models of outreach services include partnerships between mental health and aging services. Case identification can be covered by aging network activities and treatment can be provided by mental health practitioners who are reimbursed through fee-for-service Medicare, Medicaid, or private insurance.

Choose EBPs that will be Effective in Your Setting

Understanding the setting of your organization can be useful in selecting the most appropriate EBP.

Service delivery setting

Older adults live and receive services in a variety of settings. Although older adults often prefer to live in their own home or apartment, increasing numbers of older adults live in assisted living facilities, senior housing, or board and care homes. Many also receive health care services in institutional settings (e.g., nursing homes, general and psychiatric hospitals). Older adults often are reluctant to seek services in specialty mental health clinics, and instead receive mental health services in primary health care settings.

The characteristics of these settings can influence the usefulness of an EBP. For example, an effective outreach program for identifying community-residing older adults with depression is likely to be unnecessary for identifying depressed older adults who live in a nursing home.

The various EBPs are appropriate for different settings. You should consider implementing an EBP that has been developed and tested in your setting. This can narrow the range of EBPs from which you should choose.

Rural settings

Older adults living in rural areas face a number of challenges that may lead to health disparities. In general, rural older adults have less access to health care services, have lower income and asset levels, and are less likely to have insurance coverage than older adults who live in urban areas.

Similarly, problems with transportation and mental health practitioner shortages can reduce the ability of older persons residing in rural settings to access depression treatments.

Technical assistance that is offered by some EBP developers may help you focus extra attention on EBP components that are crucial for older adults who live in rural areas so that appropriate care can be made available.

Choose EBPs that are Acceptable and Feasible for Practitioners

You will want to determine whether the program fits with your staffing patterns and staff training and supervision.

An estimate of the caseload size can shape your decision process. Some EBPs require multidisciplinary teams, suggesting that a larger caseload may make them more viable and cost-effective. Other EBPs may be more appropriate for practitioners with smaller caseloads.

An EBP may be more acceptable to practitioners if it builds on their professional education base and is similar to their usual style of providing care. It is important that you consider the qualifications or expertise needed by practitioners to deliver a specific EBP.

EBPs require different types of practitioners with different levels of training. Some EBPs need practitioners with medical or nursing degrees, and others need practitioners with expertise in social work or mental health. The availability of staff – for example, in rural areas – could narrow the selection process.

Choose EBPs that are Acceptable and Feasible for Older Adults and Caregivers

In selecting an EBP, you also will want to consider whether older adults will accept and participate in the new service. A number of barriers can prevent older adults from engaging in services. These can include transportation, physical disability, cognitive impairment, stigma, lack of information, and ability to pay for services.

You should identify potential barriers that the older adult might face in accessing services. Generally, older adults and their caregivers are more likely to access and use EBPs that:

- accommodate physical disability or illness,
- are culturally sensitive and age appropriate,
- are respectful of the older adult,
- ensure the safety of the older adult,
- allow for shared decision-making,
- incorporate a recovery framework, and
- require fewer responsibilities for the older adult.

Availability of Training and Implementation Resources

In deciding which EBP to implement, you will want to consider whether training and technical assistance are available. While several of the EBPs for older adults with depression offer technical assistance and implementation support, it is not available for all programs. Important issues include:

- availability of a treatment manual,
- availability of training or technical assistance from the developer,
- location, length, and cost of formal training,
- availability of follow-up consultation or coaching, and
- availability of process (e.g., fidelity) and outcome measurement protocols.

This information is described in the EBP descriptions that follow. Further information about these resources can be obtained by contacting program developers.

Is the Study Population Comparable to Yours?

The **second set** of factors that you should consider in selecting an EBP relates to similarity between your older adult population and the older adults who participated in research studies that evaluated the EBPs. As shown in Table 2, some practices have been tested on diverse populations, while others have not.

Making decisions based on the populations tested requires caution and balancing with some of the other factors described in this booklet. Just because the evidence does not exist for a particular subset of the older adult population does not imply that the intervention will not work for that population group. However, there may be different levels of comfort in proceeding on the basis of such an assumption.

For example, studies of interpersonal psychotherapy (IPT) have included mostly female populations. This does not mean that IPT does not work for males, just that the evidence is based on research populations that are primarily female.

Among the many issues that you may consider in selecting an EBP, those factors that relate to your population include:

- gender,
- age,
- race and ethnicity, and
- health status.

Table 2: Characteristics of Older Adults Participating in Research on EBPs

	Gender	Minimum Age	Ethnic / Minority Inclusion: White, Black, Latino, Asian ¹
Psychotherapy interventions			
Cognitive Behavioral Therapy	38-92% Female	≥ 55	0-21% minority W, B
Behavioral Therapy	38-90% Female	≥ 55	0-86% minority W, B, L
Problem Solving Treatment	52-85% Female	≥ 55	20-25% minority W, B, L
Interpersonal Psychotherapy	70-78% Female	≥ 55	0-55% minority W, B
Reminiscence Therapy	54-83% Female	≥ 55	0-25% minority W, B, L
Cognitive Bibliotherapy	76-91% Female	≥ 55	0-7% minority W
Antidepressant Medications	48-78% Female	≥ 55	0-8% minority W, B
Multidisciplinary Geriatric Mental Health Outreach Programs	77-79% Female	≥ 60	43-90% minority W, B
Collaborative and Integrated Mental and Physical Health Care	65-72% Female	≥ 60	23-48% minority W, B, L, A

¹ Specific ethnic or racial minority groups are included if they comprised 5% or more of the study sample

Gender

Most of the studies evaluating the effectiveness of EBPs covered in this KIT included both men and women. However, as shown in Table 2, the majority of participants in most studies were female.

While depression is more prevalent in women than men (Narrow and colleagues, 2002), you should be aware that gender stereotyping may lead to the under-diagnosis of mental health disorders in older men. This has been shown in studies where older women are more likely to be given a depression diagnosis than older men, even when men present with the same symptoms.

Some practices specifically focus on identifying depression in older adults, regardless of gender. This is a core component of multidisciplinary geriatric mental health outreach services. Routine screening of all older primary care patients also is an important part of one model of collaborative and integrated mental and physical health care.

Age

Organizations that provide care for older adults with depression have different cut-offs for how they define older adults. This is also true for studies of depression treatment.

Some organizations and studies may consider people over age 55 as eligible for services, while others use age 60 or age 70 to define eligibility for older adult services. Some practitioners in public sector mental health settings do not provide age-specific services.

Diversity among age groups is important to consider. For example, baby boomers have very different lifestyle and behavioral characteristics than older adults born before World War II. Baby boomers are more likely to access mental health services and often feel less stigmatized. This may make baby boomers more likely to engage in

psychotherapy interventions, whereas the oldest group of older adults may be more likely to prefer antidepressant medications or other services that are provided by their primary care practitioner.

Race and Ethnicity

The older adult population is expected to become increasingly diverse over the coming decades. However, as shown in Table 2, few studies include sufficient numbers of older adults from racial or ethnic minority groups. This makes it difficult to know whether treatments for depression in older adults will work equally well for these groups.

It is important to address the unique mental health needs of racial and ethnic minority groups.

- Older adults in historically underserved racial and ethnic minority groups tend to have more chronic health conditions, less education, and fewer financial resources.
- Older adult immigrants may face obstacles posed by a different language, culture, and health care system.
- Older adults from some racial and ethnic minority groups are less likely than older Caucasians to seek mental health treatment and to use outpatient treatment services.
- Racial and ethnic minority groups may have different beliefs and vocabularies for describing depression.
- The availability of multilingual practitioners may be essential for delivering effective and appropriate services.

The prevailing approach is to assume that if an intervention works for one group of older adults, it should work for another group. However, this assumption may be incorrect. The effectiveness of an intervention that was developed and tested in Caucasian older adults in rural areas of New Hampshire may be less effective for Latino older adults in urban areas of Florida, and vice-versa.

Some studies are now testing the effectiveness of EBPs in diverse populations of older adults. If your desired intervention has not been evaluated for your target population, it becomes critically important to closely monitor outcomes to ensure that the needs of your target population of older adults are being met. The EBP descriptions that follow note those programs that have been adapted for older adults from racial or ethnic minority groups.

Health Status

It is common for older adults to have physical and mental health problems that co-occur with depression. Co-occurring physical health, mental health, and substance abuse problems can affect access and likelihood of response to treatment, as well as treatment preferences and outcomes.

Many studies that test the effectiveness of a treatment place restrictions on the older adult participants. Studies may exclude older adults with cognitive impairment or substance abuse problems. Some studies also exclude older adults with co-occurring physical health or mental health disorders.

A treatment might work equally well for people with and without co-occurring health problems; however, you will want to carefully monitor the outcomes to ensure that the program works for both groups of people.

The EBP descriptions that follow note those programs that have been adapted to address the specific needs of older adults with chronic physical illness or cognitive impairment.

Other Issues to Consider

Scientific evaluations of many of the established EBPs for depression in older adults have not included a broad cross-section of the population. In many cases, persons from different racial and ethnic minority groups were not included in the original study design, or were minimally represented. Most studies did not include a range of ages, but rather grouped anyone over the age of 55 or 60 together. There are important differences in health status, sensitivity to medications, and susceptibility to side effects between depressed individuals who are 60 years old and those who are 85 years old. Similarly, many studies have included mostly middle-class, well-educated Caucasian women. Studies also often have excluded older adults with co-occurring mental or physical health disorders.

As stated earlier this underscores the need for additional studies to test adaptations of EBPs for different populations. When information is available on these adaptations, it is provided in the EBP descriptions that follow.

It also is important to consider that when EBPs have been proven to be more effective than “usual care,” they often are not effective for all individuals receiving the EBP. As such, it becomes important to monitor expected outcomes so that treatment can be individualized within the broader EBP framework. The *Practitioners’ Guide for Working with Older Adults with Depression* contains information on measurement instruments that you can use to assess outcomes. *Evaluating Your Program* also provides helpful information on monitoring outcomes.

Specific EBPs for Older Adults with Depression

The following pages describe several EBPs for older adults with depression. For each EBP, summaries describe:

- the intervention,
- the type of practitioners needed,
- the diagnoses and disorders addressed,
- the evidence and outcomes,
- the research settings,
- populations included in the research,
- training and resources available,
- replications and adaptations of the practice,
- key issues related to implementation,
- program contact information, and
- selected references.

The descriptions of the individual EBPs are supplemented by two case briefs. One describes the implementation of the Psychogeriatric Assessment and Treatment in City Housing (PATCH) program, a model of multidisciplinary geriatric mental health outreach. The other describes the implementation of Improving Mood, Promoting Access to Collaborative Treatment (IMPACT), a model of collaborative and integrated mental and physical health care.

These case briefs are meant to highlight real-life experiences of mental health, aging, and general medical health organizations that have successfully implemented effective depression treatment programs for older adults. Case briefs describe:

The EBP program

- Core program components, and
- Staffing and intensity of services.

Providing the program

- Training,
- Supervision and support,
- Feedback and evaluation, and
- Special skills for working with older adults.

Implementation considerations

- Identifying unmet needs and existing resources,
- Identifying and engaging partners,
- Role of stakeholder groups,
- Financing,
- Adapting the program, and
- Available training and resources.

Selecting EBPs

Psychotherapy Interventions

Psychotherapy is a general term for a method of treating mental disorders by talking about mental health problems and related issues with a mental health professional. It's also known as talk therapy, counseling, psychosocial therapy or, simply, therapy or counseling.

Criteria for Psychotherapy Interventions

The psychotherapy interventions described in this KIT were chosen because they meet the American Psychological Association's criteria for evidence-based psychotherapy for older adults (Yon and Scogin, 2007). These criteria include the following:

- There must be at least two peer-reviewed between-group, within-group, or single-case design studies (or a combination) with:
 - a minimum of 30 participants across studies,
 - the same age group,
 - the same psychologically based treatment,
 - the same target problem,
 - prospective design, and
 - random assignment.
- Treatment must be:
 - better than the control or comparison condition, and

- equivalent to an already-established evidence-based treatment.
- The majority of applicable studies must support the treatment.
- The treatment procedures must show acceptable adherence to the treatment manual.

Six types of psychotherapy interventions meet this criteria. They are listed below, in order of highest to lowest amount of evidence supporting the practice.

Evidence-based Psychotherapy for Treating Depression in Older Adults

- Cognitive Behavioral Therapy (CBT)
- Behavioral Therapy (BT)
- Problem Solving Treatment (PST)
- Interpersonal Psychotherapy (IPT)
- Reminiscence Therapy (RT)
- Cognitive Bibliotherapy (CB)

Where can you find psychotherapy interventions

Psychotherapy interventions are provided by practitioners with advanced training in mental health care.

Psychotherapy interventions can be delivered by practitioners who work in:

- outpatient mental health clinics,
- inpatient mental health facilities,
- primary care settings, and
- home and community-based locations.

Comprehensive Reviews of Psychotherapy

The effectiveness of psychotherapy interventions for older adults with depression has been systematically reviewed by several groups of scientists. The following table lists comprehensive reviews of the different EBPs.

Table 3: Recent Comprehensive Reviews that Evaluate the Evidence for the Psychotherapy EBPs

	CBT	BT	PST	IPT	RT	CB
Areán and Cook, 2002	x	x	x	x	x	
Bohlmeijer, et al., 2003					x	
Frazer, et al., 2005	x	x	x	x	x	x
Frederick, et al., 2007	x	x	x	x	x	x
Hsieh and Wang, 2003					x	
Mackin and Areán, 2005	x	x	x	x	x	
McKendree-Smith, et al., 2003						x
Scogin, et al., 2005	x	x	x		x	x
Wilson, et al., 2008	x	x	x	x		x

Cognitive Behavioral Therapy (CBT) for Older Adults

Cognitive Behavioral Therapy (CBT) is a psychotherapy that is designed to change the thought patterns and behaviors that cause or maintain depression. It is generally provided by mental health practitioners with specific training in this approach and ongoing expert supervision or consultation. CBT is delivered in 20 or fewer sessions outlined in a manual. It is effective in treating depression in older adults.

Description of Intervention

Cognitive behavioral therapy (CBT) is a structured, time-limited therapy. It is intended to change the thinking and behaviors that cause or maintain depression.

CBT is an intervention based on Beck's theory of depression that states depression is caused and supported by a combination of hopelessness, a pessimistic view of the world, and a belief that one cannot have an influence on day to day events. The intervention teaches people mood regulation skills and re-orientes people from a pessimistic view of the world to a realistic and balanced view of the world and their abilities. Some versions of CBT for older adults also include teaching assertiveness skills and time management.

CBT is based on the idea that thoughts are associated with underlying beliefs, attitudes and assumptions. The most basic premise is that the way people think and make sense of their experiences determines the way they feel and behave. CBT is designed to modify thought patterns, improve skills, and change the emotional states that contribute to mental disorders.

CBT uses several behavioral and cognitive techniques. These include behavioral activation, relaxation training, assertiveness, activity scheduling, graded task assignments, problem solving techniques, thought identification and monitoring, and challenging core beliefs.

CBT focuses on health status, thoughts, behaviors, and emotions and how they interact with one another to explain depression. CBT is delivered in up to 20 individual or group sessions. The first three sessions are used for getting started. They provide an introduction to CBT and establish the goals for therapy. Sessions four through 16 cover skills training and discuss "thinking tools," "feeling tools," "doing tools," overthinking, assertiveness, problem solving, and imagery. The termination process is covered in sessions 17 to 20.

Practitioners

CBT can be provided by professional mental health practitioners, including psychiatrists, psychologists, social workers, psychiatrically trained nurses, and licensed marriage and family counselors. *Specific training guidelines are described under the heading Training and Technical Assistance.*

Diagnoses or Disorders Addressed

- Major Depression
- Minor Depression
- Dysthymia
- Depressive symptoms, as indicated by 10 or greater on the Hamilton Rating Scale for Depression, 10 or greater on the Beck Depression Inventory, or 11 or greater on the Geriatric Depression Scale.

- Moderate to severe symptoms of depression, as indicated by 69 or greater on the Zung Self-rated Depression Scale.
- Subclinical symptoms of depression

CBT also has been tested in older adults with anxiety disorders and schizophrenia.

Evidence and Outcomes

- Nine randomized controlled trials have been conducted by multiple researchers.

CBT is an established effective treatment for older adults with depression, compared to waitlist, no treatment, usual care, or placebo. In addition, CBT alone and CBT in combination with antidepressant medication are more effective than an antidepressant alone. CBT is effective in reducing depression symptoms and in improving the older adult's life satisfaction and coping strategies.

Settings of Research

- Mental health settings
- Primary care
- Home-based care

CBT can be delivered in group or individual sessions.

Populations Included in Research

Studies of CBT included treatment seeking older adult outpatients with depression. The majority of participants were female and the average age was relatively young (e.g., mid-60s). There are limited data on the effectiveness of CBT among racial and ethnic minority groups, frail elderly, and older adults with mild cognitive impairment.

Training and Resources Available

Manual Availability

CBT was developed by Beck and colleagues (1979) and has been adapted for use with older adults.

- Gallagher-Thompson, D., Steffen, A.M., & Thompson, L.W. (Eds.) (2008). *Handbook of behavioral and cognitive therapies with older adults*. New York: Springer.

This volume reviews the evidence base for CBT with common mental health problems of later life (e.g., depression, generalized anxiety disorder, substance abuse) and with less common problems (e.g., schizophrenia, bipolar disorder, suicide ideation). Chapters also discuss the application of CBT to pain management, insomnia, personality disorders, dementia, and grief reactions.

- Laidlaw, K., Thompson, L., Dick-Siskin, L., & Gallagher-Thompson, D. (2003). *Cognitive behaviour therapy with older people*. United Kingdom: John Wiley & Sons Ltd.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.
- Beck, J. S. (1995). *Cognitive Therapy: Basics and Beyond*. New York: Guilford Press.
- Wright, J. E., Basco, M. R., & Thase, M. E. (2006). *Learning Cognitive-Behavior Therapy: An Illustrated Guide*. Washington, D.C.: American Psychiatric Publishing, Inc.

Therapist and accompanying patient manuals for older adults are available through the Stanford School of Medicine's Older Adult and Family Center website: <http://oafc.stanford.edu>.

Therapist Manual

- Thompson, L. W., Gallagher-Thompson, D., & Dick, L. (2002). *Cognitive-Behavioral Therapy for Late-Life Depression: A Therapist Manual*. VA Palo Alto Health Care System & Stanford University School of Medicine.

Older Adult Client Manual

- Dick, L. P., Gallagher-Thompson, D., Coon, D. W., Powers, D. V., & Thompson, L. W. (2002). *Cognitive-Behavioral Therapy for Late-Life Depression: A Client Manual*. VA Palo Alto Health Care System & Stanford University School of Medicine.

Fidelity Measure

- The Cognitive Therapy Scale (CTS) developed by Young and Beck (1980) is used to rate fidelity.

Training and Technical Assistance

The Veterans Health Administration has recently launched a national CBT dissemination initiative, in which it is training mental health practitioners throughout the Department of Veterans Affairs health care system in the delivery of CBT for depression. The training consists of participation in an experientially-based in-person workshop, followed by ongoing weekly consultation with a training program consultant who is an expert in CBT. The protocol is based on a core competency approach and includes a special section on adapting CBT for older veterans. The national director and contact person for this program is Bradley Karlin, PhD, of the VA Central Office in Washington, DC (*See Program Contact Information below*).

Replications and Adaptations

CBT has been implemented in many locations across the country by practitioners who are trained in this practice.

CBT also has been combined with case management for low-income older adults, and was found to be more effective than CBT alone (Areán and colleagues, 2005).

The principles of CBT have been used to develop an intervention for Mandarin-speaking Chinese Americans. The intervention is delivered in eight two-hour classes (Dai and colleagues, 1999).

Numerous studies also have been conducted with distressed and/or depressed family caregivers who provide hands-on care to an older relative with Alzheimer's disease or another form of dementia. The evidence base for the success of the application of CBT with this population, including with ethnic minority caregivers, is found in a comprehensive review by Gallagher-Thompson and Coon (2007).

A form of CBT, called Coping With Depression, has been adapted and provided in the Netherlands (Haringsma and colleagues, 2006). The Coping With Depression (CWD) course can be effectively delivered to older adults as an in-person or internet-based program (Spek and colleagues, 2007; 2008).

The adult English language CWD manual is available by clicking on the "Coping with Depression course and related articles" available at: <http://www.ori.org/Research/scientists/lewinsohnP.html>. Training for therapists who provide the CWD version of CBT includes formal instruction in the program and supervision of CWD sessions. Sessions benefit from having a therapist and a co-therapist and participants are assigned homework from the book *Control Your Depression* (Lewinsohn and colleagues, 1986).

Key Issues Related to Implementation

Financing: CBT is a billable psychotherapy that is covered by all mental health plans and public insurance. There are no additional costs to patients over and above the typical co-payment that most patients generally pay for health visits (a typical co-payment is \$20 per visit; some co-payments are lower). CBT can be delivered in a group format, allowing agencies to bill for multiple patients per practitioner hour. Some clinics have opted for group based CBT because of the ability to bill as much as 10 patient hours per practitioner hour. (Of note, the suggested group size should not exceed 10 members or be lower than 4 members.) Primary care clinics that wish to offer CBT sessions to patients may need to hire mental health practitioners who can bill mental health plans for services. Currently under Medicare, beneficiaries are eligible for 20 psychotherapy sessions a year; most CBTs can be delivered in less than 20 sessions, making it an ideal intervention for Medicare beneficiaries.

Practitioner resistance: Practitioner resistance toward implementing EBPs is one of the largest barriers to use of CBT. Practitioners suggest that their cases are more complex than those of the training vignettes and that they need more supervision. More experienced clinicians often are hesitant to send tapes for supervision. Younger practitioners often are more open to learning this manual-based program.

Program Contact Information

Developers of CBT for older adults can be contacted at the following locations:

Stanford School of Medicine's Older Adult and Family Center: <http://oafc.stanford.edu>

Larry W. Thompson, Ph.D.
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Stanford University School of Medicine
P.O. Box 3926
Los Altos, CA 94024-0926
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E-mail: larrywt@stanford.edu

Dolores Gallagher-Thompson, Ph.D., ABPP
Professor of Research
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Stanford, CA 94305-5717
Phone: (650) 400-8172
E-mail: dolorest@stanford.edu

Patricia A. Areán, Ph.D.
Professor
UCSF Psychiatry
401 Parnassus Avenue
San Francisco, CA 94143
Phone: (415) 476-7873
E-mail: pata@lppi.ucsf.edu

The national director and contact person for the Veterans Health Administration training program can be contacted at:

Bradley E. Karlin, PhD
Director, Psychotherapy and Psychogeriatrics
Office of Mental Health Services (116)
Department of Veterans Affairs Central Office
810 Vermont Ave., NW
Washington, DC 20420
E-mail: Bradley.Karlin2@va.gov

Behavioral Therapy (BT) for Older Adults

Behavioral Therapy (BT) is a psychotherapy that addresses how behaviors affect mood. It focuses on identifying and increasing participation in pleasant events. It is generally provided by psychologists and counselors trained in behavioral interventions. Behavioral therapy is delivered in 18 or fewer sessions outlined in a manual or treatment protocol. It is effective in treating depression in older adults.

Description of Intervention

Behavioral Therapy (BT) is a structured, time-limited therapy. It examines the relationship between a person's behaviors and their mood. BT conceptualizes depression as the result of a lack of pleasant events and an excess of unpleasant events in a person's life.

BT is typically delivered in up to 18 one-hour group or individual sessions that occur in a clinical setting.

During sessions of BT, the practitioner teaches older adults to:

- monitor their mood,
- record pleasant and unpleasant events,
- notice the connection between pleasant events and positive mood, and unpleasant events and negative mood, and
- identify and increase participation in pleasant events.

Practitioners

BT can be provided by professional mental health practitioners, including doctoral- and masters-level psychologists, as well as social workers, psychiatrically trained nurses, and licensed marriage and family counselors.

Diagnoses or Disorders Addressed

- Major Depression
- Minor Depression
- Depressive symptoms, as indicated by 10 or greater on the Hamilton Rating Scale for Depression, 10 or greater on the Beck Depression Inventory, or 11 or greater on the Geriatric Depression Scale.

Evidence and Outcomes

- Five randomized controlled trials have been conducted by multiple researchers.

BT is an established effective treatment for older adults with depression, compared to no treatment or typical care. BT is effective in reducing depression symptoms and in improving the older adult's life satisfaction and coping strategies.

Settings of Research

- Outpatient mental health settings
- Inpatient medical rehabilitation settings

BT can be delivered in group or individual sessions.

Populations Included in Research

Participants in studies of BT varied in gender, age, and severity of depression. The minimum age of study participants was 55 years in one study and 60 years in the other studies. Most studies were conducted with Caucasian older adults. One study included mostly African American medical inpatients.

Training and Resources Available

Manual Availability

BT was developed by Lewinsohn and colleagues (1974, 1976) and has been adapted for use with older adults.

- Lewinsohn, P. (1974). A behavioral approach to depression. In Friedman, R. & Katz, M. (Eds.), *The Psychology of Depression: Contemporary Theory and Research* (pp. 157–176). New York: Wiley.
- Lewinsohn, P., Biglan, A., & Zeiss, A. (1976). Behavioral treatment of depression. In Davidson, P. (Ed.), *Behavioral Management of Anxiety, Depression, and Pain*. New York: Brunner/Mazel.

Manuals and protocols for use with older adults include the following:

- Gallagher, D. (1981) *Depression in the elderly: A behavioral treatment manual*. Los Angeles, CA: University of Southern California Press.
- Teri, L., & Lewinsohn, P. (1982). Modification of the Pleasant and Unpleasant Events Schedules for use with the elderly. *Journal of Consulting and Clinical Psychology*, 50(3), 444–445.
- Zeiss, A. M., & Lewinsohn, P. M. (1986). Adapting behavioral treatment for depression to meet the needs of the elderly. *The Clinical Psychologist*, 39, 98–100.

Fidelity Measure

- No specific fidelity measure is available.
- Practitioners providing BT in research studies received feedback and supervision to maintain treatment fidelity.

Replications and Adaptations

BT has been implemented in many locations across the country by practitioners who are trained in this practice.

BT has been adapted to treat depression in older adults with Alzheimer's disease and their caregivers (Teri and colleagues, 1997).

Key Issues Related to Implementation

Financing: BT is a billable psychotherapy that is covered by all mental health plans and public insurance. There are no additional costs to patients over and above the typical co-payment that most patients generally pay for health visits (a typical co-payment is \$20 per visit; some co-payments are lower). BT can be delivered in a group format, allowing agencies to bill for multiple patients per practitioner hour. Some clinics have opted for group based BT because of the ability to bill as much as 10 patient hours per practitioner hour. Primary care clinics that wish to offer BT sessions to patients may need to hire mental health practitioners who can bill mental health plans for services. Currently under Medicare, beneficiaries are eligible for 20 psychotherapy sessions a year; most BTs can be delivered in less than 20 sessions.

Training: Mental health practitioners need training and supervision to ensure fidelity to the model.

Problem Solving Treatment (PST) for Older Adults

Problem Solving Treatment (PST) is a psychotherapy that is designed to help older adults develop skills for dealing with stress and feelings of depression. PST can be delivered by a variety of health, mental health, and social service practitioners in mental health, long-term care, residential, and primary care settings. PST is delivered in 12 or fewer sessions outlined in a manual. Training can be conducted over a relatively short number of training sessions. It is effective in treating depression in older adults.

Description of Intervention

Problem Solving Treatment (PST) is a short term, intensive intervention where the older adult and the practitioner (often a nurse or social worker) identify problems that the older adult is facing and develop an action plan to solve the problems. PST encourages older adults to identify a particular goal to reduce depression and teaches a systematic and objective approach to working on problems.

PST is based on the idea that deficiencies in social problem-solving skills increase the risk for symptoms of depression.

PST trains older adults to develop an effective and adaptive approach for solving problems and coping with problems that lead to mental distress. Several concrete steps are associated with PST. These include:

- clarify and define the problem,
- set a realistic goal,
- generate multiple solutions,
- evaluate and compare solutions,
- select a feasible solution,

- implement the solution, and
- evaluate the outcomes.

PST is typically delivered in 12 or fewer one-hour sessions.

Practitioners

PST can be provided by trained practitioners with a bachelor's degree or higher who work in the health or social service professions.

The model has been developed specifically for non-mental health settings, like primary care medicine, so that the intervention could be delivered by a variety of health care professionals, regardless of their mental health background.

Diagnoses or Disorders Addressed

- Major depression
- Minor depression
- Dysthymia
- Severe depression symptoms, as indicated by a CES-D score of 22 or greater, or mild to severe depression symptoms as identified by the Beck Depression Inventory.

Evidence and Outcomes

- Four randomized controlled trials have been conducted by multiple researchers.

PST is an established effective treatment for older adults with depression, compared to another psychotherapy, usual care, or no treatment. PST has been compared to antidepressant medications in one study. It also has been evaluated in two studies as a component of care management.

PST is effective at reducing the symptoms of depression, reducing disability, improving quality of life, and improving problem-solving skills in older adults.

One study found that PST delivered in the primary care setting is not different than an antidepressant medication (paroxetine) or a placebo pill for older adults with minor depression or dysthymia. Both PST and antidepressant medication improved mental health functioning in patients with minor depression and initial low functioning.

PST is a component of two effective depression care management programs for older adults. The Improving Mood–Promoting Access to Collaborative Treatment (IMPACT) program treated older adults with major depression or dysthymia in primary care settings, using antidepressant medications, PST, or both. The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) provided PST to older adults with minor depression or dysthymia as a component of a home-based program for detecting and managing depression.

(Note: The PEARLS program is included in the review of Multidisciplinary Geriatric Mental Health Outreach Services. The IMPACT program is included in the review of Collaborative and Integrated Mental and Physical Health Care for Older Adults.)

Settings of Research

- Outpatient mental health settings
- Nursing home
- Primary care
- Home-based care

PST can be delivered individually, in a group setting, and over the telephone.

Populations Included in Research

Participants in studies of PST varied in gender, ethnicity, and age. For instance, the proportion of female participants in one study was 79 percent (Ciechanowski and colleagues, 2004), whereas it was 42 percent in another (Williams and colleagues, 2000). Several studies had one-fifth or more participants who were members of racial or ethnic minority groups, predominantly African American and Hispanic. The mean age in several studies was greater than 70 years. PST also has been tested in older adults with executive dysfunction, or problems in initiating and maintaining behaviors.

Training and Resources Available

Manual Availability

A general manual for delivering PST has been developed by Nezu and colleagues (1989). However, this manual is not specific to older adults.

- Nezu, A. M., Nezu, C. M., Perri, M. G. (1989). *Problem-Solving Therapy for Depression: Therapy, Research, and Clinical Guidelines*. New York: Wiley.

This manual was adapted for older adults by Dr. Patricia Areán at the University of California at San Francisco (UCSF) and is available free of charge from pata@lppi.ucsf.edu.

A manual for providing PST to older adults in the primary care setting (PST-PC) has been developed and is available free of charge at <http://impact-uw.org/>.

A manual for PST as a component of PEARLS is available free of charge at <http://depts.washington.edu/pearlspr/>.

Manuals for delivering PST to older adults with mild cognitive impairments and for the integration of PST with clinical case management also are available free of charge from pata@lppi.ucsf.edu.

Fidelity Measure

- The Problem Solving Therapist Adherence Checklist (PSTAC) is available from Dr. Areán at UCSF.

Training and Technical Assistance

Training is available either through the IMPACT website or from Drs. Areán or Hegel. Training consists of a one day workshop that can be delivered either in person, via the IMPACT website, or via Webinar (web-seminar) technologies. Participants have access to a training video through the IMPACT website. Training videos for PST with low-income and cognitively impaired older adults are available from the UCSF.

To be a certified PST specialist, three training cases must be reviewed by a PST trainer. Practitioners can seek referrals to a PST trainer by contacting the IMPACT Implementation Center at <http://impact-uw.org>.

On-going, no-cost support is available via a monthly toll free call-in number hosted by UCSF. Calls are every fourth Tuesday of the month from 11-12 Pacific Time.

Replications and Adaptations

PST has been adapted and tested among older adults with:

- mild cognitive impairment or executive dysfunction (Areán and colleagues, 2000; Alexopoulos and colleagues, 2003, 2008),
- physical health problems (PST in combination with clinical case management) (Areán and Dwyer, 2004), and
- macular degeneration (Rovner and colleagues, 2007).

Scientists at the University of Pittsburgh Medical Center are studying PST for treating co-occurring depression and pain. They are also testing PST-PC as a method for preventing depression in older primary care patients, half of whom are African American (Sriwattanakomen and colleagues, 2008). Scientists at UCSF are studying the integration of PST into substance abuse treatment models. These manuals are not yet available. An internet-based model of PST is also being developed.

The PST intervention has been translated and studied in Spanish, Cantonese, and more recently Korean.

Key Issues Related to Implementation

Financing: PST is a billable psychotherapy that is covered by all mental health plans and public insurance. There are no additional costs to patients over and above the typical co-payment that most patients generally pay for health visits (a typical co-payment is \$20 per visit; some co-payments are lower). PST can be delivered in a group format, allowing agencies to bill for multiple patients per practitioner hour. Some clinics have opted for group based PST because of the ability to bill as much as 10 patient hours per practitioner hour. Primary care clinics that wish to offer PST sessions to patients may need to hire mental health practitioners who can bill mental health plans for services. Currently under Medicare, beneficiaries are eligible for 20 psychotherapy sessions a year; most PSTs can be delivered in less than 20 sessions.

Implementation Support: PST has been widely promoted as an effective service delivered through collaborative care systems in the primary care setting (PST-PC), as well as a stand-alone intervention in other health care settings. The most support for dissemination and implementation is available for the PST-PC model.

Interpersonal Psychotherapy (IPT) for Older Adults

Interpersonal Psychotherapy (IPT) is designed to improve depressive symptoms associated with interpersonally relevant problems. The four problem areas of IPT include grief following the loss of a loved one, disputes with others, difficulty adapting to a major life change, and poor social skills. IPT is provided by professional mental health practitioners. It is delivered in 16 or sometimes fewer sessions as outlined in a manual. It is effective in treating depression in older adults.

Description of Intervention

Interpersonal psychotherapy (IPT) is a structured, time-limited therapy. IPT is based on the idea that interpersonally relevant issues often precede depression and that depression can lead to interpersonal problems.

IPT focuses on current interpersonal relationships within four areas. Treatment can address one or more of these areas.

- **Unresolved Grief (complicated bereavement):** the practitioner facilitates mourning and helps the older adult find new activities and relationships to compensate for the loss,
- **Role Transition (major life change):** the practitioner helps the older adult deal with change by recognizing the positive and negative aspects of the new and old roles and adapting to the new role,
- **Interpersonal Role Disputes (conflict with another person):** the practitioner helps the older adult understand the relationship, the nature of the dispute, and options to resolve it.

- **Interpersonal Deficits (problems initiating or sustaining relationships):** the practitioner helps the older adult identify problematic social skills and improve these skills within the context of the therapeutic frame.

IPT uses several techniques to bring about change. These include elements of exploration, clarification, and encouragement of affect; communication analysis; role playing; extensive psychoeducation about the biopsychosocial model of depression; and encouragement of alternative coping strategies.

IPT is typically delivered in 16 (and sometimes fewer) individual sessions that are held weekly for 50 to 60 minutes. IPT is divided into three phases.

- In the first three sessions of IPT, a diagnosis of depression is made and explained, an inventory of social relationships is collected, recent interpersonal problems are identified, and the goals of treatment are set.
- In the intermediate sessions (sessions 4-13), the practitioner works with the older adult to address the interpersonal problem(s).
- In the termination sessions (sessions 14-16), the course of treatment is reviewed and feelings associated with the end of treatment are discussed. The older adult is encouraged to develop ways to identify and address symptoms of depression if they should arise in the future.

Practitioners

IPT can be delivered by mental health care professionals, including psychiatrists, psychologists, social workers, and nurses.

Diagnoses or Disorders Addressed

- Major Depression
- Minor Depression
- Sub-dysthymic Depression, as defined by depressive symptoms (Geriatric Depression Scale score greater than 10) without meeting diagnostic criteria for major depression or dysthymia.

Evidence and Outcomes

IPT is an effective treatment for older adults with depression, compared to usual care, clinical management, and placebo.

- Two randomized controlled trials have compared IPT to usual care. Two randomized controlled trials have compared IPT as a component of maintenance treatment in combination with placebo or antidepressant medication.
- Randomized controlled trials have been conducted by multiple researchers.

IPT also is a component of an effective depression care management program for older adults (Schulberg and colleagues, 2007). The Prevention of Suicide in Primary Care Elderly - Collaborative Trial (PROSPECT) program treated older adults with depression in primary care settings, using antidepressant medication, IPT, or both.

(Note: PROSPECT is included in the review of Collaborative and Integrated Mental and Physical Health Care for Older Adults.)

Acute Treatment in Community Settings

Mossey and colleagues (1996) evaluated interpersonal counseling in physically ill older adults following hospital discharge. Older adults had symptoms of depression (Geriatric Depression Scale greater than 10), but did not have a diagnosis of dysthymia or major depression. Up to 10 sessions of interpersonal counseling resulted in a greater percentage of older adults with a significant reduction in depression severity, compared to usual care (61 percent versus 35 percent).

Acute Treatment in Primary Care Settings

Two studies have evaluated IPT as an active treatment for depression in the primary care setting. In both studies, mental health care professionals located in the primary care setting delivered IPT.

In a 10-session version of IPT delivered in Dutch primary care practices, van Schaik and colleagues (2006) found that IPT was superior to usual care for older adults with moderate to severe depression (Montgomery Asberg Depression Rating Scale score of 21 or greater), but not for patients with mild depression. Overall, IPT was significantly more effective in reducing the number of older adults with a diagnosis of depression, compared to usual care (51 percent versus 34 percent), but there was no difference in depression severity or the percentage of patients achieving remission.

In a study by Reynolds and colleagues (1999a), up to 16 weeks of IPT in combination with antidepressant medication resulted in the greatest rate of remission for older adults with bereavement-related major depression. IPT with a placebo medication was no better than clinical management with placebo, but it was associated with the greatest rate of treatment completion.

Maintenance Treatment

In a study of primary care patients aged 60 years and older with recurrent major depression, Reynolds and colleagues (1999b) found that maintenance treatment with both antidepressant medication and IPT was associated with the best rate of preventing or delaying the recurrence of depression. They also found that IPT plus a placebo medication performed better than their control condition (clinical management and a placebo medication).

In contrast, Reynolds and colleagues (2006) found that IPT alone, compared to clinical management, did not help prevent future episodes of depression among adults aged 70 and older who were receiving maintenance treatment. However, IPT was effective for the subset of older adults with higher levels of cognitive impairment (Carreira and colleagues, 2008). IPT plus medication and medication alone were associated with the greatest prevention of future depression episodes (Reynolds and colleagues, 2006).

IPT may be most effective as a maintenance treatment for severely depressed older adults when it is provided in combination with antidepressant medication. Additional studies may need to test whether it is effective for the oldest group of older adults, and for those with cognitive impairments.

Settings of Research

- Mental health settings
- Primary care (Note: IPT provided by mental health care professionals.)

IPT is delivered in individual sessions.

Populations Included in Research

Studies of IPT included older adults not seeking treatment, as well as older adults in active acute treatment and in maintenance treatment for depression. The majority of study participants were female. The minimum age of study participants varied across studies, ranging from 55 and older to 70 and older.

Several studies excluded older adults with mild to moderate cognitive impairment, and all studies excluded older adults with severe cognitive impairment. Most participants were Caucasian, though 55% of participants in the study by Mossey and colleagues (1996) were African American. As noted earlier, this study specifically focused on medically ill older adults.

Training and Resources Available

Manual Availability

IPT was developed by Dr. Gerald Klerman and colleagues.

- Klerman, G. L., & Weissman, M. M. (1993). *New Applications of Interpersonal Psychotherapy*. Washington, DC: American Psychiatric Press.
- Miller, M. D. (2009). *Clinician's Guide to Interpersonal Psychotherapy in Late Life: Helping Cognitively Impaired or Depressed Elders and Their Caregivers*. Oxford and New York: Oxford University Press.
- Weissman, M., Markowitz, J. C., & Klerman, G.L. (2000). *Comprehensive Guide to Interpersonal Therapy*. New York. Basic Books.
- Weissman, M., Markowitz, J. C., & Klerman, G.L. (2007). *Clinician's Quick Guide to Interpersonal Psychotherapy*. Oxford Press.

Older Adult: Treatment Manual and Training Video

A treatment manual for delivering IPT to older adults has been developed by Hinrichsen and Clougherty and a training DVD by Hinrichsen.

- Hinrichsen, G. A., & Clougherty, K. F. (2006). *Interpersonal psychotherapy for depressed older adults*. Washington, DC: American Psychological Association. Available at: <http://www.apa.org/books/4317102.html>
- Hinrichsen, G. A. (2007). *Training DVD: Interpersonal Psychotherapy for Older Adults with Depression*. Produced by American Psychological Association's APA Psychotherapy Videos. Available at: <http://www.apa.org/videos/4310796.html>

Training and Technical Assistance

- Additional training and implementation resources are available from the International Society for Interpersonal Psychotherapy: <http://www.interpersonalpsychotherapy.org/>.
- Introductory training workshops on IPT for older adults with depression are intermittently conducted at national or regional professional meetings. Individual or group supervision for those learning IPT sometimes can be arranged individually with practitioners who have advanced expertise in IPT.
- Listings of upcoming training workshops are posted with The Society of Interpersonal Psychotherapy and the American Psychological Association's Society of Clinical Geropsychology.

Replications and Adaptations

IPT is provided as a stand-alone psychotherapy and also in combination with antidepressant medications. It has been translated into the Dutch language and provided by mental health professionals located in primary care practices in the Netherlands (van Schaik and colleagues, 2007).

A manual for providing IPT as a component of maintenance treatment for older adults with recurrent depression has been developed by scientists at the University of Pittsburgh Medical Center.

- Frank, E., & Frank, N. (1988). *Manual for the adaptation of interpersonal psychotherapy to maintenance treatment of recurrent depression in late life. (IPT-LLM)*. Unpublished manuscript. Pittsburgh, PA.

IPT also has been adapted to better meet the needs of older adults with cognitive impairment (Miller and colleagues, 2006, 2007). IPT for older adults with cognitive impairment (IPT-CI) integrates the older adult's caregiver into IPT therapy sessions. A manual for IPT-CI is available (Miller, 2009).

Key Issues Related to Implementation

Financing: IPT is a billable psychotherapy that is covered by mental health plans and public insurance. Primary care clinics that wish to offer IPT sessions may need to hire mental health practitioners who can bill mental health plans for services. Currently under Medicare, beneficiaries are eligible for 20 psychotherapy sessions a year; IPT is typically delivered in less than 20 sessions.

Training: Practitioners can acquire skills for delivering IPT by attending a 16-20 hour didactic seminar, adhering to a treatment manual, and receiving intensive supervision on two to three patients with depression who are suitable for IPT.

Supervision: Practitioners should receive weekly supervision on two to three cases by a qualified trainer. Local expertise can be expanded by using a train-the-trainer model, where one practitioner receives intensive training and then provides supervision to other local practitioners.

Number of sessions: As originally developed, IPT is delivered in 16 sessions (Weissman and colleagues, 2000). Mossey and colleagues (1996) and van Schaik and colleagues (2006) suggest that 10 sessions of IPT may be insufficient to produce strong lasting effects and that maintenance IPT is important.

Potential practitioner challenges: Practitioners may face challenges in selecting appropriate older adults, clarifying older adult expectations, deviating from the interpersonal focus on current events, working within a biopsychosocial model, and adhering to the short time frame of IPT (e.g., 12–16 sessions).

Cost-effectiveness: One study on the cost-effectiveness of IPT, based on the study by van Schaik and colleagues (2006) found that IPT costs roughly the same as usual care in a Dutch primary care practice. However, this study did not find IPT to be cost-effective given the small difference in clinical outcomes at 6 and 12 months after baseline (Bosmans and colleagues, 2007).

Reminiscence Therapy (RT) for Older Adults

Reminiscence therapy for older adults is a technique that is designed to help older adults resolve conflicts and accept their successes or failures. It is generally provided in long-term care facilities, senior housing, and senior community centers by trained nurses and therapists. It is effective in treating mild levels of depression. Technical assistance and published protocols are available.

Description of Intervention

Reminiscence therapy involves the discussion of past activities, events and experiences with another person or group of people. It can be provided in many forms in order to prevent, assess, and intervene with depression and other mental health issues. Structured reminiscence approaches include *Life Review* and *Guided Autobiography*.

The concept of *Life Review* was published by Robert N. Butler in 1963. The life review process helps older adults resolve conflicts and accept both the successes and failures of their lives. In the life review process, practitioners use weekly topics to guide older adults in recalling memories from different stages of their lives and to stimulate discussion of major life events. These processes are thought to promote feelings of control over past and present life events by counteracting learned helplessness.

Guided Autobiography was developed by James Birren during the 1960s. It uses a group process with written assignments. Participants discuss significant turning points in their lives to gain additional insight about their life experiences. Weekly sessions are guided by themes that include family history, life accomplishments, life turning points, stressful experiences, and the meaning and purpose of life.

Structured reminiscence therapy is typically provided in a group setting, led by a mental health practitioner, and occurs over four to twelve weekly sessions that last 60–90 minutes.

There are several potential benefits of reminiscence approaches.

- Reminiscence approaches can be used during the assessment process to bolster older adults' confidence and self-esteem.
- Reminiscence can be integrated into a number of treatment approaches, including cognitive behavioral therapy. These approaches are effective in individual, group, marital/family, and milieu therapy modalities.
- Practitioners can use reminiscence materials to develop therapeutic resource states that facilitate change.
- Reminiscence approaches can help obtain and maintain attention and rapport for those who want to educate older adults about mental health issues.

Practitioners

Reminiscence therapy can be provided by practitioners who have received training in reminiscence therapy. Practitioners can include mental health professionals, nurses, chaplains, and other members of a multi-disciplinary team. Practitioners should integrate their reminiscence approaches within their theoretical approach and treatment plan.

Diagnoses or Disorders Addressed

- Major Depression
- Depressive symptoms, as indicated by a Geriatric Depression Scale (GDS) score of 14 or greater, or 16 or greater on the CES-D.

Reminiscence therapy has been used to prevent and assess mental health disorders. It has been used in older adults with anxiety and health conditions that cause anxiety; behavioral problems due to dementia, delirium, or other physical health disorders; normal and unresolved grief; and substance abuse. Reminiscence therapy also has been tested in older adults with dementia.

Evidence and Outcomes

- Four randomized controlled trials have been conducted by multiple researchers.

Reminiscence therapy is effective in reducing depressive symptoms of older adults, compared to a waitlist or no treatment. Reminiscence therapy also can reduce hopelessness, reduce functional disability, and improve life satisfaction.

Outcomes of reminiscence therapy have been mixed in studies where older adults did not have a diagnosis of major depression, with some studies supporting reminiscence therapy and some finding no benefits.

Reminiscence therapy is less effective than problem solving treatment and goal-focused psychotherapy.

Settings of Research

- Outpatient medical treatment facilities
- Hospitals

- Assisted living and long-term care facilities
- Retirement apartments
- Senior community centers

Reminiscence therapy can be delivered in group or individual sessions.

Populations Included in Research

Studies of reminiscence therapy included older adults of both genders, though most participants were female (range: 54–83%). Participants were age 55 and older in two studies, 60 and older in one study, and 65 and older in one study.

The amount of research on reminiscence approaches is growing rapidly. Data supports the effectiveness of reminiscence therapy among racial and ethnic minority groups and frail older adults.

Training and Resources Available

Manual Availability

Reminiscence therapy is based on the model developed by Butler (1963). A published protocol for delivering reminiscence therapy (Birren & Deutchman, 1991) has been developed and is available in bookstores and online (e.g., <http://www.amazon.com> for \$25). However, formal protocols for delivering reminiscence therapy that clearly identify the essential components of this intervention are needed.

- Butler, R. N. (1963). The life review: an interpretation of reminiscence in the aged. *Psychiatry*. 26(1), 65–76.
- Birren, J. E., & Deutchman, D. E. (1991). *Guiding Autobiography Groups for Older Adults*. Baltimore, MD: Johns Hopkins University Press.

Several books and reference manuals describe the theory and applications of reminiscence therapies.

- Gibson, F. (2004). *The Past in the Present: Using Reminiscence in Health and Social Care*. Health Professions Press.
- Haight, B. K. (1995). *The Art and Science of Reminiscing: Theory, Research, Methods, and Applications*. Washington DC: Taylor & Francis.
- Haight, B. K., & Haight, B. S. (2007). *The Handbook of Structured Life Review*. Health Professions Press.
- Kunz, J. A., & Soltys, F. G. (2007). *Transformational Reminiscence: Life Story Work*. New York: Springer Publishers.
- Webster, D. J., & Haight, B. K. (2002). *Critical Advances in Reminiscence Work: From Theory to Application*. New York: Springer-Verlag

Videos

- Kunz, J. A. (2002). *The Joys and Surprises of Telling Your Life Story*. University of Wisconsin Board of Regents.
- Kunz, J. A. (1997). *Therapeutic Reminiscence*. Video tape and work book. Mental Health Outreach Network.

Internet Resources

- Arigho, B. *How to Help Reminiscing Go Well. Principles of Good Practice in Reminiscence Work*. Age Exchange. London. http://www.age-exchange.org.uk/our_work/publications/index.html.
- International Reminiscence and Life Review Conference. (2007). *Proceedings and Selected Papers*. Published in English, Japanese, and Spanish. Available from: <http://reminiscenceandlifereview.org>.
- *Mapping Memories: Reminiscence with Ethnic Minority Elders*. Age Exchange. London. Including Chinese, African, Caribbean, and Asian older adults. Available at: [org.uk/our_work/publications/index.html](http://www.age-exchange.org.uk/our_work/publications/index.html).

Training and Technical Assistance

Customized training is available for key note lectures, workshops and other consultation from the International Institute for Reminiscence and Life Review. The goal of this institute is to provide education on reminiscence and life review practice, research, and ways to integrate the material in formal education, staff training, and volunteer organizations. Membership in the Institute provides access to a private list-serve that allows for consultation with experts in the field. The institute can be accessed at: <http://reminiscenceandlifereview.org>

Replications and Adaptations

Reminiscence work is popular in Japan and across Europe with many diverse populations. Programming and research also has been conducted within the United States. Systematic reviews have recommended the need for additional rigorous studies of the effectiveness of reminiscence therapy in older adults with depression.

Key Issues Related to Implementation

Location: Group and individual sessions of reminiscence therapy require minimal space or resources. Reminiscence therapy should be sensitive to the different needs of older adults. Reminiscence therapy should be provided in a location that can accommodate the needs of older adults, including settings that are bright, have comfortable seating, and are free from outside disturbances.

Other issues: Practitioner training is needed prior to implementing reminiscence training. It is an easily implemented intervention that is considered part of a normal developmental process (Jones and Beck-Little, 2002).

Cognitive Bibliotherapy (CB) for Older Adults

Cognitive bibliotherapy is a self-directed psychotherapy that is designed to change the thought patterns that cause or maintain depression. It is delivered through self-guided written materials, which are complemented by oversight from a mental health practitioner. No formal treatment manual is available as this is a self-directed intervention. Cognitive bibliotherapy is effective for treating mild or moderate levels of depression in older adults.

Description of Intervention

Cognitive bibliotherapy involves reading books and completing written exercises in order to learn about depression and ways to reduce its symptoms. Reading materials and written exercises are completed outside of a clinic setting, often at the participant's home and at the participant's own pace. Similar to cognitive behavioral therapy (CBT), cognitive bibliotherapy is intended to change the thinking and behaviors that cause or maintain depression.

The book *Feeling Good*, by David Burns, was read by older adults in all studies of cognitive bibliotherapy published to date. After learning to monitor depressive symptoms, readers are introduced to the concept of cognitive distortions and to techniques designed to help them question depressive thoughts and improve their mood. *Feeling Good* is divided into seven parts entitled:

- theory and research,
- practical applications (i.e., building self-esteem, defeating guilt),
- realistic depressions (i.e., depression is not sadness),
- prevention and personal growth,

- defeating hopelessness and suicide,
- coping with the stresses and strains of daily living, and
- the chemistry of mood (i.e., the mind-body connection, antidepressant medications).

Older adults can complete a course of cognitive bibliotherapy over a four-week period. During this time, it is important that practitioners with expertise in depression and CBT have brief, weekly contact with the older adult.

Cognitive bibliotherapy can be an accessible alternative to formal mental health interventions in clinic-based settings. This may be particularly relevant to older adults, who traditionally have underutilized mental health treatment.

Practitioners

Cognitive bibliotherapy is completed by the older adult. For ethical and practical reasons, completely self-administered programs for older adults with depression are not advised (Scogin and colleagues, 1987). Practitioners with expertise in depression and CBT should provide at least minimal contact with the older adult.

Diagnoses or Disorders Addressed

- Major depression
- Minor depression
- Dysthymia
- Mild to moderate depressive symptoms, as indicated by a score of 10 or greater on the Hamilton Depression Rating Scale, or 11 or greater on the Geriatric Depression Scale.

Evidence and Outcomes

- Four randomized controlled trials have been conducted by multiple researchers.

Cognitive bibliotherapy is an effective treatment for older adults with mild to moderate levels of depression, compared to a waitlist or a placebo. It can reduce symptoms of depression in older adults. One small study found it to be as effective as cognitive therapy.

Settings of Research

- Non-clinic settings (e.g., community and home)

Populations Included in Research

Participants in studies of cognitive bibliotherapy were age 55 years and older, were primarily female and Caucasian, and most were unmarried. Most participants had graduated from high school. The number of study participants ranged from 20 to 44.

Training and Resources Available

Manual Availability

No formal treatment manual is available. However, evaluations of cognitive bibliotherapy have commonly used the book *Feeling Good* (Burns, 1980), which is available through bookstores and online (e.g., <http://www.Amazon.com> for under \$15).

- Burns, D.D. (1980). *Feeling Good: The New Mood Therapy*. New York: Avon. Revised and updated, 1999.

This book also has an accompanying workbook and has been translated into Spanish.

- Burns, D.D. (1990). *The Feeling Good Handbook*. New York: William Morrow and Co. Revised and updated, 1999.
- Burns, D. (1983). *Sentirse bien*. Barcelona: Paidós, 1990.

Evaluation of Learning Principles

The Cognitive Bibliotherapy Test is a 23-item, true-false test that is designed to measure learning of cognitive therapy principles presented in *Feeling Good* (Scogin, Jamison, Floyd, & Chaplin, 1998).

In a clinical setting, the test can be taken by older adults who have read *Feeling Good*. It could be used to track changes in the older adult's comprehension of cognitive therapy principles or to identify treatment principles that the older adult's practitioner should address.

Replications and Adaptations

Cognitive bibliotherapy has not been evaluated among older adults from racial or ethnic minority groups, or for older adults for whom English is not their first language. It also has not been evaluated in older adults with severe levels of major depression.

Key Issues Related to Implementation

Older adult characteristics: Practitioners who recommend cognitive bibliotherapy should consider the older adult's reading ability, visual acuity, concentration, and motivation to engage in a self-help program (Scogin and colleagues, 1987).

Financing: The cost of cognitive bibliotherapy is less than \$10 if there is no professional contact between the practitioner and the older adult (Landreville and Bissonnette, 1997). However, it is recommended that a practitioner should have at least minimal contact with the older adult during the intervention.



Selecting EBPs

Antidepressant Medications

Antidepressant medications are used to treat the symptoms of depression. Antidepressant medications act on chemical substances found in the brain, called neurotransmitters, which are deficient or out of balance in persons with depression. Antidepressant medications are provided by health care practitioners who are licensed to prescribe and monitor medications. They are effective in treating depression in older adults.

Need for Intervention

Antidepressant medications are the most commonly used intervention for the treatment of depression in older adults. Most antidepressant medications are prescribed by primary care practitioners as the primary treatment for depression. For some older adults, the combination of psychotherapy and antidepressant medications may be more effective than antidepressant medication alone (Thompson and colleagues, 2001) and may prevent or delay the

recurrence of depression (Reynolds and colleagues, 1999).

Medication treatment may be the most appropriate treatment for some people with depression. This may include older adults who have depression with psychotic symptoms, severe depression that has responded to antidepressant medications in the past, or severe depression that does not respond to psychotherapy. Medications also may be most appropriate for older adults with depression and dementia or another cognitive impairment that limits their ability to benefit from psychotherapy.

Although many older adults with major depression prefer psychotherapy (Gum and colleagues, 2006), there are several reasons why older adults may prefer to receive antidepressant medications. Older adults may prefer medications if they do not wish to attend multiple psychotherapy sessions. For the older adult, multiple psychotherapy sessions may be associated with challenges in transportation, physical mobility, cognition, cost, and stigma perceived in attending appointments with a mental health practitioner. Psychotherapy also may be inaccessible in some locations where older adults receive care. The 50 percent Medicare co-payment for outpatient psychotherapy also may have been a substantial barrier to the use of psychotherapy for some older adults.

Description of Intervention

Antidepressant medications are administered as pills that are prescribed by a health care practitioner. Antidepressant medications act on chemical substances found in the brain, called neurotransmitters, which are deficient or out of balance in persons with depression. Antidepressant medications may work by improving the levels of neurotransmitters that support the functioning of brain cells.

A particular antidepressant medication is selected on the basis of the characteristics of the older adult, the least likelihood of problematic side effects, and any past personal or family history of responding to specific antidepressant medications.

The health care practitioner regularly monitors the patient and adjusts the medication dosage accordingly. For example, a partial treatment response may require increasing the dose of the antidepressant, or switching to a different antidepressant. The development of common side effects such as sedation, insomnia, agitation, or nausea may indicate the need to decrease the dose,

or consider a different antidepressant if these side effects do not resolve or if they worsen over time. Finally, the development of more serious side effects such as confusion, irregular heart rhythm, marked increase or drop in blood pressure, falls, or allergic responses to medication require immediate medical attention.

A variety of types of antidepressant medications can reduce symptoms of depression in older adults. For example, selective serotonin reuptake inhibitors (SSRIs) are often effective in treating depression. SSRIs include Celexa (citalopram), Lexapro (escitalopram), Luvox (fluvoxamine), Paxil (paroxetine), Prozac (fluoxetine), and Zoloft (sertraline).

Tricyclic antidepressants (TCAs) are an older and sometimes less expensive type of medicine for depression. These drugs are effective, but may have side effects that can be particularly troubling in older persons such as increased falls due to a drop in blood pressure on standing, irregular heart rate, confusion, or urinary retention.

Monoamine oxidase inhibitors (MAOIs) are another group of older antidepressant medications that are rarely prescribed, and only in situations when other antidepressants have failed. MAOIs are generally contraindicated in older adults as they can be associated with falls due to low blood pressure or dangerous episodes of extremely high blood pressure when taken with particular foods (e.g., aged cheese, Chianti wine) or medications (e.g., SSRIs, stimulants, cough medications, painkillers).

Other non-SSRI antidepressants include Cymbalta (duloxetine), Desyrel (trazadone), Effexor (venlafaxine), Serzone (nefazodone), Remeron (mirtazapine), and Wellbutrin (bupropion).

Table 4: Common Antidepressant Medications for Older Adults

Brand Name	Generic Name
Selective Serotonin Re-uptake Inhibitors	
Celexa	Citalopram
Lexapro	Escitalopram
Luvox	Fluvoxamine
Prozac	Fluoxetine
Paxil	Paroxetine
Zoloft	Sertraline
Tricyclic Antidepressant Medications	
Aventyl, Pamelor	Nortriptyline
Norpramin	Desipramine
Monoamine Oxidase Inhibitors	
Nardil	Phenelzine
Parnate	Tranylcypromine
Non-SSRI Antidepressant Medications	
Cymbalta	Duloxetine
Desyrel	Trazadone
Effexor	Venlafaxine
Remeron	Mirtazapine
Serzone	Nefazodone
Wellbutrin, Zyban	Bupropion

Criteria for Medications

The antidepressant medications described in the KIT were chosen because systematic reviews of the scientific evidence indicate that these medications are effective.

Reviews use different levels of evidence to compare one or more medications. The American Medical Association uses the following criteria to describe the levels of evidence for comparing the effectiveness of medications (Guyatt and Rennie, 2002).

Level 1:

- Randomized controlled trials that directly compare the medication of interest with another medication of the same class to determine their effects on clinically important outcomes.

Level 2:

- Randomized controlled trials that directly compare the medication of interest with other medications of the same class for their effects on validated surrogate outcomes¹.
- Comparisons across two or more randomized controlled trials comparing medications with placebos, rather than with one another, for their effects on clinically important outcomes or validated surrogate outcomes.

Level 3:

- Comparisons across subgroups of people participating in different randomized controlled trials of medications versus placebo.
- Comparisons across placebo-controlled trials with unvalidated surrogate outcome measures.

Level 4:

- Comparisons from nonrandomized studies (observational studies and administrative database research).

¹ Surrogate outcomes are not the true goal of treatment, but are intended to substitute for the final outcome of interest. To have validity, a surrogate outcome measure needs to have a strong association (e.g., a statistical association or demonstrated causality) with the final outcome measure.

Evidence and Outcomes

- Randomized controlled trials have been conducted by multiple groups of researchers.
- Systematic reviews and meta-analyses have been performed on sets of 7 to 18 randomized controlled trials comparing an antidepressant to a placebo and sets of 9 to 29 randomized controlled trials comparing two or more antidepressants.

Antidepressant medications are more effective than placebo (e.g., a sugar pill) in treating depression in older adults. Over half of older adults treated with antidepressant medications respond to treatment (defined as a 50 percent reduction in depressive symptoms). In intent-to-treat analyses², the response rates to antidepressants are 50 to 65 percent compared with 25 to 30 percent on placebo in randomized controlled trials.

Antidepressant medications also can reduce thoughts of suicide, improve cognitive and functional status, and prevent relapse and recurrence of depression.

A systematic review of randomized controlled trials found that different types of antidepressant medications (including TCAs and SSRIs) are equally effective in improving symptoms of depression. However, older adults who take TCAs are more likely to discontinue medication treatment due to worse side effects.

Evaluations of the effectiveness and safety of different types of antidepressant medications have resulted in the general recommendation of the SSRIs or selective serotonin and norepinephrine reuptake inhibitors (SSNRIs) (e.g., venlafaxine, duloxetine) as first line antidepressants in the treatment of depression for most older adults.

² An intent-to-treat analysis includes all randomized patients in the groups to which they were randomly assigned, regardless of the treatment they actually received and regardless of subsequent withdrawal from treatment or deviation from the protocol.

Although SSRIs and TCAs have comparable efficacy and rates of side effects, there are some differences in safety.

Common side effects with SSRIs include nausea, loss of appetite, agitation, insomnia, and sexual dysfunction. An uncommon, but serious side effect associated with SSRIs and SSNRIs is SIADH, or Syndrome of Inappropriate Antidiuretic Hormone. SIADH impairs the older adult's ability to excrete water, resulting in low body sodium and symptoms of confusion, weakness, decreased appetite, lethargy, seizures, and coma. Serotonin syndrome is another rare, though serious potential side effect of SSRIs and SSNRIs that most often occurs when two drugs affecting serotonin are taken at the same time. This potentially life-threatening syndrome includes agitation, uncoordinated movements, tremor, heavy sweating, over-reactive reflexes, muscle spasms, diarrhea, fever, renal failure, seizures, and confusion.

In contrast, TCAs are more likely to result in anticholinergic side effects (such as confusion, urinary retention, and delirium) or serious cardiovascular side effects. TCAs also are more likely to result in death in an overdose compared to SSRIs.

The choice among different antidepressants may be guided by potential drug interactions, simplicity of dosing, and side effect profiles.

Older adults typically begin to respond to antidepressant medication within four to six weeks of starting treatment. The benefits of treatment can increase with continued treatment. However, side effects also may appear over time as the medication accumulates in the body. Acute treatment generally lasts from 12-16 weeks.

The starting dose of antidepressant medication for older adults is often half of what is recommended for young and middle aged patients due to age-related changes in the body's ability to absorb, distribute, metabolize, and eliminate medications. Especially low starting dosages (sometimes one

quarter of what is recommended for younger adults) are prescribed to the most frail, oldest, and medically complex patients.

Aging is associated with reduced total body water and blood protein, increased body fat, reduced kidney and liver function, and differences in sensitivity to medications. In general, these changes mean that older, compared to younger adults, may experience higher blood levels of medications at the same dose, and longer periods of time required to metabolize or eliminate the drug from the body. This greater sensitivity to medications is further complicated by the frequent presence of other medications for physical conditions that commonly affect older adults

If there is little or no response to an initial SSRI, switching to a non-SSRI antidepressant (e.g. venlafaxine XR or bupropion SR) or a tricyclic antidepressant may be indicated.

Persistence is important to finding the best antidepressant medication. Among adults (aged 18+) with depression who required trials of one or more antidepressant medications, only 37% achieved full remission with the initial choice of an antidepressant agent. Among the remaining adults with partial or no treatment response, 31%, 14%, and 13% achieved remission with the second, third, and fourth trials of alternate antidepressant medications, respectively (Rush and colleagues, 2006).

Once an older adult responds to treatment, they should receive maintenance treatment to prevent the recurrence of depression. Older adults (aged 70+) who responded to treatment for major depression (many having their first episode of depression) were 2.4 times less likely to have a relapse of depression if they continued to receive an SSRI medication for the following two years, compared to placebo.

Maintenance treatment is recommended for 6-12 months following a single episode of depression for older adults, and from one to three years for patients with recurrent depression.

Where Can You Find Medication Treatment

Antidepressant medications are one of the most widely available treatments for older adults with depression. They are available in physical health and mental health care settings that have practitioners who are licensed to prescribe medications.

Practitioners

Antidepressant medications can be provided by health care professionals who are licensed to prescribe medications (e.g., psychiatrists, primary care practitioners, nurse practitioners, and psychologists – psychologists have prescribing privileges in New Mexico and Louisiana).

The common occurrence of major physical health conditions, multiple medications, and greater sensitivity to side effects experienced by older adults requires that a medical evaluation and review occur before antidepressants are prescribed, followed by ongoing medical supervision.

Diagnoses or Disorders Addressed

- Major Depression
- Minor Depression
- Dysthymia

Antidepressant medications also are effective in older adults with Unipolar Depression and Non-specified Depression.

Settings of Research

- Outpatient physical and mental health care
- Inpatient physical and mental health care
- Community-based services
- Nursing homes

Populations Included in Research

The systematic reviews of antidepressant medications included studies of older adults with depression. They excluded older adults with dementia or other mental disorders, but included older adults with co-occurring physical disorders. Study participants were of either sex and were age 55 or older.

Little is known about the treatment preferences of racial or ethnic minority groups, and few studies have compared the use of antidepressant medications across these groups. Older African Americans are less likely to receive antidepressant medications than older Caucasians (Grunebaum and colleagues, 2008; Blazer and colleagues, 2005). In contrast, Latinos are more likely than non-Latinos to receive antidepressant medications (Grunebaum and colleagues, 2008). More information is needed to help us understand whether these differences are related to older adults' treatment preferences or practitioners' prescribing practices.

Training and Resources Available

Manual Availability

Protocols can inform the delivery of antidepressant medications. Protocols for delivering antidepressant medications to older adults with depression have been developed as components of two models of collaborative and integrated mental and physical health care.

The Improving Mood, Promoting Access to Collaborative Treatment (IMPACT) program manual includes a protocol for treatment with antidepressant medications.

- Unützer, J., Oishi, S. & The IMPACT Study Investigators. (2004). *Project IMPACT Intervention Manual: Late Life Depression Treatment Manual for Collaborative Depression Management*. UCLA Neuropsychiatric Institute Center for Health Services Research. Available at http://impact-uw.org/tools/impact_manual.html

The Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) medication algorithm is available at:

- Mulsant, B.H., Alexopoulos, G.S., Reynolds, C.F., 3rd., et al. (2001). Pharmacological treatment of depression in older primary care patients: The PROSPECT algorithm. *International Journal of Geriatric Psychiatry*, 16(6), 585–592.

Information for Practitioners and Older Adults

The Agency for Healthcare Research and Quality has prepared a comprehensive review of the effectiveness and safety of second-generation antidepressants in adults, with a focus on older adults (Gartlehner and colleagues, 2007). The report is accompanied by a practitioner and a consumer guide, which are available to the public.

Practitioner Guide

<http://effectivehealthcare.ahrq.gov/repFiles/AntidepressantsClinicianGuide.pdf>

Consumer Guide

<http://effectivehealthcare.ahrq.gov/repFiles/AntidepressantsConsumerGuide.pdf>

Training and Technical Assistance

Health care practitioners who provide antidepressant medications receive formal training from a medical school or other formal institution for medical education. Practitioners require licenses to prescribe antidepressant medications.

Key Issues Related to Implementation

Medication side-effects and interactions:

Due to the potential for medication side-effects, practitioners should obtain the older adult's history of adverse medication responses and associated doses and concentrations. Tolerability of specific agents should guide the selection and dosing of antidepressant medications.

As people age, changes in body fat distribution and other physical characteristics change the way that they metabolize or break down medications. An important principle of treatment is to begin with low medication dosages and increase dosages slowly, as necessary. Once medications are started it may take much longer for the medication to be eliminated from the body, compared to a younger adult.

Numerous prescribed medications can interact with antidepressant medications. Medications should not be mixed without consulting a physician or pharmacist. Some over-the-counter medications for common physical disorders can interact with antidepressant medications, causing serious side effects or toxicity. For example, serious side effects in older adults can be caused by interactions between some antidepressants and diphenhydramine (Benadryl), antihistamines, cough medications (containing dextromethorphan), cold medications (containing ephedrine), St. John's Wort, and alcohol. Side effects from drug interactions can include confusion, increased chance of falls, lower functioning, and can result in hospitalizations and even death.

Patients and family members can help to prevent serious drug interactions by keeping a list of all prescribed and over-the-counter medications and by requesting that different prescribing practitioners communicate or share medical records to make sure that medications are checked for interactions in dosage levels.

The high number of medications taken by older adults also can lead to poor medication adherence and medication self-administration errors.

Strategies to increase the safety of older adults taking multiple medications:

- Reduce the complexity of scheduling times to take medications.
- Recommend the use of medication organizers.
- Provide educational supports.

Important Information for Older Adults:

Older adults who are prescribed antidepressant medications should know that some people experience side effects initially and may find that the side effects diminish as their body gets used to the new medication. Results of treatment using antidepressant medications vary depending on the individual. Treatment works gradually over several weeks. It may take a month before the older adult or practitioner can begin to see the benefits of medication. Ongoing monitoring is recommended.

Selecting EBPs

Multidisciplinary Geriatric Mental Health Outreach Services

Multidisciplinary geriatric mental health outreach services are effective in identifying, referring, and treating older adults with depression in a variety of community-based residential settings. Settings include senior housing, home-care, and assisted living. Several models have been tested and proven effective, including the PATCH and PEARLS models.

Multidisciplinary geriatric mental health outreach programs provide depression treatment in the homes of older adults or in the locations where older adults frequently spend time, instead of a clinic or office. These services often involve practitioners with different training and skill sets, such as psychiatrists, psychologists, social workers, nurses, or professional counselors.

Outreach services are designed to detect and treat mental health problems. Elements of outreach services can include:

- case finding,
- assessment,
- referral,
- treatment, and
- consultation, education, and training

Treatment recommendations can vary for different older adults and are implemented through a variety of sources. Some outreach teams conduct assessments and then refer older adults to other existing treatment programs. Other outreach teams will employ practitioners who both assess and provide treatment to older adults.

An outreach program might offer early intervention services, facilitate access to preventive health care services, provide evaluation services, refer individuals to community treatment or supportive services, and provide services that improve community tenure.

About half of older adults with a recognized mental disorder fail to receive mental health services (Klap and colleagues, 2003). Providing outreach services to older adults in the community has been promoted as a way to increase access to mental health care.

Criteria for Outreach Interventions

Multidisciplinary geriatric mental health outreach is an approach to delivering services to older adults. There are several different models for delivering outreach services. The structures and components of each model of outreach services are similar; however, the actual treatment delivered to the older adult, such as psychotherapy or antidepressant medication, varies depending upon the older adult's treatment needs.

Although none of the specific models of outreach services have been studied enough times to meet the criteria for an EBP alone, multidisciplinary geriatric mental health outreach services are included in this KIT as an EBP because studies conducted across several distinct outreach service models have shown this type of service delivery to be effective.

Evidence-based Outreach Services for Treatment of Older Adults with Depression

The combined evidence from several different programs show that outreach services are an effective way of improving depressive symptoms in older adults, compared to usual care. Outreach models also can increase older adults' access to depression treatment.

Five randomized controlled trials that were conducted by *multiple groups of researchers* across different outreach programs show that this model of care is effective. In addition, several other studies that are not as rigorous also indicate that outreach services are effective.

Four models of outreach services are effective in treating depression in older adults. These include:

- Psychogeriatric Assessment and Treatment in City Housing (PATCH),
- Program to Encourage Active, Rewarding Lives for Seniors (PEARLS),
- Multifaceted Shared Care Intervention, and
- The Gospel Oak Depression Program.

These are described in the pages that follow.

Where Can You Find Outreach Services

Outreach services are provided by teams of practitioners who are trained in several disciplines. Practitioners may have specialized training to provide mental health, aging, or general medical health services.

Outreach services are delivered by practitioners who work in home and community-based locations. For example, outreach services that have been shown to help reduce depression in older adults have been provided in:

- senior public housing,
- the homes of older adults, and
- residential care facilities.

Comprehensive Review of Outreach Services

Bruce, M. L., Van, Citters, A. D., & Bartels, S. J. (2005). Evidence-based mental health services for home and community. *Psychiatric Clinics of North America*, 28(4), 1039–1060.

Frederick, J. T., Steinman, L. E., Prohaska, T., et al. (2007). Community-based treatment of late life depression: an expert panel-informed literature review. *American Journal of Preventive Medicine*, 33(3), 222–249.

Van Citters, A.D., & Bartels, S.J. (2004). A systematic review of the effectiveness of community-based mental health outreach services for older adults. *Psychiatric Services*, 55(11), 1237–1249.



Psychogeriatric Assessment and Treatment in City Housing (PATCH)

Psychogeriatric Assessment and Treatment in City Housing (PATCH) is a multidisciplinary mobile outreach treatment program. Care is provided in the homes of older public housing residents by a psychiatrist, nurse, and a case manager. PATCH is effective in identifying and reducing depression in older public housing residents.

Description of Intervention

Psychogeriatric Assessment and Treatment in City Housing (PATCH) is a mobile outreach program that was developed in Baltimore, Maryland.

The PATCH model includes:

- identification of at-risk older public housing residents by casefinders (e.g., building managers, janitors, and tenant services);
- evaluation by a PATCH nurse including mental and physical health history and family and social history;
- development of a therapeutic relationship between the PATCH team and the older adult that includes building rapport and trust;
- coordination with a team psychiatrist, nurse, and case manager and development of a treatment plan; and
- tailored interventions that match the needs of the older adult and can include psychotherapy, medication, and other necessary services (e.g., transportation to medical appointments, financial assistance, and other community supports).

Many older adults in public housing facilities have physical or mental health problems that prevent them from accessing treatment in traditional health care settings. Treating emotional distress may

prevent unnecessary hospitalization, homelessness, and nursing home placement. It also may improve residents' adjustment to and acceptance of aging.

Practitioners

- PATCH case identification services are provided by public housing staff. The staff is trained to identify the signs and symptoms of mental illness and report potential problems to housing managers or building counselor, who then relay referrals to the PATCH treatment team.
- PATCH treatment services are provided by a team composed of a psychiatrist, nurse, and case manager.
- Each team can provide active treatment to 30 older adults.

Diagnoses or Disorders Addressed

- Major Depression
- Dysthymia

The PATCH model also has been tested in older adults with other mental health problems or cognitive impairment.

Evidence and Outcomes

The PATCH model was tested in a randomized controlled trial (Rabins and colleagues, 2000).

Compared to typical care, PATCH:

- reduced symptoms of depression,
- reduced other psychiatric symptoms, and
- may increase the length of time that older adults can live independently in their own apartments.

Settings of Research

- Senior public housing

Populations Included in Research

- Study participants were aged 60 and older who live in public housing facilities; 25 percent were aged 80 or older.
- Participants predominantly were female (77 percent), lived alone (89 percent), and had lower income.
- Ninety percent of participants were African American.

Training and Resources Available

Manual Availability

The PATCH program has a brief manual for practitioners. It also has a set of seven training modules that it uses to train public housing authority staff to identify and refer older adults who might need PATCH services.

Training and Technical Assistance

PATCH responds to inquiries by providing telephone-based technical assistance. In addition to the manual, other materials include a packet of four published articles that describe the program and staff roles. The PATCH staff is considering the development of a training program that would be offered at the Johns Hopkins Medical Center in Baltimore, Maryland.

Replications and Adaptations

The PATCH program serves older adults in housing facilities spread across the city of Baltimore. The program began in two housing facilities and has expanded to provide services to older adults in nineteen housing facilities within the city of Baltimore. The program has not been adapted for use with other populations of older adults.

Key Issues Related to Implementation

Therapeutic Relationship: Establishing trust and rapport is essential for delivering in-home treatment to older adults.

Collaboration: The public housing authority is a key stakeholder and should be involved in all stages of program implementation.

Financing: Innovative and creative methods for financing PATCH are needed.

Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) is a manualized, home-based outreach program. It is effective in treating late-life minor depression and dysthymia when provided in residential settings. Trained social workers provide eight sessions of problem solving treatment (PST) in conjunction with increasing participation in pleasant events.

Description of Intervention

Although higher rates of depression exist among medically ill, socially isolated, homebound, or functionally impaired older adults, these characteristics may also lead to inadequate recognition and treatment of depression. The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) addresses these issues. PEARLS is an outreach program that was developed in Seattle, Washington.

Trained social workers deliver the PEARLS intervention in the older adult's home during eight 50-minute sessions that occur over a 19-week period. The first two sessions occur weekly, the second two sessions occur every other week, and the final four sessions occur every fourth week.

Practitioners use three depression management techniques:

- problem solving treatment, in which the older adult is taught to recognize depressive symptoms, define problems that may contribute to depression, and devise steps to solve these problems;
- social and physical activation, in which the older adult is assisted in developing a program of social, recreational, and physical activities; and

- pleasant activity scheduling, in which the older adult is encouraged to engage in a pleasant activity (i.e., gardening, reading a magazine, taking photographs).

Counselors encourage participants to use existing community services and attend local events. They also work with a psychiatrist to provide potential recommendations to the older adult's primary care physician regarding the use of antidepressant medications.

Practitioners

- PEARLS treatment is provided by master's level social workers.
- Collaboration occurs between the social workers, a psychiatrist, and the older adults' primary care practitioner.
- Social workers carry 3 to 8 active cases. For cases lacking continued improvement after 4 to 5 sessions, the psychiatrist contacts the older adults' primary care practitioner to recommend initiating or adjusting antidepressants and to assess potential physical health, prescription medication, or substance abuse causes for depressive symptoms.

Diagnoses or Disorders Addressed

- Minor Depression
- Dysthymia

Evidence and Outcomes

The PEARLS outreach model was evaluated in a randomized controlled trial (Ciechanowski and colleagues, 2004).

Compared to older adults receiving usual care, after one year PEARLS participants were:

- more likely to have at least a 50% reduction in symptoms (43% vs. 15%),
- more likely to achieve complete remission from depression (36% vs. 12%), and
- more likely to report greater improvements in functional and emotional well-being.

A greater number of older adults participating in the PEARLS intervention received psychotherapy or antidepressant medications for depression, compared to those receiving usual care.

Settings of Research

- Home
- Urban and suburban settings

Populations Included in Research

- Study participants were aged 60 and older and were receiving home-based services from senior service agencies or living in senior public housing. Many participants were medically ill and had low incomes. Most were homebound.
- 79 percent were female.
- 58 percent of participants were Caucasian, 36 percent were African American, 4 percent were Asian American, 1 percent were American Indians or Alaska Natives, and 1 percent were Latino.

Training and Resources Available

Manual Availability

The PEARLS Implementation Toolkit offers detailed information on recruitment and screening, conducting PEARLS sessions, PST, data management, and clinical supervision.

- University of Washington Health Promotion Research Center. (2007). *PEARLS Implementation Toolkit*. Seattle, WA. <http://depts.washington.edu/pearlspr/>

Information for Older Adults

Some information in the PEARLS toolkit (i.e., an overview of depression symptoms and treatment) is designed for the PEARLS counselor to share with older adults.

Training and Technical Assistance

In-person training is available on an as-needed basis, and limited guidance and suggestions for program adaptation are available for PST.

Fidelity Measure

Quality assurance forms for the PEARLS program are provided by the program developers to assist supervisors in monitoring implementation fidelity. A fidelity measure is being developed for a CDC-funded dissemination research study.

Replications and Adaptations

PEARLS has been implemented in the Seattle, Washington area through two local agencies, Aging and Disability Services and Senior Services of Seattle/King County. It also will be implemented in the Spokane, Washington area by the local AAA (Aging and Long-term Care of Eastern Washington, ALTCEW).

To date, the program has not been adapted for use with other populations of older adults.

Key Issues Related to Implementation

Financing: The cost to implement PEARLS is about \$630 per patient. This estimate is based on mean costs in the 2000-2003 study, which included problem solving treatment sessions (\$422), follow-up and psychiatric telephone calls (\$40), psychotherapy quality assurance (\$87), and depression management team sessions (\$81).

PEARLS can be disseminated within community organizations that provide care for isolated, low-income older adults. Depression management can be added to existing case management services. Most social service agencies have mental health consultants who could provide oversight and quality assurance of case managers who are trained to provide PEARLS. Consultants could also deliver targeted brief telephone communication with physicians and with older adults with more severe or complex depression.

Barriers to implementation may include the lack of training infrastructure and the challenges of recruiting older adults with depression.

Other Models of Multidisciplinary Community-based Mental Health Outreach Services

Two other models of multidisciplinary community-based outreach have been tested with older adults in randomized, controlled trials.

These studies were conducted in Sydney, Australia and London, England. To our knowledge, these models have not been disseminated or used within the United States. As such, only a brief description of the intervention and supporting references are provided.

Multifaceted Shared Care Intervention

The Multifaceted Shared Care Intervention was delivered in Sydney, Australia. It combines practitioner education with health education and health promotion for the entire population of a large residential facility.

The main issues that it addresses are:

- increasing the detection rate of depression by carers,
- getting older adults to accept that depression is treatable, and
- providing accessible treatment programs in residential care.

Key elements of the intervention include removing barriers to care, practitioner education, and health education and health promotion.

Removing barriers to care is achieved by:

- promoting holistic coordinated health care through multidisciplinary collaboration;
- primarily delivering care by general practitioners and residential staff, with specialist help available;

- ensuring program feasibility and acceptability by meeting regularly with general practitioners, residents, staff, the local psychogeriatric service, and project team representatives; and
- conducting monthly liaison committee meetings to improve general practitioner and staff communication.

Practitioner education is achieved through:

- practical, case-based education that enhances pre-existing skills and promotes both psychosocial treatments and antidepressants at adequate dose and duration,
- interactive workshops for general practitioners on assessing and managing depression and related comorbid illness, and
- depression education and support for staff from a psychogeriatric nurse.

Health education and health promotion is achieved through:

- marketing the program as “healthy ageing” to minimize stigma;
- encouraging residents to recognize depression, seek help, and attend positive activities;
- sending a bimonthly newsletter that combats misconceptions about depression and its treatment to all residents, general practitioners, and staff (also available on audiotape);
- encouraging activities that include graded gentle exercise classes and talks on depression, chronic pain, relaxation and stress management, arthritis, osteoporosis, and prevention of falls; and
- developing a volunteer program to provide emotional support and assist frail, isolated, depressed residents to participate in activities.

Introduction to Case Briefs

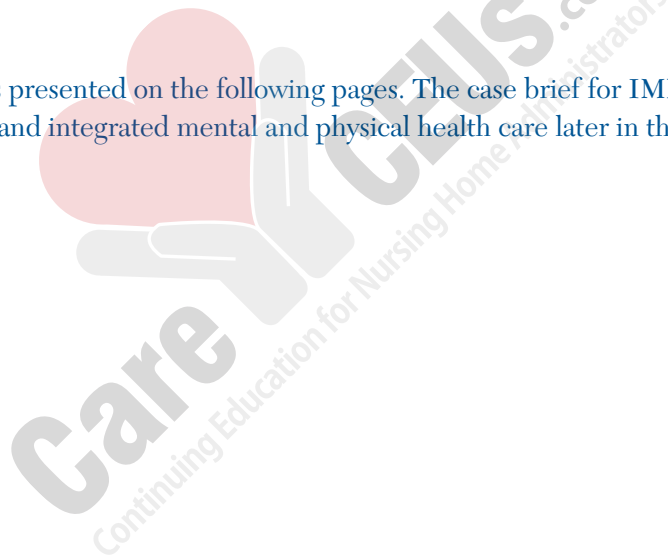
Site visits at two programs were conducted to learn in-depth information about particular aspects of implementing EBPs for older adults with depression. The site visits provided information about the development of the infrastructure needed to implement and provide EBPs, such as financing and training, as well as reflections on the implementation process by program leaders, practitioners, and older adults and their family members or caregivers.

Two case briefs summarize these site visits and are included in this KIT to illustrate how actual programs have addressed the challenges of implementation. The two case briefs focus on multidisciplinary geriatric mental health outreach and collaborative and integrated mental and physical health care. Case briefs describe:

- Psychogeriatric Assessment and Treatment in City Housing (PATCH) - a mobile treatment program that reaches out to older adults with mental illness who live in public housing in Baltimore, Maryland, and
- Improving Mood, Promoting Access to Collaborative Care (IMPACT) - a model of care that integrates mental health services into the primary care setting in New York City, New York.

These two models of outreach and collaborative care incorporate different intervention approaches, and include some of the psychotherapeutic interventions described in the KIT. Thus, these case briefs serve as a model for examining and addressing critical issues related to EBP implementation for the range of EBPs presented in this KIT.

The case brief for PATCH is presented on the following pages. The case brief for IMPACT follows the section on collaborative and integrated mental and physical health care later in this booklet.



Our goal is to keep people in their home for as long as they would like and as long as it's safe. When we talk to the clients or patients that we treat, that's always what they tell us they want. They don't say, 'I want to be healthier, I want my mental health problems treated.' They say, 'I want to stay in my home as long as I can.' By focusing on the social, the medical and the psychiatric, we allow lots of people to meet that goal.

Program Director

Along with the management staff, we have maintenance crews that go into the homes and observe a particular behavior. ... And we have security that's at the front desk. Sometimes they're the first line that sees the individual and they will note a behavior... And then, at that point, we follow up.

Housing Manager

Components

The PATCH program includes:

- case identification,
- an intake evaluation (and follow-up assessment when necessary), and
- ongoing multidisciplinary treatment that is provided by a nurse, psychiatrist, and case manager and includes referrals to appropriate services.

Case identification

PATCH uses the gatekeeper model of case finding. This model trains people who have contact with older adults to be case finders. In PATCH, this includes public housing building managers, counselors, postal workers, security staff, maintenance staff, and other individuals.

PATCH nurses conduct in-service trainings to educate staff within the housing facility to identify signs and symptoms of mental illness. Staff report potential problems to the housing managers or building counselor, who then relay referrals to PATCH, which is housed in the Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center.

Intake evaluation

PATCH nurses receive referrals and conduct an in-home assessment. Given the history of public health nursing and home health nursing, PATCH nurses often are able to build rapport with the older adult and be allowed into their homes. Older adults are more likely to accept assessment and services if the nurse can help them with a problem that they prioritize (even if it is not a mental or physical health problem).

If you somehow find a way ... to help them with something that they think is necessary, which usually is not their medical illness or their psychiatric illness, then you have a way to get the rest of their needs addressed.

Nurse

The intake evaluation covers a variety of issues.

- The nurse conducts a global assessment of well-being and a standard psycho-social assessment. This includes: demographic information, medical and psychiatric history, social support, safety, medications, general functioning (screening of functional capacity and independence), and general health (height, weight, blood pressure, and a medical problems checklist).
- Formal standardized symptom monitoring includes the Mini Mental State Examination (MMSE), Montgomery-Asberg Depression Scale, and the Brief Psychiatric Rating Scale (BPRS).

- The psychiatrist reviews the nursing assessment (in verbal and written form), conducts an assessment of medication needs, and provides additional diagnostic evaluation.

The minute you walk in someone's house, you know more than you'll ever learn in following somebody for years in a clinic, because the organization of the apartment, the way their medicines are organized or not, food that's in the house, I mean, there's a ton of information about how someone's functioning that you wouldn't have in a clinic setting.

Nurse

In addition to having a better idea about the complexity of the problems, you also get a much better sense of how well someone can function with the right supports in place. I got an incredible experience that I took to my practice with not only learning about the community resources that I could implement to keep somebody at home, but also the resilience and the capacity that someone has.

Psychiatrist

Multidisciplinary treatment

Following assessment, the PATCH mobile outreach team meets to develop a treatment plan that focuses on mental health, physical health, and support services. Treatment involves practitioners from psychiatry, nursing, and case management who work together to provide comprehensive in-home services that address the older adults' physical and mental health needs. Ongoing follow-up is provided by the nurse.

PATCH relies on collaborative relationships and coordination with other service providers. Outside services include those of Adult Protective Services, Area Agencies on Aging, Department of Social Services, Housing Authority staff and management, Meals on Wheels, Home Health, and others.

Support services offered by PATCH are important to the older adults. The case manager networks with community resources to help the older adult access support services. Networks are often developed through word of mouth and practitioner creativity.

PATCH can help older adults to address a variety of needs. These include, but are not limited to:

- help with problems in the living environment (including improving home safety and accessing home furnishings);
- help with medications (including answering questions, teaching skills for refilling prescriptions, and following medication schedules);
- help with medical appointments (including assistance with remembering appointments, accessing transportation, and understanding or following through with practitioner recommendations); and
- help to stay active and be more independent (including assistance with shopping for healthy foods or nutritional supplements and assistance finding meaningful activities such as work or a volunteer job).

You have to be extremely creative to go out there to find what you don't think is there, and it's there somewhere if you make the right connections.

... You really develop a social network and a professional network all around your area to help address and provide the services for people.

Case Manager

[PATCH] does help us, there is no doubt about that. They do a lot for me. ... They bring my spirit up ... You look at me and when they come in I'm cheerful, I'm happy. I know they're going to be there. They come to my apartment to make sure I'm okay. ... I want people to treat the people like they are treating me. See, there are people out there just like me and they need help, they don't know how to go about getting help. I've been lucky. See, I've been lucky. I think about that ... I got people on my side helping me. ... They're helping me and their program is beautiful.

Older Adult Resident

They have been very, very helpful with identifying, as well as following up on things that we identify, to help people not be evicted, not be in their units without taking their meds, not be there without anyone to speak with as far as making doctors' appointments or even eating on a day-to-day basis.

Housing Manager

We've demonstrated that you are treating and serving and collaborating with other agencies to care for folks that are never going to be found. PATCH clients would never have been identified without, number one, the training that PATCH has provided to direct care folks in the buildings. I think what happens in buildings where there isn't a PATCH kind of program... folks probably get evicted much sooner, hospitalized sooner.

Mental Health Authority

Nurse: 30-32 hours per week per team: The nurse is the first contact with the referred older adult and completes an initial assessment. The nurses establish rapport, gather information for determining a diagnosis, and manage behaviors and physical and mental health problems.

Psychiatrist: ½ day per week: The psychiatrist conducts a standard psychiatric diagnostic assessment and develops a treatment plan with the older adult and treatment team. Additional activities are dictated by the older adult's condition or treatment plan (e.g., older adults receiving medications must be seen every 90 days).

Case manager: 1 day per week per team: The case manager helps coordinate services, arrange and monitor medical appointments, assist with conflict resolution, arrange for transportation and meals, and help solve problems with benefits and entitlements.

Having a complete team is the foundation for this program to be successful in any community. Having a successful team from the administration, from the psychiatrists, from the nurses who go out and perform the assessments, to a case manager...

Case Manager

Caseload: Each team has an average case load of about 30 older adults. PATCH's funding agency expects them to see 70 new cases each year.

Duration of treatment: The program goal is to transition older adults to traditional outpatient services within six months, with services occurring on an as-needed basis. Many older adults are able to successfully transition within a year, but the duration and intensity of treatment varies across individuals.

Staffing and intensity of services

A PATCH team includes a nurse, a geriatric psychiatrist, and a case manager. The roles of these practitioners are complementary and each is essential for the program. PATCH currently runs two clinical teams, as follows:

Provision of the Program

Training

Education of Mobile Treatment Team

The skills of a nurse, psychiatrist, and social work case manager are necessary for delivering PATCH. Much of the training is “on the job” through interactions with colleagues. Practitioners should have experience working in the community to allow them to better access available services. Important staff characteristics include knowledge of geriatrics and psychiatry, an interest in working with older adults, compassion, patience, maturity, sense of humor, motivation, creativity, and flexibility.

- Practitioners in the mobile treatment team need competence in physical and mental health issues, ethical issues, an ability to function in the community and access services, and an ability to work with a team.
- Nurses should have Bachelor’s-level training, with a medical and psychiatric background, and receive additional psychiatric training and back-up from geriatric psychiatrists and fellows.
- Psychiatrists receive enhanced training from a practitioner (e.g., nurse) who can teach skills for assessing how an older adult will function in a community. Additional training or support is important around ethical issues (e.g., capacity to make decisions, ability to decide when to take away someone’s choice or independence).
- The case manager has formal training in psychology, as well as knowledge of the resources and services available in an area. The case manager must develop community networks that allow access to resources.

Education of Housing Authority Staff

- PATCH nurses provide in-service training for staff that work in the Housing Authority buildings, including managers, counselors, maintenance staff, security staff, cashiers, and others who come in contact with residents.
- PATCH staff provide a 7-module education series. Sessions include: (1) normal aging; (2-5) signs and symptoms of major mental illness, including depression, dementia, schizophrenia, and alcoholism; (6) how to do an emergency petition (e.g., hospitalized or evaluated by a psychiatrist against the patient’s will when he or she is at imminent risk of danger to themselves or others); and (7) issues related to death and dying.
- Housing Authority staff receive periodic retraining, with approximately six in-services provided across housing facilities in a year. PATCH staff also evaluate the need for additional training if referrals slow down.

As it’s been explained to us by the PATCH representatives, depression stops you from functioning completely, even paying your rent. So when management comes to me and says, ‘We’ve got a potential eviction situation,’ then I go in and I say, ‘Okay, let me do a home visit and see what the situation is.’ In doing so and observing, perhaps, what’s going on with a particular individual, it keys me to the importance of contacting PATCH immediately as it relates to our seniors. When someone just simply stops functioning, there’s a lot more to be addressed than an eviction. There’s the human element. And that’s the one thing that I really love about PATCH. They’re dealing with the human element constantly as they relate to our senior population.

Housing Counselor

Supervision and support

Mobile Treatment Team

- The nurses and case manager receive weekly supervision with a nurse supervisor to discuss emerging issues and provide team support.
- The psychiatrist and nurse meet weekly while visiting older adults in the housing facilities. This meeting may address clinical questions on patients who are seen jointly. The psychiatrist also is available to answer the nurses' questions on an as needed basis.
- The full staff from both outreach teams, including the program director (a psychiatrist) and nurse supervisor, meet once per month to review all cases.
- There are also continuing education opportunities in geriatrics, mental health, new research and treatments, and other issues that are provided to all staff of the Johns Hopkins Medical Center.

Housing Authority Staff

- Informal education is provided to Housing Authority management and staff. The PATCH team provides ongoing on-site training through their day-to-day interactions with housing staff.
- PATCH provides additional support by having an open dialogue and collaboration with Housing Authority management and staff. Management staff typically communicate with PATCH nurses on a weekly to biweekly basis. The on-site residential counselor typically communicates with the PATCH team every three weeks.

I refer most of my elderly clients who are dealing with depression and mental illnesses. And through that, I normally have follow-up meetings with the PATCH coordinators. They've been a very, very helpful tool to help me with my job, as well as to provide the services that I'm responsible for.

Housing Manager

Special skills for working with older residents

Working with older adults in public housing requires attention to several issues. These include:

- Establishing rapport,
- Continuity of care and follow-through,
- Safety for staff, including a safety and weapons assessment, as well as collecting background information on the patient prior to making contact, and
- Addressing co-occurring physical and mental health problems, as well as support issues.

Ethical issues: Blass and colleagues (2006) provide a review of ethical issues that the PATCH treatment team may encounter. The reader is referred to that article for a discussion of:

- Establishing the treatment contract versus the right to refuse treatment,
- Protecting confidentiality versus patient protection,
- Protecting autonomy versus asserting beneficence,
- Treatment termination versus open-ended treatment, and
- Cost versus benefit of care.

You have to believe in what you're doing, you have to have a lot of patience and a lot of perseverance, because you will hit roadblocks. And when you hit them, you just have to smile and know that when you bust through them it's such a great sense of satisfaction and reward to know that [the older residents] appreciate what you're doing.

Case Manager

Sometimes people get pessimistic in the face of complex problems. One of the things about working with older individuals is that problems are often complicated. We think that by having a model that brings services to people we're able to break through some of the complexity, the transportation needs that are often very challenging, the unmet medical need. While the problems are complex, when you focus on one issue at a time, set up a treatment plan where you can sequentially address issues you can make a huge difference. And even when we can't, I think we can improve the quality of life of a person and in that way I think benefit them as well.

Program Director

Feedback and evaluation

A brief set of outcomes are regularly evaluated by the PATCH mobile treatment team.

Depending upon the older adult's presenting problem, clinical outcomes may include the following measures and are collected every 6 months, or more frequently if needed:

- Depression: Montgomery-Asberg Depression Scale,
- Cognition: Mini-Mental State Examination (MMSE), and
- Psychiatric symptoms: Brief Psychiatric Rating Scale (BPRS).

Service provision (collected on a quarterly basis):

- number of new referrals*,
- number of referrals that accept service,
- number of clients in an ongoing case load,
- number of follow-up visits by a practitioner,
- number of trainings (including fluctuation in referrals around a training), and
- success in transitioning clients from home based services to clinic services.

Feedback and satisfaction from building managers is obtained on an ongoing basis.

** The Housing Authority also monitors the number of referrals to PATCH, including the date of referral and closure of cases.*

Informal assessments of fidelity are conducted routinely by the program manager during supervision meetings. No fidelity scale has been developed for PATCH.

You can visually see that there's a change happening to the person. ... cleanliness, seeming to be more relaxed. ... You see that they are perhaps even maybe a little bit more verbal. You see that they are now taking control of their lives a little bit more, even to the effect of management issues, that is as it comes to paying rent on time.

Housing Counselor

Implementation Considerations and Tasks

PATCH Requirements

- Practitioners who are knowledgeable about mental health needs of older adults.
- A community (e.g., building managers, senior community center program directors, aging program directors) that is willing to support this program and recognize that there is an unmet need for older adult services.
- A mechanism to address physical and mental health problems at the same time. This approach is important for older adults and can help bridge the gap between mental health, physical health, aging, and social service providers and practitioners.
- Identify accessible locations that have a high prevalence of older adults with depression and other mental health problems.

Start where there are a lot of people, high need, and get your feet wet and see whether you can make a difference there. And then over time if you can garner more resources, you are then able to spread out.

Program Director

Identify unmet needs and existing resources

- Talk to the aging community providers (e.g., senior community centers, home care programs, adult protective services) to identify unmet mental health needs and strategies to better reach older adults.
- Identify housing developments and other locations where older people congregate.
- Identify potential collaborators.
 - Who provides services to the population (e.g., mobile treatment services, community-based supports)?
 - What services are available in your site and which can other agencies provide?

Going directly to people who are already involved with older individuals I think is the most direct, and in some ways the simplest. People who run services that evaluate people for medical unmet need at home, people who have been neglected or abused. They very often come across high rates of mental illness, and I think they can then give an agency or anyone interested in a similar program a good idea of both how common these problems are and also where are the most high prevalent sites in that community.

Program Director

Identify and engage partners

Establish interagency commitment (at the local, state, or institutional level). This can include:

- Convincing state, local, and institutional level stakeholders of the need for the program, including the unique aspects of addressing co-occurring mental and physical health problems, and
- Educating other agencies about the principles of mobile treatment and geriatric treatment.

Identify and educate stakeholders and potential collaborators who can provide important services for older adults, and can also provide referrals to PATCH. Potential stakeholders include:

- Department of Social Services and Adult Protective Services,
- Department of Aging, Area Agencies on Aging, and Senior Services,
- Hospital discharge planners,
- Adult Evaluation and Referral,
- Meals on Wheels,
- Home health care providers,
- Public Housing Authority and their counselors from the Office of Resident Services,
- Mental health alliances and persons with disabilities, and
- Insurance providers.

Collaborate with other agencies:

- Identify capacities of existing agencies.
- Identify mutual benefits of PATCH.
- Identify strategies to support the mission of each agency through collaboration.
- Educate around principles of mobile treatment and aging issues.

Establish advisory boards

- Include key stakeholders.
- Invite a member or a representative from each collaborating agency and consumer group.
- Educate stakeholders about the model (particularly the value of the gatekeeper).
- Identify unmet needs and proposed services.
- Help stakeholders find funding and resources.

Build partnerships

- Create ties and establish agreements with Housing Authorities and other important entities.

When you have a development or a neighborhood of residents, such as Baltimore Housing, it's a diverse body of persons. With the help that PATCH has provided, it enhances the neighborhood. It enhances the social skills of our residents. Therefore, it enhances their lifestyle.

Housing Counselor

Once people realize that there are effective ways to reach people and to bring the treatments that we know are effective, I think people can get excited about adding this to the services that a state, county or city program already offer.

Program Director

It's that sharing of services, sharing of training, sharing of ideas, and ultimately working together that I think has been a true strength of the program.

Mental Health Authority

The more advisory [meetings], more sharing of clients, more working on behalf of the client that there is, the more the turf silo thing is minimized. ... We're making their lives easier in many ways, because they have an ongoing available resource. We're unique, we're offering something special and different.

Program Manager

It takes some leadership to convene groups across different agencies to put the dollars and the resources and the commitment on the table. Both at the state and the local level, a key to putting together this kind of program is the interagency interdisciplinary commitment. ... Collaboration, collaboration, and collaboration. ... Interagency collaboration is key.

Mental Health Authority

Role of stakeholder groups

Stakeholders have important and complementary roles to play in implementing PATCH. In addition to serving on an advisory board to guide the implementation of the program, stakeholder groups can provide the following support.

Older Adults and Family Members or Caregivers

- Advocate and obtain support for initiating a PATCH program with the housing management company (public or private), Area Agencies on Aging, the Department of Health and Mental Hygiene, and the Commission on Aging.
- The Baltimore Housing Authority's Resident Advisory Board (which consists entirely of public housing residents) is instrumental in reviewing the housing agencies' progress and in overseeing new policies that affect residents. They are the mediator between the residents and management of Baltimore Housing. Their goal is to ensure that resident concerns are voiced regarding safety, mental health issues, building population issues, and other issues. This kind of group can be the catalyst for educating administrators on the importance of PATCH.

Practitioners

- Develop a position paper that describes the PATCH program and how it can be used to help older adult residents.
- Recommend the implementation of PATCH to immediate supervisors, program managers, and program administrators.

Agency Administrators or Program Leaders

- Understand available data about the needs of older adults, and particularly the unmet needs.
- Engage and establish buy-in from stakeholders and policy-makers at the state, local, and institutional level.

Mental Health, Aging, General Medical Health, and Housing Authorities

- Serve as an advocate for the program.
- Establish partnerships between mental health, aging, and housing authorities.
- Collaborate with PATCH administrators to develop financing mechanisms.
- Serve as a consultant to other entities regarding implementation strategies.

Advocacy, advocacy, advocacy.

Mental Health Authority

Financing

PATCH is funded from a state grant provided through the Department of Health and Mental Hygiene through the Baltimore Mental Health Systems, Inc. It receives additional support from the Johns Hopkins Hospital and the Johns Hopkins Bayview Medical Center. The program uses existing ancillary services whenever possible.

Potential financing mechanisms may also include:

- Local or national grants, matched with state funding.
- Funding allocated through the Older Americans Act that requires local departments on aging and Area Agencies on Aging to allocate more resources toward mental health services for older adults. At a state or local level, this may be a negotiating point that is worth pursuing.
- Home and community-based waiver program. States could propose this program to the Center for Medicaid and Medicare as a novel way of offsetting expensive services and promoting the concept of aging in place. PATCH has value in offsetting potential nursing home admissions, emergency room visits, and hospitalizations.
- Potential funding from state adult protective services.

It takes a state's commitment of funding to follow through with a program of this sort.

Mental Health Authority

Obtaining adequate financing is the biggest challenge to delivering PATCH. PATCH and their funding partners have employed several strategies to enhance the financial sustainability of this program. These include:

- Convince potential stakeholders and partners that many older adults have serious psychiatric problems and that this program can make a difference.
- Published results help with sustainability discussions at the state level.

- PATCH is supported by teaching institutions, as an integrated training experience for psychiatry interns and nursing students.
- Demonstrating that PATCH is less expensive and more flexible than traditional mobile outreach teams.

I think the most important point perhaps is that we really help people, we make a huge difference to their quality of life ... I think we do prevent nursing home placement, acute hospitalizations and so I think there are benefits down the line to other funding agencies. But the most important point is people get better with what we do.

Program Director

PATCH is crucial in our line of work. With the professional staff that they have, counselors and the psychiatrists, [PATCH] is very instrumental in providing follow-up and providing detailed, specialized care in the area of mental illnesses.

Housing Counselor

Without the PATCH Program I could see individuals being placed in nursing homes. I can see individuals becoming homeless because of dementia. I can see individuals simply shutting down, not dealing with their day-to-day hygiene, their day-to-day financial needs. Without the PATCH Program, I sincerely and professionally believe that a lot of our seniors would truly not function at all.

Housing Counselor

Adapting the program

PATCH is provided in public housing facilities in Baltimore, Maryland. It provides services to older adults, most of whom are African American.

PATCH developers are unaware of adaptations that have been implemented in other settings. Minor modifications are made to PATCH to adjust to different Housing Authority buildings, as well as the needs and specific circumstances for each older adult. For instance, practitioners use terminology

that older adults are comfortable with, such as caring for someone's nerves or trouble sleeping.

It may be possible to adapt the PATCH program to fit the needs of older adults from different cultures or settings.

- Adaptations needed to provide PATCH to older adults from other cultural backgrounds may include hiring multilingual staff. Program components should also be reviewed with stakeholders to ensure that the program fits with the cultural beliefs, attitudes, and behaviors of the older adult residents.
- Adapting the program to work in other locations (urban or rural) may require collaborations with other service providers, and consideration of issues such as practitioner travel time and available community resources and networking possibilities.

Within Baltimore there are so many different cultures and different views and priorities that people have, whether it's a religious background, whether it's a race background, just really learning how to respect ... really trying to understand what's important to them and making sure that we address their needs in a way that they're comfortable with.

Case Manager

Training and resources available

PATCH responds to training inquiries by providing telephone-based technical assistance. PATCH has a manual and a seven-session educational series for public housing authority staff. Other materials include a packet of four published articles that describe the program and staff roles. In addition, PATCH staff are considering the development of a training program that would be offered at the Johns Hopkins Medical Center in Baltimore, Maryland.

PATCH Makes a Difference for Older Adults

At the end of the day, quality of life is really what we're after. So a program of this nature would do nothing more than just enhance the quality of life for persons who do not have many other options due to their financial situation or in their mental situation.

Housing Manager

[PATCH] makes it better for me. I know I'm alright, I'm safe. But, if there's not this program, ... people like me would be in trouble. And we may get lost cause we ain't got nothing to do, nobody that could understand us. ... They need programs like this for people like us 'cause ... some of us can pick up and some we can't.

Older Resident

And the funny thing, the program itself, the acronym of PATCH, truly is something that is deceiving. The wording PATCH gives one the illusion that you're gonna fix something temporarily, to patch something. I think, perhaps, if they wanted to change the wording, it should be Resolutions. Because they go in, they evaluate the situation and they resolve it. PATCH has been a godsend as it relates to our particular situation in Baltimore Housing.

Housing Counselor

It brings together the principles of mobile treatment, with the principles of geriatrics and aging, which are unique to this population. Being aware that the model has certain unique aspects to it that meet the medical and psychiatric needs somehow convinces people, because they know that older people have medically complicated situations. So appreciating that there's something unique about the model [allows] one to convince people that there's a particular role for a service like this. ... It's a group of people who have this range of knowledge and skills. It takes all of those to convince people that this is both needed and can work.

Program Director

Selecting EBPs

Collaborative and Integrated Mental and Physical Health Care

Collaborative and integrated mental and physical health care services are effective in treating depression in older adults. Mental health care is provided in the primary health care setting. Programs include collaboration between mental health and physical health care practitioners. Several models have been tested and proven effective, including the IMPACT, PROSPECT, and PRISM-E models.

Collaborative care models provide integrated mental health and physical health care in the same setting. Available models of collaborative and integrated care for older adults are located in the primary care setting. Older adults with depression receive care from on-site mental health specialists and the primary care practitioner.

Most older adults receive mental health care in the primary care setting (Klap and colleagues, 2003). Studies also have shown that older adults consider psychotherapy to be an effective

intervention and in some cases, prefer it over antidepressant medication (Landreville and colleagues, 2001).

Interventions that change the system of care provided in the primary care setting for older adults with mental health problems (including collaborative and integrated mental and physical health care) can improve engagement in treatment (Bartels and colleagues, 2004) and treatment outcomes (Unützer and colleagues, 2002; Bruce and colleagues, 2004).

Criteria for Service Interventions

Collaborative and integrated mental and physical health care is an approach to delivering services to older adults. There are several different models for delivering collaborative care. The structures and components of collaborative and integrated care programs are similar; however, the actual treatment delivered to the older adult, such as psychotherapy or medication treatment, is not specified in advance. For example, the treatment intervention may vary for an older adult receiving these services and could include problem solving treatment in one model and interpersonal psychotherapy plus medication in another model.

Although none of the specific models of collaborative care have been studied in more than one randomized controlled trial, collaborative care is included in this KIT as an EBP because studies conducted across several distinct collaborative care models have shown this type of service delivery to be effective.

Evidence and Outcomes

- Three randomized controlled trials have been conducted by multiple groups of researchers.

These programs have successfully overcome many of the barriers to standard mental health care, and have resulted in improved mental health care and outcomes for older adults with depression, including improved treatment adherence, depression response and remission, and patient satisfaction.

Collaborative and Integrated Care Programs for Treating Depression in Older Adults

Three models of collaborative and integrated mental and physical health care have been tested for older adults with depression. They are listed below, in order of highest to lowest amount of evidence supporting the practice.

- Improving Mood: Promoting Access to Collaborative Treatment (IMPACT)
- Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT)
- Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E)

These programs are described in the pages that follow.

Where Can You Find Collaborative and Integrated Care Programs

These programs are provided by practitioners with advanced training in mental health care.

Collaborative and integrated care services can be delivered by practitioners who work in:

- primary care settings.

IMPACT: Improving Mood, Promoting Access to Collaborative Treatment

Improving Mood, Promoting Access to Collaborative Treatment (IMPACT) is designed to help primary care practitioners recognize and treat depression in older adults. It is provided by primary care practitioners, depression care managers, and a team psychiatrist. These practitioners collaborate to provide effective treatment with antidepressant medication or problem solving treatment. IMPACT is outlined in a manual and the IMPACT Implementation Center has free training materials. It is effective in treating depression in older adults.

Description of Intervention

IMPACT (Improving Mood, Promoting Access to Collaborative Care) is a model of care that integrates mental health services into the primary care setting. Collaboration between the primary care practitioners and a depression care manager is the core component of the IMPACT model. The goal of IMPACT is to help practitioners identify and treat depression in older primary care patients.

The core components of IMPACT include:

- collaborative care,
- care from a depression care manager,
- consultation with a designated psychiatrist,
- outcome measurement, and
- stepped care (with antidepressant medications and problem solving treatment).

The depression care manager provides and coordinates care. He or she educates patients about depression and its treatment, provides behavioral activation, monitors depressive symptoms and response to medication, psychotherapy, or both; works closely with the primary care practitioner and a consulting psychiatrist to revise the treatment plan when patients are not improving; and offers a brief course of problem solving treatment (PST-PC).

IMPACT addresses a number of barriers that prevent older adults from receiving appropriate treatment for depression. These include lack of knowledge about depression, lack of easy access to mental health specialists, insufficient time for the primary care practitioner to address physical and mental health problems, and the inability of the primary care practitioner to actively follow the older adult to make sure that he or she gets an adequate trial of the medication or psychotherapy.

Practitioners

IMPACT is provided by primary care practitioners, depression care managers (nurse, social worker, or psychologist), and a team psychiatrist.

Diagnoses or Disorders Addressed

- Major depression
- Dysthymia

Evidence and Outcomes

- One randomized controlled trial has been conducted. This trial included 1,801 older adults who received care in one of 18 primary care clinics.

IMPACT is significantly more effective than usual care for depressed older adults, regardless of their ethnicity.

Compared to older adults receiving usual care, older adults who received the IMPACT model of care had:

- higher rates of treatment and satisfaction with care,
- lower depression severity and functional impairment, and
- increased quality of life.

Forty-five percent of older adults in the IMPACT program had a 50 percent or greater reduction in depressive symptoms, compared to 19 percent in usual care.

Settings of Research

- Primary care

Populations Included in Research

- Study participants were primary care patients aged 60 and older. The mean age of participants was 71 years.
- Two thirds (65 percent) of participants were female.
- Nearly one-quarter (23 percent) of participants were members of racial minority groups, including 12 percent African American and 8 percent Latino.

Training and Resources Available

Manual Availability

The IMPACT program manual (Unützer & Oishi) and PST-PC treatment manuals (Hegel & Areán) are available free of charge.

- Unützer, J., Oishi, S. & The IMPACT Study Investigators. (2004). Project IMPACT Intervention Manual: Late Life Depression Treatment Manual for Collaborative Depression Management. UCLA Neuropsychiatric Institute Center for Health Services Research. Available at http://impact-uw.org/tools/impact_manual.html
- Hegel, M., & Areán, P. Problem-Solving Treatment for Primary Care: A Treatment Manual for Project IMPACT. Dartmouth College. Available at: http://impact-uw.org/tools/pst_manual.html

Fidelity Measure

The IMPACT fidelity scale assesses performance in six broad areas, including the setting, staffing, and supervision of collaborative care; patient education; treatment planning and delivery; tracking of treatment outcomes; delivery of treatment based on outcomes (i.e., stepped care); and relapse prevention planning. The link below provides access to the rating scale.

http://impact-uw.org/files/FidelityScale_Dec2010.pdf

A set of six defined quality indicators can also be used to evaluate the core components of the IMPACT model. These include the percent of patients with depression screening, confirmation of diagnosis, initiation of treatment, measurement of treatment outcomes, adjustment of treatment based on outcomes, and symptom reduction.

Training and Technical Assistance

Training in the IMPACT model is provided through the IMPACT Implementation Center. The Center provides a range of materials, training, and technical assistance to help practitioners implement and adapt IMPACT in diverse settings. Resources include a free online training program, job descriptions, and work flow information. The IMPACT team also is available to answer questions via e-mail. More information can be accessed at: <http://impact-uw.org/>.

Replications and Adaptations

The original study tested IMPACT in 18 clinics associated with eight diverse healthcare organizations across the United States. Since the end of the study, a number of adaptations have been made for different populations and settings. Evaluations of these programs show that IMPACT is effective with a range of patients with depression, including adolescents, adults of all ages, and patients with diabetes or cancer.

Key Issues Related to Implementation

The IMPACT model of collaborative and integrated care of depression for older primary care patients is one of the best supported EBPs for older adults. The IMPACT Implementation Center provides training and consultation to organizations and practitioners who are interested in implementing the program.

Staff buy-in: Obtaining support and buy-in from all levels of staff is essential. Frequent routine meetings can help address staff concerns and establish effective strategies for incorporating the program into routine activities.

Financing: Cost analyses show that IMPACT is more cost-effective than usual care. The average cost of the IMPACT program is approximately \$580 per participant (Katon and colleagues, 2005). Most program costs, such as care manager visits in the primary care practitioner's office, are covered by existing health care (e.g., Medicare) benefits. Older adults who received one year of IMPACT services had lower average costs for all of their health care over a four-year period. Even when the cost of IMPACT team care treatment was included, total health care costs were approximately \$3,360 less than costs for older adults who received traditional care (Unützer and colleagues, 2008).

PROSPECT: Prevention of Suicide in Primary Care Elderly – Collaborative Trial

PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) is designed to help primary care practitioners treat depression and reduce thoughts of suicide in older adults. It is provided by primary care practitioners and depression clinical specialists. Depression care managers collaborate with primary care practitioners to monitor older adults, provide interpersonal psychotherapy, and encourage adherence to recommended treatments. PROSPECT is outlined in a manual. It is effective in treating depression and reducing thoughts of suicide in older adults.

Description of Intervention

PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) is a model of care that integrates mental health services into the primary care setting. The goal of PROSPECT is to prevent suicide among older primary care patients by reducing depression and thoughts of suicide.

The core components of PROSPECT include:

- recognition of depression and suicidal thoughts by primary care practitioners,
- use of a treatment algorithm for older primary care patients with depression, and
- treatment management by depression health specialists (e.g., care managers).

Recommended treatments include antidepressant medication (citalopram) as the first line treatment, with interpersonal psychotherapy as an alternative or augmentation to medication treatment as needed (Klerman and colleagues, 1984).

Treatment is offered for acute, continuation, and maintenance phases for up to 24 months.

The depression health specialists have several roles. They:

- educate older adults and their families about depression,
- identify and address co-occurring physical and mental health problems that may interfere with antidepressant medication,
- monitor adherence to treatment,
- manage adverse effects of treatment,
- provide interpersonal psychotherapy, and
- monitor changes in symptoms of depression.

Practitioners

PROSPECT is provided by depression clinical specialists (nurse, social worker, or psychologist) and primary care practitioners.

Diagnoses or Disorders Addressed

- Major depression
- Minor depression

Evidence and Outcomes

- One randomized controlled trial has been conducted. It included 598 older adults who received care in one of 20 primary care clinics.

PROSPECT is significantly more effective than usual care for older adults with major depression, and for older adults with minor depression who also have thoughts of suicide.

Older adults with major depression who received the PROSPECT model of care had:

- greater decreases in depressive symptoms,
- greater chance of remission of depression after 4 months (40 percent versus 23 percent), and
- greater decreases in the rate of suicidal ideation (from 29 to 17 percent among older adults receiving PROSPECT; from 20 to 17 percent among those receiving typical care).

PROSPECT is associated with a significant reduction in the risk of death over a 5-year period for patients with major depression.

- Compared to 627 older primary care patients without depression, older patients with major depression had a greater risk of dying if they were from usual care but not if they were from practices that implemented PROSPECT.
- Patients with major depression in practices that implemented the PROSPECT intervention were less likely to die over a 5-year period, compared to patients with major depression in usual care practices.

Settings of Research

- Primary care

Populations Included in Research

- Study participants were primary care patients aged 60 and older. Nearly one-third (31 percent) of participants were aged 75 or older.
- Most participants (72 percent) were female.
- Nearly one-third (32 percent) of participants were members of racial or ethnic minority groups, although specific minority groups were not identified in study publications.

Training and Resources Available

Manual Availability

The PROSPECT program is described in an unpublished treatment manual and a video, which are available from the program contact person listed below. The treatment manual provides instructions for each phase of treatment and describes the role of the depression health specialists. It also describes measures and protocols for monitoring treatment.

- *PROSPECT Study: Intervention practice treatment manual and the health specialist's role.* (2000, June). Unpublished document.
- *PROSPECT Study: Physician education* [VHS]

The PROSPECT medication algorithm is available at:

- Mulsant, B. H., Alexopoulos, G. S., Reynolds, C. F., 3rd., et al. (2001). Pharmacological treatment of depression in older primary care patients: The PROSPECT algorithm. *International Journal of Geriatric Psychiatry*, 16(6), 585–592.

Unlike other models of collaborative and integrated mental and physical health care, the PROSPECT program was not designed or funded to be packaged for implementation. While formal technical assistance is not available at this time, program materials are available through the program contact person.

Replications and Adaptations

PROSPECT was implemented by its developer in 20 primary care practices in the New York City, Philadelphia, and Pittsburgh regions. No population-specific or culture-specific adaptations have been identified.

Key Issues Related to Implementation

Use of treatment algorithms: Implementation of the PROSPECT program relies on educating primary care practitioners to recognize symptoms and apply a clinical algorithm. The algorithm is based on depression treatment guidelines for older adults from the American Psychiatric Association, the Agency for Healthcare Research and Quality, and the Texas Department of Mental Health.

Comorbid anxiety: Co-occurring anxiety can reduce the rate of remission in older adults who receive PROSPECT. Practitioners should recognize that older adults with co-occurring depression and anxiety may warrant referral to a psychiatrist.



Other Models of Collaborative and Integrated Mental and Physical Health Care

The Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E) study evaluated another model of collaborative and integrated mental and physical health care. Unlike the other studies that compared collaborative and integrated care to typical primary care treatment, this study compared it to an enhanced model of referral to specialty mental health services.

Description of Intervention

In a randomized controlled trial funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), older adults with depression, anxiety, or at-risk alcohol use were assigned to integrated care or to an enhanced model of referral to specialty mental health care.

In the integrated care model, a mental health practitioner was located in the primary care practice and worked with the primary care practitioner to provide mental health services to the older adult.

Older adults in the enhanced referral model were referred to a mental health practitioner, most often to a geriatric psychiatrist for traditional psychiatry treatment. Enhancements included transportation, some case management, and communication with the primary care practitioner.

Practitioners

In the integrated model of care, licensed mental health practitioners from various disciplines, including social workers, nurses, counselors, and psychiatrists, were co-located in primary care and communicated with the primary care practitioner.

Diagnoses or Disorders Addressed

PRISM-E was evaluated among older adults with major depression, minor depression, dysthymia, anxiety, or at-risk drinking.

Outcomes

Older adults receiving integrated care were more likely to engage in treatment, compared to those receiving enhanced referral (71% vs. 49%). The integrated model and enhanced referral model were equally effective in improving depression.

Populations Included in Research

Study participants included older adult primary care patients. Forty percent of the sample were aged 75 or older. Most participants (71 percent) were female and nearly half (48 percent) were members of ethnic or racial minority groups, including 25 percent African American, 15 percent Latino, and 6 percent Asian.

Key Issues Related to Implementation

Older adults preferred receiving treatment at their primary care practitioner's office. Providing mental health and physical health care at the same location is critical to this intervention.

Primary care practitioners preferred the integrated model to the referral models, some technical assistance to the primary care practitioners is critical to effective implementation.

Enhancing specialty referral care was effective and provided better outcomes for older adults with a mental health disorder and a substance abuse disorder. Coordinating this care with the primary care practitioner is a key element in enhancing this model.



IMPACT was developed by a team of researchers, led by Dr. Jürgen Unützer from the University of Washington. Research has shown that IMPACT reduces symptoms of depression and improves older adults' ability to function in daily activities, compared to care that is normally provided by a primary care practitioner. A research study found that 45 percent of IMPACT patients had a 50 percent or greater reduction in depressive symptoms, compared to 19 percent in the comparison group. IMPACT is significantly more effective than usual care for depressed older adults, regardless of their ethnicity.

A number of organizations in the United States and abroad have adapted and implemented IMPACT with diverse patient populations. IFH was one of the first health care organizations to implement Project IMPACT, following the completion of the research study conducted in 18 primary care clinics. Project IMPACT has become a routine component of the services that IFH provides to all of their adult primary care patients.

We can demonstrate through the studies that we've done that it helps not only deal with identifying the depressed patients but also improves their outcomes and their chronic illnesses and cuts down on unnecessary visits.

IFH Regional Medical Director

Once they've been provided services either via medication or therapeutic services, I've seen a tremendous change in them, just the way they look at life, the way they present themselves, the way they communicate with my staff. It's a phenomenal experience.

IFH Practice Administrator

Core components

The core components of IMPACT include:

- collaborative care,
- depression care management,
- consultation from a designated psychiatrist,
- outcome measurement, and
- stepped care.

Collaborative care, depression care management, and consultation from a designated psychiatrist

Collaboration between the older adult's primary care practitioner and a depression care manager is the core feature of the IMPACT model. The primary care practitioner works with a depression care manager to develop and implement a treatment plan that includes medications, psychotherapy, or both. The depression care manager and the primary care practitioner also consult with a psychiatrist to change the treatment plan if the older adult's depression does not improve.

Outcome measurement

Depression care managers measure symptoms of depression at the start of the older adult's treatment and regularly thereafter, using the Patient Health Questionnaire (PHQ-9).

Stepped care

Treatment for the older adult is adjusted based on clinical outcomes and an evidence-based algorithm. The goal of treatment is to achieve at least a 50 percent reduction in symptoms of depression within 10 to 12 weeks. If the older adult has not significantly improved after 10 to 12 weeks, the treatment is changed. This change can be an increase in medication dosage, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatments suggested by the team psychiatrist.

Staffing and intensity of services

Many staff at IFH are involved with Project IMPACT, ranging from receptionists to administrators. The primary team members who are responsible for delivering depression care include the primary care practitioner, depression care manager, and consulting psychiatrist.

Primary care practitioner

The older adult's primary care practitioner initiates and maintains most treatments for the older adult, including prescriptions for antidepressants, treatments for physical health problems, and referrals to specialty care. He or she encourages and supports older adults to participate in depression care activities with the depression care manager.

Depression care manager

The depression care manager can be a nurse, social worker or psychologist and can be supported by a medical assistant. The depression care manager:

- educates and coaches older adults about depression and behavioral activation;
- supports antidepressant therapy prescribed by the primary care practitioner, if appropriate;
- offers a six to eight session course of Problem Solving Treatment in Primary Care (PST);
- monitors symptoms of depression to see if the older adult is responding to treatment; and
- completes a relapse prevention plan with each older adult who has improved, and follows them with monthly telephone contacts, and in-person contacts as needed, to reduce their risk of relapse or recurrence for a period of six to twelve months.

The depression care manager is on-call throughout the day to meet the needs of patients with depression. This availability helps provide effective and efficient care, and allows patients in crisis to immediately meet with the care manager.

[IMPACT] gave us an opportunity to provide some very intensive services to folks who really needed them. Once you identify someone and assign them a depression care manager the relationship is often very empowering. And sometimes just the virtue of having someone call you or talk to you or having a scheduled time to come in and meet with someone, people really look forward to it.

VP for Psychosocial Services and Community Affairs

Consulting psychiatrist

At IFH, a geriatric psychiatrist supports depression treatment with weekly caseload supervision, suggests changes in treatment, provides telephone or in-person consultation to depression care managers and primary care practitioners and, when clinically necessary, sees older adults who do not respond to treatment after ten to twelve weeks.

Duration of treatment

PST is given on a weekly basis and medications are monitored on a regular basis. Monitoring of depression occurs on an ongoing basis for all patients.

It's very difficult for older adults to seek treatment, to seek counseling on their own. The primary care office is a very good entry point for the patients to be identified as depressed, if they are. Usually older adults go undiagnosed. So this program is very easy to implement once it's rolling. It's very simple to screen patients and provide them with needed medication or counseling and support to improve their lifestyle.

Depression Care Manager

Providing IMPACT at the Institute for Family Health

Experiences of the IFH staff offer an example of how Project IMPACT can be effectively implemented. This section describes:

- screening and treatment activities,
- special issues for working with older adults,
- training,
- supervision and support, and
- evaluation and feedback.

Screening and treatment activities

IMPACT gave a very concrete model that we could follow and implement in our centers. It gave us a tool, the PHQ-9, that was not hard for us to teach people to use, was not hard to administer to patients, and allowed us to give our providers, our social workers, and care managers a score about which they could communicate ... previously it was very hard for them to communicate around depression.

VP for Psychosocial Services and Community Affairs

Screening

At the Institute for Family Health, Project IMPACT is incorporated into care for all older adults, as well as all adults. IFH uses several models to screen for depression. The most successful model incorporates screening into the nursing intake and triage process, in a similar manner to standard health screenings such as blood pressure and weight.

A positive score on the PHQ-2, a two-question depression screening instrument, triggers the nurse to provide the older adult with a paper copy of the PHQ-9. The older adult is asked to complete the form while they wait for their primary care practitioner. To accommodate patient diversity, nurses have access to copies of the PHQ-9 in multiple languages and can assist patients who are unable to read, or have translation or other special needs.

Some smaller health centers modify this screening process and only ask patients to complete the PHQ-9. In those centers, the front-desk receptionist gives the PHQ-9 to the patient and asks them to complete it while waiting for their appointment. It is then either given directly to the primary care practitioner, or returned to the receptionist who gives it to the nurse or the primary care practitioner.

Depending on the results, or the number count on the PHQ-2, [the intake or triage nurses] directly go into the PHQ-9. ... It's probably a two minute process, if that. From there, the nurses document our electronic health record and prepare [the patient] for the doctor.

IFH Practice Administrator

[Older adults] are frequently overlooked in terms of being diagnosed with mental health problems. They are often unwilling to initially provide the information that might direct the provider to consider such diagnoses. The provider, at the same time, is so focused on the numerous medical problems and numerous medications that the senior is on.

IFH Regional Medical Director

Having a set protocol to deal with the positive screen, and it not being just on the physician, definitely helps increase the likelihood that you're going to want to screen and want to follow up with that screening and be thinking about depression in all of the patients.

Research Director for Family Medicine Residency

Treatment and management of depression

The primary care practitioner generally reviews the PHQ-9 at the beginning of the patient's session, and then enters the score into the electronic medical record as a lab value. If the patient is depressed, treatment options are discussed.

The older adult is referred to talk with a depression care manager who provides follow-up and coordinates depression care. Treatment for depression may include problem solving treatment, antidepressant medications, or both. Other basic social services also are addressed, such as home and environmental safety. During the acute phase of treatment, the depression care manager has weekly in person or telephone contact with the older adult.

The severity of the patient's depression is monitored at all visits (using the PHQ-9) and is recorded in their electronic medical record. Older adults who score ten or more on the PHQ-9 have their score coded as an abnormal lab value, which allows the care managers to better track that patient.

Project IMPACT and the use of these screening tools brings depression to the forefront in the visits that the geriatric patients have with the primary care physicians.

IFH Regional Medical Director

I met a doctor who is a charming gentleman and has a very nice way about him. He sits down and he talks to you about things and he asks you strange questions. After a while you have a conversation with him and he finds out all the things he wants to know about you, which is very pleasant to have a doctor to sit down with you and to talk about your problems. After a while he gave me an examination about my mental state. It was a very pleasant experience. I kept seeing him a couple of times, and he thought that it would be very nice if I talked to a psychologist also. First I wasn't at all accepting of the idea of talking to a psychologist. I felt I took care of myself quite well and I didn't need that. But with the help of [my doctor] and my nephew and some friends everybody said yes, do it. It's good for you. So I did.

Older Patient

Problem solving treatment

Problem Solving Treatment (PST) is a short term, intensive intervention where the older adult and the depression care manager identify problems that the patient is facing. PST encourages patients to identify a particular goal to reduce their depression. Several concrete steps are associated with PST:

- clarify and define the problem,
- set a realistic goal,
- generate multiple solutions,
- evaluate and compare solutions,
- select a feasible solution,
- implement the solution, and
- evaluate the outcomes.

She has a magical way of making me talk about myself. It feels good ... So I've decided to see her some more. Makes it a little easier when I'm alone at home and I think about the conversations we had and her suggestion of what I should do.

Older Patient

One of the great things about [problem solving treatment] is that it gives the patient the opportunity to come up with what some of their problems are and work through the problems. ... I think that helps them feel like they're a team player as well and it's not just the social workers, the doctors and the psychiatrists. We're all on an even playing field.

Depression Care Manager

Other services

Depression care managers educate older adults about medication management issues and initiate monthly telephone outreach. They connect patients to community resources and can refer them to meet with a psychiatrist to follow-up on psycho-pharmacology issues, when needed.

You can identify depression, but to get the patient to come back is another step, too. ... So there has to be a lot of steps to encourage them, like outreach, telephone outreach, to see how they're doing. Letters, with the questionnaire, with the questions, even the self addressed envelope to say well, bring this in so we'll know exactly where you are at this time.

IFH Regional Director

Collaboration

Collaboration between practitioners from different disciplines is a key component of Project IMPACT. Communication between the nurses, doctors, social workers, and other staff leads to more complete care for the older adult and can help reduce the stigma of receiving depression care.

This is about collaboration. It's about professionals of different disciplines maximizing the benefits of each of the disciplines without any one trying to do the work of another. It makes it efficient for physicians to focus in on that which they're best prepared to deal with.

Family Member of Older Patient

Geriatric patients are often hesitant about dealing with their depression. The Project IMPACT program being inter-collaborative, involving their primary care physician and occurring within the primary care physician's practice has meant that they have become comfortable with their treatment and have had a general improvement in their well being without feeling that they were identified as psychiatric patients.

IFH Regional Medical Director

Special issues for working with older adults

Older adults often are less willing than younger adults to report feelings of depression. Routine screening can help prevent mental health problems from being overlooked by a primary care practitioner, in the context of multiple medical problems.

A lot of times I find that [older adults] don't even know they're depressed and ... I think that a lot of [older adults] feel relief. I came to the doctor for one thing and I'm going to get help in something else.

Intake/Triage Nurse

Project IMPACT provides a safe context for sharing feelings and dealing with stress. Several issues can help overcome the hesitation that older adults may have in addressing these issues.

- Frame the issue of depression as a problem that can complicate physical health problems.
- Teach older adults that depression screening and care are completely confidential, similar to other medical conditions.
- Address stigma by educating older adults about depression and, at times, avoiding the use of words such as mental illness or depression.
- Emphasize that depression screening and treatment by a collaborative team is a standard part of care for all patients.

I explain that it's important as far as treating their medical conditions that we address the ability of their minds to be able to be rested and to be able to focus so that they can get along with the difficult business of healing, because that's the reason they come to me.

Physician and Medical Director

I don't think we can reinforce enough how much we really try and make it a normal part of the treatment. We really try and have the patient see that everyone over sixty or anyone with these depressive symptoms are seeing the social worker and it's not just them but the same way they might be referred to an eye doctor or cardiologist within the building, as we try and refer everyone to the social worker. ... When the doctor can meet with the patient and see that they're having depressive symptoms and walk the patient over to the social work office and say 'This is someone that I work very closely with. I trust that they'll give you good care and we'll work closely together.' That really increases the compliance on behalf of all the patients and they feel like it's more of a team setting, that it's normal.

Depression Care Manager

Training

The Institute for Family Health conducts a series of four trainings when initiating Project IMPACT at one of their health centers.

- The first training educates staff about Project IMPACT, creates excitement about taking on a new way of practicing, and is designed to obtain buy-in from the whole practice.
- The second training provides education on depression (e.g., description, prevalence, importance of providing care).

Implementing the program was [the first step in] starting to get everyone understanding what depression is. It was more about discussing educational depression: what are the signs, what things to look for, and how this can be good for the patients to reduce their depression and live a better life. And explain to people why this is important for everyone, we're all in it, to collaborate on the services.

IFH Regional Director

- The third training is for medical practitioners and is broken into two sessions. One session focuses on prescribing medications for depression and is designed to increase practitioner comfort and knowledge. Another session focuses on depression management skills, including self-management, motivational interviewing, and problem solving treatment. Role plays are conducted and information is given to practitioners for their use in clinical practice.
- The fourth training is for care management staff. It addresses self management goals, depression care management, and strategies for conducting patient follow-up (e.g., mailings and telephone contact).

Practitioners stress the importance of several other components of training. These include:

- access to treatment manuals,
- trainings, workshops, and supervision in problem solving treatment, and
- hand-outs that describe the program and its importance.

We send certain social workers to different outside trainings to learn more about the older population if they weren't previously engaged with that particular population.

IFH Regional Director

Developers of PST have provided training to depression care managers, who have since become certified providers of PST. IFH developed a train the trainer model where any student or new staff member can receive individual and group training in PST. New staff members also complete the online training module.

It is critical that trainings help primary care practitioners understand the importance of addressing depression and how this will improve the well-being of their patients. Trainings help practitioners understand how depression interacts with physical health conditions and provide explicit guidance around the PHQ-9 and problem solving techniques that they can use with patients. Primary care practitioners also benefit from training on preventing suicide and diagnosing bipolar disorder.

Family medicine residents who rotate through IFH also are trained in the IMPACT model of care, which teaches them how to address depression in the primary care setting. Project IMPACT improves standard resident education around bio-psycho-social medicine and the integration of physical and mental health issues.

It's rewarding to train physicians using the IMPACT model. You know that they'll be able to take the PHQ-9 screening tool that they're comfortable using and comfortable making management plans based on it out into practice... It's in the public domain. It's something that they can use in multiple settings. It's something that's very transportable and very simple to use.

Research Director for Family Medicine Residency

Supervision and support

IFH uses supervision to ensure that the IMPACT model is used with the medical practitioner, with nursing, with social work, and with the psychiatrist.

Depression care managers also receive ongoing supervision to provide PST. Supervision includes:

- formal and informal support for implementing PST and tailoring it to individual clients, and
- role-playing and feedback on cases.

We have competencies around problem solving treatment. One of our certified staff members listens on the phone or on a video-taped session for individuals just starting in our centers and critiques them and signs off on their competencies before they begin to do this work. We have cultural competencies and age specific competencies.

VP for Psychosocial Services and Community Affairs

Feedback and evaluation

The two-item Patient Health Questionnaire (PHQ-2) is used to screen all older adults who receive care at IFH.

The PHQ-2 includes the following two questions:

- 1) Over the past two weeks, have you felt little interest or pleasure in doing things?
- 2) Over the past two weeks, have you felt down, depressed, or hopeless?

The PHQ-9 is administered to any older adult who answers yes to either question from the PHQ-2. For older adults with identified depression, the PHQ-9 is re-administered every time that the older adult meets with his or her depression care manager or primary care practitioner. Documentation of screening and PHQ-9 results are entered into the electronic medical record as a lab value and are monitored over time.

The use of the screening tools for Project IMPACT has enabled us to measure our ability to make a difference for our geriatric patients ... That has enabled the program to demonstrate to all of the providers in our organization that this is a worthwhile project.

IFH Regional Medical Director

Using their electronic medical record, the Institute has designed reports for tracking outcomes by practitioner, center, and the organization. Data is used to identify areas for program improvement (e.g., improve patient outreach) and to alert the practitioner of the need to modify treatment for an individual patient. Reports track:

- percent of patients screened,
- percent of patients with a PHQ-9 score greater than 10 who received a self-management goal or intervention (e.g., medication, referral for treatment or care management),

- percent of patients with a 50 percent decrease in their PHQ-9 score after every 3 months,
- percent of patients given a follow-up medical appointment after a PHQ-9 score of 10 or more.

Reports also monitor patients with special conditions (e.g., re-administration of the PHQ-9 after a myocardial infarction).

Those measures are very important for us to follow because we can understand which way we are moving with this project.

IFH Regional Director

Our organization has an electronic health record and we chose to enter the PHQ-9 into it as a laboratory value. We can then monitor the progress of laboratory values in flow sheets. Through that, we were able to demonstrate the improvement in the PHQ-9 scores for the patients in the project. At the same time, we could track those patients if they were diabetic by monitoring their hemoglobin A1C or blood pressure if they were hypertensive. We then do studies and we make presentations to our medical staff demonstrating the improvements in many of these measures with the patients in IMPACT.

IFH Regional Medical Director

The IMPACT Implementation Center encourages all organizations that implement or adapt IMPACT to measure the effectiveness of their program using a set of six quality indicators, including the percent of patients with depression screening, confirmation of diagnosis, initiation of treatment, measurement of treatment outcomes, adjustment of treatment based on outcomes, and symptom reduction.

Implementation Considerations and Tasks

Project IMPACT began at IFH with support from research grant funding. After the completion of the research study, Project IMPACT has been incorporated as a “way of life” for IFH and has been initiated throughout many of their health centers. Important components of implementation and sustainability include:

- addressing special challenges,
- identifying and engaging partners,
- establishing roles of stakeholder groups,
- financing,
- adapting the program, and
- accessing training and other resources.

Address special challenges

At IFH, several characteristics define centers that had the easiest time implementing IMPACT. These centers:

- had practitioners with high interest in addressing psychosocial issues, such as depression,
- had low staff turnover,
- were well organized, and
- had a stable team of practitioners who worked well together.

Our organization facilitated the implementation of the Project IMPACT program by choosing individual clinicians and individual sites where we introduced it first. By introducing it on a small scale with a few providers and then doing the studies with those providers' outcomes and presenting that to the organization at large we were able to win over some individuals at the onset when we made a more system wide program.

IFH Regional Medical Director

Implementing Project IMPACT requires substantive changes in the health care system. The IFH leadership recognizes that change is often met with resistance. Overcoming resistance from physical and mental health practitioners was important. Several points of resistance and strategies to address them are described below.

- Primary care practitioners had concerns about role responsibilities, lack of knowledge for addressing depression, and their ability to fully address depression in the context of a brief medical visit. The most effective strategy for addressing these concerns was to have several successful practitioners educate new practitioners on strategies that they have found to be effective.
- IFH leadership helps practitioners recognize the importance of IMPACT by showing that effective depression care can positively affect their “high utilizer” patients.
- IFH leadership changed the length of a visit from 15 to 30 minutes for some patients and taught practitioners how to collaborate and consult with the depression care manager and psychiatrist.

[Practitioners] need to hear different models and talk to the providers to be able to figure it into their own workflow.

VP for Psychosocial Services and Community Affairs

Having the social worker integrated into the whole process provided a strong support for the primary care providers and also made it easier for them to intervene because they didn't feel like they were carrying this whole burden on their own.

Physician and Medical Director

For most physicians, it's about time management and it's about ease of use that inhibits us from doing the things that we know and want to do. Having something that's set up that you give this tool, you get this score, ... these are the things you can do. Having a set flow for that makes it much more likely for you to do that, particularly with patients with chronic diseases where your office visit is often overwhelming with multiple medical problems.

Research Director for Family Medicine Residency

- Mental health practitioners had concerns that the use of PST didn't allow them to spend enough time with their patients or address all of their patients' concerns. To overcome this concern, PST was presented as a "tool that may help patients."

Once people try it, they begin to see differences, but it is hard to pull people away from the long-term therapy concept.

VP for Psychosocial Services and Community Affairs

- Overcoming practitioner resistance also required educating them about the linkage between depression and physical health problems, addressing misperceptions and personal beliefs about depression, and educating them on the components and purpose of Project IMPACT.

Educate them on what Project IMPACT is so we can help them understand that this is not just to give them more work but [is here] to help the patients. It's really not that much to do, it's just certain questions to ask your patients that can really open the patients up to discussing what is going on in their lives and really helping them to put things in perspective in regard to depression with diabetes, depression with high blood pressure. All these things are connected.

IFH Regional Director

Hesitation from practitioners can also be overcome when they recognize the positive outcomes that their patients are achieving from Project IMPACT.

From the standpoint of the providers, it didn't take too long for them to understand that some of the patients who they had not previously identified as depressed but who were depressed and now getting treated were doing better in all aspects of their medical care. That made their job easier taking care of those geriatric patients, and in the long run decreased their work load.

IFH Regional Medical Director

Intake and triage nurses were initially resistant to administering the PHQ-2 screening questions. Their concerns were addressed by streamlining the assessment process and incorporating it as a standard part of health screening.

The intake was basically to give them a PHQ-2... to explain to the patient what we were doing. ... After the PHQ-2 became part of a CQI [continuous quality improvement] project that we had here, it got a lot better and we were able to actually move a little bit quicker.

Intake/Triage Nurse

One of the biggest challenges for IFH was embedding Project IMPACT into their health care system in a manner that sustains it during times of change or in the absence of a program leader or champion. Ongoing problem solving has allowed them to overcome this challenge.

You have to be diligent when you implement this and follow the practice for a year or better. As changes [arise, you need to] really work [through] them.

VP for Psychosocial Services and Community Affairs

IFH held regular ongoing meetings around implementation issues. This helped to create an “environment of change.” Regular meetings allowed staff to:

- problem solve around important implementation challenges,
- engage and buy into Project IMPACT,
- address staff concerns, including those regarding depression, and
- provide training based on expected scenarios that may arise in the IMPACT model, including self-management goals, patient follow-up, use of the electronic medical record, and others.

At the sites where we implemented the project we involved everybody at the site in the project. ... Not surprisingly, we had many staff members who were very much involved and concerned about the geriatric population. The secretaries and nurses spent a lot of time with the geriatric patients and know them well, and they became part of the team.

IFH Regional Medical Director

Identify and engage partners

IFH partners with several community organizations to provide depression care. Partners include:

- organizations or settings where patients congregate (e.g., meal program, church, or congregate housing),
- senior service organizations, and
- community mental health providers.

Project IMPACT has helped IFH connect with community partners around a common mission of providing good mental health care. IFH benefits from these partnerships by obtaining assistance in:

- managing patients with thoughts of suicide or who need ongoing therapy,
- providing outreach and tracking of patients without phones or in transitional housing,
- co-managing patients, and
- identifying new patients.

The ability to find a community partner who can provide mental health services – who can come onsite to do assessments or do intensive case management – is really critical. It can help ease the anxiety of some of your providers if they know they have a support system.

VP for Psychosocial Services and Community Affairs

Role of stakeholder groups

Implementation of Project IMPACT requires buy-in from practitioners and administrators. At IFH, practitioner and administrator stakeholder groups have important roles to play in implementing Project IMPACT.

Practitioners

- Participate in bi-monthly meetings with all project staff to provide feedback, identify barriers, and brainstorm ideas on how to improve the implementation of the program.
- Understand the program components and the benefits to patients and practitioners.
- Receive training in problem solving treatment and other aspects of the program.
- Assign a team leader to guide the team through the implementation process and provide feedback to agency administration.

You always need to have a medical provider who's interested in doing the work and being a champion. To have a physician champion is really critical. They're the ones who are going to bring the other providers onboard.

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Administrators

There are several activities that will help administrators to implement Project IMPACT.

- Understand the prevalence of depression and how it affects patients.
- Understand the Project IMPACT model and how it can help the clinic and patients with depression.
- Assess the organization's readiness to change, particularly with respect to providing collaborative and integrated mental and physical health care. Centers that are already providing integrated care may have better success in adopting this model, compared to those who lack onsite mental health resources or potential depression care managers.
- View the program as a complete package and present it to practitioners as such.
- Understand the day to day activities or role of each practitioner.
- Understand challenges and create solutions.
- Commit to sustaining Project IMPACT during times of change.
- Demonstrate success and positive outcomes associated with the program.

Administrators need to view the program as a complete package and need to present it to their providers in that way. They need to make sure that everybody in the organization sees the benefit of this program. They need to be clear about the treatment and outcome and benefits that will come out of the program. Instituting the program without discussing the benefits to the patient and the benefits to the provider will not make it a program that people are interested in.

IFH Regional Medical Director

Role of a Champion

IFH found that it was important to have a champion to implement the program. The champion, or program leader, helps to initiate and sustain system change across the organization. At IFH, a champion can have any level of training and has several important roles:

- advocate for the program,
- run monthly meetings to discuss staff issues and outcomes,
- identify new directions and areas for improvement,
- oversee the program,
- supervise staff, and
- problem-solve around important issues.

Financing

The financing of IMPACT is really complicated. Part of the problem is that health care is complicated and that it's always changing.

VP for Psychosocial Services and Community Affairs

Financing of Project IMPACT should consider care quality and financial gains. Quality gains include a decrease in the amount of time people spend with the primary care practitioner, greater engagement in care, greater patient retention, improved relationships with community partners, and a decrease in no show rates.

We've learned that making the initial connection [between the patient and social worker] really decreases the no show rate. ... It's better to bring that person down the hall and make the introduction, even though you're going to lose that same day visit. In the long run you're going to have a higher show rate for that visit which is going to benefit you, and you may be able to bill for "incident-to" or through some other mechanism for that second visit. We have found that the impact on the no show rate has been so great that it's worth the little hit we take for that couple minute introductory session the first time.

VP for Psychosocial Services and Community Affairs

Financial reimbursement for services depends on the setting in which services are provided. IFH has federally qualified health centers. In some states, these are able to bill for social work services or depression care management services that allow an onsite practitioner to do this work.

Options for financing Project IMPACT include:

- Partner with managed care organizations. Identify the benefits of providing depression care management to beneficiaries and develop quality initiatives to support IMPACT.
- Some managed care organizations and insurance companies pay for the PHQ-9. Organizations can examine their payer mix and identify some of their bigger payers to discuss incentives for providing depression care.
- Federally qualified health centers have federal subsidies for providing care that help cover the difference between what managed care organizations or Medicaid managed care organizations pay and the organizational assigned rate from Medicaid. Federally qualified health centers can bring in extra dollars by entering into quality arrangements with managed care companies.

- Under Medicare, depression care management is provided “incident-to” the primary care visit. If the patient is referred by the primary care practitioner who is onsite, then “incident-to” dollars can be collected for that visit. The inability to bill for same day visits is a barrier to financing. In order to bill for mental health services that are incident to the medical visit, the visits have to happen on a day when the patient is not seeing the general medical practitioner. In many cases, it is possible to bill Medicare for a same day visit if billing occurs for two different diagnoses and practitioners from two different disciplines provide services.
- HRSA codes are available for health behavior assessments and follow-ups that can be done by a nurse or a medical assistant as part of a primary care visit. These codes can provide an enhanced rate or can be billable.

The most important piece as we look at some of the billing is that people really need to take the opportunity to join some of the advocacy efforts that are going on now in the state level. Folks are pushing to have better reimbursements for individuals getting mental health services in community health centers, to be able to bill for same day visits. ... The whole purpose of trying to do this work is that you’re providing integrated services and [current financing regulations] just defeat the entire purpose.

VP for Psychosocial Services and Community Affairs

Adapting the program

IMPACT was originally tested among older adults with depression who received care in the primary care setting. It has been adapted to work with different populations and settings. IFH has expanded its collaborative care program to provide services to all adults ages 18 and older in a diverse group of centers that vary with respect to part-time versus full-time clinics, small and large clinics, urban and rural communities, and with community partners.

We’ve really tried to stay true to the model in that we identify and screen everyone and follow the care management guidelines, but it would be really impossible to implement it in one way across a wide system.

VP for Psychosocial Services and Community Affairs

Adaptations implemented at IFH include:

- Small health centers with limited resources and space may use off-site care managers or care managers who serve multiple sites.
- Large centers with high volume have incorporated medical assistants to do some depression care management.
- Rural settings with fewer resources and transportation issues may provide telephone-based depression care management.
- Case managers from community partners, including adult protective workers and community center staff, act as partnering depression care managers.

We have done it in community centers where folks who are delivering meals or working with seniors have been trained to do the PHQs and coordinate with the primary care provider. It's important to think about where your resources are and try to use them in the model.

VP for Psychosocial Services and Community Affairs

IFH serves persons from many different racial and ethnic minority groups. To accommodate the needs of these individuals, IFH has bilingual staff and has conducted focus groups to determine how to best meet the needs of these patients.

We did focus groups, particularly in our Bronx practice where there's a primarily Black and Hispanic population. ... Almost unanimously they said, 'We would really like a group experience. We don't get to talk to people much. We don't know our neighbors any more. We feel very isolated.' In the Bronx practices, we get a lot of folks who come from other countries and may not have big support systems here. So, we began to run groups and folks came and we gave very different topics. People would bring photographs, people would talk about experiences in church or family stories, or they would watch a movie. We would do PHQs on a monthly basis and they would talk about them. We almost trained them in some ways to be depression case managers for other folks in the group.

VP for Psychosocial Services and Community Affairs

Training and resources available

Training in the IMPACT model is provided through the IMPACT Implementation Center. The Center assists practitioners and organizations who are interested in bringing IMPACT depression care into their clinical practice.

The Center provides a range of materials, training, and technical assistance to aid the adaptation and implementation of IMPACT in diverse practice settings. Resources include a free online training program, job descriptions, and work flow information. The IMPACT team also is available to answer questions via e-mail. More information can be accessed at: <http://impact-uw.org/>

In order to implement Project IMPACT in a new center or organization I think it would be really helpful for people to talk to other people that have done the model or have been doing the model. I think you need to pull folks together from each discipline who have decided that they're going to be champions for their particular discipline and in the center.

VP for Psychosocial Services and Community Affairs

Traditionally before we go into a new center or even when I talk to an organization who's considering implementing the model I tell them to visit the website [<http://impact-uw.org/>]. The website is wonderful. We use it all the time. We use it not only for the problem solving treatment, but also just to explain the model. There are a lot of operational pieces there.

VP for Psychosocial Services and Community Affairs

IMPACT Makes a Difference for Older Adults

[My doctor] has a very different approach, and I wasn't prepared for that at all. I mean, he gave me a mental exercise which was, I thought, rather childish. I thought, well he's having a good time. And I like him a lot. He's charming. Then when I went back he told me the results of his interview. I said 'You saw all that?' He said 'Yes.' I said 'Well, I better think about it', because I wasn't aware that I had a problem. But he thought I did and he probably was right. But probably I found out he was right. It was a good feeling.

Older Patient

What a wonderful contribution, what a wonderful service, what a wonderful expansion of the otherwise very narrow role a physician can pursue. I just say thank you to those people who had the foresight and the wisdom and the commitment to address the resources that it took to implement this program and we're simply beneficiaries of that. My aunt has demonstrated over many years that she was not open to a mental health referral. This made it happen.

Family Member of Older Patient

As a primary care provider I began to recognize that a number of my geriatric patients were depressed and I hadn't identified that previously. I felt it made a difference in the way I related to them, it made a difference in their health care. And because I had a means to treat them it also made a tremendous difference for them in terms of their level of depression.

IFH Regional Medical Director



“This course was developed from the public domain document: Selecting Evidence-Based Practices For Treatment of Depression in Older Adults– U.S. Department of Health and Human Services, Center for Mental Health Services Substance Abuse and Mental Health Services Administration (HHS Pub. No. SMA-11-4631), 2011.”