

CONSENSUS PANEL MEETING

Older Adults

Evidence-Based Practices: Implementation Resource Kit

December 5, 2005

Alexandria, Virginia

Meeting Report

The NASMHPD Research Institute convened a meeting in Alexandria, Virginia on December 5, 2005 of the Older Adults' expert consensus panel (Participant List, Appendix A). The members represented key stakeholders, including or representing consumers, family members, advocacy and provider organizations, subject matter and cultural competence experts and the NASMHPD Older Adults Division. The primary objective of this consensus panel meeting was to help define the scope and content of the Implementation Resource Kit, and to ensure that the design of the toolkit meets the specific needs of the older adult mental health community.

Over the course of the meeting, the consensus panel discussed the lessons learned from the first set of IRKs with regard to formatting issues and layout of the toolkit. The group's next task was to identify the domain of the toolkit to reach its target audience effectively. The meeting concluded with plans for next steps. The first issue the consensus panel addressed is the format and layout of the toolkit.

One of the greatest lessons learned from the first round of Implementation Resource Kits (IRK) is that a bulky, three-ring binder is not effective. The format of this round of toolkits needs to be more accessible and dynamic by design. Placing this information on a CD or the internet with an accompanying hardcopy manual or booklet accomplishes this goal. The consensus panel placed special emphasis on creating an interactive and technologically advanced learning tool. (One example of such a learning tool is the website www.howsyourhealth.com, which is set up to give age-specific results to inform consumers.) Such a learning tool allows the IRK to reach multiple audiences and encourage EBP dissemination. The research on adult learning theory serves as a guide for the consensus panel to reach its intended audiences effectively.

With regard to layout, Charlotte Kauffman suggested that the group create a set of booklets. The first booklet should cover core competencies, age-appropriate assessment, medical co-morbidity, financing and consumer issues; the second should contain information about the appropriate evidence-based practices (EBP) for a certain disorder; and finally, the third should include the provider profile, core competencies or readiness to provide these types of services. The consensus panel recommended that the toolkit include an implementation manual that will guide the administration of a specific intervention or service. The toolkit will also contain an implementation guide complete with assessment tools, available EBPs, and links to specific EBP resources. Information regarding the culture of EBPs will also be included, which will examine the principles in adapting services and interventions that are appropriate for the aging population. Financing and reimbursement issues in mental health services for older adults will be included in the administrative section of the toolkit.

To determine which domain to use for the toolkit, the group found it necessary to identify the end users and the real value that the toolkit will bring. The team needs to identify what the significant outcomes of this toolkit should be. Charlotte Kauffman suggested that this would be a great place to start to destigmatize aging with a focus on cultural competence, resiliency, and recovery. (NREPP and NASMHPD are creating a consensus paper regarding the “official” definitions of recovery.) Vijay Ganju suggested organizing the toolkit around the criteria that are significant to this group. To see the complete list of criteria taken into consideration for this discussion, see Appendix B.

Steve Bartels presented a list of the three “big choices” the group is faced with making. The options are, 1) to select one EBP intervention or service with the greatest impact, generalizability, and scientific support, 2) to select one disorder (e.g. depression) and associated EBPs, or 3) to develop a model guide to clinical assessment, identification of EBPs, general descriptions of EBPs and referral to specific EBP resources. The group discussed which of the previous options would be best to follow for the creation of the toolkit. The following is a description of the key points made in that discussion and the consensus of recommendations that ensued.

The group agreed that it would be most useful to select one disorder (such as depression or anxiety) and the associated EBPs, and combine this idea with the development of a model guide to clinical assessment, identification of EBPs, general descriptions of EBPs and referral to specific resources. Very few members of the consensus panel recommended selecting only one EBP intervention or service. Melen McBride expressed interest in creating a hybrid model with plenty of room for adaptability and flexibility. Geriatric centers are very different in the manner in which they address mental health, and that flexibility encourages providers to adapt guidelines and manuals to their specific communities. This also allows for enhanced promotion of cultural competence (i.e., adapting the manual to allow the story-telling approach used by Native Americans). Betsy, Steve, Vijay, and a large majority of the consensus panel supported the idea of allowing room for flexibility in the toolkit.

To identify which disorder the toolkit should focus on, the consensus panel addressed issues such as prevalence of the disorder in older adults, as well as the unique effect the disorder has on the aging population. Depression emerges as the disorder with the greatest need and the largest amount of existing research. The general assumption of the population is that depression is a natural part of aging. To improve the image of aging the group made it a priority to include material and language in the manual that would facilitate the destigmatization of aging. To accomplish this, greater attention to cultural competence and a strategy focused on “wellness” (or quality of life), rather than recovery will be incorporated into the toolkit. It is necessary to include EBPs in the manual that promote the use of cultural competence and wellness.

Cognitive Behavioral Therapy (CBT) emerged as the leader of the psychosocial clinical interventions. The inclusion of care-giving and family-centered models was also greatly encouraged because they allow for adaptation to culturally sensitive settings. Mildred Reynolds added that support groups are also extremely useful and cost effective. Many

of the experts are concerned that incorporating multiple EBPs will create too much work in relation to the time and resources available. To limit the amount of work and expense of resources, Aricca Van Citters and Vijay Ganju suggested that the group build from the places where strong evidence already exists; for thoroughness, the manual should provide several interventions that build on both the current evidence-base and the resource-base. The next EBP-related item discussed is whether the manual should teach people how to implement an intervention or how to work with the aging population.

The consensus panel decided that a combination of teaching objectives will be used. To accurately address both needs, it is important to identify which setting (i.e. primary care, long-term care, specialty mental health, home and community-based, faith-base, rural mental health, etc...) and provider type (i.e. mental health clinician, aging services provider, primary care clinician, family member, etc...) the manual will be targeted to serve. The manual will aim to teach methods that implement specific EBPs, and incorporate information targeted to working with older adults. To promote knowledge about the aging population, the IRK will also include information about the demographic trends and key facts with reference to aging in America. Incorporated into the toolkit will be basic principles of geriatrics; including physical, cognitive, social, and income changes associated with aging. The IRK will also attempt to expose myths and stereotypes associated with geriatrics by showing positive and successful examples of aging.

The consensus panel was very satisfied about the dialogue that took place during the meeting and was optimistic about the progress the team will make in the upcoming year. The next step is for NRI, Steve, and Betsy to create and distribute an outline of the next steps by the middle of January. Feedback from members of the consensus panel on the outline is welcome and encouraged. Following the distribution of the outline, a conference call will be set up for all members of the consensus panel to set the project in motion. In the meantime, a forum for the group will be set up in the form of a list serve online to allow for constant updates and communication.

Appendix A

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Appendix B

Framing the question on what should be the domain:

- Intervention
 - Psychosocial clinical (e.g. CBT, PST, etc...)
 - Pharmacological clinical
 - Services (e.g. collaborative care, multidisciplinary outreach teams, etc...)
 - Preventive (universal, selective, indicated)
- Setting
 - Primary care
 - Long-term care (e.g. ALFs, nursing homes, etc...)
 - Specialty mental health
 - Home and community-based
 - Faith based
 - Rural mental health
- Disorder
 - Affective (e.g. depression, anxiety, disorders)
 - Psychotic (e.g. schizophrenia)
 - Serious Mental Illness (SMI)
 - Substance use disorders
 - Other mental health
 - Neurodegenerative disorders
- Provider Type
 - Mental health clinician
 - Aging services provider
 - Primary/general health care
 - Consumer-based peer support
 - Faith based
 - Family member
- Special Needs Subgroup
 - Oldest elderly
 - Rural elderly
 - Minority elderly
 - Complex comorbid medical and mental health disorders
- Intent/Aims/Process
 - Implementation manual: detailed specific implementation of specific intervention or service
 - Implementation guide: assessment tools, identification of EBPs, linkage to specific EBP resources
 - Culture of EBPs: principles in adapting services and interventions to be age-appropriate
- Criteria-based
 - Identify what has the greatest public health significance
 - Identify what is most supported by the research literature
 - Identify what is most practical and basic
 - Identify what is most specified and detailed (manuals exist)

- Identify what is the easiest to generalize (across settings and providers)
- Identify what is most feasible

Proposed domains:

- Core competencies
 - Demographic trends and key facts about aging in America
 - Basic principles of aging
 - Variability and aging
 - Physical changes associated with aging
 - Cognitive changes associated with aging
 - Social changes associated with aging
 - Income changes associated with aging
 - Myths and stereotypes of aging
 - Positive and successful aging
- Overview of disorders
 - Prevalence
 - Characteristics
 - Difference in older adults
 - Impact on functioning and public health significance
- Age-appropriate assessment
 - Principles of geriatric assessment
 - Geriatric functional assessment
 - Examples of age-appropriate mental health assessment measures
- Modifying treatment to be age-appropriate
 - Pharmacological
 - Psychosocial
- Medical comorbidity
 - Addressing the needs of the “whole person”
 - Interactions between medical and mental health approaches to integrated models of care
- Settings and providers
 - Primary care
 - Long-term care
 - Specialty care
 - Home and community based
 - Faith based
 - Rural mental health
- Financing and reimbursement issues in mental health services for older adults
- Cultural competence and aging
- Consumer issues
 - Stigma, mental health and aging
 - Consumer advocacy
 - Peer support and family support services
 - Principles of evidence-based practice and informed shared decision-making
 - Review of evidence-based practices

- Reaching audiences: evidence-based dissemination (marketing, e-learning, interactive learning, web-based formats, experiential learning, etc...)
- Adult learning theory

The Big Choices:

- To select one EBP intervention or service with the greatest impact, generalizability, and scientific support; or
- To select one disorder (e.g. depression) and associated EBPs; or
- To develop a model guide to clinical assessment, identification of EBPs, general descriptions of EBPs and referral to specific EBP resources.