

# Evidence-Based Practices

## BOOKLET 3: Older Adults' Evidence-Based Practices Implementation Resource Kit

### WHAT ARE EVIDENCE-BASED PRACTICES?

Evidence-based practices are interventions that have strong scientific proof that they produce certain outcomes. This does not mean that other interventions do not work or do not produce good outcomes. It just may mean that research has not been conducted at a level to say that there is strong evidence for that practice.

A major reason for the attention to evidence-based practices in mental health is that the body of knowledge about what works has grown dramatically. There are many more practices that have strong evidence than there were twenty years ago. Yet these are not readily available. They are not part of the usual array of services for most mental health providers. They may be available at a few sites but not throughout the state.

The big push for evidence-based practices is to make these interventions more widely available for persons needing such interventions. Not everyone needs a specific evidence-based practice. The selection of a practice depends on a person's problems, the outcomes desired, and consumer choice. This is as true for mental health interventions as it is for health interventions. For example, not everyone needs heart bypass surgery, but most people want it to be available so that they can get it if needed. Similarly, not all people needing mental health services need to get a specific evidence-based practice, but they do want it to be available if the need arises.

### DEFINITION OF EVIDENCE-BASED PRACTICES

Below are some definitions of evidence-based practices:

- An evidence-based practice is considered to be any practice that has been established as effective through scientific research according to a set of explicit criteria (*Drake et al, 2001*).
- Evidence-based treatment is the use of treatments for which there is sufficiently persuasive evidence to support their effectiveness in attaining desired outcomes (*Rosen and Proctor, 2002*).
- Evidence-based practice is an approach to healthcare wherein health professionals use the best evidence possible to make clinical decisions for individual patients (*McKibbin, 1998*).
- Evidence-based practice is the integration of best research evidence with clinical expertise and patient values (*Institute of Medicine, 2001*).

As the definitions indicate, there are two major aspects of these definitions. The first is based on the idea of *scientific proof* or *evidence*. The first two definitions emphasize this idea. The second is based on the *use* of evidence-based practices. That is, they emphasize the responsibility of the provider to inform the consumer and/or family member about the best intervention for the problem and for desired outcomes. Based on this information, both the health provider and the consumer can decide together which intervention to select. This shared decision-making is an important principle identified by the Institute of Medicine (2001).

**“EBPs have strong scientific proof that they work... yet they are not widely available.”**

### LEVELS OF EVIDENCE

How do we know that the evidence for one intervention is better or stronger than for some other intervention?

The answer to this is that it depends on the way the studies are designed and conducted. When a study is done to see if an intervention is effective and makes people better, an important aspect is to try and be sure that people who received the intervention did not get better for some other reason. Research designs do this by controlling for variables that could contribute to the person's improvement. For example, people can get better because the illness took its course, or perhaps their health improved because of the care they were receiving in addition to receiving the inter-

vention itself. Others might appear to get better because of the way the study was designed and conducted. If the study was not designed well, it might seem that the intervention made people better when that was not the case.

Some research designs compare one group of persons who received the intervention (the experimental group) with another group that did not (the control group). If most of the people in the experimental group improved while those in the control group did not, one conclusion might be that the intervention is effective and makes people better.

Can we say that? Is such a conclusion valid? No, not necessarily because there might have been significant differences between the two groups in terms of age, sex, ethnicity or other characteristics that could affect the outcome. Researchers use specific designs called *randomized control trials* to control for such variables address these alternative explanations.

A randomized control trial is one of the best ways to study the outcomes of an intervention. It is the “gold standard” for assessing the effectiveness of an intervention. As defined by Webster’s New World Medical Dictionary (2003), “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.” When randomized control trials are done, they are considered to have stronger “proof” 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. These are then the interventions that get the highest rating in terms of “evidence.”

There are other studies that may have been conducted by just one group of researchers or in just one place. These interventions have less evidence, but may still be effective. Additionally, there are studies termed “quasi-experimental,” which are defined similarly to the randomized control trial, except there are no random assignments to the different groups. This study is still useful in determining the effectiveness of an intervention, but not as strong as a randomized control trial.

Or, sometimes, the intervention seems to work but the experimental and control groups are not equivalent. In some studies, there is no control group. Such interventions have lower levels of evidence.

The point is that there are some interventions that have more or higher levels of evidence than others. These 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 has a hierarchy of the levels of evidence. NIMH also has an approach to such levels. These can be accessed at [www.apa.org](http://www.apa.org) and [www.nimh.nih.gov](http://www.nimh.nih.gov).

## FIDELITY

Sometimes an evidence-based practice does not produce expected outcomes because it is not being implemented according to the “model” (the “model” is the version of the intervention that research found to be effective). A practice is not implemented well or “according to the model” when critical features or components of the intervention are not included in the version of the EBP being implemented.

Research has shown the EBP to be effective if key components of the intervention are in place. When these components are absent, the version of the EBP being implemented is no longer “true to the model.” It lacks *fidelity*.

Fidelity refers to the degree that the version of the EBP being implemented is “true to the model.” If most of the key components are present, the implemented version has high fidelity; if most are absent, it has low fidelity.

Fidelity scales are used to measure the degree to which the critical components of an EBP are present. The reason such scales are important is that they are like a thermometer—they tell you if the EBP is being implemented as it should or if there are adjustments that need to be made. For many EBPs, however, fidelity scales do not exist. Other mechanisms are used to ensure that critical components of the EBP are present, such as standards and guidelines.

Often, if an intervention is not producing desired outcomes, a clinician will recommend an alternative. But before switching interventions, it helps to make sure that the intervention was properly designed and administered. Fidelity scales indicate any modifications that are needed. In this sense fidelity measures are a gauge of the quality of services that consumers and family members receive.

For many interventions, fidelity scales do not exist. In this situation, standards and clinical guidelines are used to assure quality instead of fidelity measures.

## IMPLEMENTATION OF EVIDENCE-BASED PRACTICES

A common approach to implementing evidence-based practices is to train clinicians and providers to provide that practice. While such training is necessary, it is not enough. In fact, various stakeholder groups have responsibilities to ensure that practices are supported and maintained. Clearly, *clinicians* and *providers* have a responsibility to learn about the practice—the problems that the practice addresses, the outcomes produced, the populations for whom the EBP works. *Consumers* and *family members* have a responsibility to learn about the practice and adhere to the treatment plan that is developed. *Provider organization administrators* have a responsibility to provide the resources (financial and other), infrastructure and supports so that the clinicians and supervisors can receive training and deliver the EBPs with a reasonable degree of fidelity. *State-level policy makers and administrators* have a responsibility to provide adequate training and financial incentives and to ensure that policies, rules and standards support the implementation of the EBP.

Each stakeholder group has a role. For EBPs to be successfully implemented, a partnership needs to exist so that the various groups are mutually reinforced. Each group needs to do its part!

### LIMITATIONS OF EVIDENCE-BASED PRACTICES

Even though mental health EBPs are increasingly available, they have several limitations. First, the studies conducted have not always been conducted for a broad cross-section of the population. In many cases, persons from different ethnic and cultural backgrounds were not included in the original study design, or minimally represented. The question that arises is whether research findings should be applied to all populations. The prevailing approach is to assume that if it works for one group of persons that it should work for another group. At the same time, there are more studies being done on adaptations for different populations and on applications for diverse populations.

Second, the “evidence” related to EBPs is usually related to specific outcomes. For example, brief alcohol intervention programs work well for reducing at-risk alcohol use in older adults. In contrast, cognitive behavioral therapy helps older persons reduce symptoms of depression. And third, EBPs often require

qualified staff with various kinds of training. Such staff are not always available in different parts of a state. Such staffing constraints make it difficult if not impossible to provide—or get—the EBP.

### WHAT ARE EVIDENCE-BASED PRACTICES FOR OLDER ADULTS WITH DEPRESSION?

This section of the toolkit presents information on practices for older adults with depression that have some level of empirical support. The criteria used for their selection was that the research studies conducted had to be of high quality and that there needed to be more than one study. Please note that not all these studies have the same level of evidence. Those with the highest level of evidence are indicated by an asterisk. However, all these interventions have some level of empirical support.

Ten practices were identified; some of these practices have higher levels of evidence than others. Those with the highest level of evidence are indicated by an asterisk. The practices are:

- Multidisciplinary Geriatric Mental Health Outreach Services\*
- Gatekeeper Case Identification Model
- Cognitive Behavioral Therapy for Older Adults\*
- Problem-Solving Therapy for Older Adults\*
- Collaborative and Integrated Mental and Physical Health Care for Older Adults\*
- Reminiscence Therapy for Older Adults\*
- Cognitive Bibliotherapy for Older Adults\*
- Brief Psychodynamic Therapy for Older Adults
- Community-based Psychosocial Interventions for Older Adults with Serious Mental Illness
- Pharmacological Interventions for Older Adults\* contrast

For each intervention, there are summaries which include: a description of the intervention, the evidence, expected outcomes, populations included in the research, the research settings, target populations, the need for the intervention, issues related to implementation, the type of providers needed, and the availability of manuals and supporting materials. These are provided on the following pages.

# Multidisciplinary Geriatric Mental Health Outreach Services

*Older Adults' Evidence-Based Practices Implementation Resource Kit*

## DESCRIPTION OF INTERVENTION

Outreach services are designed to detect and treat mental health problems in settings where older adults live, spend time, or seek services. Elements of outreach services include case finding, assessment, referral, treatment, and consultation, education, and training services. For instance, outreach programs may offer early intervention, facilitate access to preventive healthcare services, provide evaluation services, refer individuals to community treatment or supportive services, and provide services designed to improve community tenure.

Most evaluations of community-based geriatric mental health outreach examine the impact of these services on symptoms and community tenure. These models generally employ a multidisciplinary team of providers to develop a care management protocol, which is implemented within a residential setting. Treatment recommendations vary significantly across individuals and are implemented through a variety of sources. Some outreach teams employ a model consisting of assessment and referral, while others directly implement treatment recommendations by clinicians on the assessment team.

## EVIDENCE

### Study types and numbers:

Randomized controlled trials: 5<sup>1-7</sup>

Quasi-experimental studies: 1<sup>8</sup>

Uncontrolled cohort studies: 6 – Prospective (4)<sup>9-12</sup>; Retrospective (2)<sup>13,14</sup>

Multiple researchers: Yes

## OUTCOMES OF INTERVENTION

A recent systematic review found that outreach interventions were associated with significant improvement in depressive symptoms, relative to usual care<sup>15</sup>. Of note, Rabins and colleagues<sup>2</sup> also found that outreach services were associated with a decrease in overall psychiatric symptom severity for individuals with a variety of psychi-

atric disorders. Findings from the small group of longitudinal cohort studies suggest positive effects of multidisciplinary outreach teams in reducing psychiatric symptoms from baseline levels. These studies provided in-home assessment, followed by interventions ranging from referral and linkage to outpatient treatment to in-home psychiatric care. However, the specific interventions and outcomes differed, limiting cross-study comparisons or pooling of results. These studies found that multidisciplinary geriatric mental health outreach interventions were associated with improved global functioning<sup>9</sup>, reduced psychiatric symptoms<sup>11,14</sup>, and fewer behavioral disturbances<sup>10</sup>, relative to baseline measurements of symptoms and functioning. In addition, these interventions were associated with maintained independence<sup>12,13</sup> and were perceived as helpful to caregivers and referring agents<sup>10</sup>. No difference was found in the degree of being homebound<sup>9</sup>.

## POPULATIONS INCLUDED IN RESEARCH

Participants included in these studies frequently lived alone, were female, and were over age 70. Several studies included large numbers of minority participants, including Hispanics and African Americans. For instance, 90% of participants in the PATCH (Psychogeriatric Assessment and Treatment in City Housing) program<sup>16</sup> and 36% of participants in PEARLS (the Program to Encourage Active, Rewarding Lives for Seniors)<sup>1</sup> were African American. Fourteen percent of participants in another study were Hispanic<sup>9</sup>.

## SETTINGS OF RESEARCH

Community (Home care, residential care, senior public housing)

## TARGET POPULATIONS/DIAGNOSES OR DISORDERS ADDRESSED

Depression

Dementia

Other psychiatric illnesses

## NEED FOR INTERVENTION:

Although approximately one-fifth of older adults have a late-life mental illness<sup>17</sup> and a substantial evidence for efficacy of several pharmacological and psychotherapeutic interventions exists, mental illness is under-recognized and under-treated in community-based settings. It is estimated that approximately half of older adults with a recognized mental disorder fail to receive mental health services<sup>18</sup>. Older adults fail to utilize traditional clinic-based mental health services for a variety of reasons, including physical frailty, transportation difficulties, isolation, and stigma<sup>19</sup>. Community-based mental health outreach models provide services in the settings where older adults reside or spend a significant amount of time. The provision of outreach services to older adults in non-institutional community-based settings has been promoted as a potential mechanism for increasing access to mental health care.

## ISSUES RELATED TO IMPLEMENTATION

Implementation of care management protocols are generally developed by a multidisciplinary team. Examples of multidisciplinary outreach models include the PEARLS program and the PATCH program, which were provided in senior residential settings. The preponderance of evidence supports the use of multidisciplinary community-based interventions for persons with depressive disorders.

## SERVICE PROVIDER

Providers differ across studies and include nurses, care managers, physicians, social workers, and residential staff.

## REFERENCES

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# Gatekeeper Case Identification Model

## DESCRIPTION OF INTERVENTION

The “gatekeeper” model recruits community service personnel who have frequent contact with older persons (i.e., meter readers, utility workers, landlords, etc.) to identify and refer at-risk older adults for assessment. Assessment focuses on identifying unmet needs and comprehensively evaluating physical health, mental health, and psychosocial needs. Based on identified needs, treatment recommendations are developed in concert with a multidisciplinary team.

## EVIDENCE

### Study types and numbers:

Controlled prospective cohort: 1<sup>2</sup>  
Outcome data on intervention and control cohorts: 1<sup>3-5</sup>.

Multiple researchers: Case finding studies are primarily conducted by one group of investigators. However, the “gatekeeper” model has been used in multiple studies, including the PATCH study<sup>8</sup> (see Multidisciplinary Geriatric Mental Health Outreach section).

## OUTCOMES OF INTERVENTION

The “gatekeeper” model has been compared with traditional referral sources (i.e., medical providers, family members, informal caregivers, and other concerned persons). Two evaluations compare referral by gatekeepers to traditional referral sources<sup>2-5</sup>. In these studies, gatekeepers identified approximately 40% of older persons referred to elder services. Older adults referred by gatekeepers were significantly more likely to live alone and were more often widowed or divorced, compared to those referred by medical or other traditional sources. Moreover, individuals referred by gatekeepers were significantly more likely to be affected by economic and social isolation. These findings suggest that the gatekeeper approach reaches individuals who are less likely to access services through conventional referral approaches. At the time of referral, individuals referred by gate-

keepers were significantly less likely to use services than individuals referred through traditional sources, had similar service needs, and thus had a larger gap between services needed and services received<sup>3-5</sup>. At one-year follow-up, older persons referred from gatekeepers had no difference in service utilization or out-of-home placements compared to individuals who were referred by traditional sources<sup>2</sup>.

## POPULATIONS INCLUDED IN RESEARCH

Studies included isolated older adults in home and residential settings. Over half of participants had cognitive impairment. Up to half of participants were widowed and most lived alone. The average of participants ranged from 76 to 79 years and over three-fifths were female. Ethnicity of study participants was not noted in these studies.

## SETTINGS OF RESEARCH

Community (Home, residential care, senior public housing)

## TARGET POPULATIONS/DIAGNOSES OR DISORDERS ADDRESSED

- Dementia or cognitive impairment
- Emotional disturbances, depression, bipolar disorder.

The gatekeeper model has been described as appropriate for community-dwelling older adults who experience any, or all, of the following signs or symptoms of distress: a serious and persistent mental illness, emotional or behavioral problems, poor health, social isolation, abuse or neglect, substance abuse problems, and reluctance or inability to seek help on their own behalf or the absence of someone to seek help for them.

## NEED FOR INTERVENTION:

Older adults have historically underutilized mental health services<sup>6</sup>. Untreated mental illness in older adults has a significant impact on health, functioning, and health service utilization and costs. Low service utilization has been attributed to both per-

sonal (i.e., stigma) and system (i.e., lack of transportation) barriers. To overcome these barriers and increase use of mental health services, the gatekeeper case identification model has been developed to identify the most socially isolated and disadvantaged older adults who are least likely to seek out mental health care.

### ISSUES RELATED TO IMPLEMENTATION

Gatekeepers are community-based service personnel. As such, this model of case identification is likely to be low-cost and feasible in identifying at-risk older adults in a range of geographic locations (i.e. rural, urban). Although there are no randomized controlled trials of the gatekeeper case identification approach, this model has been included within a randomized controlled trial of multidisciplinary outreach care (e.g., PATCH program). The model has been adapted successfully in urban, rural, and suburban communities and coordinated by single service systems or in collaboration with multiple systems.

### SERVICE PROVIDER

Gatekeepers include employees of corporations, businesses, and other community organizations who have contact with the target population (e.g., meter readers, utility workers, bank personnel, apartment managers, postal carriers, fuel oil dealers, police, sheriff and fire department personnel, and others).

### MANUAL AVAILABILITY

A manual and technical assistance are available to guide program development. Materials are available from the Washington Institute for Mental Illness Research and Training <sup>7</sup>.

### FOR A COMPREHENSIVE REVIEW SEE:

Van Citters, A.D., Bartels, S.J. A systematic review of the effectiveness of community-based mental health outreach services for older adults. *Psychiatric Services*. 2005; 55(11): 1237-1249.<sup>1</sup>

For additional information, please see: Gatekeeper Case Finding and Response System Model Program at: [modelprograms.samhsa.gov/print.cfm?pkProgramid=99](http://modelprograms.samhsa.gov/print.cfm?pkProgramid=99).

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# Cognitive Behavioral Therapy for Older Adults

*Older Adults' Evidence-Based Practices Implementation Resource Kit*

## DESCRIPTION OF INTERVENTION

Cognitive-behavioral therapy (CBT) is an active, time-limited, and structured therapy that is intended to change the thinking and behaviors that cause or maintain depression, anxiety, and other mental health symptoms. CBT is based on the idea that cognitions/thoughts are associated with underlying beliefs, attitudes and assumptions. CBT is designed to modify thought patterns, improve skills, and change the emotional states that contribute to mental disorders. The most basic premise of CBT is that a person's feelings and behaviors determine the way that a person thinks and makes sense of their experiences. CBT is designed to help individuals identify, challenge, and alter maladaptive information processing. Finally, CBT incorporates a variety of behavioral techniques, including behavioral activation, relaxation training, and assertiveness. CBT explicitly uses cognitive and behavioral techniques such as activity scheduling, graded task assignments, problem solving techniques, thought identification and monitoring, and examining and challenging core beliefs.

## EVIDENCE

### Study types and numbers:

*Depression:* 6 RCTs (Total of 12 studies evaluating cognitive-behavioral therapies <sup>1</sup>)

*Anxiety:* Randomized controlled trials: 8

Case series: 3; Open-label trial: 1; Multiple baseline study: 1

Multiple researchers: Yes

## OUTCOMES OF INTERVENTION

*Older Adults with Depression:* As identified in recent systematic reviews <sup>1-3</sup>, CBT is an established effective treatment for older adults with depression, compared to waitlist, no treatment, usual care, or placebo. In addition, several studies have evaluated the effectiveness of combined antidepressant medication and CBT in older adults with depression. These studies noted that the combination of antidepressant medication and CBT was more efficacious than an antidepressant alone <sup>4</sup>.

*Older Adults with Anxiety Disorders:* As identified by a recent systematic review of interventions for older

adults with anxiety disorders <sup>5</sup>, the evidence-base supporting the effectiveness of CBT in older adults with anxiety disorders is growing. Several studies have focused on group- and individually-delivered CBT for older adults with generalized anxiety disorder (GAD). Response rates include 28-45% for group-delivered CBT, 40% for individually-delivered CBT, and 75% for an enhanced version of individual CBT. In contrast, minimal contact and waitlist control groups had response rates of 5-14%. The effectiveness of CBT has also been studied among older adults with anxiety and impaired executive functioning (EF). Those with intact and improved EF were more likely to respond, while those with impaired EF did not respond to CBT.

Several small open label and case series studies have examined group and individual CBT among older adults with mixed anxiety disorders. Group-delivered CBT was effective in improving several measures of anxiety symptoms in patients with specific phobias, agoraphobia, social phobia, or generalized anxiety symptoms. Individual, home-delivered CBT was more effective than supportive counseling (SC) on self-ratings of anxiety and depression, with response rates of 71% in CBT and 39% in SC. In addition, 10 individual 90-minute sessions of CBT among patients with panic disorder was associated with improvements in measures of panic, anxiety, and depression. Finally, the combination of CBT and medication management (MM) was more effective than MM alone in improving symptoms, and had equivalent efficacy in reducing dependence on anxiolytic medications among older adults with mixed anxiety disorders. Response rates were 64% in CBT and MM and 36% in MM alone.

## POPULATIONS INCLUDED IN RESEARCH

These studies included treatment seeking older adults with depression and anxiety disorders. The majority of participants were female and the average age was relatively young (e.g., mid-60s). The majority of older adults with cognitive ment <sup>1</sup>. In addition, there has been little examination of differences with respect to age, ethnicity, education, functional status, or medical health <sup>5</sup>.



## SETTINGS OF RESEARCH

- Mental health settings
- Primary care
- Home-delivered care
- VA outpatient settings

## TARGET POPULATIONS/DIAGNOSES OR DISORDERS ADDRESSED

- Depression, including family caregivers
- Anxiety disorders (Generalized anxiety disorder, mixed anxiety disorder)
- Schizophrenia (see review of CBSST in previous section)

## NEED FOR INTERVENTION

Depression and anxiety disorders are among the most common mental health problems in older persons and affect approximately 3-7% and 11% of the general older adult population, respectively<sup>6</sup>. The prevalence of these disorders is heightened among persons receiving health care in the primary care system, in outpatient mental health settings, and in nursing homes<sup>7,8</sup>. Left untreated, these problems are associated with significant morbidity and heightened health care utilization.

## ISSUES RELATED TO IMPLEMENTATION

The evidence supporting the use of CBT for older adults with depression and generalized anxiety disorders is robust. Additional research will help clarify the role of CBT in persons with other anxiety disorders.

## SERVICE PROVIDER

Professional mental health service providers, including psychiatrists, psychologists, social workers, psychiatrically trained nurses, and licensed marriage and family counselors

## MANUAL AVAILABILITY

CBT was developed by Beck and colleagues<sup>9</sup> and has been adapted for use with older adults<sup>10-12</sup>. Therapist and accompanying client manuals specific to the needs of older adults are available through the Stanford School of Medicine's Older Adult and Family Center: <http://www.med.stanford.edu/fm/?/oac/&CBT.html>

## FOR A COMPREHENSIVE REVIEW SEE:

- The effectiveness of CBT has been systematically reviewed among older adults with depression<sup>1-3</sup> and anxiety<sup>5</sup> disorders.

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# Problem-Solving Therapy for Older Adults

## DESCRIPTION OF INTERVENTION

Problem-solving therapy (PST) is based on the theory that deficiencies in social problem-solving skills increase the risk for depressive and other psychiatric symptoms. By improving problem-solving skills, older patients are given skills that allow them to cope with stressors and as a result experience fewer psychiatric symptoms. PST begins with intensive training in developing an appropriate orientation to coping with mental health problems. PST teaches skills for using active and adaptive approaches to problem solving. Participants are taught to better define and formulate problems, to generate a wide range of alternative solutions, to examine the possible consequences of each solution in order to select the best approach, and to monitor and evaluate the outcomes of each solution following implementation.

## EVIDENCE

### Study types and numbers:

Randomized controlled trials: 4<sup>8-11</sup>

Component of care management: 2<sup>1, 12</sup>

### Multiple researchers: Yes

## OUTCOMES OF INTERVENTION

There is good evidence for the effectiveness of PST in treating older adults with depression. Three RCTs have found PST to be superior to other therapies and no treatment<sup>8-10</sup>. However, one RCT found no difference between a shortened version of PST delivered in the primary care setting, as compared to an antidepressant medication (paroxetine) or a placebo for older adults with minor depression or dysthymia<sup>11</sup>. In this study, both paroxetine and PST improved mental health functioning in patients with minor depression and initial low functioning. However, only paroxetine was associated with improvement for older adults with dysthymia.

PST has also been incorporated into two studies of depression care management among older adults. A model of delivering PST to older adults with major depression or dysthymia in primary care settings (PST-PC), in combination with antidepressant medications, was evaluated in the Improving Mood—Promoting Access to Collaborative Treatment

(IMPACT) program<sup>12</sup>. IMPACT was associated with superior depression outcomes, in comparison to usual care. The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) also provided PST to older adults with minor depression or dysthymia through a home-based program of detecting and managing depression, in combination with antidepressant medication recommendations to primary physicians<sup>1</sup>. The PEARLS program was associated with improved depressive symptoms and functional and emotional well-being. In addition, compared to a control group, those receiving PST were more likely to achieve remission of depressive symptoms (36% vs. 12%).

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

## POPULATIONS INCLUDED IN RESEARCH

Participants in these studies varied in gender, ethnicity, and age. For instance, the proportion of female participants in one study was 79%<sup>1</sup>, whereas it was 42% in another<sup>11</sup>. Several studies had one-fifth or more participants who were members of ethnic minority groups, predominantly African American and Hispanic minorities. Finally, the mean age in several studies was greater than 70 years.

## SETTINGS OF RESEARCH

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

## TARGET POPULATIONS/DIAGNOSES OR DISORDERS ADDRESSED

- Major depression
- Minor depression
- Dysthymia

## NEED FOR INTERVENTION:

Major depression affects approximately 3-7% of the general older adult population<sup>5</sup>, however the prevalence of depression is heightened among persons receiving health care services<sup>6,7</sup>. Without

adequate and effective treatment, mental disorders in older persons are associated with significant disability and impairment, including impaired independent and community-based functioning, compromised quality of life, poor health outcomes, cognitive impairment, increased disability and mortality, and increased caregiver stress<sup>13</sup>. Older adults with depression also have increased numbers of service visits, increased burden to medical care providers, and heightened annual costs of care<sup>14-17</sup>.

### ISSUES RELATED TO IMPLEMENTATION

The PST intervention 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, through funding from the John A. Hartford Foundation.

### SERVICE PROVIDER

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

### MANUAL AVAILABILITY

A general manual for delivering PST has been developed by Nezu and colleagues<sup>18</sup>. However, this manual is not specific to older adults. 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 [www.impact.ucla.edu/tools.html](http://www.impact.ucla.edu/tools.html). (For further information, see section on Collaborative and Integrated Mental and Physical Health Care for Older Adults.)

### FOR A COMPREHENSIVE REVIEW SEE:

- The effectiveness of PST among older adults with depression has been reviewed in several systematic reviews<sup>2-4</sup>.
- Scogin F, Welsh D, Hanson A, Stump J, Coates A. Evidence-based psychotherapies for depression in older adults. *Clinical Psychology*. 2005;12(3):222-237.
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# Collaborative and Integrated Mental and Physical Health Care for Older Adults

*Older Adults' Evidence-Based Practices Implementation Resource Kit*

## DESCRIPTION OF INTERVENTION

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 have been located in the primary care setting and have provided shared care of depressed patients between on-site mental health specialist and the primary care clinician<sup>3</sup>. Three primary models of collaborative care have been evaluated specifically for older adults. These include Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E)<sup>4</sup>, Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT)<sup>5</sup>, and Improving Mood: Promoting Access to Collaborative Treatment (IMPACT)<sup>2</sup>. 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, outcomes, and patient satisfaction<sup>3</sup>.

## EVIDENCE

Study types and numbers:

Randomized controlled trials: 3<sup>2,4,5</sup>

Multiple researchers: Yes

## OUTCOMES OF INTERVENTION

The integrated model of care tested in the PRISM-E project was associated with greater engagement in care than a comparison condition consisting of an enhanced model of referral to specialty mental health or substance abuse services. The integrated model and enhanced referral to specialty care were equally effective in improving depression and at-risk alcohol use. The PROSPECT model of care was associated with greater depression response and remission, compared to usual care. The IMPACT model of care was associated with improved reduction in symptoms, higher rates of treatment and satisfaction with care, lower depression severity and lower functional impairment, and increased quality of life, compared to usual care.

## POPULATIONS INCLUDED IN RESEARCH

Study participants included older adult primary care patients. The mean age of participants in the IMPACT study was 71 years. Participants age 75 and older represented 40% of the PRISM-E sample and 31% of the PROSPECT sample.

The majority of participants in all three studies were female, including 65% in the IMPACT study, 71% in the PRISM-E study, and 72% in the PROSPECT study. Approximately two-fifths to one-half of participants were married (43.5% to 48%).

Finally, the proportion of minority participants varied across studies, including 23% in the IMPACT study, 32% in the PROSPECT study (12% African American, 8% Latino), and 48% in the PRISM-E study (25% African American, 15% Hispanic/Latino, and 6% Asian).

## SETTINGS OF RESEARCH

- Primary care settings

## TARGET POPULATIONS/DIAGNOSES OR DISORDERS ADDRESSED

- Major depression (IMPACT, PROSPECT, PRISM-E)
- Minor depression (PROSPECT, PRISM-E)
- Dysthymia (IMPACT, PRISM-E)
- Anxiety disorders (PRISM-E)
- Substance abuse (PRISM-E)

## NEED FOR INTERVENTION:

Older adults prefer to seek mental health care in the primary care setting<sup>1</sup>. In addition, studies have shown that older adults consider psychotherapy to be an effective intervention and in some cases, prefer it over antidepressant medication<sup>6</sup>. Interventions which impose systems-based changes in the primary care setting (including integrated mental health collaborative care) can improve the treatment and outcomes of older adults with mental health problems.

## ISSUES RELATED TO IMPLEMENTATION

Dissemination and implementation of the IMPACT model of collaborative and integrated care is the most well-supported and widely available. The Hartford Foundation has committed resources for training and dissemination of this intervention.

### SERVICE PROVIDER

PRISM-E: Licensed mental health providers from various disciplines, with verbal or written communication with the primary care provider  
PROSPECT, IMPACT: Depression clinical specialist (nurse, social worker, or psychologist), primary care provider, and a team psychiatrist

### MANUAL AVAILABILITY

The IMPACT program manual and PST-PC treatment manuals are available at [www.impact.ucla.edu/tools.html](http://www.impact.ucla.edu/tools.html) free of charge <sup>7,8</sup>. Training and technical assistance in this model is also available. The availability of treatment manuals corresponding to the PRISM-E and PROSPECT models is unknown.

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# Reminiscence Therapy for Older Adults

*Older Adults' Evidence-Based Practices Implementation Resource Kit*

## DESCRIPTION OF INTERVENTION

Reminiscence Therapy involves the discussion of past activities, events and experiences with another person or group of people, usually with the aid of tangible prompts such as photographs, household and other familiar items from the past, and music and archived sound recordings. Reminiscence groups typically involve group meetings in which participants are encouraged to talk about past events. In contrast, life review typically involves individual sessions, in which the person is guided chronologically through life experiences, encouraged to evaluate them, and may produce a life story book. Reminiscence and life review techniques involve going back over one's life and remembering particular days and events. The two therapies are similar, although reminiscence tends to be more about remembering pleasant events spontaneously, while life review therapy is more structured and involves an evaluation of one's life.

## EVIDENCE

### Study types and numbers:

Randomized controlled trials: 5+ studies  
depression; 5+ studies dementia

### Multiple researchers: Yes

## OUTCOMES OF INTERVENTION

*Depression:* Reminiscence therapy is an evidence-based therapy for older adults with major depression<sup>1</sup>. Most high quality studies support the effectiveness of reminiscence therapy in improving depressive symptoms. However, reminiscence therapy was found to be less efficacious than goal-focused psychotherapy in one of five reviewed studies. The efficacy of reminiscence therapy is more pronounced in populations of persons with major depression. In studies in which participants did not have major depression, outcomes were mixed, with some supporting reminiscence therapy and some finding no benefits. Both structured and unstructured life review therapies have been found to be effective compared with a no-treatment control condition among older adults with depression.

*Dementia:* Four randomized controlled trials were evaluated in a recent systematic review<sup>2</sup>. Several were very small studies, or were of relatively low quality, and each examined different types of reminiscence work. Cognition and mood improved 4 to 6 weeks after the treatment, care-givers of a relative with dementia in a reminiscence group reported lower strain, and people with dementia were reported to show some indications of improved functional ability. In view of the limited number and quality of studies, the variation in types of reminiscence work reported and the variation in results between studies, this review noted the need for more and better designed trials so that more robust conclusions may be drawn.

## POPULATIONS INCLUDED IN RESEARCH

Older adults; male and female; cognitively impaired individuals

## SETTINGS OF RESEARCH

- Long-term care facilities
- Retirement apartments
- Community residents attending a senior center

## TARGET POPULATIONS/DIAGNOSES OR DISORDERS ADDRESSED

- Depression
- Depressive symptoms
- Dementia

## NEED FOR INTERVENTION:

Major depression affects approximately 3-7% of the general older adult population<sup>3</sup> and the prevalence is heightened among persons receiving health care services<sup>4,5</sup>. The prevalence of depressive symptoms is significantly higher. In addition, dementia affects nearly 5% of community dwelling adults ages 65+ and affects nearly 16% of older adults over age 75<sup>6</sup>.

## ISSUES RELATED TO IMPLEMENTATION

Reminiscence should be sensitive to the different needs of individuals. Of note, reminiscence therapy is one of the most popular psychosocial interventions in dementia care, and is highly rated by staff and participants<sup>2</sup>. However, it should be

noted that randomized controlled trials of reminiscence therapy in persons with dementia have included small sample sizes and the level of cognitive impairment varies across studies from mild to severe. Rigorous systematic reviews have recommended the need for additional evaluation of the effectiveness of this approach in persons with both depression and dementia<sup>1,7,8</sup>. Reminiscence therapy requires minimal resources and is a therapy that is readily available anytime and anywhere for older adults.

### SERVICE PROVIDER

Trained therapists can provide reminiscence therapy. In studies, reminiscence therapy has been provided by advanced graduate students in clinical psychology.

### MANUAL AVAILABILITY

Reminiscence therapy is based on the model developed by Butler<sup>9</sup>. A published protocol for delivering reminiscence therapy<sup>10</sup> has been developed and is available in bookstores and online (e.g., Amazon.com for twenty-five dollars). However, systematic reviews have suggested the need for formal protocols for delivering reminiscence therapy that clearly identify the essential components of this intervention<sup>2</sup>.

### FOR A COMPREHENSIVE REVIEW SEE:

- Reminiscence therapy has been specifically evaluated in several systematic reviews<sup>2,11,12</sup>. In addition, it has also been systematically reviewed along with other psychosocial treatments for geriatric depression<sup>1,7,8</sup>.
- Woods B, Spector A, Jones C, Orrell M, Davies S. Reminiscence therapy for dementia. *The Cochrane Database of Systematic Reviews*. 2005;2.
- Hsieh HF, Wang JJ. Effect of reminiscence therapy on depression in older adults: a systematic review. *International Journal of Nursing Studies*. 2003;40(4):335-345.
- Bohlmeijer E, Smit F, Cuijpers P. Effects of reminiscence and life review on late-life depression: a meta-analysis. *International Journal of Geriatric Psychiatry*. 2003;18(12):1088-1094.

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# Cognitive Bibliotherapy for Older Adults

*Older Adults' Evidence-Based Practices Implementation Resource Kit*

## DESCRIPTION OF INTERVENTION

Cognitive bibliotherapy involves reading books or using the Internet or computer programs to find out about depression and learn how to reduce symptoms. Written exercises can complement reading materials and are completed outside of a clinic setting at the participant's own pace. Similar to CBT, cognitive bibliotherapy is intended to change the thinking and behaviors that cause or maintain depression and other mental health symptoms.

## EVIDENCE

Study types and numbers: 4 RCTs<sup>1-4</sup>

Multiple researchers: Yes

## OUTCOMES OF INTERVENTION

Three of four RCTs evaluating bibliotherapy among older adults found it to be more effective in reducing depressive symptoms than a wait list or a placebo control. A fourth RCT found cognitive bibliotherapy to be as effective as therapy provided by a mental health treatment professional.

## POPULATIONS INCLUDED IN RESEARCH

Participants were age 55 and older, were primarily female and Caucasian, and most were unmarried. Most participants had graduated from high school.

## SETTINGS OF RESEARCH

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

## TARGET POPULATIONS/DIAGNOSES OR DISORDERS ADDRESSED

- Mild to moderate depression

## NEED FOR INTERVENTION:

Major depression affects approximately 3-7% of the general older adult population<sup>5</sup> and the prevalence is heightened among persons receiving health care services<sup>6,7</sup>. The prevalence of depressive symptoms is significantly higher. Cognitive bibliotherapy potentially provides 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<sup>8</sup>.

## ISSUES RELATED TO IMPLEMENTATION

No studies have evaluated the use of cognitive bibliotherapy among older adults with severe depression. In addition, most studies of cognitive bibliotherapy have included small numbers of participants. As such, there is a need for additional research that clearly identifies the effectiveness of this intervention, especially in comparison to other interventions for older adults with depression.

## SERVICE PROVIDER

- Self-administered

## MANUAL AVAILABILITY

Evaluations of cognitive bibliotherapy have commonly utilized the book *Feeling Good*<sup>9</sup>, which is available through bookstores and online (e.g., Amazon.com for under \$15).

## FOR A COMPREHENSIVE REVIEW SEE:

- The effectiveness of cognitive bibliotherapy for older adults with depression has been reviewed in several systematic reviews<sup>10-12</sup>
- Scogin F, Welsh D, Hanson A, Stump J, Coates A. Evidence-based psychotherapies for depression in older adults. *Clinical Psychology*. 2005;12(3):222-237.
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# Brief Psychodynamic Therapy for Older Adults

*Older Adults' Evidence-Based Practices Implementation Resource Kit*

## DESCRIPTION OF INTERVENTION

Brief psychodynamic therapy is designed to help persons understand and cope with unresolved issues and conflicts and typically is delivered in 20 sessions or fewer. This intervention focuses on reflecting on past experiences, clarifying feelings, developing a therapeutic relationship, and addressing interpersonal issues. Brief psychodynamic therapy can address issues such as dependence and independence, understanding past losses and conflicts in separation and individuation, self-esteem, and grief.

## EVIDENCE

Study types and numbers: 2 RCTs <sup>1,2</sup>

Multiple researchers: No

## OUTCOMES OF INTERVENTION

Brief psychodynamic therapy has been found to improve depressive symptoms among older adults. It does not differ in effectiveness from behavioral therapy or cognitive therapy.

## POPULATIONS INCLUDED IN RESEARCH

Participants evaluated in studies of brief psychodynamic therapy have primarily been female, Caucasian, well-educated, and of middle to upper socioeconomic status

## SETTINGS OF RESEARCH

Not stated

## TARGET POPULATIONS/DIAGNOSES OR DISORDERS ADDRESSED

- Major depression
- Family caregivers with depressive disorders (major depression, minor depression, intermittent depressive disorder)

## NEED FOR INTERVENTION:

Major depression affects approximately 3-7% of the general older adult population <sup>3</sup> and the prevalence is heightened among persons receiving health care services <sup>4,5</sup>. The prevalence of depressive symptoms is significantly higher.

## ISSUES RELATED TO IMPLEMENTATION

Only one research group has evaluated the effectiveness of brief psychodynamic therapy in older adults. In addition, study samples have been small and have had limited generalizability. Additional research in this area could help clarify the effects of this intervention as well as the generalizability to a broader population.

## SERVICE PROVIDER

Masters and doctoral level therapists provided the studied interventions.

## MANUAL AVAILABILITY

The principles for providing brief psychodynamic therapy are described in the literature <sup>6-8</sup>. We are not aware of a manual or protocol that specifically describes the components of the intervention.

## FOR A COMPREHENSIVE REVIEW SEE:

- The effectiveness of brief psychodynamic therapies for older adults with depression has been reviewed in several systematic reviews <sup>9-11</sup>.
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# Community-based Psychosocial Interventions for Older Adults with Serious Mental Illness

## Older Adults' Evidence-Based Practices Implementation Resource Kit

### DESCRIPTION OF INTERVENTION

Three promising psychosocial interventions have been developed and evaluated among middle-aged and older adults with serious mental illness (SMI) <sup>1-5</sup>. These include a combined skills training and cognitive behavioral treatment program <sup>1-3</sup>; a social skills training program <sup>4,6</sup>; and a combined skills training and health management intervention <sup>5</sup>.

The Cognitive Behavioral Social Skills Training (CBSST) program consists of group training in cognitive restructuring and illness self-management skills. Cognitive behavioral strategies were used to challenge convictions regarding delusional beliefs, and to explore resistance to treatment recommendations, including medication nonadherence and homework noncompliance <sup>1-3</sup>.

The Functional Adaptation Skills Training (FAST) program consists of a 24-week modular skills training intervention to improve community functioning in middle-aged and older adults with chronic psychotic disorders. The FAST intervention included modules related to medication self-management, social skills, communication skills, organization and planning, transportation, and financial management <sup>4</sup>.

The Skills Training and Health Management (ST+HM) intervention was developed to enhance independent functioning and health care outcomes <sup>5</sup>. Weekly skills training (ST) classes are provided in community living skills, social skills, leisure skills, and wellness self-management. The skills acquired in these manualized classes are complemented by group practices sessions in the community. Health management (HM) is provided by a nurse within the mental health center who conducts a health assessment; provides health education; facilitates healthcare screening, immunizations, and primary care office visits; and monitors treatment of chronic medical conditions.

### EVIDENCE

#### Study types and numbers:

CBSST: RCT <sup>2</sup>; small pilot RCT <sup>1</sup>, case series <sup>3</sup>

FAST: Two small pilot RCTs <sup>4,6</sup>

ST+HM: Small pilot quasi-experimental

study <sup>5</sup>

Multiple researchers: Across interventions: yes;

Within interventions: no

### OUTCOMES OF INTERVENTION

CBSST: Significant improvements compared with care as usual in "social functioning", cognitive insight (insight about beliefs), and performance on a comprehensive test of skills taught in the program <sup>2</sup>.

FAST: Positive findings included greater improvement in community functioning skills for the FAST group, compared with the care as usual group <sup>4</sup>. FAST was translated and adapted for middle-aged and older Latinos into a program entitled PEDAL (Programa de Entrenamiento para el Desarrollo de Aptitudes para Latinos; PEDAL), with similar positive findings <sup>6</sup>.

ST+HM: Compared with persons who received health management (HM) alone, those who received ST+HM had significant improvement in independent living skills, social functioning, self-care and health management skills. Positive findings from the health management component included identification of previously undetected medical conditions in approximately one-third of the sample and greater receipt of preventive health care services <sup>5</sup>.

### POPULATIONS INCLUDED IN RESEARCH

The average age of participants varied across interventions: CBSST (range 42 to 74); FAST (range 42-69); ST+HM (age 60+). In addition, the majority of participants in CBSST and FAST were male (13%-31% female), while the majority of participants in ST+HM were female (75%). The CBSST and FAST/PEDAL programs were conducted in urban settings in California, while the ST+HM program was conducted in a small city in New Hampshire. The majority of participants in most studies were Caucasian, however, the PEDAL intervention was specifically designed and delivered to older Latinos.

### SETTINGS OF RESEARCH

- Outpatients
- Board and care home residents

## TARGET POPULATIONS/DIAGNOSES OR DISORDERS ADDRESSED

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder

### NEED FOR INTERVENTION:

Less than 1% of older adults have schizophrenia or bipolar disorder<sup>7</sup>. However, the number of older adults with SMI is expected to increase dramatically in the coming decades. Older adults with SMI use a disproportionate amount of mental health resources and are at high risk of institutionalization, underscoring the need for effective treatment approaches. As increasing numbers of people with schizophrenia are expected to continue to live in the community as they age, it becomes important to establish effective interventions that are tailored to treat the unique needs of this population.

### ISSUES RELATED TO IMPLEMENTATION

Psychosocial interventions for older adults with SMI are in the early stages of development and have only recently begun to be evaluated in RCTs. Most data has been derived from small pilot studies. These interventions vary in duration from 12 to 24 weeks for CBSST, 24 weeks for FAST/PEDAL, and 12 months for ST+HM. Larger RCTs of these interventions are currently in process.

### SERVICE PROVIDER

CBSST: Led by two therapists (doctoral-level psychologists or senior graduate students in clinical psychology with at least 2 years of clinical experience).

FAST: A master's or doctoral-level therapist and a para-professional such as might be found in typical board and care settings or nursing homes.

ST+HM: A nurse and a master's level therapist.

### MANUAL AVAILABILITY

Each of these interventions has been manualized for use in randomized controlled trials. However, to our knowledge, training manuals and technical assistance are not publicly available.

### FOR A COMPREHENSIVE REVIEW SEE:

- The effectiveness of psychosocial interventions for older adults with serious mental illness has been reviewed in two recent systematic reviews

<sup>8,9</sup>.

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# Pharmacological Interventions for Older Adults

*Older Adults' Evidence-Based Practices Implementation Resource Kit*

## DESCRIPTION OF INTERVENTION

Pharmacological interventions have been the mainstay of treatment for many older adults with psychiatric disorders. Several extensive reviews of the evidence supporting pharmacological interventions have been published. The evidence supporting each class of medication varies, with the most evidence supporting antidepressant therapy for older adults with depression. The evidence for pharmacological interventions for older adults with other mental health problems is less rigorous.

## EVIDENCE

### Antidepressant Medications for Older Adults with Depression:

Antidepressant medications are more effective than placebo in treating depression among older adults<sup>1</sup>. A systematic review of over 29 randomized, controlled trials found that different types of antidepressant medications (including tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRIs)) are equally effective in improving depressive symptoms. However, classical tricyclic antidepressants are associated with a higher withdrawal rate (e.g., discontinuation) due to worse side effects<sup>2,3</sup>.

### Antipsychotic Medications for Older Adults with Schizophrenia:

Antipsychotics are commonly used in the treatment of older adults with schizophrenia. Two recent systematic reviews have identified a variety of small studies that have examined the effectiveness of these agents. Fourteen pharmacological studies focus exclusively on the treatment of older adults (age 50+) with schizophrenia, including five double-blind RCTs<sup>4-9</sup>, two open-label RCTs<sup>10,11</sup>, two quasi-experimental studies<sup>12,13</sup>, and two non-controlled prospective cohort studies<sup>14,15</sup>. Available evidence suggests that antipsychotic medications are generally effective in improving psychiatric symptoms, however, there is little data available to guide clinicians with respect to the most appropriate drug to prescribe<sup>16,17</sup>.

### Pharmacological Interventions for Older Adults with Anxiety Disorders

Few treatment trials have addressed the impact of pharmacological treatment for anxiety disorders in older patients. Only three RCTs have evaluated benzodiazepines among older adults with anxiety disorders<sup>18-20</sup>. Two of these focused on GAD<sup>18,19</sup>. In all of these studies, medication was more effective than a placebo<sup>19</sup>. Response rates to medication ranged from 57% to 83%<sup>18,19</sup>. Clinical recommendations for the use of benzodiazepines with older adults suggest that lower doses of medications with shorter half-lives be used over a briefer interval than for younger patients<sup>21</sup>. Antidepressants have been evaluated in several studies among older adults with anxiety disorders. These studies have focused on patients with panic disorder, mixed anxiety disorders, and GAD<sup>22-25</sup> and have found that sertraline, citalopram (both SSRI antidepressants), and venlafaxine were associated with improvements in anxiety symp-

toms and moderate response rates. Most interventions for older adults with anxiety disorders have been evaluated among individuals with GAD.

### Pharmacological Interventions for Older Adults with Bipolar Disorder

There is an emerging evidence-base on the effectiveness of different approaches to treatment of bipolar disorder in older adults<sup>26-28</sup>. Standard pharmacological approaches consisting of lithium and divalproex used in younger adults appear to be effective in older adults as well, though lower initial doses and close attention to monitoring serum levels are necessary. Aggregate results from four uncontrolled studies showed that that two-thirds of older adults with bipolar disorder had improved outcomes following lithium treatment<sup>26</sup>. However, the use of lithium in older persons is complicated by lowered renal clearance and a longer elimination half-life compared to younger persons<sup>28</sup>. Aggregate data from five studies evaluating divalproex in older adults found that 59% improved following treatment<sup>26</sup>. As with lithium, the elimination half-life of divalproex is greater compared to that of younger adults. To date, research is lacking on the comparative effectiveness of lithium and divalproex in older adults with bipolar disorder. The data supporting the use of other anticonvulsants and antipsychotic medications are limited<sup>28</sup>.

Multiple researchers: Yes

## OUTCOMES OF INTERVENTION

Generally small to modest improvements in psychiatric symptoms (See above).

## SETTINGS AND POPULATIONS INCLUDED IN RESEARCH

- Varied

## TARGET POPULATIONS/DIAGNOSES OR DISORDERS ADDRESSED

Varied: Depression, Anxiety disorders (primarily Generalized Anxiety Disorder), Schizophrenia, Bipolar disorder

## NEED FOR INTERVENTION:

Approximately one-fifth of older adults have a significant mental health problem, including 16% with a primary psychiatric disorder and 3% with dementia complicated by psychiatric symptoms<sup>31</sup>. Many of these psychiatric disorders can be treated with pharmacological interventions.

## ISSUES RELATED TO IMPLEMENTATION

Due to the potential for medication side-effects, a history of adverse medication responses and associated doses and concentrations should be obtained and tolerability of specific agents should guide the selection and dosing of pharmacotherapy. Moreover, additional studies evaluating the effectiveness of

pharmacological interventions are needed to improve our understanding of their impact on older adults with anxiety disorders, schizophrenia, and bipolar disorder.

### SERVICE PROVIDER

Health care professionals who are licensed to prescribe medications (e.g., psychiatrists, primary care providers).

### MANUAL AVAILABILITY

Protocols can inform the delivery of some pharmacological interventions. For instance, the IMPACT program manual includes a section describing protocol-driven treatment with antidepressant agents<sup>32</sup>. However, the availability of protocols developed for older adults is limited. Guidelines, based on expert consensus, also provide direction in the delivery of antipsychotics for older adults and pharmacological interventions for depression<sup>29,30</sup>. However, expert consensus guidelines represent a low level of evidence in the evidence-based medicine hierarchy, compared to randomized controlled trials.

### FOR A COMPREHENSIVE REVIEW SEE:

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