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Implementing Evidence-Based Psychotherapies in Settings Serving Older Adults: Challenges and Solutions

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Abstract

This commentary addresses challenges in the implementation of psychotherapy interventions in settings serving older adults and provides solutions for ensuring older Americans have access to effective mental health services. There is considerable movement toward developing the geriatric mental health workforce, and it is important that these efforts include a discussion of implementation issues with regard to evidence-based psychotherapies as they are provided in aging services.

Psychotherapies for late life mental health problems are considered first-line treatments, but implementation of psychotherapy remains a significant challenge on multiple levels (Leslie, 2007). Cognitive-behavioral therapy, interpersonal therapy and problem solving therapy are considered evidence-based (EBP) for late life depression (Mackin & Arean, 2005), and cognitive-behavioral therapy is an EBP for generalized anxiety (Wetherell, Gatz, & Craske, 2003). Older adults often prefer psychotherapy to medication, (Raue, Schulberg, Heo, Klimstra, & Bruce, 2009) yet like other care delivery innovations, psychotherapies have been poorly translate into practice (Pincus, 2010). In addition, many older adults do not seek care in mental health settings because of the stigma associated with mental health care. As a consequence, for improved access EBPs, they must be integrated into aging services, specifically residential care, home health care and day treatment (Choi, 2009). The implementation and maintenance of psychotherapies in these settings is complicated by a number of policy and system-level issues (Mancini et al., 2009), such as the under valuing of psychotherapy/psychiatric services by Medicare, clinician training, and lack of technical assistance to sustain treatment fidelity.

Undervaluing Psychotherapy Services

A significant limiting factor in the implementation of EBPs is the undervaluing of psychiatric services, and lack of recognition in reimbursement for certification in geriatric subspecialties by insurers such as Medicare (Moran, 2010). As a result few clinical trainees elect to work with older adults, leading to a deficit in the U.S. workforce serving the needs of older people. Additionally, the value placed by Medicare on psychotherapy services is minimal. By design most EBPs require weekly visits that are 30-45 minutes long. Many aging service providers work in the patient's home. However, the weekly travel involved is not reimbursed by many insurers, making the delivery of psychotherapy inefficient and ultimately unavailable. Although research has pointed to high acceptability and comparable effectiveness of telephone-based psychotherapy (which makes treatment delivery more efficient), (Mohr, Carmody, Erickson, Jin, & Leader, 2011) Medicare does not reimburse for telephone contact.

Staff and Setting Limitations

Two of the major limitations in the implementation of psychotherapies within aging services are the skill sets required to implement them effectively, and the organizational culture of

many aging services. In some senior service agencies, bachelor's level clinicians provide an array of mental health services under the supervision of a licensed professional who can bill Medicare if directly providing the service. Although using non Master's-level providers results in a low-cost solution to the dearth of professionals who can work with older adults, it creates other problems implementing evidence-based psychotherapy. With few exceptions, psychotherapies are developed for providers with basic psychotherapy skills (e.g., how to establish therapeutic rapport), for those who have control over their case-mix and have the resources needed to provide the treatment. Many aging service providers work in settings with limited resources and large, complex caseloads. When aging service agencies attempt to implement an evidence-based psychotherapy, they may find the treatment ineffective partly because their staff lacks resources and skills needed to conduct psychotherapy appropriately. The implementation of EB psychotherapy would require considerable organizational restructuring for many aging service agencies that do not have supervision beyond administrative review.

Certification and Sustainability

Most aging service settings do not provide incentives for certification in an evidence-based psychotherapy. Certification typically involves participation in a training workshop, followed by observational review of cases. Although certification can be inexpensive in direct costs, the certification process in community settings can be complicated by the inability of clinicians to identify cases willing to be audiotaped, lack of extra time for supervision, and staff turnover requiring retraining and re-certifications, all to be done without a reimbursement incentive from Medicare.

An additional complication is clinicians' treatment fidelity will often drift over time (Fiander, Burns, McHugo, & Drake, 2003). Suboptimal long-term fidelity is due to lack of ongoing support from EBP experts, and lack of accountability from insurers and from organizational leadership for following treatment guidelines. While training programs are available, these programs rarely have opportunities for ongoing consultation and may impose another cost barrier.

Solutions to Overcome Implementation Barriers

Although the implementation of psychotherapy is challenging, there are a number of policy and practice innovations that can facilitate access to high quality psychotherapy for older adults. The Patient Protection and Affordable Care Act (ACA) heralds changes in both national policy and funding for psychotherapy, and opportunities to grow the workforce through incentives, education and training grants. These policies could be strengthened by clearly defined skills needed to implement psychotherapy. One promising development is the American Psychological Association's recently appointed task force to develop clinician guidelines for treatment of mental illnesses, particularly psychotherapy for all demographic and age groups. These guidelines can instruct states and organizations on the level of provider training needed to implement psychotherapy and training resources. The Institute On Medicine (IOM) Geriatric Workforce Development in Mental Health workgroup is another policy forum that could be help in defining the credentials needed for clinicians to successfully delivery EBPs.

Training programs for middle-level managers in aging services on the effective implementation of EBPs are showing promising results. Successful managers who implement new practices learn the model, solicit feedback from their staff, hold staff accountable for being trained in the intervention, and are clear about why the intervention was selected. (Choi, 2009) In our experience implementing problem solving treatment, counties that have held providers accountable for becoming certified within three months of

program roll out are more likely to have a fully trained team than counties without timely certification mandates. Organizations that have incentivized staff to become certified have overcome initial provider reluctance to learn a new psychotherapy. Further, organizations that factor in costs of on-going consultation and technical assistance sustain the new practice better than those who stop investment after certification (Aarons, Sommerfeld, Hecht, Silovsky, & Chaffin, 2009).

Access to certification and technical assistance has benefitted considerably from technologies by providing accessible training, supervision and fidelity evaluations through the internet. We have dealt with difficulties in certification and long-term fidelity by using a fidelity monitoring tool for structured case supervision and for rural and international collaborations, we have used Skype technologies to observe in vivo treatment interactions. Other promising technologies for ensuring fidelity to treatment include the use of computerized support tools for clinicians (Craske, et al., 2009).

The implementation and sustainability of psychotherapies into systems of care that serve older adults is challenging but not impossible. Policy makers and organizational leaders need not decide to limit investment in successful interventions that are also preferred by older adults simply because of these challenges. Changes in policy, better recognition of what is an evidence-based psychotherapy, and better access to appropriate training and support are on the horizon, making psychotherapy a viable intervention choice for all older adults.

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