Published in final edited form as:

J Evid Inf Soc Work. 2016 ; 13(4): 362–372. doi:10.1080/23761407.2015.1086712.

A Multi-Stakeholder Process to Transform a Community-based Screening and Referral Program to Implement Evidence-Based Depression Care

Renee Pepin^a, Jessica Hoyt^b, Bernadette Seifert^{a,c}, and Stephen J. Bartels^a

^aGeisel School of Medicine at Dartmouth and the Dartmouth Centers for Health and Aging Lebanon, NH, USA

^bNational Center for PTSD, Department of Veterans Affairs, White River Junction, VT, USA

^cNational Alliance on Mental Illness New Hampshire, Concord NH, USA

Abstract

Background—Screening and referral for geriatric depression by service agencies is associated with poor treatment engagement indicating the need to transform services to directly provide depression care.

Objective—To describe a multi-organization workgroup implementation planning process used to transform a community-based screening and referral program to provide a brief evidence-based intervention for older adults with depressive symptoms.

Methods—An iterative implementation procedure use by a multi-stakeholder group that selected an evidence-based practice, planned implementation rollout, planned counselor training, and designed an implementation evaluation.

Results—The workgroup successfully followed the implementation procedure and developed a plan for the implementation of an evidence-based intervention. Overall, the workgroup prioritized decisions that favored feasibility and low implementation burden.

Conclusion—A multi-organization workgroup can benefit from a semi-structured implementation planning procedure because it provides all stakeholders with a shared roadmap for implementation planning.

Keywords

evidence-based practice; implementation; community-based mental health services

Mental health screening and referral programs for older adults in the community are often promoted as the solution to improving access to geriatric mental health services, without evidence that this approach is desired or effective. Even under optimal circumstances, less than one-third of older adults screened and referred to specialty mental health services for depression, anxiety, or substance use disorders engage in treatment (Bartels et al., 2004).

Overall, only 10% of older adults with mental health conditions receive appropriate services (Eden, Maslow, Le, & Blazer, 2012). In contrast, the effectiveness of community-based mental health interventions for depression in older adults is supported by numerous randomized trials (Bartels et al., 2003; Bruce, Van Citters, & Bartels, 2005; Van Citters & Bartels, 2004). For example, PEARLS (the Program to Encourage Active, Rewarding Lives for Seniors) has been shown to reduce depressive symptoms and has been successfully implemented in community-based settings (Ciechanowski et al., 2004; Steinman, Cristofalo, & Snowden, 2012). Yet depression treatments for older adults are rarely implemented in community-based settings (Eden et al., 2012). The goal of this report is to describe the process of an implementation initiative to transform a community-based screening and referral program for older adults to deliver a brief evidence-based intervention for depression.

Community-based implementation of evidence-based practices (EBPs) is complex due to the variety of stakeholders involved, such as clinicians, program staff, agency leadership, and policy makers, each with different interests and priorities (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009). Community-based services are also challenged by broad target populations, fragmented service systems, complex financing, and limited resources. The multilayered systems of community-based services further compound these challenges as stakeholders representing different organizations may have different approaches, interests, priorities, missions, and mandates.

One method for facilitating implementation of EBPs is to assemble a workgroup, comprised of key stakeholders, to plan and oversee implementation. Engaging workgroups that involve multiple stakeholders has been promoted as an implementation strategy (Powell et al., 2012) and a critical implementation step (Meyers, Durlak, & Wandersman, 2012). Implementation efforts within mental health service settings often benefit from multiple stakeholder perspectives (Aarons et al., 2009; Bellamy, Bledsoe, & Traube, 2006; Green & Aarons, 2011; Green, Fettes, & Aarons, 2012). The importance of securing buy-in from stakeholders has also been a supported critical component of implementation (Meyers et al., 2012; Powell et al., 2012). Stakeholders from different organizations are socialized to different cultures, values, and goals (Aarons & Sawitzky, 2006), and may have different or conflicting expertise, expectations, or priorities (Aarons, Fettes, et al., 2014). However, the complexities associated with gathering diverse stakeholders for collaboration and implementation are often overlooked (Aarons, Fettes, et al., 2014; Green & Aarons, 2011). Community organizations are faced with the difficult task of enlisting stakeholder collaborations to facilitate adoption and implementation but lack sufficient guidance to successfully engage diverse individuals in the process.

We considered three questions with the goal of identifying a systematic, yet flexible, approach to engage stakeholders in planning an implementation aimed at transforming an existing program:

- Is a multi-stakeholder approach a feasible and effective strategy for transforming the purpose and function of an existing community-based program?

- What is a feasible approach to obtain input from multiple stakeholders throughout planning implementation?
- What are the barriers to and facilitators of successful implementation?

Procedure

Description of the Original Screening and Referral Program: Referral, Education, Assistance, and Prevention (REAP)

Referral, Education, Assistance, and Prevention (REAP) is a statewide mental health outreach program for older adults in New Hampshire (Pepin, Hoyt, Karatzas, & Bartels, 2014) designed to identify older adults in the community at risk for mental health and substance misuse conditions and provide referrals to specialty services. REAP began in 1992 and provides mental health outreach to older adults free of charge through blended funding from four state agencies: the Housing Finance Authority, the Bureau of Drug and Alcohol Services, the Bureau of Elderly and Adult Services, and the Bureau of Behavioral Health. REAP employs approximately 40 part-time counselors across the state who are subcontracted through New Hampshire community mental health centers. Services are primarily delivered within the homes of participants. From 2010 through 2012, REAP screened over 750 older adults for depressive symptoms and over 825 older adults for alcohol misuse (Pepin et al., 2014). Screened individuals had high proportions of distress including 64% with depressive symptoms, 13% with at-risk alcohol use, and 10% with both.

While case identification and referral practices may improve screening rates (Barrett, Secic, & Borowske, 2010; Emlet & Hall, 1991; Florio et al., 1996), older adults are unlikely to pursue referrals to specialty mental health services even under optimal circumstances (Bartels et al., 2004). For this reason, REAP was tasked by leadership from the State of New Hampshire Department of Health and Human Services with transforming the case identification and referral model to incorporate a brief evidence-based mental health intervention. In October 2012, leaders from New Hampshire's mental health, substance abuse, and aging agencies met in a regional policy academy supported by the Substance Abuse and Mental Health Services Administration to develop a plan to address behavioral health and aging within the state. Attendees identified an opportunity for REAP to move beyond providing outreach and referral to include the delivery of brief intervention. This transformation required that REAP adopt and implement a practice outside of its scope and capacity and required a shift in mission from identifying older adults at risk for mental health conditions to identifying older adults at risk for mental health conditions **and** delivering a brief evidence-based intervention. The implementation project was identified as "Enhanced REAP".

Participants: Multi-Organization Workgroup

Consistent with Powell and colleague's description (2011), a multi-organization workgroup was assembled to allow key stakeholders to collectively oversee implementation efforts. This statewide transformation impacted REAP program leadership, 40 counselors, 4 state agencies, 10 community mental health centers, an academic/community partnership, and hundreds of older adults and their families annually. Participation was sought from REAP

program staff, representatives from four bureaus of the State's Department of Health and Human Services, NH Housing Finance Authority (i.e., funders/state government), and academic researchers/educators. Additionally, participants of the New Hampshire Coalition on Substance Abuse, Mental Health and Aging were invited to participate. As shown in Table 1, the workgroup was comprised of 10 participants spanning disciplines, organizations, and roles. Members shared commitment to this initiative and experience working with older adults. However, members held diverse expertise, skill sets, and preferences. Additionally, the organizations represented by stakeholders had varied scopes, capacity, funding, and missions.

The workgroup met face-to-face for 90-minute, monthly meetings over the course of eight months. It was established in the first meeting that the implementation planning was to be a time-limited but intense process, and all members committed for the duration of the planning period. Members dedicated time outside of meetings to complete action items and members participated in additional sub-committee meetings as needed.

Process: Implementation Planning

The workgroup followed an implementation procedure that provided all stakeholders with a shared roadmap for implementation planning. The procedure was established based on 1) relevant implementation planning strategies and 2) key tasks of implementation preparation. Using an iterative process, members worked together on three key strategies of implementation planning: **gathering information**; **identifying strengths and barriers**; and **developing implementation approaches** (Aarons, Hurlburt, & Horwitz, 2011; Meyers et al., 2012; Powell et al., 2012). These strategies were followed consecutively to accomplish four relevant tasks of implementation planning including (1) selecting an EBP; (2) planning the implementation rollout; (3) planning counselor training; and (4) designing the implementation evaluation (see Figure 1). These are described in more detail in the following section.

Results

Table 2 summarizes the process used by the multi-organization workgroup to complete the tasks required to plan this community-based implementation of an EBP.

Task 1: Selection of the Evidence-Based Practice

Gather information—The workgroup reviewed information on EBPs for depression because it is the most prevalent mental health condition among the target population. A consensus was reached that practices must be brief, suited for community-based delivery including in-home delivery, and effective in the treatment of late-life depression. The workgroup selected two brief depression interventions that had empirical support for use with older adults: Problem Solving Therapy and Behavioral Activation. Two approaches to adoption of these interventions were considered: 1) developing a program based in Problem Solving Therapy or Behavioral Activation, or 2) adopting an existing program PEARLS (a model of Problem Solving Therapy) or Healthy IDEAS (a model of Behavioral Activation).

Academic members reviewed and synthesized the literature of each approach and presented findings to the workgroup.

Identify strengths and barriers—The workgroup evaluated EBPs on compatibility with REAP's strengths and limitations. A grid was created to facilitate EBP deliberation. On one axis were the EBPs under consideration and on the other axis were REAP logistical constraints such as cost, time, and clinician qualifications. A strength of the REAP workforce was previous training and service delivery in motivational interviewing, and some REAP counselors had training in a motivational interviewing intervention for at-risk drinking. Barriers to effective implementation included time required to deliver the intervention (i.e., number of sessions); required qualifications of providers; frequency and intensity of training and supervision; and estimated cost of providing the service. For example, limited access to a psychologist and physician for regular supervision at REAP sites prompted the workgroup to rule out PEARLS. Similarly, lack of time available for training and additional case supervision prompted the workgroup to rule out Problem Solving Therapy.

Develop implementation approach—The workgroup selected an EBP viewed as feasible for REAP to implement. Given that all examined interventions had empirical support, the workgroup considered the rigor of the evidence base to be secondary to practical concerns such as ease of implementation and program delivery. Behavioral Activation, a brief behavioral intervention that increases engagement in reinforcing activities (Lejuez, Hopko, & Hopko, 2001), was considered to be the most feasible approach as it met the practical constraints of REAP and the qualifications of the providers. Additionally, the workgroup determined that REAP counselors could broaden their capacity by providing the Brief Alcohol Intervention (Barry & Blow; Barry, Blow, Cullinane, Gordon, & Welsh, 2006) for at-risk drinking. The Brief Alcohol Intervention uses a manual-guided motivational interviewing approach and was selected because motivational interviewing was familiar to counselors and a feasible component that could be added with brief, targeted training.

Task 2: Planning Implementation Rollout

Gather information—The workgroup focused on the complexities of implementing a new program statewide that is outside the existing scope of services. To aid the sequencing of rollout across sites, REAP members provided information on each REAP site's existing level of program buy-in, the ratio of counselors to number of people served, and whether a site was rural or not. State government members provided information on spending and reimbursement. Several implementation approaches were considered including a stepped wedge, rapid cycling, and a two-phase implementation in which half the sites would implement Enhanced REAP in the first phase, followed by the second half in the subsequent phase.

Identify strengths and barriers—The workgroup evaluated methods to rollout Enhanced REAP that enabled the program to be widely available as soon as possible, but also provided ample time for counselor training as well as an opportunity for implementation evaluation. Stakeholders held different preferences in implementation

approaches. For example, state government members recommended rapid adoption to facilitate quick, statewide access to the services. On the other hand, academic members advocated for an established implementation design with a comparison condition to evaluate outcomes. REAP members advocated for an approach that allowed two phases of implementation in order to refine training and implementation procedures before they were disseminated statewide. Strengths included immediate access to funding for Enhanced REAP services and robust estimates of participants that would be eligible for Enhanced REAP based on previous screening. However, the heterogeneity of sites presented significant challenges. A grid similar to that used to select an EBP was created to display for each site: level of buy-in to the existing REAP program (high, low); ratio of counselors to participants (high, low); and geography (rural, not rural).

Develop implementation approach—The workgroup selected a rollout plan that provided a staggered implementation to efficiently provide Enhanced REAP statewide and foster formative evaluation. The workgroup selected a two-phase implementation rollout following a three month preparation period to develop training and update the web-based documentation system designed and used by REAP. In Phase 1 (months 1-6) the first five REAP sites participated in training and implementation of Enhanced REAP, followed by Phase 2 (months 7-12) for the remaining five sites.

Task 3: Planning Counselor Training

Gather information—The workgroup focused on gathering information that accommodated the wide range of backgrounds in the REAP workforce. REAP members provided information on counselors' training backgrounds, degrees, and licensure, as well as the content of previous REAP trainings. Academic members gathered information on Behavioral Activation and Brief Alcohol Intervention curriculum and explored resources for training. Workgroup members designed and administered a brief survey that assessed counselors' experience with motivational interviewing.

Identify strengths and barriers—The workgroup aimed to develop counselor training with an emphasis on leveraging existing resources. Strengths of the REAP counselors included experience working with older adults and a background in motivational interviewing. The workgroup also benefited from access to experienced trainers provided at no cost through our regional Geriatric Education Center.

While one of REAP's identified strengths was the successful leveraging of existing statewide workforce by subcontracting counselors from community mental health centers, this was also associated with challenges related to counselor training. In addition to being located throughout the state, REAP counselors have a wide range of training, backgrounds, and clinical experience. Furthermore, most counselors only dedicate a minority of their time to REAP, having other clinical responsibilities as their primary obligation. These factors created significant challenges in developing training appropriate for this heterogeneous group and in assembling all REAP counselors for training and supervision.

Develop implementation approach—The workgroup selected an approach to counselor training that provided group training to address each major component of Enhanced REAP and that leveraged existing resources. The face-to-face training was designed to have the following modules: 1) an introduction to Enhanced REAP, 2) screening instruments, 3) Behavioral Activation, 4) Brief Alcohol Intervention, and 5) the intersection of Behavioral Activation and Motivational Interviewing. The training outline was approved by the workgroup, training content was developed in collaboration with REAP members, the training process and continuing education credits were organized by our regional Geriatric Education Center, and the training was delivered by REAP and Dartmouth Centers for Health and Aging staff.

Task 4: Design Implementation Evaluation

Gather information—The workgroup considered evaluation measures that collected participant level information (i.e., depressive symptoms and at-risk drinking). REAP members provided the screening tools used by the REAP counselors as well as a description of screening procedures and previous trainings in screening. Academic members gathered information on previous REAP counselor screening adherence rates and alternative instruments to screen for symptoms of depression and at-risk drinking.

Identify strengths and barriers—The workgroup appraised evaluation procedures based on feasibility and opportunities to be embedded within existing data collection procedures in order to minimize staff and participant burden. Members differed in perspectives on the priority of evaluation and acceptable amount of time to document outcomes. For example, REAP members advocated for the fewest possible measures and limited documentation required by the counselors. In contrast, academic members advocated for standardized measures for baseline and follow-up data collection. Existing resources to facilitate the evaluation included a website for tracking program activities and a protocol to screen for depressive symptoms and at-risk drinking. However, barriers included a history of low screening adherence, no precedent for follow-up assessments, and a reporting website that was not designed to accommodate multiple time-point assessments.

Develop implementation approach—The workgroup selected evaluation procedures viewed as feasible to implement and that leveraged existing data collection procedures. Similar to selection of an EBP, members prioritized feasibility over rigor in selection of evaluation tools and outcome measurement. REAP adopted several changes in assessment procedures to develop an approach that could capitalize on REAP's strengths while remaining compatible with barriers. These changes not only resulted in a briefer screening battery, but the use of instruments that were more consistent with program goals. The workgroup also identified the need to upgrade the reporting website in order to support adherence to routine screening and simplify documentation.

Discussion

We found that a multi-organizational workgroup guided by a shared roadmap was successful in planning an implementation to transform an existing screening and referral program for

older adults to a program designed to deliver an intervention. Throughout this process, several lessons emerged. First, including key stakeholders resulted in a process that integrated existing REAP strengths and minimized potential implementation barriers. Second, the workgroup process resulted in significant buy-in by the key stakeholders as an essential ingredient in subsequent implementation and adoption. Third, the presence and support of leaders from state agencies support empowered and motivated the workgroup. Fourth, stakeholders tasked with transforming existing programs needed to expand beyond their typical roles. Finally, the workgroup prioritized decisions that favored feasibility and low implementation burden. Throughout the process stakeholders found that practical Implementation involved collaboration and compromise.

Use of a multi-organization workgroup facilitated ongoing reflection on REAP's strengths and weakness. By including stakeholders that represented various sectors of service REAP staff, state government/funding representatives, and academic researchers/educators, the workgroup benefited from varied perspectives on the values and strengths of the program. For example, although all group members recognized that REAP is the only program that targets at-risk drinking among older adults, the member representing the NH Bureau of Drug & Alcohol Services consistently advocated for an implementation plan that leveraged this unique strength. Additionally, because stakeholders represented multiple levels of the implementation delivery system, group members identified potential barriers to EBP adoption, funding, evaluation, and training, and problem solved these before implementation went live. Further, the workgroup composition allowed efficient review of information. By having members gather, summarize, and present information pertinent to their expertise, the group benefited from access to information across many domains (e.g., funding stipulations, the research evidence base, organizational structure, etc.). This approach also addressed a prominent barrier to implementation in community mental health of inadequate access to EBP research (Alegria et al., 2011; Bellamy et al., 2006; Biegel, Kola, Meeks, Stevenson, & Beimers, 2010; Jones & Sherr, 2014).

Regular contact strengthened relationships between stakeholders across organizations, bolstered buy-in, and allowed for a rich and robust exchange of viewpoints. This is consistent with findings highlighting the importance of facilitating buy-in of various stakeholders for implementation (Aarons et al., 2009; Bellamy et al., 2006; Brooks, Pilgrim, & Rogers, 2011; Green & Aarons, 2011; Green et al., 2012; Powell et al., 2012; Proctor et al., 2007). Stakeholders often held differing, at times opposing, preferences and most decisions required negotiating these diverse perspectives. Despite differences, group members developed and shared ownership of the implementation plan.

While the overarching goal of implementing an EBP within REAP was determined prior to the workgroup and sanctioned by New Hampshire Department of Health and Human Services administration, the specifics of which EBP and how it would be implemented were not prescribed by leadership. Developing a plan to expand REAP was an action step developed by New Hampshire human services leadership at a 2012 regional policy academy supported by the Substance Abuse and Mental Health Services Administration. This policy academy emphasized participation from multiple state agencies, thus setting the stage for multi-organizational participation in implementation planning. The generation of strategic

initiatives at upper-level leadership is common and the importance of leadership in EBP implementation is well documented (Aarons, 2006; Aarons, Ehrhart, & Farahnak, 2014; Aarons & Sommerfeld, 2012). Provided there is key leadership buy-in, implementation efforts may be best guided by individuals who are involved in service delivery (Aarons, Ehrhart, Farahnak, & Sklar, 2014).

The group was tasked to plan the implementation of a significant transformation within a system of care while the general system of care and its administrators remained the same. Many workgroup members had worked together and some held their positions for several years. Although this unique history allowed for a workgroup with strong cohesion, the group was also at risk of maintaining status quo. Therefore, the implementation planning procedure was distinguished as separate from other activities, and early on, to enable members to assume the expanded roles the process required. Several factors enabled workgroup members to expand beyond their typical roles including the semi-structured implementation planning procedure, empowerment by state leadership, early involvement of the workgroup, and conducting this process outside of existing meetings. These features are similar to those highlighted by Bryson and colleagues (Bryson, Akin, Blase, McDonald, & Walker, 2014) among eight factors critical in the engagement of a partnership to select an EBP. In general, assembling stakeholders from various organizations facilitated dynamic discussion and allowed people to step outside of their typical roles and consider alternative possibilities.

A primary theme throughout the process was the importance of ease of implementation and feasibility. Low burden of implementation superseded other factors, including rigor across each of the tasks of implementation planning. The group selected the EBP based on ease of training and delivery, rather than greatest clinical gains in research studies. Similarly, developing a plan for standardized outcome measurement was challenging, and required a balance of amount of information obtained and frequency of assessment. After considerable negotiation, the group opted for brief and clinically relevant instruments that could be administered at each session.

Despite the success of this approach, there are several limitations that warrant consideration. First, the multi-organization workgroup lacked consumers and community members. Although the workgroup benefited from professional patient and family advocates (i.e., National Alliance on Mental Illness New Hampshire), consumer and family involvement might have enhanced the process by directly incorporating the perspectives, values, and preferences of those receiving services. Second, REAP counselor involvement was limited to the two program administrators who routinely provided REAP counseling but may not represent the perspectives of the front line REAP counselors. This also limited the opportunity to generate buy-in from the front line workforce. Third, the inclusion of formal qualitative methods might have enhanced the quality and depth of the description of the workgroup process. Finally, our experience assembling a multi-organization workgroup may not generalize to other settings. New Hampshire is a small, rural state with a relatively stable group of ethnically homogenous clients across organizations.

We found the multi-organization workgroup seemed to be successful when transforming an existing program from a referral service model to a delivery service model. Although our experience relates to depression care in older adults, this report potentially has implications for other services and populations who may benefit from the process described here when transforming the roles, purpose and function in any community-based program. As workforce issues continue to challenge existing models of care, new approaches are being developed and implemented that require existing service delivery systems to transform. Substantially involving stakeholders can facilitate this transition, provided they have a procedure to follow which facilitates a unified approach.

Acknowledgments

This research was supported in part by an NIMH training grant (T32 073553). The authors thank Jennifer Kinsey, Lydia E. Gill, and Dave Richardson for their help preparing this manuscript.

References

- Aarons GA. Transformational and transactional leadership: association with attitudes toward evidence-based practice. *Psychiatric Services*. 2006; 57(8):1162–1169. doi: 10.1176/appi.ps.57.8.1162. [PubMed: 16870968]
- Aarons GA, Ehrhart MG, Farahnak LR. The Implementation Leadership Scale (ILS): development of a brief measure of unit level implementation leadership. *Implementation Science*. 2014; 9(1):45. doi: 10.1186/1748-5908-9-45. [PubMed: 24731295]
- Aarons GA, Ehrhart MG, Farahnak LR, Sklar M. Aligning leadership across systems and organizations to develop a strategic climate for evidence-based practice implementation. *Annual Review of Public Health*. 2014; 35:255–274. doi: 10.1146/annurev-publhealth-032013-182447.
- Aarons GA, Fettes DL, Hurlburt MS, Palinkas LA, Gunderson L, Willging CE, Chaffin MJ. Collaboration, negotiation, and coalescence for interagency-collaborative teams to scale-up evidence-based practice. *Journal of Clinical Child & Adolescent Psychology*. 2014; 43(6):915–928. doi: 10.1080/15374416.2013.876642. [PubMed: 24611580]
- Aarons GA, Hurlburt M, Horwitz SM. Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and Policy in Mental Health and Mental Health Services Research*. 2011; 38(1):4–23. doi: 10.1007/s10488-010-0327-7. [PubMed: 21197565]
- Aarons GA, Sawitzky AC. Organizational Culture and Climate and Mental Health Provider Attitudes Toward Evidence-Based Practice. *Psychological Services*. 2006; 3(1):61–72. doi: 10.1037/1541-1559.3.1.61. [PubMed: 17183411]
- Aarons GA, Sommerfeld DH. Leadership, innovation climate, and attitudes toward evidence-based practice during a statewide implementation. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2012; 51(4):423–431. doi: 10.1016/j.jaac.2012.01.018. [PubMed: 22449648]
- Aarons GA, Wells RS, Zagursky K, Fettes DL, Palinkas LA. Implementing evidence-based practice in community mental health agencies: a multiple stakeholder analysis. *American Journal of Public Health*. 2009; 99(11):2087–2095. doi: 10.2105/ajph.2009.161711. [PubMed: 19762654]
- Alegria M, Wong Y, Mulvaney-Day N, Nillni A, Proctor E, Nickel M, Wells KB. Community-based partnered research: new directions in mental health services research. *Ethnicity & Disease*. 2011; 21(3 Suppl 1):S1–8-16. [PubMed: 22352075]
- Barrett DL, Secic M, Borowske D. The Gatekeeper Program: proactive identification and case management of at-risk older adults prevents nursing home placement, saving healthcare dollars program evaluation. *Home Healthcare Nurse*. 2010; 28(3):191–197. doi: 10.1097/01.NHH.0000369772.41656.4e. [PubMed: 20308813]
- Barry KL, Blow FC. Prevention and Management of Alcohol Problems in Older Adults: Screening and Brief Intervention Implementation Manual.

- Barry, KL.; Blow, FC.; Cullinane, P.; Gordon, C.; Welsh, D. The effectiveness of implementing a brief alcohol intervention with older adults in community settings. National Council on Aging; Washington, DC: 2006.
- Bartels SJ, Coakley EH, Zubritsky C, Ware JH, Miles KM, Arian PA, Levkoff SE. Improving access to geriatric mental health services: a randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *The American Journal of Psychiatry*. 2004; 161(8):1455–1462. doi: 10.1176/appi.ajp.161.8.1455. [PubMed: 15285973]
- Bartels SJ, Dums AR, Oxman TE, Schneider LS, Arian PA, Alexopoulos GS, Jeste DV. Evidence-based practices in geriatric mental health care: an overview of systematic reviews and meta-analyses. *Psychiatric Clinics of North America*. 2003; 26(4):971–990. [PubMed: 14711131]
- Bellamy JL, Bledsoe SE, Traube DE. The Current State of Evidence-Based Practice in Social Work: A Review of the Literature and Qualitative Analysis of Expert Interviews. *Journal of Evidence-Based Social Work*. 2006; 3(1):23–48. doi: 10.1300/J394v03n01_02. [PubMed: 20871786]
- Biegel DE, Kola LA, Meeks D, Stevenson L, Beimers D. A university-agency mental health research collaboration: a case example. *Care Manag J*. 2010; 11(2):83–90. [PubMed: 20560517]
- Brooks H, Pilgrim D, Rogers A. Innovation in mental health services: what are the key components of success? *Implementation Science*. 2011; 6:120. doi: 10.1186/1748-5908-6-120. [PubMed: 22029930]
- Bruce ML, Van Citters AD, Bartels SJ. Evidence-based mental health services for home and community. *Psychiatric Clinics of North America*. 2005; 28(4):1039–1060. x–xi. doi: 10.1016/j.psc.2005.08.002. [PubMed: 16325739]
- Bryson SA, Akin BA, Blase KA, McDonald T, Walker S. Selecting an EBP to reduce long-term foster care: lessons from a university-child welfare agency partnership. *Journal of Evidence-Based Social Work*. 2014; 11(1-2):208–221. doi: 10.1080/15433714.2013.850325. [PubMed: 24405144]
- Ciechanowski P, Wagner E, Schmalting K, Schwartz S, Williams B, Diehr P, LoGerfo J. Community-integrated home-based depression treatment in older adults: a randomized controlled trial. *The Journal of the American Medical Association*. 2004; 291(13):1569–1577. doi: 10.1001/jama.291.13.1569. [PubMed: 15069044]
- Eden, J.; Maslow, K.; Le, M.; Blazer, D. The mental health and substance use workforce for older adults: in whose hands?. National Academies Press; 2012.
- Emler CA, Hall AM. Integrating the community into geriatric case management: public health interventions. *The Gerontologist*. 1991; 31(4):556–560. [PubMed: 1894162]
- Florio ER, Rockwood TH, Hendryx MS, Jensen JE, Raschko R, Dyck DG. A model gatekeeper program to find the at-risk elderly. *Journal of Case Management*. 1996; 5(3):106–114. [PubMed: 9257625]
- Green AE, Aarons GA. A comparison of policy and direct practice stakeholder perceptions of factors affecting evidence-based practice implementation using concept mapping. *Implementation Science*. 2011; 6:104. doi: 10.1186/1748-5908-6-104. [PubMed: 21899754]
- Green AE, Fettes DL, Aarons GA. A concept mapping approach to guide and understand dissemination and implementation. *J Behav Health Serv Res*. 2012; 39(4):362–373. doi: 10.1007/s11414-012-9291-1. [PubMed: 22892987]
- Jones JM, Sherr ME. The role of relationships in connecting social work research and evidence-based practice. *Journal of Evidence-Based Social Work*. 2014; 11(1-2):139–147. doi: 10.1080/15433714.2013.845028. [PubMed: 24405138]
- Lejuez CW, Hopko DR, Hopko SD. A brief behavioral activation treatment for depression. *Treatment manual. Behavior Modification*. 2001; 25(2):255–286. [PubMed: 11317637]
- Meyers DC, Durlak JA, Wandersman A. The quality implementation framework: a synthesis of critical steps in the implementation process. *American Journal of Community Psychology*. 2012; 50(3-4): 462–480. doi: 10.1007/s10464-012-9522-x. [PubMed: 22644083]
- Pepin R, Hoyt J, Karatzas L, Bartels SJ. New Hampshire REAPs Results: Tailored Outreach Program Assists Older Adults at Risk for Mental Health Conditions and Substance Misuse. *Generations*. 2014; 38(3):68–74. [PubMed: 25635156]

- Powell BJ, McMillen JC, Proctor EK, Carpenter CR, Griffey RT, Bunger AC, York JL. A compilation of strategies for implementing clinical innovations in health and mental health. *Medical Care Research and Review*. 2012; 69(2):123–157. doi: 10.1177/1077558711430690. [PubMed: 22203646]
- Proctor EK, Knudsen KJ, Fedoravicius N, Hovmand P, Rosen A, Perron B. Implementation of evidence-based practice in community behavioral health: agency director perspectives. *Administration and Policy in Mental Health and Mental Health Services Research*. 2007; 34(5): 479–488. doi: 10.1007/s10488-007-0129-8. [PubMed: 17636378]
- Steinman L, Cristofalo M, Snowden M. Implementation of an evidence-based depression care management program (PEARLS): perspectives from staff and former clients. *Prev Chronic Dis*. 2012; 9:E91. [PubMed: 22537909]
- Van Citters AD, Bartels SJ. A systematic review of the effectiveness of community-based mental health outreach services for older adults. *Psychiatric Services*. 2004; 55(11):1237–1249. doi: 10.1176/appi.ps.55.11.1237. [PubMed: 15534012]

Figure 1.
Illustration of iterative implementation planning procedure. Arrows denote implementation strategies consecutively followed to accomplish relevant tasks of implementation planning.

Table 1**Multidisciplinary Workgroup Members**

Affiliation	Discipline (Degree)	Sector	Focus	Role
REAP Director	Social Work (LICSW, CPS)	Community Mental Health	Day-to-day operations	REAP budget, policies & procedures, counselor advocate
REAP Coordinator & REAP Counselor	Social Work (LICSW)	Community Mental Health	Day-to-day operations	REAP budget, policies & procedures, counselor advocate
Administrator Bureau of Drug & Alcohol Services	Alcohol and Drug Counseling (MS, MLADC)	State Government	Drug & alcohol use	Drug & alcohol intervention expert and advocate administrator
Administrator Bureau of Behavioral Health Services	Mental Health (MA)	State Government	Finances, statewide impact	State budget, funding representative, community mental health administrator
Program Specialist, Bureau of Elderly & Adult Services	Program Administration (MA)	State Government	Impact for participants, sustainability	Participant & program sustainability advocate
Administrator, Bureau of Developmental Services,	Social Work (MSW)	State Government	Impact for participants, sustainability	Participant & program sustainability advocate
Coordinator of Older Adult Programs NAMI NH/Dartmouth Centers for Health & Aging	Social Work (LICSW)	Advocacy/Academic	Group coordination & communication	Workgroup facilitation and coordination, training coordination, caregiver advocate
Director, Dartmouth Centers for Health & Aging	Geriatric Psychiatry (MD,MS)	Academic	Evidence base, outcome measurement	Research and present evidence and outcome measurement training expertise
Postdoctoral Fellow, Dartmouth Centers for Health & Aging	Geropsychology (PhD)	Academic	Evidence base, outcome measurement	Research and present evidence and outcome measurement, training
Project Director, Center of Aging & Community Living	Psychology (MA)	Advocacy/Academic	Evidence base, outcome measurement	Research and present evidence and outcome measurement

Stepped Process of Implementation Planning

Table 2

Workgroup Tasks	Strategies of Implementation Planning		
	Gather Information	Identify Strengths & Barriers	Develop Implementation Approach
1. Select an EBP	<ul style="list-style-type: none"> Intervention that is brief, suitable for community-based delivery, and effective for late life depression Problem Solving Therapy PEARLS Behavioral Activation Healthy IDEAS 	<p>Strengths</p> <ul style="list-style-type: none"> Motivational interviewing experience <p>Barriers</p> <ul style="list-style-type: none"> Time Required qualifications of providers Frequency and intensity of training and supervision needed Estimated cost of providing the service 	<ul style="list-style-type: none"> Solutions should prioritize feasibility over effectiveness Adopt Behavioral Activation Adopt Brief Alcohol Intervention for at-risk drinking
2. Plan the implementation rollout	<ul style="list-style-type: none"> Implementation approaches (stepped wedge, rapid cycling, and a two-phase implementation) REAP site's characteristics likely to impact roll out (e.g., buy-in, rurality, ratio of counselors to clients) 	<p>Strengths</p> <ul style="list-style-type: none"> Availability of funding Robust estimates of potential participants <p>Barriers</p> <ul style="list-style-type: none"> Heterogeneity of sites 	<ul style="list-style-type: none"> Employ a two-phased implementation rollout Phase 1 implementation with sites having high REAP buy-in and a low ratio of counselors to clients and a range of rural and non-rural settings
3. Plan the counselor training	<ul style="list-style-type: none"> Counselors characteristics likely to impact training (e.g., training backgrounds, degrees, and licensure) Content of previous REAP trainings Behavioral Activation training curriculum Brief Alcohol Intervention training curriculum 	<p>Strengths</p> <ul style="list-style-type: none"> Experience working with older adults Experience with motivational interviewing Access to trainers <p>Barriers</p> <ul style="list-style-type: none"> Heterogeneous group of counselors Assembling REAP counselors for training and supervision 	<ul style="list-style-type: none"> A face-to-face training that includes <ol style="list-style-type: none"> Introduction to Enhanced REAP Screening instruments Behavioral Activation Brief Alcohol Intervention Intersection of Behavioral Activation and Motivational Interviewing
4. Design the implementation evaluation	<ul style="list-style-type: none"> Screening Instruments used by REAP Previous screening adherence rates Alternative instruments for measuring of symptoms of depression and at-risk drinking 	<p>Strengths</p> <ul style="list-style-type: none"> Existing website Protocol for screening <p>Barriers</p> <ul style="list-style-type: none"> History of low screening adherence Time constraints No precedent for follow-up assessments Website did not accommodate multiple time-point assessments 	<ul style="list-style-type: none"> Replace the Geriatric Depression Scale with Patient Health Questionnaire Replace Short Michigan Alcoholism Screening Test-Geriatric version with the Alcohol Use Disorders Identification Test Upgrade the reporting website Administer surveys to counselors during training sessions