EXPERT PANEL MEETING
OLDER AMERICANS SUBSTANCE ABUSE AND MENTAL HEALTH TECHNICAL ASSISTANCE CENTER
MARCH 29, 2005

Meeting Summary

August 18, 2005

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I. WELCOME

A. WELCOME AND INTRODUCTION

Jennifer Solomon, MA (Public Health Analyst, the Center for Substance Abuse Prevention [CSAP]) of the Substance Abuse and Mental Health Services Administration (SAMHSA) serves as Task Order Officer of the Older Americans Substance Abuse and Mental Health Technical Assistance Center. The Expert Panel was convened on March 29, 2005, to provide guidance to the Center. The meeting was held at the SAMHSA offices in Rockville, Maryland. Jennifer Solomon brought the Expert Panel meeting to order at 9:00 a.m. The meeting began with several executive level briefings.

B. CENTER FOR SUBSTANCE ABUSE PREVENTION

Jennifer Solomon introduced Bob Stephenson, MPH, Acting Deputy Director of CSAP. Bob Stephenson reported that he was serving as the representative for Beverly Watts Davis, the Director of CSAP, who was unable to attend the meeting. As Director of Workplace Programs at CSAP, Bob Stephenson stated that he is always looking for more effective—and more cost-effective—ways to prevent substance abuse. The Center has great promise to assist in this effort.

C. CENTER FOR SUBSTANCE ABUSE TREATMENT

Richard Kopanda, Deputy Director of the Center for Substance Abuse Treatment (CSAT), then spoke. He welcomed the Expert Panel members on behalf of H. Westley Clark, MD, JD, MPH, Director of CSAT.

D. OFFICE OF POLICY, PLANNING, AND BUDGET

Daryl Kade, MA, Associate Administrator of SAMHSA's Office of Policy, Planning and Budget, and older adult matrix lead, reviewed the process of setting priorities in the agency. The process is based on the Matrix of Programs and Principles, which contains 11 priority areas, one of which is Older Adults. The priority areas include:

- Mental Health System Transformation
- Strategic Prevention Framework
- Substance Abuse Treatment Capacity

- Children and Families
- Seclusion and Restraint
- Co-occurring Disorders
- Disaster Readiness and Response
- Homelessness
- HIV/AIDS and Hepatitis
- Criminal and Juvenile Justice
- Older Adults

II. INTRODUCTIONS AND OVERVIEW OF CENTER

A. PRESENTATION BY JENNIFER SOLOMON, TASK ORDER OFFICER

INTRODUCTIONS OF ATTENDEES

Jennifer Solomon asked each member of the Expert Panel, Federal representatives, and other attendees to identify him or herself briefly.

- Nancy S. Bohman
  Retired teacher and community activist
  Board of Directors of San Antonio Fighting Back

- Carol Colleran, CAP
  Executive Vice President of Public Policy and National Affairs
  Hanley Center

- Carol D'Agostino, CSW, CASAC
  Director
  Geriatric Addictions Program
  LIFESPAN of Greater Rochester

- Gayathri Dowling, PhD
  Deputy Branch Chief
  Science Policy Branch in the Office of Science Policy and Communications, National Institute of Drug Abuse, National Institutes of Health

- Larry Dupree, PhD
  Chair
  Department of Aging and Mental Health
  Louis de la Parte Florida Mental Health Institute

- Jim Firman, EdD, MBA
  President
  National Council on the Aging

- R. Turner Goins, PhD
  Associate Professor
  Department of Community Medicine and Associate Director for Research at the Center on Aging, School of Medicine
  West Virginia University

- Catherine Gordon, RN, MBA
  Senior Public Health Analyst
  Office of the Director
  Centers for Disease Control and Prevention

- Mary Guthrie
  Acting Director
  Center for Planning and Policy Development
  U.S. Administration on Aging

- Kevin Ann Huckshorn, RN, MSN, CAP
  Director
  Office of Technical Assistance and National Technical Assistance Center
  National Association of State Mental Health Program Directors

- Julie E. Jensen, PhD
  Director
  Washington Institute

- Denise Juliano-Bult, MSW
  Chief
  Systems Research Branch in the Division of Services and Intervention Research
  National Institute of Mental Health, National Institutes of Health

- Christopher A. Langston, PhD
  Senior Program Officer
  John A. Hartford Foundation, Inc.

- David Oslin, MD
  Assistant Professor of Psychiatry
  University of Pennsylvania Medical Center and the Philadelphia Veterans Hospital

- Louise Quijano, MSW
  Doctoral Candidate
  Baylor College of Medicine

- Marcia Scott, PhD
  Division of Epidemiology and Prevention Research
  National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health

- John Shipherd
  New York State Office of Alcoholism and Substance Abuse Services

Substance Abuse and Mental Health Services Administration

Joe Gfroerer
Ingrid Goldstrom, MSc
Kevin Hennessy, PhD
Betsy McDonel Herr, PhD
Daryl Kade, MA
Richard Kopanda
Stephen LeBlanc
Lisa Park, MSW, Alternate Task Order Officer
Pamela Roddy, PhD
Jennifer Solomon, MA, Task Order Officer
Bob Stephenson, MPH
Paul Wohlford, PhD

The U.S. Administration on Aging

Diana Lawry, MEd
Katrina Morgan, MHS

The National Council on the Aging

Alixe McNeill, MPA
Nancy Whitelaw, PhD

Westat/Center Staff

Stephen Bartels, MD, MS, Scientific Co-Director
Frederic C. Blow, PhD, Scientific Co-Director
Laurie Brockmann, Research Assistant
Dianne McElroy, MA, Project Manager
Garrett Moran, PhD, Corporate Monitor
Rebekah Muck, Research Associate
Lisa Patton, PhD, Project Director
Aricca Van Citters, Research Assistant

Two invited and confirmed members were unable to attend the meeting.

OVERVIEW OF THE OLDER AMERICAN SUBSTANCE ABUSE AND MENTAL HEALTH TECHNICAL ASSISTANCE CENTER

Jennifer Solomon then presented an overview of the Center's mission:

> To enhance the quality of life and promote the physical and mental well-being of older Americans by reducing the risk for and incidence of substance abuse/misuse and mental health issues late in life.

The Center's overarching goal is to create sustainable changes in the field of geriatrics around substance abuse and mental health, for recognizing and planning for these issues. Its key activities include:

- Helping States develop State plans for substance abuse and mental health.
- Identifying evidenced-based programs for older adults on substance abuse, mental health, health promotion, and health education.
- Offering training and technical assistance to States, communities, and health and social service providers.

The Expert Panel, in turn, will play the vital role of helping narrow the objectives and define specific products and processes that will help the Center achieve its mission. The objectives of the Expert Panel meeting were to:

- Familiarize the Expert Panel with the Center's priorities, goals, and objectives.
- Identify priority areas for technical assistance and training.

In terms of expected accomplishments for the meeting, it is anticipated that center staff and SAMHSA will be able to use the expertise of the Expert Panel regarding advice and guidance on how best to develop, plan, communicate, and disseminate information on a range of issues related to substance abuse and mental health programs and initiatives for older adults.

The Center will form and maintain partnerships with a variety of other organizations to identify and disseminate evidence-based programs and help to develop substance abuse and mental health State plans for older adults. These organizations include:

- The U.S. Administration on Aging.
- State and territorial aging, mental health, and substance abuse agencies.

- Other SAMHSA Technical Assistance Centers, such as the Centers for the Application of Prevention Technologies and the Addiction Technology Transfer Center Network.
- The National Council on the Aging.
- Professional associations.

The Center will have a regularly updated web site, where mental health and substance abuse consumers and providers may find resources, including effective programs, training activities, professional conferences, and links to other aging-related web sites. It will also have a quarterly electronic communication containing professional articles, highlights of successful programs and practices, and the most current behavioral health information on the needs of older Americans. Jennifer Solomon concluded by stressing the importance of the Center's mission and the recommendations of the Expert Panel.

Jennifer Solomon briefly reviewed SAMHSA's progress to date in addressing the needs of older citizens. Demographic trends are clear. As the baby boomers grow older they will challenge the nation's system for caring for those with substance abuse and mental health issues. The sheer numbers of baby boomers, as well as their longevity and specific drug-abusing behavior, will create systemic challenges unseen in the past. In helping assess these trends, she said, the Center's Scientific Co-Directors, led by Frederic Blow, PhD, of the University of Michigan, and Stephen Bartels, MD, MS**,** of Dartmouth University, has been invaluable. Lisa Patton, PhD, of Westat, serves as Project Director.

B. PRESENTATION BY STEPHEN BARTELS AND FREDERIC C. BLOW, SCIENTIFIC CO-DIRECTORS

Jennifer Solomon introduced Stephen Bartels and Frederic Blow, Scientific Co-Directors for the Center, who gave their presentation jointly. In thinking about preventing substance abuse and addressing mental health needs**,** it is critical to note that the expected increase in the numbers of older citizens will result in a concomitant increase in substance abuse and mental illness among the elderly. Older adults' overall health and functioning will be adversely affected by both substance abuse and mental illness. Further, the total financial cost for addressing or failing to adequately address these issues will rise significantly. Prevention messages need to be tailored to address older adults' particular needs.

Rates of depression and anxiety among older adults differ depending on the setting. For example, fewer than 5 percent of those over 55 living in the community report major depression, compared to 7 percent in

primary care settings, and 4 percent to 15 percent in nursing homes. Depressive symptoms have been reported at rates ranging from 3 percent to 26 percent in the community, 7 percent to 12 percent in primary care settings, and 16 percent to 30 percent in nursing home populations. With anxiety disorders, we see rates of 2 percent to 12 percent in community samples, with generalized anxiety disorder and phobias most common. Anxiety symptoms are found in up to 24 percent of older adults in the community and more than 40 percent in hospital settings. To some degree, prisons and nursing homes have become the new mental hospitals.

Alcohol poses greater risks for older adults as compared to younger adults because it interacts with other drugs (both prescription and over the counter) and can have unpredictable effects in combination with these drugs. Studies suggest the following rates of substance abuse among older adults:

- Alcohol: 2–18 percent.
- Psychoactive Prescription Drugs: 2–4 percent.
- Other Illegal Drugs (marijuana, cocaine, narcotics): less than 1 percent.

In 2002, more than 616,000 adults age 55 or older reported alcohol dependence in the past year. Alcohol misuse (binge and heavy drinking) is the area of greatest concern among this population. There are some indications that baby boomers are likely to retain previous patterns of drug use established by their particular age groups. Thus, abuse of cocaine, marijuana, and narcotics among older adults is expected to rise substantially over the next few years, along with abuse of multiple drugs simultaneously.

In recent years, discussion regarding the importance of identifying and disseminating evidence-based practices (EBPs) has been at the forefront for SAMHSA, other government agencies, and industry. Social scientists have been called upon to examine measurable performance standards and, of particular importance to this group, to increase knowledge regarding successful techniques for addressing substance abuse and mental health issues. For example, in the areas of the prevention and early intervention of substance abuse, EBPs include brief alcohol interventions, conducted both in health clinic and home settings. Brief alcohol interventions have been shown to reduce alcohol use among older adults for at least 12 months and seem to reduce alcohol-related harm and health care utilization during that same timeframe.

Different models of mental health services, including Integrated Mental Health Services in Primary Care and Community Multidisciplinary Outreach Services, have been examined. Several evidence-based

treatment interventions have been developed for older adults with depression. In addition, EBPs have been developed for prevention and early intervention of co-occurring disorders. EBPs, which have been established largely for younger persons, must be translated to older persons, for example, in the Integrated Dual Diagnosis Treatment model.

Technical assistance and on-site training are regarded as highly important by most State mental health program directors. Nearly 90 percent, when surveyed, call technical assistance and training either "very" or "extremely" important. By similar margins, they favor dissemination of EBPs for older adults along with greater funding for such endeavors.

On the basis of these survey findings, the top two priorities for the Center should be:

- Providing technical assistance with respect to the prevention and early intervention of substance abuse, medication misuse and abuse, mental health disorders, and co-occurring disorders.
- Disseminating and implementing evidence-based and promising practices.

Target audiences include States, policymakers, community leaders, organizational and administrative leadership, providers, health care practitioners and service providers, consumers, and older adults and their caregivers, families and concerned others.

For the past few years, SAMHSA has maintained a national registry of effective programs and practices, called the National Registry of Evidence-based Programs and Practices (NREPP). Through the Center, programs may be nominated to NREPP through the following procedure:

- The U.S. Administration on Aging and other partner organizations provide candidate NREPP programs.
- The staff of the Center (two or three members) conducts an initial review.
- The Center determines if the program is ready for NREPP nomination.
- Where gaps or deficits are identified, Center staff offer support and linkages to further technical assistance.

Programs that do not make the final cut will receive review information on areas to improve, as well as technical assistance regarding these needs. Programs will be encouraged to reapply as appropriate. Kevin

Hennessy, SAMHSA's Science to Service Coordinator, later provided the Expert Panel with a thorough overview of the NREPP.

III. QUESTION AND ANSWER SESSION

Q. Jim Firman asked how the NREPP system will distinguish medication abuse from issues related to medication interactions, underuse of medication, and other medication problems.

A. Frederic Blow answered that that remains to be defined.

A. Stephen Bartels agreed that EBPs in these areas has not been consistently defined. Varying levels of rigor exist across programs and practices and the evaluations conducted. "Promising practices" and "value-based practices," such as peer support, must also be considered.

Q. Nancy Bohman asked how the Center will be able to identify all of the elderly in the community, ensuring that elderly consumers' needs are properly met.

A. Frederic Blow answered that the Center's focus is not primarily individuals but rather State and community-level providers, with an emphasis on substance abuse prevention rather than treatment.

Q. Denise Juliano-Bult asked whether the Center will do extension services (on the model of the agricultural extension), which have proven valuable at NIMH.

A. Frederic Blow and Stephen Bartels agreed that the Center should consider using this model.

Q. Catherine Gordon asked for clarification about the Center's budget.

A. Jennifer Solomon responded that the budget is limited, and this is another critical reason for the Center to focus on relationship-building and leveraging all possible resources. Jennifer Solomon also noted that simply establishing the Center and its Expert Panel is a positive move and that generating more knowledge in the area of older adults is critical.

A. Frederic Blow added that the Center staff needs the Expert Panel's help in terms of relationship-building and effectively enhancing capacity.

A. Stephen Bartels added that there is newfound recognition for the importance of addressing the substance abuse and mental health needs of this population. The need for extensive social marketing is gone. However, States are cutting funding in these areas. EBPs in the areas of substance abuse prevention and early intervention can help serve to expand limited resources.

A. Kevin Huckshorn pointed out that one can have great success in putting together communities of interest in the States.

Q. Denise Juliano-Bult asked what the age threshold for the Center is.

A. Jennifer Solomon stated fifty-five and up, although there is still opportunity to discuss whether that should be changed.

A. Frederic Blow suggested that perhaps the age should be even younger in order to coordinate with retirement planning.

A. Stephen Bartels pointed out that no matter where you make the cut, the cohort of baby boomers is huge.

Q. Jim Firman asked what would constitute success for the Center noting that, with a limited budget, success must be defined very carefully.

A. Stephen Bartels agreed, stating that we need the Expert Panel's advice on the scope. The value of the Center will be judged on its products.

The group turned to a discussion of the need for clear definitions.

- David Oslin said that it is important to define everything carefully. The standards of EBPs first of all must be very clear. Second, the interventions that the Center will focus on need to be defined. What are the models? Do they include treatment?

- Nancy Bohman added that you need to identify the interface between interventions at different levels - individual, provider, community.

- Julie Jensen added that Gatekeeper programs are the main early interventionists. Connections to services help to avoid more negative outcomes. Prevention needs to begin as early as possible.

- Turner Goins stated that the distinction between prevention and early intervention needs to be made clear.

- Marcia Scott noted that speaking the language of the service providers is critical.

IV. INTRODUCTION TO SAMHSA'S NATIONAL REGISTRY OF EVIDENCE-BASED PROGRAMS AND PRACTICES

Jennifer Solomon introduced Kevin Hennessy, SAMHSA's Science to Service Coordinator, who reviewed the history and status of the NREPP process, which is intended to be "a voluntary rating and classification system for substance abuse and mental health prevention and treatment interventions." SAMHSA's vision, Kevin Hennessy said, is for "NREPP to become a leading national resource for contemporary and reliable information on the scientific basis and practicality of substance abuse and mental health prevention and treatment interventions." This will serve to support the successful replication of these approaches nationwide. NREPP is being branded as a signature SAMHSA product, and the new version will be launched in fall 2005.

NREPP was launched in 1998 by SAMHSA's Center for Substance Abuse Prevention, as the National Registry of Effective Prevention Programs. Over the next 5 years it reviewed and rated about 1,100 substance abuse prevention programs, and offered information on more than 150 of them on the website. In 2004, NREPP was expanded to include substance abuse treatment and mental health promotion and treatment programs. An evaluation process determines if the program is appropriate for dissemination to the field and is rated by three qualified independent reviewers who base their scores on scientific merit and utility. Programs receiving an NREPP rating fall into one of four categories: (1) Program or Practice of Interest (2) Emerging (3) Conditionally Effective and (4) Effective Program or Practice. The numbering was set up to reflect a range of scores assigned when reviewing each individual outcome measure (0-4, with 0 being no evidence and 4 being the highest). A recent revision of NREPP offers many opportunities for expanded inclusion of older adult programs into the new NREPP.

NREPP will have several purposes including the following:

- To influence SAMHSA discretionary and block grant investments.
- To serve as a resource for States and communities seeking to implement evidence-based mental health and substance abuse prevention and treatment services.
- To provide an important tool for public and private purchasers in selection of effective services.

The new NREPP system is expected to be fully transparent to its target audience. The revamped NREPP criteria include detailed ratings on 19 different factors. NREPP is intended to become a primary source of information on the strength of evidence in support of substance abuse/mental health promotion, prevention and treatment programs and practices.

Kevin Hennessy said that he is excited to collaborate with the Center and that it can play a key role by helping to identify quality programs for NREPP review.

V. QUESTION AND ANSWER SESSION

Q. The first set of questions was directed to Kevin Hennessy of SAMHSA. Christopher Langston asked Kevin Hennessy what he could say about the distribution of ratings in the original NREPP since he had stated that they were not precise enough.

A. The old version had too many programs that fell into the "effective" category (the middle ranking).

Q. Kevin Ann Huckshorn asked whether the NREPP contains proprietary programs.

A. Yes.

Q. Jim Firman suggested that the Center promote dissemination or diffusion of good ideas and products. It may be possible to see effects before and after particular activities and programs are put into place.

A. The NREPP is basically designed to identify individual programs but meta-analysis could expose patterns of programs that work well.

Q. Jim Firman asked whether SAMHSA's information toolkits might be mentioned as a model.

A. Yes, the "Get Connected! Toolkit" was developed by SAMHSA and the National Council on the Aging and is available for distribution.

Q. Julie Jensen said that when she has a request for information on her program, which is part of NREPP, she hands out large numbers of the "Get Connected! Toolkit." However, few people know about the toolkit and it needs to be promoted, particularly for clinicians working with older adults.

A. The new version of NREPP should make it easier to find information of this kind.

Q. Nancy Bohman stressed the importance of information that is easy to understand and tailored to different classes of users, such as consumers and clinicians.

A. Each program will be classified according to appropriate users, Kevin Hennessy answered. Practical information about how to get on the NREPP will also be available to interested programs.

The session continued with discussion regarding other topics.

Q. Catherine Gordon said that the Centers for Disease Control and Prevention is running a 2-year evidence-based review of depression treatments.

A. Jennifer Solomon stated that she is aware of this work.

A. Kevin Hennessy said he, too, is aware of it, since he sits on the "investors group."

Q. Another panel member suggested that funds are needed to support the NREPP submission process.

A. Kevin Hennessy answered that Westat will be the source of some free technical assistance. Once the new NREPP web site is up, it will be fairly easy to use.

A. Jennifer Solomon stressed the need to have basic "how-to" information on EBPs and how to use them.

A. Lisa Patton promised the group that the Center is looking for all relevant programs.

Q. Larry Dupree asked what makes the Center unique and asked to have the Center's role defined.

A. Stephen Bartels replied that developing the Center identity and role is part of what is needed from the Expert Panel.

VI. ADDITIONAL DISCUSSION OF PREVENTION/EARLY INTERVENTION

In a departure from the schedule, Stephen Bartels and Frederic Blow discussed the options for additional early intervention and prevention training resources. They displayed a graphic (drawn from the later session on “Overview of Goals for Breakout Sessions”) headed “Prevention/Early Intervention Curriculum.”

Stephen Bartels pointed out that the Center’s scope will include early interventions and prevention, as well as treatment and health services. This broad scope presents an organizational challenge. The jointly developed and supported SAMHSA, the National Council on the Aging and the U.S. Administration on Aging “Get Connected! Toolkit” and associated materials can serve as models for developing training curricula in the area of early intervention and might be replicated in this case.

Frederic Blow added that we need to look at the risks of substance abuse and mental health problems throughout the life course and how to be innovative in working with older adults.

Stephen Bartels posed several questions, including where should the Center be in three years? What are the objectives that are relatively easily obtained and what requires a longer-term perspective?

VII. QUESTION AND ANSWER SESSION

Q. R. Turner Goins asked what prevention means. It is a semantics problem.

Q. Louise Quijano asked if we might bring pieces of treatment closer to referral.

The questions are open to further investigation and/or discussion. The following brainstorming comments were made with regard to the prevention and early intervention.

C. Carol Colleran commented that it is difficult to do prevention and early intervention without also doing treatment.

C. Julie Jensen remarked that early intervention is the gatekeeper to the prevention of worse outcomes, based on connecting to service and individualized need.

C. Christopher Langston observed that it is hard to think about prevention and not treatment. It is also hard to think about prevention starting at age 55.

C. Kevin Hennessy suggested thinking about it in terms of the prevention framework (i.e., universal, selective, indicated).

C. Denise Juliano-Bult added that early intervention might be a gatekeeper model—the intervention is actually getting people together.

C. Marcia Scott stressed that there is a need to develop and define a vocabulary to transcend information to target audiences.

C. David Oslin noted that some of the terms are very charged.

VIII. OVERVIEW OF GOALS FOR BREAKOUT SESSIONS

Since the group was to form four parallel breakout groups (to discuss the State, Community, Providers, and Consumers) later in the afternoon, Stephen Bartels and Frederic Blow led a discussion regarding the objectives of the breakout discussions. To shape the discussion, they introduced a matrix labeled "Product Grid" (Table 1). The Product Grid was introduced as a discussion guide to be used to prompt thinking in each of these areas and to solicit ideas regarding recommendations in these areas. Each of the four breakout groups was asked to consider recommendations in the areas of State/Agency Planning and Implementation, Development and Dissemination of Resources, and Promotion of Resources and Enhancement of Partnerships.

Table 1. Product Grid

	State/Agency Planning and Implementation	**Develop and Disseminate Resources**	**Promote Resources and Enhance Partnerships**
State			
Community			
Providers			
Consumers			

Priorities for the new Center, Stephen Bartels and Frederic Blow proposed, should be to provide technical assistance with respect to (a) prevention and early intervention of substance abuse; medication misuse and abuse; mental health disorders; co-occurring disorders and (b) dissemination and implementation of evidence-based and promising practices**.**

The Scientific Co-Directors acknowledged that State and agency plans are highly variable and should be assessed individually. They concluded with a series of specific discussion questions, keyed to the specific headings found in the product matrix.

State/Agency Planning and Implementation

- What initiatives will best promote State planning and implementation of prevention and early intervention strategies?
- What communication mechanisms need to be set up to encourage and facilitate planning?
- Who should be contacted in order to engage States/agencies in adapting initiatives to plan and implement evidence-based prevention and early intervention strategies?
- What are the short-term and long-term approaches to meeting these priorities?

Develop and Disseminate Resources

- What products should be developed at these different levels to address prevention and early intervention?
- What media or communication mechanisms should be utilized to disseminate resources?
- Who are the primary targets for these materials?
- What are the short-term and long-term approaches to meeting these priorities?

Promote Resources and Enhance Partnerships

- What initiatives will best promote partnerships in developing early intervention?
- What communication mechanisms need to be established to promote partnerships?
- What are the primary constituencies that should be targeted in order to promote resources and enhance partnerships?
- What are the short-term and long-term approaches to meeting these priorities?

Frederic Blow concluded by reminding the group that they can provide valuable help by describing specific lessons learned from other projects. After a brief review of the agenda for the rest of day, he stressed a final question: "If we can produce only three "deliverables" in the next year, what should they be?" Pre-breakout discussion and recommendations followed.

Pre-Breakout Discussion

- Carol D'Agostino said the problem is basic access.
- Frederic Blow responded that you need to document that early intervention and prevention are possible and cost-effective.
- Christopher Langston agreed that it is important to document how the system works.
- Denise Juliano-Bult asked, on the State level, what agencies should be involved? NIMH has just contacted all of the children's programs of mental health and substance abuse.

- Larry Dupree suggested that training should be focused to help inform the State officials that matter.

- Nancy Whitelaw asked who the Center's target audience is. We can document the effectiveness and cost-effectiveness of particular States and give them a greater number of evidence-based programs to use.

- Kevin Ann Huckshorn asked what specific target we should have in mind. Stephen Bartels replied that we should examine the two or three programs with the greatest payoff.

- Julie Jensen stated that, in Washington, as in other States, you need to build continuity and consensus among the main players, because policymakers have a variety of things competing for their attention. It needs top-level attention. Stephen Bartels agreed. You can boil it down to "Depression is diabetes." We need to make those cases.

- Larry Dupree said that in 2002 (for the President's New Freedom Commission on Mental Health) we looked at Florida's health plan. In most States there is no policy on the elderly.

- Carol Colleran suggested that we need to develop screening instruments, for use by low-cost personnel (triage nurses at emergency rooms, for example). The language is key. Asking "Do you have an alcohol problem?" can be too direct.

- Christopher Langston agreed. In addition, he said general medical centers need to be involved. People age 65 and over have Medicare. Stephen Bartels also agreed, adding that there's a "Welcome to Medicare" assessment that should be used to identify problems.

- Betsy McDonel Herr suggested that the Center can dovetail with other SAMHSA products, such as the Center for Mental Health Services, and various SAMHSA toolkits (including the Get Connected! Toolkit).

- Catherine Gordon said she is struck by the number of elderly who end up in primary care without being screened previously for mental health and substance problems. Personnel there need help with simple screening tools.

- David Oslin said the "Welcome to Medicare" assessment could be used as a screening tool. The physician or physician's assistant in those situations should be targeted with information.

- Marcia Scott suggested that State agencies be given well-crafted information on screening techniques.

- Carol D'Agostino suggested that personnel there be given simple algorithms to screen more complex combinations of mental health and substance abuse problems.

- Julie Jensen said it takes only one person per State to make a difference, but identifying and reaching that person is hard.

Stephen Bartels summarized the foregoing by suggesting the following:

1. State organizations are critical.

2. Medical providers are a critical link (e.g., Medicare).

3. General purpose screening (some algorithm to screen comorbidities of alcohol, drugs and depression) should be a goal.

IX. BREAKOUT: SMALL WORKGROUP DISCUSSIONS

From 1:15 to 3:15 p.m., the Expert Panel members met in four separate breakout groups (Breakout Group members and facilitators can be found in Appendix B). Each breakout group discussed their separate topics (State, community, providers, and consumers) before reconvening to report their findings to the group.

X. REPORTS TO FULL EXPERT PANEL

After the full group reconvened, each of the four breakout groups presented highlights from their discussions. Some groups chose to follow the grid format while others chose not to use the grid.

A. STATE BREAKOUT GROUP

- Recommendations:
  - Provision of technical assistance to Federal and State policymakers.
  - Development and testing of State and/or multistate approaches.
  - Support of ongoing followup by State teams, to include a series of focus groups with State leaders to determine needs and provide training.
  - The identification of EBPs that can have the greatest impact on the largest number of older adults, i.e., practices and programs, that are fairly low-cost and can be readily implemented in a range of communities.

- The Center should engage policymakers and providers at the Federal and State levels in several ways:
  - Developing consensus statements about standards of care.
  - Producing and carrying out focus groups with State officials to identify multistate needs.
  - Conducting pilot tests to accelerate the adoption of new approaches.
  - Continually revising the menu of technical assistance products and services.
  - Conducting internal reviews of its strategies for responding to requests.

B. COMMUNITY BREAKOUT GROUP

- The Center should develop and test several products:
  - Clear presentations (in a variety of media), informing audiences of the key points of substance abuse and mental health issues for older adults. The use of actual case studies can serve to make the presentations as realistic and as engaging as possible.
  - The Center web site should offer interactive tools to test consumers' risks of drug interactions and other problems. (A "Medication Management Wizard" might be one example.) Feedback from web site users should be encouraged.
  - Information on local, State, and regional programs that have been screened by the NREPP system.

C. PROVIDER BREAKOUT GROUP

The provider breakout group recommended that the Center focus on informational products, appropriate to an array of audiences and focused on a range of topics.

- Four products were recommended:
  - Technical reports in the Center's newsletter.
  - Brochures and posters for professionals at all levels of the system, alerting them to screening opportunities such as the "Welcome to Medicare" assessment.
  - Lists of active partnering organizations such as providers (e.g., American Association of Retired Persons, National Association of Social Workers).
  - A systematic scan/review of prevention/early intervention tools, including screening of the NREPP.

- Additional Recommendations:
  - Help develop user-friendly, informative documents appropriate to a range of medical, substance abuse, and mental health professionals.
  - Highlight the simplest approaches, sensitive to the time and financial pressures of medical providers.
  - Systematically review prevention/early intervention tools and screening alternatives.
  - Identify and support programs through the NREPP process, promoting accepted programs throughout the country.

D. CONSUMER BREAKOUT GROUP

- Two products were recommended:
  - A briefing paper on senior advocacy groups promoting mental health and preventing substance abuse.
  - Technical assistance to State governments and State consumer organizations around mental health and substance abuse efforts.

- Additional Recommendations:
  - "Did You Know" and anti-stigma campaign that address stigma reduction and knowledge development among the target population.
  - Medicare Management Wizard provides easily accessible on-line assistance to identify the use of interactions of medications among older adults.

- Potential partners:
    - American Association of Retired Persons
    - National Council on the Aging
    - Pharmaceutical companies
    - U.S. Administration on Aging
    - Professional organizations

E. PARTNERSHIP/COALITION DEVELOPMENT

The overarching issue of partnership or coalition development was also addressed by the Expert Panel. For the sake of cost-effectiveness, the Center must take advantage of the widest possible network of organizations in the public, private, and nonprofit sector.

Strategically, the Center should work to promote partnerships through:

- Staff presenting at conferences.
- Disseminating existing resources for States and local providers of services.
- Brokering knowledge of aging.

Potential partners include:

- The National Institute on Alcohol Abuse and Alcoholism (NIAAA), which has a variety of effective teaching materials and curricula aimed at discouraging underage drinking. These materials and methods could be adapted to meet the needs of the target population of older adults.
- The National Association of Social Workers, among other professional associations, includes many members who provide services to the aging.
- Other Federal agencies such as the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services have much to contribute in both knowledge and resources.
- Other recommended partners include the American Association of Retired Persons, the American Society of Addiction Medicine , and a wide range of professional associations.

The Center should offer:

- Clear information on how to access its services.
- Clear information regarding how the Center will respond to requests.
- Provision of technical assistance materials to help users get the most out of the evidence-based programs and practices that the Center will be identifying and promoting.

XI. FULL GROUP DISCUSSION

POST-BREAKOUT DISCUSSION

The Expert Panel discussed the breakout presentations and other critical elements of the Older Americans Center and its role.

- Nancy Whitelaw suggested that an important product would be a review of solid evidence for NREPP. Stephen Bartels agreed. It is necessary to capture a systematic, thorough review of the evidence base for prevention/early intervention for substance abuse and mental health in the case of older adults. For example, you might: (a) "grade" level of evidence; (b) take advantage of existing reviews (e.g., screening); and (c) do a literature review article/monograph as the main product.

- Carol D'Agostino asked for a definition of "prevention." Is it well enough defined? Stephen Bartels replied that policy analysts distinguish "prevention" from "early intervention." The latter is on a stronger footing.

- Carol D'Agostino then asked if "coalitions" are synonymous with "partnerships." Carol Colleran said she finds partnerships a more inviting term, since it implies equality. David Oslin opined that there are several kinds of partnerships/coalitions.

- Carol D'Agostino pointed out that the NIAAA social work curriculum recommended in the "Building Partnerships and Coalitions" breakout group is something that already exists for training purposes.

- David Oslin thought the web-based interface for "Welcome to Medicare" providers to use was promising. Julie Jensen agreed and suggested steering geriatric medical centers in that direction.

- The breakout group on "Involving State and Federal Policymakers" had pointed to the need to rethink the Center's strategy for responding to requests for information from States and providers.

- Nancy Whitelaw stated that the Center, with its small staff, needs to have an explicit strategy for answering requests for information. Lisa Patton agreed that the Center tries to identify specific EBPs with the greatest impact.

- Stephen Bartels said we have to decide what our strategy for responding is. We are not a data warehouse.

NEXT STEPS

Jennifer Solomon asked Stephen Bartels to review the final agenda items: The three concrete measures that will set the pace for the Center and its many partners.

1. *Summary of Recommendations.* Prepare a summary of the Expert Panel's recommendations.

2. *Comments on Summary.* Distribute the Expert Panel summary.

3. *Center Strategic Plan.* The Center's strategic plan will key into the SAMHSA plan, and spell out in measurable terms its goals and objectives and resources.

Jennifer Solomon adjourned the meeting at 5:00 p.m.

APPENDIX A. AGENDA

8:30 a.m.	**Shuttles Arrive at SAMHSA**
8:30 - 9:00	**Continental Breakfast**
9:00 - 9:40	**Welcome** Beverly Watts Davis, Director, CSAP Daryl Kade, Director, Office of Policy, Planning and Budget Richard Kopanda, Deputy Director, CSAT
9:40 - 10:30	**Introductions and Overview of Center** Jennifer Solomon, Task Order Officer Lisa Park, Alternate Task Order Officer Fred Blow, Scientific Co-Director Steve Bartels, Scientific Co-Director
10:30 – 10:45	**Question and Answer Session**
10:45 – 11:00	**Morning Break**
11:00 – 11:30	**Introduction to SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)** Kevin Hennessy, Science to Services Coordinator
11:30 – 11:45	**Question and Answer Session**
11:45 a.m. - 12:00 p.m.	**Overview of Goals for Breakout**
12:00 - 1:00	**Lunch**
1:00 - 1:15	**Overview of Goals for Breakout (cont.)**
1:15 - 3:15	**Breakout: Small Workgroup Discussions**
3:15 - 3:30	**Afternoon Break**
3:30 - 4:30	**Report to Full Expert Panel**
4:30 - 5:00	**Full Group Discussion**
5:00 p.m.	**Shuttles Depart from SAMHSA**

APPENDIX B.

Small Group Breakouts

Community (Dianne McElroy, Facilitator)

Nancy Bohman
Turner Goins
Julie Jensen
Marcia Scott
Nancy Whitelaw
Diana Lawry

Consumer (Aricca Van Citters, Facilitator)

Carol Colleran
Carol D'Agostino
Larry Dupree
Alixe McNeill
Katrina Morgan

State (Lisa Patton, Facilitator)

Gayathri Dowling
Kevin Huckshorn
Denise Juliano-Bult
Garrett Moran
John Shipherd

Provider (Laurie Brockmann, Facilitator)

Catherine Gordon
Mary Guthrie
Christopher Langston
David Oslin
Louise Quijano