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Older Adult Volunteers' Experiences Delivering a Lay-Led Behavioral Activation Program for Depression Among Community-Dwelling Older Adults: A Mixed Methods Study

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AUTHOR CONTRIBUTIONS

Nicole Crawford and Lesley Steinman conceptualized this implementation study and drafted the manuscript. Nicole Crawford, Isabel Rollandi, and Brittany Mosser collected the study data. Nicole Crawford, Lesley Steinman, Brenden Li, Julien Rouvere, and Brittany Blanchard performed the analysis. Amber Gum, Jo Anne Sirey, and Patrick Raue provided study oversight. All authors reviewed and revised the work. All authors approved of the final version.

DATA STATEMENT

All study data may be shared with other researchers via NIMH's National Data Archive (NDA). No direct identifiers will be shared. Participants have consented to the sharing of this information during the provision of informed consent. Despite using direct identifiers to generate GUIDs for the NIMH's NDA, the GUID is not identifiable. We will remove identifiers (name, date) from any audio recordings when sharing them with other researchers via the NDA.

DISCLOSURES

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Abstract

Objectives: To evaluate coaches' experiences delivering a lay-led depression intervention (Do More, Feel Better; DMFB) during a Type I hybrid effectiveness-implementation RCT.

Methods: We conducted a process evaluation to assess DMFB feasibility, appropriateness, fidelity, and acceptability in 12 senior centers in Florida, New York, and Washington (USA). DMFB is streamlined Behavioral Activation delivered by older adult volunteers from senior center communities. Data sources included eligibility and exit interviews with surveys and external fidelity ratings of session recordings.

Results: The study sample included 45 older adults ($M_{age} = 69.8$, $SD_{age} = 6.3$), 85.3% women, 45.4% people of color, 24.1% low-income, 53.1% live alone. Feasibility: Of 66 individuals interested in serving as DMFB lay coaches, 45 (68.2%) were eligible, 34 (51.2%) were trained, 27 (40.1%) were certified, and 24 (36.4%) engaged 1 or more clients. Appropriateness: Eligible older adult volunteers had high capacity to serve as coaches ($M = 5.3$, $SD = 0.8$, 6-pt scale), bringing lived experience helping others, managing their mental health, good communication and organizational skills, and valuing volunteering. Fidelity: External global ratings were "very good" ($M = 4.6$, $SD = 0.7$, 5-pt scale); areas for improvement were managing time for PHQ- administration and activity scheduling, and need for more person-centered communication. Acceptability: Coaches rated high confidence delivering DMFB ($M = 4.7$, $SD = 0.6$, 5-pt scale) and that they received adequate training ($M = 4.5$, $SD = 0.6$, 5-pt scale) and supervision ($M = 4.6$, $SD = 0.6$, 5-pt scale). Coaches found satisfaction helping others, connecting with clients, and applying DMFB to their mental health.

Conclusions: This study adds to limited literature on implementation outcomes for lay-led community-based interventions for older adults. Preliminary findings document successful implementation.

Keywords

Community-based organizations; depression; lay delivery; volunteers; mixed methods; implementation outcomes

OBJECTIVES

One in six people will be over the age of 60 by 2030.¹ To support healthy aging, alternative options for mental health care are needed. Prevalence estimates suggest over 31% of adults 60 and older experience some level of depression.² Depression often goes undiagnosed and undertreated in older adults, due to lack of access to care, cost, stigma, ageism, racism, and other systemic inequities,³ as well as workforce shortages contributing to a lack of adequate clinical services. Over 150 million people live in mental health shortage areas, also called service deserts, where access to behavioral health providers including psychiatrists and counselors is limited.⁴ Social determinants of health, isolation, and preferences for unavailable psychosocial treatments can further compound the mental health burden faced by older adults living with depression.⁵

Community-based interventions offer one path for improving access to quality mental health care. Task shifting from clinicians to trained community providers (e.g., volunteers, community health workers) can address the widespread problem of mental health care workforce shortages.^{6,7} Senior centers represent promising service settings in which to offer acceptable care. Across the United States, over one million older adults are served by 11,000 senior centers.⁸ Senior centers are part of the national aging service networks that support older adults aging in place (independently). They provide important services that address social determinants of health like housing and social support⁵ for the many older adults living longer yet with limited incomes.⁹ Senior centers offer nutrition programs, health and wellness programming, case management, and recreational activities.

Senior centers provide older adults with diverse opportunities to volunteer within the centers and through other community connections. Approximately one in three older adults volunteer, with 22 million older adults volunteering 2.2 billion hours in 2018.¹⁰ Volunteering can increase individuals' physical activity, self-esteem, and self-efficacy, and decrease isolation and depression.^{11,12} Older adult volunteers provide value to the communities they serve and, with appropriate training in evidence-based programs, may be one solution to address the mental health workforce shortage. Lay-delivered interventions may be equally or more acceptable to older adults and may show similar effectiveness in improving clinical outcomes.^{13–15} In addition, training older adults to deliver lay interventions that support mental wellness also offers potential for improving their own mental health.^{16–18}

In response to large numbers of senior center clients who live with untreated depression and the dearth of geriatric mental health providers, our research team partnered with senior centers to streamline Behavioral Activation (BA) to match the skill set of older volunteers ("Do More, Feel Better"; DMFB). The lay-delivery model utilizes existing volunteer resources that can address the insufficient workforce and has potential for being an acceptable and sustainable delivery model.^{13–15,19} We are currently testing the effectiveness of the DMFB lay coach model in increasing activity level and reducing depressive symptoms in a multi-site, noninferiority randomized controlled trial (RCT).⁶

This RCT also offers an opportunity to evaluate DMFB delivery by lay coaches. Effective implementation is typically gauged by evaluating implementation outcomes—intermediate outcomes which can impact the success of delivering an intervention in a specific context.²⁰ These include constructs like feasibility of implementation, appropriateness of program fit in different populations, providers, and settings, fidelity to delivering the program as intended, and acceptability of the program to providers and participants.²¹ A recent review²⁰ of the Implementation Outcomes Framework (IOF) found that only 6.3% and 8.3% of implementation outcomes studies to date have been conducted in social service settings and with older adults, respectively. As such, implementation scientists may inadvertently perpetuate gaps in mental health care by not engaging with populations and in settings that are recommended to improve mental health equity for older adults.³ It is particularly important to engage interventionists' voices in research as key ingredients for implementation success.²² As such, we conducted implementation research as part of our effectiveness RCT to understand the feasibility, appropriateness, and acceptability of DMFB

from coaches' perspectives, as well as their fidelity to the intervention based on external expert ratings.

METHOD

Design

We conducted an exploratory process evaluation during our ongoing multi-site RCT to evaluate the effectiveness of Do More, Feel Better (DMFB).⁶ We used a parallel mixed methods design to evaluate early-stage implementation outcomes, simultaneously collecting quantitative and qualitative data to evaluate coaches' experiences delivering DMFB.^{23,24} This study was reviewed and approved by our UW Institutional Review Board (#11434).

Intervention

DMFB is a streamlined manualized version of Behavioral Activation (BA), an established psychotherapy with strong evidence for treating depression among older adults from diverse backgrounds.²⁵ BA counters the tendency for people with depression to withdraw, be inactive, and isolate, through planning and engaging in meaningful and rewarding activities. DMFB is delivered in nine weekly 45–60-minute phone, video-conferencing, or in-person sessions with trained lay coaches – older adult volunteers from senior centers and other community-based settings.¹⁹ DMFB clients meet weekly with their coach to choose and reflect on activities that might help to boost their mood. DMFB implementation strategies²⁶ include capacity-building strategies to support older adults to deliver DMFB (training, technical assistance, and clinical supervision) and integration strategies to embed DMFB in social service settings.²⁷

Setting and Participants

The study was conducted in three U.S. locations: Hillsborough County, Florida; New York City, New York, and the Seattle metro area, Washington. In 2021–2023, we recruited twelve senior centers as study sites, who partnered with our research teams to engage older adult volunteers as DMFB coaches. Volunteers were recruited via various outreach strategies (e.g., word of mouth, presentations, newsletters) and screened for eligibility using a structured interview.

Volunteers were eligible for training to become coaches if they were age 60 or older; met criteria for good interpersonal and organizational skills (research staff rating of open-ended interview questions), emotional stability (Patient Health Questionnaire-9²⁸ [PHQ-9] < 10), and cognitive functioning (6-Item Memory Cognition Screen²⁹); and did not have experience as a clinical mental health professional. Older adult senior center clients were eligible if they had clinically significant depressive symptoms (PHQ-9 $\geq$ 10 and Hamilton Depression Scale³⁰ [HAM-D] $\geq$ 10) and were ineligible if they were experiencing active suicidal ideation, had a diagnosis of bipolar disorder, psychotic-spectrum disorder, dementia, or other significant cognitive impairment (Telephone Interview for Cognitive Status-Modified³¹ [TICS-M]<21), or were in weekly psychotherapy or on antidepressants unless taking stable doses for $\geq$ 12 weeks.⁶

Data Collection

Data sources: Data were collected from potential volunteer coaches via eligibility interviews during the preparation phase and exit interviews during the implementation phase after coaches delivered DMFB with up to five clients. These 30–45 minute interviews included both open-ended qualitative questions and close-ended quantitative questions (Supplementary 1). Trained research staff conducted interviews by telephone or video-conferencing, and all coaches were invited to participate. We used REDCap³² for data collection and management.

Implementation outcomes: These included feasibility, appropriateness, and acceptability, three constructs that reflect the fit of an evidence-based program or its implementation strategies to some criterion,³³ and fidelity of volunteer coaches delivering behavioral activation as intended. Figure 1 provides details on implementation outcome definitions, criteria, and measures used. Implementation outcomes were assessed both during preparation (pre-implementation) and implementation phases.²²

Data Analysis

We used R³⁴ for quantitative analysis and Excel for qualitative analysis. Quantitative analysis included descriptive statistics of quantitative indicators (i.e., frequency and percentage for categorical variables, mean and standard deviation for continuous variables). Qualitative data were analyzed via thematic analysis³⁵ using the rapid framework method³⁶ to understand key patterns in the data. Data was reduced with two coders using deductive coding with the IOF and inductive coding to allow additional themes to emerge that may not be captured in the IOF as it has not been applied extensively to older adults or community-based organizations. Discrepancies were resolved with the PIs and lead authors and member checking was done with community partners. We organized themes using interpretation memos and used joint display tables³⁷ to integrate the qualitative and quantitative data to evaluate DMFB's feasibility, appropriateness, fidelity and acceptability.

RESULTS

Characteristics of eligible DMFB coaches ($N = 45$) are provided in Table 1. These 45 older adults had a mean age of 69.8 (SD = 6.3), 85.3% were women, 45.4% were people of color, 24.1% were low-income, and 53.1% lived alone.

Feasibility

Forty-five (68.2%) of 66 individuals interested in serving as a DMFB coach met eligibility criteria. Of the 66 interested volunteers, 34 (51.2%) were trained, 27 (40.1%) were certified as coaches following adequate fidelity working with an initial “practice” client, and 24 (36.4%) engaged 1 or more subsequent clients (Fig. 2). Among eligible coaches ($N = 45$), 34 (75.6%) began training, 27 (60.0%) were certified, and 24 (53.3%) engaged at least one DMFB client. Reasons cited for noncertification or dropout were time commitment, co-occurring health issues (e.g. being hospitalized), caregiving duties, and no longer being interested.

Appropriateness

Study investigators rated the 45 volunteers who met eligibility criteria to serve as coaches as having high capacity to coach ($M = 5.3$, $SD = 0.8$; Table 2). Reasons for ineligibility included lower interpersonal skills ($M = 4.8$, $SD = 0.5$), emotional stability and cognitive functioning ($M = 3.5$, $SD = 1.0$), commitment to serve as coach for 1 year (25% did not commit); and higher PHQ-9 ($M = 9.1$, $SD = 3.1$) and self-reported memory problems (50%). Ineligible coaches were rated as borderline capacity to serve as coaches ($M = 3.5$, $SD = 1.0$).

Qualitative data offers additional insights into volunteers' fit as DMFB lay coaches. In the eligibility interviews, volunteers shared their experience helping and in service to others. Many were caregivers or had worked or volunteered in health-related fields – for example, one person led a Buddhist mediation group, and another managed a group home for people living with mental health conditions. Some coaches brought their lived experience managing mental health conditions (depression, anxiety, bipolar), which connected them to clients through their shared experience and provided hope and confidence in living well with depression. Volunteering with older adults was a way to give back to their community and help others. Volunteering also brought structure to their day which they were accustomed to in previous life roles working and raising families.

Coaches also brought skills in planning and organizing – they offered examples of ways they prioritized and accomplished tasks including how they used calendars or other tools to cue them, all skills that DMFB requires of both coaches and clients. Coaches also evidenced critical thinking skills from their work and family, managing diverse people in different situations and roles, which at times can be stressful. Similarly, coaches displayed good communication and conflict management skills (e.g., working with people with different viewpoints or that they did not get along with), and interpersonal skills such as empathy, compassion, and active listening.

Fidelity

External global ratings from 52 randomly selected coach sessions ranged from “good” to “very good” ($M = 4.62$ of 5, $SD = 0.65$) overall and across the three sites, with only one session receiving a less than adequate fidelity rating (< 3 ; Table 3). Item-specific fidelity ratings (e.g., helping clients schedule rewarding daily activities) were also high.

Qualitative data from external raters for sessions with high ratings of 4 or 5 ($N = 50$) offer some insight into what coaches did well delivering DMFB to protocol. These sessions brought strong process skills, with coaches setting an agenda at the start of the session, administering the PHQ-9, discussing activities from the past week and reviewing successes and challenges with past week activity goals, supporting the participant in identifying and planning regular mood-boosting activities in the upcoming week, and wrapping up the session with reminders about upcoming homework.

Experts also rated coaches highly on their communication and interpersonal skills. They were warm, confident, knowledgeable, supportive, and empathetic to help address the low motivation and negative thinking that often accompanies depression. They managed time well to cover all agenda items while allowing space for clients to share their ideas. Coaches

who were able to first engage the client well and get them to “buy into” the DMFB model subsequently had an easier time moving to the next step of helping clients list and plan activities. Coaches were observed to gently redirect clients back to the DMFB protocol when they started discussing extraneous topics.

Expert raters noted coaches’ strong “patient-centeredness,” allowing clients to guide activity planning and PHQ-9 rating of symptoms, and using clients’ own words and phrases to amplify their role in self-managing their depression. Coaches were also very attuned to the participant’s symptoms and how distress was impacting their ability to engage in the program and carry out planned activities. Being person-centered was particularly important for fidelity when clients were ambivalent about changing their behaviors or following the DMFB protocol.

Two sessions had lower fidelity ratings (one rated 2, one rated 3); here, coaches displayed poorer time management, deviated from the agenda during the PHQ-9 administration and activity planning, and provided direct advice rather than facilitating client independence in the process.

Acceptability

During the exit interview, coaches who had served DMFB clients ($N = 22$) self-rated as highly confident delivering DMFB ($M = 4.7$, $SD = 0.6$; Table 4). Coaches also reported that both training ($M = 4.5$, $SD = 0.6$) and supervision ($M = 4.6$, $SD = 0.5$) were adequate on 5-point Likert scales.

From the qualitative portion of the exit interviews, coaches felt well-prepared by the training and materials provided, and they continued to feel supported by regular group supervision with a professional and other DMFB coaches; some coaches continued supervision after their responsibility ended to stay connected and maintain skills. Supervision brought “comfort”—providing a “*chance to check in, especially with difficult clients*” and a place to feel “*acknowledged and supported*” (White WA woman age 71). Some coaches desired more role plays and practice during or after the training or to shadow a coach to prepare them to deliver DMFB. Suggested ways to improve supervision include ensuring everyone can attend all sessions and better facilitating engagement from all coaches during sessions.

DMFB coaches described several ways they benefited from delivering DMFB. Coaches welcomed the satisfaction they got from helping others, seeing people make changes in their lives and get better—as one coach described, “*being part of someone’s happiness was incredibly gratifying*” (Black FL woman age 70). Coaches felt needed and valued because they were able to effectively help others. Furthermore, some coaches had lived with depression and had received help in the past, so doing DMFB offered a way for them to give back.

Coaches also liked applying the knowledge and skills they gained from being a DMFB coach to their own mental health—one coach appreciated how delivering DMFB helped them to learn about and understand more about late-life depression, recognizing “*the fact that it (depression) can happen to anyone at any time*” including herself [Black NY woman

age 73]. Another coach shared how the client reminded them of the importance of DMFB's rationale and skills —“*my last client mentioned these words to me: ‘I need to find my even keel.’ I learned what that meant and was able to apply it to my life*” [Latina FL woman age 60]. Coaches also realized they were not doing enough for themselves and would do more for self-care or other meaningful activities. Coaches welcomed how DMFB provided a way for them to keep their mind going, fill their day, and apply their education and skills towards something.

Lastly, coaches found the connection with clients appealing through the shared experiences of aging, and in some cases this bond continued after the program ended. Coaches found community in interacting with other older adults and having the “*opportunity to talk about mental health openly*” [white WA woman age 68]. The DMFB experience was a “*two-way street*” (Black NY woman age 73) in which coaches and clients connected over applying DMFB in their lives to feel better. As one coach put it, she could “*see herself in her clients*” [Black NY woman age 69], which allowed her to feel less alone, realize she needed to do things for herself, and both make changes in her life where she could while accepting that not all changes were possible.

Several factors lowered DMFB's acceptability for coaches. One-third of coaches that completed exit surveys experienced some difficulty in their role. Qualitative interview data suggested that some of these unintended stresses were logistical - due to technology hurdles on the client side, or to challenges with scheduling both around their own and the client's schedules. In addition, coaches described DMFB as less acceptable when they had poor rapport and struggled to get through to clients. In one instance, a coach talked about feeling they did not have enough knowledge or experience to adequately address a complex and challenging situation that a client was facing. Thus, providing DMFB can also have a negative emotional impact on some coaches.

DISCUSSION

This study lends empirical support for the implementation of lay-delivered behavioral activation (DMFB) in senior centers that reach older adults historically underserved by mental health care. One in three older adults initially interested in serving as a coach were successfully trained, certified, and engaged as DMFB coaches, while other time commitments, caregiving duties, and health issues lowered the program's feasibility. Trained older volunteers were appropriate for providing a mental health intervention to their peers due to their experience helping others and managing their own mental health, intervention delivery skills, and value of volunteering. DMFB coaches demonstrated high fidelity to the intervention, executing the protocol well while centering the needs of clients. In addition, coaches reported DMFB was acceptable, feeling very confident in delivering the program. They also found training and supervision to be adequate in their preparation and support, and suggested improvement with more role plays and ways to engage all coaches. Coaches felt satisfied helping and connecting with others and applying DMFB to their own mental health. DMFB was less acceptable when coaches experienced challenges with logistics, rapport, or working with clients with complex psychosocial issues. Implementation

outcomes were similar for coaches across the three study locations regardless of different demographic characteristics.

These findings are consistent with previous research with Do More, Feel Better^{19,38} which found strong feasibility, fidelity, and acceptability, with volunteers increasing confidence over the course of the program. Other research with peer- and volunteer-led models has similar findings – for example, Woodard and colleagues¹⁷ reported comparable implementation outcomes in the context of a brief structured behavioral intervention for depression delivered by nonspecialists, while also pointing to needing to support managing coaches' emotional investment in client's success. Bryant and colleagues³⁹ documented that volunteer-delivered BA was feasible and acceptable for treating depression in residential care facilities, with volunteers benefiting from helping others and gaining skills from the program.

Our study also suggests opportunities to improve the delivery of DMFB and other lay led mental health programs in real-world social service settings. Feasibility can be improved by making ineligibility criteria more prominent when outreaching to volunteers and building in flexibility to accommodate lay coaches' competing demands. Appropriateness can be strengthened by including the DMFB study interview guide in the DMFB practice manual so sites can use this to gauge experiences and skills that are a good fit for DMFB – experience helping others, skills planning and organizing, and the value of giving back. To increase acceptability, we recommend highlighting the benefits that made DMFB acceptable identified in this study - social connection, tools to support your mental health, satisfaction from helping others – to engage new DMFB coaches. It will also be helpful to build in supports for the things that make DMFB less acceptable, such as challenges using technology and scheduling clients, and learning strategies to work with clients where rapport is lacking or clients are facing multiple complex life situations. Lastly, fidelity can be maximized by building training and supervision content on strategies for time management, agenda setting and sticking, and client-driven rather than advice-giving communication.

While this study provides strong evidence that older adult volunteers can be successful lay DMFB coaches, engaging and sustaining diverse coaches is hindered by older adults' competing demands like health and caregiving issues and the need for ongoing recruitment for this short-term volunteer workforce. This points to the need for better supports which we will evaluate in our next implementation study to evaluate the effectiveness and costs of training, supervision, and other implementation strategies to support this workforce that reaches underserved older adults via senior centers and other community-based organizations.

This study brings several strengths and contributions to the literature. Our research adds to the dearth of implementation science studies in community-based social service settings and with older adults,²⁰ and applying the Implementation Outcomes Framework to this population identified areas where DMFB delivery is effective and opportunities for improvement. Furthermore, conducting mixed methods research in the context of implementation and centering implementers' perspectives²⁴ are key for guiding future adaptations and logic models to strengthen implementation research and practice for healthy

aging.⁴⁰ Our small sample size may limit generalizability to other contexts. Furthermore, additional research is needed to determine whether these implementation outcomes hold for DMFB coaches outside an RCT study context.

In summary, this study suggests older adult volunteers can effectively deliver quality streamlined BA for late-life depression. Our learnings can also guide future research and practice with lay-led interventions. DMFB is promising for closing the mental health care gap for older adults where they live, work, play, pray and age.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Highlights

What is the primary question addressed by this study?

Can simplified behavioral activation (“Do More, Feel Better”) be delivered successfully by older adult lay volunteer coaches?

What is the main finding of this study?

The lay volunteer coaches were able to deliver the program with fidelity and they found it feasible, appropriate, and acceptable.

What is the meaning of the finding?

These findings add to limited literature on implementation outcomes for lay-led community-based interventions for older adults and document successful implementation.

Feasibility	Appropriateness	Fidelity	Acceptability
Definition: The extent to which an innovation can be successfully used or carried out within a given agency or setting Criterion: Practical. Exploring the ease with which DMFB can be delivered given existing resources and circumstances like effort and timing Quantitative data Preparation: #/% of older adult volunteers interviewed, eligible, trained, certified Implementation: #/% of coaches retained (delivered DMFB to the target of 4 clients), and dropped out Qualitative data Preparation: Reasons for ineligibility, non-certification Implementation: Reasons for choosing to discontinue	Definition: Perceived fit, relevance, or compatibility of the innovation for a given: • purpose (improve access to late-life depression care) • person (senior center volunteer coaches) • place (senior center) Criterion: Technical or Social. Was DMFB seen as achieving some purpose given older adults' presenting problems, or consistent with norms or values that guide people who go to and who volunteer at senior centers? Quantitative data Preparation: Eligibility interview staff ratings of volunteers' capacity to coach and show specific competencies (6-point Likert, higher scores = greater capacity) Qualitative data Preparation: Coach interest in volunteering, concerns about working with older adults with depressive symptoms, and research staff notes on coach competencies	Definition: The extent to which the program is implemented consistently across different settings, staff, and participants Criterion: NA Quantitative data Implementation: Ratings completed by external experts (licensed behavioral health professionals with expertise in BA and DMFB) to evaluate global fidelity and specific DMFB processes on 5-point Likert scales (higher scores = greater fidelity) Qualitative data Implementation: External fidelity rater notes on specific examples of fidelity and areas for improvement	Definition: The extent to which an innovation is perceived as "agreeable, palatable, or satisfactory" Criterion: Personal. Each person will judge DMFB differently based on their needs, preferences, or expectations Quantitative data Implementation: Adequacy of DMFB implementation strategies (training and clinical supervision) and confidence delivering DMFB, coach-rated using a 5-point Likert scale (higher scores = greater adequacy). Yes/no item on negative consequences Qualitative data Implementation: Coaches open-ended exit interview comments on perceived adequacy of training and supervision and how they could be improved; benefits and stresses/harms

FIGURE 1. Implementation outcomes: Definitions, criteria³², implementation phase, data source. The definitions for implementation outcomes²¹ come from the Implementation Outcomes Framework.

The criterion come from Weiner et al.'s 2017 paper.

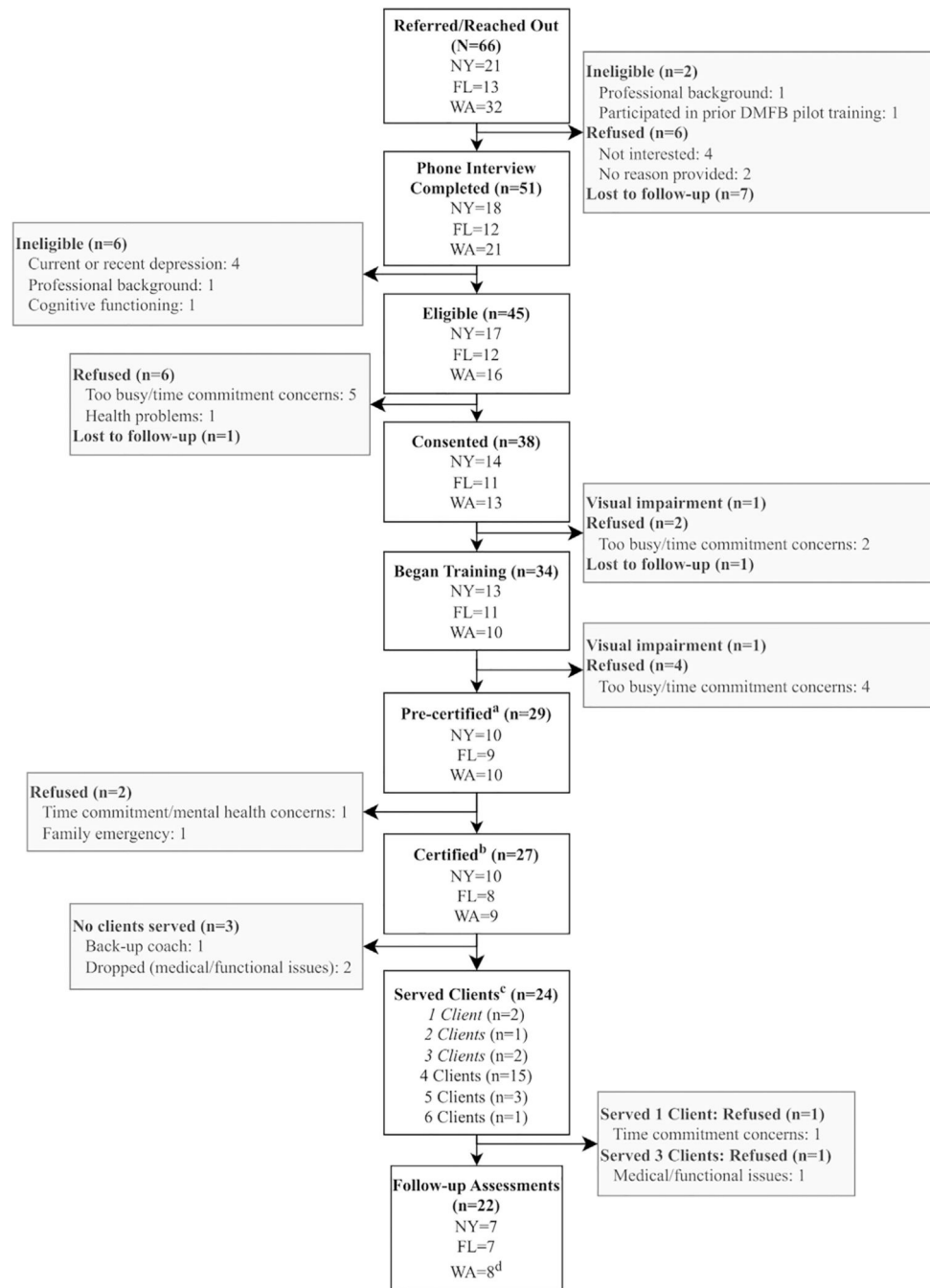


FIGURE 2. CONSORT diagram to show feasibility of DMFB implementation.

^aApproved to see first “practice” case. ^bCertified coaches successfully completed one “practice” case. ^cThe study design aimed for four RCT clients per coach. ^dIncludes one participant who provided partial follow-up assessment data when leaving the study after serving four clients.

TABLE 1.

Participant Characteristics (Eligible DMFB Coaches) (N = 45)

	Eligible (n = 45)	Trained, Not Certified (n = 7)	Certified (N = 24)	FL (n = 7)	NY (n = 9)	WA (n = 8)
Age, M(SD)	69.8 (6.4)	67.3 (8.3)	69.9 (6.3)	67.1 (7.4)	73.8 (5.5)	67.6 (3.4)
n	37	5	23	7	9	7
Gender ^a						
n	34	5	24	7	9	8
Woman	29 (85.3%)	4 (80%)	21 (87.5%)	7 (100%)	8 (88.9%)	6 (75%)
Man	5 (14.7%)	1 (20%)	3 (12.5%)	0	1 (11.1%)	2 (25%)
Race						
n	33	4	24	7	9	8
White	18 (54.6%)	1 (25%)	14 (58.3%)	4 (57.1%)	3 (33.3%)	7 (87.5%)
Black or African American	11 (33.3%)	2 (50%)	7 (29.2%)	2 (28.6%)	4 (44.4%)	1 (12.5%)
Asian or Pacific Islander	1 (3%)	0	1 (4.2%)	0	1 (11.1%)	0
Native American or Alaskan Native	0	0	0	0	0	0
Other ^b	3 (9.1%) ^d	1 (25%) ^d	2 (8.3%)	1 (14.3%)	1 (11.1%)	0
Ethnicity						
n	33	4	24	7	9	8
Yes	4 (12.1%)	1 (25%)	2 (8.3%)	2 (28.6%)	0	0
No	29 (87.9%)	3 (75%)	22 (91.7%)	5 (71.4%)	9 (100%)	8 (100%)
Nativity						
n	32	4	23	7	8	8
United States	28 (87.5%)	4 (100%)	19 (82.6%)	6 (85.7%)	5 (62.5%)	8 (100%)
Another country ^c	4 (12.5%)	0	4 (17.4%)	1 (14.3%)	3 (37.5%)	0
Marital Status						
n	32	4	24	7	9	8
Married or living as married	11 (34.4%)	2 (50%)	7 (29.2%)	2 (28.6%)	1 (11.1%)	4 (50%)
Widowed	4 (12.5%)	1 (25%)	3 (12.5%)	0	1 (11.1%)	2 (25%)

	Eligible (n = 45)	Trained, Not Certified (n = 7)	Certified (N = 24)	FL (n = 7)	NY (n = 9)	WA (n = 8)
Separated	0	0	0	0	0	0
Divorced	7 (21.9%)	0	6 (25%)	2 (28.6%)	2 (22.2%)	2 (25%)
Single or never married	8 (25%)	1 (25%)	6 (25%)	2 (28.6%)	4 (44.4%)	0
Refused	1 (3.1%)	0	1 (4.2%)	0	1 (11.1%)	0
Not asked	1 (3.1%)	0	1 (4.2%)	1 (14.3%)	0	0
Living situation						
n	32	4	24	7	9	8
Alone	17 (53.1%)	2 (50%)	13 (54.2%)	5 (71.4%)	6 (66.7%)	2 (25%)
With others	14 (43.8%)	2 (50%)	10 (41.7%)	2 (28.6%)	3 (33.3%)	5 (62.5%)
Refused	1 (3.1%)	0	1 (4.2%)	0	0	1 (12.5%)
Years of schooling, M(SD)						
n	16.6 (2.8)	16.7 (1.2)	16.5 (3.1)	16.4 (4.5)	15.2 (2.4)	17.9 (1.6)
Income	31	3	24	7	9	8
Income						
n	29	3	23	7	8	8
<\$17,599	1 (3.4%)	0	1 (4.3%)	1 (14.3%)	0	0
\$17,600–\$31,999	6 (20.7%)	1 (33.3%)	5 (21.7%)	2 (28.6%)	3 (37.5%)	0
\$32,000–\$74,999	6 (20.7%)	1 (33.3%)	4 (17.4%)	1 (14.3%)	2 (25%)	1 (12.5%)
\$75,000 or more	6 (20.7%)	0	4 (17.4%)	0	1 (12.5%)	3 (37.5%)
Don't know	2 (6.9%)	0	2 (8.7%)	1 (14.3%)	1 (12.5%)	0
Refused	8 (27.6%)	1 (33.3%)	7 (30.4%)	2 (28.6%)	1 (12.5%)	4 (50%)
Currently working						
n	32	4	24	7	9	8
Yes	2 (6.3%)	0	1 (4.2%)	1 (14.3%)	0	0
No	29 (90.6%)	4 (100%)	22 (91.7%)	6 (85.7%)	9 (100%)	7 (87.5%)
Refused	1 (3.1%)	0	1 (4.2%)	0	0	1 (12.5%)
Currently on Medicaid						
n	30	3	23	7	8	8
Yes	4 (13.3%)	0	3 (13%)	2 (28.6%)	1 (12.5%)	0

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	Eligible (n = 45)	Trained, Not Certified (n = 7)	Certified (N = 24)	FL (n = 7)	NY (n = 9)	WA (n = 8)
No	22 (73.3%)	2 (66.7%)	17 (73.9%)	4 (57.1%)	7	6 (75%)
Don't know	1 (3.3%)	0	1 (4.3%)	0	0	1 (12.5%)
Refused	3 (10%)	1 (33.3%)	2 (8.7%)	1 (14.3%)	0	1 (12.5%)

^aOriginal response options for gender identity were “female” and “male,” and are reported as “woman” and “man,” respectively.

^bOne participant from FL specified “Jewish.”

^cOne participant from NY specified “Israel.” One participant from FL specified “Nassau (Bahamas).”

^dOne participant selected “NA.”

TABLE 2.

Appropriateness (Older Adults Interviewed for Eligibility) (N = 45)

	Eligible (N = 45)	FL (n = 12)	NY (n = 17)	WA (n = 16)	Ineligible (n = 6)
Interpersonal skills, <i>n</i>	44	11	17	16	4
<i>M</i> (SD)	5.3 (0.6)	5.3 (0.6)	5.4 (0.5)	5.3 (0.6)	4.8 (0.5)
Emotional stability and cognitive functioning, <i>n</i>	44	12	17	15	4
<i>M</i> (SD)	5.5 (0.7)	5.3 (0.5)	5.5 (0.9)	5.5 (0.5)	3.5 (1.0)
Volunteer capacity to serve as coach, <i>n</i>	45	12	17	16	4
<i>M</i> (SD)	5.3 (0.8)	5.5 (0.7)	5.1 (0.9)	5.3 (0.6)	3.5 (1.0)
Commitment to serve as coach to see 5 clients over 1 year, <i>n</i> (%)	42/43 (97.7%)	11/11 (100%)	16/16 (100%)	15/16 (93.8%)	3/4 (75%)
Comfort with confidentiality, <i>n</i> (%)	45/45 (100%)	12/12 (100%)	17/17 (100%)	16/16 (100%)	4/4 (100%)
PHQ-9, <i>n</i>	24	7	12	5	3
<i>M</i> (SD); score for <i>n</i> = 1	1.3 (1.4)	0.7 (1.1)	1.4 (1.5)	2.0 (1.4)	9.7 (3.1)
Did not meet criteria for memory and cognition screen (<3), <i>n</i> (%)	0	0	0	0	0
Past mental health treatment, <i>n</i> (%)	23/42 (54.8%)	7/12 (58.3%)	7/14 (50%)	9/16 (56.3%)	2/4 (50%)
Past mental health hospitalization, <i>n</i> (%)	2/41 (4.9%)	0/12 (0%)	1/13 (7.7%)	1/16 (6.3%)	1/4 (25%)
History of psychosis, <i>n</i> (%)	1/40 (2.5%)	0/12 (0%)	1/13 (7.7%)	0/15 (0%)	0/4 (0%)
Self-reported memory problems, <i>n</i> (%)	5/40 (12.5%)	3/10 (30%)	2/14 (14.3%)	0/16 (0%)	2/4 (50%)

Table 3.
Fidelity Ratings^a from DMFB Coach sessions (N=52 sessions).

Quantitative Mean(SD) Fidelity Rating ^b		Qualitative Fidelity Reviewer Feedback
<u>Higher fidelity ratings (4 or 5):</u>		
Global Fidelity Rating	4.62(0.65)	<u>Process skills (e.g. time management):</u> <i>Excellent session. Coach set and kept to an agenda, explored the past week in depth, and asked detailed questions about activities participant might want to do.</i>
Reviewed Progress (PHQ-9, Planned Activities)	4.63 (0.67)	<u>Communication and interpersonal skills, e.g. empathetic:</u> <i>Another thoughtful and thorough session. Participant had struggled a little with motivation and negative thinking in past week. Coach provided helpful suggestions to keep momentum going on enjoyable activities and think ahead about how to overcome barriers in next week.</i>
Scheduled Activities	4.66 (0.72)	<u>Person-centered:</u> <i>This was a slightly more difficult than average session, as the participant is engaged in many activities, although not fulfilled, and is not bought into the idea that adding any more activities will improve depression. Coach did a good job meeting the participant where she was at, rolling with resistance, and encouraging participant to articulate changes she wanted to make.</i>
Concluded Session + Homework	4.52 (0.82)	<u>Engaged participant:</u> <i>Great second session! Excellent rapport. Coach is well-organized and clearly has materials/questions together to guide session in a responsive way. This participant was very receptive, so is possible coach may experience new challenges with a participant with more barriers to action.</i>
<u>Lower fidelity ratings (2 or 3):</u>		
Process Tasks	4.54 (0.82)	<u>Poor time management and not being person-centered:</u> <i>The PHQ-9 took 11 minutes to complete...It would be helpful to set a verbal agenda at the start of the session, to keep on track with completing session items...No activity form was formally reviewed, though there was a general discussion of her week. The agenda for the DMFB intervention was not followed.</i>
Communication & Interpersonal Skills	4.62 (0.63)	

^aExternal fidelity ratings were conducted for 52 coach sessions.

^bScale of 1 to 5, with 5 being highest rating

TABLE 4.

Acceptability (DMFB Certified Coaches) (N=22)^c

	Overall (N = 22)	FL (n = 7)	NY (n = 7)	WA (n = 8)
Volunteer questionnaire, <i>M</i> ^a	21	7	7	7
Coach training, <i>M</i> (SD)	4.5 (0.6)	4.6 (0.5)	4.4 (0.5)	4.4 (0.8)
Coach supervision, <i>M</i> (SD)	4.6 (0.5)	4.6 (0.5)	4.6 (0.5)	4.7 (0.5)
Confidence, <i>M</i> (SD)	4.7 (0.6)	4.7 (0.5)	4.7 (0.5)	4.6 (0.8)
Negative consequences, <i>n</i> (%)	6/18 (33.3%)	2/7 (28.6%)	2/7 (28.6%)	2/4 ^b (50%)

^aRange = 1–5.

^bIncludes one participant who provided a response for negative consequences when leaving the study; this participant did not complete the volunteer questionnaire.

^cTwo of the 24 DMFB coaches did not complete follow-up assessment data.