

California Mental Health Older Adult System of Care Project

Deliverable 3 Report: Secondary Data Analyses and Key Informant Interviews

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Project Overview

The UCLA Center for Health Policy Research received a 2-year contract from the California Mental Health Services Oversight and Accountability Commission (MHSOAC) to assess the progress made in implementing a system of care in California for older adults with SMI and to identify methods to further statewide progress in this area.

The assessment methods include examining the extent to which a representative sample of counties have systematically implemented services tailored to meet the distinctive challenges and needs faced by the older adult population, including historically disadvantaged and un/underserved older population subgroups. In addition, the assessment shall consider the extent to which the Mental Health Services Act (MHSA), passed in 2004, has facilitated or bolstered the implementation of a system of care for older adults.

The UCLA Center for Health Policy Research shall also identify and document the challenges and barriers to meeting the unique needs of this population, as well as strategies to surmount these obstacles. In order to support the State's ability to promote improvements in the quality of mental health services for older adults, a series of indicators was developed that focus specifically on older adults and systems of care for older adults. These new indicators will assist future MHSOAC data strengthening and performance monitoring efforts. Lessons learned and resultant policy recommendations for improving older adult mental health programs at the State and local levels shall be developed and presented to the Commission.

A key process in the project was assembling a statewide project advisory committee (PAC) that represents key stakeholders in the area of mental health for older adults. The PAC includes representatives from different geographic regions who are older adult consumers, family members/caregivers of older adults, community-based providers contracted by counties, county program administrators and other relevant county representatives, evaluation experts with experience in older adult systems of care, representatives from relevant stakeholder associations (e.g., those focused on racial/ethnic/demographic minorities, and un/under-served populations), and relevant state-level representatives (e.g., California Department of Aging) who are subject matter experts in the area of program and service delivery for older adults. The final PAC member roster with their affiliation, contact information and stakeholder representation is provided in Appendix A. The PAC provides meaningful stakeholder input for all phases of the study.

Deliverable 3 Overview

This report presents findings that address two components of Specific Aim 1: To assess the progress made in California towards implementing a system of care for older adults with SMI. We are using three primary methods to address the research questions related to Specific Aim 1:

- i) Key informant interviews with both county and state-level representatives,
- ii) Focus groups, and
- iii) Secondary data analysis.

As per the terms of our executed contract, the Deliverable 3 Report presents our findings from: i) Key informant interviews and iii) Secondary data analysis. The Deliverable 3 Report is organized in two parts: Part 1 presents the findings from the Secondary Data Analyses and Part 2 provides the findings from the Key Informant Interviews. There is an Executive Summary for each part. Appendices are provided as noted throughout the report as a separate document.

Meaningful Stakeholder Input

To assure meaningful stakeholder input for Deliverable 3, we have utilized our PAC throughout the design and execution of these major project activities. Their contributions have been instrumental to the work summarized in this report, as they have reviewed and provided valuable input on numerous project products, including: recruitment flyers; key stakeholder interview data collection instruments; approaches and content for the secondary analyses and early review of the Deliverable 4 Report. Feedback from the PAC has been solicited and provided both in the course of regularly scheduled PAC meetings (December 9, 2015; May 4, 2016; December 8, 2016, February 22 and 23, 2017) and through individual phone calls and emails exchanged in between formal meetings.

Approach

Our approach to the project, including the work within Deliverable 3, was based on four key principles, which are described below:

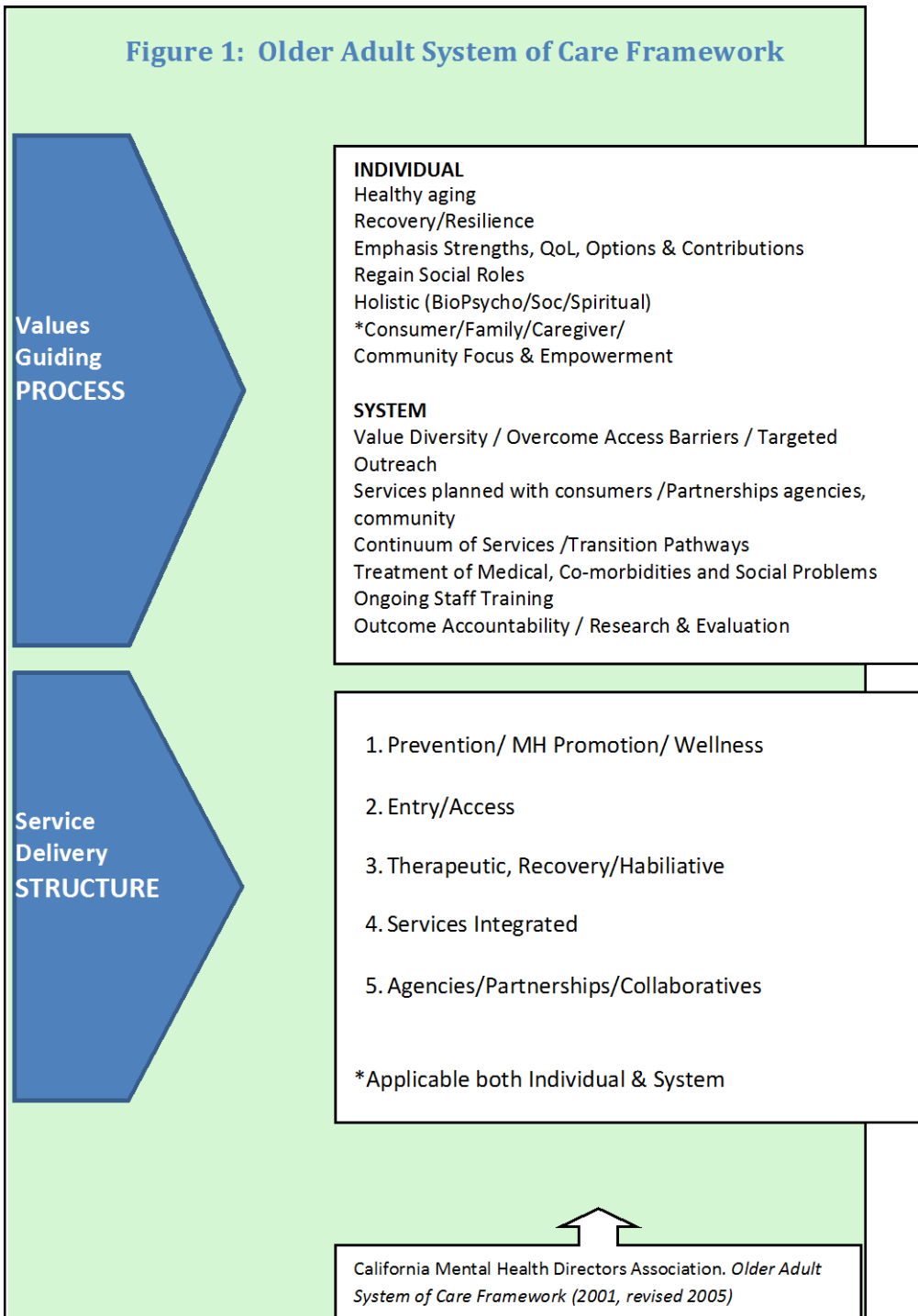
1. Use the values and principles laid out during seminal work in California for an Older Adult System of Care (OASOC) (See Figure 1 below)
2. Build on evaluations and reports by leaders and stakeholders in the area of public mental health services for older adults
3. Utilize key stakeholder input and recommendations to shape the design, process and reporting of findings within Deliverable 3

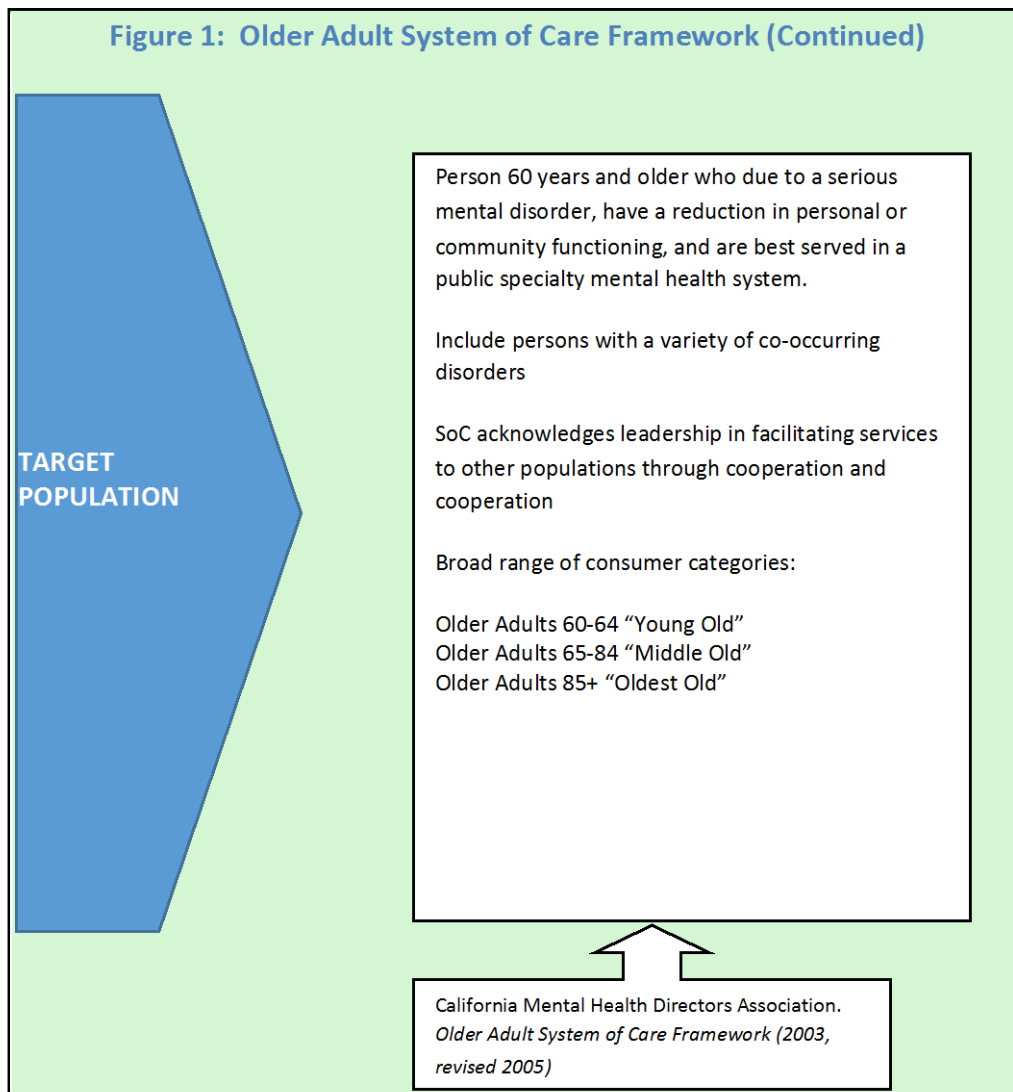
4. Gather information from a wide range of diverse key informants and stakeholders to inform the project

Even prior to the passage of the Mental Health Services Act (MHSA), considerable work had been completed in outlining key components for an Older Adult System of Care (OASOC). As described previously, the project team analyzed several models that were presented and discussed early in the project with the PAC. The framework put forth by the California Mental Health Directors Association (2001, with revision in 2005), was adopted for the project on December 9, 2015. This framework is presented in Figure 1.

A system is more than a set of services. It is an **organization of parts/programs** integrated through processes, in order to accomplish its purpose. It has boundaries and a mechanism for decision making in order for the system inputs and outputs to produce a dynamic stability and **outcomes in interaction with its environment**. There is ongoing feedback among these various part/ programs to ensure they are aligned to **accomplish the overall system goal**. The framework below of the OASOC has guided all components of the project, and has been instrumental in guiding the study, including the Secondary Analyses and Key Stakeholder Interviews reported for Deliverable 3.

Figure 1: Older Adult System of Care Framework





Adapted from the Older Adult System of Care Framework developed by California Mental Health Director’s Association (2001, revised 2005)¹, the California Mental Health Planning Council “Chapter 6 Planned System of Care for Older Adults”² and approved by our Project Advisory Committee on December 9, 2015

PART I: SECONDARY DATA ANALYSES

Executive Summary for Part 1

The Deliverable 3 Report for the California Mental Health Older Adult System of Care Study provides findings from the secondary data analyses and key stakeholder interviews, which are two of the three planned data sources for the study.

Part 1, the Secondary Analyses, included the review and analyses of three categories of documents: 1) evaluation reports commissioned by the Mental Health Services Oversight and Accountability Commission (MHSOAC) and 2) evaluations and reports produced by other governmental, California mental health and/or older adult stakeholder groups; and 3) Three-Year Program and Expenditure Plans and Annual Updates from the six counties participating in the study.

For the Secondary Data Analyses, 100 reports were reviewed, with in-depth analyses completed for 35 reports. This extensive data was then organized, for the first two data categories, into 10 content themes. The ten themes include 1) Background on OASOC Development, 2) MHSA Overview: Transforming Delivery of Public Mental Health, 3) Components of MHSA, 4) MHSA Administrative Structure and Oversight, 5) Perspectives on MHSA Implementation, 6) Financing of California's Mental Health Services and the MHSA Contribution, 7) Outcomes Evaluation, 8) Service Delivery, 9) Evidence of Older Adult Services and Care in MHSA Component Evaluations, and 10) Workforce Development. Top-line summary of the data and commentary is provided for each of the 10 themes.

1) Background on OASOC Development: The development of an OASOC pre-dated the passage of the MHSA. The California Mental Health Planning Council and the California Mental Health (now Behavioral Health) Director's Association were instrumental in developing and testing OASOC features through early demonstration projects and advocacy. At the time of the passage of the MHSA, about 25% of counties reported having an established OASOC. No additional research has provided any new data as to the prevalence in counties reporting an OASOC since 2006.

2) MHSA Overview: Transforming Delivery of Public Mental Health: The goals of the MHSA were to transform the delivery of public mental health from predominately providing crisis care to a consumer wellness, recovery, and resilience model. This transformation provided a changed context of care for the continued development of an OASOC. The MHSA focuses on adult and older adult needs specifically, along with other specific age groups. The MHSA and

OASOC espouse consistent values for mental health services. However, older adults (“seniors” is the term used in the legislation) are not designated for any specific funding mandates for service provision in the legislation, as are other age groups, such as children and TAY.

3) Components of MHSA: MHSA funds are distributed to structural types of programs and services commonly known as MHSA components: 1) Prevention and Early Intervention (PEI), 2) Community Services and Supports (CSS), which includes the Full Service Partnership (FSP), 3) Innovation (INN) 4) Capital Facilities and Technological Needs (CF/TN); Innovation (INN); 5) Workforce Education and Training (WET). Previous models for the OASOC had not been structured into these MHSA funded components. The MHSA components provided new potential building blocks for an OASOC but were not fiscally structured specifically for this population.

4) MHSA Administrative Structure and Oversight: The MHSA established the Mental Health Services Oversight and Accountability Commission (MHSOAC) as an independent entity to oversee the implementation and evaluation of the MHSA. Initially, this was a shared responsibility with the Department of Mental Health (DMH). However, in 2012, the DMH was closed and its functions were moved to a new unit within the Department of Health Care Services (DHCS), which is now the agency for mental health data reporting. The MHSOAC and the DHCS work closely together. External stakeholders have recommended a more robust role for the MHSOAC in implementation management and oversight/evaluation.

5) Perspectives on MHSA Implementation: The MHSA provided an exceptional legislative opportunity, but progress toward improved approaches to service delivery and measurement of outcomes has not been accomplished statewide. As with most major new legislation, the planning and implementation for service roll-out was often problematic. The roll-out of MHSA service components was staggered over time. There was a trend to move oversight from the MHSOAC, who initially was tasked with plan approval, to the counties. Now, county supervisors review and approve county plans. A consistent concern has been the ability to generate outcomes data to be used in planning and evaluation. While there is a state reporting system within DHCS, comprehensive data is only required for the FSP component of MHSA.

6) Financing of California’s Mental Health Services and the MHSA Contribution: Since the 2004 MHSA passage to 2014, more than \$13 billion dollars in tax revenues have been moved into MHSA funds. Currently, this represents about 25% of mental health service funding. The Affordable Care Act, other major federal legislation, and State realignment dollars have created more service dollars for mental health services. Funding is distributed to counties through a population-based formula, without regard to differential needs of population groups, such as

older adults; or other criteria, such as medically-underserved regions. There is not any designated funding or mandates for any segment of the MHSAs funded services to be provided to older adults, even though there are such requirements for other age groups.

7) Outcomes Evaluation: Across reports reviewed, there was a critical consensus that MHSAs outcomes reporting is inadequate and should be strengthened. Currently, service utilization data and client outcomes are submitted to the State and stored in the electronic Client and Service Information (CSI) system. However, this state level outcome data is not systematically used to provide transparent information for decision making and planning to improve services. It was also noted that data is not consistently being collected by service type by age group, which is essential. More leadership at the State level is required to assure core data elements like this are collected and reported, given the variation across the 58 counties at this time.

8) Service Delivery: The backbone of county services is inclusive and adequate planning, referred to as Community Program Planning (CPP). One study found that seniors and veterans were among the least common stakeholder groups that took part in the CPP process. No reports provided data on older adult service need or penetration of mental health services. However, penetration rates for mental health services, as provided under the State's Medi-Cal Specialty Mental Health Services (SMHS), showed that older adults utilized 6% of the \$22.2 billion of SMHS funds. One qualitative study reported on facilitators to increase older adult service utilization. These include access to PEI and FSP programs, stigma reduction efforts, peer support services, outreach to hard-to-reach groups, and community involvement in service development.

9) Evidence of Older Adult Services and Care in MHSAs Component Evaluations: A number of studies that were reviewed did not provide outcome data for older adults. Studies that did report older adult data showed a steady improvement in the numbers of older adults receiving services since the passage of MHSAs. They also noted that, compared to need, there was great unmet need for services for older adults with SMI across all MHSAs service components. One study reported data from 45 counties, showing 15 counties (33%) using PEI programs to serve older adults. Those age 60 and above accounted for 1.5% of those receiving prevention services. Of the 40 counties reporting early intervention services, 32 counties (80%) served older adults. Clients age 60 and above were 13.1% of those receiving early intervention services. However, when older adults are linked to services, for example FSP, they show clinical improvements and reduced costs of care, such as hospitalizations. Based on state FSP data, reports documented important outcomes for older adults, including reductions in emergency room visits, psychiatric hospitalizations, arrests and incarcerations and homelessness. Two

studies reviewed plans for MHSAs sponsored Innovation Projects. One study reported that of the 33 counties that participated, 3 had allocated Innovation funding to older adult specific programs, 19 had multi-age programs that included older adults and 7 counties had not allocated any Innovation funding for either older adult specific nor older adult inclusive projects. The second study reported data from 52 counties regarding 166 projects from 2014-2015. Based on these results, only 4 counties had older adult targeted projects. The results were not presented in a way that our project team could discern programs that may have been focused on multi-age and inclusive of older adults across all counties.

10) Workforce Development: In 2012, oversight of WET programs was transferred from DMH to the Office of State Health Planning and Development (OSHPD). The most recent 5-Year Plan, and OSHPD reports summarize key findings and recommendations including a continuing need for increased financial incentives for students interested in older adult populations; geriatric psychiatry as one of the hardest to fill and retain specialties; and few professionals that provide care for older adults have received education in both mental health and geriatrics. Leadership in statewide education and advocacy about the deficit in workforce preparedness has been provided by the CBHDA, the CDA, and the California Geriatric Behavioral Workforce Coalition. Despite decades of efforts to remedy the severe lack of qualified clinicians to meet the needs of older persons with mental illness, there still remains great need for current staff development and recruitment into behavioral health professions training and education programs.

In the report section, **Results of the Secondary Analyses Using Data Category 3: Assessing the Older Adult Systems of Care in Study Counties**, the third data category was used to report in-depth county examples of services for older adults for the six counties participating in the study (Alameda, Los Angeles, Monterey, San Diego, Siskiyou, and Tulare). Service matrices, based on the OASOC Framework, were developed for three OASOC domains: Prevention, Access, and Recovery and information from the Three-Year Plans and Annual Updates were used to populate the matrix.

Results show that the majority of OASOC prevention services provided in participating counties are either inclusive or targeted for older adults. Siskiyou, the smallest participating county, provides all services to older adults through inclusive programs within their adult service system. Of all the prevention services, counties were least likely to provide abuse and neglect prevention and education in the system and least likely to have community mental health consultation targeted for older adults.

The majority of Access services are targeted or inclusive of older adults in the participating counties. Among those counties that provide older adult targeted services, over 80% of OASOC

access service types are targeted for older adults. The one service not provided in the system in two counties is services to people with dementia.

Delivery of Recovery services was varied across the study counties. Two counties provided all or most services targeted for older adults; two counties provide the majority of these Recovery services inclusive of and targeted for older adults; and two counties provided about 70% of Recovery services in the OASOC within their county systems.

Altogether, participating counties provided the highest proportion of older adult targeted services in the *Access* domain and the least proportion of older adult targeted services in the *Recovery* domain. The numbers being served in any of the domains were not able to be discerned due to the planning aspect of the documents. In addition, the publicly available reports alone did not tell the complete story of available services and counties augmented the matrix information. Finally, counties with a designated OASOC provided more service types within the model than those without an OASOC.

Secondary Data Analysis: Selection Process and Analysis Methods

The secondary data analysis includes three categories of documents: 1) evaluation reports commissioned by the Mental Health Services Oversight and Accountability Commission (MHSOAC) and 2) evaluations and reports produced by other governmental, California mental health and/or older adult stakeholder groups; and 3) Three-Year Program and Expenditure Plans and Annual Updates from the six counties participating in the study.

For the Secondary Data Analyses, 100 reports were reviewed, with in-depth analyses completed for 35 reports, as shown in Table 1. Information related to older adult mental health services was extracted from these documents using a systematic approach tailored for each report type as described below.

TABLE 1: Secondary Data Summary: Number of Reviewed Reports versus Analyzed Older Adult Relevant Reports

REPORT TYPE	YEARS	NUMBER REPORTS REVIEWED	NUMBER of REPORTS ANALYZED
Mental Health Services Oversight & Accountability Commission (MHSOAC) contracted reports and evaluations	2004-2015	37	16
Stakeholder reports and evaluations	2000- 2015	7	7
Three-Year Program and Expenditure Plans and Annual Updates	Three-Year Plans FY 2014- 2017 and Annual Updates FY 2015-2016	56	12 (2 per county)
TOTALS		100	35

Specific Methods Utilized for Data Categories

Data Category 1: MHSOAC Evaluations

The Mental Health Oversight and Accountability Commission (MHSOAC) oversees the Adults and Older Adults Systems of Care Act and the evaluation of MHSOAC funded programs and services. The MHSOAC has sponsored a number of evaluations of various aspects of the MHSOAC services and impact. Although these evaluations are not focused solely on older adult services, selected reports provide information that is useful to understanding progress in implementing an Older Adult System of Care (OASOC) since the passage of the MHSOAC in 2004.

The MHSOAC provides 47 research and evaluation documents on their website. These include: reports, training documents, templates, planning tools and appendices that fall into four categories: Documenting Programs and Services, Measuring Outcomes, Ensuring Fiscal

Accountability and Improving Data Quality. The project team reviewed the online evaluations. Excluding from review those evaluations that were specific to children or transitional aged youth, reporting templates and training tools, there were 35 potentially relevant research and evaluation documents selected from the OASOC website. In addition, members of the Project Advisory Committee (PAC) also provided 2 reports for review that were not located on the MHSOAC website, resulting in 37 documents. In total, 16 of the 37 documents (43 percent) provided information that was relevant to older adults (Appendix B).

Reports were analyzed to identify data and findings related to older adult mental health care across counties and throughout the state. The search terms “older”, “elder”, “aging”, “senior”, “OA”, “55”, “60”, “and 65” were used to review each of the 16 reports for findings related to services for older adults. Information about these programs and services and the numbers and proportions of older adults served was extracted from the reports and organized into the following categories:

- Findings about county planning
- Findings on older adult access to mental health services
- Findings on older adults served through Community Services and Supports, Prevention and Early Intervention, and Innovation Funding

Data Category 2: Stakeholder Evaluations

Stakeholder reports and evaluations for mental health services in California were selected based on their relationship to the research question: *What progress has been made at the State and local levels in the past decade toward implementing an integrated and comprehensive system of care for older adults with serious mental health needs?* The decade is defined as the period of time since the MHSOAC passage in 2004. The secondary data filter for the analysis of the reports is relevance to service system development for older adults with or at risk of mental illness. In addition, a number of reports were reviewed because they provided important context or policy environment background for the development of such a service system. The data described in this section is either singularly documenting OASOC, or contains within the report substantial content related to issues relevant to the OASOC. The authors of these reports are predominantly representing an external review perspective. We also note reports that do not include identification of the older adult population in their MHSOAC analysis. The assessments were analyzed in chronological order to add to longitudinal understanding of the context of development of an OASOC in California.

Data Category 3: Three-Year Plans and Annual Updates

Welfare and Institutions Code Section (WIC) §5847 requires that counties receiving MHSA funds submit *Three-year Program and Expenditure Plans* and *Annual Updates* to those plans. These reports describe planned and implemented programs and services that are provided through MHSA funding components^a

The initial purpose of the review of annual updates and plans was to 1) assess proportion of older adults served in our participating counties over time 2) to determine whether the service strategies necessary for an OASOC are currently provided and targeted for older adults (OA) and 3) to determine whether publicly available annual updates and three year plans provide adequate information to assess local progress towards an OASOC.

Websites of the six participating study counties (Alameda, Los Angeles, Monterey, San Diego, Siskiyou and Tulare) were searched to locate public postings of their Three-year Plans and Annual Updates. Although plans and updates were not available for all years across all counties via county websites, a total of 56 plans, updates and other MHSA reports were cataloged for the six counties through our search.

After initial review of historical annual updates, it became clear that reliable estimates on the annual numbers of older adults served could not be gathered across counties. This point is further discussed in the findings section. To achieve the other two goals of this part of the secondary data analysis (mentioned above), the most recent available *Three-Year Plan* (FY2014/15- FY2016/17) and *Annual Update* (FY 201/16) from each of the six participating counties were included in the analysis.

The project team developed a service matrix template to guide the analysis of Three-year plans and Annual Updates based on the OASOC Framework (see Figure 1) used in this study. Project staff documented services targeted and inclusive of older adults in each county using the service matrix template developed for this purpose (Appendix C). Using the template, data was pulled from the descriptions of programs and services reported by counties. The twelve reports, (6 plans and 6 updates), were reviewed twice, first reviewing sections of the reports explicitly relevant to Older Adult Services (e.g. Older Adult FSP) and then again using the search terms “older”, “elder”, “aging”, “senior”, “OA”, “55”, “60”, “65”, to make sure that services provided to older adults in general programs were not overlooked.

^a MHSA components include Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation Projects (INN), Work force Education and Training (WET), Capital Facilities & Technological Needs (CF/TN)

Going beyond the secondary analyses of publicly available documents, to assure as complete a picture as possible, each participating county was then given the opportunity to conduct a third and final review of the service matrix in order to provide additional information or edits. The added materials were considered as primary data provided by the counties to supplement information available for the secondary analyses. The study team was interested in documenting the discrepancy between information on services available in the public reports compared to programs and services that were identified by county administration when given this opportunity. Thus, a second type of analyses was completed to illustrate the differences between those materials publicly available and those provided by county administration directly, that were either not publicly available or not readily found by the study team.

Results of the Secondary Analyses Using Data Categories 1 and 2

Using the data extracted from Data Categories 1 and 2, described above, we identified themes that emerged and organized findings within these themes. The ten themes discussed in the report sections below include 1) Background on OASOC Development, 2) MHSA Overview: Transforming Delivery of Public Mental Health, 3) Components of MHSA, 4) MHSA Administrative Structure and Oversight, 5) Perspectives on MHSA Implementation, 6) Financing of California's Mental Health Services and the MHSA Contribution, 7) Outcomes Evaluation, 8) Service Delivery, 9) Evidence of Older Adult Services and Care in MHSA Component Evaluations, and 10) Workforce Development.

Background on OASOC Development

The California Mental Health Planning Council (CMHPC) has had a longstanding federally-mandated responsibility to provide oversight for the seriously mentally ill (SMI). The Council has advocated for an OASOC since 1991. In 2003, the OASOC was included in the California Master Plan: A Vision for California. Prior to MHSA in 2004, the Adult and Older Adult Mental Health Systems of Care Act in 1996 outlined treatment for adults and older adults with SMI. However, this was a voluntary service delivery model without mandates or funding attached. The 2004 report reviewed here³ presents the evidence base for the OASOC in California and was used by the CMHPC to develop a framework.

The research was supported over a three-year period with approximately \$5 million dollars from the Substance Abuse and Mental Health Services Administration (SAMHSA), prior to the passage of the 2004 Mental Health Services Act (MHSA). The goals for the study are listed in Table 2, below. Four counties were selected for the study, including both urban and rural representations, for four different regions of the State. All four counties were selected on the

basis of having established an OASOC that was designed to meet their county’s needs. San Francisco County targeted the homeless, Tuolumne County emphasized linkage to primary care practices; Humboldt used teams for outreach to the rural area and Stanislaus utilized a care coordination process across services. The design of the evaluation provided comprehensive oversight activities as well as local data, reports submitted to the Department of Mental Health (DPH) and consumer-level data.

The Council’s report³ provides information regarding the implementation of the project, and evaluation results regarding the extent to which county systems of care (1) implemented system of care components as intended, (2) served the older adult target population, and (3) achieved positive older adult consumer outcomes. It also provides recommendations for future older adult system of care planning. Importantly, it provides definitions, philosophy, values, and comparison of ‘regular’ systems of care and the optimal components of OASOC, and also addresses training issues. This seminal work was the precursor to the OASOC Framework adopted to guide the current project. Many of the lessons learned from the demonstration sites are the solid foundation of the OASOC models presently used.

Table 2: Goals of the Older Adult System of Care Demonstration Project, Fiscal Years 2000 – 2003

<p>Establish Mental Health and Aging : Services Integrated; Agency and Partnership Collaborations</p> <p>Implement comprehensive system or care design and services: Entry/Access; Therapeutic, Recovery and Habilitative</p> <p>Document the trajectory of older adult movement through the levels and types of services</p> <p>Increase the number and diversity of older adults served</p> <p>Demonstrate the substantial need of older adults by presenting diagnosis, functional limitation and outcomes</p> <p>Measure the increases in positive consumer outcomes: Recovery/Resilience; Emphasis on Strengths, Quality of Life, Options and Contributions</p> <p>The research report covered gender/race/ethnicity client representation, diagnosis, functional limitation, medical provider referrals, and individual barriers to services.</p>

The four counties were selected based on the commitment to development of an OASOC prior to the MHSA; thus, it is not representative of the level of development in the years 2000-2003 in the State. It does describe four different models with similarities and differences for accomplishing a robust OASOC. The diagrams for each county that track consumers moving through the system are particularly useful in presenting what different “systems” look like, compared to an enumeration of lists of services for older adults (See Appendix D). This health services research project demonstrates that this degree of accountability and outcome tracking for an OASOC is possible and useful. Streamlining the tracking of outcomes to statewide documentation across counties remains a challenge.

There were three key recommendations from this study:

- 1) Based on the aims and outcomes of the study, the demonstration sites provide evidence for the development of OASOC as adapted by different counties;
- 2) Many older adults presenting with mental health needs may have other social and medical needs, instead or in addition to, behavioral health services; and
- 3) Consider lowering the present age categorization of older adults with mental illness from 60 and older to 55 and older.

OASOC Survey of Counties

In 2002, the CMHPC OASOC Subcommittee, in collaboration with the California Mental Health Director’s Association (CMHDA) OASOC Committee conducted a survey to assess the progress made by county mental health programs in implementing the OASOC model statewide. All counties responded to this survey and fourteen (24%) reported affirmatively to having an OASOC. Several other counties reported they were in stages of development with the vast majority answering “no” to having any OASOC. The following counties, which are included in the current study reported as follows: Two study counties, Los Angeles and San Diego, reported having an OASOC. Four counties, Alameda, Monterey, Siskiyou and Tulare reported not having an OASOC.

The same collaborators conducted a second survey in 2005 with a response rate of 64% (38 counties). At that time, an OASOC was established in only 26% of the responding California counties^b. Using the OASOC Framework, the counties with an OASOC reported the following elements most frequently:

^b *OASOC Survey results provided by the California Mental Health Planning Council*

- Collaboration and partnership across individuals, families, and community systems
- Multidisciplinary teams
- Mobile service delivery
- Outreach

Counties with an OASOC had twice as many OASOC elements as those counties without an OASOC (6 elements, compared to 3). Workforce components were core to providing services to older adults in both counties with and without an OASOC. All counties with an OASOC had clinicians or case managers specifically trained to work with older adults, with 42% of the counties providing needed training on older adults to their service providers. About 25% of counties provided evidence-based programs and had a performance measurement system in place. The same percentage (25%) provided services for clients with both mental health and substance abuse diagnoses. Half the programs had senior peer counseling programs.

MHSA Overview: Transforming Delivery of Public Mental Health

Since its passage in 2004, the MHSA has aimed to transform the delivery of public mental health from predominately providing crisis care to a consumer wellness, recovery, and resilience model. This transformation provided a changed context of care for the continued development of an OASOC. The MHSA seeks to address service needs and make prevention programs available for all age groups, delineating children, transitional age youth (TAY), adults and older adults (also referred to as “seniors”). Excerpts from the MHSA legislation outline its purpose and intent in Table 3 below.

Table 3: Excerpts from the Mental Health Services Act, Revised September 2013⁴
(a) To define <u>serious mental illness</u> among children, adults and seniors as a condition deserving priority attention, including <u>prevention and early intervention services and medical and supportive care</u> .
(b) To <u>reduce the long-term adverse impact</u> on individuals, families and state and local budgets resulting from untreated serious mental illness.
(c) To <u>expand the kinds of successful, innovative service programs</u> for children, adults and seniors begun in California, including <u>culturally and linguistically competent approaches for underserved populations</u> . These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of SMI.
(d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. <u>State funds shall be available to provide services that are not already covered</u> by federally sponsored programs or by individuals’ or families’ insurance programs.
(e) To ensure that all <u>funds are expended in the most cost effective manner</u> and services are provided <u>in</u>

Table 3: Excerpts from the Mental Health Services Act, Revised September 2013⁴

accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

The MHSA focuses on adult and older adult needs specifically. It states that services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria; and that for purposes of this act, seniors means older adult persons. Funding of services, not available from other mental health funding sources, shall provide each adult and senior served with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.

Importantly, the Act recognizes the importance of planning services in accordance with the OASOC and consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers. Table 4, below, shows how the MHSA and the OASOC are synergistic in values.

Table 4: MHSA and OASOC: Consistent Values for Mental Health

- (1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
- (2) To promote consumer-operated services as a way to support recovery.
- (3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.
- (4) To plan for each consumer's individual needs.

Page 5 of the Mental Health Services Act

Components of MHSA

The MHSA aims toward expansion into new service delivery models and to serve diverse populations. The State was clearly required to maintain funding for existing community and clinical mental health services. Some of the services provided through MHSA programs are eligible for federal Medicaid reimbursement and some are not. Consumer, family, and stakeholder engagement is a required component for planning of all services

MHSA funds are distributed to structural types of programs and services commonly known as MHSA components: 1) Prevention and Early Intervention (PEI), 2) Community Services and Supports (CSS), which includes the Full Service Partnership (FSP), 3) Innovation (INN) 4) Capital Facilities and Technological Needs (CF/TN); Innovation (INN); 5) Workforce Education and

Training (WET). A brief description of these five broad categories is provided in the Table 5, below.

Table 5: MHSA Components
<p>1. Prevention and early intervention (PEI): Prevention and Early Intervention services are intended to promote a “help-first” approach in county mental health care. PEI funding is aimed at increasing public awareness about mental health through public education, facilitating access to supports at the earliest possible time for those who may go on to experience mental illness and building capacity for providing mental health early intervention services in the community⁵.</p>
<p>2. Community Services and Supports (CSS): CSS is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component. Full Service Partnerships (FSP) are a part of CSS and are designed to promote a “whatever it takes” approach towards care and recovery for clients with the greatest need.</p>
<p>3. Innovation (INN): Innovation projects are to be developed within communities through a process that is inclusive and representative, especially of un-served, underserved and inappropriately served individuals. MHSA, Part 3.2 INNOVATIVE PROGRAMS 5830, it states that Innovation Programs shall have the following purposes: To increase access to underserved groups; To increase the quality of services, including better outcomes;</p>
<p>4. Capital Facilities and Technology Needs (CFTN): CFTN component works towards the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system.</p>
<p>5. Workforce Education and Training (WET): WET state funds are to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.</p>

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Previous models for the OASOC had not been structured into these MHSAs funded components. The MHSAs components provided new potential building blocks for an OASOC but were not fiscally structured specifically for this population.

MHSA Administrative Structure and Oversight

California has a complex governance structure for public mental health services⁶. The governance responsibility lies with three bodies: Department of Health Care Services (DHCS), California Mental Health Planning Council (CMHPC) and the Mental Health Services Oversight and Accountability Commission (MHSOAC). The latter is an independent agency, funded to oversee implementation and evaluation of MHSAs through the Act.

*A Complex Case : Public Mental Health Delivery and Financing in California*⁶ is a report that discusses the current process for MHSAs program administration. Counties now receive funds directly from the DHCS, with each county's Board of Supervisors having approval of MHSAs spending. The DHCS oversight of Medi-Cal, the Affordable Care Act, dental health, substance use disorder services, long-term care and now public mental health, which is a new, is small piece of this large responsibility. The MHSOAC continues to have a strong role in providing plan oversight, evaluations, outcomes reporting, training and technical assistance to counties, but does not actually approve the plans and reports.

According to the Little Hoover Report⁷, the legislature appropriately empowered the MHSOAC by making it independent, but it still lacks teeth and shares oversight responsibilities for the MHSAs with the DHCS. A recommendation in the report is for the legislature to expand the authority of the MHSOAC. Specially, it should have the authority to conduct up-front reviews of the more controversial preventive programs funded by the Act and be empowered to impose sanctions if counties misspend funds from the Act or fail to file timely reports with the State.

Perspectives on MHSAs Implementation

The secondary analyses included two reports that focused on the implementation processes of the MHSAs since its passage in 2004. The first report, *California Health Care Almanac: Mental Health Care in California: Painting a Picture*⁸, provides an overview of mental health in California using state level data from 2009 to 2010.

Notably the Almanac did not report the data for older adults, except once in a chart on suicide prevalence by age. Suicide for those over 65 years of age in 2010 was 16.8 per 10,000, more than double the rates for adolescents, but slightly lower than for adults ages 45 to 61 at 17.1.

However, in spite of lack of focus on older adults and mental health in California, the Almanac addresses several emerging trends relevant to MHSA and the OASOC. Overall findings for the adult population are relevant to older adults as well: half of adults with mental health needs do not receive treatment, the prevalence of SMI varied by income, with much higher prevalence for low income persons; and Native American, multiracial, and African American populations experienced the highest rates of SMI.

Both national and California policy- related issues specified in the Almanac report are major elements in the environment in which MHSA in California is being implemented and the OASOC is developing. Table 6 lists these recent policy changes, below.

Table 6: National and California Policy Related to OASOC Development
<ul style="list-style-type: none">• The Mental Health Parity Act (2008) and the Affordable Care Act (2010) are expected to increase access to treatment for insured and uninsured Californians with mental health needs.• In 2011, a realignment was legislated, giving counties more money and more responsibility for mental health, substance abuse and criminal justice services.• In 2012, the Department of Mental Health (DMH) was eliminated through legislation and all community mental health services came under the Department of Health Care Services (DHCS). MHSA WET fund administration and management were moved to the Office of Statewide Planning and Development (OSHPD).

Another relevant finding from the Almanac report was that the supply of acute psychiatric beds had declined over the last 15 years in California. The State's bed-per-capita ratio was much lower than the nation's. California would need an additional 1,029 beds to reach the national average of 20.5 beds per 100,000 population. Expenditures for inpatient and residential treatment declined, as expenditures for prescription drugs and outpatient care increased as a percentage of total expenditures.

The second report included in the secondary analyses that addresses MHSA implementation processes and progress is the Little Hoover Report⁷. The Little Hoover Commission, an

independent State oversight agency since 1962, also had produced MHSA reports in both 1991 and 2000. To frame the background for their report at this time, the Commission wrote:

“California recently marked the 10th anniversary of a landmark mental health ballot initiative that promised additional help for the severely mentally ill and bold new programs to emphasize prevention and early intervention. The Mental Health Services Act – or Proposition 63 – won a majority vote in November 2004 with promises of fewer mentally ill Californians on the streets and in jail, better community-based care and strict oversight of spending. (January 27, 2015)”

The MHSA provided an exceptional legislative opportunity, but progress toward improved approaches to service delivery and measurement of outcomes has not been accomplished system-wide. The impetus to accomplish change embodied within the MHSA was met with impediments internally, within the bureaucracy; as well as externally, within the economic context. These in turn impacted the development of OASOC and documentation of its level of achievement. The barriers have been in the larger economy, the changes in healthcare legislation nationally, state and county bureaucracy and within the MHSA itself. Key barriers discussed in the Little Hoover Report are listed in Table 7.

Table 7: Little Hoover Commission Report Identified MHSA Barriers (2015)
undefined roles and responsibilities in management and oversight
lack of coordination
staggered implementation
lack of impact evaluation processes and outcomes

Financing of California’s Mental Health Services and the MHSA Contribution

The Arnquist and Harbage report⁶ is comprehensive and provides a perspective on MHSA funding and the resources available for the OASOC. The federal, state and county governments all have a role in the California funding for mental health services. Delivery of all services is at the county level, with the state role being focused on oversight and the federal focus on Medicaid guidelines for care. Since 2011, no general funds from the State have been directed to mental health. Of a \$7.76 billion budget in FY 2012-13, MHSA contribution was \$1.4 of that total. The Criminal Justice System was \$2.0, Realignment \$1.94, the Federal Medi-Cal was \$1.67.

Though the MHSA is not the largest source of county mental health funding, it is the largest funding source for counties to provide non-Medi-Cal community mental health services. MHSA annual revenue —more than \$1 billion — represents about one-quarter of all counties’ mental health funding combined. Between 2006 and 2012, county administered mental health services main increase in funding was through MHSA. MHSA boosted the increase for county spending to 30%, versus only 6% without it. Since the 2004 MHSA passage to 2014, more than \$13 billion dollars in tax revenues have been moved into MHSA funds⁷.

The proportion of MHSA revenue each county receives is based on a formula that takes into account each county’s total population, proportion of households with incomes below 200% of the federal poverty level, proportion of uninsured residents, and prevalence of mental illness. The funding is income, not age based. The result is adjusted based on cost of living and available resources. Small counties with fewer than 200,000 residents each receive a set minimum payment per county.

The MHSA goal was to transform public mental health from predominately providing crisis care to a consumer wellness, recovery, and resilience model. The MHSA makes specific mention of children with Severe Emotional Disturbance (SED) and adults with Serious Mental Illness (SMI). Additional specific MHSA funding has been dedicated to children and transition aged youth services (TAY). It further specifically mentions adults and TAY who are “unserved, underserved, or inappropriately served”. This includes the homeless, frequent users of hospitals, or those with a criminal justice history.

Relationship to Federal programs and policies

The decade of MHSA funding included the period of the national “Great Recession”. The Little Hoover report⁷ points to the severe budget cuts during the Great Recession that diminished state and county revenues. The MHSA funding stream, which was aimed to enhance and build programs, was instead often used to sustain the community mental health programs and infrastructure.

During the time of the enactment of the MHSA, the Mental Health Parity Act (2008) and the Affordable Care Act (2010) were also enacted by the federal government. These laws have increased access to treatment for insured and uninsured Californians with mental health needs. Ensuring access to coordinated mental health and physical health services is imperative to improving population health outcomes, particularly for the older adult population. A central

theme of federal health reform is promoting such coordination by aligning financial incentives. California is expanding coordinated care throughout its health systems, with many pilot projects being implemented to increase integration of primary care and mental health services.⁶

Additionally federal funding came from block grants for Substance Abuse and Mental Health Services Integration. Under the ACA in 2014, health plans participating in California's Health Benefit Exchange must cover 10 Essential Health Benefit categories, including mental health and substance use disorder services. These services must be provided at parity with medical and surgical benefits, in accordance with the 2008 federal Mental Health Parity and Addiction Equity Act⁷.

Outcomes Evaluation

According to the report by Arnquist and Harbage⁶, a major concern with evaluating the impact of MHSA, as well as with many county-based health and social service programs, is that comparisons and outcome reporting for analysis are not systematically available across the State. The bodies charged with oversight do require statewide standardized reporting and outcome measurement system, including payers and programs. In 1991, the realignment law "mandated the creation of a statewide system for measuring and tracking community mental health system performance toward client outcome goals and cost effectiveness". Still no performance measurement or accountability system has been uniformly adopted and made available to the public.

Currently, service utilization data and client outcomes is submitted to the State and stored in the electronic Client and Service Information (CSI) system. These data could provide a comprehensive tracking of each county and cumulative data across the state for elements of mental health service delivery. The Steinberg Institute⁹ recently reported that state level outcomes for MHSA, even though this data is collected by the State, has not been used for this purpose routinely. According to the authors of the report, data is not systematically used to provide transparent information for decision making and planning. Barriers to better use of the data system include inconsistent quality and timeliness of the county-level collected data. However, in 2013, DHCS was developing State regulation regarding PEI and Innovation programs. DHCS has also developed new county performance contracts.

The Little Hoover Commission⁷ also expressed outcome reporting concerns and made several recommendations to strengthen data reporting. Basic quantitative reporting with certainty is needed about how many people received services and what type of service; how many were

served in the geographic areas of the county; and how many people by age, gender, race, ethnicity, socioeconomic status were served. Of special consideration are the State's rural counties with populations of 200,000 or less. These counties present distinct challenges in implementing the MHSAs. Smaller counties generally face staffing and other challenges.

Service Delivery

Planning

The MHSAs mandate the county to involve consumers, families, and other stakeholders in a three-year planning process to set local priorities for MHSAs funds. As a result of this emphasis on community goals, there is great diversity in MHSAs programs. Based on a statutory change in 2011, the only review and approval of the county plans that is required is by the county's Board of Supervisors⁶.

One report¹⁰ looked at the counties process for Community Program Planning (CPP). CPP "refers to the structured process implemented by counties in partnership with stakeholders to determine appropriate uses for available MHSAs funds"(pg 12). Their investigation found that seniors and veterans were among the least common stakeholder groups that took part in the CPP process. The majority of CPP participants identified as English-speaking, white female adults between the ages of 25 and 59.

Access and Penetration

In order to provide a comprehensive analysis of the progress of MHSAs in developing an OASOC, it is important to describe access to services among older adults over time. Access is one of the four domains of the OASOC Framework (see Figure 1) and is especially important because of the significant difficulties that older adults experience seeking and accessing services¹¹.

Table 8, adapted from the Arnquist and Harbage report⁶, provides valuable secondary data all California counties, with the six participating counties in our study selected for presentation here. While it does not delineate MHSAs only funds, it provides penetration rates for Medi-Cal mental health services as provided under the State's Medi-Cal Specialty Mental Health Services (SMHS). Older adults utilize 6% of the \$22.2 billion of SMHS funds. It is presented here as an example of recommended data collection by age category and penetration rate that could be generated for MHSAs funded programs. Medi-Cal Mental Health Managed Care, established in 2015, to deliver SMHS is another major change in the delivery environment of MHSAs since its

inception. Medi-Cal contracts and plans for medical care compared to delivery of mental health vary significantly and are described in the report, but is beyond the scope of this review.

Table 8: Mental Health OASOC Selected Counties: County Comparison of Medi-Cal Specialty Mental Health Services (SMHS) Expenditures and Penetration Rates, by Age Group 2011

	age 0–5			age 6–17			age 18–59			age 60+		
	Number Served	Penetration Rate*	Average Payment	Number Served	Penetration Rate*	Average Payment	Number Served	Penetration Rate*	Average Payment	Number Served	Penetration Rate*	Average Payment
STATEWIDE	26,051	1.75%	\$3,797	167,626	7.52%	\$6,342	224,317	7.37%	\$4,164	39,270	3.42%	\$3,170
Alameda	1,387	3.17%	\$7,740	7,966	12.33%	\$8,433	12,058	11.43%	\$5,195	2,003	3.95%	\$4,020
Los Angeles	10,260	2.32%	\$4,056	58,337	8.14%	\$8,049	65,124	6.85%	\$4,583	13,916	3.41%	\$2,892
Monterey	401	1.74%	\$5,811	1,412	5.15%	\$6,289	2,346	5.88%	\$6,464	281	3.00%	\$6,738
San Diego	1,795	2.01%	\$1,676	11,141	8.70%	\$4,347	16,045	9.67%	\$2,756	2,528	3.50%	\$2,149
Siskiyou	40	2.32%	\$4,580	351	13.14%	\$9,447	603	11.88%	\$3,911	84	5.22%	\$3,162
Tulare	293	0.81%	\$2,969	3,978	7.35%	\$5,654	2,699	3.90%	\$4,200	294	1.95%	\$3,273

Source: A Complex Case: Public Mental Health Delivery and Financing in California, 2013

A series of reports produced from research conducted by the UC Davis Health System Center for Reducing Health Disparities presents findings regarding access to care among older adults at both the state and local levels^{12–15}. These reports capture facilitators and barriers to access for the older adult population, and provide quantitative data on the demographics of populations served through CSS services. Older adult related findings are presented below.

In one of the studies¹³, findings were reported from focus groups conducted with several key stakeholder groups including 22 older adults receiving services in San Diego county. Their goal was to answer three primary questions: 1) How has the MHSA helped to address and reduce health disparities for un(der)served groups? 2) What are the most common barriers to the effective delivery of mental health care for un(der)served groups in California? In what ways has MHSA helped to mitigate these barriers, and what problems still persist? 3) What are the current gaps and persistent issues for un(der)served groups? Table 9 below summarizes the older adult focus group findings on facilitators and barriers that they believed helped reduce their disparities in access:

Table 9: Facilitators and Barriers to the Delivery of Mental Health Services: responses from older adult focus group - San Diego (Deliverable 2c)

Facilitators that help reduce disparities in mental health services	Barriers to delivery of mental health services
PEI and FSP Programs	Inadequately trained staff for older adults with comorbid conditions
Stigma reduction efforts	Medi-cal eligibility and out of pocket costs
Peer support services	Transportation
Outreach to hard-to-reach groups	Difficulty with understanding the enrollment process
Community involvement in service development	Limited English proficiency or low literacy
	Vicarious Trauma
	Poverty
	Physical Pain
	No knowledge of services

Source: Evaluating the Impact of the Mental Health Services Act on Reducing Disparities in Access - Deliverable 2c

A second report in the UC Davis Health System series¹², provided longitudinal county-level estimates of the proportion of older adults served and estimated need for services from 2005-2012. Estimates were calculated using data from the CSI System, the California Health Interview Survey (CHIS) and the U.S. Census American Community Survey (ACS). The CSI system data reflects both Medi-Cal and non-Medi-Cal clients. CHIS data assesses the need for mental health services through a combination of distress and functional impairment measures. The ACS provides population estimates by geography and various demographics. The report focused on clients enrolled in CSS, including FSP, GSD and other subcategories of CSS programs that vary by county. Clients whose information is entered into the CSI System is a subset of the older adult population served through MHSA funding and represents those that have been diagnosed with SMI, in addition to other mental health clients.

This research found the largest disparities in access to mental health services among adults and older adults. When looking at the older adult population by age groups, the younger older adults (ages 60-64) had the best relative access to mental health services compared to older

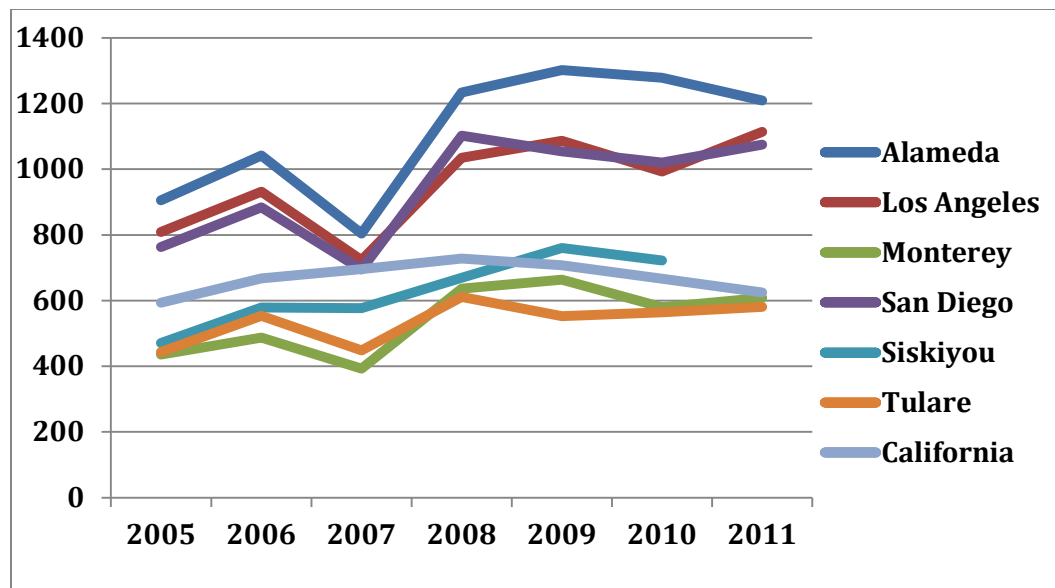
age groups 65 and above¹². Although the authors note that one reason for this trend could be the transfer of patients to Medicare providers working outside the county system.

Figure 3 below present the data for the six study counties and the State as a whole. In terms of the proportion of older adults served at the local level, study counties (Alameda, Los Angeles, Monterey, San Diego, Siskiyou and Tulare), as well as the State, served the highest proportion of older adults (per 100,000 population) in 2008 and 2009, compared to all other years between 2005 and 2011. Proportions were used in this research, as opposed to percentages, because researchers wanted to “normalize” the data. They used the following equation to calculate this rate specific to each sub population:

$$(\# \text{ of older adults served in year } x / \# \text{ of older adults in the population in year } x) * 100,000 = \text{proportion served per 100,000 population.}$$

Normalizing data adjusts for sub-population growth and decline over time. This allows for a comparison among subgroups (between older and younger populations) and between years. According to the report, the proportion of older adults served in our study’s **participating counties** has increased since 2005 (Figure 2) suggesting an improvement in reaching older adults over time. The **State**, however, did not experience this same level of success; the proportion of older adults served by California is roughly the same in 2012 as it was in 2005.

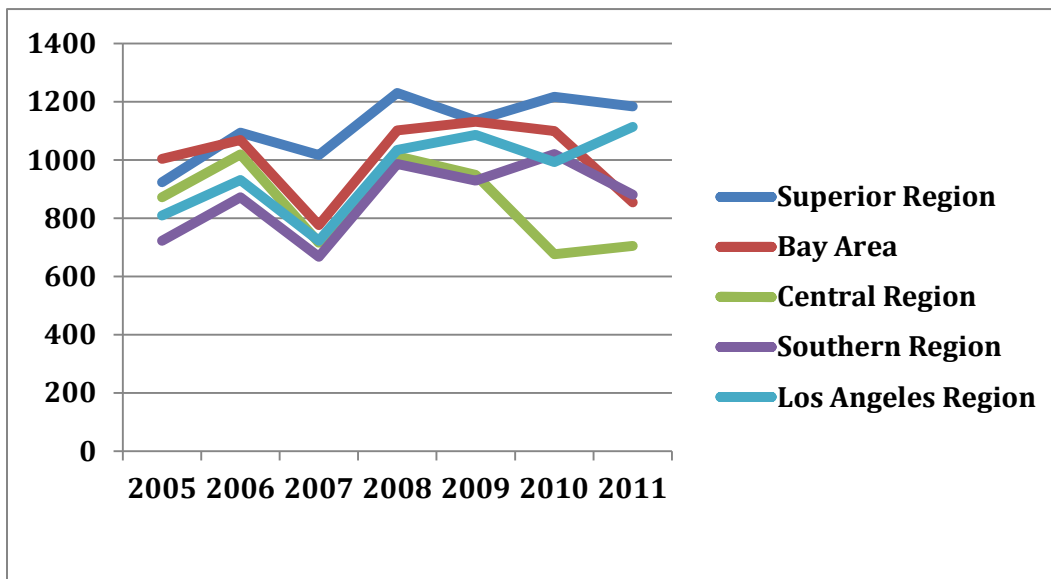
Figure 2: Trends in Proportion of Older Adult Clients served through Community Services and Supports, per 100,000 population in participating counties 2005-2011



Source: Aguilar-Gaxiola, Analyzing the Impact of the Mental Health Services Act on Reducing Disparities in Access - Deliverable 1aⁱⁱ

Examining the proportion of older adults served by region sheds some light on why State estimates did not improve over time on the State level (Figure 3). While there are likely additional explanations, it is also clear that the proportion of older adults served over time has declined in the Bay Area and Central Regions but has increased in the Superior, Southern and Los Angeles Regions (Figure 4). This simultaneous rise of proportion of older adults served in some regions and decline in others has likely resulted in little to no increase when looking at the State as a whole.

Figure 3: Trend in proportion of older adults served through Community Services and Supports per 100,000 by region (2005-2011)



Source: Aguilar-Gaxiola, Analyzing the Impact of the Mental Health Services Act on Reducing Disparities in Access - Deliverable 1aⁱⁱ

Although this report also assessed need across the State, it did not provide county level estimates of need by age. Estimates on the prevalence of SMI among older adults by county were difficult to identify in publically available documents. One research effort¹⁶, used census data and the Collaborative Psychiatric Epidemiology Surveys (CPES) to indirectly estimate^c county level prevalence of SMI by matching on population characteristics such as age, sex, education, poverty, residential status. The CPES incorporates data from three national surveys:

^c Methods found on page 3 <http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf>¹⁶

The National Comorbidity Survey Replication (NCS-R), the National Survey of American Life (NSAL) and the National Latino and Asian American Study (NLAAS).^d

Data in this 2010 report uses estimates from 2000-2002 and unfortunately, did not provide information for adults 60 + (but did report estimates for adults ages 55+). In order to estimate cases among those 60+, our project team used 2000 census data and the population difference between adults 55+ and older adults 60+ to indirectly estimate the proportion of older adults (60 +) with SMI. The proportion of older adults 55+ with SMI was calculated with the same methodology^e used to calculate the proportion of older adults 60+ served through CSS (last column).

Table 10 characterizes relative need versus service delivery for older adults at state and local levels for the six study counties. The study team developed this data table from three sources, the Census^{17,18}, UC Davis Center for Reducing Health Disparities –Deliverable 1aⁱⁱ¹² and the report on California SMI estimates¹⁶. Table 10 shows that the State and participating study counties served the highest proportion of older adults in 2008 and 2009, relative to other years between 2005 and 2012. The last column presents this data from 2008 or 2009, depending on which year the county or state served the highest proportion of older adults. The purpose of presenting the year that the highest proportion of older adults were served is to show the gap in estimated need compared to the proportions of older adults served in the year where services to older adults is at its peak. Although there are limitations to interpreting the data, in general, in years where the state and counties served the highest proportion of older adults, there is still significant unmet need. This disparity is most pronounced in Monterey, Siskiyou, Tulare and the State as a whole.

This table should be interpreted with care. One limitation is that the proportion of older adults 60+ with SMI is estimated for is for the year 2000. We assume that current need is greater. It is estimated that the number of people older than 65 years with psychiatric disorders in the United States will increase from about 4 million in 1970 to 15 million in 2030¹⁹. However, the proportion of older adults served in California and participating counties has declined after 2008-2009¹².

^e pg 11 Deliverable 1aⁱⁱⁱ UC Davis Health System: Center for Reducing Health Disparities¹²

Table 10: Local and state estimates on the proportion of older adults with SMI & served through CSS

Participating Counties & State	2000				Proportion of Older Adults 60+ Served through CSS (per 100,000 population)
	Population 55+	Cases SMI 55+	Proportion of Older Adults 55+ with SMI (per 100,000 population)	Proportion of Older Adults 60+ with SMI* (per 100,000 population)	
Alameda	260,456	6421	2465	1848	1302~
Los Angeles	1,622,893	46569	2870	2181	1087~
Monterey	68,739	1817	2643	2023	664~
San Diego	518,416	14086	2717	2118	1102^
Siskiyou	13,199	441	3341	2626	760~
Tulare	61,823	2135	3453	2648	611^
CALIFORNIA	6209751	176,186	2837	2168	728^

~2009 data, ^ 2008 data;

Sources: Analyzing the Impact of the Mental Health Services Act on Reducing Disparities in Access – Deliv. 1a1i, Census estimates 2000, California Prevalence Estimates, Task Team: HSRI, TAC, Charles Holzer

Evidence of Older Adult Services and Care in MHSA Component Evaluations

MHSOAC contracted evaluations about PEI; Innovation (INN); and CSS, which includes the FSP programs. A number of these contracted projects included information relevant to older adult mental health care and were included in the secondary data analysis. These findings are summarized below.

Prevention and Early Intervention funded services for Older Adults

Prevention is an important part of the OASOC framework and understanding how PEI programs are provided to older adults can help characterize the progress towards the development of an OASOC. There were four contracted evaluations analyzed in the secondary data analysis relevant to PEI funded services for older adults. These reports presented results from the evaluation of PEI plans, reported PEI services and the effectiveness of evidence base practices for older adults covering the years of 2008-2014.

The California Department of Aging (CDA) conducted a systematic review of 51 MHSA PEI Plans that had been approved by the MHSOAC and three PEI Plans that had been submitted for

approval as of February 26, 2010²⁰. CDA's goal was to determine the degree to which older adult mental health PEI services were being funded and implemented. Of the 53 plans reviewed, CDA found that as of 2010, 42% of county PEI plans (22 counties) had at least one older adult specific program, 79% (42 counties) had multi-age programs that included older adults and 13 % (7 counties) had no older adult specific or inclusive PEI programs in their plans. All those with no PEI programs for older adults were small counties. County specific findings are presented in Appendix E.

A second evaluation led by UCLA researchers (2011)²¹ also examined PEI services by looking at intended outcomes in three-year plans and annual updates from 37 counties during implementation periods FY08-09 and FY09-10 (reporting years FY10-11 and FY11-12). The team found that of the 37 plans, 15 (or 40%) included intended outcomes for older adults.

A third evaluation conducted by UCLA²² collected data from counties on the population served through PEI funding in FY2011-2012, which reflected services provided in FY9-10. This evaluation reported the proportion of counties providing services to older adults through activities and programs that were defined as follows: **prevention**, defined as activities that intend positive mental health outcomes for individuals at risk of SMI and **early Intervention**, for those that intend positive mental health outcomes for individuals with early onset of a serious emotional disturbance (children/youth) or SMI (adults/older adults). Unlike the CDA evaluation, this UCLA report does not specify whether older adult programs and services were specific for older adults versus inclusive of older adults. Instead, it reports the number of counties that provide prevention and early intervention to different demographic groups. Of the 45 counties that reported providing prevention programs and services, 15 counties (33%) served older adults. Those age 60 and above accounted for 1.5% of those receiving prevention services. Of the 40 counties reporting early intervention services, 32 counties (80%) served older adults. Clients age 60 and above were 13.1% of those receiving early intervention services.

The fourth PEI related evaluation²³ included in this secondary data analysis, examined clusters of counties where specific evidence-based programs were provided to older adults. This research endeavor evaluated the effectiveness of the same PEI programs implemented in multiple counties. The evaluation criteria were specific to reduction of depression, a very common mental health issue for older adults. They found that, on average, IMPACT, Healthy IDEAS, and PEARLS participants moved from the moderate depression range to the mild depression range based on their PHQ-9 scores.

While all of these evaluations provide snapshots of various information related to PEI services for older adults, these reports did not build on one another and therefore it is difficult to paint a cohesive picture of prevention and early intervention for seniors. We can conclude from the CDA evaluation that a large proportion of PEI plans submitted as of 2010 were inclusive of older adults (79%) and 42% were specific for older adults. Data from the subsequent two UCLA evaluations have a much lower response rate than the Department of Aging evaluation, making it difficult to draw conclusions on a statewide level. On the other hand, the fourth cluster evaluation suggests that other counties looking to implement older adult PEI services should consider IMPACT, Healthy IDEAS and or PEARLS, which have all been successful in reducing depression among most older adult age groups and across race/ethnicities.

Community Supports and Services: Full Service Partnerships

Similar to the purpose for reviewing PEI evaluations, reviewing reports that describe FSP services for older adults helps to further characterize the mental health care environment for this population in California. Five reports in the secondary data analysis examined older adult services provided through FSPs, three of which²⁴⁻²⁶ collected data from the State's mandatory client service database systems and two that collected data directly from counties and from their available reports. These documents together are relevant to clients enrolled in a FSP program between FY2004-2005 and FY2011-2012, including outcomes reported through June 2014. Information provided in the following summary of these evaluations can be used to build on for future evaluation of mental health services for older adults.

Between FY2006-07 and FY2009-10, counties reported planned service strategies in 14 categories, three of which are required by MHSA²⁷. Of the counties participating in this study, the highest proportion planned to implement the three required MHSA strategies as well as outpatient services, peer related services and specific positions for clients/family for older adults. The lowest proportion of counties planned to implement evidence-based practices and discharge coordination services for older adults.

Of particular interest are the "Outpatient services" which includes five service types that are part of the OASOC Framework: individual therapy, group therapy, medication support, crisis intervention and crisis management. Although 92.6% of counties reported that at least one of these was planned for older adults, less than half of participating counties reported planned individual and group therapy services. Most counties (76%) reported crisis intervention services.

A second report²⁴ analyzed for this study looked at similar service and reporting years and presented findings related to FSP consumers across the State from FY2004-05 through FY2011-

12. Data for this report was extracted from the State’s Data Collection and Reporting (DCR) System and provides longitudinal information about clients served for twelve “Priority indicators” proposed and defined by the CMHPC.

Of the twelve priority indicators, seven were tracked for FSP consumers by age: “School Participation”, “Employment”, “Homelessness/Housing”, “Arrests”, “Demographic profiles of existing and new consumers” and “Access to Primary Care Physicians”. Of these seven, only three are presented in the table below: homelessness, access to a PCP and proportion FSP consumers that are older adults. Others were omitted due to issues of diminished relevance to older adults.

TABLE 11: Select Priority Indicators for Older Adult FSP Consumers (FY2005-06 – FY2011-12)

INDICATOR	FY	FY	FY	FY	FY	FY	FY
	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
% of New FSP consumers that are OA		17.90%	16.10%	15.40%	15%	14.20%	13%
% of all FSP Consumers that are OA	12.60%	17.80%	16.90%	16.60%	16.60%	16.90%	17.10%
PCP access among OA FSP Consumers	73.30%	67.90%	80.60%	85.10%	90.70%	91.60%	92.50%
Homelessness among OA FSP Consumers	25%	17.60%	11.40%	9.90%	8.70%	8.70%	8.20%

Source: Priority Indicators Trends Report – Executive Summary, UCLA, 2014

There was steady decline of new older adult FSP consumers during the study period, however, there was an increase in proportion of all older adult FSP consumers during this same time period. These trends suggest that older adults may remain in the system longer, which would explain an increase in the representation of older adults in FSPs from year to year. There was also a significant increase (almost 20%) in access to primary care physicians for older adults.

Equally as encouraging is the remarkable decline in homelessness among older adults FSP consumers over time. This 12.8% drop suggests that counties are utilizing FSP funds to assist with and identify housing for older adult mental health clients.

The Steinberg report ⁹ was written by the primary author of Proposition 63 which established the MHSA. This report summarizes publicly available data on MHSA from the FY2011-12, including outcomes reported through June 2014. The report focused on the outcome indicators for over 35,000 clients utilizing services within the FSP program. The report for 2012 and 2013, provides evidence that MHSA is reducing hospitalizations, jail time, out-of-home placement for children, and improving the lives of recipients. This report begins to fill a gap in outcomes measurement for MHSA. It asserts the need for more regular reporting of outcome-based data that the public and State government can rely on for proper oversight of MHSA.

FSPs utilize about 40% of MHSA funding and serve about 35,000 people. These comprehensive services are available for the most complex and high-risk SMI clients, including many who are homeless. The three age groups of adults were: Transition Age Youth (TAY)-ages 16 to 25, Adults- 26 to 59 and Older Adults 60+. For homelessness there was a decrease at discharge from FSP admission respectively of 28%, 54% and 58% for older adults. The Mental Health Act Housing Program was a one-time investment in 2007 for across-the-state development of housing options for persons with mental illness. This project is managed jointly by the DHCS and the California Finance Housing Agency. The majority of housing is still under development. It is expected this project will produce 9,000 units in 157 housing properties.

Other older adult outcomes are:

- Reduction in emergency room visits from 36.5% to 6.2% (82% decrease)
- Reduction in psychiatric hospitalizations from 28% to 14% (50% decrease)
- Reduction in arrests from 8% to 1% (91% decrease)
- Reduction in Incarcerations from 5% to 4% (24% decrease)

Other specific indicators for children are reported, but there are not indicators specific to older adults reported. Outcomes for new programs which comprise 20% of the FSP budget, were not reported by age. Three county examples of these programs were: Urgent Care and Crisis Stabilization, Mental Health Urgent Care Centers, and the Community Crisis Response Team.

FSP programs are reported to have significant cost savings. These are reported by adult age category. This accounting also documents the markedly smaller number of recipients in the

older age population: 2,977 TAY, 4,702 adults and 645 older adults. Older adults only comprised less than 8% (7.7%) of FSP clients. Cost savings were calculated based on inpatient psychiatric hospitalizations, long term psychiatric care, juvenile hall and camp involvement, skilled nursing facilities, emergency room use and jail. The percent of cost savings was 72% for older adults.

The evaluation of FSP reported by Steinberg⁹, for the first time in this depth, presents positive outcomes and few challenges are identified. The data is regularly collected by FSP providers. The authors are committed to working with the California State Legislature and agencies to ensure that going forward there is no question as to the effectiveness of the MHSA FSP program, or the means by which the results are proven.

The final two reports discussed in this section presented findings related to psychiatric and substance abuse related hospitalizations. *Statewide Full Service Partnership (FSP) Outcomes Report*²⁵ queried data from the DCR repository while the UCLA report, *Summary and Synthesis of Findings on CSS Consumer Outcomes*²⁶ conducted a content analysis on 542 documents. Both reports came to similar conclusions about psychiatric hospitalizations among older adult FSP consumers. In general, the conclusion was that participation in MHSA funded CSS and FSP services reduces acute psychiatric hospitalizations among older adult consumers. In FY 2010-11 there was a 9% decrease in older adult partners (clients in FSP) with psychiatric hospitalizations from the year before to the year during partnership, (from 28% of OA consumers to 18.7%)²⁵. This situation improved in the following year (FY 2011-12) with a larger decrease in older adult consumers with psychiatric hospitalizations (from 27.8% in the year before partnership to 14% in the year during partnership). Similarly, approximately 36% of older adult partners reported a mental health or substance abuse related emergency^f in the year before partnership, and this was reduced in the first year of partnership from 34.4% to 10.3% in FY2010-11 and from 36.5% to 6.2% in FY2011-12²⁵.

Innovation Services for Older Adults

Two evaluations included in the secondary data analysis were relevant to MHSA Innovation (INN) funding. The INN component has less specific guidelines compared to other MHSA components. INN projects must be aligned with the General Standards as set forth in Title 9 of

^f A substance abuse related emergency intervention is a substance use problem that results in being admitted to a hospital, treatment by a crisis intervention program outside of the FSP, or FSP staff being called in outside of regular work hours⁴⁰

the California Code of Regulations (CCR), section 3320. These guidelines provide direction with examples while maintaining the spirit of flexibility intended by the MHSA for this component²⁸.

In order to receive INN funding, a county must draft an INN work plan and submit it as part of its Three-Year Plan. The California Department of Aging conducted a review of INN plans submitted to the MHSOAC as of Spring, 2011²⁹. This review was similar to the systematic review of PEI plans conducted in 2010. The purpose of the review was to determine the extent to which the county MHSA Innovation Plan Projects target and/or benefit older adults.

CDA reviewed 36 county plans from 33 counties that included 92 INN projects. Of these 33 counties, 3 had allocated INN funding to older adult specific programs, 19 had multi-age programs that included older adults and 7 counties had not allocated any INN funding for either older adult specific nor older adult inclusive projects. In 18 counties where there were multi-age programs inclusive of older adults, CDA also collected information on the proportion of funds allocated to older adults, which ranged from 3.2% to 25.7%. The majority of the counties providing multi-age Innovative programs allocated between 11-15% towards older adults. Appendix F, presents results from the CDA review by county.

In 2015, the California Institute for Behavioral Health Solutions released an inventory³⁰ on INN plans based on a two-step data collection process to: 1) verify planned, in progress, and completed INN Projects and 2) gather information on the confirmed INN Projects and evaluations through surveys. They collected data from 52 counties regarding 166 projects from 2014-2015. Based on these results, only 4 counties had older adult targeted projects. The results were not presented in a way that our project team could discern programs that may have been focused on multi-age and inclusive of older adults across all counties.

INN funding provides an excellent pathway for counties that do not currently target older adults to pilot older adult specific services. In their 2011 INN report, the CDA commented, “older adult specific programs best promote Older Adult System of Care development” (CDA²⁹, pg. 4) Unfortunately, the INN evaluations analyzed here suggest that there has been no significant increase in counties providing older adult targeted INN programs. Future INN evaluations should build on current evaluations so longitudinal information about progress can be more easily assessed.

Workforce Development

The MHSA recognized that workforce development was necessary to provide comprehensive and high quality mental and behavioral health services so a WET component was included in the Act.

In 2008, the DMH released a five-year WET development plan (2008-2013), which discussed the need for technical assistance and training related to needs of older adults and presented an action item for funding portions of residency programs that focused on geriatric psychiatry³¹. Not long after, in 2010, the CMHDA released an issue paper “Mental Health & Aging Workforce Education Training: Recommendations to Promote Planning, Funding, Implementation and Oversight”. Table 12 presents key recommendations. This issue paper was developed out of concern that county WET plans may not focus on mental health and aging education and training and that the aforementioned Five-year Plan did not promote secondary education to promote geriatric-trained mental health specialists across disciplines. The CMHDA report provided background as to the importance of an older adult specialized workforce in mental health care. It also delineated the MHSA policies that support such an effort, and provided examples of geriatric-related education and training initiatives in different counties. CMHDA highlighted a series of recommendations to develop a mental health practice workforce adequately trained to provide services to older adults³². As shown in the text box below, these included local and statewide recommendations as well as creating the capacity to maintain the workforce development efforts.

Table 12: CMHDA Mental Health & Aging Workforce Education Training: Recommendations to Promote Planning, Funding, Implementation and Oversight
County mental health departments work internally to identify age-specific training needs among workforce
Counties work collaboratively with system partners to provide older adult mental health training and education
Create a statewide clearinghouse of older adult mental health education and training resources
Fund a specialist that would promote the planning, implementation and oversight of geriatric focused education and training at the local, regional and state levels

In 2012, oversight of WET programs was transferred from DMH to the Office of State Health Planning and Development (OSHPD). More recently OSHPD released the next five-year plan, which built on DMH’s report from 2008. They also produced additional reports that evaluated

the status of WET programs and workforce education and training needs and capacity in California³³⁻³⁸. Older adult stakeholder input was included in this report series. Key findings and recommendations related to workforce development for older adult mental health care: there needs to be an increase in financial incentives for students interested in older adult populations, geriatric psychiatry is one of the hardest to fill and retain specialties and few professionals that provide care for older adults have received education in both mental health and geriatrics. These reports include data specific to some counties and county size related to geriatric trained workforce.

An Issue Brief produced by the California Geriatric Behavioral Workforce Coalition in 2013 is not focused specifically on the MHSA OASOC paradigm but rather more broadly on the severe lack of qualified health professions in California to meet the needs of older persons with mental illness³⁹. It builds on data from other recent reports (most from 2011 to 2013).

The foundation for need to develop a geriatrically-prepared behavioral health workforce in California is built on two major factors. First, the demographic. California has the most persons over 65 years of age (4.4 million) in any state, and that population is growing at a faster rate than any other state. California's large older population is also the most diverse. Secondly, the prevalence of 20% of older adults having a mental health disorder, which is broadly defined and includes SMI and substance abuse. Dementia is an additional condition impacting 6% to 10% of persons over 65. Additional evidence of need for geriatric behavioral health providers are the California suicide rates. These climb from 15.7 per 100,000 persons for those 65 to 84 years of age to 22.8 for those age 85 and over³⁹.

The Issue Brief recognizes that older persons present mental health issues to the primary care physician. A chart is presented which depicts the declining number of geriatricians. Other issues, such as the expected future demand for nurses, social workers and psychologists with geriatric training are enumerated. Additionally the crisis in recruiting and training direct care workers is made clear from the work of the Eldercare Workforce Alliance.

The recommendations are highly relevant to the MHSA funded services and the OASOC which aims to increase the early intervention and case finding for older persons with symptoms of behavioral health problems. The most salient "calls to action" are consolidated here:

- Direct the appropriate California agency to coordinate state and local efforts to develop and, coordinate data collection and reporting for geriatric mental health and substance abuse workforce education and training

- Ensure that all state agencies - including CDA, DHCS, BHCS, DPH, OSHPD, and the California Mental Health Planning Council - assume responsibility for building the capacity and facilitating the deployment of the geriatric mental health workforce for older Californians.

A critical additional aspect of workforce not addressed in the Issue Brief is the imperative for an increase in the number of geriatric psychiatrists across the State. There is a dramatic national urgency for this level of expertise for the complex medical needs of older persons with both medical and mental health symptoms, especially as it pertains to medication management for older adults. The need to consider the distribution of geriatric professionals across the state, both urban and rural is not a specific recommendation³⁹.

Workforce development was identified as a problem to be reckoned with by Steinberg⁹ at the time of the passage of the MHSA. At that time there was a 20 to 25% vacancy rate in mental and behavioral health positions across the State. Vacancies are higher in rural areas. Efforts began in FY 2008-2009 to increase recruitment to careers in mental health for social workers, nurses, MFTs, and clinical psychologists. Based on the more recent reports, and the concerns with WET plans, workforce development to serve older adults with SMI, is still a critical issue.

Results of the Secondary Analyses Using Data Category 3: Assessing the Older Adult Systems of Care in Study Counties

As described in the Data Category 3 Methods Section, the study team designed a service matrix template to extract data from the three-year plans and annual updates of the 6 study counties (Alameda, Los Angeles, Monterey, San Diego, Siskiyou and Tulare). The service matrices developed for the study for the six participating counties were analyzed with two purposes in mind: 1) to determine whether the service strategies necessary for an OASOC are currently provided and targeted for older adults and 2) to determine whether publicly available annual updates and three year plans provide adequate information to assess local progress towards an OASOC.

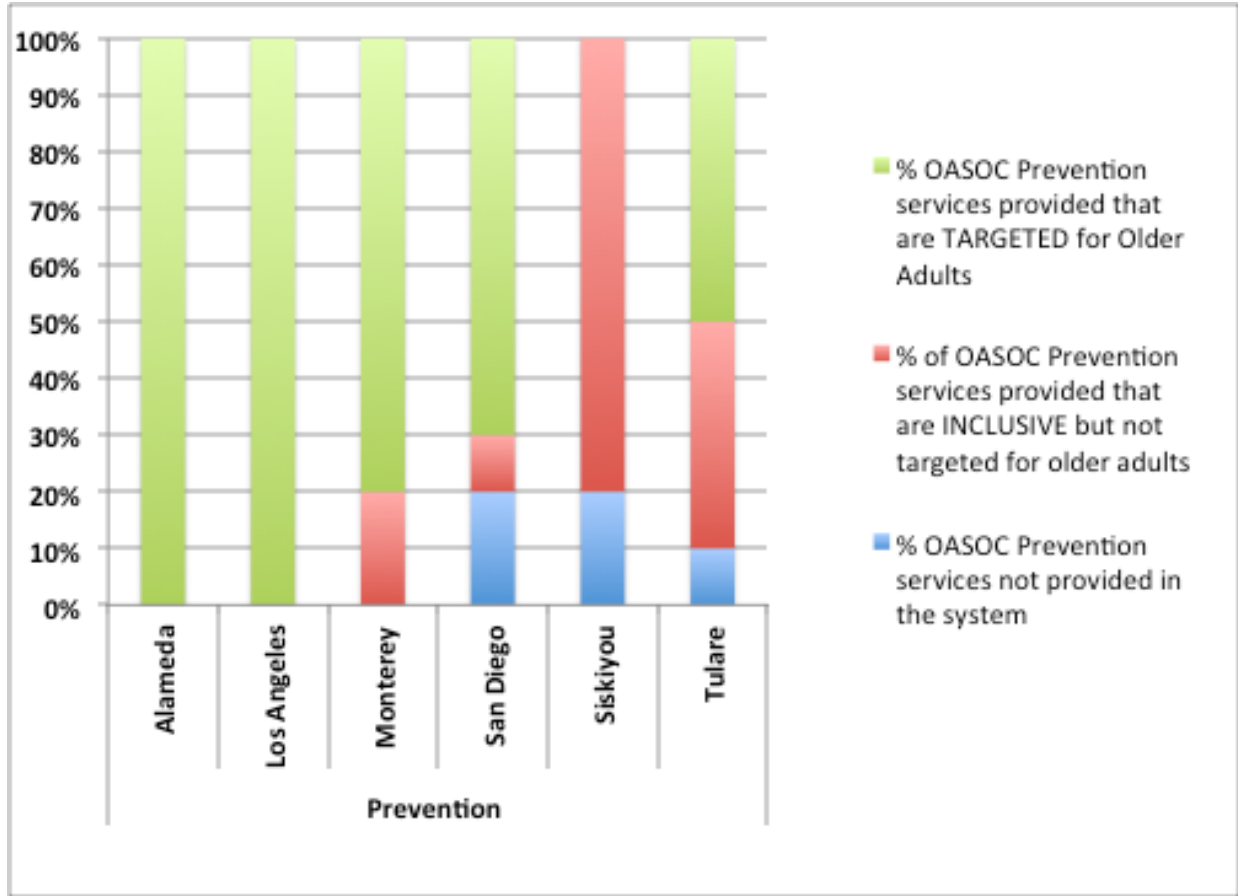
These matrices were based on the OASOC Framework, which includes four domains: Prevention, Access, Recovery and Service Integration (see Figure 1). Only three of these four domains are examined in the findings below: Prevention, Access and Recovery. The fourth

domain, Service Integration, is also an essential part of a system of care but was intentionally left out of the analysis because it is defined as a process as opposed to a category of service type, and therefore not well suited to examine using the same methodology. In this case, “targeted” means that the program or service is specific for older adults or includes a component that is specific for older adult needs.

Information from the final matrices was translated into several data tables to examine the proportion of OASOC service types that were targeted to, or inclusive of, older adults; and to quantify the discrepancy between what the project team could identify through public reports and what counties identified as services provided. The project team felt it was important to document, from a secondary data perspective, what was publicly available. However, the team also wanted to provide as full a picture as possible of available services in the study counties. Thus, as described in the Methods section, we sent “our” version of the matrix out to the county liaison for the study, inviting their review. The information provided external to our review is considered primary data, not a component of the secondary review.

The findings of the matrix analysis are presented in six figures below. Two figures are presented for each OASOC Framework domain. The first in each sequence (Figure 4a, 5a, 6a) shows show the proportion of OASOC service types that are older adult targeted, older adult inclusive or not found in the county system. The second figure (4b, 5b, 6b) for each domain shows the proportion of older adult targeted and inclusive services that project team could identify, versus what was added by County administration in their review of the matrices.

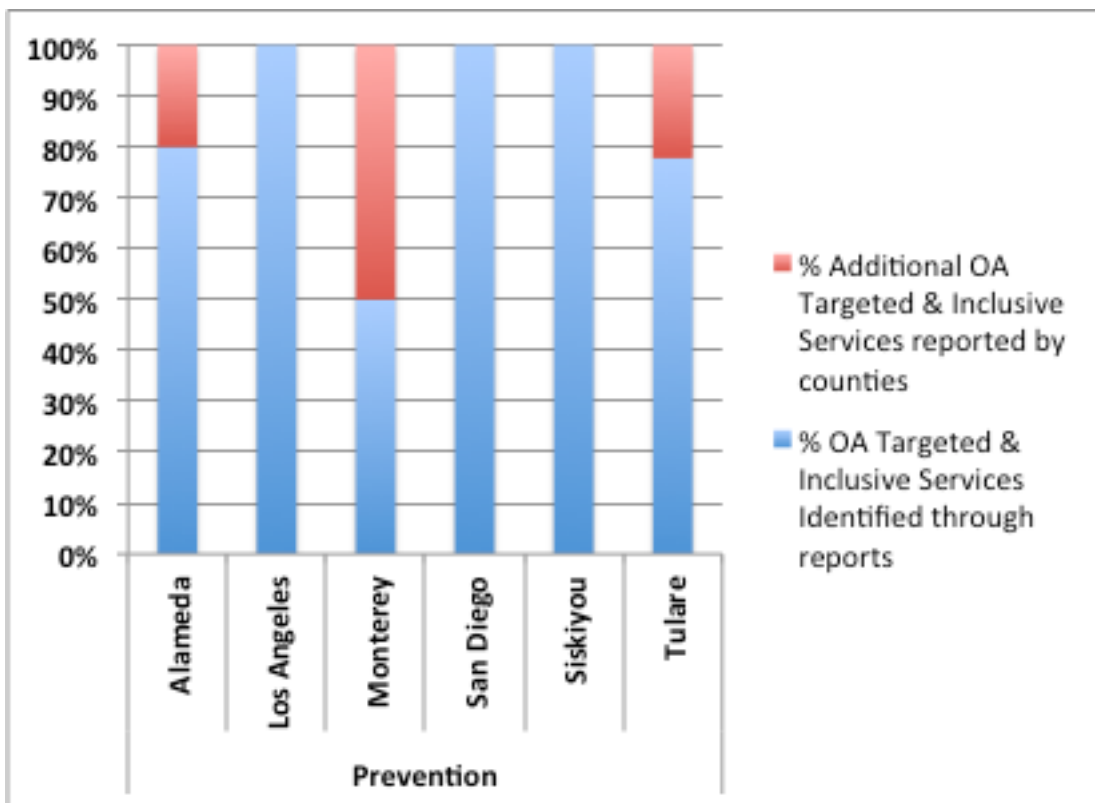
Figure 4a. Proportion of OASOC Prevention Services – Targeted or Inclusive of Older Adults by County (FY15-16)



The Prevention domain of the OASOC Framework includes 10 service types: *early detection and prevention, suicide prevention education and training, behavioral health screenings (biopsychosocial, drug/alcohol/depression), community mental health consultation, anti-stigma and discrimination education/training, community education & training, abuse and Neglect prevention & education, senior peer counseling, information and referral community resources, physical health promotion and wellness programs (e.g. nutrition, physical fitness, chronic disease self-management).* Results show that the majority of OASOC prevention services provided in participating counties are either inclusive or targeted for older adults. Siskiyou, the

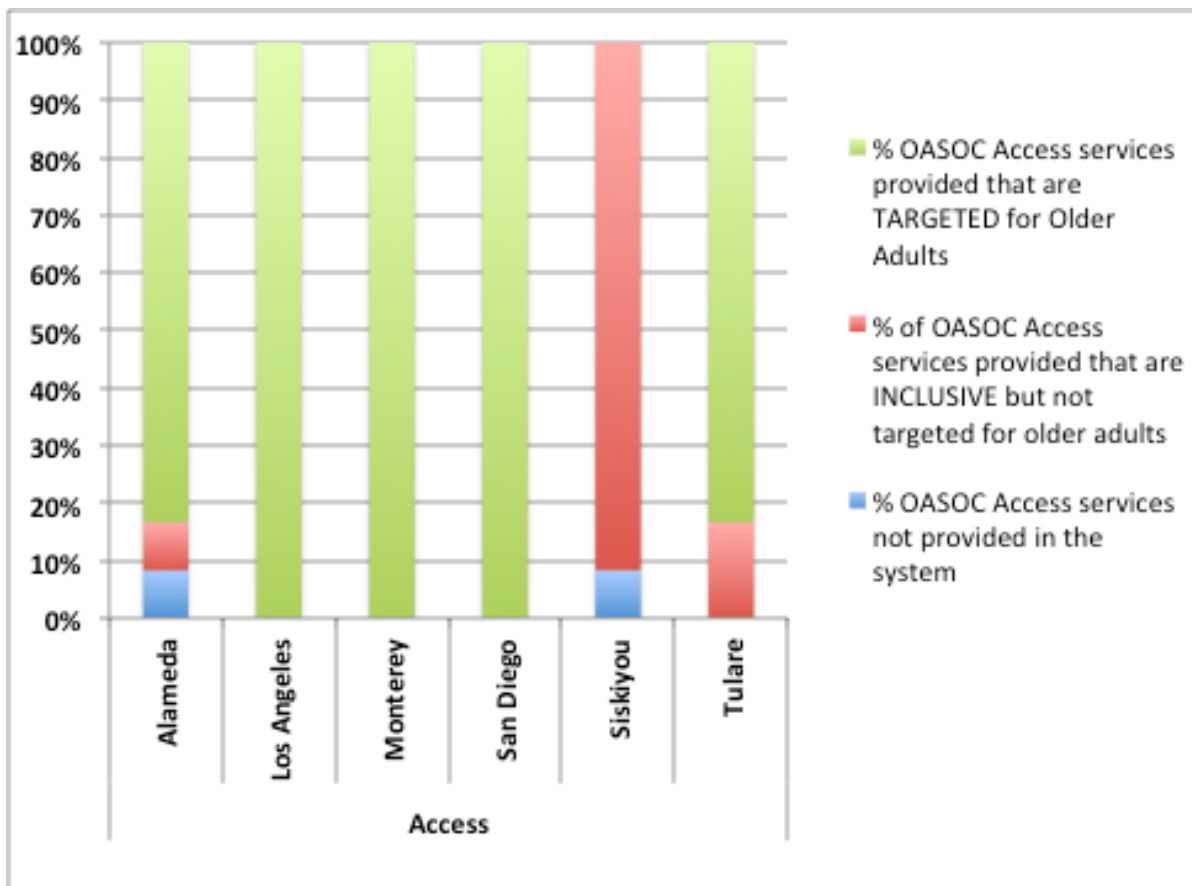
smallest participating county, provides all services to older adults through inclusive programs within their adult service system. Of all the prevention services, counties were least likely to provide abuse and neglect prevention and education in the system and least likely to have community mental health consultation targeted for older adults.

Figure 4b: Proportion of Older Adult (OA) Targeted & Inclusive Prevention Services Identified in Annual Updates (FY15/16)



The project team was able to identify all older adult targeted and inclusive service types provided from the Los Angeles, San Diego and Siskiyou Annual Updates and most in Alameda and Tulare. Only half of these services provided by Monterey could be identified through the publicly available reports.

Figure 5a. Proportion of OASOC Access Services – Targeted or Inclusive of Older Adults by County (FY15-16)

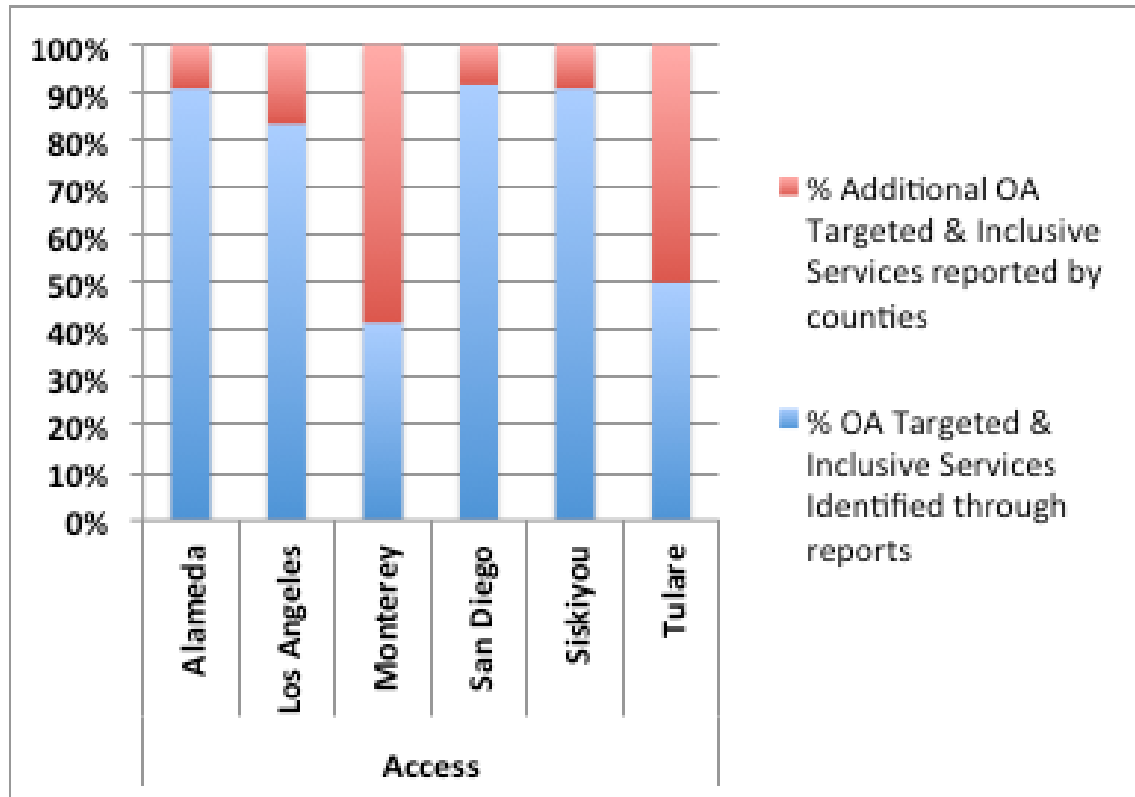


The Access domain of the OASOC Framework includes 12 service types: *outreach services, mobile-based outreach, clinic-based outreach, transportation, advocacy (E.g. peer, benefits, access, etc), advocacy for underserved groups, linkages to health services, initial screening and assessment, family/caregiver collaboration and support, services to persons with limited cognitive ability/dementia, services to meet needs of physically disabled, services to persons with limited or no English language proficiency.*

The majority of Access services are targeted or inclusive of older adults in the participating counties. Among those counties that provide older adult targeted services, over 80% of OASOC

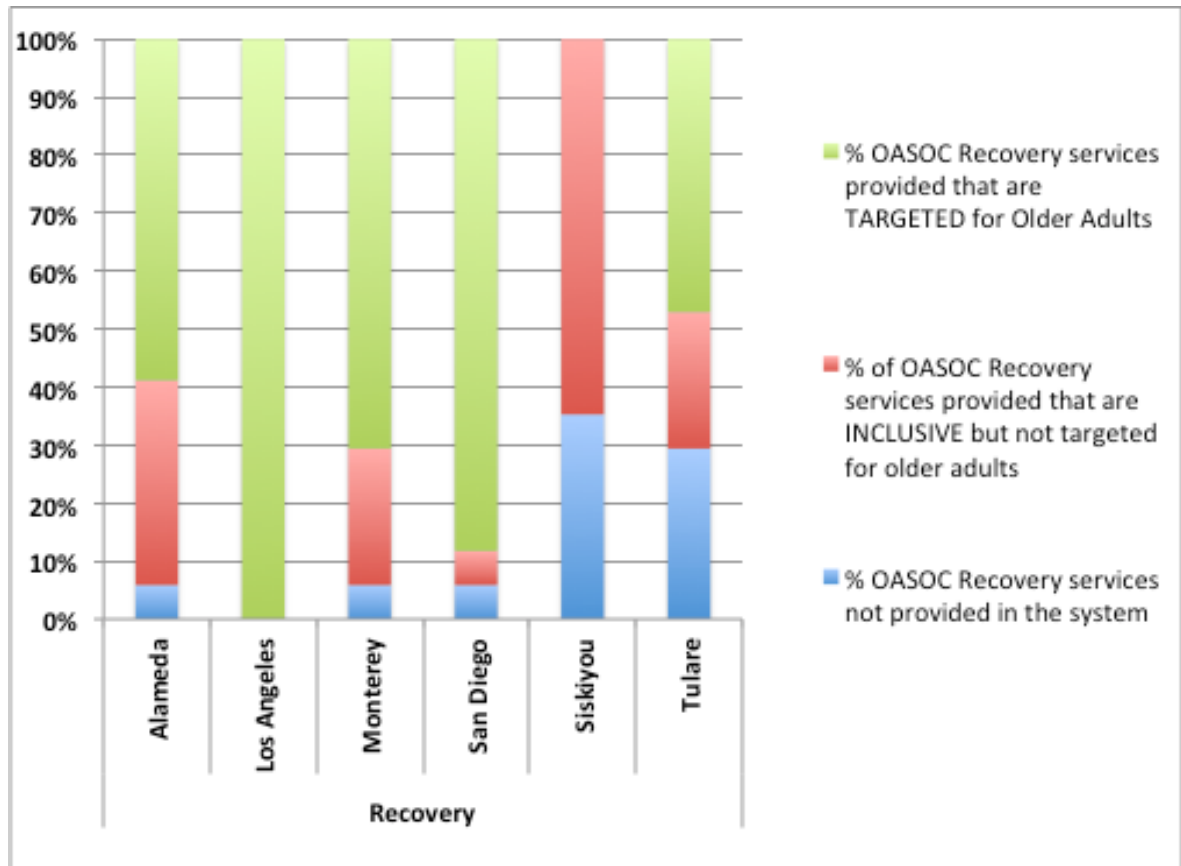
access service types are targeted for older adults. The one service not provided in the system in Alameda and Siskiyou is services to people with dementia.

Figure 5b: Proportion of Older Adult (OA) Targeted & Inclusive Access Services Identified in Annual Updates (FY15/16)



The project team was not able to identify all older adult targeted and inclusive Access services in participating counties, but found the majority of these services in Alameda, Los Angeles, San Diego and Siskiyou. We were only able to identify half of the services in Tulare and less than half in the Monterey reports.

Figure 6a: Proportion of OASOC Recovery Services – Targeted or Inclusive of Older Adults by County (FY15-16)

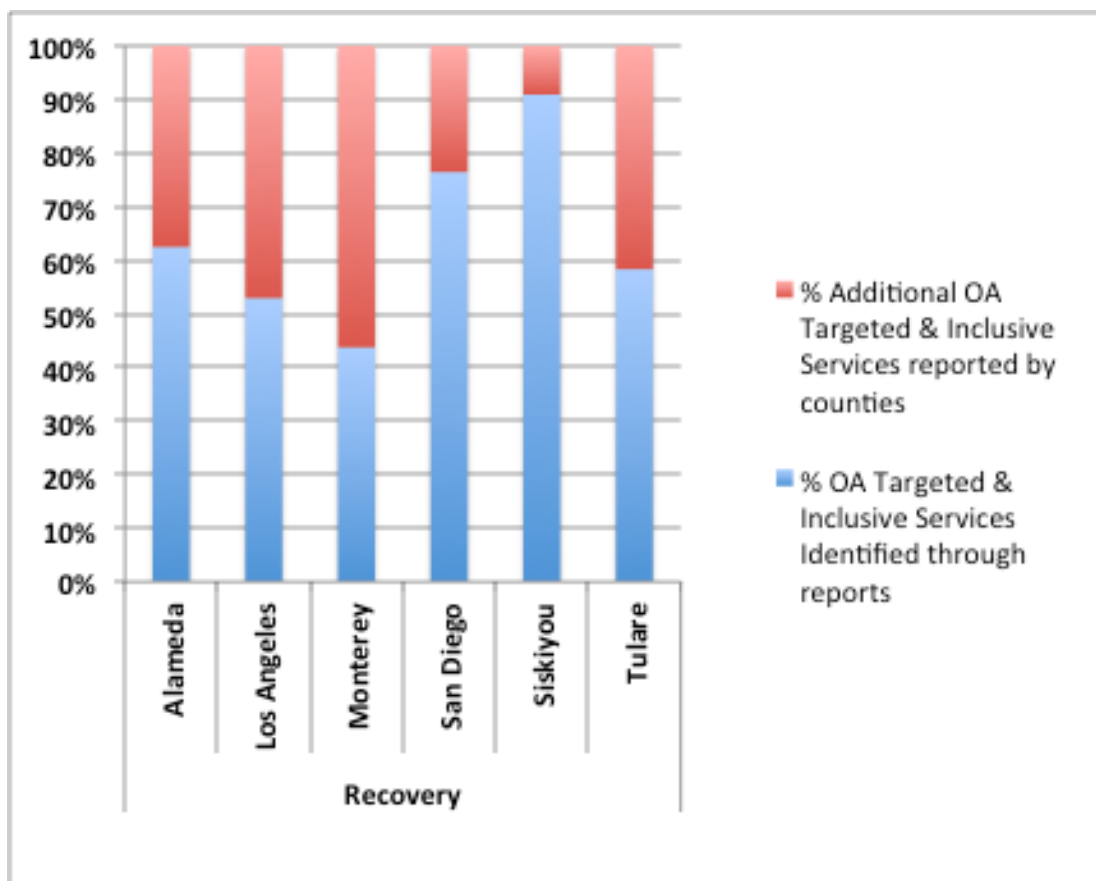


The Recovery domain of the OASOC Framework includes 17 service types: *Comprehensive mental health assessment (biopsychosocial, drug/alcohol/depression screening), medical screening, comprehensive mental health treatment, treatment Planning, psychotherapy /counseling (individual and group and family), medication stabilization and maintenance, crisis intervention, suicide intervention, 24-hour acute hospitalization, psychiatric hospitalization-long term care, forensic mental health services, residential services, day treatment services, case management, home assistance, relapse prevention/skill building, other aging and social services (e.g., social support, caregiver support, information and referral, clergy support, Meals-on-Wheels or other meals services, emergency financial assistance).*

Los Angeles provides all of these services targeted for older adults and San Diego provides the majority of these services targeted for older adults. Alameda and Monterey provide the

majority of these Recovery services inclusive of and targeted for older adults. In the smaller counties, Tulare and Siskiyou, 30% or more of Recovery services in the OASOC were not found in the county system. Half of participating counties did not have *medical screening, 24-hour acute hospitalization or psychiatric hospitalization- long term care* recovery services in their system although these services may have been referred out. Similarly one-third of participating counties did not have forensic mental health services or day treatment services provided in the system.

Figure 6b: Proportion of Older Adult (OA) Targeted & Inclusive Recovery Services Identified in Annual Updates (FY15/16)



Older adult targeted and inclusive recovery services were the most difficult to identify in county annual updates. Over 70% of these services were identified in San Diego and Siskiyou reports. Less than 65% of older adult targeted and inclusive recovery services were identified in Alameda, Los Angeles, Monterey and Tulare reports.

Altogether, participating counties provided the highest proportion of older adult targeted services in the *Access* domain and the least proportion of older adult targeted services in the *Recovery* domain. Los Angeles was the only county that provided all services targeted for older adults in every domain of OASOC framework. Alameda provided all prevention services targeted at older adults. Monterey and San Diego provided all OASOC access services targeted for older adults, while Tulare provided all access services targeted or inclusive of older adults.

We were able to identify all older adult targeted and inclusive *Prevention* services provided in Los Angeles, San Diego and Siskiyou counties. Aside from these three cases, however, services targeted for older adults were generally difficult to identify particularly in the *Recovery Domain*.

MHSA Three-Year Plans and Annual Updates are publically available county specific reports that describe the types of services provided and the populations served through MHSA funding. These characteristics make them an attractive source to assess local OASOC information. One challenge we faced using these reports however, is that formatting and content was not standard and there is little State guidance around these aspects of the reports. Counties have discretion in the way that information is presented, resulting in significant variation in the data that can be identified and analyzed. Until there are standards around how programs planned and implemented are described, it will be challenging to use these documents as a source for assessing the OASOC.

In addition to the types of programs and services targeted for older adults, we also reviewed annual updates and three year plans for the number of older adults served during a given time period. There were several issues that arose when we attempted to quantify older adult services across counties. A significant one is that counties do not standardly report unique numbers of clients, by age group and across MHSA funding components (CSS, FSP, PEI, INN). Counties also supplement their reports with evaluation reports from contracted organizations resulting in a lack of consistency in how services are discussed and reported. This is a particularly relevant point for PEI programs, where it is not mandatory to input client information in any database where they can be uniquely counted. Furthermore, as opposed to reporting clients served, some counties reported the goal or average number of clients that have been served (in the annual update), making it difficult to assess how many people actually received services.

At the time of this report, numbers on unique number of older adults served by counties can only be obtained through the county or State database systems. This information can only be

obtained for older adults in the CSS programs and not those who are solely enrolled to receive PEI services, or through Innovation projects, or other services. Until the counts of unique clients served is required across all MHSA funding components, it will continue to be challenging to assess progress and quantify the numbers of older adults receiving services through MHSA-sponsored programs using publicly available information .

Secondary Analyses Gaps and Limitations

These secondary analyses have several significant gaps and limitations. One limitation of evaluating trends over time in older adult services is the gaps and inconsistencies in reporting program targets and individual utilization by the older adult age group. In different reports older adults are grouped by different chronological age: over 55 or 65 versus the majority of reports that were using the standard of over 60 years of age. Also the data that is reported by age may not denote unique individuals. Many reports did not designate older adults at all in their reports.

Second, most state reports and evaluations were completed for different years and the complexities of roll-out of MHSA components may confound cross-time comparisons. Thus, the findings cannot be compared across measures of MHSA components because one document has used FY 2007-2008 data and another FY 2005-2006. Some reports contain comparisons across sequential years but many reports utilize data from one year only. No reports included all of the decade of data since 2004, when the MHSA began, for OASOC related content. A related limitation is the lack of availability of county reports for all years during this same time period.

A third limitation in state-wide and county reports is that studies used different methodologies for reporting prevalence and service utilization, making it difficult to assess change over time or make comparisons across reports. While reporting is required by counties, the State does not provide standard guidelines, so the result is considerable variation in the county reports.

Findings from the matrix analysis should be interpreted with care as well. In some instances, counties may have over reported older adult targeted services. Also, counties sometimes reported additional services that could not be identified through the three-year plans and annual updates but were offered to older adults through the county system. In turn, some of the older adult targeted or inclusive services represented in the figures (5a/b through 7a/b) may include non-MHSA funded services.

Furthermore, the matrix was intended to capture whether services are available or not and not the reach, availability or quality of the services. For example, if a county reports that they provide older adult targeted treatment planning, we cannot tell if that service is provided to 10% or 80% of their older adult clients, nor can we tell if the service provided is effective.

Finally, the reports selected for the secondary analyses may not represent a complete compendium of potential reports for inclusion. For example, MHSA or OASOC evaluations that are not publically available or published may not have been included in this secondary analysis. Also, there are activities in progress that have not been completed for reporting.

Secondary Analyses Summary and Implications

The secondary data analysis included three categories of documents: 1) evaluation reports commissioned by the Mental Health Services Oversight and Accountability Commission (MHSOAC) and 2) evaluations and reports produced by other governmental, California mental health and/or older adult stakeholder groups; and 3) Three-Year Program and Expenditure Plans and Annual Updates from the six counties participating in the study. Altogether, 100 reports were reviewed, with in-depth analyses completed for 35 reports. This massive data was then organized, for the first two data categories into 10 content themes. The third data category was used to report in-depth county examples of services for older adults identified within the OASOC for the six counties participating in the study.

This secondary analysis provides a more longitudinal perspective on the research question for the current UCLA Center for Health Policy Research study: *What progress has been made at the State and local levels in the past decade toward implementing an integrated and comprehensive system of care for older adults with serious mental health needs?* The secondary analysis of both MHSOAC-funded and external stakeholder reports provides a view of the contextual elements in both the policy and institutional environment in which MHSA was implemented. A type of environmental scan evolves that is useful for ascertaining both internal and external influences on MHSA development and for an OASOC particularly. It allows for taking into account OASOC facilitators and barriers related to accomplishments, stalls, progress and implications for future plans. In addition to the secondary reports and evaluations, Appendix G provides demographic and older adult incidence and risk statistics from public sources which are critical to understanding the goals and impact of counties' varying population and geographic domains.

Prior to MHSA passage, some counties had developed integrated and comprehensive mental health care systems, including an OASOC. The Adult and Older Adult Mental Health Systems of Care Act in 1996 outlined treatment for adults with SMI. However, since this legislature was a voluntary service delivery model⁶ without funding attached, it has not been as impactful as one might hope. The SAMHSA demonstration site research provided evidence for replication of varying models of an OASOC³ and showed that systems can include outcomes reporting that are necessary for evaluation.

Beginning in 2004, the MHSA built a new structure of services aimed at prevention and early intervention and comprehensive “all it takes” services, as well as program innovations. Counties moved to implement new programs based on MHSA goals and funded service components. Using these new service “building blocks” to complement and build the OASOC was not necessarily a strategic plan for each county. However, data show, especially for the FSP, that important improvements in mental health outcomes are possible for older adults with SMI. PEI successes for older adults, and other aspects of the CSS, were not as clearly highlighted in the reports reviewed.

What is clear, where numbers are available, is that compared to the potential SMI older adult population, those being reached and served is not adequate. A particular concern is the unmet need for mental health services generally and particularly for specific racial and cultural groups. Over half of adults with mental illness do not receive treatment. There were significant racial and ethnic disparities for incidence and treatment of SMI among adults with Native American, multiracial, and African American populations experiencing the highest incidence rates⁸.

Several new federal policies changed the context for mental health service delivery in California. The Mental Health Parity Act (2008) and the Affordable Care Act (2010), provided increased access to treatment for insured and uninsured Californians with mental health needs^{6,8}. This influx of new funding for mental health services created new synergies for MHSA-sponsored programs. State legislation, including realignment funding in 2011, also increased both funding and county responsibility for mental health, substance abuse and criminal justice services. In 2012, the DMH was eliminated through legislation and all community mental health services came under the DHCS^{6,8}. The trend over the decade since passage of the MHSA, has been to give more responsibility and decision-making to counties. While this approach is beneficial to assure local needs are identified and met; it has resulted in 58 versions of county mental health services, and greatly curtails the potential for cross-county state-level data.

The in-depth use of the six study county data from the required MHSA planning documents is a case-in-point. The data show that a number of important OASOC services were being provided within the domains of prevention, access, and recovery. The numbers being served were not able to be discerned through these data sources. In addition, the publicly available reports alone did not tell the complete story of available services. Finally, counties with a designated OASOC provided more service types within the model than those without an OASOC.

Geriatric workforce development to assure a well-prepared workforce for older adults has been identified as a critical issue in service delivery since before the MHSA. Yet, despite early policy work by the CMHDA and the CDA, there is no evidence of any priority focus for geriatric behavioral health training, staff development or graduate or post-graduate education support.

A consistent concern across reports is the lack of transparent accountability data for implementation of MHSA. There is a marked lack of data for the older adult age group^{6,7,9}. Other than for the FSP, there is currently no State mandate for counties to collect and report specific data on utilization or outcomes by program by age group. This is a major impediment to the assessment of the growth of effective OASOC programs across counties.

MHSA contributes about 25% of all funding available for mental health services, and is an important factor in funding increases. The development and sustainability of an OASOC depends on more than the MHSA funding contribution. It must also be built from the range of clinical and community services supported by Medicaid funds and Realignment funds, new efforts at integrated care, as examples. Aligning these funding streams to benefit older adult mental health services, working in tandem with MHSA, is needed for a robust OASOC.

The secondary analyses points to new opportunities for improvement. Several of these are already in planning and development, such as the development of a more robust outcome reporting system for mental health services and increased housing resources. Several should be simple: count people and report an unduplicated number in a consistent way by service type by age to the State. Some are much more complex and have to do with resource availability: more funding for more needed services so all age groups get adequate funding for needed services; more funding for outreach and service to un(der)served populations; more supportive housing with embedded behavioral health services; more incentives for workforce development in geriatric behavioral health; more psychiatric beds and psychiatrists; more linkages across funding streams to provide more integrated services to address the complex needs of older adults. These types “wicked problems” require leadership, collaboration, and innovation. Perhaps these types of issues should be the future focus for MHSA Innovation funding.

PART 2: KEY INFORMANT INTERVIEW REPORT

Executive Summary for Part 2

Part 2, of Deliverable 3, reports on the Key Informant Interview process and findings. This was a major study component that provides primary data to answer the research questions about progress in OASOC development and role of the MHSA. As previously described, we selected six counties that represented the key differences in counties across California. The six study counties included Alameda, Los Angeles, Monterey, San Diego, Siskiyou and Tulare.

We recruited key stakeholders from within the six counties and at the state level who represented varying perspectives about older adult mental health services and the MHSA. Of the 72 interviews completed, 59 were conducted with county-level stakeholders. These included consumers, mental health administrators, clinicians/direct providers of both mental/behavioral health and aging Services, aging services administrators, advocates and one Health and Human Services Administrator. Thirteen key stakeholders were interviewed at the State level, including administrators from public health, health care services, aging services, advocates, and staff and leadership from professional associations and commissions.

The final phase of coding interview summaries was conducted in a software program called ATLAS.ti which facilitates the management, organization and analysis of large amounts of qualitative data. The data was developed into 8 themes, including: Status of an OASOC; Responsiveness to Individual Values; System-level Planning; Pathways to Care; Service Gaps; Housing Needs; Workforce Training and Supply; and the Promise of Integrated Care. A section summary precedes the extensive data narrative for each of these themes.

For this Executive Summary, we provide excerpts of the key findings for each thematic section.

OASOC. Based on stakeholder input, there is great variation in the existence and development of an OASOC across counties. The MHSA, while it did identify older adults as a priority population and promoted an OASOC to serve them, did not provide any specific mandates or funding priorities within the legislation. Across counties, examples of a delivery *system* promoting OASOC values were more the exception than the rule. County key informants more often provided examples of individual *programs* that embraced and promoted OASOC values in delivering services to older adults.

Responsiveness to Individual Values. Most key informants were able to identify mental health services that were responsive to the needs of older adults and reflect the individual values promoted by the OASOC framework. Several examples illustrate the delivery of mental health services that are sensitive to cultural, racial, ethnic, linguistic, and other special population needs. When considering the reach of these services, however, key informants in most counties reported that penetration with the older adult population was limited. The degree to which consumers and family members were actively involved in the MHSA planning process also varied. In most counties, the degree of older adult representation and involvement at these meetings does not appear robust. Despite informant accounts of efforts taken to provide holistic care to older adults, some county mental health departments are undermined by very basic gaps, such as lack of provider training in geriatric issues, such as differential diagnosis.

System-level Planning. Planning at both state and county levels is deficient, which is explained by inadequate staffing and resources, poor data collection, inconsistent reporting and needs assessment, and no reporting mandates for older adults. Much of the planning, implementation and service delivery work is done at the county level, with little guidance from the State. The type and level of data reported varies by county, and many counties focus more on dollar spending than on service utilization. Where strategic multi-year planning processes exist, they typically involve a combination of any of the following: conducting population-level needs assessment, surveys, mapping of social determinants of health, stakeholder input (consumers, families, county contractors, professional staff), strategizing, and drafting of short and long-term goals for the county.

Pathways to Care. Older adults with mental health needs are identified or access care in a variety of ways. Outreach efforts vary by county. Much more needs to be done to reach out to older adults who are not making their way to services. PEI programs are one important vehicle for outreach to older adults at risk of SMI. Mobile-based outreach is noted to be especially important in rural and frontier counties as well as in rural pockets within larger more densely populated counties. Furthermore, mobile outreach is seen as essential for all older adults - rural or urban - who are homebound, limited in their mobility, and/or socially isolated.

The majority of the older adult service population is represented by those who have been living with SMI, often for many years, and have aged within the system. Once clients enter the system, they undergo in-take assessment, including administrative processing and standardized screening. Most counties conduct an intake assessment that is designed for the general

population and, as such, does not account for the special needs of older adults. However, one large county does conduct geriatric-specific assessments.

Barriers to accessing care include unmet basic needs (e.g., food, clothing), geographic disparities (especially rural vs urban areas), transportation and housing deficits, insufficient workforce, administrative and bureaucratic constraints, and insurance coverage and care costs.

Facilitators to accessing care include increased awareness about mental health, increased consumer knowledge about the system and services available, home-based service provision, smooth referral pathways, and improved transportation infrastructure.

Service Gaps. Service gaps have been observed across all counties, although some informants note that there are fewer gaps now than there were before the passing of the MHSA. There are many factors that contribute to service gaps, but notable issues include insufficient funding and the set of constraints attached to particular funding sources. There are gaps in services for older adults with cognitive impairment; and for older adults in general, including long-term case management, therapy and psychiatric counseling, peer services, transportation, transition/step-down services, and culturally-appropriate services.

Housing Needs. Overall, housing is inadequate to serve the older adult SMI population in California. Although state and county stakeholders have reported progress in the area to meet the housing needs of mentally ill older adults, they also thoroughly characterized the current inadequacy of housing for the older adults in terms of availability, accessibility and quality. Both an urban and rural county reported working in collaboration with the housing commission/authority. At the state level, there has been collaboration between DHCS (Mental Health Services Division), Housing, and Community Development, which has led to the passage of the “No Place Like Home” legislation.

Workforce Training and Supply. Key informants reported that MHSA has made a noticeable impact on county capacity to support workforce training and education related to older adult mental health care, yet gaps remain. MHSA WET funds have increased both the educational capacity of professionals, and consumer and family member employment within the public mental health system.

However, the rapid growth of an aging population, the historical lack of geriatric training in higher education for the helping professions, on top of an existing behavioral health workforce shortage crisis, has created many challenges. Despite progress made, WET

funding has not been prioritized to address the well-documented need for an adequately trained workforce to serve older adults with mental health needs.

State WET reporting focuses on the demographics of trainees receiving stipends and loan forgiveness. There is no data statewide on the numbers of training programs on geriatric topics provided through WET funding; nor for the numbers of trainees who may have received older adult focused mental health training.

Promise of Integrated Care. Key informants in all counties discussed and provided examples of service delivery integration activities. At the county-level, reports of integration initiatives spanned across agencies, departments, and community-based organizations. Across the board, the co-location of mental health services with primary care was described as an important innovation that has improved access to care, especially for older adults who are more likely to have multiple chronic conditions. Integrated care was also reported to help address geographic barriers to receiving care, an issue especially relevant in rural counties and in rural pockets of large counties where there is little or no service delivery infrastructure.

Two specific examples of where service integration needs are not being addressed are in long-term care settings and with older adults who have a dual diagnosis of mental illness and dementia. Barriers to integration include the marginalization of some trusted community providers in a health care delivery environment that increasingly requires the capacity to scale up and provide better care at a lower cost. Opportunities to advance integration are found in leveraging the momentum of county-wide initiatives through the dedicated work of champions, advocates, and leaders in aging.

Summary and Analysis of Key Informant Interview Data

Background

Since passage of the Mental Health Services Act (MHSA or Act) by California voters in 2004, progress has been made in enhancing behavioral health programs and services designed to meet the needs of those with serious mental illness (SMI) and to expand available services and resources to previously unserved and underserved communities. Prior to passage of the MHSA, a great deal of effort was invested in designing a comprehensive and integrated Older Adult System of Care (OASOC), similar to the systems developed for both children and adults.

Despite progress made over a decade ago to develop this system of care, the extent to which the OASOC has been implemented at the local level across the State is unknown. Similarly, the extent to which the MHSA may have facilitated or bolstered such implementation is unknown. Challenges in implementing a comprehensive and integrated system of care for this population appear to still exist.

Primary Research Question

Establishing a better understanding of what has been done and challenges that have been faced, including those that have been overcome and those that remain, may provide insight regarding strategies for furthering progress in this area across the State, which are primary goals of this research. As such, we posed the following primary research question:

- i. What progress has been made at the State and local levels in the past decade toward implementing an integrated and comprehensive system of care for older adults with serious mental health needs?*

Under this primary query, we posed the following series of sub-questions:

- a. How has, if at all, the MHSA bolstered or facilitated implementation of an Older Adult System of Care?*
- b. What obstacles and barriers have been identified in implementing a comprehensive system of care for older adults at the State and local levels? What strategies have been identified to overcome obstacles and achieve sustained improvement in the older adult system of care? What, if any, challenges have been insurmountable via State and local efforts? What gaps exist in services for older adults with serious mental illness across the state?*

Methods

County and State Level Key Informant Interviews

To answer these research questions we used a qualitative and stakeholder-engaged approach, collecting primary data through semi-structured key informant interviews with a broad range of stakeholders at both the county and state levels in California. This methodological approach was chosen because it provides an effective way to gather, synthesize, and represent the perspectives of multiple stakeholders. The qualitative method further supports the investigation of contextual factors and processes that may bolster or inhibit the effective delivery of MHSA-funded mental health services to older adults. In addition, these qualitative

data can be used to complement and supplement findings from our secondary data analysis of the Counties' Three Year Program and Expenditure Plans (FY2014/15 - FY2016/17) and Annual Updates (FY15-16). Finally, this stakeholder-engaged approach directly reflects one of the hallmarks of the MHSA, i.e., ensuring that there is meaningful stakeholder input in every phase of MHSA's development, implementation, and evaluation of outcomes.

Selection of County Study Sample

In order to account for the geographic diversity of California, we identified and selected a purposive yet representative sample of six counties representing key regions of the State (i.e., inland, coastal, north, south, central); various county sizes (i.e., small, medium, and large); and key characteristics of various regions of the State (i.e., urban, rural, highly resourced, poorly resourced, high and low proportions of older adults). We further ensured that at least one county would be selected from each of the 5 mental health regions designated by the County Behavioral Health Directors Association (CBHDA).

The counties were identified based on the evaluation of a minimum set of criteria specified in the contract and additional criteria found to be essential to developing a representative sample. The minimum set of criteria considered includes region, county size, population density, resource level and proportion of older adults. Additional criteria considered for each county included proportion of minority and non-minority residents, proportion of adults over age 75 and proportion of older adults who are Medi-Cal eligible. Siskiyou, Alameda, Monterey, Tulare, Los Angeles, and San Diego counties were selected for inclusion in the study based on their collective representation of California's regions and diverse populations.

Since there are five identified behavioral health regions and the goal of selection was to identify a minimum of six, one additional county was selected in the Bay region. The characteristics of Monterey County are different than Alameda County, the other county selected in that region. In addition to the six counties selected for inclusion, three alternate counties were selected in the event that the primary counties are unable to participate in the study. The process used to make the final selection involved assembling the most recently available data on each county, organizing all counties by region and conducting a within region comparison between counties to identify the ones that represented the above criteria in the most comprehensive way. Other information reviewed, as background to the selection process, included the Older Adult System of Care in the county. The evidence for the existence of an OASOC varied widely by county. All criteria, operational definitions and information sources are identified in Appendix E. Detailed information on the selected and alternate counties is provided in Appendix F.

Selection of Key Informants

Within each sampled county we identified a minimum of eight individuals representing the following groups: older adult consumers of public mental health services, family members of older adult consumers, community-based providers of mental health and/or aging services, county administrators and direct providers of mental health and/or aging services, and advocates concerned with local services/programs for older adults.

At the State level, we identified individuals from mental health consumer organizations (e.g., NAMI), relevant state departments/entities (e.g., OSHPD, Aging , Public Health/Office of Health Equity, Mental Health Planning Council, Department of Health Care Services), stakeholder advocacy organizations (e.g., Racial and Ethnic Mental Health Disparities Coalition), and individuals with a depth of knowledge regarding the MHSA and its implementation (e.g., authors of the MHSA, representatives from the County Behavioral Health Directors Association).

Development of Interview Guides

The content of the interview guides was informed by a review of the literature of studies of older adults with mental illness that identified relevant content area and specific topic areas/questions to be considered for inclusion. We also considered the fundamental concepts included in the Older Adult System of Care (OASOC) framework (see Figure 1) put forth by the California Mental Health Directors Association (2001, with revision in 2005) to ensure that these core philosophies and values were represented. We then shared the major domains and topic areas identified with the Project Advisory Committee (PAC) at an in-person meeting convened on 12/9/15. We asked them to review the interview guide domains and specific topic areas, add topics identified as missing, and then prioritize the final set of specific topic areas within each domain.

We used this input from the PAC to develop a draft version of an interview guide for each stakeholder type (i.e., county level administrators; direct service providers; consumers, family members, and advocates; state level administrators). The draft interview guides were circulated to members of the PAC for specific feedback. We asked PAC members to review the guide that most closely reflected their own stakeholder position, e.g., county level administrators reviewed and provided feedback on that draft version, to assure that questions for each audience were appropriate and informative. Once PAC member input was incorporated, the refined interview guide was pilot tested with 7 stakeholders in counties not included in our sample. We pilot tested at least one within each stakeholder group to ensure that the questions

were understandable, and that the length of interview time was reasonable. Based on the results of the pilot tests, we made some minor revisions and finalized the interview guides.

The final interview guides include (as applicable) the following domains:

- Organizational Affiliation/Context (of key informant)
- Current Status of Older Adult Mental Health Services
- Impact of Policy Changes on Older Adult Mental Health Services
- Assessing and Planning for Older Adult Mental Health Needs
- Barriers and Facilitators to Implementation of Older Adult Mental Health Services
- Partnerships and Integration
- Strategies to Improve Delivery of Mental Health Services to Older Adults
- Strategies to Support Comprehensive and Integrated Mental Health Delivery System

To review the complete set of 4 stakeholder interview guides and specific questions within, please see Appendices G-J.

IRB Review and Approval

All draft recruitment and data collection protocol, procedures and documents were submitted to the UCLA Institutional Review Board for approval. Any refinements to these documents as they went through further stakeholder review and pilot testing were submitted to the IRB as an amendment to the original IRB approval. Approval for the overall study was granted on February 26, 2016. Follow up amendments were approved as needed, with the last amendment approved on November 30, 2016. One participating county required that all protocols, procedures and documents go through their Human Subjects Review Committee (HSRC). In order to meet the requirements of that County's HSRC, some revisions to the study protocol and documents used with that county were made.

Data Collection

Key informants were identified and recruited through a review of public records and with the assistance of members of the PAC. We asked PAC members to recommend non-consumer stakeholders who were especially knowledgeable of older adult mental health services at the county and/or state level. In each county, we aimed to include specific county-level administrators in key positions overseeing the delivery of mental health and/or aging services (e.g., Behavioral Health Directors, Area Agency on Aging Directors).

As per the requirement of the UCLA IRB, consumers and family members were not directly recruited. Instead, we worked with our PAC to develop and circulate recruitment flyers in strategic locations within the participating counties. Prospective consumer and family member participants were able to call a toll-free line and get more information about the study. At the same time, we used a screening script to determine if they were eligible. If eligible and willing to participate, we completed a consent process and followed up by mailing or emailing the prospective participant a project information sheet.

Key informant data collection began in May 2016 and was completed in January 2017. We completed a total of 59 Key Stakeholder interviews in 6 counties and 13 at the State level. The majority of these 72 interviews were conducted in person and all were conducted by 2 members of the research team. Fifteen were conducted by phone. Consumers and family member participants were accommodated for interviews at a location of their choice, including their homes or a public coffee shop or restaurant. Interviews ranged from 25 – 117 minutes in length: on average, 64 minutes. After asking for, and being granted the key informant's permission, all interviews were audio-recorded.

59 of the 72 interviews were conducted with county-level stakeholders, including:

15 Consumers, Family Members

15 Mental Health Administrators

12 Clinicians/Direct Providers: Mental Health/Aging Services

14 Aging Services Administrators

2 Advocates (professional)

1 Health and Human Services Administrator

The remaining 13 of the 72 completed key stakeholder interviews represent State-level stakeholders, including:

1 Administrator, Public Health

1 Administrator, Health Care Services

2 Administrators, Aging Services

4 Administrators: State-Level Association, Council, or Commission

2 State-Level Advocates (professional)

- 2 Administrators, Office of Statewide Health Planning and Development
- 1 Other State-Level Perspective

The majority of key informants were female (79%) and ranged in age from 27 to 83 years. Sixty percent identified as Caucasian (n=43), while the remaining 40% identified as Latino (n=8), African American (n=7), Biracial (n=7), Asian (n=2), Native American (n=1), Arab (n=1), or Other (n=3).

Data Analysis

All key informant interviews were (with the participant's permission) audio-recorded. These audio tapes were then reviewed and summarized independently by two members of the research team, one of whom participated in the interview. The first reviewer focused on substantive content, while the second reviewer focused on adding important content and nuances not captured by the first review, making corrections as needed, and identifying and highlighting illustrative quotes and useful program examples. Both reviewers use a template we developed to organize the summary of information gleaned from each interview (Appendix K). As the reviewers summarized the interviews, they noted recurring content and concepts by flagging segments of the summary with a specific word or code. These code words were boldened and presented in front of the segment of the interview data summarized.

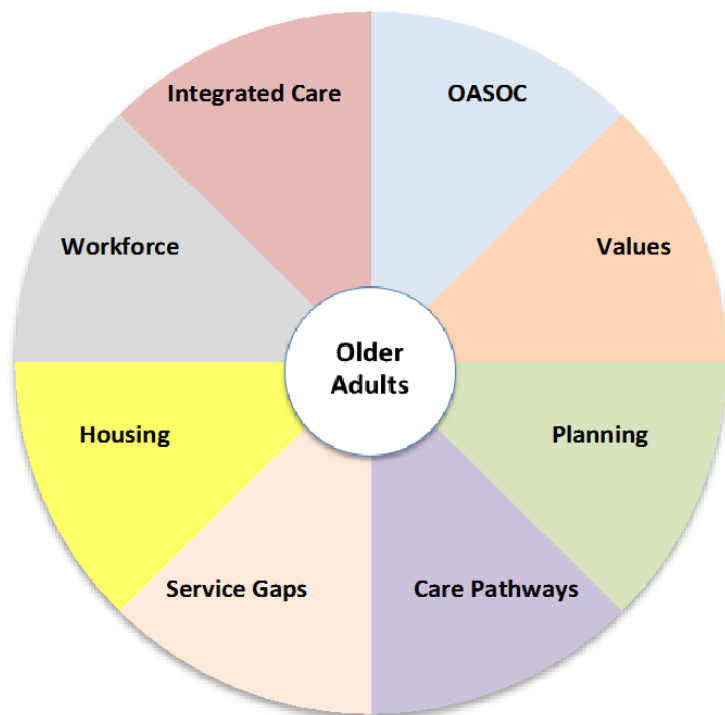
After a preliminary sample of transcripts was summarized and an initial set of codes independently generated, the team met to compare and discuss codes, identify points of concurrence or divergence, and develop a code list. In the course of several team meetings, the code list was further refined through an iterative process of identifying, defining, and categorizing codes. The refined code list was applied to subsequent data summaries.

The final phase of coding interview summaries was conducted in a software program called ATLAS.ti which facilitates the management, organization and analysis of large amounts of qualitative data. This software is especially helpful for the purpose of analyzing these data across the counties and across the different stakeholder types. Completed interview summaries were uploaded into this software program and a final set of codes was applied across the 2 reviewer summaries. Through this phase of analysis, recurring patterns, emerging themes and outliers in the data were identified.

In addition to conducting analyses in ATLAS.ti, the team member who completed 2nd review summaries drafted a memo to identify highlights of the cross-stakeholder data for a particular county or for the subgroup of state-level stakeholders. We also developed and used a template for these memos (See Appendix L). The memo includes the identification of barriers or facilitators to improving the delivery of mental health services to older adults, observations about whether the different stakeholder perspectives across the county or at the state level are similar or divergent, and documentation of any observations about the culture of the county/state, and the status of an Older Adult System of Care. These memos provide another source for validation of the themes emerging from the analysis using ATLAS.ti coding.

Findings

Eight themes emerged from the data, including Status of an Older Adult System of Care; Values; System-level Planning; Pathways to Care; Service Gaps; Housing Needs; Workforce Training and Supply; and the Promise of Integrated Care. Figure 8 (adjacent) graphically represents these themes. The key-stakeholder interview findings are presented and discussed within each of these themes. Because of the richness of the data, we begin each theme with a Section Summary that provides the “top-line” findings and issues discussed within the theme.



Status of an Older Adult System of Care

Section Summary

In all six study counties, the OASOC remains “work in progress” with the recognition of an OASOC and status of its implementation ranging from formal designation and full implementation of a wide array of older adult specific programs and services, to a system in which older adults are served as part of the Adult System of Care and there is little or only emerging recognition of older adult specific needs.

Depending on county size and existing resources, the utilization of MHSA funds for older adult services varies. Constraints on funding and other resources often affect the county’s overall capacity to innovate and develop or expand mental health services and programs that appropriately serve older adults. Despite variation in the status of an OASOC, in most counties, key informant reports about access to quality mental health services for older adults suggest that service delivery is uneven, even in counties with a formally designated OASOC.

At the state level, there is no dedicated leadership, committee, council, or advocacy group that is concerned with the needs of older adults with mental illness. The County Behavioral Health Directors Association has multiple subcommittees, but none are currently focused on the older adult population. Because there are no State mandates to prioritize MHSA programs for older adults, the work is decided by counties, which have many competing priorities for MHSA funding allocations.

At the county level, activities related to the OASOC appeared to fall largely on the leadership of a few very dedicated advocates, providers, and administrators. Examples of a delivery *system* promoting OASOC values were more the exception than the rule. County key informants more often provided examples of individual *programs* that embraced and promoted OASOC values in some way. Furthermore, in most counties, reports of older adults being engaged or well represented in the MHSA planning process were scant or non-existent.

Key informants from all counties reported both challenges and opportunities to advancing an OASOC. Challenges include a fragmented service delivery system, and a lack of resources, leadership, and staff trained in geriatrics, and a lack of knowledge of existing community resources for older adults. Opportunities include county-level leadership and advocacy related to aging, existing geriatric networks and advocacy groups, and collaborative activities between public agencies and community organizations that have the potential to create the impetus and infrastructure for real systems change.

Variation in System Development

While advancement of the concept and implementation of an Older Adult System of Care (OASOC) predates passage of the MHSA, it appears that the MHSA has not been instrumental in supporting its continued development. In all six study counties, the OASOC remains a “work in progress”. The recognition of an OASOC and status of its implementation ranges from formal designation and full implementation of a wide array of older adult specific programs with important linkages and services; to a system in which older adults are served as part of the Adult System of Care (ASOC), and there is little or only emerging recognition of older adult specific needs. Specifically, two of the six study counties have a formally designated OASOC, one county has a joint ASOC and OASOC, while the remaining three counties serve older adults within their ASOC. State key informants also observed that statewide, the development of an OASOC differs depending on the county, and that counties are at various stages of development.

Depending on county size (both by population and geography) and existing resources, the utilization of MHSA funds for older adult systems development and services varies. Through key informant interviews, we learned that constraints on funding and other resources often affect the county’s overall capacity to innovate and develop or expand mental health services and programs to appropriately serve older adults. For example, due to fiscal problems that resulted in an audit, one large rural county was very late to adopt and develop MHSA services in general. As a result, their attention to older adult specific needs and their penetration with this age group has been quite limited. At the other end of the spectrum, a large urban county with a formally designated and more fully developed OASOC provides services that are specifically tailored for older adults and reach all geographic corners of the county.

Despite variation in the status of an OASOC, in most counties, key informant reports about access to quality mental health services for older adults suggest that service delivery is uneven, even in counties with a formally designated OASOC. For example, one large urban county with a formal OASOC describes significant efforts to promote the values and principles of an OASOC. However, they are limited by a service delivery network which, to date, has a relatively small number of older adult specific programs, many of which are clustered in certain geographic areas of the county. As a result, when measured by the absolute numbers of older adults served, relative to the population of the county, the OASOC has very limited reach or penetration. According to one key informant, the majority of older adults receiving mental health services in this county are served in the Adult System of Care. State key informants also note that in most counties only a small proportion of older adults are served by older adult specific programs.

Recognition of an OASOC

At the state level, there is no dedicated leadership, committee, council, or advocacy group that is concerned with the needs of older adults with mental illness. One county-level leader stated,

“I would hypothesize that one of the reasons there is not an OASOC in counties is because there isn’t one at the state level to model and where support can come from.”

State key informants report that the DHCS has become more committed to mental health since departments were combined. But specific attention to the needs of older adults with mental illness at the state level, or to the provision of an OASOC at the county level, does not appear to be a priority. Some suggest that the lack of leadership reflects a perception that there isn’t a lot of need for public mental health services for older adults because of earlier mortality (i.e., the belief that there are not many older adults with SMI) and because they are served by Medicare.

The County Behavioral Health Directors Association (CBHDA) has multiple subcommittees, but none are currently focused on the older adult population. An OASOC committee used to exist but in recent years was collapsed with the Adult System of Care (ASOC) committee, resulting in the absence of a forum in which to discuss older adult specific needs. State informants note that a focus on children’s welfare in the mental health delivery system is politically appealing and children’s interests tend to dominate because there are many children’s health advocacy groups that are very vocal.

As one informant noted: *“People have to carry the torch...we’re going backwards because of [reduced] funding, but also may be [because of] the commitment of who’s in charge.”*

One state informant observed that the lack of advocacy for aging issues in general at the state level is a more recent phenomenon. Many long-time advocates have retired or passed away, or have become “burned out” following the grueling budget fights to preserve the funding of services for the elderly and disabled during the Great Recession. She notes that funding priorities have since shifted and many programs that were specifically tailored to older adults have now fused with other adult programs. In many cases, progress made for older adults has been stifled because of loss of funding or lack of leadership commitment.

Because there are no state mandates to prioritize MHSAs programs for older adults, decisions are made by counties, which have many competing priorities for MHSAs funding allocations. As noted earlier, different counties are at different stages in development of systems and tailored services. . Some larger counties can dedicate resources to older adult mental health while smaller counties have greater difficulties or need to balance multi-age programs. One state key informant observed that there are few incentives for leadership or funds for addressing older adults or training in older adult services.

For many of the study counties, an OASOC is not an articulated reference point for discussing mental health service delivery. In counties where the OASOC is combined with the ASOC, or where there is no separate OASOC, recognition or promotion of services that are specific to older adults tends to be less pronounced. The impact of these services for older adults, given that reporting on outputs and outcomes is typically not segmented by age group, is often unknown. At the same time, key informants in these counties indicate that attention to the concerns of older adults is beginning to grow. Some report on new and planned efforts to augment mental health services for older adults, specifically through innovation projects and through newly formed or strengthening relationships with aging services and other community providers that touch older adults.

One key informant describes the status of an OASOC in her county:

“Is there an OASOC? A conscious system...not necessarily, but there are services. I would say yes. To the extent there is a strategic plan with an assessment, that would be a system of care. We are, however, a part of the overarching plan that provides services to older adults.”

Other key informants describe county-level leadership with a vision that embraces the principles of an OASOC, but with an infrastructure that is just beginning to build the programs and linkages needed to develop a comprehensive system of care for older adults with SMI. One rural county key informant describes their older adult services as “progressing” and becoming more specialized as county-level leadership begins to see value in having separate discussions about the specific interests of older adults served through the county public mental health system. In addition to reporting increasing awareness, key informants from this county indicate they are engaged in intentional efforts to identify and access resources that will bolster programs and services for the older adult population.

Components of an Older Adult System of Care

Key informants in counties with a formally designated OASOC reported the existence of a range of services and programs designed to address a continuum of need among older adults with mild, moderate, or severe symptoms of mental illness. Their programs have linkages across other county systems and resources and generate data for quality management and planning. Programs targeting prevention and early intervention were typically described as having been more recently developed and implemented, and were often directly attributed to the MHSA. Many informants in these counties also reported the use of evidence-based screening tools, practices, and programs.

Activities related to the OASOC appeared to fall largely on the leadership of a few very dedicated advocates, providers, and administrators from different sectors (e.g., aging services network, non-profit organizations, community advocacy groups). Within the county mental

health departments, formally designated OASOCs had specific leadership roles, most typically assumed by someone with the title of a MHSA or OASOC coordinator. In addition to program oversight and administration, some coordinators play a role in advancing geriatric training, both directly to mental health staff and to staff in other county departments or contracted agencies.

Beyond offering concrete programs and services for older adults, key informants from all counties provided examples of the concepts and values explicitly represented in the OASOC framework (see Figure 1) being actively promoted and practiced. One urban county's MHSA-funded peer-led program was particularly robust in this regard. Key informants described older adult-specific peer groups that embodied the values of the OASOC framework by representing the consumer voice, identifying issues of concern to older adults, providing social engagement and empowerment opportunities, supporting a recovery philosophy, and encouraging the participation and contributions of older adult consumers.

Some state key informants observed that some counties are developing programs that focus on the wellness and recovery of older adults, with an acknowledgement that mental illness may present differently in older adults. In one county, key informant administrators described a service delivery system within one city that actively promotes and embraces a philosophy and application of interdependence, at the individual, community, and systems levels. The exceptional example they presented epitomized a holistic approach to serving the aging population; albeit in a limited geographic area. The municipality had created its own OASOC, by identifying and addressing the needs of older adults with SMI within a larger network of community services and civic engagement activities.

Key informants in this county, and in others with a designated OASOC, acknowledged that they do not come close to addressing all of the need. Even in counties that offer innovative programs that are tailored to meet the needs of older adults, their reach is usually limited to a small proportion of older adults with need who are located in a specific geographical area of the county or, in some cases, are members of a special population group.

"There is a shortage of services in different areas; there are a lot of isolated seniors in the community. There aren't services for all of them, and that's not just in mental health."

It is important to note that some counties without a formally designated OASOC employ practices that are sensitive to the needs of older adults and which promote the principles of the OASOC framework. Key informants from one such county described the existence of several programs and services which target older adults, some of which include a coordination component that allowed providers from different sectors to provide better care. Others reported on efforts and progress made towards developing a formally designated OASOC. Another county without an OASOC described how they developed an immediate plan to address a report of increased suicide rates among older adults. The resulting successful

program demonstrates that the county has the capacity to be adaptable and responsive to current information that directly affects the health and welfare of older adults.

However, across counties, examples of a delivery *system* promoting OASOC values were more the exception than the rule. County key informants more often provided examples of individual *programs* that embraced and promoted OASOC values in some way, albeit at a much smaller scale. Furthermore, in most counties, reports of older adults being engaged or well represented in the MHSA planning process were scant or non-existent.

Challenges to advancing an OASOC

Key informants from all counties reported challenges to advancing an OASOC, regardless of the status of the OASOC in their respective counties. In one urban county with an OASOC, we heard reports that it was very under-resourced, that service delivery was fragmented, and that there was “lots of work to do”. In other counties without a designated OASOC, challenges included a lack of leadership, i.e., no designated point person on older adult issues; a lack of providers and administrators trained or specializing in geriatrics; and a lack of knowledge/ awareness of existing community resources for older adults.

At the state level, a few key informants acknowledged that older adults should be served as a distinct population with distinct needs, but also pointed out that mental health services have historically been focused on children and the generalized adult population. While one informant believes there is growing commitment by officials at the state level for serving older adults, she points out that that sentiment is not shared by all counties. Furthermore, State mandates related to the delivery of mental health services focus on children. In the absence of State mandates for older adults, there have been few opportunities to measure the effects of the MHSA for older adults.

State informants also report challenges at the point of service delivery, especially because county mental health services are typically not well coordinated or integrated with primary health care. In particular, they say there is a need for bidirectional data sharing so that clinicians can better manage the chronic health conditions and medications that older adults with SMI so typically present.

“The system is not necessarily equipped to handle... the interplay of medications...severe diabetes....[for older adult consumers] not engaged in the health system. Until we can get good back-forth [data sharing/communication system] to better manage everyone holistically, maybe the health system is a better place to manage all those individuals because at least all info is available in one file.”

Perceptions of older adult needs and utilization of resources also present a challenge for many counties. On the service *delivery* side, several key informants pointed out that serving older adults is often perceived by county governments as a resource-intensive enterprise. In some counties this translates to a lack of political will to offer older adult specific programs, or to develop an OASOC because the population is feared to overwhelm the service capability. Even in counties with robust aging advocacy networks and the political will to advance the interests of older adults in general, there appears to be limited attention or dedication of resources to older adults with SMI.

Interestingly, responses to the “resource intensiveness” associated with the provision of older adult mental health services were varied. In some counties, key informants indicated that the cost of care associated with older adults with SMI was a source of anxiety, and an issue that the county appeared to (willfully or not) avoid or ignore. In other counties, certain mental health programs and services were *only* available to consumers with the highest needs, i.e., those who were identified as High Utilizers of Multiple Services (or HUMS). These counties appear to be taking a very direct and targeted approach to prevent the escalation of costs associated with complex care needs by intervening and being deliberate in their allocation of resources.

Another challenge conveyed by key informants is a conundrum that exists between a call for more attention to older adult specific needs and a competing idea that too much attention to older adult specific services may lead to further marginalization of the older adult population. One key informant described the older adult population in her county as a “step child”, and noted that the integration of older adult services with adult services effectively masks both the number of older adults served and the impact of these services.

Data measurement and sharing are a major concern voiced by several state key informants. They note that the integration of different state level departments in recent years has led to confusing and overlapping roles, with a lack of clear accountability and oversight. Because counties are ultimately in charge of managing MHSA funds with limited State oversight, there have been difficulties in monitoring MHSA and tracking quality. Furthermore, informants observe that the county data reported are often aggregated and do not distinguish between different age groups. As no older adult performance outcomes are required by the State, it is thus impossible to assess how older adults in the public mental health system are faring, let alone the progress or status of an OASOC.

Finally, key informants from the State and from both large urban and small rural counties also brought attention to the receiving end of services, where it is essential to first address the “basic” needs (i.e., food, housing, medical) of older adults) - before being able to effectively address their mental health needs through an OASOC.. This is especially true for those who are most impoverished, or who are just coming out of the criminal justice system. They suggest that specialty mental health care becomes both more accessible and more effective for older

adults who first have an adequate source of nutrition, an appropriate place to live, and their physical health care needs addressed.

Opportunities to advance an OASOC

Reports from numerous key informants suggest that efforts to develop an OASOC are usually led by local county champions, who are typically not incentivized or supported by the State. As such, the extent of county-level leadership and advocacy related to older adult issues in general has the potential to either support or impede efforts to advance an OASOC.

In some counties, existing geriatric networks/advocacy groups and champions are poised to make inroads. At least two counties have a robust aging advocacy network that pre-dates the MHSA which, while not solely focused on mental health issues, is well positioned to ensure older adults are part of county-level planning discussions. Key informants from one of these counties describe the influence that “champions” for older adult issues have had. They have leveraged their efforts with the Board of Supervisors and other community leaders to increase political will and create positive and forward movement with county-level planning for the aging population in general (even if not specifically for mental health). They note that advancing an OASOC requires advocacy efforts that are specifically focused on older adult mental health, and that having a formal and dedicated position within the county department of mental health is an important starting point for the increased recognition of and response to older adult mental health needs.

In addition to aging champions and advocates, opportunities to build bridges across county sectors through partnerships and collaborations also hold promise for advancing the development of a robust network of services and programs that can support needs of older adults with SMI. In most counties, this goal has not yet been actualized.

For example, in one county, the Area Agency on Aging (AAA) had just recently been invited to participate on the MHSA committee and become involved with planning and recommendations. While grateful to be included, this informant expressed a concern that because they had not been involved from the beginning, it may be too late to make any major inroads. Another key informant stated that she thought that every county MHSA planning or advisory committee should be required to include at least one representative from the aging network.

Some counties are working on partnerships and collaborations at a more macro level. They are trying, for example, to improve affordable housing opportunities, develop better data exchange systems, encourage integration and collaboration across all county and community sectors. Some state key informants concur that different county programs are developing better connections between substance abuse, housing, law enforcement, behavioral health, physical health, and mental health services. They note that this integration of services has allowed for

more funding to support innovative projects that address mental health from a more holistic perspective.

In three counties, key informants noted that connecting OASOC efforts to other policies and initiatives underway at the county level hold promise. At least two counties are currently engaged in implementing “Whole Person Care” pilots under the auspices of MediCal 2020. Key informants note that the goals of these pilots align well with the principles advanced by the OASOC and are particularly relevant for older adults, i.e., integrated and holistic care, addressing the social determinants of health, enhanced social and supportive services.

These county-level efforts are encouraging more collaborative activities between public agencies and community organizations, creating opportunities for integration that can be leveraged by OASOC advocates and have the potential to create the impetus and infrastructure for real systems change. As one key informant noted, perhaps this is an opportunity to build an OASOC from a starting point that is outside of the mental health department, i.e., “outside-in” versus “inside-out”. Another key informant offered an important caveat, stating that while these larger county initiatives may provide opportunities down the road for progress in the area of mental health service delivery for older adults, they are unlikely to address imminent needs.

Responsiveness to Individual Values

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Most key informants were able to identify mental health services that were responsive to the needs of older adults and reflect the individual values promoted by the OASOC framework. Several examples illustrate the delivery of mental health services that are sensitive to cultural, racial, ethnic, linguistic, and other special population needs. When considering the reach of these services, however, key informants in most counties reported that penetration with the older adult population was limited.

Key informants in most counties discussed health and wellness services that were available to older adults and promote healthy aging. These services were broadly defined, from peer-led services that encourage engagement in the community to county-wide initiatives to make the physical environment more accessible to older adults. Across counties, key informants recounted the importance of recognizing older adult individual strengths in the delivery of mental health services. In particular, they discussed programs that are supportive of consumer resilience and encourage them to strengthen or regain the social roles they hold in the community. Many provider informants understand the need for holistic provision of service, and believe that this approach has the greatest potential to achieve the best outcomes for older adults. Several examples of community-based peer programs that are designed to empower consumers of mental health services were provided. Some of these programs are

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tailored for older adults.

Reports of older adult consumer, family member and caregiver involvement in service planning and decision making were mixed. While most clinical providers stated that consumers are directly involved in setting goals and developing individual treatment plans, the role or involvement of family members and caregivers in service planning was rarely mentioned. The degree to which consumers and family members were actively involved in the MHSA planning process also varied. In most counties, the degree of older adult representation and involvement at these meetings does not appear robust.

Despite informant accounts of efforts taken to provide holistic care to older adults, some county mental health departments are undermined by very basic gaps, such as providers not understanding or being able to identify the difference between dementia and depression. In addition, informants in three counties report a level of fragmentation in the county system (organizational, financial) that prevents any one organization from drawing on resources to care for someone holistically. In some counties, especially under-resourced counties, there appears to be little consideration or capacity to address the needs of special populations (e.g., LGBT, certain racial groups, homeless seniors). While providers emphasize an organizational culture of dignity and respect for older adults, some consumer stories suggest a different experience.

Most key informants were able to identify mental health services in their respective counties that were responsive to the needs of older adults and reflect the individual values promoted by the OASOC framework (see Figure 1) Some informants discussed programs and services that are specifically tailored for older adults, while others gave examples of programs that are inclusive of older adults. Several examples illustrate the delivery of mental health services that are sensitive to cultural, racial, ethnic, linguistic, and other special population needs. When considering the reach of these services, however, key informants in most counties reported that penetration with the older adult population was limited.

Healthy Aging

Services provided to older adults that promote healthy aging were broadly defined, from peer-led services that encourage engagement in the community to county-wide initiatives to make the physical environment more accessible to older adults. Key informants in most counties discussed health and wellness services that were available to older adults being served by the public mental health system.

One urban county offers peer-based services to individuals ranging in age from their late 50s up to their early 90s. The program emphasizes recreating consumer strengths and connections in the community, so that consumers rely less and less on the provider organization and more fully engage in a healthy and independent life in the community. A rural county consumer informant described an evidence-based Wellness Recovery Action Plan (WRAP) that she facilitates. Although not age-specific, the plan includes a “wellness toolbox” with tips for staying healthy, a “trigger toolbox” to help manage psychological/emotional triggers, and a menu of daily and occasional activities that are recommended to maintain wellness.

Key informants note that many older adults with SMI are also dealing with chronic medical conditions (e.g. chronic pain) or acute medical conditions, so the primary goal of providers is to keep them as healthy as possible by addressing both their physical and mental health needs. Three counties made specific references to wellness centers that serve older adults. One rural county recently opened an MHSA-funded wellness center that replicates an existing wellness model offered in two adjacent counties. It is a client-centered drop in location for people with SMI that epitomizes the recovery and resilience values of the MHSA. Another mid-size county offers a wellness center through the local community hospital. Anyone who’s had a treatment from the hospital is eligible for sliding scale access to the gym (which includes a swimming pool and sauna, and weight-lifting and cardio work-out machines).

Finally, one urban county recently adopted and is implementing the World Health Organization’s Aging Friendly framework, which encourages healthy engagement and physical activity in the community by adjusting the physical environment (parks, sidewalks) to better accommodate older adults.

Recovery and Resilience: Regaining Social Roles

Key informants across counties recounted the importance of recognizing older adult strengths in the delivery of mental health services. In particular, they discussed programs that are supportive of consumer resilience and encourage them to strengthen or regain the social roles they hold in the community. One advocacy program in an urban county specifically serves older adults and focuses on participant strengths, quality of life, and personal contributions to society.

The principles of recovery provide an anchor for those who work with older adults. As described by one clinical provider, the recovery treatment plans developed with older adult consumers are focused on mental health recovery, through the reduction of symptoms and impairments. Therapists and consumers engage in shared decision-making with treatment goals directed by consumers. Others offered similar descriptions, describing approaches with older adults that embrace self-determination and are focused on recovery and regaining social roles

in the community. These approaches look towards the inherent strengths of individuals and communities.

In addition to taking a recovery approach in the delivery of services in clinical settings, a few informants provided examples of the recovery approach being embedded in other settings. A contracted agency in one county reports using a recovery model in its supportive housing services. Another county informant describes a SNF that provides mental health services, life-skills, horticultural therapy, and other age-appropriate courses. One consumer informant noted the importance of a wellness and recovery approach that integrates spirituality into its programs. Another consumer appreciates the availability of different social activities involving resources outside of mental health (e.g., events at the public library, holiday parties for older adults).

A state key informant discussed the value of programs that are providing assistance to formerly incarcerated individuals, helping them regain their social roles in the community. The Council on Mentally Ill Offenders (COMIO) - housed within the Department of Corrections and Rehabilitation - has worked with MHPA advocacy committees to advance programs that engage people in the justice system prior to their release to offer physical, mental, and substance abuse training. These programs also provide vocational training and assistance with housing. The end goal is to reduce recidivism and increase success upon community integration. This informant notes that older adults in the justice system have especially complex needs and can benefit from intensive case management both prior to and upon release.

Finally, in efforts to advance a recovery approach with older adults, one state key informant observes that, even with the great diversity that exists within the aging population, there is a common desire - regardless of physical/mental status - to have a purpose, to be able to engage in some form of meaningful activity:

“I’m in the older adult age group, and think it’s important to recognize that as we age, we don’t necessarily fall into the same needs decade after decade. Someone in their 60s may not be as medically fragile as someone older or even people younger in their 50’s who have needs for a primary care physician on a regular basis and so on. Many folks who are in their late 60s are quite active and involved. It’s important to recognize the individualized capabilities and the thinking around aging because it’s the purpose that one has in life that really activates them. And that’s part of wellness. So, I’m always sensitive to people who really are vivacious and involved in whatever they do, whether it’s community work or family or even if they are alone without family around. Do they get involved socially? Do they volunteer? ... Older people want to get out, if they are able to, and can do something of benefit.”

Emphasis on Strengths, Quality of Life, Options & Contributions

Key informants also provided examples of programs for older adults that place an emphasis on individual strengths. For example, one county informant discussed an MHSA Innovations project that included outcomes focused on increasing participation and involvement of older adults in the community, helping them find their voices. Others informants embrace a service delivery approach that emphasizes the dignity and respect of all individuals. One county's behavioral health department uses strengths-based management, i.e., looking at what people bring to the table rather than focusing on their deficiencies. Others described how these principles of care are operationalized through their Assertive Community Treatment (i.e., intensive outreach) programs. Finally, one urban county department of mental health reports that they offer programming that aims to maximize the quality of life of older adults, by valuing self-determination, dignity and respect through a bureau that is specifically dedicated to their interests.

Exemplary program

One urban county has an exceptionally diverse population with new refugee and immigrant populations emerging over time that require cultural awareness and service programs focused on special needs. They have developed a PEI program that supports peer-based outreach to and engagement with older adult refugees from East Africa, the Middle East, and the Philippines. The program is administered by a non-profit organization through a contract with behavioral health services. Clients are visited in their homes and communities (senior apartments, faith-based organizations) by clinicians who conduct screening and assessments, provide supportive services, and connect older adults with services, including short term case management.

Holistic Approach (Biological / Psychological / Social / Spiritual)

Across counties, key informants provided examples of integrated care that, by definition, should be positioned to address the more holistic needs of older adult consumers with SMI (See Promise of Integrated Care section). In most counties there are current efforts, and growing interest, in increasing efforts in this area. Many provider informants spoke of taking a bio-psycho-social approach to care, understanding the need for holistic provision of service, and believing that this approach has the greatest potential to achieve the best outcomes for older adults. These providers recognize, for example, that a homeless senior, in addition to needing housing, may also need therapy and counseling for substance abuse, medication for a moderate to severe mental health disorder, and assistance with securing food and managing physical health challenges.

A more holistic approach to care is being promoted by counties in a number of ways. Some counties are planning or implementing Whole-Person Care pilots for people with complex needs. Others are advancing county-level initiatives that are integrating the administration of

multiple agencies with the goal of leveraging resources, increasing efficiency, and improving care. One urban county's department of mental health is creating a new leadership position that will specifically focus on integration opportunities within the department and across other county agencies and CBOs. Other counties are funding the integration of mental and physical health at FQHCs. Yet another county is developing an MHSAs Innovation grant with plans to provide more wrap-around services for consumers with physical, mental health and substance abuse needs. Finally, one city in an urban county has developed a holistic one-stop shop for older adults, providing services for mental health, dementia, and social support.

Role of Consumers, Family Members, Caregivers

Key informant reports of older adult consumer, family member and caregiver involvement in service planning and decision making are mixed. Many clinical provider informants described how consumers are directly involved in setting goals and developing individual treatment plans. However, the role or involvement of family members and caregivers in service planning was rarely mentioned. Furthermore, while providers in at least one county made reference to training opportunities for family members and caregivers of older adults with dementia, there was no mention of such opportunities for family members and caregivers of older adults with SMI.

Reported levels of involvement of consumers and family members in the MHSAs planning process also varied across counties. Although stakeholder involvement is mandated by the MHSAs, in most counties the degree of older adult representation and involvement at these meetings does not appear to be very robust. Some key informants suggested that older adults may not be as involved because most are not aware of the stakeholder process. Other key informant administrators emphasized that they greatly value and carefully incorporate the stakeholder input they get from older adult consumers, family members and other community-based stakeholders.

“You’ve got to have community involvement because that’s where the change happens. That’s what’s exciting about MHSAs. They were the agents of change to bring that about.”

One state-level informant stressed that counties need to take steps to ensure that older adults are included in the stakeholder process, to be the voice for older adults. She notes that older adults need to be better integrated into the planning process and that counties need to be more accountable in their responsibility to include older adults on stakeholder advisory groups. The State used to have an Older Adult Mental Health Liaison position that ensured that older adult services providers, families, organizations, and consumer organizations were aware that funding for older adult mental health services was available through Community Services and Supports. It also facilitated the involvement and perspectives of older adults in the stakeholder process. This position was the only state-level position that specifically represented the

interests of older adults within the public mental health system. When it was defunded, leadership for, and accountability to, this population was lost. Today, there are other untapped opportunities to advance a voice for older adults - through the Mental Health Consumer Network, and through the National Alliance for Mental Illness, organizations that also lack older adult consumer input in their organizational structure.

“There’s always something lost when you don’t mandate money for a certain age group. It depends on who speaks the loudest, who can get to the table, and older adults, their family caregivers and consumers, are really hard to advocate for themselves. It often rests on the professional advocates to do that.”

Community Focus & Empowerment

“Empowerment is a huge, huge motivation for folks to get better”.

County key informants provided examples of community-based peer programs that are designed to empower consumers of mental health services. Some of these programs are tailored for older adults. One program has embedded older adult peers into a clinical team. Another program has a committee that is specifically focused on the concerns of older adults.

Exemplary program

One peer program in an urban county empowers consumers to organize, plan, and do outreach and social engagement. It is always well attended (50-75 attendees at any given event), and participants are provided a stipend of \$20 per hour. The program is organized around a number of committees, including the Elderly, African Americans, Hispanics, and the topics of Trauma and Spirituality. Peers provide training on how to conduct presentations, and the program supports transportation costs to and from Sacramento for advocacy purposes. Two older adult consumers who were involved with this program discussed the positive impact that their involvement had on their self-worth and social functioning. One describes the experience as follows:

“That was kind of exciting to me. I wanted to get involved with it because it made me feel comfortable that other people that came to do the orientation were consumers as well. They made me feel comfortable, there was no stigma, discrimination, people accepted me the way I was, there was no judgment. I really felt comfortable in that group. They asked me to be on one of their committees, focused on helping to transform the mental health system. I joined...in 2008, and I almost immediately got into one of their committees. We have 15 different committees that help address issues that the consumers themselves have, or the County leadership wants us to have feedback on. The

[program has] helped me move further in my recovery. I felt better about myself. I felt like I was contributing."

Exemplary program

A non-profit organization in an urban county started a program to help older adult consumers learn about and access the benefits and services they needed to live independently in the community. Over time, the program evolved into a peer-run advocacy group that has developed a strong network of trained peers who are concerned with local and state policy issues. The objective is to empower individuals who then contribute their voices in policy making at State and local level, to improve their health and therefore the communities they live in. Recent examples of their work include advocacy supporting "Californians for SSI" and the decriminalization of homelessness. The group meets weekly, and they coach individuals to develop scripts.

"There is a pride that's there; I am doing something for my community, whereas perhaps before I was told I was just taking from it, robbing it. It's a great extension, of recovery, the community, all of the above, to help this person be fully who they really are."

What most of these programs have in common is a focus on self-advocacy, problem-solving, building life skills and a sense of community. One key informant notes that these are the essential ingredients needed to address the stigma that can accompany mental illness:

"We promote community – we encourage people to talk to their neighbors, the more you talk to people the easier it gets. Getting people engaged in the community reduces stigma."

Ongoing challenges

Despite many informant accounts of efforts and actions taken to provide holistic care to older adults, some county mental health departments are undermined by very basic gaps, such as providers not understanding or being able to identify the difference between dementia and depression. In addition, informants in three counties report a level of fragmentation in the county system (organizational, financial) that prevents any one organization from drawing on resources to care for someone holistically. This directly affects system-level planning and the ability of county agencies to effectively refer within the system and/or to successfully integrate the delivery of services.

In some counties, especially under-resourced counties, there appears to be little consideration or capacity to address the needs of special populations (e.g., LGBT, certain racial groups, homeless seniors). While providers emphasize an organizational culture of dignity and respect for older adults, some consumer stories suggest otherwise, describing for example shelter

conditions and law enforcement encounters that undermine dignity and respect towards the homeless.

As noted earlier, the role of older adult consumers, family members, and caregivers in MHSA planning appears to be quite limited. Some counties report that the process of stakeholder engagement is not very functional and provides very little opportunity for input. One informant suggests that planning decisions are often driven by individual staff priorities, and are a matter of chance, i.e., whether or not that individual staff member values older adults.

A state level informant points out that the voices heard at the MHSOAC are not necessarily focused on older adults, that older adults have never been high on the MHSA policy agenda. The focus of the MHSA was on the underserved, especially the homeless who are the most expensive to treat. The recent \$2 billion bond for housing initiative rose out of frustration that MHSA did not do enough for housing. Older adults are still not a priority.

Another state informant's comment captures the continued invisibility of older adults in mental health policy discussions:

"I'm embarrassed to say that I haven't been thinking very much about older adults and this conversation has definitely motivated me to talk about that more and start looking. That is an area that [we] can very much have a voice and advocate for..."

MHSA Planning

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Planning at both state and county levels is deficient, which is explained by inadequate staffing and resources, poor data collection, inconsistent reporting and needs assessment, and no reporting mandates for older adults. Much of the planning, implementation and service delivery work is done at the county level, with little guidance from the State. The type and level of data reported varies by county, and many counties focus more on dollar spending than on service utilization. In smaller, more rural counties, some planning efforts had begun only very recently (approximately one year ago), bringing healthcare, social services, and law enforcement together for the first time. Where strategic multi-year planning processes exist, they typically involve a combination of any of the following: conducting population-level needs assessment, surveys, mapping of social determinants of health, stakeholder input (consumers, families, county contractors, professional staff), strategizing, and drafting of short and long-

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term goals for the county.

System-level planning

Key informants note inadequate, and in some cases even absent, service planning, service integration, and inter-agency collaboration. This is especially true among county-level agencies, such as Area Agency on Aging, Behavioral Health, and Public Health. Planning at the state level is also problematic: one state agency does a four-year planning process, containing a state-level demographic update, examining trends and stating objectives. MHSA funds were incorporated in their plans. This State plan goes into a federal agency to fund grants for services. This state department's plan is not shared with DCHS or utilized for mental health service planning.

Much of the planning, implementation and service delivery work is done at county level, with little guidance from the State. However, counties must conduct needs assessments as part of their 3-year program planning and annual updates. The type and level of data reported varies by county, and one State informant described difficulties in aggregating data produced by counties. For example, one state-level informant pointed out that they have yet to know exactly how many older adults with SMI there are and what services they need. Another informant noted that many counties record dollar spending, rather than service utilization. This makes cross-county comparisons difficult, and undermines a cohesive story about service utilization.

In smaller, more rural counties, some planning efforts had begun only very recently (approximately one year ago), bringing healthcare, social services, and law enforcement together for the first time. In one county, the establishment of the MHSA Planning Committee has prompted many conversations about the inadequacy of service provision to older adults, and established this problem as “really critical.”

Where strategic multi-year planning processes exist, they typically involve a combination of any of the following: conducting population-level needs assessment, surveys, mapping of social determinants of health, stakeholder input (consumers, families, county contractors, professional staff), strategizing, and drafting of short and long-term goals for the county.

Planning barriers

At the state level, agencies do not have sufficient staff and infrastructure to manage county data and generate needed reports for planning and evaluation. There are competing demands

for working with data to figure out the best methods to organize the resources to report data. Mandates for reporting by the State take priority. There is little room for discretionary work and further exploration. Mandates for reporting are currently in place for children, but not older adults. Since DHCS inherited the DMH data system, they are not getting the full picture, because not all people in the system are on Medi-Cal. Also, although there are robust data in FSP, not every person who has a mental illness is in FSP.

Data collection is an issue across counties, and systematic data collection does not appear to be an established practice. This is explained in part by incompatible agency-specific electronic systems, and in part by the fact that the State has to pay counties to cover expenses for collecting and reporting mandated outcomes data.

County and State planning processes insufficiently reflect culturally diverse groups of older adults, such as LGBTQ and other minority groups. This is a problem despite the fact that counties seem to be aware of demographic shifts locally.

The statewide coordination infrastructure for OASOC is deteriorating. Previously every county used to have a coordinator, or person responsible for older adults services. They met under the auspices of the CBHDA as the OASOC committee. Several years ago the OASOC was merged into the Adult SOC Committee, and more recently they have not been meeting.

There is system fragmentation across counties, with county-level agencies operating in silos, without considering, or sometimes knowing, what other organizations are doing. This entails a lack of intelligent planning around population needs, and insufficient consumer involvement.

A few informants mentioned that needs assessments do not tease out older adults; instead they subsume older adults under adults. Stakeholder involvement in some counties has not been functional because sessions are not advertised in advance, or are held at inconvenient times/locations. Several consumer informants lamented that there is not much opportunity for consumer involvement. One state informant has indicated that stakeholder engagement has not met the spirit of MHSA engagement, and often counties assert themselves in establishing population needs, without considering stakeholder input.

In one county MHSA planning is driven by MHSA committee staff priorities. So consideration of older adults in the planning process depends on individual priorities. This means that the process is often not transparent, so it is unclear how the interests of consumers, families, the needs of minority communities are considered, or how the funding process occurs.

“The committee members don’t have ownership, they don’t have an opportunity as they would like for a lot of input.”

In some counties, historically, some agencies such as AAA, had been excluded from MHSA Committees. They have only recently joined the process. In other counties, not all relevant agencies participate in the planning process, for example, Public Health.

Planning facilitators

At the state level, a system is in development to assist with county data collection and aggregation, which would address some of the issues with service delivery and program outcomes.

“We don’t have the system [for performance outcomes] that we need. Is there work being done to try and get us there – yes, absolutely. Is there progress being made? I’m not sure there is such a thing as progress. We either have it or we don’t, and at the moment, we don’t.”

Informants in a rural county explained that integration and planning had been facilitated by agency reorganization, i.e. bringing Health and Human Services, Social Services, Public Health, Behavioral Health and Emergency Services under one super agency.

Leadership in several counties acknowledges that considering older adults separately from the general adult population, planning for the long term, and maintaining continuity are important. State-level informants also underline the importance of distinguishing older adults from adults, which assumes different population needs, and as such, different types of services to be provided.

Larger, more urban counties, with more institutional resources (i.e., staff, funding), report multi-level planning processes, with numerous opportunities to involve consumers and providers. Informants in several of these large, urban counties describe consumer forums that are very well-attended, often standing room only. In addition, advising committees draw on consumer representation.

“The stakeholder piece, all of that, we didn’t really have an older adult stakeholder group. And so once a month we meet with them...I always give an update of what’s going on in the department and then we present on different issues. Sometimes we have them present and have a discussion. And then we also train consumers to work with

other consumers and they're called service extenders and some of them are out in the field working with the teams."

Examples of good stakeholder involvement in a small county include the use of their Adults System Improvement Care Committee which involves consumers, family members, and professional staff; and the In-home Supportive Services (IHSS) Advisory Council, which has consumers and advisers on it. A number of stakeholders discussed inter-agency collaboration. County-level agencies are working together, and with community-based organizations, clinics, and universities to understand population needs, build capacity, and provide holistic care. For example, one county is conducting a Whole-Person Care Pilot by focusing on high-utilizers of multiple systems (HUMS) adults. Another example comes from a large, urban county which is planning housing services by working with developers and the Housing Department. Another county assesses and meets its workforce training needs by working with an area university. One state-level informant said five counties are looking to pilot wrap-around services that include intensive case management, crisis services, mental health, substance use disorder services, all co-located.

Highlight: Exemplary planning

In one county, one municipality appeared to have a more advanced system-level planning. Informants there report that such planning occurred, in part, under the city's embrace of the WHO Aging Friendly framework. The framework aims to make cities more friendly towards aging populations, by removing environmental barriers and improving public infrastructure such as parks and sidewalks. Embracing this framework reflects their recognition that there is a high concentration of older adults in that area, which necessitates coordination of service provision, asset mapping, and planning between city agencies and non-profit organizations.

Suggested improvement strategies

One informant suggested that counties steer clear of the medically-based billing system and designing services based on payer sources. Instead services should reflect population needs. One consumer informant said that ideally the stakeholder input should reflect the following principles: 1) alternatives to hospitalization; 2) revise rights for mentally ill persons; 3) housing; 4) employment; 5) nothing about us without us. Finally, one state informant said there needs to be greater focus on data and performance driven methods for data analysis. Too often, focusing on compliance of county mental health services has led to many unanswered questions as to the populations being served by MHSA. The 5% of MHSA funding set aside for the state was originally intended to run strong evaluations for outcome exploration that is data and performance driven.

Pathways to care

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Older adults with mental health needs are identified or access care in a variety of ways. Much more needs to be done to reach out to older adults who are not making their way to services because of the stigma of mental illness or the nature of their mental illness. Outreach efforts vary by county: some are engaged in active outreach efforts, for example, through regularly scheduled community-based trainings and information sessions addressing stigma and discrimination. Some of these sessions are targeted to reach underserved racial, ethnic, cultural, other special identity groups, and older adults at supportive care facilities, low income senior housing, and senior centers. Mobile-based outreach is noted to be especially important in rural and frontier counties as well as in rural pockets within larger more densely populated counties. Furthermore, mobile outreach is seen as essential for all older adults - rural or urban - who are homebound, limited in their mobility, and/or socially isolated.

The majority of the older adult service population is represented by those who have been living with SMI, often for many years, and have aged within the system. Because of restrictive eligibility criteria, older adults with emerging mental health needs are often not identified and served. Older adults with moderate symptoms were most typically identified and served through PEI programs, which are sometimes a pathway to programs that serve those with more severe symptoms and/or late onset mental illness.

Once clients enter the system, they undergo in-take assessment, including administrative processing and standardized screening. Most counties conduct an intake assessment that is designed for the general population and, as such, does not account for the special needs of older adults. However, one large county does conduct geriatric-specific assessments.

Referrals and linkages to and from appropriate services vary depending on program eligibility requirements, the resources available and whether effective referral mechanisms are in place. Most counties have a triage process for all clients who come in for assessment. In one county, depending on the result, the client is either served directly by the county, referred to a source of primary care, or to a county-run or contracted Medi-Cal managed care provider.

Regarding client progression through the system, counties seem to have different capacities to respond to different levels of service needs. Some counties have a continuum of services which enables them to serve older adults at the prevention, mild to moderate, and severe levels of acuity. In other counties this continuum is weakened because of different funding streams for clinical services.

Barriers to accessing care include unmet basic needs (e.g., food, clothing), geographic disparities (especially rural vs urban areas), transportation and housing deficits, insufficient

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workforce, administrative and bureaucratic constraints, and insurance coverage and care costs.

Facilitators to accessing care include increased awareness about mental health, increased consumer knowledge about the system and services available, home-based service provision, smooth referral pathways, and improved transportation infrastructure.

Outreach and Access

County key informants report that older adults with mental health needs are identified or access care in a variety of ways. They note that much more needs to be done to reach out to older adults who are not making their way to services because of the stigma of mental illness. Some counties are engaged in active outreach efforts, for example, through regularly scheduled community-based trainings and information sessions addressing stigma and discrimination. Some of these sessions are targeted to reach underserved racial, ethnic, cultural, and other special identity groups. In addition to county-sponsored formal training and information sessions, some contracted agencies also conduct targeted outreach to reach older adults at supportive care facilities, low income senior housing, dialysis centers, adult day health centers, and community medical clinics and senior centers.

Some counties go out into the community to directly engage and assess older adults. Peer outreach was reported by many to be a very effective strategy. One urban county's peer group has an elder committee that does outreach at community events and fairs where they provide information about the peer program and about the services offered through the county department of mental health.

Mobile-based outreach is noted to be especially important in rural and frontier counties as well as in rural pockets within larger more densely populated counties. Furthermore, mobile outreach is seen as essential for all older adults - rural or urban - who are homebound, limited in their mobility, and/or socially isolated. One rural county reported that the need for mobile outreach services was identified through their MHSAs stakeholder engagement process. This county now has large mobile units that cover the northern and southern parts of the county and include the services of a public health nurse. Key informants noted that given the prevailing stigma in rural communities, the public health nurse alleviates some of the concern because the initial encounter with the consumer is a physical health check.

Other counties are using PEI funds to conduct mobile-based outreach in conjunction with short-term supportive services, usually to facilitate access to services for those in need. One large and densely populated county's mobile team reaches out to emergency rooms and to Emergency Medical Services (EMS) to identify older adults who need support, e.g. people who show up with falls, or with suicidal ideation. They also administer the Geriatric Depression Scale

(GDS) at health fairs and reach out to Psychiatric Emergency Services (PES) for persons who have been engaged in an involuntary psychiatric hold (i.e., 5150) as per the Lanterman-Petris-Short (LPS) Act. Their goal is to provide support as early as possible, stabilize and then link to services. Typical linkages include medical support, case management, and psycho-therapy, as needed.

Another county is engaged in an innovative approach to reach homebound and isolated seniors through a partnership with postal and food delivery workers, who are most likely to have a regular point of interaction with older adults who are not otherwise engaged in the community or connected with services. Other points of access to mental health services identified by key informants require older adults or their family members to take the initiative to reach out for services, e.g., through toll-free information and assistance or crisis intervention hotlines available to all age groups. Finally, many consumer key informants reported entering the mental health system from the Emergency Room (ER) and/or through psychiatric hospitalization.

Older Adult Population Served

Most county key informants report that the majority of their older adult service population is represented by those who have been living with serious mental illness, often for many years, and have aged within the system. One key informant indicated that the county mental health agency through its eligibility criteria (need and income) effectively limits service delivery to only those with serious and persistent mental illness. Some contracted programs that provide intensive team-based services for older adults with serious mental illness are only available to clients who have been determined to be high cost and high services utilizers and who are directly referred by the county's subacute psychiatric center.

Given these criteria, there are older adults with emerging mental health needs who may not be identified and served. Indeed, several key informants report that the older adult population with late onset mental illness is generally harder to identify and link to services due to: social isolation, primary care providers (PCPs) not being set up to identify and refer; and the safety net social service providers who don't have the necessary training to effectively deal with an older SMI population. One rural county informant reported that for this group, the way into the system is typically through the general hospital which does not have any psychiatric beds. The hospital's case manager then works with the behavioral health department to find treatment options and alternative placements (sometimes in neighboring counties). Another key informant reported that patients who don't meet the acuity of depression required for county services are referred to other places for counselling; when, in fact, all they needed was a short-term treatment to help with grieving for loss. She fears that some get lost in the system.

One key informant observed that older adults with late onset mental illness are less likely than younger age groups to ever be referred to county mental health. If they are older and have a

usual source of primary health care, it was posited that they stay within the primary care health system to maintain continuity of care for their physical health needs. Whether their mental health needs are being effectively addressed, however, is an open question.

Older adults with moderate symptoms were most typically identified and served through PEI programs, which are sometimes a pathway to programs that serve those with more severe symptoms and/or late onset mental illness. These PEI programs are often provided by contractors with the county, and sometimes delivered by providers within the aging services network. One contractor in a large urban county reported that the majority of their clients are newly onset but severe; primarily depression and anxiety. However, they also serve a small percentage of older adults aging with SMI, most typically bi-polar disorder or schizophrenia.

Assessment

When outreach efforts are successful, older adults are referred to county mental health departments from a variety of sources: by senior centers, information and helplines, and peer counseling programs, to name a few. Typically, their entry is marked by the completion of an intake assessment. Ideally, the results of the intake assessment inform the referral to appropriate programs and resources.

Most counties conduct an intake assessment that is designed for the general population and, as such, does not account for the special needs of older adults. For example, one key informant reported that if an older adult needs a Board and Care placement, there is a more specific form that needs to be completed which is not part of their standard assessment. Another key informant described that her county uses a full psycho-social assessment for both adults and children. They use the same tool across the lifespan, because when people enter the system, they receive an in-depth assessment from a psychologist. If an adult of any age is severely mentally ill or has functional impairment, they get into the county's adult system of care. Older adults presenting with mild and moderate symptoms receive treatment through a different program provided by county contractors.

One exception to the general population intake assessment was noted by key informants from a large and densely populated county. This county does a geriatric-specific assessment through their field and capable clinical services (FCCS) program. They send a nurse and a social worker team out to meet older adults in their homes or other community settings. There they conduct a complete bio-psycho-social assessment, which evaluates mental health and physical health as well as more holistic concerns, i.e., adherence to medication, nutritional needs, home environment, etc.

County key informants also reported on a number of standardized screening and monitoring tools they use to evaluate older adult consumers, both at the beginning and throughout their course of receiving county mental health services. The standardized tools used include the

Mini-Mental Status Exam (MMSE), the Geriatric Depression Scale (GDS), and the Columbia Suicide Severity Rating Scale (C-SSRS). One key informant observed that the use of standardized assessment tools is good clinical practice. Their use benefits consumers, supports continuity of care; while also providing a common language and way to standardize care across geriatric, primary care, mental health, and other agency settings. For example, one county's protocol and assessment for hoarding (using the Clutter-Hoarding scale, 1- 5) provides common understanding across medical and mental health clinicians, and also helps code enforcement, housing departments, and other first responders who deal with hoarders.

However, key informants reported that the consistent use of standardized tools varies. One key informant contracted by a large county reported using the county's mandated tools and then adding some of their own preferred tools to the mix, which were not required but perceived to be useful and effective with older adults. Another key informant reported that assessments in her organization are not done systematically, that there is no check-list, except "in the clinician's 'head'". A geriatric rural outreach worker in a large county reported very little use of standardized assessment instruments, and no connection to a computerized medical record for her notes.

One key informant noted the value of screening older adults for depression: "I also do the Geriatric Depression Scale but I also know that I'm probably the only one that does that. I wish that it was done on all of our older adults but, you know, work in progress..." Indeed, depression screenings are not routinely done in most counties and key informants mentioned untapped opportunities to identify unmet needs in settings that frequently touch older adults, like hospitals. One key informant reported success using the Geriatric Depression Scale (GDS) at health fairs to screen for depression and suicidal ideation, identifying "emerging" older adults with, or at risk for, SMI, and connecting them to appropriate services. Another county contracted provider plans to start using Adult Needs and Strengths Assessment (ANSA) in the near future, as required by the county. But in the interest of improving their assessment of older adults, they are considering adapting ANSA to better reflect older adult needs.

Finally, one key informant observed that in her county older adults with mental illness are often placed in skilled nursing facilities without a complete assessment or setting of goals. She suggests that the county become more strategically engaged with skilled nursing and assisted living facilities. She believes that would facilitate early intervention and the capacity to screen and intervene in settings where challenging behaviors, complex cognitive and other psychiatric issues often converge in a difficult way.

Referrals and Linkages

Referrals and linkages to and from appropriate services vary depending on the resources available and whether effective referral mechanisms are in place. For example, one county has to refer to a neighboring county for psychiatric hospitalization and most counties have few, if

any, supportive housing resources for older adults. Referrals also depend on program eligibility requirements, including the results of certain screenings to assess the acuity of the mental health concern.

Key informants in most counties describe a triage process for all clients who come in for assessment. In one county, depending on the result, the client is either served directly by the county, referred to a source of primary care, or to a county-run or contracted Medi-Cal managed care provider. Within the county mental health system, eligibility for specific programs may also be determined through an assessment process. For example, one county's mental health department has implemented an evidence-based PEI program to address older adult hopelessness. It is a voluntary program for adults 55 years of age and older who are assessed using a standardized hopelessness scale. Those who score moderate to severe on the scale meet with the doctor. They are then eligible for short-term therapy, medication and may be connected with resources in the community to address big stressors such as lack of food, or problems with shelter.

While primary care providers can refer their patients to county mental health, a key informant in one county indicated that they tend not to do so. They noted that most primary care providers want to prescribe the medication themselves, for their patient's anxiety or depression, for example. But this raises the question of whether the primary care physician should instead be making a referral to specialty care since s/he may not have received sufficient training to effectively manage mental health problems and medications, especially for older adults.

Aging service providers provide another source of services for older adults with mental health concerns. Half of our study counties contract with the local Area Agency on Aging or other aging services providers to provide PEI services such as senior peer counseling and senior outreach programs, or linkages to supportive services including adult day health care, congregate and home-delivered meals, case management, and transportation. Most of these aging service providers do not provide clinical services and, in turn, can refer clients to the department of mental health when these services are needed. However, the nature of the relationships between these service sectors vary, with some counties reporting fully engaged partnerships; and others describing pathways for referrals but little, if any, follow up to know the outcome.

Progression Through “The System”

County key informants report different capacities to respond to different levels of service needs. Counties (or sometimes specific cities or geographic areas within counties) that have a more developed and comprehensive system are describe by some key informants as having a continuum of services which enables them to serve older adults at the prevention, mild to moderate, and severe levels of acuity. In the best scenarios presented, the system is adaptable and responsive to the consumer's changing needs. For example, the system provides on-going

support for people who entered the MHSA program at high level of need, then improved, are now stabilized and at a moderate level of need, facilitating the consumer’s ability to “step-down” and not lose services.

Some key informants describe the benefits that accrue to consumers when all services are provided under the same umbrella or system of care. As one large county key informant describes it, they are using MHSA PEI dollars to provide help to folks they wouldn’t previously have seen. Then, if the older adult starts with PEI and they’re not progressing enough, they can switch them to their field capable clinical services program where the consumer can benefit from some long-term services. If an even higher level of care is needed, the consumer can then be referred to Full Service Partnerships (FSP) under the Adult System of Care. They can continue their field capable clinical services until they are really ready for the transition, which makes for a really warm hand off. This allows the county department of mental health some flexibility, while also increasing their responsibility and accountability.

Other key informants, however, report that because clinical services for older adults are differently funded and not always MHSA influenced, there is sometimes a challenge to link PEI and FSP to clinical care that is age targeted. As a result, some older adult recipients of PEI who need more than prevention, i.e., who need clinical services, are not gaining access to the types of services they most need. In counties with less fully-developed systems, key informants report that service gaps sometimes result in providers in institutional settings (e.g., sub-acute psychiatric care) being reluctant to discharge because of insufficient transitional/step-down services.

Barriers to Accessing Care

Both county and state key informants observed that public mental health services are not always accessible to the older adults who need them. Informants detailed a range of barriers to access, including: unaddressed basic needs; geographic disparities; transportation and housing deficits; workforce shortages; administrative and bureaucratic challenges; and insurance coverage and care costs.

Basic needs

Key informants in both rural and urban counties said that for many older adult consumers, basic needs (i.e., food, housing, clothing, medical care) must first be addressed before mental health services can be appropriately accessed and used.

Geographic disparities

Access to certain services may depend on where you live. In some counties, specialized mental health programs for older adults are only available in certain geographic areas, typically the cities or more densely populated areas. In other counties, even basic services are not available in certain geographic pockets. In one county, the mobile crisis units were only available in one part of the county. In other parts of the county, they had to resort to using the police who were

not ideally trained or prepared to deal with behavioral health issues and were intimidating to clients.

“Equity is one of the issues. Where you live...it depends on...where you live, whether you’re going to get connected with the service you need, or be on a waiting list, or really have your issues addressed in an effective way.”

State key informants also note geographic disparities in staffing and programming for rural residents. Rural areas are a priority of managed care, as they often lack provider networks. Despite the lack of networks, rural providers do not turn away individuals. Some state key informants expressed concern that these providers would be penalized if placed under audit. Additionally, state key informants noted ongoing access problems related to rural health workforce shortages. While across California there is a well-documented shortage of geriatric specialists, they point out that this deficit is even more pronounced in rural areas.

Transportation and housing deficits

Transportation challenges exist in both rural and urban areas. For rural counties that span a large geographic area with many remote communities, transportation is a huge issue. Predominantly urban counties also have pockets of remote communities that are hard to access. Due to geographic distances, it is costly and time-consuming to provide transportation to and from these remote areas. Yet funding is provided based on population, and does not take into account that service delivery and transportation costs are greater in a rural county. Public transportation options, while widely available within urban areas, tend to have limited service to the more remote areas within counties, and so are also inadequate.

Transportation barriers are even greater among the segment of the older adult population that has mobility limitations, cognitive impairment, and complex chronic conditions that make travel difficult even in areas with robust public transportation options. Sometimes the costs of public transportation (between \$2.50 - \$5.00 per ride in one county) are prohibitive for older adults with mental illness who are living on a very limited and fixed income.

Across all counties, the need for more supportive housing for older adults was mentioned. Key informants spoke of the barriers that older adults with physical health / mobility problems face securing affordable and supportive housing situations. Furthermore, homeless older adults face additional barriers to care, as some programs will not accept older adults who are homeless, even when affordable and appropriate housing options are virtually not available.

Workforce-related issues

At the state level, informants report that MHS budget cuts that eliminated older adult mental health liaison positions between state and county mental health departments have created

discrepancies in how MHSA funds are used. The lack of liaison positions at both state and local levels has made it more difficult to introduce and maintain older adult perspectives in MHSA planning and stakeholder groups, which require 50% of members from consumer and family groups. However, it is especially difficult to include older adults because of additional challenges they face related to physical health, mobility, and transportation.

In the counties, geography also affects the availability and efficiency of providers: in a more rural region of one county there is a market failure. There are very few behavioral health offices and clinician caseloads are large, typically between 28 to 40 people. Case managers in these remote communities are also very saturated. So whenever the county adds a new contract, they emphasize services in the rural region to incentivize them. The county is concerned with regional equity and thus is focusing resources to the more underserved regions through their contracting.

Workforce shortages have also limited *who* gets served in the public mental health system. For example, a large Spanish-speaking community in a remote area of a rural county currently has only one Spanish speaking case manager and no Spanish speaking clinicians; in effect, there is almost no capacity to serve the older adult members of this community who have mental illness. Another barrier to access noted by informants in most counties is a lack of personnel with clinical expertise in dual diagnoses, especially for older adults with SMI and dementia, or with SMI and substance use disorders. This staffing deficit is further complicated by the administrative complexities of who can provide mental health services, who can provide dementia care services, and how these providers get paid.

Administrative and bureaucratic constraints

Some direct service providers note that there is an undue burden of paperwork for consumers. They point out that the process of completing paperwork often induces anxiety and makes older adults feel inadequate and no one should be made to feel like that. County mental health staff also described being overwhelmed with paperwork, slowing their ability to act on referrals. In one county, this created a backlog for a community aging services provider who was unsuccessful after repeated attempts to refer older adult consumers with serious mental illness to the county mental health department.

Another administrative constraint noted was a contracting process that is unduly lengthy and sometimes leads to unspent funds. When this happens, access to appropriate mental health services is compromised and some older adults who need care end up in emergency rooms. Finally, both state and county informants observe that the interpretation of the Health Information Portability and Protection Act (HIPPA) can create barriers to communication between mental health and physical health practitioners that affect access to care. While some organizations have legal counsel that interprets HIPPA to facilitate the communication of health

information between providers, most are more conservative in their interpretation and tend to err on the side of restricting such communications.

Insurance coverage and care costs

At the consumer level, key informants report that co-pays for certain medications under Medicare, and for some Medi-Cal services (including share of cost for some In-Home Supportive Services (IHSS) recipients) can greatly hinder people's ability to access needed services and follow through on treatment plans. Several consumer informants reported incurring out-of-pocket costs, especially for individual counseling/talk therapy.

In addition, consumers with only Medicare coverage report difficulties in getting mental health services. One informant provided the following example: An older adult consumer was referred to a community behavioral health clinic to get an evaluation. She was told: "they can help you from there". However, they couldn't help her because she had only Medicare (they only accept those with Medi-Cal) and she was not psychotic. To see a therapist in behavioral health, she would have had to go through a long chain of command: a doctor would need to establish that she needed a case worker, and then the case worker would need to establish that she needed to see a therapist.

One state key informant noted that implementation of the ACA supports the delivery of services for people with mild and moderate mentally illness through the health system, while the public mental health system continues to focus on the SMI population. When mental health services for the SMI population are thus carved out of health care, there needs to be a more effective pathway to screen and link individuals with SMI to primary care providers or federally qualified health clinics.

Facilitators to Accessing Care

State and county key informants also provided examples of actions that have facilitated access to care, including: increasing awareness and use of MHSA funding by community-based organizations; bringing services to the homes of older adult clients; increasing consumer knowledge and use of benefits; improving referral pathways; and enhancing transportation options.

Increasing awareness of MHSA funding

One state informant observes that government bureaucracy has often deterred community based organizations (CBOs) from doing business with the State. In response, the State has eased the request for proposal (RFP) process and also made the procurement process more culturally competent. Additionally, state departments have partnered with universities to conduct educational outreach and increase awareness of MHSA funding. The State hopes to build bridges between county mental health and CBOs to increase sustainability of programs.

Bringing services to the homes of older adults

Tele-psychiatry has increased access to psychiatry services by using clinic computers to give consumers “face-to-face” time with psychiatrists. One county has enhanced this option by bringing tele-psychiatry into clients’ homes, via laptops and other electronic devices which facilitate access to psychiatric services, especially for those who are homebound.

Increasing consumer knowledge and use of benefits

An MHSA-funded wellness center in a rural county provides support to older adult consumers who need assistance accessing and managing forms related to Social Security benefits, enrollment in Obamacare, applications to the Department of Housing and Urban Development, to name a few. The center also provides information about, and linkages to, other county services and resources, including employment services, aging services, financial management, and medication management.

Improving referral pathways

One rural county is planning an MHSA innovation project to develop a better system for referrals between hospitals, clinics and behavioral health, systems that are currently disconnected and not communicating with each other.

Enhancing transportation options

Counties are engaged in a number of efforts to improve transportation options. One county’s mental health department provides transportation to their clients, using their own fleet of cars and behavioral health aides. Another county is working on establishing bus stops outside of all senior centers. Yet another has a program where seniors serve as peer companions, and help clients make it to their appointments. These efforts have been especially important to reaching older adults who are socially isolated, have mobility problems, or who don’t have access to adequate transportation options.

Service Gaps

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Service gaps have been observed across all counties, although some informants note that there are fewer gaps now than there were before the passing of the MHSA. There are many factors that contribute to service gaps, but notable issues include insufficient funding and the set of constraints attached to particular funding sources. There are gaps in services for older adults with cognitive impairment; and for older adults in general, including long-term case management, therapy and psychiatric counseling, peer services, transportation, transition/step-down services, and culturally-appropriate services.

Services for older adults with cognitive impairment

Across all counties there is a service gap in this area because of the dementia carve-out, since dementia is an excluded diagnosis for behavioral and mental health service provision. Among providers, there is a much confusion and misinformation about where older adults with a dual diagnosis of SMI and cognitive impairment are entitled to receive services and how they are paid for. In some counties, key informants report that older adults with dual diagnosis have access to care. However, the order of diagnosis matters: the primary impairment has to be related to mental health (psychiatric) and not dementia. This raises questions when providers can't tease out a diagnostic path (e.g. untreated UTI, vitamin deficiencies, vs dementia). In at least one county, dually-diagnosed are difficult to place, with many long-term care settings reluctant to take them.

“So if you are wandering, or if you are psychotic, it has to be because you’re confused, and you are [not] sundowning, and how you tease that out becomes a challenge, knowing the mandate, knowing the funding stream.”

Service gaps for adults with both SMI and dementia include: long-term case management; housing; support for daily activities; and training, education, and respite for families and caregivers of older adults with dementia.

Insufficient service coordination

Across all counties, service coordination between behavioral health and public health and geriatric specialists is inadequate. This affects referrals and access to care. Informants in five counties also stressed that lack of coordination means that services often do not reflect the medical and social complexity of older adult needs. A state informant noted that older adults who are managing both physical and mental illness need to have services juxtaposed to better serve them holistically (specifically for the dual-eligible population).

“Older adults have a unique array of case management needs that our younger adults haven’t arrived at yet; they have lost their natural social support, their families, so the clinic may be their only source of support”.

Insufficient funding for older adult services in general

In most counties, lack of funding for older adult services in general has resulted in service gaps in the following areas:

- case management;

- therapy and psychiatric counseling (4 counties);
- substance abuse therapy (2 counties);
- field-based services (including mobile clinics);
- peer services (including training of peers, and implementation of peer support);
- transitional/step-down services and housing (targeted at, for example, homeless adults about to be discharged from hospital);
- linguistic and culturally competent services (for instance, LGBTQ, undocumented refugees, older adults survivors of trauma; more evidence-based programming needed);
- in-home supportive services (particularly in rural counties with poor transportation infrastructure, and limited eligible pool to recruit and retain volunteers);
- transportation support services (4 counties, particularly rural ones);
- outreach and awareness regarding county-level services;
- depression screening and suicide intervention (older men have higher suicide rates compared to women of the same age);
- housing and mid-range supported care facilities for older adults who are not ill enough to be referred to a SNF.

Below are several quotes of perspectives shared by administrators and providers:

“I think we would all agree, here in my department, that the older adult population is not as fully funded as it could be, not as robust.”

“We are really opening up a conversation with our Behavioral Health Director about the growing need of the baby-booming population, the older adult population, and how we are not able to place them all. There are sizable limits to what we are able to do for them. They have needs that exceed our capacity: community resources across the spectrum of the older adult needs, in-home services, adaptive devices, transportation, medical case management, affordable housing.”

From the consumer perspective, these thoughts are shared:

“From day one with the County I’ve always requested psychotherapy along with the medications. The public health system has always told me I have to go out and find my own therapist. I don’t feel good about that, but that’s how the system works.”

“For quite a few years I haven’t seen a therapist at all. With this age I am at, approaching 62, I kind of grew desperate to start having counseling therapy again”

Insufficient funding for older adult services may also explain the lack of focus on older adult workforce training. Across all counties there is a shortage of geriatricians and other providers with geriatric expertise. The shortage is more severe in smaller, rural counties than in large, urban ones. One state informant notes that there needs to be greater incentives created to promote training about the complexities of older adults with mental illness at the state level. State departments are well aware of workforce gaps, however, these training opportunities for geriatric workforce preparation has not been prioritized through WET funding. .

Service gaps in primary and specialty care

Many informants described insufficient access to primary and specialty care because of lack of insurance/under-insurance/co-pays, across all counties. In particular, they noted lack of access for Medicare-only populations, as well as homeless older adults. One state informant said that older adults with SMI who enter emergency rooms as 5150 holds are “*service/system failures.*” The lack of sufficient outpatient services for older adults is of major concern.

As expressed by one consumer informant:

“Where I come from, the state law requires anybody who’s prescribed psychotropic medication must be offered psychotherapy to go along with it. And I was used to that. I had that, and I expected it when I got here. They were like ‘psychotherapy, we don’t offer it, you’re on your own’. Call the resources people, find a therapist. All you can really find on a limited income is somebody who is gaining hours to get licensed to be a therapist.”

Suggested improvement strategies

Informants made several suggestions to reduce the service gaps described above. Regarding diagnosis of cognitive impairments, and dual diagnoses, there should be an improvement in diagnostic awareness among healthcare professionals, particularly primary care providers (PCPs). Older adults should receive care, including long-term care, from an inter-disciplinary team of professionals, that includes geriatricians. Moreover, clinical care should be age-appropriate.

“The contract agency did not want to take on board and care. So once older adults hit that certain level of too many co-occurring conditions, they are at a loss as to how to help them.”

Concerning transitional residential programs, they should have carefully timed phases, supported by services: for instance, after 3-6 months of receiving services, residents should begin to move out into the community. Housing development should be prioritized, and should

include considerations of embedded behavioral health services, transportation infrastructure, environment, parks, and safety.

“We are trying to find housing that doesn’t cost [Institutions for Mental Diseases] IMD rate, doesn’t provide the limited services they receive in Board and Care, but rather something in between.”

Finally, when developing programs and mental health services for older adults, policymakers should harness communications technology (such as Skype) to facilitate service provision, particularly in under-staffed and rural settings.

Housing Needs

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Overall, housing is inadequate to serve the older adult SMI population in California. Although state and county stakeholders have reported progress in the area to meet the housing needs of mentally ill older adults, they also thoroughly characterized the current inadequacy of housing for the older adults in terms of availability, accessibility and quality.

County-level agencies note that funding levels for housing do not match the level of demand for housing and waitlists for supportive and subsidized housing range from 2 – 10 years. Many of their older adult clients spend more time in hospitals, simply because there isn’t safe and stable housing available.

Even when housing is available, the accessibility is limited based on income. In all counties it was noted that the lowest fee for most B&Cs is beyond Supplemental Security Income (SSI) income. Although homelessness is pervasive among older adults with mental illness, very few had programs aimed at identifying older adults at-risk of becoming homeless. When housing is available and accessible, the quality of housing remains questionable. Informants note that transitional housing for the homeless is often inadequate and disrespectful of human dignity.

Despite challenges, some counties have been able to make progress in providing secure and supportive housing for older adults with SMI. Some urban counties report offering good housing options that are part of their FSP program, providing homeless older adults with subsidized housing and integrated mental health services (including wellness and recovery training). Both an urban and rural county reported working in collaboration with the housing commission/authority. At the state level, there has been collaboration between DHCS (Mental

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Health Services Division), Housing, and Community Development, which has led to the passage of the “No Place Like Home” legislation.

Stakeholders also suggested strategies to improve the adequacy of housing provided through MHSA. A current limitation that can be addressed is that MHSA outcomes related to housing provision only assess whether housing is provided, and not whether housing is accompanied by essential supportive services for older adults.

Housing has emerged as a critical unmet need across all counties. County-level agencies note that funding levels for housing development do not match the level of demand for housing, nor real-estate prices. As a result, there are serious shortages of Board & Care (B&C), Skilled Nursing Facilities (SNFs), and a range of transitional and permanent housing options that are appropriate and affordable for older adults with mental illness. Reports from county key informants indicate that waitlists for supportive and subsidized housing range from 2 – 10 years, and three counties gave examples of older adults who only found housing outside their current county of residence, thereby splitting families apart and disrupting the services consumers were receiving from a familiar network.

Costs of Housing

In all counties it was noted that the lowest fee for most B&Cs is beyond Supplemental Security Income (SSI) income, hence the need for subsidies. Even with subsidies, some consumers struggle. One county reported that Section 8 vouchers were prioritized for veterans, further constraining access for older adults with mental illness who don’t meet these criteria. In some cases, a consumer’s ability to secure housing also affects their access to services (such as eligibility for the PACE program) which, in at least one county, requires consumers to have housing as a condition of participation. Key informants in one rural county note that their MHSA housing budget (about \$600,000) is inadequate to develop the housing needed for those with mental health or substance abuse problems.

Supportive Housing Needs

Populations especially affected by these housing constraints include older adults who are homeless, and those with moderate to serious mental health disorders, some of whom also suffer cognitive impairments (e.g. dementia) or other severe physical health deterioration. Many older adults cannot live independently and require daily supervision and assistance with

activities of daily living, case management, psychiatric or nursing support, and rehabilitation services (e.g., substance abuse treatment, physical therapy).

Older adults who already have permanent housing may require in-home support to ensure independent living at home, such as home-delivered meals, medical/nursing care, assistance with daily activities, and transportation. Yet, as one county key informant points out, MHSA outcomes related to housing provision only assess whether housing is provided, and not whether housing is accompanied by these essential supportive services. In rural counties, the cost of such programs is high because of the long delivery distances and locations of food distribution centers. At the same time, one urban county informant reports that it is more cost-effective to bring services to someone's home than it is to institutionalize them. In all counties, home-based services are often used as screening opportunities, looking for mental and physical health problems in older adults.

Lack of Appropriate Housing

Several county informants observe that the older adult SMI population has special challenges in maintaining stable housing and that case managers spend a lot of time trying to solve issues around housing. Many of their older adult clients spend more time in hospitals, simply because there isn't safe and stable housing to release them to. Informants also point to the difficulties of placing older adults who are not physically ill enough to go to SNFs, but need a supportive housing environment that addresses their chronic care and mobility needs. Such options fall somewhere between placement in overly restrictive institutional care settings or in unlicensed B&C facilities; neither of which is typically staffed, nor otherwise equipped, to appropriately address either the mental health and/or the physical health needs of older adults. Informants also note discrepancies in the quality of housing and care services provided by licensed vs. unlicensed B&Cs, with the latter being less likely to provide an appropriately supportive environment for older adults. Even when appropriate, licensed and unlicensed B&Cs are sometimes selective of the clients they accept, usually avoiding people with complex needs, a problem compounded by regulatory barriers (e.g., Medicare reimbursements).

State key informant reports mirror county-level concerns surrounding housing policy, and recognize that older adults who are both physically and mentally ill often face greater challenges in securing adequate housing. Furthermore, they note that the growing crisis of access to housing is compounded with a decline in the availability of, and access to, providers. As one key informant observes:

“The population is growing and we don't have enough service providers. I see this pressure cooker thing happening. The housing is becoming more expensive. [As] everything is becoming

more expensive, older adult anxiety and depression are going to increase. Eventually the pressure cooker is going to blow... [there are not] sufficient resources.”

Older Adults Not Prioritized in Housing Policy

While older adults with moderate to severe mental illness have been significantly affected by the growing housing crisis, to date, they have not been a focus of the policy discussion. One state key informant notes that while housing policy is most often prioritized to homeless individuals with mental illness, there is growing evidence that the state and county mental health departments could save more money by investing in older adult housing. This informant further suggests that the MHSOAC should lead advocacy efforts for older adults and encourage counties to gather and deliver age-specific information (and needs assessments) to better inform policymakers.

Homelessness and Older Adults

Although all counties acknowledged a growing problem with homelessness, including among older adults, very few had programs aimed at identifying older adults at-risk of becoming homeless. One rural county never spent any of its MHSA funds to create a housing resource for its SMI clients. They report that, while they have both a stable and transient homeless population, their FSP program does not offer transitional or temporary housing as a component of FSP services. As a result, case managers spend a lot of time piecing together supportive or transitional housing for clients. In this county, there are virtually no homeless services other than a shelter that is open 6 days a week in the winter months. The shelter is not supported by MHSA funds; it is a collaborative of churches and community agencies that began to work together after several homeless people died due to exposure a few years ago.

Generally speaking, the larger study counties have been doing more to address homelessness. Two urban counties report a range of housing and wrap-around services for homeless older adults. One county’s department of mental health now convenes a homeless subcommittee that has been learning more about the housing market, i.e., how it works, and how to access it. This county ranks people based on the amount of time they have been homeless, and prioritizes housing vouchers for those who have been homeless the longest. They are also engaged in current efforts to develop MHSA housing for seniors. While they don’t have a specialized older adult homeless team, they have teams in each of the county’s service areas, and on each of those teams there is an older adult service person.

Even where housing resources exist, however, informants note that transitional housing for the homeless is often inadequate and disrespectful of human dignity (unhygienic conditions, bed bugs, loud noises). Consumers report variance in the level of quality of shelters and transitional

housing that ranges from good to deplorable. Especially for those with SMI (e.g., post-traumatic stress disorder), these unhealthy conditions can act as triggers that accelerate or exacerbate symptoms and may lead to a mental or physical health crisis.

Housing for Older Adults: Promising Programs

A large urban county offers an example of good housing options that are part of their FSP program, providing homeless older adults with subsidized housing and integrated mental health services (including wellness and recovery training). The pathway into the program is by caseworker referral, followed by an intensive two-day assessment. One consumer informant who had gone through this process felt that his needs were met, but added that it was in part because he knew how to navigate the system.

Another mid-size county described an assisted living facility and a Residential Care Facility for the Elderly (RCFE), both of which are housing older adults with mental illness. The mid-range assisted living facility helps residents with medications, and offers meals on wheels, maid service, and socialization groups. Each person has a small studio apartment where they can prepare their own meals and live independently. They accept clients of all ages, but currently only have 7 seniors, some of whom have aged into this facility. One of our informants spoke highly of this facility and said she would like to see ten more of these facilities in the county.

The same county has a state-licensed RCFE (housing with supportive services). While the county pays for 23 beds in this facility, the balance of 26 beds is allocated to neighboring counties. The program is fully utilized (100% capacity), and there is a waiting list. It targets older adults with mental illness and chronic diseases. One consumer informant is a current resident and was very pleased with the peer programs and residential support.

Another exemplary program is currently under development by the county department of behavioral health services in an urban county. This program targets TAY, adults, and older adults with SMI, and provides housing and wrap-around services. It is estimated that once fully implemented, it will house up to 1250 consumers.

Housing for Older Adults: Successful Collaborations

In an urban county, the department of behavioral health services works with the housing commission to provide housing subsidies. In addition, they are working with housing developers to repurpose a 100-year old building. It took 18 months to get all the players to agree. The PACE Program provides support within the housing units.

In a rural county, the health and human services agency maintains a strong working relationship with the housing authority in the community. They have a number of placements, ranging from augmented B & C (mental health staff 24/7, 36 beds); to step down units (i.e., transitional housing); and permanent supported housing for mentally ill consumers. They are about to embark on two more permanent supported housing projects. Some older adults utilize these housing services. While there is no waitlist for these units, Section 8 housing applications have long wait lists. There are also plans to expand augmented Board and Care (15 more beds), for people coming out of psychiatric hospitals that need a high level of care.

Finally, collaboration at the state level, between DHCS (Mental Health Services Division), Housing, and Community Development has led to the passage of the “No Place Like Home” bill which aims to address the issue of homelessness across the state. While this law has the potential to improve access to affordable housing in general, it is not focused on the specific needs of older adults with SMI.

Workforce Training and Supply

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Key informants reported that MHSA has made a noticeable impact on county capacity to support workforce training and education related to older adult mental health care, yet gaps remain. MHSA WET funds have increased both the educational capacity of professionals, and consumer and family member employment within the public mental health system.

However, the rapid growth of an aging population, the historical lack of geriatric training in higher education for the helping professions, on top of an existing behavioral health workforce shortage crisis, has created many challenges. Understaffing and inadequate geriatric and mental health training have emerged as issues across all counties, although some of the larger counties provide more specialty training to agency staff and providers. Rural counties have critical recruitment and retention issues, and often rely on trainees receiving WET stipends and loan forgiveness for clinical service delivery.

Despite progress made, WET funding has not been prioritized to address the well-documented need for an adequately trained workforce to serve older adults with mental health needs. State WET reporting focuses on the demographics of trainees receiving stipends and loan forgiveness. There is no data statewide on the numbers of training programs on geriatric topics provided through WET funding; nor the numbers of trainees

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who may have received older adult focused mental health training.

Progress made possible by MHSAs funding

Counties and the State reported several workforce development outcomes for older adult care that have been made possible through MHSAs funding. The state has worked with the CMHPC, the MHSOAC and the CBHDA to inform counties about WET funding, develop and disseminate strategies to improve older adult related education and training, and evaluate county programs and practices. Larger counties have been able to develop a specialized workforce to serve the older population with mental health needs. They have been able to recruit from graduate programs, but also have invested in workforce development through in-service training. To this end, one county agency leader said, *“If I can’t find you, I will build you.”*

Well-resourced large counties employ geriatric psychiatrists, geriatric care managers, geriatricians, and have leadership that are trained in geriatric care. They also provide reimbursement for older adult care-related trainings and education. WET funded older adult specific trainings that counties provide include communication with older adults, working with law enforcement and with older adults released from jail, older adult and LGBTQ older adult peer counselor training, cross training for aging services personnel, suicide prevention, and data analysis. Rural counties have also offered in-service training on older adult mental health issues, such as suicide prevention and medication management. One rural county described its plans to do cross-training about older adult mental health issues to Meals-On-Wheels drivers, and other personnel such as law enforcement.

Gaps in knowledge about older adults

Despite progress that has been made, key informants reported that counties still face challenges in the knowledge and training of staff and the recruitment and retention of qualified staff, especially in leadership positions; these challenges are exacerbated in rural counties. Across counties, there is a need for dementia care training and geriatric trained providers in all behavioral health clinical care areas; and in related services, such as in residential care settings. Some counties had no providers formally trained in older adult mental health care and cited the need for training on older adult suicide screening. State stakeholders acknowledged that training on medication management and drug interactions is an especially important area of education that may be lacking among providers serving older adults.

Challenges to developing geriatric workforce capacity

Challenges related to workforce capacity include staff shortages, and high turnover of clinical staff in general, and staff with geriatric training in particular. Lack of case management staff overburdens clinicians and licensed providers. In one rural county, recruitment and retention of high level agency administrators was also a major issue. Informants reported several possible reasons for these challenges. In addition to a lack of funding, and retirement of the workforce, it can be difficult for staff to keep up their large caseloads and required reporting. Work saturation is also a problem; often county staff feel overworked beyond what is required in their job descriptions and are managing very large caseloads.

Most counties described that volunteers were difficult to recruit and retain, especially in rural counties. In low-income rural areas, it was especially difficult to recruit volunteers, although they were described as an essential part of the workforce. In one rural county, the requirement of drug testing was identified as a barrier for hiring drivers for transportation services. Rural counties are at a severe disadvantage for recruiting and retaining clinicians and often rely on trainees who are receiving State WET stipends and loan forgiveness. One administrator from a large rural county shared that often, when trainees have completed their education, they move to other counties or positions that offer higher pay. The almost constant turnover of clinical staff is very problematic.

State efforts to buttress the geriatric workforce

The State has provided support for workforce development in counties by assisting with WET county plans, county capacity building and direct transfer of WET funds for county use. Previously the OASOC committee of the CBHDA had as one of its missions the development of more older adult specialists and the creation of a system more responsive to the needs of older adults. This committee was collapsed into the Adult System of Care Committee and no longer meets regularly. CBHDA provided group training for all behavioral health staff that work with older adults and also produced blueprint position papers on how to use WET funds to improve older adult related education and training. The State also provides consumer-training programs that include senior peer counselors and stipends and loan forgiveness for education or training. None of these stipends specifically support education around older adult mental health care.

Barriers to advancing geriatric training

At the same time, state-level informants have also acknowledged challenges in supporting county older adult mental health care. Budget cuts have resulted in less staff dedicated to the delivery of MHSA services. A major barrier to workforce development of staff with expertise in older adult mental health care is that counties have discretion in how they use their WET funds. This results in very little focus in many counties on the mental health needs and complexities of older adults with SMI in sponsored education and training programs. Furthermore, with the

distribution of MHSA WET funds in bulk, some counties spent all funds ‘early’ and this has made it difficult for counties to respond to emerging workforce training needs in the past few years.

Role of culturally and linguistically appropriate providers

County key informants highlight cultural sensitivity training and recruitment of staff that speak other languages as particularly important for the care of older adults. However, they also note the challenges of rapidly responding to changing cultural and language demographics of the populations served. In some counties, there remains a lack of bi- or multilingual providers appropriate for the demographics of the service population. Interpreter services are often used, and this may result in a lack of cultural awareness that can create issues when trying to provide quality care. Larger counties have been able to address some of these challenges through employing a diverse staff with fluency in other languages such as Spanish, Korean, and Farsi.

Quantifying WET Funded Training for Older Adult Mental Health

It is not possible to quantify how WET funds have been used across counties for preparing the workforce to appropriately serve older adults with SMI. Data collected by the State catalogues the demographics of the participants in the stipend programs and not the type or content of training received. While some counties do catalogue the types of training provided, there is not a State requirement to report this information. There is no data reported to the State on the numbers of training programs offered with WET funding about older adult mental health care, nor the numbers of staff who have attended this type of training. Although WET funds are often used in all counties to support loan forgiveness and provide stipends for social workers and psychologists, the State does not know if there is geriatric content provided in this training.

Improvement strategies

Counties have suggested and implemented creative strategies to overcome barriers in workforce development and training and to use WET funds efficiently. These include cross-training initiatives between different county departments, providing dementia training for first responders, and encouraging MSW programs to have an older adult specific component. Other strategies include encouraging county leadership to actively promote training and education, empowering staff to make decisions around training and workforce education, and supporting informal on-the-job training, sometimes through integrated care teams that include geriatric specialists.

Promise of Integrated Care

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Key informants in all counties discussed and provided examples of service delivery integration activities. At the county-level, reports of integration initiatives spanned across agencies, departments, and community-based organizations. Three study counties had recently developed “super agencies” or entities that administratively connect multiple departments/agencies. In one rural county, the 5-year old super agency structure was engaged in efforts to facilitate collaboration between the siloed departments of health and human services, public health, social services, emergency services, and mental health, in order to improve service delivery.

Across the board, the co-location of mental health services with primary care was described as an important innovation that has improved access to care, especially for older adults who are more likely to have multiple chronic conditions. The co-location of providers at the point of service delivery has especially facilitated the delivery of integrated care. Examples include mental health services embedded within primary care settings, primary care services embedded within mental health settings, and mental health embedded within supported housing settings, aging/social services, the justice system, hospital settings, public health, and other settings.

Integrated care was also reported to help address geographic barriers to receiving care, an issue especially relevant in rural counties and in rural pockets of large counties where there is little or no service delivery infrastructure. These geographic barriers are seen as especially challenging for older adults who are more likely to have mobility limitations and are at heightened risk due to social isolation.

Two specific examples of where service integration needs are not being addressed are in long-term care settings and with older adults who have a dual diagnosis of mental illness and dementia. Skilled nursing facilities generally don’t provide mental health care, and regulations related to the use of certain medications in these settings sometimes result in inadequate doses and psychiatric crises. A lack of expertise in conducting dual diagnoses, and confusion about how and where to provide services to older adults with SMI and dementia are ongoing concerns.

Barriers to integration include the marginalization of some trusted community providers in a health care delivery environment that increasingly requires the capacity to scale up and provide better care at a lower cost. Opportunities to advance integration are found in leveraging the momentum of county-wide initiatives through the dedicated work of champions, advocates,

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and leaders in aging.

Across all counties, key informants discussed service delivery integration activities and provided examples of integration efforts. These efforts included county-level integration initiatives that spanned across county agencies and community-based organizations; administrative integration of county agencies/departments; co-location at the point of service delivery. Most examples of integration were across broad sectors of service delivery, and were not older adult specific; however, many of the efforts discussed have implications for the delivery of mental health care to older adults. State key informants also noted the importance of creating integrated service delivery systems and suggested that integrated care is strongly supported by mental health leadership within the Department of Healthcare Services.

County-level integration efforts

In one county that is developing a Whole Person Care (WPC) pilot program (part of the California Medi-Cal 2020 demonstration), a key informant provider who is contracted by the county noted that the goals of the WPC pilot align well with their own agency's model of holistic and integrated care. She also noted that many provisions of the Affordable Care Act (ACA) have supported and incentivized similar types of integration efforts (e.g., Medicaid Health Homes).

“There’s a big push right now with everything going to Whole Person Care. And we like to say that we’re already doing it because we’re helping our clients so much with their health care and treating all...the whole person.”

A key informant in another county also referenced the impact of ACA provisions on integration efforts currently underway in their county, including the duals demonstration (aka Cal MediConnect) which is part of California's Coordinated Care Initiative. This demonstration has resulted in contracts and information sharing between county mental health departments and managed care plans as specialty mental health remains carved out of what the managed care plans directly provide to consumers.

Another key informant from a large urban county noted that advocates have made progress in recent years by shifting their focus from state-level to local-level policies. In particular, they have advanced how the county perceives aging services, and increased understanding of the importance of integrating the delivery silos of social services and health services. Through these

advocacy efforts, they have secured more funding in the arena of supportive services for older adults, and established priority areas in aging that were not previously part of the county's agenda.

The same group of aging advocates is at the table when the WPC pilot is being discussed. As the county aims to improve its systems, especially as related to high service utilizers, advocates expect that they will first focus on high utilizers with mental illness who are younger, homeless, and considered to be the most at risk. According to one informant, the prevailing wisdom is that "fixing the system for them will fix it for others". She notes, however, that the many stakeholders involved in WPC planning view the same problem very differently, and sometimes miss the social determinants that also affect individual health outcomes. By having a seat at the table, aging advocates are positioned to raise questions that are relevant to the concerns of older adults: What's the social network for a person? Do they have housing? Do they need a pal, a friendly visitor? Do they need reconnecting with the family? Are they isolated? She points out that these are all questions that need to be considered, especially when taking a holistic approach to older adults with complex care needs.

Informants also provided examples of integration across county departments/agencies. At least three of the six study counties have recently developed "super agencies" or entities that administratively connect multiple departments/agencies. One rural county moved to a super agency structure about 5 years ago and was currently engaged in efforts to create better bridges between the siloed departments within their "super agency" (i.e., health and human services, public health, social services, emergency services, mental health) to facilitate collaboration and improve services delivery. One key informant from an urban county with a super agency structure described extending its collaborative efforts out to include the comprehensive array of community agencies with which it contracts, with the end goal of improving service coordination.

Another urban county was in the early stages of forming an integrated health agency, by connecting the departments of mental health, health services, and public health under one administrative umbrella. Key informants from that county are hoping that integration will help leverage resources, including WPC funds, to improve coordination between health and mental health, especially for people with dementia. While they already co-locate primary care and mental health care in many locations, key informants say they would like to see more, especially because their older adult consumers would benefit by working more closely with the county department of health services, including the federally qualified health centers.

"Now that we're part of the County integrated agency we're hoping to strengthen that

partnership”

“I think as we integrate [systems] more and more, the [mental health] department will – and has started to really look at integrating more health concerns.”

Finally, one urban county provided an example of efforts to advance integration *within* the county department of mental health, as they are planning to fund a new Director position to work across all systems of care (Children, Transitional Age Youth, Adult, Older Adult) and specifically focus on identifying and developing care integration opportunities throughout the county.

Co-location of services

In addition to integration at the fiscal/administrative level, key informants from all counties gave examples of the co-location and integration of primary care and mental health at the point of service delivery. Across the board, the co-location of mental health services with primary care was described as an important innovation that has improved access to care, especially for older adults. Older adults are more likely to have multiple chronic conditions that require regular interaction with medical care providers. They also may be less likely than younger adults to seek, or be successful in accessing, mental health care directly.

State key informants note that some counties have provided feedback and the evaluation of their local integration efforts, specifically those related to the development of Medicaid Health Homes and Whole Person Care pilots. They report that despite the dissemination of best practices for the integration of mental health services with primary care, implementation is not always up to par. Some of the challenges include primary care doctors who are insufficiently trained to address both the physical and mental health needs of older adults. Furthermore, there are additional difficulties in navigating Medicare reimbursements when these services are integrated.

Mental health services embedded within primary care settings

One rural county reported that they can see older adults at any of their mental health clinics. However they find that it is usually easier to engage older adults at the health clinic, since older adults go there often to see their primary care physicians. To achieve their goal of integrating mental health into county health clinics, this county’s mental health department has been focused on building rapport with the physicians and, more specifically, getting them on board to identify depression in the larger patient population. Key informants report that before these integration efforts started, many primary care doctors were unwilling to prescribe their patients anti-depressants; instead they just wanted their patients to go to the county mental health

clinic. Other counties echoed reports of success in providing more holistic care to older adults by housing mental health services within a variety of primary care settings, including community health centers. These included FQHCs, clinics administered by county health services or public health departments, and especially those offering older adult-specific programs.

One county used MHSA PEI funds to develop a program that mimics adult day health care, and effectively serves racially and ethnically diverse populations of older adults. These programs are offered in multiple locations across the county and take integration to the next level by providing services that are multilingual and culturally competent, and successfully serving diverse cultural, lingual and ethnic communities that otherwise do not access or under-utilize services.

Other examples of integrated care shared by key informants help address geographic barriers to receiving care, an issue especially relevant in rural counties and in rural pockets of large counties that have little or no service delivery infrastructure. Key informants note that these geographic barriers are especially challenging for older adults who are more likely to have mobility limitations and are at heightened risk due to social isolation. One rural county's department of mental health was funded through a private grant to start an integrated healthcare project in a community located in a particularly remote region of the county. In the past they had struggled to provide sufficient coverage in that area, which is about an hour and a half drive from the county seat. Now they are providing mental health services in partnership with an existing FQHC in that location. They have recently applied for an MHSA innovation grant with the goal of sustaining these integrated services.

State-level key informants note that older adults are more likely to discuss and accept treatment in the primary care setting, especially when receiving initial diagnoses. They further observe that while the Affordable Care Act emphasizes the increased integration of services with primary care, it has not yet become the reality for all counties.

Primary care services embedded within mental health settings

Most counties also reported some progress in integrating primary care within mental health delivery sites. One rural county was currently constructing two exam rooms for the purpose of providing physical health screenings within one of their mental health clinics. Key informants reported that other county mental health clinics have at least basic screening capabilities.

Two urban counties reporting having primary care services co-located in some of their mental health clinics. One reported that FQHCs were providing primary care services in two of their

adult mental health clinics and that there were plans to bring these services to a third clinic. One key informant said that bringing a geriatrician into the department of MH has been “the best money spent”. Interestingly, this approach to advancing specialty mental health services for older adults has served as a model for the delivery of pediatric mental health in this county.

One mid-size county reported that when they first looked at their county’s health care utilization data, they realized that a majority of their service population with serious mental illness had not seen a primary care doctor. They have since made significant progress addressing this issue by developing a medical home model that integrates physical health care services within their mental health clinics. To date, these efforts have been supported by a SAMHSA grant. When these funds run out, the county hopes to replace them with MHSA innovation funds so that they can sustain these services.

Other co-locations

Mental health and housing

In all counties, key informants identified a dearth of housing options for persons of all ages with serious mental illness (see “Housing Needs” section, page 99). They further note that the inventory of supportive housing specific to older adults is even more limited. Key informants in three counties provided examples of existing or emerging efforts to provide older adult housing with behavioral health supports embedded. One county provided the example of an assisted living facility where both mental health and dementia care services are embedded as part of a supportive housing model. However, while offering an impressive array of supportive services, the number of beds dedicated to these “special” populations was quite small relative to countywide demand. In this county, as in others, many older adults with supportive housing needs were not able to be accommodated in their county of residence. They had to be relocated to neighboring counties in order to be served; often at the cost of being near family, friends, and familiar mental and physical health service networks.

Mental health and aging/social services

County key informants also provided examples of co-locating or integrating mental health services within aging and other social service settings. Examples ranged from actually co-locating MHSA-funded mental health services within senior centers, to the use of Older Americans Act programs to address moderate level mental health needs. Mental health services provided at senior centers include narrative therapy, journaling, grief and caregiver support, medication management, and wellness models that address both physical and emotional health needs. One urban county’s mental health department co-locates mental health services within the Adult Protective Services department, providing staff to accompany

APS social workers and ongoing therapeutic care as appropriate. In addition, county mental health staff collaborates with other agency providers as part of an interdisciplinary elder abuse forensic team that evaluates individual elder abuse cases.

Mental health and the justice system

A mental health department in an urban county has implemented an integration program concerned with the needs of justice-involved older adults. They have co-located services by embedding mental health teams in the jails and in the courts. Through this program, they provide cross-training on the special needs of this population to the mental health and the justice system workforce, to ensure that justice-involved older adults are offered appropriate levels of support and access to mental health services both while in jail and when returning to the community.

Several state-level key informants noted that older adults leaving the criminal justice system is a newly identified issue. These older adults often have complex needs (e.g. medical, mental, social, economic) as they transition. The State recently sponsored demonstration grants for Certified Community Behavioral Health Clinics, and five funded counties are piloting comprehensive services for older adults who are leaving the criminal justice system. Services include intensive case management, crisis services, mental health, and substance abuse services. All services are co-located and contracted with primary care providers. Some grantees are also endeavoring to integrate housing.

Another promising program identified by a state informant involves collaboration between law enforcement, adult protective services, and the county department of mental health in a city in the Central Valley. The program aims to increase awareness of the problems older adults may experience (e.g. exploitation, mental illness) and has been successful in increasing police awareness and appropriate action when encountering older adults with mental health problems.

Mental health and hospital settings

One rural county recently received an innovation grant to build an integrated health program to address high needs clients with both physical health and mental/behavioral health problems. The project will be a partnership between the local hospital and medical center and the county. Presumably this project will include older adults since they tend to have more complex medical needs. Another key informant in an urban county noted that even in hospitals that offer both geriatric and psychiatric expertise, these services are not always physically co-located nor are they coordinated, suggesting an unmet need for better integration of medical and psychiatric care in hospital settings, particularly for older adults.

Mental health and other settings

One urban county key informant spoke about the non-traditional ways they reach older adults, including through co-locating services within senior centers and faith-based organizations and reaching consumers in their own homes. They see these alternative approaches as necessary because some of their clients are homebound or frail, or may refuse to walk into a mental health clinic because of stigma and fear of discrimination. This year the county expanded their field-based services by bringing MHSA-funded tele-psychiatry services into the consumer's home, facilitating direct linkages to care by connecting consumers and psychiatrists via laptop computers and electronic tablets.

Integration at the point of service delivery

Other examples were provided through key informant reports of integration at the point of service delivery. In particular, key informants provided examples of the use of interdisciplinary teams to integrate and respond to the more holistic needs of older adult consumers. They also discussed programs that integrate the delivery of mental health and substance use disorder services, and of mental health and public health services.

Use of interdisciplinary teams

The integration of mental and physical health service delivery is not always dependent on the co-location of these services. In some cases, the use of interdisciplinary teams achieves the same objectives, only by bringing these disciplinary perspectives out into the community and into peoples' homes. One large urban county has a long history of providing field-based mental health services that pre-dates passage of the MHSA. This model of service delivery uses an interdisciplinary team approach, with a nurse and a social worker team working together to screen and assess older adults with mental health concerns and determine the type and level of services needed. The team completes a bio-psycho-social assessment in the person's home. They first rule out or address any physical health issues (e.g. pain level) before they look into mental health. The holistic assessment considers a wide range of concerns, including adherence to medication, nutritional needs, and safety of the home environment. In addition to dedicated field staff, the county works with geriatric fellows from a local university to help expand their coverage.

The value of working as part of an interdisciplinary team is well captured by this key informant:

"I think that's a benefit of having the nurse as part of the team because now I'm talking to the doctor who's a medical person and he gets that I get what he's talking about. So, it already opened up a line of communication. I just think as providers – mental health and physical health - we just need to get over our own idiosyncrasies and just talk to each other for the betterment

of the client.”

Informants from another county mental health department described integrating social services through all of their programming. For example, for older adult consumers with food insecurity, they work with food banks to ensure that the consumer’s nutritional needs are met.

Mental health and substance use disorders

Both state and county key informants discussed a need to increase the linkages between services that address substance abuse with those who work in mental health. Some suggest that older adults are often overlooked in this category, even though they are increasingly presenting with dual diagnoses. Providers reported seeing increased demand for these services, especially among baby boomers and veterans. One articulated the need for a dual diagnosis specialist who understands the needs of individuals who face both mental illness and substance abuse issues.

A state key informant noted that Medi-Cal 2020 offers a better way to organize and deliver services through PEI programs that integrate mental health and alcohol and drug abuse services. In an effort to better integrate their mental health and substance use disorder (SUD) services, one urban county has embedded MHSA-funded PEI programs within some of their SUD programs, providing licensed clinicians who can consult with program participants. By leveraging existing resources, they believe they are now better positioned to address co-occurring addiction and mental health issues. In addition, they have recently dedicated PEI funding to do homeless outreach through their SUD programs.

However, across counties we heard that there is much work yet to do in this area. One key informant family member in a rural county commented that there are competing demands on resources, and when substance abuse and mental health are combined in service provision, chemical dependency is prioritized over mental health needs. A contracted provider in an urban county noted the need for...*“a little bit more integration as far as substance abuse and mental health services, a more seamless transition. Because right now...they’re absolutely intertwined but we don’t have direct intervention available as far as substance abuse.”*

In a rural county in which substance abuse is increasing in scope and severity, key informants report that the county has made good progress bridging their mental health and substance use departments which have historically operated separately. While not specifically focusing on older adults, these integration efforts are a start and might help better address these co-occurring conditions.

Mental health and public health

Reports of integrated public health and mental health services include a public health department in an urban county that has recently hired a nurse case manager to serve older adults with chronic conditions, including those with mental illness. The mental health department notes that this is an important step toward addressing the needs of many of their older adult consumers with unmanaged chronic health needs.

Other fruitful collaborations between county public health and mental health departments are exemplified by the activities reported by two rural counties. One county's mental health department worked with the public health department to secure a nutritionist who now provides services at county mental health clinics and at an MHS-funded wellness center. They hope to expand this collaboration to increase disease prevention education in general to people with mental illness. In the other county, the public health department has led the charge to implement a suicide prevention task force, in collaboration with the department of mental health and with the engagement of community members.

While providing many promising examples of co-located or integrated services, key informants across all counties indicated that many of these efforts are new or emerging practices and serve only a small fraction of the need. Furthermore, many are operating under time-limited funding sources and do not see a clear path to sustainability.

Unmet integration needs

Key informants mentioned two specific areas where integration needs are not being addressed: in long-term care settings and with older adults who have a dual diagnosis of mental illness and dementia. One key informant noted that skilled nursing facilities (SNFs) generally don't provide mental health care, and they should. Others enumerated the challenges of serving older adults with serious mental illness in SNFs which, due to regulations, are incentivized not to use certain medications and to decrease the doses of certain medications they are using. Often these regulations on medication usage result in inadequate doses and psychiatric crises. One county informant, who works for an organization that advocates for people in SNFs, emphasized the need to educate providers within SNFs so that they better understand and respond to the needs of consumers with mental health concerns.

Across counties, key informants discussed the complexity and challenges involved in addressing the needs of older adult consumers with a range of both cognitive and psychiatric symptoms. They identified a need for providers with both expertise and standard protocols to recognize and better respond to the interaction of mental health diagnoses with other medical (especially neurological) diagnoses.

Integration challenges

While noting the promise of integration, key informants also observed a number of barriers to realizing this promise. As county departments and agencies are fiscally and administratively combined, some of the formerly independent agencies and trusted community organizations they contract with are concerned about blurring the scope of practice and the boundaries of reimbursement. Many community providers that have a long history of serving older adults fear that their organizations will lose turf and become marginalized in such a fast-paced and ever-changing health care delivery environment that increasingly requires the capacity to scale up and provide better care at a lower cost. As observed by one key informant, many non-profit and social service organizations don't know how to navigate and avail themselves of Medicare and Medi-Cal billing which is key to advancing integrated care and traversing the silos of social, behavioral and physical health care.

Another concern raised by some is that the integration of agencies, departments and/or services may result in diluting the attention paid to the mental health needs of older adults. For example, within county mental health departments, this may be a factor when adult and older adult systems of care are integrated or blended, creating a challenge to ensuring adult services are reaching the older population in sufficient numbers and with age appropriate models of care.

Both county and state key informants note that staffing barriers continue to hinder the integration of mental health with other social, behavioral, and medical services. And this is especially the case when it comes to integrating services for older adults. At the county level, stakeholders note the lack of geriatric expertise or specialization across professions (i.e., psychiatry, psychology, medicine, nursing, social work). At the State level, key informants note that most state agencies currently lack the staff necessary to cultivate partnerships with other agencies. They also observe that a lack of state-level advocacy for integration further silos the provision of mental health services across all age groups.

Integration opportunities

There are opportunities for advancing integration efforts to better serve older adults in the public mental health system. One strategy discussed by many informants involves leveraging the momentum of county-wide initiatives through the dedicated work of champions, advocates, and leaders in aging. Informants note, however, that these champions need to show up at county committee meetings to ensure that the concerns of older adults are represented in all planning discussions and decisions. One such key informant is an integral part of a county-wide effort to enrich and integrate all of their public services. She describes her contribution:

“Now I am in charge of integrating, synthesizing, bringing together all sorts of different funding streams to make a seamless community-based program, that has case management, behavioral health, community health, public health prevention programs, and wellness programs. So there’s this full continuum of services that I integrate.”

She explains that her presence on a committee helped increase attention to older adult issues in general and contributed to their decision to hire a nurse case manager, specifically for chronic disease management with older adults. Other fruitful points for aging advocacy have included positions on the MHSA stakeholder group and on the county planning committee for aging services. In the latter role, she successfully pressed the Board of Supervisors to develop an aging services county plan. Now, for the first time, they’ve been able to get different department and agency directors together to discuss aging: social services, health care services, behavioral health, public health – all sitting down now on a regular basis. State key informants point to a statewide model of integrated care, California’s Coordinated Care Initiative (CCI). The CCI is expected to be especially effective in serving high service utilizers and complex cases, including older adults with mental illness. They note that aging advocacy at the county level has been re-energized around the implementation of the CCI, and those new and strengthened partnerships between aging, disability and managed care providers have created a productive venue for shared learning and opportunities to advance integration efforts through collaboration.

Finally, key informants also note that MHSA dollars have helped mental health administrators advance integration efforts in their counties. As one key informant reports: *“Our programs have grown tremendously.”* Not only have they been able to increase their capacity with more providers and the ability to reach older adults in each of the county’s service areas, they also have expanded their scope of services to include housing, senior centers, and collaborative efforts with adult protective services.

Limitations

Before concluding, we must acknowledge some study limitations. First, the use of cross-sectional data limits the examination of key informant reports and observations of California’s public mental health system to just one particular point in time. Respondent self-reporting may also introduce a bias, especially when questions about the effectiveness of the county public mental health system were asked.

The key informants in this study were an invited or self-selected convenience group from 6 of California's 58 counties, plus an additional group of state-level informants. As such, the observations and experiences discussed may not be exhaustive, nor represent the most common issues or characteristics across California's county public mental health system. Those who responded to the invitation and participated in this study may have certain shared characteristics that have the potential to bias the findings.

Since only six of California's 58 counties were included in the key stakeholder interviews, the data from the variety of stakeholders interviewed may not represent shared perspectives or circumstances for other counties not included in the studies. To address the issue of representativeness, the study team took care in county selection to represent the variety and differences inherent across California counties.

The counties selected were a purposive, yet representative sample, from key regions of the State (i.e., inland, coastal, north, south, central); various county sizes (i.e., small, medium, and large); and key characteristics of various regions of the State (i.e., urban, rural, highly resourced, poorly resourced, high and low proportions of older adults). We further ensured that at least one county would be selected from each of the 5 mental health regions designated by the CBHDA.

The counties were identified based on the evaluation of a minimum set of criteria specified in the contract and additional criteria found to be essential to developing a representative sample. The minimum set of criteria considered includes region, county size, population density, resource level and proportion of older adults. Additional criteria considered for each county included proportion of minority and non-minority residents, proportion of adults over age 75 and proportion of older adults who are Medi-Cal eligible.

It is also important to recognize the limitations of conducting key informant interviews only in English. While the next study phase will include Spanish language focus groups, this will not fully address the very real linguistic limitations of the study. Viewpoints from the diverse population groups across California are not well-represented in the sample of interviewees. In addition, the study sample only included 15 consumers, which surely does not represent the perspectives of all public mental health older adult service recipients. As noted in the data, the consumers had typically "aged into" the older adult service system after receiving public mental health services for sometimes decades. The sample is thus limited in its representation of viewpoints of older adults with late-onset mental health issues.

Key Stakeholders Interviews: Summary and Implications

Part 2 of this Deliverable presents the information from the Key Stakeholder Interview component of the project. This was a major study component that provides primary data to answer the research questions about progress in OASOC development and role of the MHSA. As previously described, we selected six counties that represented the key differences in counties across California with regards to State regions (i.e., inland, coastal, north, south, central); county sizes (i.e., small, medium, and large); and key characteristics of various regions of the State (i.e., urban, rural, highly resourced, poorly resourced, high and low proportions of older adults). We further ensured that at least one county would be selected from each of the 5 mental health regions designated by the County Behavioral Health Directors Association (CBHDA).

We recruited key stakeholders from within the six counties and at the state level who represented varying perspectives about older adult mental health services and the MHSA. We completed a total of 59 Key Stakeholder interviews in 6 counties and 13 at the State level. The majority of these 72 interviews were conducted in person and all were conducted by 2 members of the research team. Fifty-nine of the 72 interviews were conducted with county-level stakeholders, including: 15 Consumers, Family Members; 15 Mental Health Administrators; 12 Clinicians/Direct Providers: Mental Health/Aging Services; 14 Aging Services Administrators; 2 professional Advocates and 1 Health and Human Services Administrator.

At the State level, we interviewed 13 key stakeholders, including 1 Administrator, Public Health; 1 Administrator, Health Care Services; 2 Administrators, Aging Services; 4 Administrators: State-Level Association, Council, or Commission; 2 State-Level professional Advocates; 2 Administrators, Office of Statewide Health Planning and Development; and 1 Other State-Level stakeholder.

The majority of key informants were female (79%) and ranged in age from 27 to 83 years. Sixty percent identified as Caucasian (n=43), while the remaining 40% identified as Latino (n=8), African American (n=7), Biracial (n=7), Asian (n=2), Native American (n=1), Arab (n=1), or Other (n=3).

To manage the interview data, a robust set of codes were developed, mirroring the key interests of the research questions and the OASOC framework. Two research staff, one who had participated in the interview, applied the codes to the interview summary text. The final

phase of coding interview summaries was conducted in a software program called ATLAS.ti which facilitates the management, organization and analysis of large amounts of qualitative data. This software is especially helpful for the purpose of analyzing these data across the counties and across the different stakeholder types. Completed interview summaries were uploaded into this software program and a final set of codes was applied across the 2 reviewer summaries. Through this phase of analysis, recurring patterns, emerging themes and outliers in the data were identified.

The data was developed into 8 themes, including: Status of an OASOC; Values; System-level Planning; Pathways to Care; Service Gaps; Housing Needs; Workforce Training and Supply; and the Promise of Integrated Care. Each of these major themes has sub-themes that allow a rich discussion of the data. Varying perspectives are called out, and differences and consensus across county stakeholders are identified. There is a “section summary” for each theme; and overall findings within these themes are summarized in the Part 2 Executive Summary that begins on page 58. Rather than repeat that material here, we provide the top-line highlights for the themes and discuss the implications of these for OASOC development and MHSA facilitation and remaining challenges and barriers.

For five of the six study counties, the existence of an OASOC has not changed during the decade since the passage of the MHSA. One county did not have an OASOC in 2002, and now has one that is linked to the ASOC for the county. For the State as a whole, the existence of an OASOC by county has not been catalogued since a 2002 CMHPC survey (reported on in Part 1 of this Report). Based on stakeholder input, there is great variation in the existence and development of an OASOC across counties. The MHSA, while it did identify older adults as a priority population and promoted an OASOC to serve them, did not provide any specific mandates or funding priorities within the legislation. Without mandates or funding, the value of the OASOC is just a suggestion. As one county stakeholder said, *“I would hypothesize that one of the reasons there is not an OASOC in counties is because there isn’t one at the state level to model and where support can come from.”*

Stakeholders discussed the growth of types and numbers of services for older adults, and all other age groups, since the passage of the MHSA. More older adults are probably being served than before the MHSA, but unfortunately data is not available to verify this statement. Since the MHSA provided two new features to public mental health services, PEI and FSP; for sure, more older adults are receiving these types of services than before the MHSA since they did not exist previously. Robust data is available for FSP clients (called Partners) due to State

mandates, but many counties do not distinguish older adults from the general adult population they are serving for other MHSA sponsored programs.

Stakeholders also consistently reported that there is great unmet need for mental health services at all levels of severity for older adults. This is true even in counties with very robust OASOCs and extensive services. There are disparities in service provision due to geography, inadequate provider networks, diagnostic carve-outs (dementia), mobility and functional status deficits, insurance type, and ageist attitudes. Unmet need has not been quantified through the MHSA planning process. Consistent reports from stakeholders indicate that older adults are often not sought out and typically do not participate in the community planning process that MHSA requires.

MHSA funds, and other funding from national initiatives, have provided counties with resources to develop specialized services and innovative programs that are either specifically targeted to older adults, or include them in the all-adult programming. Even those not targeted for older adults, could differentially benefit them because the programs are focused on high utilizers, SMI persons with multiple co-morbidities, or those with multiple needs for cross-sector support – often people with these characteristics are older adults. Mobile-based outreach is identified as especially important in rural and frontier counties, as well as in rural pockets within larger more densely populated counties. Mobile outreach is seen as essential for all older adults - rural or urban - who are homebound, limited in their mobility, and/or socially isolated. One rural county reported that the need for mobile outreach services was identified through their MHSA stakeholder engagement process and they now have an extensive mobile outreach service system.

Older adults in the county mental health system have typically aged into the older adult category, having been in the system for years. Most mental health provider Informants did not have, or had very few, “new” older adult-onset clients in their caseloads. Several stakeholders identified PEI programs as a potential route for SMI older adult case finding. Other stakeholders discussed the collaborations with other public service programs, like APS, as potential referral sources for new clients. One high-level county behavioral health administrator actually confused service utilization with potential need, saying that since the county did not serve many older adults, there must not be much need for services in the older population. They went on to say that “after all” the data shows that people with SMI die 25 years early, so the assumption was they do not reach older ages. Rather, other stakeholders in this county recounted the lack of outreach, the lack of involvement in service planning, and the

lack of leadership and advocacy for the needs of older adults with SMI and other mental health issues.

In most counties, lack of funding for older adult services, in general, has resulted in service gaps in the following areas:

- case management;
- therapy and psychiatric counseling (4 counties);
- substance abuse therapy (2 counties);
- field-based services (including mobile clinics);
- peer services (including training of peers, and implementation of peer support);
- transitional/step-down services and housing (targeted at, for example, homeless adults about to be discharged from hospital);
- linguistic and culturally competent services (for instance, LGBTQ, undocumented refugees, older adults survivors of trauma; more evidence-based programming needed);
- in-home supportive services (particularly in rural counties with poor transportation infrastructure, and limited eligible pool to recruit and retain volunteers);
- transportation support services (4 counties, particularly rural ones);
- outreach and awareness regarding county-level services;
- depression screening and suicide intervention (older men have higher suicide rates compared to women of the same age);

Using MHSA funds, often through the Innovation Project component, a number of our study counties have developed, or are beginning to develop, integrated care projects. Again, even if not designed specifically for older people, they will benefit from integrated programs since the majority of older adults with SMI have multiple co-morbidities and complex needs. These programs are delivered in a variety of forms, but the important component is the linkage between mental health, medical care and other needed services.

Adequate, affordable, transitional and supportive housing was consistently identified across stakeholder groups as a great need for older adults with SMI in all study counties. However, since the MHSA, much attention has been paid to the development of housing for the SMI population, including older adults; and often supportive housing with embedded behavioral health services. Some counties have parlayed MHSA funding into other funding streams for housing development, supportive service delivery and transitional housing. This is quite uneven across the study counties. New housing development efforts, and new State legislation, will promote additional needed housing across the State.

Most counties had developed older adult special population programs and services, for example for Spanish-speaking or LGBTQ populations. Several small counties, with limited provider networks, struggled to deliver services to Spanish-speaking Hispanic communities due to an insufficient number of bi-lingual providers. All counties had recently sponsored training in cultural competence for their providers. All counties had provided training to their providers about the special needs of older adults at least once in the decade since the passage of the MHSA.

There were striking differences between the more rural and highly urban counties. These differences included variation in availability and size of provider networks, service resources, geographic reach, higher poverty levels, recruitment and retention issues for both leadership positions and clinicians, staffing adequacy, availability of services specifically targeted to older adults, transportation services, homeless services and linkages across public service systems. Additional recognition is needed for the high costs of delivering services in large geographic, but sparsely populated regions. When funding is allocated based on population, the fact that services cost more to deliver in rural counties is ignored. The CBHDA has a “small counties” committee that has been advocating as to geographic disparities and additional needs in the many California counties with populations of less than 200, 000 people.

The MHSA has provided important new funds for additional mental health services, and permeated many counties with a recovery and resilience model of care. This has occurred in counties with and without an OASOC. The MHSA also introduced PEI and FSP services; the first to outreach to people with less severe mental health problems, and the latter to provide “whatever it takes” to serve SMI persons. The MHSA has not had much influence on the development of an OASOC for counties that didn’t have one at the time of its passage. The MHSA also has not inspired counties to prioritize services for older adults, even though older adults are a population designated for services and a system of care are identified in the Act.

Uniformly, informants identified vast unmet need in serving older adults with SMI and less severe forms of mental illness. The unmet needs begins by deficits in involving older adults in the required MHSA planning process; and continues in all aspects of outreach and service delivery, workforce development, outcomes measurement and reporting. The MHSA provides about 25% of funding to counties for mental health services for all populations. It was never designed to prioritize and meet the complex needs of the burgeoning older adult SMI population. It is up to State and county leadership, advocates and consumers, to utilize MHSA

resources to the fullest to address the unmet needs for older adults with mental illness. We have identified a number of exemplary programs and service models that can be disseminated and scaled up, with appropriate resources and the political will to do so.

References

1. California Mental Health Directors Association. *Older Adult System of Care Framework*; 2005.
2. California Mental Health Planning Council. *California Mental Health Master Plan: A Vision for California*; 2003.
3. Mayberg SW. *Analysis of the Older Adult System of Care Demonstration Project*; 2004.
4. *Mental Health Services Act*. Sacramento: California State Legislature; 2013:1-21.
5. California Department of Mental Health. *Mental Health Services Act Proposed Guidelines Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan*; 2008.
6. Arnquist S, Harbage P. *A Complex Case : Public Mental Health Delivery and Financing in California*; 2013. <http://www.chcf.org/publications/2013/07/complex-case-mental-health#ixzz2j4ShEi5m>.
7. Little Hoover Commission. *Promises Still to Keep: A Decade of the Mental Health Services Act*; 2015.
8. Holt W, Adams N. *California Health Care Almanac: Mental Health Care in California: Painting a Picture*; 2013.
9. Steinberg Institute. *Prop 63 Review: Mental Health Services Act Delivering on Promis to Californians*; 2015.

10. Resource Development Associates. *MHSA Community Program Planning Processes- Technical Evaluation Report.*; 2014.
11. Gilmer TP, Ojeda VD, Fuentes D, Criado V, Garcia P. Access to Public Mental Health Services Among Older Adults with Severe Mental Illness. *Int J Geriatr Psychiatry.* 2009;24(3):313-318. doi:10.1002/gps.2123.Access.
12. Aguilar-gaxiola S, Geraghty EM. *Analyzing the Impact of the Mental Health Services Act on Reducing Disparities in Access - Deliverable 1aii.*; 2014.
13. Aguilar-gaxiola S, Paterniti DA. *Evaluating the Impact of the Mental Health Services Act on Reducing Disparities in Access - Deliverable 2c.*; 2014.
14. Aguilar-Gaxiola, S., & Paterniti DA. *Evaluating the Impact of the Mental Health Services Act on Reducing Disparities in Access- Final Report.*; 2014.
15. Aguilar-gaxiola S, Geraghty EM. *Analyzing the Impact of the Mental Health Services Act on Reducing Mental Health Disparities Analysis- Deliverable 1b.*; 2014.
16. Human Services Research Institute, Technical Assistance Collaborative, Holzer C. *California Mental Health Prevalence Estimates.*; 2000.
17. U.S. Census Bureau, Census 2000 Summary.
18. U.S. Census Bureau, 2014 American Community Survey 1-Year Estimates.
19. Jeste D, Alexopoulos GS, Bartels SJ. Consensus Statement on the Upcoming Crisis in Geriatric Mental Health. *Arch Gen Psychiatry.* 1999;56(9):848.
20. California Department of Aging. *California Department of Aging Review of Mental Health Services Act (MHSA) Prevention and Early Intervention Plans.*; 2010.
21. UCLA Center for Healthier Children Families and Communities. *Evaluation Report: Summary and Synthesis of PEI Evaluations and Data Elements.*; 2011.

22. UCLA Center for Healthier Children Families and Communities. *Prevention and Early Intervention : California's Investment to Prevent Mental Illness from Becoming Severe and Disabling.*; 2014.
23. UCLA Center for Healthier Children Families and Communities. *MHSA Early Intervention Evaluation, Final Report Cluster 3. Programs Serving Older Adults - Deliverable 2E.*; 2014.
24. UCLA Center for Healthier Children Families and Communities. California ' s Mental Health Services Act — Statewide Evaluation: Priority Indicators Trends Report- Executive Summary. 2014:1-45.
25. University Enterprises, Mental Health Data Alliance. MHSOAC Statewide Full Service Partnership (FSP) Outcomes Report. 2014.
26. UCLA Center for Healthier Children Youth and Families, Evaluation Management Training. *Evaluation Brief, Summary and Synthesis of Findings on CSS Consumer Outcomes.*; 2011.
27. UCLA Center for Healthier Children Youth and Families. Full Service Partnerships: California's Investment to Support Children and TAY with Serious Emotional Disturbance and Adults and Older Adults with Severe Mental Illness - Contextual Factors and the Relationship to Expenditures and Cost Offsets. 2013;(April).
28. California Department of Mental Health. *MENTAL HEALTH SERVICES ACT Proposed Guidelines for the Innovation Component of the County's Three-Year Program and Expenditure Plan.*; 2008.
29. California Department of Aging. *California Department of Aging- Summary Report. Review of MHSA Innovation Plans.*; 2011.
30. California Insitute for Behavioral Health Solutions. *MHSOAC Innovation Evaluation Project.*; 2015.
31. California Department of Mental Health. *Mental Health Services Act Five-Year Workforce Education and Training Development Plan (April 2008-April 2013).*; 2008.

32. California Mental Health Directors Association. *Mental Health & Aging Workforce Education/Training: Recommendations to Promote Planning, Funding, Implementation and Oversight.*; 2009.
33. Office of Statewide Health Planning and Development. *Mental Health Services Act Workforce Education and Training Five-Year Plan.*; 2014.
34. Resource Development Associates. *Mental Health Services Act (MHSa) Workforce Education and Training (WET) Five-Year Plan 2014-2019 Needs Assessment : Report 1 - MHSa WET Program Evaluation.*; 2014.
35. Resource Development Associates. *Mental Health Services Act (MHSa) Workforce Education and Training (WET) Five-Year Plan 2014-2019 Needs Assessment : Report 2- Analysis of Stakeholder Feedback on Public Mental Health Workforce Needs.* 2014;(September).
36. Resource Development Associates. *Mental Health Services Act (MHSa) Workforce Education and Training (WET) Five-Year Plan 2014-2019 Needs Assessment : Report 3- Analysis of County Reported Public Mental Health Workforce Needs.*; 2014.
37. Resource Development Associates. *Mental Health Services Act (MHSa) Workforce Education and Training (WET) Five-Year Plan 2014-2019 Needs Assessment : Report 4- Analysis of Mental Health Workforce Supply.*; 2014.
38. Resource Development Associates. *Mental Health Services Act (MHSa) Workforce Education and Training (WET) Five-Year Plan 2014-2019 Needs Assessment : Report 5- Educational Training of Mental Health Professionals.*; 2014.
39. California Geriatric Behavioral Workforce Coalition. *Behavioral Health Workforce Needs : A Looming Crisis for an Aging California.* Vol 65.; 2013.
40. DCR FAQ: Frequently Asked Questions about the MHSa Data Collection and Reporting System. <https://www.sfdph.org/dph/files/CBHSdocs/MHSAdocs/DCR/Docs/DCR-FAQ.pdf>. Accessed February 22, 2017.

Additional Resources not directly cited:

1. Systems definition based on General Living Systems Theory in Miller, J.G., 1978). Living Systems. McGraw-Hill, New York.
2. UCLA Center for Healthier Children Youth and Families. (2013). *California 's Investment in the Public Mental Health System : Prop 63 Expenditures and Activities - A Snapshot of Outreach and Engagement (FY 09-10)*.

Definitions and Abbreviations

AAA	Area Agencies on Aging
CDA	California Department of Aging
CSS	MHSA Community Supports and Services Programs
CMHDA/CBHDA	California Mental Health Directors' Association which changed its name to California Behavioral Health Directors' Association
CMHPC	California Mental Health Planning Council
DHCS	California Department of Health Care Services
DMH	California Department of Mental Health
FSP	MHSA Full Service Partnerships Programs
INN	MHSA Innovation Project Funding
MHSA	Mental Health Services Act
MHSOAC	California Mental Health Services Oversight and Accountability Commission
OASOC	Older Adult System of Care
OSHPD	California Office of Statewide Health Planning and Development
PEI	MHSA Prevention and Early Intervention Programs
SMI	Seriously Mentally Ill

WET

MHSA Workforce Education and Training