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Health Policy Brief

January 2018

Older Californians and the Mental Health Services Act: Is an Older Adult System of Care Supported?

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"By 2035, the number of California adults ages 60 and above is expected to increase by 64 percent, to 12 million."

SUMMARY: This policy brief summarizes findings from the first study to evaluate how California's public mental health delivery system has served older adults (60 years of age and over) since the passage of the Mental Health Services Act (MHSA) in 2004. Study findings indicate that there are unmet needs among older adults with mental illness in the public mental health delivery system. There are deficits in the involvement of older adults in the required MHSA planning processes and in outreach and service delivery, workforce development, and outcomes measurement and reporting. There is also evidence of promising programs and strategies that counties have advanced to address these deficits. Recommendations for improving mental health services for older adults include designating a distinct administrative and leadership structure for older adult services in each county; enhancing older adult outreach and documentation of unmet need; promoting standardized geriatric training of providers; instituting standardized data-reporting requirements; and increasing service integration efforts, especially between medical, behavioral health, aging, and substance use disorder services.

By the age of 75, close to half of all Americans will have experienced a diagnosable mental disorder.[1] Yet, less than one-third of older adults in need of mental health services receive appropriate care.[2, 3, 4] Older adults diagnosed with a mental illness are more likely to develop chronic conditions and dementia as they age, intensifying their care needs.[5]

The World Health Organization estimates that worldwide, 15 percent of adults ages 60 and over live with mental illness, including neurological disorders such as dementia.[6] In the U.S., a national survey found that 14.5 percent of adults ages 55 and older met the criteria for at least one personality disorder, 11.4 percent reported having an anxiety disorder, and 6.8 percent experienced a mood disorder (with major depression being the most commonly reported of these), while the prevalence of substance use disorder was 3.8 percent.[7] A small but notable proportion of older adults experience the late onset of severe psychotic or affective disorders, such as schizophrenia or bipolar disorder.[8, 9] Older white men are particularly at risk for suicide, with the suicide rate of those 85 years of age and older rising above 47 per 100,000 per year – nearly four times the nation's overall rate of 12.7 per 100,000 in 2011.[10]

Against this backdrop of challenging unmet needs is a dramatic shift in demographics. By 2050, the number of adults ages 65 and over in the U.S. will have nearly doubled, from 43 million to 84 million.[11] In California, the number of adults ages 60 and above is expected to increase by 64 percent, to 12 million, by 2035.[12] The diversity of California's aging population will also increase,

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Funding for this policy brief was provided by California's Mental Health Services Oversight and Accountability Commission.

with older adults of color representing a majority (55 percent) by 2035. Importantly, older adults of color are more likely than their white counterparts to report high levels of psychological distress and serious mental illness (SMI).[13]

There is tremendous potential variation of need within the large category of adults who are 60 years of age and older. "Younger" older adults—i.e., "baby boomers" ages 60 to 74—exhibit a higher prevalence of anxiety and substance use disorders. "Older" older adults, those ages 75 to 84, may experience higher levels of stigma when seeking help than their younger counterparts, especially for mental health services. About one-third of the "oldest old," those 85 years of age and older, have dementia, further complicating the delivery of care to those who are also aging with SMI.[8, 14] Research has shown that reducing the symptoms of mental illness can improve the physical health of older adults and decrease health care utilization, including the risk of premature nursing home placement.[15] Thus, there is potential for significant cost savings associated with effective mental health treatment and services.

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In 2003, the California Mental Health Planning Council and the California Mental Health Directors Association* recognized the need to develop a framework that both identifies the unique needs of older adults living with mental illness and informs the implementation of an Older Adult System of Care (OASOC).[16, 17] The OASOC, which predates passage of the Mental Health Services Act (MHSA), promotes a comprehensive and integrated set of services to assist older adults in navigating multiple physical, socioeconomic, social, and age-related stigmas and barriers when seeking mental health care.

By 2014, more than $13 billion dollars in tax revenues had been moved into MHSA funds, representing about 25 percent of mental health service funding in California.[20] This influx of funds provided the opportunity to support the continued development of an OASOC. Yet, a distinct administrative structure and specific funding for older adult services were not mandated in the MHSA legislation, as they were for children under the age of 18.

* In 2014, the California Mental Health Directors Association (CMHDA) and the County Alcohol and Drug Program Administrators Association of California (CADPAAC) together became the County Behavioral Directors Association of California (CBHDA).

The Mental Health Services Act (MHSA)

The MHSA was passed by voters in California in 2004, with the goal of transforming the delivery of public mental health from a system that predominantly provides crisis care to a model of consumer wellness, recovery, and resilience.[18] The MHSA comprises five distinct components: [19]

1) Prevention and Early Intervention
2) Community Services and Supports (which include the Full Service Partnership program and Field Capable Clinical Services)
3) Innovation
4) Capital Facilities and Technological Needs
5) Workforce Education and Training

For more information, visit: *http://www.mhsoac.ca.gov/components*

The California Mental Health Older Adult System of Care Project

Three different data sources were used to assess the implementation of a system of care in California for older adults with SMI: secondary data (more than 100 publications and evaluation reports, including county three-year program and expenditure plans and annual updates); 72 key informant interviews across six counties and at the state level (59 county-level and 13 state-level informants, including

consumers, family members, program administrators, providers, and clinicians); and six focus groups (representing 33 older adult consumers and 11 family members). The six California counties (San Diego, Los Angeles, Tulare, Monterey, Alameda, and Siskiyou) represented all designated mental health regions, differences in geography, population size and density, ethnic and racial diversity, income level, and the continuum of older adult system of care (OASOC) development across the state. Findings include:

Implementation of older adult public mental health services is uneven.

The study revealed that the OASOC remains a work in progress, with an OASOC varying from a formal designation and comprehensive implementation of older adult–specific programs with linkages in services, to a system in which older adults were served as part of the Adult System of Care, with little recognition of the specific needs of older adults.[21]

Across all MHSA programs, there is unmet need for services among older adults with SMI. We found that while all six study counties offer programs that serve older adults, there is more need for programs to engage in targeted outreach and to be specifically tailored for older adults. In counties that offer older adult–specific programs, available programs are often limited to a specific geographic area and reach only a small segment of the potential service population. For example, in our secondary data review, one study of 45 counties reported that consumers ages 60 and over accounted for only 1.5 percent of those receiving MHSA prevention and early intervention services.[22]

While one of MHSA's foundational principles is that consumers be included in planning and implementation, one study found that seniors and veterans were among the least represented stakeholder groups in Community Program Planning.[23] Our key informants supported this finding and indicated that older adults were underrepresented in planning and decision-making processes.

Although many older adults receiving public mental health services have aged within the system, the pathway to care for those with late-life onset mental illness is less clear. For instance, older adults without Medi-Cal coverage sometimes have difficulty entering the public system. Many cannot find Medicare providers who will provide care due to lower reimbursement rates. Key informants reported that Prevention and Early Intervention programs embedded in community settings where older adults congregate have promise. However, the extent of collaboration between county mental health departments and other community-based programs that serve older adults varies greatly from one county to the next.[24]

Overall, the analysis revealed that more needs to be done to reach older adults who are not making their way to services. There is marked variation across county mental health departments in planning, preparation, and expertise in older adult services. The will to address these issues may be hampered by fear that the potential costs associated with caring for older adults will be too high. The increased incidence of dementia as people age exacerbates these concerns. Differential diagnosis between mental illness and dementia requires significant clinical expertise. Currently, individuals who receive a primary diagnosis of dementia are served through the county health (not the behavioral /mental health) service agency or through some other source of primary medical care. Older adults with SMI who develop dementia often fall through the cracks between the two systems and thus do not receive the care they need.

MHSA outcome reporting is inadequate for measuring the reach and effectiveness of service delivery among older adults or for informing future planning.

Although the California Department of Health Care Services has a state reporting system, comprehensive data are required for only one MHSA program (Full Service Partnerships).

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"There is a deficit of geriatric psychiatrists and, across specialties, limited cross-training in mental health and geriatrics."

The MHSA invested in the development of a more comprehensive system for CSS; however, the use of the new system is optional. Currently, most counties report aggregate outcome data that are not differentiated by age, race/ethnicity, or other defining characteristics. The few studies in the review that included outcome data for older adults showed a steady increase in the numbers of older adults served since passage of MHSA, yet provided no data on the penetration, success, or effectiveness of these programs.[25]

State-level watchdogs have voiced concerns that existing MHSA outcome data are not systematically used to provide transparent information for decision-making and planning.[20] Key informants in the current study echoed these concerns. County supervisors in each county review and approve county plans without a standardized reporting and decision-making process.

There are significant and persistent deficits in the geriatrics workforce.

The secondary analyses of research reviewed in the study identified significant challenges to developing an older adult–specialized workforce in mental health care. Among the obstacles: a deficit of geriatric psychiatrists and, across specialties, limited cross-training in mental health and geriatrics.[16, 26, 27]

Key informants reported that MHSA has made a noticeable impact on their county's capacity to support workforce training and education related to older adult mental health care. Still, gaps remain.[28] For example, there have been no data collected about the number of trainings on older adult mental health topics or the numbers of professionals who have received such training. Cultural sensitivity training and the recruitment of staff who speak other languages were highlighted as particularly important for the care of older adults.

There are numerous barriers to the provision of public mental health services to older adults.

Key informant and focus group participants identified numerous barriers to care, including unmet basic needs (e.g., food, housing, and transportation), a shortage of needed transitional programs, and a lack of culturally and linguistically appropriate services. Many also brought attention to geographic disparities in the availability of services, with some individuals having to travel for more than an hour each way to get to needed services. According to one key informant: *"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."*[28]

Consumer and family member participants also spoke about the direct impact of cultural beliefs that stigmatize mental illness and aging, the experience of not being able to access services from providers with whom they can identify, and the experience of feeling overwhelmed and discouraged by duplicative paperwork and other such bureaucratic barriers.[28] County administrators and providers observed many of the same barriers, as well as the additional challenges experienced by older consumers with chronic conditions and limited physical mobility, many of whom are homebound and socially isolated.

Trusted sources, familiar locations, and mobile outreach help in the delivery of more responsive and inclusive services.

Consumer participants emphasized the value of receiving information and services from trusted sources, including peers and members of their communities. Increasing education and awareness about mental illness within the general community, while also increasing consumer knowledge about the system and services available, were seen as helpful in reducing stigma and increasing service use.

County administrators and providers reported success in reaching older adults through regularly scheduled community-based trainings and information sessions that address stigma and discrimination, with some targeted to reach underserved racial, ethnic, and cultural groups. Some contracted agencies conduct targeted outreach at supportive care facilities, low-income senior housing, dialysis centers, adult day health centers, and community medical clinics and senior centers. Mobile-based outreach was noted to be especially important in rural and frontier counties, as well as in rural pockets within larger, more densely populated counties.

Both providers and consumers noted that peer and other social support groups are especially effective for those in recovery. Older adult consumers emphasized the value of incorporating family and spirituality into their recovery process, and they commented on the benefit of having supportive services available to family members. Many participants discussed how important it was for them to be engaged and to have a purpose, often through volunteer work. One participant shared how volunteering contributed to his mental health and spirituality: *"I'm finding for me that I have to learn how to keep myself busy…. There's always something I can do to help me spiritually and mentally."*

Facilitators to accessing care included home-based services, smoother referral pathways, improved affordable transportation options, and financial supports. Many participants noted that access to care has been greatly improved through the provision of integrated services, specifically through the co-location of mental health services with primary care services and/or substance use services. These "one-stop shopping" options, where they exist, were highly valued by older adults, particularly those with mobility limitations.

Finally, secondary data indicate that Full Service Partnerships have improved outcomes for older adults, specifically through increased access to primary care providers and through reductions in costly psychiatric hospitalizations and in emergencies relating to mental health and substance use.[29]

> *"Full Service Partnerships have increased access to primary care providers and reduced costly psychiatric hospitalizations as well as emergencies relating to mental health and substance use."*

Policy Recommendations

The findings suggest several actions that can be taken to improve the delivery of public mental health services to Californians who are aging with mental illness, as shown in Exhibit 1.

Addressing Issues Through Policy Change **Exhibit 1**

Issue	Policy Recommendation
Uneven implementation of older adult public mental health services within and across counties.	Designate an administrative structure for older adult mental health services with dedicated leadership positions.
Inadequate reporting of MHSA outcomes: not distinguished by age, race/ethnicity, or other important characteristics.	Institute mandatory and standardized needs assessment and data reporting requirements.
Significant and persistent deficits in the geriatric mental health workforce, including limited cross-training in mental health and aging.	Promote standardized geriatrics training for all mental health professionals who work with older adults.
Barriers to public mental health care, including unmet basic needs (housing, food, transportation), shortage of transitional programs, lack of culturally and linguistically appropriate services.	Increase outreach to older adults who are not making their way to services. Increase service integration, especially the integration of medical, behavioral health, aging, and substance use services.

"Counties need to know how many older adults are undiagnosed or are going without treatment... and systematically measure and monitor their progress in serving the mental health care needs of older adults."

Designate an administrative structure for older adult mental health services with dedicated leadership positions, within and across state and county mental health and aging units.

A distinct OASOC should be designated in all counties. Ideally, the OASOC would explicitly align with all of the MHSA programs and be geographically inclusive. The OASOC would also have distinct administrative leadership (e.g., an OASOC coordinator) and staff (e.g., older adult program specialists). Smaller rural counties, due to limited resources, may choose to organize regionally across several counties (as several Area Agencies on Aging have done) or formally designate an administrative lead within the behavioral health department for older adult services, so that at least one person is the "watchdog" and departmental lead for older adult mental health services within a particular county.

Finally, all county departments of mental health—whether large or small, urban or rural—should establish (or join) an Aging Advisory committee. This committee would be tasked with addressing the concerns of older adults served by a range of county public agencies.

Institute mandatory and standardized needs assessment and data-reporting requirements.

Counties should systematically investigate and document the unmet needs of older adults with mental illness. Specifically, counties need to know how many older adults are undiagnosed or are going without treatment, and they should have a more detailed demographic profile of the older adults they serve.

Counties also need to systematically measure and monitor their progress in serving the mental health care needs of older adults. Current county-level data reporting is insufficient and needs to be refined and systematized. Leadership and oversight at the state level must ensure that core data elements are not only collected and reported, but also—importantly—are used to measure reach and effectiveness and to inform future program planning. As part of an earlier phase of this study, a recommended essential set of data elements to measure older adult outcomes in the public mental health system was developed and published.[30]

Promote standardized geriatrics training for providers across disciplines and scope of practice.

At a minimum, core geriatrics training should be provided to all mental health professionals and paraprofessionals who work with older adults. An ideal standardized training would also account for the rich cultural and linguistic differences evidenced across the aging population, including the diversity represented by generational cohort, race/ethnicity, gender identification, and sexual orientation.

Increase outreach to older adults who are not making their way to services.

Outreach strategies must be specific to older adults, take into account where and how best to identify those in need, and reach out to locations in the community where older adults are more likely to congregate. Efforts must be made to identify the more socially or geographically isolated through family members, faith-based organizations, and aging services providers. At the state level, MHSA resources should be reallocated to conduct outreach and to deliver services that better reflect the additional costs of providing services in rural counties or in rural pockets within urban counties.

Increase service integration, especially the integration of medical, behavioral health, aging, and substance use services.

To effectively integrate services at the point of service delivery, the funding sources and administrative agencies must first align. This requires coordination across the relevant state and county administrative agencies

MHSA Evaluation:
This policy brief is part of a six-county study of public mental health services for older adults funded by the MHSA. For more information on this evaluation, and to see all related publications, please visit: *http://www.healthpolicy.ucla.edu/Older-Adult-Mental-Health*

and funding sources. At the point of service delivery, this type of systems integration would support more opportunities for physical co-location and service integration.

Funder Information

Funding for this work and brief was provided by the California Mental Health Services Oversight and Accountability Commission.

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Acknowledgments

We are deeply grateful for all of the study participants who made this work possible. We are further indebted to the members of the California Mental Health and Older Adults Project Advisory Committee, who provided invaluable guidance all along the way.

For their thoughtful reviews of this policy brief, we would also like to thank Maria P. Aranda, Linda Dickerson, Susan H. Babey, and D. Imelda Padilla-Frausto.

Suggested Citation

Kietzman KG, Dupuy D, Damron-Rodriguez J, Palimaru A, del Pino HE, and Frank JC. 2018. *Older Californians and the Mental Health Services Act: Is an Older Adult System of Care Supported?* Los Angeles, CA: UCLA Center for Health Policy Research.

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For a summary of these findings, please visit: *http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1710*

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PB2018-1

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