

**Master Plan for Aging
Recommendation Form
Improve Behavioral Health Services for Older Adults**

To submit your recommendation, fill out as many of the fields below as possible. It is fine to leave some blank. Recommendations can be submitted at engage@aging.ca.gov. Initial recommendations are requested to be submitted by December 13, but they may be submitted after this date as well.

Issue Statement: [State the problem your recommendation will address. Insert links to reports where appropriate.]

Older adults in California with behavioral health problems, which include both mental health and/or substance abuse issues, are unserved and underserved relative to their needs. 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

According to a recent report by the California Behavioral Health Planning Council,¹¹ a review of the data (DHCS, 2017) for Specialty Mental Health Services (SMHS) services indicates that older adults are underserved by SMHS services relative to their percentage of total adult clients eligible for Medi-Cal funded services. Adults age 65 and above were 16.0 % of the adult Medi-Cal population, but only 1.7% received one or more SMHS services during the year (FY 2016-2017).

An argument could be made that perhaps the low numbers described above might be counterbalanced by Medicare-covered services received by those over 65. Also, some of these older adults qualify for both Medicare and Medi-Cal. Although most adult citizens over 65 are Medicare eligible, the types of behavioral health (BH) services covered are limited in scope and quantity. It is problematic to draw overall conclusions because we have little to no data about Medicare-funded delivery of BH services in California.¹¹

Reviews of other recent data suggest that older adults, especially the baby boomer cohort, have had more life experience with so called ‘recreational’ substance use, and are experiencing an increased incidence of drug-based substance use disorders (SUD) relative to prior generations which may have experienced more alcohol-related SUD than drug abuse per se. But all of these older cohorts are experiencing vulnerability to dependence on opioid pain medications and accidental addiction

following recovery from surgery or other painful condition. Based on our review of statewide ‘Drug Medi-Cal’ treatment data for adults, it appears that older adults are underserved by county-based or county-contracted SUD treatment relative to their percentage of total adult Medi-Cal clients eligible for services.¹¹

Other research, including a recent study of the public mental health system and older adults by the UCLA Center for Health Policy Research,^{12,13} document unmet need for all types of services funded by the Mental Health Services Act (MHSA), the need for more systematic data collection, shortages in geriatrically-prepared behavioral health workforce, geographic and racial disparities in service availability, and a lack of state guidance and leadership to promote an older adult system of care for behavioral health services. Older adults with behavioral health needs, coupled with physical health issues is all too common among older adults who are best served with integrated health models that increase access and convenience to meet their needs.^{12,13,14}

MPA Framework Goal: [Insert which goal/s from the framework this recommendation addresses. [View MPA Framework here.](#)]

Goal 3: Health & Well-being. We will live in communities and have access to services and care that optimize health and quality of life.

MPA Framework Objective: [Insert which objective/s from the framework this recommendation addresses.]

Objective 3.2: Californians will have access to quality, affordable, and person-centered health care through delivery systems that are age-friendly, dementia-friendly and disability-friendly.

Recommendation: [Explain your recommendation in one to two sentences.]

To improve behavioral health services for older Californians in need, we recommend establishing a new administrator with gerontology/geriatric expertise within the Department of Health Care Services, behavioral health unit, to work collaboratively with the Department of Aging, and other state level departments (e.g., Housing, Transportation) to focus on improving data collection, needs assessment, service delivery, behavioral health workforce training, integrated service models and other activities needed to improve behavioral health care for older adults.

Target Population and Numbers: [Describe groups of Californians impacted by this recommendation, with numbers if available.]

A comprehensive and succinct prevalence data source for behavioral health disorders in older adults in the United States is provided in the 2012 Institute of Medicine Report, “In Whose Hands?”¹¹ We excerpt data provided from this report: From 6.8 to 10.2 percent of community-living adults age 65 and older had one or more of the 27 behavioral health problems focused on in the report (this figure does not include older adults in nursing homes, which have substantially higher prevalence rates). This equates to between 544,000 and 816,000 community living older adults in California. The conditions with the highest prevalence are depressive disorders, and behavioral and psychiatric problems associated with dementia. In 2010, 3 to 4.5 percent of community-living older adults had

major depressive and dysthymic disorders, or between 240,000 to 360,000 in California. Serious mental illness (SMI) includes disorders such as schizophrenia and bi-polar disorder. From 3 to 4.8 percent of the older population had SMI in 2010, equating to 240,000 to 384,000 community living Californians.

A substantial proportion of older adults with behavioral health conditions live in nursing homes and other congregate-living settings, such as assisted living, senior housing, and public housing facilities. Race and ethnicity are associated not only with differences in the prevalence of behavioral health conditions, but also with the kinds of treatment and services that are needed and will be used.

It is clear that older veterans, at least those who are enrolled in the VA health care system and use VA health care services, are more likely than other older adults to have behavioral health conditions and to have particular conditions (e.g., PTSD) that influence their service needs.

- **Detailed Recommendation:** [Insert detailed bullet points describing your recommendation.] Designate a new older adult administrative unit (administrator with geriatrics/gerontology expertise and support staff) within the California Department of Health Care Services, Behavioral Health unit to provide leadership to improve older adult service delivery and work collaboratively across state departments and with county mental health and aging units. Note: AB 480 (Salas) is a model legislative effort that was not approved in 2019 awaiting the development of the Master Plan on Aging.¹⁷
- To improve the planning and delivery of behavioral health care to older adults, consumer advocates and/or people with geriatric/gerontology behavioral expertise should be “at the table” within important statewide agencies and professional organizations, with designated slots or committees organized around the issues of older adult behavioral health.
- Conduct dedicated outreach and document unmet need among older adults with mental illness. 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.
- Promote standardized geriatric training of providers working with older adults 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.¹⁶
- Institute mandatory and standardized data reporting requirements at state and local (county) levels. Counties should systematically investigate and document the unmet needs of older adults with behavioral health disorders. 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 behavioral 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. The UCLA Center for Health Policy Research has developed and published a recommended essential set of data elements to measure older adult outcomes in the public mental health system.¹³

- Increase service integration efforts, especially the integration of medical, behavioral health, aging and substance abuse 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 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.^{12,14,15,18}

Evidence that supports the recommendation: [Add links or summaries of research evidence that support the recommendation.]

1 Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. 2005. Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry* 62(6):593-602.

2 Conner KO, Copeland VC, Grote NK, Koeske G, Rosen D, Reynolds CF, Brown C. 2010. Mental Health Treatment Seeking Among Older Adults with Depression: The Impact of Stigma and Race. *American Journal of Geriatric Psychiatry* 18(6):531-43.

3 Olfson M, Blanco C, Marcus SC. 2016. Treatment of Adult Depression in the United States. *JAMA Internal Medicine* 176(10):1482-91.

4 Tran LD, Ponce NA. 2016. Who Gets Needed Mental Health Care? Use of Mental Health Services Among Adults with Mental Health Need in California. *Californian Journal of Health Promotion* 15(1):36-45.

5 Karel MJ, Gatz M, Smyer MA. 2012. Aging and Mental Health in the Decade Ahead: What Psychologists Need to Know. *American Psychologist* 67(3):184.

6 World Health Organization. April 2016. *Mental Health and Older Adults* (Fact Sheet No. 381). Retrieved from: <http://www.who.int/mediacentre/factsheets/fs381/en/>

7 Reynolds K, Pietrzak RH, El-Gabalawy R, Mackenzie CS, Sareen J. 2015. Prevalence of Psychiatric Disorders in U.S. Older Adults: Findings from a Nationally Representative Survey. *World Psychiatry* 14 (1):74-81. Note: these classifications of mental and substance use disorders are not mutually exclusive; therefore, the survey results are not cumulative.

- 8 Hybels CF, Blazer DG. 2003. Epidemiology of Late- Life Mental Disorders. *Clinics in Geriatric Medicine* 19(4):663-96.
- 9 Howard R, Rabins PV, Seeman MV, Jeste DV. 2000. Late-Onset Schizophrenia and Very-Late-Onset Schizophrenia-Like Psychosis: An International Consensus. *American Journal of Psychiatry* 157(2):172-8.
- 10 Conwell Y, Van Orden K, Caine ED. 2011. Suicide in Older Adults. *Psychiatric Clinics of North America* 34(2):451-68
11. Committee on the Mental Health Workforce for Geriatric Populations; Board on Health Care Services; Institute of Medicine; Eden J, Maslow K, Le M, et al., editors. Washington (DC): [National Academies Press \(US\)](#); 2012 Jul 10. In Whose Hands? Recommendations for Strengthening the Mental Health and Substance Use Workforce for Older Americans. <https://www.ncbi.nlm.nih.gov/books/NBK201404/>
12. California Behavioral Health Planning Council, 2017 Project on Behavioral Health Services for Older Adults in California Prepared by Linda Dickerson, PhD, Susan Morris Wilson and the Data Notebook Workgroup for the California Behavioral Health Planning Council, December, 2018. https://www.calbhbc.com/uploads/5/8/5/3/58536227/2017_18_statewide_summary_of_all_2017_data_notebooks_12.31.2018_final.pdf
13. Frank JC, Kietzman KG, Damron-Rodriguez J, Dupuy D. California Mental Health Older Adult System of Care Project: Proposed Outcomes and Indicators for Older Adult Public Mental Health Services. UCLA Center for Health Policy Research. 2016, June 30. <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1559>
14. 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. <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1710>
15. Crowley RA, Kirschner N, Health, et al. The integration of care for mental health, substance abuse, and other behavioral health conditions into primary care: executive summary of an American College of Physicians position paper. *Annals of Internal Medicine*. 2015; 163(4):298-299
16. Frank JC, Kietzman KG, Palimaru A. 2019. *California's Behavioral Health Services Workforce Is Inadequate for Older Adults*. Los Angeles, CA: UCLA Center for Health Policy Research. <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1710>
17. Salas, AB 480, proposed legislation 2019. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB480
18. Dupuy D, Kietzman KG, Damron-Rodriguez J, Palimaru A, del Pino HE, and Frank JC. 2018. Promising Older Adult Mental Health Programs. Los Angeles, CA: UCLA Center for Health Policy Research. <https://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1712>

Examples of local, state or national initiatives that can be used as an example of a best practice: [Provide any available links and sources.]

- Local:
- State:
- National:
- Other:

Please link to the Promising Older Adult Mental Health Programs fact sheet and compendium here for a listing of promising behavioral health programs in California. (These are examples from our research and not a comprehensive listing):

<https://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1712>

Implementation: [Insert actions state agencies, legislators, counties, local government, or philanthropy can take to move this recommendation forward. Some of the entities listed below may or may not be applicable to each recommendation.]

- **State Agencies/Departments:** [action to be taken by Governor or specific state agencies]
 1. Establish new administrative unit within the Department of Health Care Services (DHCS), behavioral health unit (or most appropriate place) to implement recommended actions.
 2. The Office of Statewide Health Planning and Development, which currently administers the MHSA Workforce, Education and Training (WET) program, should include priority slots for behavioral health professionals pursuing geriatric/gerontology specialization in their education program for loan forgiveness and stipend programs.
 3. The Department of Aging should collaborate with both the new older adult behavioral administrator and the MHSAOAC to further activities to improve older adult behavioral health services.
 4. The California Behavioral Health Planning Council, within its purview of approving WET plans, should assure that such plans include incentivized funding priorities for behavioral health trainees specializing in geriatrics/gerontology.
- **State Legislature:** [legislation needed to implement recommendation]
 1. Resubmit and pass legislation modeled after AB 480 legislation (Salas) to establish and fund the new DHCS new administrator and support staff unit, with outlined duties and collaborations.
 2. Legislation would be required to amend the MHSA for the composition of the Mental Health Services Oversight and Accountability Commission (MHSAOAC), to include at least one member of the Commission who represents the interests of older adults and has expertise in older adult behavioral health services.

3. Assure that the legislature protects the universal service provision which is the foundation of the MHSA for public mental health programs. In recent years, MHSA amendments have sought to set priorities for special populations (e.g., college students) that would exclude large portions of Californians, including older adults, from needed services.

- **Local Government:**

1. Counties have a great deal of independence in behavioral health planning and service provision. Assure that there is an older adult consumer/advocate committee at the county level (or regional level for groups of small counties) that can represent the interests of older adults in both the planning and allocation of funding for services discussions and activities.
2. County Departments of Mental/Behavioral Health should designate an appropriate number of trainee slots for stipends and loan forgiveness for trainees specializing in geriatric behavioral health professions (could be based on county population of adults 60 years and older).

- **Federal Government:**

- **Private Sector:**

- **Community-Based Organizations:**

1. County/regional Area Agencies on Aging should include older adult behavioral health specialists on their advisory committees.
2. Area Agencies on Aging, and contracted service providers should apply to be sites for Prevention and Early Intervention MHSA with their counties; and make their locations available for behavioral health outreach activities, planning meetings, and programs.

Philanthropy:

Other:

1. The Commission on Aging should assure that at least one Commissioner is a person with expertise in behavioral health.
2. The California Behavioral Health Directors Association (CBHDA) should reinstate its Older Adult System of Care committee and support its effectiveness administratively.

Person-Centered Metrics: Individual measures of inputs or outcomes that can be used to measure the recommended action's impact on people.

Evaluations: [How will we know that the recommended action is successful once it has been implemented?]

- **Short-term (by 2020):**
- **Mid-term (by 2025):**
- **Long-term (by 2030):**

Please see evaluation plan table attached.

Data Sources: [What existing data can be used to measure success or progress?]:

- Existing data sources: [specify datasets, variables, and data owner/location]
- Suggestions for data collection to evaluate implementation of this goal when no data sources exist:

See references listed in Evidence to support recommendation section and evaluation plan table attached.

Potential Costs/Savings: [insert any research, actuarial analysis or other evidence of the cost of this recommendation or potential savings]

We are not aware of cost analyses research for older adult behavioral health services; but will continue to search, and welcome any suggestions/sources.

Prioritization: [How would you prioritize this issue in importance relative to other needs/priorities – e.g., low, medium, high):

High

Name of person(s)/organization submitting recommendation:

Janet C. Frank, DrPH, MSG and Kathryn G. Kietzman, PhD, MSW are submitting as individuals (UCLA Center for Health Policy Research for identification purposes only)

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Date of submission: January 15, 2020 (original); February 21, 2020 (updated to reflect California Behavioral Health Council joining in submission – no other changes)

OLDER ADULT BEHAVIORAL HEALTH RECOMMENDATIONS EVALUATION PLAN

Short-term (by 2020)	Mid-term (by 2025)	Long-term (by 2030)
<p>1. Designate a new older adult behavioral health (BH) administrative health (BH) administrative unit (administrator with geriatrics/gerontology expertise and support staff) within the California Department of Health Care Services.</p> <p>Introduce legislation like AB 480 to establish the position and support unit</p>	<p>Pass legislation in 2021</p> <p>Hire administrator and staff</p> <p>Administrator and staff begin work on collaborations and developing plans for improvement</p> <p>Statewide plans get county buy-in and begin to be implemented</p> <p>BH geriatric core competency training is developed and tested (see recommendation 4 below for details)</p>	<p>BH Geriatrics Administrator works collaboratively across state departments, the CBHDA, and with counties to continue improvement plans for older adult BH services</p>
	<p>New administrator works with OSHPD and CBHPC to put into place WET geriatric BH training incentive program to attract more students/trainees to geriatric BH</p> <p>Trainees specializing in geriatric behavioral health begin receiving WET priority slots for loan forgiveness and stipend programs in state programs and in 50% of the counties by 2025</p>	<p>75% of counties have priority slots for WET loan forgiveness and stipend programs for trainees in geriatric BH profession</p>
<p>2. Promote actions to ensure that consumer advocates and/or people with geriatric/gerontology behavioral expertise are “at the table” within important statewide agencies and professional organizations.</p>		
<p>Introduce legislation to amend the MHSAC Commission to designate one slot for an older adult consumer/advocate and/or person with BH older adult services expertise</p>	<p>Pass legislation in 2021 and recruit person to fill Commission position</p>	

OLDER ADULT BEHAVIORAL HEALTH RECOMMENDATIONS EVALUATION PLAN

Short-term (by 2020)	Mid-term (by 2025)	Long-term (by 2030)
<p>Department of Aging (CDA) leadership to review with the California Commission on Aging (CCoA) the necessary process to designate one Commissioner to be a person with geriatric behavioral health expertise; Initiate process</p>	<p>Complete process (2021) to have one Commissioner on Aging with geriatric behavioral health expertise; solicit appointee applications; appoint person (Governor’s office)</p>	
	<p>New geriatric BH Administrator meets with the CBHDA to request they reinstate Older Adult System of Care Committee (2021); CBHDA reinstates committee and appoints chair (by 2022), quarterly meetings begin with representatives from counties (or regions for small counties, as desired)</p>	
<p>3. Conduct dedicated outreach and document unmet need among older adults with mental illness. MHSOAC provides available data and requests data as needed for a baseline of what counties currently do for older adult outreach and service planning; identify best practices for small, medium and large counties</p>	<p>New geriatric BH administrator works with MHSOAC, CBHPC and CBHDA to develop improvement plan for outreach and metrics to identify penetration Plan is developed and tested Plan is implemented in 25% of counties</p>	<p>Plan is evaluated in counties that have implemented it using the outcome of numbers of older adults evaluated and served (as compared to pre-plan) Plan is revised Plan is rolled out in 75% of counties, including those with largest percentages of older adults in their county population</p>
<p>4. Promote standardized geriatric training of providers working with older adults across disciplines and scope of practice. Representatives from CDA and CBHPC meet with OSHPD WET leadership to assess best way to accomplish standardized core geriatric BH training program development and develop a plan</p>	<p>New geriatrics BH administrator joins planning group, oversees training program development and begins implementation and testing (2023) in 5 counties OSHPD WET plan, approved by CBHPC, includes this core training requirement for all existing and new BH clinical personnel Training program is evaluated and revised (2024), with roll out to counties beginning in 2025</p>	<p>75% of counties have implemented training program with existing clinical staff and new clinical hires</p>

OLDER ADULT BEHAVIORAL HEALTH RECOMMENDATIONS EVALUATION PLAN

Short-term (by 2020)	Mid-term (by 2025)	Long-term (by 2030)
<p>5. Institute mandatory and standardized data reporting requirements at state and local (county) levels.</p> <p>Representatives from the MHSOAC and CDA review Geriatric Indicators Policy Brief by Frank et al., and other resources for suggested potential uniform minimum geriatrics BH data</p>	<p>MHSOAC reviews state level data collection process currently used and additional fields that are optional in new system developed by UC San Diego</p> <p>MHSOAC reviews data collected by counties, and identifies promising fields and indicators</p> <p>New geriatrics BH administrator works with representatives from MHSOAC and CBHDA to develop new uniform minimum data set for geriatric BH services</p> <p>Statewide collection of uniform minimum geriatric BH data set is rolled out, with training provided as needed</p>	<p>75% of counties submit uniform minimum geriatric BH data as a component of their statewide reporting requirement</p>
<p>6. Increase service integration efforts, especially the integration of medical, behavioral health, aging and substance use disorder services.</p>		
	<p>New geriatric BH administrator identifies model programs and promising practices statewide</p> <p>MHSOAC and CBHDA sponsor a conference or web-series to highlight program models and featuring outcome data to promote county adoption of service integration programs</p>	<p>50% of counties have integrated BH health service programs</p>

OLDER ADULT BEHAVIORAL HEALTH RECOMMENDATIONS EVALUATION PLAN

Short-term (by 2020)	Mid-term (by 2025)	Long-term (by 2030)
	New geriatric BH administrator develops tool kit of resources for counties to develop service integration programs and works with CBHDA to support new program development	