

Older Adult System of Care Framework

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OLDER ADULT SYSTEM OF CARE FRAMEWORK

INTRODUCTION:

The California Mental Health Directors Association has designed this framework to articulate our vision of an ideal integrated Older Adult System of Care (OASOC). The ideal OASOC would be:

- Fully-funded
- Culturally and linguistically competent
- Age appropriate, and
- Gender sensitive

This framework identifies the values and beliefs, structural elements, population definitions, and service delivery mechanisms necessary to deliver optimal specialty public mental health services to older adults throughout California. This framework will provide guidance to both policy makers and service providers on policy and program development at the state, regional, and local levels of service delivery.¹

As a publicly funded mental health system for the state of California, the framework must address the current shifts in our state demographics. California's baby boomer population is steadily growing and getting older, and many aging baby boomers continue to move to California for retirement making California the largest home for the elderly population in the United States. With the influx of recent immigrants, there has been a dramatic increase of elders with traditional beliefs and practices which will affect the utilization of mental health services. The framework also needs to address the indigent older adult population to the extent that resources are available.

A fully-funded and implemented OASOC would require a priority for significant funding increases from the State and local governments, particularly for outreach to ethnic and other underserved older adult populations. This document can be useful without additional fiscal resources, both as a template for counties searching for ways to identify structural modifications that will enhance their mental health services delivery systems for the target population, and as a template that State policy makers can use to identify funding shortages and critical policy issues.

This framework upholds improving a person's quality of life. It establishes service delivery designs that support effective, high quality, culturally competent, linguistically appropriate, recovery oriented services for older adults, which can be used independently and in tandem with

¹ This framework is designed to be flexible, and recognizes that even if it were possible to implement an OASOC in all counties, not all public mental health systems would need or desire to implement all of the service elements that are included in this framework. In order to provide for such flexibility, and in view of prevailing inadequacy of resources, it is important to emphasize that this document is not a set of regulations or review standards to be imposed on local government. It is, rather, an articulation of values and goals to which mental health directors are strongly committed.

community-based supports. The needs of older adults in recovery/habilitation from mental illness drive the access to and duration of services that are designed to assist them to negotiate multiple physical, socioeconomic, social and age-related stigmas and barriers. This dynamic framework allows older adults to enter, access, re-enter or exit the system at any point, depending on their needs. Services do not follow a particular order, but build bridges with the community in which the consumers and their families live.

Mental health promotion, education and prevention, and wellness activities increase community awareness about mental health issues and the resources available for older adults. To dispel myths and stigmas commonly associated with accessing the public mental health system by older adults, the public mental health system must reach and establish collaboration and partnership with community and faith-based organizations for cross-training to address discrimination issues (such as ageism, racial/ethnic prejudice and the stigma of mental illness).

ISSUE STATEMENT

The current public specialty mental health delivery system is one of uneven distribution and development. Some of these issues include multiple public and private health insurance plans, disparate and unreliable funding streams, multiple entry points, multiple third party payors, and an incomplete patch-work of state and local laws and policies that are frequently in conflict. Often, exclusionary rules and payor policies involving diagnosis or service restrictions complicate efforts to provide services to older adults, and result in increased service demands without additional dedicated resources. In addition, multiple socioeconomic, cultural, linguistic, disabilities and age related stigmas further confound efforts to redress the barriers faced by older individuals in recovery or habilitation from mental illness as well as co-occurring substance abuse disorders.

The costs of health care to the public and to older adults are staggering. Increases in the rate and severity of mental illness are due to underutilization of publicly available mental health resources (often as a result of fear and perceived stigma) and/or unrecognized, untreated or misdiagnosed mental disorders or co-occurring substance abuse disorders. This is especially true when combined with cultural and linguistic barriers which ethnic populations and their families encounter in seeking behavioral health services. These factors result in an increase in the rate of institutionalization, long term care, medical services, hospital, and emergency services, as well as in the rate and incidence of morbidity, mortality and emotional suffering due to untreated mental illness.

OASOC PHILOSOPHY

An OASOC is a seamless system of services for older adults with mental health issues. It establishes collaborative and cooperative relationships between county public specialty mental health systems in partnership with older adults and their families. Service planning and delivery partners must include CBO's, faith-based organizations, grass roots organizations, and the aging network. OASOC focuses on developing a comprehensive, age appropriate, culturally competent, accountable system of public supports that consumers can readily access and negotiate to help facilitate their recovery or habilitation, as they themselves define it. The ultimate goal of an OASOC is to achieve quality of life as defined by the elder in partnership with their natural relationships (i.e., family, community, etc.) in his or her life.

The concepts of recovery and habilitation are used in mental health policy and program design and are the means for enhancing quality of life. Though competing definitions exist for each, we

have chosen the following definitions as they most nearly approximate our understanding of these concepts. “Recovery” is a personal process through which an individual can choose to change his or her goals, with the ultimate objective of living a healthy, satisfying, and hopeful life despite limitations and/or continuing effects caused by his or her mental illness. “Habilitation” is a strength-based approach to skills development that focuses on maximizing an individual’s functioning. The services that consumers require for their recovery and habilitation are unique to every older adult.

Refocusing mental health service delivery on recovery or habilitation represents a profound shift from previous understandings of the service provider and consumer roles. The needs of the adult transitioning to an older adult system of care is complex. The recovery and habilitative services need to be individualized. The knowledge of transitioning an adult to an older adult system of care is critical to their success. A comparison of the old mental health model and the new older adult system of care model is illustrated in Table 1.

COMPARISON OF MENTAL HEALTH MODELS	
Old Model (Done to/for)	OASOC Model (Done with)
Individual focus	Consumer/Family/caregiver/community focus
Aging as pathology	Healthy Aging
Emphasis on deficits and pathology	Emphasis on strengths, options and quality of life
Office based	Community based
Individual clinician	Geriatric Multiple Disciplinary Team
Mental Illness symptom reduction focus	Holistic approach (Bio-psycho-social) and spiritual Improve quality of life and regain personally meaningful social roles
Services delivered to consumer	Services planned collaboratively with consumer
Providing Advocacy	Consumer and community empowerment, shared responsibility between consumers, families and providers
Quantitative Accountability	Outcome accountability
Service delivery in isolation	Emphasis on cooperation, collaboration, a partnership with other agencies & community
Deny ethnic and cultural differences	Value diversity of ethnic and special populations

Table 1: Older Adult System of Care Paradigm Shift

VALUES AND BELIEFS

1. Mental illness can occur at any age within a person’s lifespan.
2. Consumers of all ages (and diagnostic categories) can and do recover. Human beings are resilient. Support and challenge are both important to reestablish quality of life.
3. Consumers and providers enjoy a relationship in which power is a shared responsibility. The power enjoyed by each balances their relationship, and enhances service quality and delivery.

4. OASOC values the unique role that an older adult has in a family and community system which acknowledges their wisdom, knowledge and ceremonial functions and ability to transmit healthy traditional beliefs and practices.
5. An OASOC is a continuum of services that includes prevention, intervention, treatment and recovery services. These services are delivered in the older adult preferred language.
6. Program design supports the people we serve to move through our programs to the greatest extent possible. Programs should have clear “pathways” for progress, accomplishment, and movement. A graduation or ‘exit’ from the mental health system for many is a possibility and goal.
7. Services are consumer-driven and governed by consumers’ choices. They maintain consumer rights, dignity, and respect, and recognize the unique experiences and world views that each older adult brings to a system of care.
8. Older adults are more likely than other adults to have co existing medical conditions, possible addictions, multiple losses, cultural isolation, socio-economic stressors, transportation problems, ageism issues and stigma.
9. OASOC system of services seeks to overcome access/services barriers associated with age, race, national origin, gender, sexual orientation, religion, and/or physical disability.
10. Targeted outreach in natural community settings is a critical component to access services to older adults, especially for ethnically diverse populations.
11. Critical components of the recovery/habilitation process must be supported by appropriate resource allocation in order to access quality clinical care, housing, transportation, education, employment or volunteer opportunities, meaningful activities, access to physical health care, treatment for co-occurring substance abuse disorders, and an array of community supports.
12. Quality of life (recovery/habilitation) is supported by access to high quality clinical services, delivered by skilled and motivated clinical personnel who can use culturally-based practices and recognize the importance of integration into the older adults components of quality of life.
13. The OASOC makes an effort to work with the family and understand the impact of acculturation process in determining the primary caregiver responsibilities and the level of care needed for the older adult.
14. Quality of life (recovery/habilitation) is anchored in a range of interpersonal relationships, including families, caregivers, peers, friends, significant others and community supports.
15. Service agencies must create a culture of mutual respect and support, which empowers staff to work effectively together to provide quality care. This includes empowering and supporting each other in the workplace and creating the kinds of organizational environments that support recovery/habilitation for older adults we serve.
16. Services are strength-based, recognizing that consumers with varying strengths, symptoms, life situations, experiences, and cultural values have unique goals and approaches to their recovery/habilitation processes.
17. Effective clinical services are supported by on-going training, consultation, and technical assistance.
18. Service quality requires development of appropriate benchmarks and accountability, with ongoing monitoring for consumer satisfaction and relevant clinical structures, processes and functional outcomes
19. Attention to problems of elder abuse and neglect, including self-neglect, needs to be identified and addressed.
20. Research and evaluation policies need to be developed that include diverse ethnic populations.

OLDER ADULT SYSTEM OF CARE DEVELOPMENT

This parameter defines the aspects of a System of Care's organizational infrastructure that are required to transform diverse services into a gender-sensitive, culturally and linguistically competent continuous and comprehensive system. The aspects to which we refer are collaboration and partnership, transition, governance and organizational structure, outreach, education and advocacy, strategic planning, community and human resource development, and accountability.

Collaboration and Partnership

The success of a recovery-based system of care is anchored in providers collaborating with consumers, families, and community, requiring inter-organizational, inter-agency, and intra-county collaboration as well. Collaboration must occur between agencies and/or individuals that are involved in a consumer's life in terms of policy, planning, and service delivery. Collaboration across individual, family, and community systems is needed to identify older adults who would benefit from public mental health services.

Families, the community and caregivers are at the core of a successful partnership in recovery. 'Family members' is defined broadly to include relatives, caregivers, peers, friends, and significant others as determined by the individual consumers. Services will include consumer-driven quality of life plans that honor and protect consumer privacy and choice with regards to the involvement and re-involvement of family members and caregivers.

Local inter-agency collaboration begins with and is supported by state level inter-agency collaboration. State agency commitments must be clearly communicated to local agencies. Many mental health departments rely on relationships with other government agencies to offer access to important services and supports like housing, transportation, health care, employment, and education. Collaboration will be stronger if requirements and incentives to collaborate are similar across local agencies, and this in turn will require commitment and collaboration by state departments and agencies. The role of the State Mental Health Department includes assisting local agencies in designing the right kind of supportive services that will accommodate consumer needs, and in establishing collaborative relationships that work.

For many mental health or behavioral health departments, formal and informal collaboration with community-based and faith-based organizations is required to build the organizational infrastructure necessary to ensure that consumers have access to a wide variety of therapeutic and support services and opportunities for community integration. Contracting partnerships with community-based organizations can offer rich and seamless services for consumers with the goal of including community partners in the healing process. Bridges built between mental health departments and a variety of local social service and peer support, health care, substance abuse treatment providers, and aging networks give consumers in recovery/habilitation broader opportunities to settle into appropriately designed community supports. Abuse/neglect prevention and education need to be addressed across the systems of care serving all age groups.

Transition Services

Formal, system-embedded transition services into and out of age-based OASOC should be strong, specific, planned, and collaborative.

Transitional Adults: Specific planning must occur between ASOC and OASOC to develop individual transitions for adults who might need to access the specialized services of the OASOC. The purpose of integrated joint planning is to build a bridge between adult system services and the services to meet special needs of older adults. Integrated planning should begin based on the functionality of the individual, the likelihood that the person will need the intensive linkage to health and support services available under OASOC and the desire to provide continuous care during the transition. Services to older adults during this period may include:

- Identification of specialized residential facilities that can serve linguistically and ethnically diverse consumer population for intensive care and security.
- Consultation to other agencies and providers with a focus on assisting with culturally appropriate and differential diagnosis and identifying existing co-morbid conditions
- Strengthening linkages to health care providers
- Intensive work with families and caregivers, focused on education regarding mental health needs and advocacy for appropriate linkage to other community supports
- Assessments of the need for alternative care options.

Governance and Organizational Structure

The county mental health department is responsible for taking the leadership role in the development of the OASOC. This entity has the authority at the policy, program, and funding level to coordinate services that may be provided by the local mental health department (i.e. therapeutic and support services) and responsibility for linkages with services and supports provided by other local agencies, and/or local service and support organizations (i.e. housing, education, employment, peer support networks, and health care providers).

System of Care Councils must be established that represent two levels of input and collaboration - one for resource and policy development and a second to coordinate hands-on delivery of services. Both should reflect the ethnic and cultural diversity of the community.

- Develop written operational guidelines which would address cultural competency
- Develop, disseminate and maintain a local OASOC plan
- Coordinate with local boards and commissions

Outreach, Education, and Advocacy

Outreach, education and advocacy are pivotal to a system of care. Targeted community outreach, education, and advocacy efforts, focused on system of care values and beliefs, should be part of every mental health department's strategy. Older adults are affected by stigma, ageism, discrimination, and cultural and linguistic isolation that greatly impact their ability to access and utilize mental health services. Effective outreach, education, and advocacy may be provided through the use of home and/or community based activities, mass media, peers, and families and must address all ethnic communities in the target service population.

Strategic Planning

County mental health departments must assemble the partners to develop a framework for long-term planning and organizational development for the Older Adult System of Care. This framework will guide regional and local resource allocation, and will allow utilization of funds to

build the essential elements of a culturally competent, value-based, treatment-effective, and coherent OASOC. Stakeholder involvement that includes consumers and families is crucial to effective planning.

Human Resources Development

Recruitment and retention of geriatrically trained staff who are culturally competent and ethnically diverse is a large and growing problem in the public mental health system. Strategies for recruitment and development of staff must be a part of OASOC design and implementation. Training of current and new staff in the values and strategies of a recovery/habilitation-based OASOC is needed for organizational development. Training is also needed for ongoing system operation. Training must be a regular part of every OASOC project and must include staff, consumers, family members, faith-based, community-based, grassroots organizations, health and social service providers, the public, collaborative partners, academic and research institutions, and the recovery/habilitation community. OASOC programs must have a human resource component that includes:

- Identification of staff with expertise in aging who are representative of the ethnic and linguistic needs of consumers
- Development and implementation of a retention plan for these highly trained staff
- Training specifically designed to provide geriatric competency across cultures
- Development and usage of peer counseling networks

Accountability

Accountability and service quality must be guaranteed through development of policy, procedures, and performance outcome data that ensure:

- Review and monitoring of individual aggregate outcomes
- Use of age-specific service quality indicators
- Cultural and linguistic congruence
- Clear documentation of medical necessity for clinical services
- Clear accounting of all funding sources and expenditures
- Ongoing monitoring of consumer and caregiver satisfaction
- Sharing of outcomes and other relevant information with local collaboratives
- Use of outcomes to improve service quality, and
- Gender sensitivity

Evidence-based, Effective, and Promising Practices

Identification, development, promulgation, and adoption of evidence-based, effective, and promising practices guidelines for care must be an integral part of ongoing OASOC design and modification. These guidelines should be driven by continuous quality improvement, outcome-based measurements, and the incorporation of new knowledge and technology.

Values-driven, evidence-based practices are defined as “practices that reflect key values of the California *Mental Health System* mental health system stakeholders-such as recovery/resiliency

and cultural competence-and which are supported by an identified level of scientific evidence.”² The concept of a *hierarchy of scientific evidence* acknowledges the existence of numerous types of scientific evidence ranging from rigorously designed research trials to systemic observations, including those that are part of a structured continuous quality improvement process.

SERVICE POPULATION DEFINITION

The OASOC service population includes persons 60 years and older, who, due to a serious mental disorder, have a reduction in personal or community functioning, and are best served in the public specialty mental health system. This may include persons with a variety of co-occurring disorders (cognitive disorders, developmental disorders, or substance abuse disorders) who have serious mental illness. The system of care acknowledges its leadership role in facilitating services needed by other populations through cooperation and collaboration.

Services will be provided until the individual recovers or no longer accepts services, or until consumer outcomes would be better served outside the public specialty mental health system.

Older Adults

The OASOC recognizes that older adults present unique needs, challenges, and opportunities that may include:

- Biological changes associated with normal aging
- Multiple losses
- Cultural values, world view and beliefs as they relate to the role of an older adult, their place in the family and care-giving expectations
- Increased risk of cognitive impairment, physical illness, and functional disability
- Language needs that predispose older adults to linguistic isolation
- Recognition of merits of survival resilience

The Older Adult System of Care service population includes three broad service-based consumer populations:

- Older Adults 60 - 64 “Young Old”
 - Pre-retirement age
 - Working age (may lack SSI and Medicare eligibility)
 - Transitional age adult into older adult
 - Language needs that predispose older adults to linguistic isolation
- Older Adults 65–84 “Middle Old”
 - Retirement age
 - Access to SSI and Medicare and other pension systems
 - May have increased risk of loss in social support, physical health and income
 - Highest risk group for completing suicide

² The California Institute for Mental Health. (2003). Toward Effective Mental Health Practices: A Strategic Work Plan to Develop Organizational Capacity for Incorporating Values and Science into Mental Health Practices. Retrieved from the California Institute for Mental Health website on 1/5/2005 at http://www.cimh.org/projects/executive_summary.cfm.

- Recognition of merits of survival/resilience
- Older Adults 85+ “Oldest Old”
- Fastest growing segment of the older adult population
- Highest risk for cognitive impairments, physical, social and financial problems
- Cohort differences, especially in relation to definition of self, illness and society (e.g. role, identity changes)

The age ranges stipulated in the foregoing population definitions do not imply actual or expected service delivery requirements, but are included here for planning, and to delineate three broad subsets of the population along a continuum of service needs. OASOCs recognize that every consumer is unique, and that each must make individual choices about his or her service needs.

SERVICE ELEMENTS

The following service elements reflect the vision of an age-specific culturally and linguistically competent, recovery/habilitation-oriented OASOC. This "menu" of service elements has been developed as though full funding would be made available. The full menu may not be achievable for every locality immediately. The list of service elements is intended to serve as a guideline for counties in creating comprehensive systems that are responsive to the diverse needs of local communities.

Service elements will reflect the needs of the populations served. That is, services should be age-specific, culturally competent and linguistically appropriate for the demographics of the geographic area served. Sites targeted for outreach and services should be the natural gathering places or homes of older adults as often as possible.

Multi-disciplinary teams have been demonstrated to be effective, especially when available on a mobile basis, and may include professionals, para-professionals and consumers. The delivery service of the team may require services to be rendered at the home, alternate service-sites, shopping malls, and in the community. It is through the activities of the team that services become truly seamless and accessible.

Access to and duration of services are individually determined and directed by the consumer. The framework is designed to be dynamic so that individuals can enter/access services and can exit or re-enter the system at any service point, depending on their needs.

The standard for an OASOC is to be "recovery/habilitation" focused and designed to provide services across four primary dimensions:

- 1. Prevention, promotion, and wellness**
- 2. Entry/Access**
- 3. Therapeutic/Recovery/Habilitative Services**
- 4. Services provided by integrated agencies and/or with community collaboration and partnership**

1. **Prevention, promotion, and wellness:** These activities complement direct service and recovery/habilitation activities by increasing community awareness about mental health issues and the resources available within Systems of Care as well as other community resources. Specific elements are as follows:

- Education to dispel the myths and stereotypes commonly held by the elderly about mental illness.
- Anti-stigma education (e.g. mental illness and ageism)
- Behavioral health screenings
 - Bio-psycho-social screenings
 - Alcohol/Drug screenings
 - Depression screenings
- Community education and training (e.g., law enforcement, adult protective services, aging network, family caregiver resource, health care provider)
- Community mental health consultation (e.g.. liaison with government and other organizations; problem-solving around community mental health issues and older adults)
- Abuse/neglect prevention and education options (e.g. Multidisciplinary Teams, CARE Teams, and FAST Teams.)
- Information referral and linkage to appropriate community resources
 - Community resources
 - Assisting in accessing appropriateness of community resources

2. **Entry/Access:**

The OASOC should minimize barriers and create services that are easily identifiable and available throughout the community.

- Consumer, family, and caregiver training on how to access services
- Linkages to health services (i.e. medical, dental, placement; community residential options)
- Assertive mobile outreach to older adults' natural settings, such as senior centers, mobile home parks, senior education classes, recreation centers, and residential settings in collaboration with the community.
- Communication among social and health service providers working with older adults.
- Transportation-identify and overcome barriers to adequate transportation systems in both rural and urban areas.
- Engagement - problem resolution of consumer-identified needs (for example, housing assistance, physical and dental health care, educational services and other community resources) (These should include linguistically competent, age-sensitive approaches.)
- Screening and/or initial assessments by mental health professionals trained in age specific issues, cultural competency, and respecting older adult values and beliefs
- Specific screening and assessment services focused on identification of a variety of co-occurring disorders (substance abuse disorders, medical problems, developmental disorders)
- Advocacy for historically underserved groups
- Family, caregiver support, and community consultation and collaboration

- Assertive involvement with discharge planning (e.g. education on symptom management support services in the community)
- Enter/Exit System – any service point depending on consumer’s needs
- Continuity of care /older adult services – age appropriate services delivered by specially trained staff across the continuum of need, including in-home care and assistance with activities of daily living

3. **Therapeutic/Recovery/Habilitative Services:**

The OASOC is a continuum of care and works in cooperation with other community services and supports. These mental health services and supports may include case/care management, assessment/evaluation, outpatient/inpatient treatment, and residential care, etc. The following services may be provided by other agencies and coordinated by the case/care management teams.

- Comprehensive assessment including a clinical assessment as well as assessment for non-clinical support needs such as housing, occupational, recreational, or volunteer involvement, income, social supports, education, co-occurring disorder needs, health care, in-home supportive services, etc.
- Care management and coordination (linkage, brokerage and advocacy, SSI, Medi-Cal, food stamps, physical health care) consultation and referral services
- Crisis services (includes mobile crisis as appropriate)
- Stabilization services
- Comprehensive services for recovery/habilitation of persons with co-occurring disorders
- Psychotherapy/Counseling (Individual, Group, Family)
- Mental health education
- Medication stabilization and maintenance
- Forensic mental health services
- Acute and long term inpatient care
- Residential care with a therapeutic environment tailored to the needs of older adults
- Home care assistance, including training of caregivers and providers about enhancing the ‘therapeutic environment’ of the home
- Skill building (e.g., relapse prevention/WRAP, stress management)
- Clinical management related to somatic treatments, including collaboration with general medical providers

4. **Services Provided by Integrated Agencies and/or with Community Collaboration:**

Collaboration is key to successfully providing mental health services to older adults and their families. OASOCs must emphasize formal and informal collaboratives, and promote integration of service provision in their communities.

- Supportive and independent housing
- Supportive and independent employment or personal growth opportunities
- Supportive and independent education
- Peer supports (peer recovery/habilitation network, drop-in centers, day centers, etc.)

- Family and caregiver support and consultation
- Exit planning and successful linkage to other supports
- Cultural and ethnic services
- Chemical dependency treatment providers (residential and non-residential)
- Gender and sexual orientation based services
- Senior centers
- Freestanding wellness recovery/habilitation centers
- Residential care facilities for elderly with therapeutic environments (including a supplemental rate for mental health services)
- Physical health care
- Senior legal aid
- Faith based organizations and spiritual groups
- Dispute resolution
- Traditional healers
- Senior peer counseling
- Intensive case management
- Family advocate
- Adult day health care
- Adult day care
- Partial hospitalization
- Geriatric assessment centers
- Private caregiver resource centers
- Senior nutrition centers
- Adult Protective Services
- In-home Supportive Services
- Multi-Service Senior Programs
- Senior volunteer programs
- Foster Grandparents
- Shared housing
- Veterans Services
- Transportation services
- Fitness centers
- Community colleges
- Public Guardian: LPS and probate guardianships
- Regional Centers
- Consumer support groups
- Grief/loss support groups
- Self help groups (i.e. COPD, Overeaters Anonymous, Hospice, cancer, asthma, pain, Parkinson's, Alzheimer's, Alanon, AA, NA.)
- Multigenerational family consultation
- A full array of outpatient services specializing in geriatric diagnosis and treatment
- Criminal Justice System

CONCLUSION

In summary, the OASOC framework is designed to be flexible, and recognizes that each county has its own particular community needs with respect to this population. The services and

structures outlined in this document are meant to serve as a guide for those planning to develop or enhance their local OASOC.

The recent Older Adult System of Care Demonstration Project (FY 2000-2003), verified the need for and success of the components outlined in the framework. A core element that was attributed to the success of the projects was establishing coalitions and service coordination with other service agencies. They found success in increasing access to services for older adults through the use of mobile multidisciplinary teams, out-stationed staff in primary care clinics, establishing peer counseling, combining mental health and health needs assessments, conducting focused outreach and providing educational training for primary care clinic staff. In addition, the need for a standardized comprehensive assessment that encompassed both health and mental health needs was recommended.

The CMHDA acknowledges the many contributions that older adults have made, and continue to make to society. It is in recognition of these many contributions that this framework is dedicated.