California Mental Health Older Adult System of Care Project

Executive Summaries for Project Deliverable 3: Secondary Analysis and Key Stakeholder Interviews

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Deliverable 3, 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 MHSA 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 MHSA 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 MHSA 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 MHSA. They also noted that, compared to need, there was great unmet need for services for older adults with SMI across all MHSA 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 MHSA 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 proved 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.

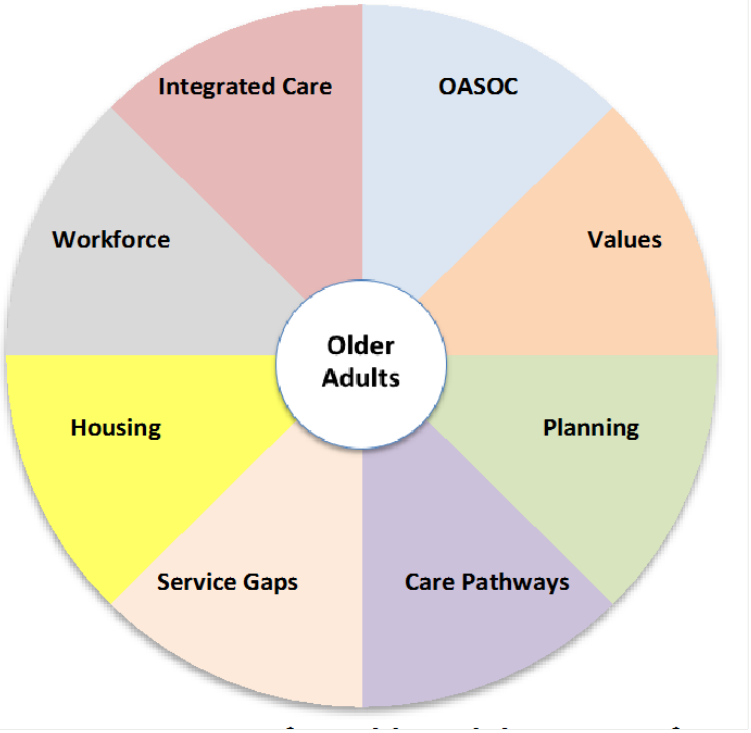
Executive Summary for Part 2: Key Informant Interview Findings

Part 2, of Deliverable 3, is the report 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 h 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.

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. 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.

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 LGTBQ 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.

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