

Exhibit A

**California Department of Aging
2007-08 Budget Change Proposal**

Mental Health Services Act

STATE OF CALIFORNIA
 BUDGET CHANGE PROPOSAL - COVER SHEET
 FOR FISCAL YEAR
 DF-46 (WORD Version)(REV 07/06)
 Please report dollars in thousands.

Department of Finance
 915 L Street
 Sacramento, CA 95814
 IMS Mail Code: A-15

BCP # 10	PRIORITY NO. 2	ORG. CODE 4170	DEPARTMENT AGING
PROGRAM 40	ELEMENT	COMPONENT	

TITLE OF PROPOSED CHANGE
 IMPROVING ACCESS TO MENTAL HEALTH SERVICES FOR OLDER PERSONS AND ADULTS WITH DISABILITIES

SUMMARY OF PROPOSED CHANGES

This Budget Change Proposal requests approval for one (1.0) position and \$93,000 authority to coordinate and monitor efforts to improve access to mental health services for older persons and adults with disabilities. This position will be funded from the Mental Health Services Fund.

REQUIRES LEGISLATION <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	CODE SECTION(S) TO BE AMENDED/ADDED	BUDGET IMPACT—PROVIDE LIST AND MARK IF APPLICABLE <input type="checkbox"/> ONE-TIME COST <input type="checkbox"/> FUTURE SAVINGS <input checked="" type="checkbox"/> FULL-YEAR COSTS <input type="checkbox"/> REVENUE <input type="checkbox"/> FACILITIES/CAPITAL COSTS
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PREPARED BY <i>[Signature]</i>	DATE 2/16/07	REVIEWED BY <i>[Signature]</i>	DATE 2-20-07
DEPARTMENT DIRECTOR <i>[Signature]</i>	DATE 2/16/07	AGENCY SECRETARY <i>[Signature]</i>	DATE 2/22/07

DOES THIS BCP CONTAIN INFORMATION TECHNOLOGY (IT) COMPONENT(S)? YES OR NO
 IF YES, DEPARTMENT CHIEF INFORMATION OFFICER SIGNATURE _____ DATE _____

FOR IT REQUESTS, SPECIFY THE DATE SPECIAL PROJECT REPORT (SPR) OR FEASIBILITY STUDY REPORT (FSR) WAS APPROVED BY THE DEPARTMENT OF FINANCE.

DATE _____ PROJECT # _____ FSR OR SPR

IF PROPOSAL AFFECTS ANOTHER DEPARTMENT DOES OTHER DEPARTMENT CONCUR WITH PROPOSAL?
 YES NO ATTACH COMMENTS OF AFFECTED DEPARTMENT, SIGNED AND DATED BY THE DEPARTMENT DIRECTOR OR DESIGNEE

DEPARTMENT OF FINANCE ANALYST USE
 (ADDITIONAL REVIEW)
 CAPITAL OUTLAY OTROS FSCU OSAE CALSTARS
 DATE SUBMITTED TO THE LEGISLATURE _____ PP54

STATE OF CALIFORNIA
 BUDGET CHANGE PROPOSAL—FISCAL DETAIL
 STATE OPERATIONS
 DF-46 (REV 07/06)

Department of Finance
 915 L Street
 Sacramento, CA 95814
 IMS Mail Code: A-15

Please report dollars in thousands.

PROP #	DATE	TITLE OF PROPOSED CHANGE				
		PROGRAM	ELEMENT	COMPONENT		
10						MENTAL HEALTH
40						
	PERSONNEL YEARS					
	CY	BY	BY + 1	CY	BY	BY + 1
TOTAL SALARIES AND WAGES ¹		1.0	1.0	\$	\$ 56	\$ 59
SALARY SAVINGS	-	-	-	-	--3	--3
NET TOTAL SALARIES AND WAGES				\$	\$53	\$ 56
STAFF BENEFITS ²				\$	\$21	\$22
TOTAL PERSONAL SERVICES				\$	\$74	\$78
OPERATING EXPENSES AND EQUIPMENT ³						
GENERAL EXPENSE					3	3
PRINTING					1	1
COMMUNICATIONS					1	1
POSTAGE						
TRAVEL—IN STATE					6	6
TRAVEL—OUT OF STATE						
TRAINING					1	1
FACILITIES OPERATIONS					6	6
UTILITIES						
CONSULTING & PROFESSIONAL SERVICES: Interdepartmental ⁴						
CONSULTING & PROFESSIONAL SERVICES: External ⁵						
DEPT OF TECHNOLOGY SERVICES CONSOLIDATED DATA CENTER						
DATA PROCESSING					1	1
EQUIPMENT ³						
DEBT SERVICE						
OTHER ITEMS OF EXPENSE: (specify below)						
TOTAL OPERATING EXPENSES AND EQUIPMENT				\$	\$19	\$19
SPECIAL ITEMS OF EXPENSE ⁴				\$	\$	\$
TOTAL STATE OPERATIONS EXPENDITURES				\$	\$ 93	\$ 97
SOURCE OF FUNDS	APPROPRIATION NO.					
	ORG	REF	FUND			
GENERAL FUND				\$	\$	\$
SPECIAL FUNDS				\$	\$	\$
FEDERAL FUNDS				\$	\$	\$
OTHER FUNDS (MHSF)	4170	001	3085	\$	\$93	\$97
REIMBURSEMENTS				\$	\$	\$

¹ ITEMIZED DETAIL ON PAGE 13 BY CLASSIFICATION AS IN SALARIES AND WAGES SUPPLEMENT.

² PROVIDE DETAIL ON PAGE 13.

³ PROVIDE LIST ON PAGE 14.

⁴ SPECIAL ITEMS OF EXPENSE MUST BE TITLED. PLEASE REFER TO THE UNIFORM CODES MANUAL FOR A LIST OF THE STANDARDIZED SPECIAL ITEMS OF EXPENSE SUBJECT WHICH MAY BE USED.

CALIFORNIA DEPARTMENT OF AGING
2007-08 GOVERNOR'S BUDGET
BUDGET CHANGE PROPOSAL # 10

**Title: Improving Access to Mental Health Services for Older Persons and Adults
with Disabilities**

A. Nature of the Request

This Budget Change Proposal (BCP) requests one permanent AGPA position effective fiscal year (FY) 2007-08 to provide programmatic expertise on the mental health issues of the population served by the California Department of Aging ("CDA" or "Department"). This position is necessary in order for CDA to participate in addressing the significant under serving of the older adults by the existing mental health system. The position would (1) facilitate and provide technical assistance to local entities in their efforts to establish and/or expand mental health service models responsive to the needs of older adults and/or adults with disabilities; (2) serve as an internal consultant to CDA programs on promising practices that increase access to effective mental health services for older persons and adults with disabilities; and (3) support CDA's active participation in the state level policy and implementation activities pertaining to the implementation of the Mental Health Services Act (MHSA) and the implementation of the Older Adult System of Care model.

The position will be 100 percent funded through the Department of Mental Health Mental Health Services Fund state operations monies.

B. Background/History

Historical Inequities in Mental Health Services for Older Adults

An estimated 20 percent of adults age 55 and over experience mental disorders that are not a part of normal aging.¹ The most common disorders, in order of prevalence, are anxiety disorders, such as phobias and obsessive-compulsive disorders; severe cognitive impairments, including Alzheimer's Disease; and mood disorders, such as depression. Schizophrenia and personality disorders are less common.²

However, some studies indicate that mental disorders in older adults are substantially underreported. One study for example found that 8-20 percent of older adults in a community and up to 37 percent of those receiving primary care experience symptoms of depression.¹ An estimated two thirds of nursing home residents suffer from a mental disorders, including Alzheimer's and related dementias.³

Older adults with mental illness differ widely as to the onset of their illness. Some have suffered from serious and persistent mental illness for most of their adult life, while others have only had periodic episodes of mental illness. A substantial number experience mental illness for the first time in later life, exacerbated by bereavement, role loss, income insecurity, and/or physical illness. These mental disorders can range from problematic to fatal.

Poor physical health is a key risk factor for mental disorders. One of the hallmarks of late life depression is its co-existence with physical health conditions. Medical illnesses may develop independently from mental illness, but may also be associated with them. For example, one epidemiological study found that chronic depression (lasting an average of four years) raises the risk for cancer by 88 percent in older adults.²

Left untreated, mental illness can turn minor medical conditions into a life-threatening condition.² Medical comorbidity is present in the majority of older adults with serious mental illness and is associated with worse medical outcomes and higher mortality compared to individuals without mental illness.¹⁴

While family care giving has been documented as delaying the institutionalization of an ill relative, that role puts family caregivers themselves at risk of physical and mental illness.⁴ Older spouses, siblings, and children in their 60's and 70's make up a sizeable portion of that caregiver group. One study found that 46 percent of family caregivers were clinically depressed, but only 10-20 percent of those individuals used any formal services, which might have reduced their level of stress.^{5,6,7}

Older adults have the highest suicide rates in the U.S. population. Suicide rates increase with age. Older white men having a rate of suicide up to five times that of the general population.⁸ California's suicide rate mirrors the national rates, with males age 85 and over account for the highest age-specific suicide rate.⁹

Although older adults represent 13 percent of the U.S. population, they receive only 6 percent of community mental health services.¹⁰ In California, 4-6 percent of county Medi-Cal mental health services are spent in care for older adults.¹¹

Six factors account for older adults' significant underutilization of mental health services:

1. Stigma associated with being diagnosed as having a mental illness and myths about what is normal aging (e.g. depression may be viewed as "normal" given an individual's functional loss, pain, loss of spouse, reduced interest in life, etc.)
2. Lack of Physician/Mental Health Practitioner Geriatric Training Older adults most frequently express physical complaints that in fact could be symptoms of their mental health problems to their primary care physician (PCPs). But most PCPs have received little if any specialized training on geriatric mental health diagnosis and treatment. Most mental health practitioners have also received little if any specialized geriatric education. This lack of training has tragic consequences. One third of older adults who commit suicide have visited their PCP within a week before their death; seventy percent have seen their PCP within the month prior to their death. These were missed opportunities for depression screening and intervention.
3. Need for Specialized Geriatric Assessment and Diagnostic Tools Older adults often present different symptoms of mental illness than younger people. It may be more difficult to distinguish mental health symptoms from other potential or co-occurring chronic health problems. Because of these differences, specialized assessment and

diagnosis tools and treatment models may be needed to effectively treat an older adult's mental disorder.

4. Limited Medicare Coverage Medicare, the primary health insurer for older adults, reflects the traditional lack of parity in covering mental health services. Given that limited coverage, it is not surprising that only 0.57 percent of total Medicare expenditures are for mental health services. Medicare provides 80% payment for medically based services; the beneficiary is then responsible for the 20 % copayment. But for non-medical mental health services, such as psychotherapy, Medicare provides only 50 percent of the payment, requiring the beneficiary to pay the 50% copayment. Prior to the implementation of Medicare Part D, the beneficiary would also have to pay 100 percent of any medications prescribed for their mental health condition. Medicare's low provider reimbursement to psychiatrists has also created a fiscal disincentive to specialize in geriatric psychiatry.
5. Rationing Resources Some state and federal policymakers have rationalized not funding geriatric mental health services because older adults have traditionally underutilized generic mental health services. Others have "rationalized" that scarce resources should go to younger people more responsive to treatment and with a longer life expectancy. Research over the past decade demonstrates that cost effective models of geriatric mental health treatment exist and that the cost of geriatric mental health problems will be borne by society either through increased medical health utilization or through appropriate mental health treatment.
6. Fear of Overwhelming the Mental Health System The high incidence of Alzheimer's and other related dementias in advanced age (e.g. an estimated 45 percent of the population age 85 and over has some symptoms of dementia), and the prevalence of co-occurring severe mental illness among those with Alzheimer's disease or other dementias, has traditionally created panic among the funders of mental health, due to concerns that if they treat the co-occurring mental health condition they will also end up footing the bill for the individual's on-going long term care costs, particularly since it may be difficult to find suitable housing for these individuals.

This understandable concern has resulted in older adults with dementia and co-occurring mental health conditions receiving very little assistance from county funded mental health services. Among persons with dementia, an estimated 5-20 percent have hallucinations, while 13-33 percent have delusions.¹² An estimated 50 percent of persons with Alzheimer's disease meet the criteria for major depression or dysthymia.¹³ Depression is extremely common in persons with vascular dementia.

As a result of these six factors, most older adults with serious mental illness live in the community without mental health services until a crisis occurs. If they do receive home and community based services, it may be a patchwork of uncoordinated services (e.g. home delivered meals through Area Agencies on Aging, short or long term care management from the county adult protective services program or county mental health program, personal care assistance from the county In Home Supportive Services program). Since the services that exist are a "patchwork," local and state interagency and interdepartmental efforts to streamline access and coordinate services for this population are imperative.

Given this patchwork of community services and the large gaps in resources to serve a geriatric population, when a crisis does occur, older adults with mental illness are significantly more likely to be admitted to a nursing home and remain there because the needed community supports do not exist or are overburdened. This pattern persists even though short-term intervention with care management follow up would be more cost effective than on-going institutionalization.

Department of Aging Responsibilities

The California Department of Aging administers programs serving older adults, adults with disabilities, family caregivers and residents in long-term care facilities throughout the state. Funding for these services comes from the federal Older Americans Act, the state's Older Californians Act, and the Medi-Cal program. The array of programs and services includes: information and assistance, in-home services, congregate and home-delivered meals, community service employment, advocacy and protection, health insurance counseling, case management, long-term care Ombudsman services, and respite services. The Department also has program oversight for approximately 200 Adult Day Health Care Centers and 56 Alzheimer's Day Care Resource Centers and administers the Multipurpose Senior Services Program, a Medi-Cal waiver serving over 10,000 seniors throughout the state.

CDA also serves on the California Geriatric Education Center (GEC) Advisory Committee (funded under Title VII of the Public Health Services Act) that works with the UC and CSU campuses to ensure that physicians get some basic skills to address geriatric health issues, including mental health.

Although CDA does not directly fund or administer mental health services, many of the supportive services administered by CDA help older adults and adults with disabilities that have a mental illness to remain in the community. The Family Caregiver Support Program also provides respite, counseling and other supportive services to family members who may be ill equipped, overwhelmed or seriously depressed as a result of their care giving responsibilities. For example, we know that 36.5% of the 47,182 clients served in the Adult Day Health Care (ADHC) program have a psychiatric diagnosis.

In California, the AAAs are often the lead agency or a strong partner in advocating for increased mental health services for older adults and in seeking to build responsive service models in the counties they serve. This is especially true in the larger counties where the County Department of Social Services is also the AAA. But, while CDA oversees the AAAs, the Department does not currently have staff to provide any significant input to them on mental health issues.

Recent Federal Action

2005 White House Conference on Aging (WHCoA) Every decade, the President calls for a WHCoA to identify from seniors and those who serve them what the most critical issues and needs are. In December 2005, WHCoA delegates voted on over 50 proposed resolutions. "Improved recognition, assessment and treatment of mental

illness and depression among older Americans" ranked in the top ten of the delegates priorities.

On October 17, 2006, President Bush signed the Older Americans Act of 2006, which reauthorizes the Act for five years. The OAA establishes the policy objectives and broad program requirements for the federal Administration on Aging, state units on aging, area agencies on aging and the funding formulas for program funding allocations. The revised Act authorized the AoA Assistant Secretary to designate an individual within her agency "responsible for the administration of mental health services authorized under the Act and to develop objectives, priorities, and a long term plan for supporting state and local efforts involving education about and prevention, detection, and treatment of mental health disorders, including age-related dementias, depression, and Alzheimer's disease and related neurological disorders." While not providing additional funding for these activities, the Act "directs AAAs to revise their plans and provide assurances that they will increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including screening)." Since CDA and the 33 AAAs do not directly provide mental health screening or services, compliance with these new requirements will require close collaboration with the county mental health department and local mental health service providers.

Opportunity for Improving Access Under the Mental Health Services Act

The MHSA (Proposition 63) was approved by California voters in 2004. The funding, generated by a 1 percent increase in the personal income tax for adjusted gross income over \$1 million, is to be used to expand, not supplant, mental health services. The MHSA requires that each county develop, with diverse local public input, a plan for the use of those funds. This plan must be reviewed and approved by the Department of Mental Health (DMH) and within the first three years the counties must determine how they will meet the special community service and support needs of children and youth, adults, and older adults. The overarching goals are to focus on outcomes and accountability; cultural competence in outreach and service delivery; and improving services to underserved populations. The impetus for the MHSA was not just to raise additional mental health service revenues. Its goal is to transform existing mental health services by identifying and evaluating promising evidence-based clinical practices and disseminating these innovations to increase the use of successful cost effective interventions.

Since older adults represent an underserved population, the county MHSA plans will specify a certain percentage of the overall funding request to improving mental health services for older adults. While each county plan must articulate how it will transform its local mental health system, dialogue across counties should be encouraged to identify and share promising models, lessons learned, opportunities for cross-county collaboration, workforce training, and consumer-focused approaches for providing mental health services that are coordinated with other needed social/health services for currently underserved age groups.

C. State Level Considerations

General Fund Cost Avoidance

Many Californians with mental illness successfully reside in the community. However, because most older adults who first exhibit symptoms of mental illness in later life do not receive treatment at an early state of their illness, intervention often does not occur until a crisis develops. At that point, the individual may require evaluation and treatment in a locked psychiatric facility or a skilled nursing facility or an Institution for Mental Disease (IMD). Cost for psychiatric facilities and IMDs are borne by the county. Individuals placed in a skilled nursing facility that is not an IMD either pay privately or may spend down any existing assets and become Medi-Cal eligible. If the client has exhausted his/her family caregiver support system or has none, once institutionalized, if they are not quickly stabilized, their transition back home becomes less likely.

While specific data is not available to present a cost benefit analysis of providing home and community based mental health services versus on-going institutional care, for at least of some portion of the population, prevention and early intervention services could generate Medi-Cal cost avoidance and improve the quality of life for many older and disabled Californians.

As an example, the County of Los Angeles found it cost effective to develop multidisciplinary geriatric rapid assessment teams that included county mental health and aging service specialists to quickly assess and develop a care plan/intervention for certain older adults referred to APS. The cost for funding these rapid assessment teams was far less than the cost for repeat police and social service visits, incarceration, hospitalizations, and/or institutional placement.

Better Use of Scarce Health Resources

Failure to treat depression among the elderly clearly results in significantly higher medical costs.¹⁵ In one study, total ambulatory costs for depressed older adult patients were 45 to 52 percent higher and total ambulatory and in-patient costs were 47 to 51 percent higher than their non-depressed counterparts after adjustment for chronic medical illnesses.¹⁶ Studies that have included older adult subjects have shown that even modest psychological interventions have resulted in reduced hospital stays of approximately 1.5 days.¹⁷

The acute and primary health care costs for older adults with untreated mental illness are primarily borne by the federal Medicare program. However, in an environment where emergency rooms are overcrowded and frequently closed and there are on-going hospital bed shortages, California's entire health care system, and each one of us who may personally need emergency or acute care, are ill served when the system is inefficiently treating patients by not addressing their underlying problem—whether that is medical or mental.

Cost of Informal Caregiving

Not only is caregiving associated with increased risk to the caregiver's physical and mental health, but the number of hours spent in caregiving almost doubles when the older family member had multiple depressive symptoms. Family caregiving for depressed older Americans represents a yearly cost of about \$9 billion. This cost translates into a significant societal economic cost and, for many employers and employees, lost work productivity.¹⁸

Promotes Olmstead Goals and Objectives

Because older adults have historically been underserved by both federal and state mental health systems, they are more likely to be institutionalized as a result of untreated and potentially undiagnosed mental illness. Family caregivers overwhelmed by their responsibilities are not only at risk for health and mental illness, but they may endanger the person they are caring for through physical or verbal abuse or neglect. In some cases, early intervention, respite, and other services can support the family member in continuing to care for their loved one in their own home. In other cases, the health and safety of both the caregiver and the care recipient require that other care options are found. This proposal would promote California's Olmstead efforts by seeking to expand and better coordinate the home and community based services needed by older adults, adults with physical disabilities, and family care givers who are suffering from a mental illness so that they can remain in or return to the most independent setting possible.

Health, Safety, and Quality of Life Issues

Persons with mental illness suffer from debilitating depression, delusions, paranoia and cognitive disorders. All of these conditions significantly reduce an individual's quality of life and potentially jeopardize their health and safety. They may refuse to take needed medication for physical health conditions; fail to maintain safe housing conditions putting them at risk for eviction; may be unwilling to leave their home or refuse social service providers access to their home even though they are unable to perform their personal care needs or maintain their home. Individuals with mental health disorders, regardless of their age, can not only endanger their own well being, they can endanger the life and safety of loved ones, friends and neighbors, and strangers in the community who could be victimized by their dangerous and/or anti-social behavior.

Older adults, particularly those age 85 and older, the fastest growing age group, has the highest rate of suicide. Without increased mental health screening and interventions targeted to older adults, this rate will likely continue to increase.

D. FACILITY/CAPITAL OUTLAY CONSIDERATIONS

None.

E. JUSTIFICATION

The MHSA creates an opportunity for increased mental health services to older adults and adults with disabilities throughout the state. However, since the development of successful service delivery models, particularly for older and physically disabled adults

will likely require additional social and health services, a multidisciplinary approach at the local and state level will be required. This multidisciplinary effort will need to include the AAAs, adult day health care centers and the Medi-Cal waiver program for older adults (i.e. the Multipurpose Senior Services Program [MSSP]) at the local level. Mental health advocates expect the Department of Aging to be equally involved in these efforts at the state level. However, CDA has not had any resources to allocate to these activities on an on-going basis.

The Older Americans Act of 2006 establishes new requirements of AAAs pertaining to older adult mental health screening and service delivery. As the state unit on aging, CDA will be responsible for overseeing AAAs in collaborating with the county mental health department and local mental health service providers.

Workload

The additional resources being requested would permit CDA to begin addressing these mental health issues across the Department's various programs. The workload for the positions includes:

- Preparing a baseline assessment of AAA involvement in mental health activities
- Reviewing and updating assessment tools
- Reviewing local program referral protocols
- Developing state staff and local provider in-service training opportunities
- Partnering with other agencies to encourage counties to implement effective older adult treatment models; geriatric mental health training opportunities for PCPs and mental health practitioners; and outreach to older adults (and their families) potentially in need of these services
- Representing CDA on an on-going basis in the MHSA implementation process and at the meetings of the Older Adult Subcommittees of the California Mental Health Planning Council and the County Mental Health Directors Association (CMHDA). The Planning Council and CMHDA meet quarterly and provide leadership in coordinating and promoting implementation of the Older Adult System of Care model.
- Developing AAA Area Plan guidance to include AAA involvement in older adult mental health screening and service delivery and monitoring the submitted 33 Area Plans for this element.
- Providing internal CDA technical assistance on programmatic mental health issues and incorporating mental health considerations into the programs CDA administers
- Acting as a liaison to the CA Geriatric Education Center via their Statewide Advisory Committee in fostering opportunities for primary care physicians, mental health and social service practitioners to gain geriatric assessment, diagnoses, and treatment skill as well as an understanding of successful evidence-based mental health interventions for older adults.

The DMH does not have sufficient staff resources with expertise in both older adult mental services and the aging services system to directly provide this technical assistance to local counties and community partners as they seek to implement the MHSA.

There is consensus that older adults have been underserved by the existing mental health system. Failure to address these needs has translated into poor quality of life for many older Californians and transferred those problems to a medical care system, poorly equipped to address geriatric mental health needs. Older adults represent the fastest growing segment of the state's population. Unless effective mental health treatment options are implemented and practitioners trained to use them within the next decade, California will resort to institutionalizing significantly increased numbers of older adults and that cost will be borne by the Medi-Cal program, with costly consequences to the state general fund.

Funding

This position would be funded through the Mental Health Services Fund for state operations. DMH is aware of and has a copy of this proposal.

F. OUTCOMES AND ACCOUNTABILITY

The incumbent in this position will be reviewing Area Plans, working with local AAAs, monitoring and documenting outcomes to ensure increased coordination and promotion of community based mental health services for underserved older adults and adults with disabilities. This position will assess opportunities to better incorporate mental health screening and strategies for improved mental health referrals and identify promising models and lessons learned across the programs administered by CDA.

Through participation on the Older Adult Subcommittees of the CA Mental Health Planning Council and the CMHD Association, this position will be directly involved in the statewide MHSA efforts to implement improved services.

As a liaison to the CA Geriatric Education Center via their Statewide Advisory Committee CDA will be involved in fostering opportunities for primary care physicians, mental health and social service practitioners to gain geriatric assessment, diagnoses, and treatment skill as well as an understanding of successful evidence-based mental health interventions for older adults.

G. ANALYSIS OF ALL FEASIBLE ALTERNATIVES

Alternative One: Establish one AGPA position effective July 1, 2007 using MHSA services funding. This alternative would assure sufficient resources to respond to the needs identified above.

Increasing community based mental health services to older adults will reduce costs to the General Fund. The lack of alternatives means that many older clients who are temporarily institutionalized for evaluation or treatment in a crisis end up staying in the institutional care. Prevention and early intervention services could generate Medi-Cal cost avoidance and improve the quality of life for many older and disabled Californians.

This alternative supports better use of California's scarce health resources. In an environment where emergency rooms are overcrowded and there are on-going hospital bed shortages, California's entire health care system is negatively impacted by

inefficient treatment of patients with mental health issues. It is known that even modest psychological interventions have resulted in reduced hospital stays of approximately 1.5 days.¹⁷

This alternative would promote California's Olmstead efforts by seeking to expand and better coordinate the home and community based services needed by older adults, adults with physical disabilities, and family care givers who are suffering from a mental illness so that they can remain in or return to the most independent setting possible.

Failure to approve this alternative would result in CDA's inability to (1) participate in MHS implementation efforts; (2) engage in opportunities to address the unmet need for geriatric mental health services that results in significant administrative hospital bed days when alternative discharge options cannot be found; and (3) implement new OAA state oversight requirements pertaining to the AAAs role in mental health screening and service delivery.

Alternative Two: Redirect staff from within the Department.

This alternative is not possible because the Department cannot absorb this workload. Due to prior staffing reductions, CDA is already not able to meet all of its mandated monitoring responsibilities. Redirection would put the Department at risk of federal audit findings.

Alternative Three: Do nothing.

This alternative would eliminate the need for the requested position. It would result in the negative consequences listed above in Alternative One.

H. TIMELINE

This position would be established as of July 1, 2007 and effective when the budget is approved.

I. RECOMMENDATION

CDA recommends approval of Alternative One:

Establish the AGPA position to permit CDA to (1) actively participate in state level efforts aimed at increasing access to mental health services for older adults and adults with disabilities; (2) engage in efforts to create effective home and community based mental health treatment options for older adults; and (3) assist AAAs in their role in mental health screening and service delivery.

References

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² Department of Health and Human Services, (1999) *Mental Health: A Report from the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental

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WORKLOAD ANALYSIS
Department of Aging

Establishing a Geriatric Mental Health Specialist

Associate Government Program Analyst

Activity	Number of Items	Hours per Item	Total Hours
<p>Represent CDA at quarterly meetings of the general Mental Health Planning Council meetings and the Older Adults Subcommittee meetings. Attend monthly Mental Health Services Act Oversight and Accountability Commission meetings. Participate in County Welfare Directors Older Adult Taskforce meetings when adult protective services and mental health issues for older adults, adults with disabilities, and family caregivers are to be discussed. Report back to CDA Deputy Director for Long Term Care and Aging Division on relevant issues raised at these meetings. Present key issues at CA Association of Area Agencies on Aging (C4A) meetings. July 2007 on-going.</p>	78	Varies	236
<p>Prepare a baseline assessment of AAA current involvement in (1) efforts to coordinate/improve mental health access and service delivery; (2) public education on these issues; (3) screening activities; and (4) funding mental health services for these populations. Baseline survey will be used to measure local improvements made which will be identified in the AAA Area Plans and annual updates. July 2007-December 2007.</p>	33	2	66
<p>Review and approve the 33 AAA area plan sections addressing provision of mental health services for compliance with AoA requirements. Provide technical assistance to AAAs whose plans do not meet the requirements. On-going.</p>	66	On-going	198
<p>Identify potentially promising practices and/or innovative approaches in addressing older adult and caregiver mental health issues from Area Plan reviews. Analyze findings from these practices/innovations to determine their value in increasing public awareness of older adult and caregiver mental health issues; improved access to mental health services, including screening; and the degree to which increased home and community-based mental health services for these populations can reduce institutionalization and generate General Fund cost savings. On-going.</p>	Varies	On-going	386

Review assessment, screening and care management tools and protocols being used by Linkages, the Multipurpose Senior Services Program (MSSP), the AAA Information and Assistance Programs and the Adult Day Health Care Program to identify improvements that could be made in these programs to better screen for potential mental health issues, make appropriate referrals for services, provide needed services (for ADHC clients), and improve multidisciplinary care management practices to monitor mental health issues. On-going.	308	On-going	400
Facilitate in-service opportunities for appropriate CDA staff on geriatric mental health issues; organize presentations on mental health issues for older adults, adults with disabilities and family caregivers at the C4A Allied Leadership Conference (to include promising practices at the county level, MHSA implementation updates/issues, etc.); convene teleconference technical assistance calls with various CDA contractors (e.g., AAAs, I&A subcontractors, MSSP site staff, Linkages program staff) in order to increase awareness of and access to mental health services for these populations. On-going.	Varies	On-going	310
Identify or develop, in conjunction with other relevant state and county organizations, public information materials on the unique mental health issues for these populations that can be distributed by the aging network and through the media. Beginning in January 2008 and on-going.	Varies	On-going	204
Total hours for workload projected for this classification			1800
1800 hours = 1 PY			
Actual number of PYs requested			1.0 PY