



April 1, 2010,

Dear Colleague,

The California Mental Health Directors Association (CMHDA) Older, Adult of Care (OASOC) Committee is pleased to inform you about the following Issue Paper it developed to promote geriatric mental health education and training for the public mental health workforce and its system partners who are providing services to older adults with mental health needs:

**Mental Health & Aging Workforce Education/Training:
Recommendations to Promote Planning, Funding, Implementation and Oversight**

Attached is a copy of the Executive Summary. The complete Issue Paper, including Appendix V Attachments and Brochure, are posted on the CMHDA OASOC Committee's web page:

<http://cmhda.org/go/Committees/OlderAdultSystemofCareCommitteeOASOC/OASOCDocuments.aspx>

The Mental Health Services Act (MHSA) provides an opportunity to:

- Develop age-appropriate and culturally competent mental health services across the lifespan,
- Ensure persons working with any age group and diverse population with mental health needs and their families in the public mental health and system partners have the knowledge and skills to do so effectively and with competence,
- Support cross-training among system partners to promote collaboration and service integration.

We hope this Issue Paper, which includes an inventory of mental health and aging education and training resources, will assist you in addressing the geriatric mental health education and training needs of your workforce.

Please contact Heather Anders, System of Care Liaison at CMHDA, if you have any questions or comments about the Issue Paper (916/556-3477, ext 119; handers@cmhda.org). We welcome additional information about geriatric mental health education training resources to include in this document

Sincerely,

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California Mental Health Directors Association (CMHDA)
Older Adult System of Care (OASOC) Committee'

ISSUE PAPER

Mental Health & Aging Workforce Education/Training:
Recommendations to Promote Planning, Funding,
Implementation and Oversight

CMHDA Older Adult System of Care ,Committee Approval, 9/9/09
CMHDA Governing Board and All Directors Meeting Approval, 12/10/09

The CMHDA OASOC Committee WET Issue Paper, including Appendix V Attachments and the **Brochure**, are posted on the CMHDA OASOC Committee webpage:
<http://cmhda.org/go/Committees/OlderAdultSystemofCareCommitteeOASOC/OASOCDocuments.aspx>

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I. Talking Points

- Developing a highly skilled and specially trained workforce to meet the multifaceted needs of an elderly client population should be the goal of every Older Adult System of Care project.
- Existing and projected workforce shortages and the need for gerontology and geriatrics training are well-documented challenges facing the mental health, health, aging, social services and alcohol/other drug systems as they struggle to meet the increasing needs of aging baby boomers.
- By 2030, an estimated 71.5 million people will be 65 and older, representing nearly 20 percent of the total U.S. population. In California, the cohort age 60 and over is projected to increase from 6.4 million in 2010 to 14.6 million by 2050, representing nearly 25 percent of the state population. The accelerated growth of this population, particularly persons age 85 and over who have increased needs for health, mental health and supportive services, will impact health and human services systems including the of their workforce.
- Specialized training is needed as elderly mental health clients have different care needs than younger adults; they are routinely involved with multiple, inter-related systems (health, aging, social services, alcohol/other drug, law enforcement and providers); have multiple health, medication and cognitive concerns; and respond differently to treatments.
- Mental Health service providers can benefit from the existing specialized trainings on issues of aging available through system partners in the aging network as well as offer specialized mental health training to the aging network that provide services to "shared" clients.
- Collaborating in the development and dissemination of information about specialized trainings related to geriatric mental health issues with system partners within other networks will enhance and leverage limited resources to serve "shared" clients.
- This Issue Paper provides a list of system partners as well as an inventory of currently available trainings on aging issues that pertain to mental health clients and their service providers. However, a statewide training needs assessment and inventory of available trainings across Systems is needed to develop a comprehensive list and centralized "clearinghouse" of training resources/opportunities.
- A key recommendation is to contract with a Mental Health & Aging Training Specialist to provide technical assistance to counties and the Regional Partnerships in the planning and implementation of older adult mental health specialty training; maintain the Health & Aging Workforce Education & Training Inventory"; participate on California Institute of Mental Health (CIMH) planning committees for conferences/trainings to promote inclusion of older adult training topics/issues and identify potential presenters.
- The clinical and economic benefits of collaborative training includes improved use of mental health and system partner limited resources, improved communication and service collaboration across systems, improved client outcomes, and improved workforce morale and retention.

II. Executive Summary

The California Mental Health Directors Association (CMHDA) Older Adult System of Care (OASOC) Committee formed a Workforce Education/Training Workgroup to explore how to promote the planning, funding, implementation and oversight of "Mental Health & Aging Workforce Education/Training" in counties, regionally and statewide in the context of the Mental Health Services Act (MHSA). Education and training encompasses continuing education and in-service training for the existing workforce as well as post-secondary or higher education. (Issue Brief, p. 13; Appendix I)

The Committee wants to ensure that persons working with older adults in the public mental health system (including consumer, peer family advocates) have the knowledge and skills to do so effectively and with competence. MHSA policies support the need for age-specific education and training for the existing and future public mental health workforce including system partners. (Issue Brief, pp. 14-15; Appendix II)

The CMHDA Older Adult System of Care Framework (2003) provides the foundation for the Work Group's focus and the Issue Paper's recommendations. The Framework establishes the importance of having a workforce with expertise in mental health and aging as well as geriatric competency across cultures. It describes the central role that health and human services systems (system partners) have in collaboration with mental health to support adults, with mental illness in the community. Collaboration across systems is essential to addressing the, holistic, multidimensional and multidisciplinary needs of older adults with mental illness to prevent hospitalization, institutionalization and other negative outcomes. Evidence-based practice with older adults requires a systems approach to service, delivery as well as to education and training. (Issue Brief, pp. 13-15; Appendix III)

The committee recognizes that MHSA Workforce Education and Training (WET) planning and implementation is well underway in the majority of counties-41 counties have approved MHSA Three-Year Program and Expenditure WET Plans, MHSA Regional Partnerships are developing regional priorities, and the MHSA Five-Year Workforce Education and Training Development Plan is funding post-secondary education mental health curricula development and stipend initiatives across disciplines.

This Issue Paper was developed because of the following concerns:

- County WET Plans and Regional Partnership workforce education/training activities may not be focusing on Mental Health & Aging continuing education training for the existing public mental health workforce and system partners working with older adults;
- The Five-Year WET Development Plan initiatives are not promoting the post-secondary education of *geriatric* mental health specialists across disciplines, including geriatric psychiatrists for which there are significant shortages.

These concerns based on the review of a sample of approved County WET Plans, the knowledge that the County WET Plan Needs Assessment template does not suggest identifying the availability of age-specific specialists the educational needs of persons working with age-specific populations, and a review of the statewide funding initiatives of the Five-Year WET Development Plan."

The CMHDA Older Adult System of Care Committee is hopeful that county mental health, the Regional Partnerships, the California Department of Mental Health the California Mental Health Planning Council's Human Resources Committee will identify opportunities within the framework of current and future county, regional statewide MHSAs WET Plans (and Plans of other MHSAs funding components) to:

- Support Mental Health and Aging specialty training for the existing mental health workforce;
- Invite county mental health and system partners to participate in joint mental health and aging continuing education opportunities;
- Promote geriatric specialization within mental health across disciplines in post-secondary education and stipend opportunities.

There are several imperatives driving the need for geriatric training across health and human service systems, including public mental health: (Issue Brief, pp. 16-18; Appendix IV)

- Development of MHSAs-funded older adult mental health specialty services, including services for diverse elders;
- Existing and projected workforce shortages of health and human services providers with competencies, including mental health providers;
- Projected growth in the aging population including diverse elders and the oldest old who have the greatest need for health, mental health and social services.

California has the largest population of persons over age 65 (over 3.9 million) and the largest population of ethnic elders in the nation. The elderly population is expected to grow than twice as fast as the total population-an overall increase of 112% from 1990 to 2020. By 2050, the majority of elders will be from groups formerly considered to be minorities.

Geriatric mental health training is distinctive from adult mental health training because it is rooted in the clinical needs of older adults the inter-relationship of health, mental health, substance use, cognition, social supports and function. Older adults require a multidisciplinary/interdisciplinary approach to assessment treatment and the involvement of multiple systems and care providers (including family/informal caregivers) to promote health and wellness. Therefore, service models need to be developed and the workforce needs to be trained to address these issues across systems. Examples of Mental Health and Aging Training and an Inventory of Training Resources are included in the Issue Paper. The Inventory will need to be updated as new training resources/opportunities are identified. (Issue Brief, pp. 18-24; Appendix V)

The following are key recommendations of the Issue Paper: (Issue Brief, pp. 24-25; Appendix VI to review all recommendations)

- 1) Identify the age-specific training needs for persons working in the public mental health workforce with older adults to promote a coordinated, collaborative and cost effective approach to geriatric mental health training in counties, regionally and statewide;
- 2) Identify opportunities within the framework of current and future county, regional and statewide MHPSA Plans (or Plans of other MHPSA funding components) to:
 - Support Mental Health and Aging specialty training for the existing mental health workforce;
 - Invite county mental health and system partners to participate in joint mental health and aging continuing education opportunities;
 - Promote geriatric specialization within mental health across disciplines in post-secondary education and stipend opportunities.
- 3) Create a statewide "clearinghouse" for Mental Health & Aging Workforce Education/Training that includes the training resource information listed in Appendix V, to be updated as new training resources/opportunities are identified.
- 4) Identify funding support for a Mental Health & Aging Training Specialist Consultant to provide technical assistance to CMHDA, the California Institute of Mental Health (CIMH), County MHPSA WET Coordinators and Training Directors, the MHPSA Regional Partnerships, the California Mental Health Planning Council (CMHPC) and the California Department of Mental Health (DMH) and others to:
 - Promote the planning, coordination, implementation and **oversight** of Mental Health & Aging Specialty at the local, regional and statewide level;
 - Ensure coordination, cost effectiveness and efficiencies in the provision of geriatric specialty training.

The CMHDA OASOC Committee is requesting approval of the **Issue Paper** by the CMHDA "Governing Board" before its dissemination: After approval, the Committee will offer presentations on the Issue Paper to the MHPSA Regional Partnerships in collaboration with CIMH; County MHPSA WET Coordinators in collaboration with CMHDA; and the California Mental Health Planning Council Human Resources Committee in collaboration with DMH, CMHDA, and CIMH. More information about "Next Steps" is described in the Issue Paper. (Issue Brief, pp. 25-27)

In Conclusion

The primary goal of this Issue Paper is to ensure that the public mental health workforce is trained to work competently with older adults, including diverse elders, who are seriously mentally ill. It also promotes inclusion of system partners in these trainings appropriate to their skill level and scope of practice so that they can work effectively with older

adults with mental health and substance use needs in their systems (who may also be shared clients with county mental health.) In turn, mental health providers can benefit from trainings provided by system partners to promote collaborative 'integrated' care. Working successfully with older adults who have health, mental health, co-occurring and functional complexities requires knowledge and skills across disciplines and systems...

The following New York Times article "Invisible Immigrants, Old and Left With 'Nobody to Talk To'" captures the vulnerability and invisibility of elder immigrants, who are isolated, lonely and at-high risk depression. Older adults represent the fastest-growing immigrant group-in California, one in nearly three seniors is foreign born. These individuals require culturally competent, age-appropriate specialty health and human services delivered by a workforce with specialized knowledge and skills, including cultural and linguistic competence, to address their complex health, mental health, social service and cultural needs. The MHSA provides an opportunity to address these needs.

New York Times,
August 31, 2009

Invisible Immigrants, Old and Left With 'Nobody to Talk To' 1

By PATRICIA LEIGH BROWN

FREMONT, Calif. -

They gather five days a week at a mall called the Hub, sitting on concrete planters and sipping thermoses of chai. These elderly immigrants from India are members of an all-male group called 'The 100 Years Living Club'. They talk about crime in nearby Oakland, the cheapest flights to Delhi and how to deal with recalcitrant daughters-in-law. Together, they fend the well of loneliness and isolation that so often accompany move to this country late in-life from distant places, some culturally light years away.

"If I don't come here, I have sealed lips, nobody to talk to," said Devendra Singh, a 79-year-old widower. Meeting beside the parking lot, the men were oblivious to their fellow mall rats, backpack-carrying teenagers swigging energy drinks.

In this country of twittering youth, Mr. Singh and his friends form a gathering force: the elderly, who now make up America's fastest-growing immigrant group. Since 1990, the number of foreign-born people over 65 has grown from 2.7 million to 4.3 million - or about 11 percent of the country's recently arrived immigrants. Their ranks are expected to swell to 16 million by 2050. In California, one in nearly three seniors is now foreign born, according to a 2007 census survey.

Many are aging parents of naturalized American citizens, reuniting with their families. Yet experts say that America's ethnic elderly are among the most isolated people in America. Seventy percent of recent older immigrants speak little or no English. Most do not drive. Some studies suggest depression and

1 <http://www.nytimes.com/2009/08/31/us/31elder.html?pagewanted=print>.

psychological problems are widespread, the result of language barriers, a lack of social connections and values that sometimes conflict with the dominant American culture, including those of their assimilated children.

The lives of transplanted elders are largely untracked, unknown outside their ethnic or religious communities. "They never win spelling bees," said Judith Treas, a sociology professor and demographer at the University of California, Irvine. "They do not join criminal gangs. And nobody worries about Americans losing jobs to Korean grandmothers."

The speed of the demographic transformation is leading many cities to reach out to the growing numbers of elderly parents in their midst. Fremont began a mobile mental health unit for homebound seniors and recruited volunteer "ambassadors" to help older immigrants navigate social service bureaucracies. In Chicago, a network of nonprofit groups has started The Depression Project, a network of community groups helping immigrants and others cope.

But their problems can go unnoticed because they often do not seek help. "There is a feeling that personal, and within the" said Gwen Yeo, the co-director of the Geriatric Education Center at the Stanford University School of Medicine.

Many who have their grown children here have fulfilling lives, but life in this country does not always go according to plan for seniors navigating the new, at times jagged, emotional terrain, which often means living under a child's roof.

Mr. Singh, the widower, grew up in a boisterous Indian household with 14 family members. In Fremont, he moved in with his son's and devoted himself to his grandchildren; picking them up from and ferrying them to soccer practice. Then his son and daughter-in-law decided "they wanted their privacy," said Mr. Singh, an undertone of sadness in his voice. He reluctantly concluded he should move out.

So when he leaves the Hub, dead leaves swirling around its fake cobblestones, Mr. Singh drives to the rented room in a house he found on Craigslist. His could be a dorm room, the arthritis heat wraps packed neatly in plastic bins.

"In India there is a favorable bias toward the" Mr. Singh said, sitting amid Hindu religious posters and a photograph of his late wife. "Here people think what is convenient and inconvenient for them.)"

Move to the Ethnoburbs

Sociologists call Mr. Singh and his cohort the ".5 generation" (distinct from the 1/1.5 generation) - younger who became bicultural through school and work. Immigrant elders leave a familiar home, some without electricity or running water, for a multigenerational home in communities Fremont that demographers call ethnoburbs.

A generation ago, Fremont was 76 percent Caucasian. Today, nearly one-half of its residents are Asian, 14 percent are Latino and it is home to one of the country's largest groups of Afghan refugees (it was a setting for the best-selling book "The Kite Runner"). Along the way, a former beauty college has become

a movie house became a Bollywood multiplex; a bank, an Afghan market, and a stucco-lined street renamed Gurdwara, after the Gurdwara Sahib Sikh Temple.

Reliant on their children, late-life immigrants are a vulnerable population. "They come anticipating a great deal of family togetherness," Professor Treas said. "But American society isn't organized in a way that responds to their cultural expectations."

Singh, 76, and his wife, Pal Keur, 67, part of Fremont's large Sikh community, live above the office of the Fremont Frontier Motel, its lone nod to a Western motif a dilapidated wagon wheel sign. They rented the fluorescent-lighted apartment after living for three years with their daughter, Kamaljit Purewal, her husband, his mother and two grandchildren. As the children grew, Mr. Singh and Mrs. Keur were relegated to the garage, transformed into a room. As Mr. Singh said, "winter it was too much cold." (Ms. Purewal said that she "tried to give them a better life," but felt unappreciated because her parents favored her older brother in India. "You're a happy family, a small house is a big house," she said.)

Fraught family dynamics when elderly parents move in with children often leave older members without a voice in decision-making, whether about buying a house or using the shower.

Pravinchandra Patel, the 84-year-old founder of the 100 Years Living Club, intervened when he heard that the son in one family was taking his parents' monthly Supplemental Security Income check, for \$658, then doling out \$20 for spending money.

"I ask the son, 'How much money do you figure you owe your parents for your' he said.

Crying, Not Smiling

Once a lush landscape of fruit trees and cauliflower fields, Fremont, 40 miles south of San Francisco, is now the Bay Area's fourth-largest city, with voters from 152 countries. Physical distances can be compounded by psychic ones: 13 percent of the city's immigrant seniors live in households isolated by language. There is a late-life journey without a map.

For the men in the 100 Years Living Club, the road leads to the Hub, where they have been meeting for 14 years, the Target store was a Montgomery Ward. Mr. Patel, who was an herbal doctor in India, started the club after he noticed his friends were in "house prisons," as he put it, without even the confidence to use a bus. The men keep their spirits alive by sharing homemade chaat snacks. They are the lucky ones.

Two miles away, Zia Mustafa, an Afghan widow, sits at her kitchen table with its plastic tablecloth, looking at a scrapbook with bright color postcards of Turkmen girls in elaborate dress posed against an azure sky. Mrs. Mustafa arrived here on a desolate emotional road. Her husband and eldest son were killed by a rocket in Kabul; her son Waheed, now 24 and living with her in Fremont, lost his leg in the attack. Other children remain in Afghanistan and Pakistan. "My family is divided in three," she said through a translator, weeping.

Waheed Mustafa, after surgery in Afghanistan, leads the life of a young man in his 20s - going to school, working out, talking on his cellphone, hanging out with friends. Mrs. Mustafa, who was home-schooled in the Koran, spends her days watching television soap operas, attempting to decipher stories through

actors' facial expressions. She sleeps with the lights on, worrying that even within these safe white walls this son, too, will not come back. '

"They come from a country where it takes so much to survive, yet they feel they haven't done enough," said Dr. Sudha Manjunath, a psychiatrist who consults with the mental health unit. "To tell them now, *it's* time to take care of yourself" - well, never heard of such things."

A recent health survey by Dr. Carl Stempel, a sociology professor at California State University, East Bay, found that most Afghan here suffer from post-traumatic stress.

"I thought they would be so happy in this country - all the houses, the food, the cars," said Najia Hamid, who founded the Afghan Elderly Association of the Bay Area, an outreach group for widows, with seed money from Fremont. "But I met with crying."

Young couples who need to work to support families have imported grandparents in part to baby-sit. There is a misguided assumption that baby-sitting is sustenance enough for the aging, said Mo'ina Shaiq, founder of the Muslim Support Network, which brings seniors together. "We are all social beings. How much can you talk to your grandchildren?" Mrs. Shaiq said.

Small Things Matter

In 1965 changes to immigration policy allowed naturalized citizens to sponsor the immigration of parents without quota restrictions. By 1996, a growing perception that immigrants were "gaming the system" - that their children were pledging to support them then enrolling their parents in the Supplemental Security Income and food stamp programs - became an impetus for welfare reform.

Congress imposed a "five-year waiting period for Medicaid and Temporary Assistance for Needy Families and restricted S.S.I. and food stamp eligibility for adults. Some states, including California and New York, have chosen to eliminate the waiting period for Medicaid for lawfully residing immigrants; paying with state money.

Michael Fix, senior vice president of the Migration Policy Institute, a nonprofit center in Washington, said that as immigrants form a larger part of the elderly population, "all the issues that on health care and social services will increasingly be in part into immigrant issues."

In 2007, according to census data, about 16 percent of immigrant seniors lived below the poverty line, compared with 12 percent of native-born elderly, said Steven P. Wallace, the associate director of the Center for Health Policy Research at the University of California, Los Angeles. Another 24 percent of immigrant elderly are "the near-poor," he said, "sitting on the edge of a cliff."

Kashmir Singh Shahi, 43, a former engineer who was born in India, is a volunteer for Community Ambassador Program for Seniors, offering people like Hardev Singh an attuned ear. Mr. Singh, a retired driving instructor for the Indian army, is 76 and determined to work full time. He takes two buses to work the night shift at a gas station an hour away. "I don't want to become idle in the heart," he said matter-of-factly. Mr. Singh had not been to a doctor in years, and Mr. Shahi helped him and his wife apply for Medicare. Mr. Singh is also entitled to Social Security but will accept the additional assistance.

Mr. Shahi's experiences with his own parents have illuminated the way for his clients. He came to the Bay Area in 1991 to work at a fiber optics company, and he sponsored his parents six years later. After his father died, Mr. Shahi changed careers so he could care for his mother, who has suffered from depression. She shares a room with her 12-year-old grandson, Kirat, improbably surrounded by Iron Man and Incredible Hulk posters. In this affectionate setting, amid decorations for her granddaughter's Sweet 16 party, the 84-year-old woman sat quietly, blue slippers on her feet, her eyes cast downward at her folded hands.

"In India, she would walk to the grocery store, go next door to have tea, talk about common things like the wheat and the corn," said Mr. Shahi of the ingrained visiting culture so universally missed by many ethnic elders. "At any time anyone can knock on the door anytime, to relieve the pressure. Here nothing is similar." So at the end of his day counseling others, Mr. Shahi sits with his mother before she goes to bed. He always asks if she needs any warm milk.

"The small things matter," he said of his mother and other elders longing for home. "The feeling that they are welcomed."

III. Issue Brief

Older adult service providers in the public mental health system as well as system partners want to promote shared funding and collaborative support for "Mental Health & Aging Workforce Education/Training" for all persons working with older adults with mental health needs and their family caregivers across systems:

Developing a specialized workforce with expertise in aging and mental health is a critical component of Older Adult System of Care development as described in the California Mental Health Directors Association (CMHDA) Older Adult System of Care Framework:²

Training must be a regular part of every Older Adult System of Care project and must include staff, 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. Older Adult System of Care programs must have a human resources component that includes: the 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.³

Charge 1 of CMHDA OASOC Committee Mental Health & Aging Workforce Education/Training Work Group

The Mental Health Services Act (MHSA) provides an opportunity to promote Older Adult System of Care Development as well as to train a specialized workforce. To seize this opportunity, the California Mental Health Directors Association (CMHDA) Older Adult System of Care (OASOC) Committee formed the "Workforce Education/Training Work Group" with the following "Charge":

Explore how to promote the planning, funding implementation and oversight of "Mental Health & Aging Workforce Education/Training" in counties, regionally and statewide for the existing and future public mental health workforce and system partners who work with older adults with mental health needs and their family caregivers, including older adults from diverse populations.

The Work Group's charge is supported by the CMHDA Mission Statement and Purposes⁴ as described in the CMHDA By-Laws, and CMHDA's Strategic Goals for 2008-2010 specific to the Older Adult System of Care Committee:⁵

² California Mental Health Directors Association (CMHDA) Older Adult System of Care Framework. http://cmhda.org/committees/documents/OASOC_Framework_282-9-0529.doc

³ CMHDA Older Adult System of Care Framework, op.cit. p. 7.

⁴ <http://www.cmhda.org/about/documents/CMHDA%20Bylaws%20Adopted%2003-13-08.pdf>

Refer to Appendix J: CMHDA Mission, Purpose and Strategic Goals Supporting the Charge of the CMHDA OASOC Committee Workforce Education/Training Work Group.

Mental Health and Workforce Transformation

The MHSA is transforming the public mental health system. It is funding programs that provide a range of services from prevention and early intervention to full service partnerships for the seriously mentally ill. These services target age-specific populations with mental health needs (children and youth, transition age youth, adults and adults) including those from diverse ethnic, racial and cultural backgrounds (Native American; African American; Hispanic, Asian Pacific Islander; Lesbian, Gay, Transgender, Bisexual, Questioning.)

Transformation of the mental health system requires a highly skilled and workforce. It is critical that the existing and future workforce of public mental health the skills and competencies to work with age-specific and diverse populations. They also, require training to provide services consistent with MHSA values and principles, e.g. wellness, recovery, and resilience; cultural and linguistic competence; client and family-driven; service integration; and community collaboration.

MHSA has funded the development of adult specialty services such as Older Adult Full Service Partnerships and Older Adult Prevention and Early Intervention (PEI) Programs which requires a workforce trained in geriatric mental health. Older adults also receive services within the Adult System of Care by persons who may not have training in geriatric mental health. Therefore, geriatric specialty training should be provided to the existing public mental health workforce working in any program that serves older adults their family caregivers, including diverse elders, to quality of evidence-based and successful outcomes.

MHSA Policy Support for Specialty Training of Mental Health Workforce and System Partners

Providing geriatric mental health specialty training to the public mental health workforce and system 'partners in care' with public mental health is supported by the following MHSA policies:

1. MHSA Proposed Guidelines, Workforce Education and Training Component of the Three-Year Program and Expenditure Plan for Fiscal Years 2006-07, 2007-08, 2008-09;⁶
2. MHSA Five-Year Workforce Education and Training Development Plan, April 2008-April 2013;⁷

⁵ <http://www.cmhda.org/about/documents/mjcrsopf%20w%20-%20CMHDA%20Strategic%20Plan%202008-2010%20Goals%20-%20Adopted.pdf>

⁶ http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-14_Enclosure1A.pdf.

⁷ http://www.dmh.ca.gov/prop_63/MHSA/Workforce_Education_and_Training/docs/MHSA_FiveYearPlan_5-06-08.pdf

3. Mental Health Services and Oversight Accountability Commission Position Paper on Training and Education.⁸
4. MHSA Prevention and Early Intervention (PEI) Funds for Training, Technical Assistance and Capacity Building Statewide Projects;⁹

For detailed excerpts, refer to Appendix II: MHSA Policies Supportive of "Mental Health & Aging Workforce Education/Training" for the Public Mental Health Workforce and System Partners Working with Older Adult with Mental Health Needs.

System Partners

System partners that provide services to older adults with mental health needs include health, aging, social services, alcohol/other drug, law enforcement, faith-based, cultural brokers and others. Some of these older adults also receive services from county mental health ("shared clients.") System partners function as gatekeepers, first responders and care coordinators for older adults with mental health needs.

With specialty geriatric mental health training, these partners can improve the quality of care in their systems for older adults with mental health needs; assist in recovery for "shared" clients who are receiving public mental health services; intervene to prevent the onset or progression of a mental illness and reduce negative outcomes such as suicide; and provide recovery interventions for older adults who refuse to enter the public mental health system. They provide community support services for older adults served in the public mental health system to help them remain as independent as possible and to reduce hospitalization and institutionalization:

System partners can be invited to participate in mental health training provided to the public mental health workforce depending on the topic, their skill level and scope of practice. In turn, mental health service providers can tap into the existing specialized training on issues of aging available through aging network and other systems. These training issues include elder abuse and neglect, substance use, health and medication issues of older adults, competency assessment, community resources and more.

Joint multidisciplinary, collaborative training can enhance the capacity and leverage the limited resources of all systems to provide quality, collaborative, integrated care; promote best practices; and improve client outcomes across systems. The training and technical assistance of system partners supports the MHSA guiding principles to promote service integration and community collaboration.

⁸http://www.dmh.ca.gov/MHSOAC/docs/TrainingEducationRolesPriorities_07Mar7Final.pdf

⁹<http://www.dmh.ca.gov/DMHDocs/docs/notices08/08-37.pdf>

Refer to Appendix III: System Partners for Mental Health & Aging Workforce Education and Training for a list of system partners who are "partners in care" with public mental health.

Imperative for Geriatric Specialty in Public Mental Health and Across Systems

There is an existing and projected workforce shortage for geriatric specialists in California's public mental health, aging, social services, alcohol and drug, and health systems, and a demographic imperative to address this. This shortage is particularly true for persons across all systems who work with older adults.

Older adults require a multidisciplinary/interdisciplinary approach to assessment and treatment and involvement of multiple systems and care providers. Therefore, service models need to be developed and the workforce needs to be trained to address these complexities and the interrelationship of mental health, health, substance use and social service needs across systems serving older adults.

Workforce Shortages

Prior to the passage of MHPA, there was a shortage of mental health service providers. In 2000, a Task Force was formed as a result of SB 1748 (Perata) to identify the mental health staffing needs of state and county health, human services, and criminal justice agencies. It found vacancy rates of 20-25% for core occupations such as psychiatrists, psychologists, licensed clinical social workers, registered and psychiatric technicians.

MHPA has increased the demand for these specific disciplines including those with expertise in working with age-specific and diverse populations. The MHPA Five-Year Workforce Education and Training Development Plan (2008-2013) states that "particularly severe shortages exist for mental health practitioners with skills to work effectively with such groups as children, transition aged youth, older adults and other diverse ethnic/cultural populations heretofore underserved or underserved."¹⁰

In 2005, the Archstone Foundation provided support for Aging Initiative labor force development projects. The California Social Work Education Center Aging Initiative (CalSWEC AI) conducted an Aging Services Labor Survey from 2006 to 2008 resulting in two Aging Initiative Labor Force Survey I: Public Services for Older Adults, and Aging Initiative Labor Force Survey II: Community Based Services for Older Adults.¹¹ This survey was distributed to Adult Protective Services (APS), In Home Supportive Services (IHSS), Area Agencies on Aging (AAAs) and their subcontractors, and Adult Day Health Care (ADHC) providers. These organizations serve older adults with mental health needs, some of whom are shared clients with county mental health,

¹⁰ MHPA Five Year Workforce Education and Training Plan 2008-2013, op. cit., p. 4.

¹¹ CalSWEC AI, Aging Initiative Labor Force Survey I: Public Services for Older Adults, Aging Initiative Labor Force Survey II: Community Based Services for Older Adults, <http://calswec.berkeley.edu/Cal5WEClindexAge.html>.

need referral to county mental health, or who have significant risk factors for developing a serious mental illness. The survey results concluded that although the ethnic representation in the staff of _____ and social services programs corresponded fairly well to client ethnic characteristics, there currently is and will continue to be a shortage of professionals to reach optimal caseload size. One of the most concerning conclusions was that the *majority of public agencies and community-based organizations do not have any staff with formal education in geriatrics/gerontology*. These results support the need for specialty training in gerontology/geriatrics within the aging and social services systems

The Institute of Medicine (IOM) released the Report, Retooling for an Aging America: Building the Health Care Workforce¹² citing a shortage of geriatric specialists to care for an aging population that will double between 2005 and 2030. The baby boomer generation starts to turn age 65 in 2011 and the nation's workforce is not prepared for the impending "age wave." Thus, the IOM recommends the following: "Enhance the geriatric competence of the entire workforce, increase the recruitment and retention of geriatric specialists and caregivers, and improve the way care is delivered."

Demographics

There will be an accelerated growth of diverse _____ with chronic illness who will impact health and human services systems including the capacity and abilities of their workforce.

- By 2030, there will be an estimated 71.5 million older persons, representing 20% of the population;
- The number of older adults in the United States will almost double between 2005 and 2030 and they are becoming more racially and ethnically diverse as the overall minority population grows and experiences greater longevity;
- Between 2007 and 2030, the white population 65+ is projected to increase by 68% compared with 184% for older minorities, including Hispanics (244%), African-Americans (126%), American Indians, Eskimos, and Aleuts (167%), Asians and Pacific Islanders (213%).¹³

Preparing for the aging of _____ including its increased diversity will be required by all health and human services systems because older adults have complex medical, mental health and social service needs and have higher _____ of health services utilization than non-elderly.¹⁴ This is particularly true of racially and ethnically diverse elders who are more likely to live in poverty

¹² Institute of Medicine, "Retooling for an Aging America: Building the Health Care Workforce," National Academies Press, Washington, DC, 2008. Full text of report available at: www.nap.edu.

¹³ DHHS Administration on Aging, Older Adults and Mental Health: Issues and Opportunities, <http://www.aoa.gov>, pp.3-6.

¹⁴ Institute of Medicine, Retooling for an Aging America, 2008, www.nap.edu, pp. 40-67.

and be socially isolated. Multicultural geriatric competencies will be essential for those working with diverse elders.¹⁵

These demographic changes will impact California's public mental health system that currently serves seriously mentally ill adult and older adult populations that have medical, mental health and substance use needs. As the Adult System of Care population ages, and as California's aging population grows (particularly its Oldest old, age 85+, who have complex medical, mental health, functional, and social service issues), there will be an increased need for the public mental health workforce and system partners to be trained in the principles and competencies of geriatric care, including multicultural geriatric care, that is holistic, comprehensive, multidisciplinary and integrated..

Refer to Appendix IV: The Imperative for Mental Health & Aging Education and Training for more information about workforce shortages and the demographic imperative that are driving the need for geriatric service development and geriatric specialty training within public mental health and across health and human services.

Rationale for Mental Health & Aging Training/Geriatric Specialty Training

While some may believe that good adult mental health is adequate to working with older adults, there are a number of issues which strongly indicate the need for specialized geriatric training:

1. The interface of dementia, delirium, and cognitive impairment, how to differentiate these conditions from one another and from mental illness, and how to respond to these conditions when they co-present with mental illness;
2. The numerous conditions and medications which complicate the presentation and treatment of mental illness in older adults, and how to respond appropriately;
3. Treatments which are especially relevant to later life developmental issues, such as grief, reminiscence & life review therapies;
4. Generational differences particularly to persons born prior to 1950, including post-traumatic issues related to the Great Depression, World War II; the Korean and Vietnam Wars;
5. Racial, ethnic and cultural issues of elder immigrant populations who are growing and represent one out of three elders in California;
6. The pivotal role that health and human services providers as well as family caregivers play in supporting older adults with mental health needs to live as independently as possible and to prevent hospitalization and institutionalization;

¹⁵ Multicultural Competency in Geropsychology, A Report of the APA Committee on Aging and its Working Group on Multicultural Competency in Geropsychology, <http://www.apa.org/oi/multicultural-competency-geropsychology.pdf> > <http://www.aoa.org/pi/multicultural-competency-geropsychology.pdf>

7. The system navigation skills required to determine potential eligibility for and access to the diverse multifaceted services that provide care and support to elderly clients multidisciplinary, complex needs.

Needs of Older Adults Guide Service Development and Workforce Education/Training

The following reflects the interrelationship of health, mental health, substance use and function of older adults which needs to guide older adult mental service development and specialty geriatric workforce education/training across systems:¹⁶

- Physically disabled adults report higher rates of mental health conditions.
- Mental health conditions are more prevalent among community dwelling older adults with limitations in activities of daily living (ADL) and instrumental activities of daily living (IADL).
- People with depressive symptoms often experience higher rates of physical illness, health care utilization, disability and an need for long term care services.
- Depression in later life is associated with poor health habits, diminished adherence to treatment for co-existing medical disorders. ,
- Depression is the most prevalent mental health problem among older adults and is associated with distress and suffering that can lead to impairments in physical, mental and social functioning. Depressive disorders can adversely affect the course and treatment of other chronic diseases. Older adults with depression visit the doctor and emergency room more often, use more medication and stay longer in the hospital.
- Misuse of alcohol, drugs, and prescriptions and over the counter medication is a growing problem older adults and the cause of physical and mental health problems, especially for older men. The combination of heavy alcohol or substance use with depressive symptoms is associated with high risk for suicidal ideation and physical well-being.
- of mental disorders in adults is complicated by the high co-morbidity with other medical disorders.¹⁷

Vulnerability to mental health conditions tends to increase with age due to decline in health, loss of loved ones and stressful life events.¹⁸

- Approximately 20 percent of persons age 55 older have a mental, health condition. The most common are mood disorders such as depression and bipolar disorder, anxiety disorders, and cognitive disorders.¹⁹

¹⁶ Institute of Medicine, Retooling for an Aging America, 2008, p. 44 (www.nap.edu)

¹⁷ Mental Health: A Report of the Surgeon General, p. 36-37

¹⁸ Institute of Medicine, op:cit. p.44. .

- Mental health issues, particularly depression, are strong risk factors for suicide. Older white men have the highest suicide rate of any age group, and men aged 85 year or older have the highest. Because depression is a highly treatable yet under-treated condition among community-dwelling older adults, all disease prevention programs for older adults should include a treatment component.²⁰
- Alzheimer's disease, affecting 8 to 15 percent of people over age 65 and 30 to 45 percent of those over age 85, causes cognitive impairment as well as delusions (30-50 percent), hallucinations (10-25 percent), and depression (40-50%). Caregivers of persons with a dementia are at significant risk for depression.²¹
- Unrecognized or untreated depression, alcohol and drug misuse and abuse, anxiety, late-life schizophrenia, and other can be severely impairing, even fatal.²²

Although seniors are high users of healthcare services, they underutilize mental health services, due to many factors:

- Stigma,
- Lack of accessible, and age-appropriate health services,
- Poor recognition of mental health needs by older adults themselves, their family caregivers, as well as the professionals working with them who have not received specialty geriatric training.

According to the Kaiser Family Foundation Commission on Medicaid and the Uninsured²³, seniors and non-elderly persons with disabilities who have both Medicare and Medi-Cal (dual eligibles) are among the nation's most vulnerable populations:

- These individuals are at high risk for utilizing health and human services, are low income, in poor health, have complex healthcare needs and need assistance with multiple activities of daily living (ADLs.) They are among the sickest and poorest individuals covered by either Medi-Cal or Medicare.

¹⁹ The State of Mental Health and Aging in America, "Why is Mental Health a Public Health Issue?", Centers for Disease Control, Healthy Aging Program, 2008, p. 2., www.cdc.gov/aging; www.chronicdisease.org

²⁰ The State of Mental Health and Aging in America, "Depression as a Public Health Issue," Centers for Disease Control, Healthy Aging Program, 2009, p. 1. (www.cdc.gov/aging; www.chronicdisease.org)

²¹ Mental Health: A Report of the Surgeon General. Excerpt: Older Adults and Mental Health, DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, NIH, NIMH, 1999, p. 52-55.

²² Mental Health: A Report of the Surgeon General. Excerpt: Older Adults and Mental Health. op.cit, p.

²³ "Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries," Kaiser Commission on Medicaid and the Uninsured, April, 2009, (www.kff.org/KCMU), Publication #7895, p. 1-5.

- Dual eligible elderly are more likely to have a diagnosis of diabetes, heart disease, lung disease, mental illness and Alzheimer's disease compared to those who are not dual eligible.
- Dual eligible non-elderly are slightly less likely to have physical illnesses such as diabetes and heart disease, but substantially more likely to have mental illness and mental retardation compared to the non-dual disabled population. ²⁴
- Diabetes and heart disease have a high co-morbidity with mental illness, particularly depression, which requires a system that integrates primary care with behavioral health and has a multidisciplinary workforce trained in interdisciplinary care.

A 2003 report by the Medi-Cal Policy Institute, "Medi-Cal for Seniors" indicated that nearly one in four California seniors were covered by Medi-Cal, and 87 percent of these were dual eligible. The remaining 13 percent had Medi-Cal only. ²⁵

Examples of Mental Health & Aging/Geriatric Training

Mental Health System

The CMHDA OASOC Committee is aware of the following geriatric mental health specialty training being provided to the public mental health workforce and system partners:

- Geriatric Mental Health Certificate Training developed and presented by the Center for Aging Resources (CFAR) in collaboration with WISE & Healthy Aging and other training partners to the mental health workforce of Los Angeles and San Diego County Departments of Health and their system partners. This certificate training is tailored to meet the needs of each county. (More information about this training is included in Appendix V.)
- Monterey County's WET Plan includes "Monterey Bay Geriatric Resource Training" a 30 hour interdisciplinary leadership development program in geriatrics and chronic care management.

Aging and Social Services Systems

For Adult Protective Services (APS) Programs and system partners (including public mental health), there are two training initiatives underway that provide cross-training opportunities between APS and mental health:

²⁴ "Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries," op.cit, April, 2009, p. 2. (www.kff.org)

²⁵ California HealthCare Foundation, "Medi-Cal for Seniors." Medi-Cal Policy Institute, September 2003, Number 14 (<http://www.chcf.org/documents/policy/MediCalSeniors.pdf>), p. 1.

- The Statewide Adult Protective Services Training Project, coordinated by the Bay Area Academy/Regional Training Academy Consortium/RTAC (comprised of the Bay Area Academy, the Northern Training Academy, Central California Child Welfare Training Academy, the Academy for Professional Excellence) in with the Protective Services Operations Committee of the California Welfare Directors Association and the California Social Work Education Center/CalSWEC); and
- Project MASTER, a program of the Academy for Professional Excellence.

Both training programs are collaborating to help Adult Protective Services programs develop a competent workforce to meet the challenges of larger caseloads, increased case complexity especially financial abuse, mental self-neglect cases, and a growing and diverse population served by the APS program. Inclusion of multidisciplinary team (MDT) partners, in APS training such as Aging, In Supportive Services (IHSS), Public Guardian, District Attorney/Law Enforcement, and Behavioral Health provides a means of improving the overall delivery and coordination of services to the adult protective services population in California. (More information about these APS training programs is included in Appendix V.)

Archstone Foundation funding enabled the California Social Work Education Center Aging Initiative (CalSWECAI), in collaboration with Boston University Institute for Geriatric Social Work (IGSW), to pilot a 5-Course Aging Certificate Program to APS and IHSS county employees in an ongoing online, interactive format. The courses included:

- Basic Issues in Aging,
- A Guide to the Aging Network, Geriatric Assessment,
- Mental Health & Aging Issues,
- Substance Abuse Among Older Adults

The results of this pilot training were positive and to expand the training exists; however, the funding for this training has ended. Boston University's IGSW online courses and certificate programs are available for a fee.²⁶

The Archstone Foundation also supported the establishment of three Regional Collaboratives comprised of county/university entities representing southern, central; and northern California. In-service training funds available over a two-year period for the Regional Collaboratives to address regional training needs. Unfortunately, the funding for these trainings has ended. Examples of in-service training topics included:

- Creative Approaches to Mental Health Issues,
- Death, Grief and Loss,
- Assessing Cognitive Changes in Older Adults,

²⁶ <http://www.bu.edu/igsw/index.html>

- Working with Elders in the Community: A Multigenerational/Intergenerational Framework

Health and Mental Health Systems (Service Integration)

Geriatric specialty education and training of healthcare providers and system partners is relevant to the following initiatives in California to promote the integration of primary care and behavioral health:

- "Integration Policy Initiative (IPI)" to promote the integration of Primary Care and Mental Health/Substance Use Services. ²⁷ The California Institute of Mental Health, the California Primary Care Association (CPCA) and the Integrated Health Project (IBHP) with the support of The California Endowment are collaborating to develop a model for system design and financing that will inform and support primary care and behavioral health integration in California. The primary goal for this service integration is to reduce the health disparities that the current health and mental health systems fail to address. Successful implementation of this integrated model will require workforce education and training on issues such as principles of multidisciplinary team care, and recovery, and chronic disease self-management. However, age-specific training on health, mental health, substance use and available community resources to provide support will also be necessary to promote evidence-based practice relevant to specific populations, including older adults.
- IMPACT, a depression care management model within a primary care setting. This model requires workforce education and training to promote service integration, but also age-specific training to care for the older adult population which is one of the target populations for this model. Contra Costa, Marin, Alameda and other counties are in the process of implementing the IMPACT model in primary care clinics and are coordinating the IMPACT training on a regional basis.

Contra Costa County is implementing additional age-specific workforce education/training to mental health, health and system partners that will benefit adults:

- Medical residents rotating through Contra Costa County's Older Mental Health Services Program and the Intensive Care Management Teams as well as the IMPACT program within Primary Care. They will receive specific training in working with older adults with mental health needs. Healthcare system partners were invited to participate in the IMPACT training along with the mental health workforce involved in its implementation.
- A Psychiatric Nurse Practitioner will be working in the Older Adult Mental Health Program along with a psychiatrist to promote service between behavioral

²⁷ <http://www.ibhp.org/index/ohp>

health and primary care'. In addition, there are plans to integrate primary care into the mental health clinics to provide adult and older adults with healthcare services within the mental health setting. Workforce education and training is an important dimension of this service integration, including geriatric specialty training.

- Patrick Arbore, PhD, Program Director of the Center for Elderly Suicide Prevention at the Institute on Aging in San Francisco, provided an in-service training on the "Impact of Trauma in the Lives of Older Adults" to all older adult and adult mental health staff working with older adults. System partners also invited, including Senior Peer Counselors, Adult Protective Services; Lifelong Clinic, the Elder Actualization Project and the Center for Human Development.

Substance Use

An estimated one in five older Americans (19%) may be affected by combined difficulties with alcohol and medication misuse. Early intervention or targeted prevention strategies such as brief advice by primary care physicians and other brief interventions in health care settings have reduced alcohol consumption among older adults. With training, service providers within health, aging social services systems including physicians can function as gatekeepers and provide brief intervention services for seniors with substance use issues:

- The Society on Aging (ASA) offers six free non demand" web seminars covering aspects of older adult alcohol and other drug use, including medication use and cultural competency issues related to older adult substance abuse treatment. These are funded with a contract from the California Department of Alcohol and Drug Programs. CEU credits are offered.²⁹ (Additional older adult substance use training resources are included in Appendix V.)

Refer to Appendix V: Inventory of Mental Health & Aging Workforce Education and Training Resources for more examples of mental health and aging/geriatric specialty training. This inventory will need to be updated as new training resources/opportunities are identified.

Recommendations to Promote Planning, Funding, Implementation and Oversight of Mental Health & Aging Workforce Education/Training

The CMHDA OASOC Committee is proposing recommendations to support and promote a coordinated, and cost-effective approach to Mental Health & Aging/Geriatric Specialty Training for the public mental health workforce and system partners at the county,

²⁸ Prevention of Alcohol Misuse in Older Adults, Older Americans Substance Abuse & Mental Health Technical Assistance Center, http://www.samhsa.gov/OlderAdultsTAC/docs/Alcohol_booklet.pdf, p. 2.

²⁹ ADD-Alcohol, Medication & Other Drugs, <http://www.asaging.org/fasav2/aod/>

regional and statewide level. These recommendations are targeted to the entities/organizations that play a key role in workforce education and training activities within public mental health as well as with system

The following are key recommendations of the Issue Paper:

1. Identify the age-specific training needs for persons working with older adults with mental health needs to promote a coordinated, collaborative and cost effective approach to geriatric mental health training in counties, regionally and statewide;
2. Identify opportunities within the framework of current and future county, regional and statewide MHSA WET Plans (or future Plans Cf other MHSA funding components) to:
 - Support Mental Health and Aging specialty training for the existing mental health workforce;
 - Invite county mental health and system partners to participate in joint mental health and aging continuing education opportunities;
 - Promote geriatric specialization within mental health across disciplines in post-secondary education and stipend opportunities.
3. Create a statewide "clearinghouse" for Mental Health & Aging Workforce Education/Training that includes the training resource information listed in Appendix V, to be updated as new training resources/opportunities are identified.
4. Identify funding support for a Mental Health & Aging Training Specialist to provide technical assistance to CMHDA, the California Institute of Mental Health (CiMH), County MHSA WET Coordinators and Training Directors} the MHSA Regional Partnerships} the California Mental Health Planning Council (CMHPC) and the California Department of Mental Health (DMH) and others
 - Promote the planning/coordination} implementation and oversight of Mental Health & Aging Specialty Training at the regional and statewide level;
 - Ensure coordination, cost effectiveness and efficiencies in the provision of geriatric specialty training.

This proposed consultant is modeled after the Adult Protective Services (APS) Project Coordinator funded by the California Department of Social Services Adult Services Branch and implemented through the Statewide APS Training Project/Bay Area Academy. A description of the APS Project Coordinator position is included in the Attachments.

Refer to Appendix VI: Recommendations to Promote Planning, Funding, Implementation and Oversight of Mental Health & Aging Workforce Education/Training for a complete list of Recommendations.

Next Steps

The CMHDA OASOC Committee Workforce Education/Training Work Group developed this Issue Paper as an educational and technical assistance tool to benefit those involved in the

planning, funding, implementation and oversight of workforce education and training activities at the county, regional, and statewide level. These include CMHDA, CiMH, County MHS WET Coordinators and Training Directors} the MHS Regional Partnerships} the California Mental Health Planning Council (CMHPC) and the California Department of Mental Health (DMH.)

Once the Issue Paper is approved by the CMHDA Governing Board, it will be distributed to these entities as well as the following system partners who would benefit from joint training with county mental health, provide training to the public mental health workforce and other system partners} and/or could identify additional training resources not included in Appendix V:'

Aging Services of California, Association of California Caregiver Resource Centers, California Alcohol and Drug Programs, California Association of Adult Day Services, California Association of Area Agencies on Aging, California Association of Marriage and Family Therapists, California Association of Public Authorities for In-Home Supportive Services, California Council on Gerontology and Geriatrics, California Department of Aging, California Department of Social Services, California Geriatric Education Center, California Public Authority Association for In Home Supportive Services, California Social Work Education Center Aging Initiative and Mental Health Initiative, California Welfare Directors Association, Family Caregiver Alliance, Mental Health Association in California, Multipurpose Senior Services Program Site Association, Inc., National Association of the Mentally Ill, California, Racial and Ethnic Mental Health Disparities Coalition, Regional Training Academy Consortium (Bay Area Academy) Northern California Training Academy, Central California Child Welfare Training Academy, Academy for Professional Excellence) and others to be identified.

A presentation on the Issue Paper will be offered initially to the following:

- MHS Regional Partnerships in consultation and collaboration with CiMH to explore how MHS funding can be used to support regional Mental Health & Aging Workforce Education and Training. CiMH provides technical assistance and support to the five geographic Regional Partnerships in California} including some sub-regions (Greater Bay Area Region, Superior Region} Central Valley, Southern Region, Los Angeles.)³⁰ These Regional Partnerships have allocated funding and are developing proposals for approval. The CMHDA OASOC Committee is hopeful that the Regional Partnerships will identify regional mental health and training and support/coordinate regional training.
- County mental health MHS WET Coordinators during their conference calls convened by CMHDA to determine how the recommendations can be implemented within counties as well as the Regional Partnerships.
- California Mental Health Planning Council Human Resources Committee at a quarterly meeting.

³⁰ [http://www.dmh.ca.gov/DMHDocs/docs\(notices08/08-20.pdf](http://www.dmh.ca.gov/DMHDocs/docs(notices08/08-20.pdf)

Formal presentations to other entities and system partners will be determined. Additionally, this Issue Paper can be used to seek funding support for older adult mental health specialty training from other funding sources (e.g. foundation grants, etc.)

Concluding Comments

Through MHSA, the public mental health system has an opportunity to provide age-specific and cultural competence training to its existing public mental health workforce in the children's, adult and older adult systems of care as well as with system partners. Persons with mental health needs have health and social service needs that must be addressed in a coordinated and collaborative way across systems in order to provide holistic, quality care. This requires a workforce across systems that have shared knowledge and skills.

This Issue Paper has identified mental health and aging specialty training that can be provided to the public mental health workforce working with older adults in its Adult and Older Adult Systems of Care including system partners. It has also identified training developed by system partners that could benefit the public mental health workforce working with older adults. This cross training requires collaboration, coordination and shared

Collaborative joint training can improve client assessments and interventions across systems, communication and referral relationships among service providers, and improve the use of mental health and system partner limited resources for training. Harnessing the knowledge and leveraging the resources across systems, including educational institutions, to provide mental health & aging workforce education/training to the public mental health workforce and system partners in a coordinated way makes clinical and fiscal sense. Coordination of workforce education and training activities across systems will promote collaborative care, service integration and transformation which are guiding principles of MHSA.

Appendix I:

CMHDA Mission, Purpose and Strategic Goals Supporting the Charge of the CMHDA OASOC Committee "Workforce Education/Training Work Group"

The CMHDA OASOC Committee and its "Workforce Education/Training Work Group" are guided by the CMHDA Mission Statement and Purposes³¹ (as described in the CMHDA By-Laws) and CMHDA's Strategic Goals for 2008-2010.³² The "Charge" of the CMHDA OASOC Committee "Workforce Education/Training Work Group" is supported by these guiding principles:

CMHDA Mission Statement: "To provide leadership, advocacy, expertise and support to California's county and city mental health programs (and their system partners) that will assist them in serving persons with serious mental illness and serious emotional disturbance. Our goal is to assist in building a public mental health system that ensures the accessibility of quality, cost-effective mental health that is consumer- and family-driven, resiliency-based and culturally competent,"

CMHDA Purposes: "1) To advocate for social justice and the needs of persons with mental illness in California, especially those who are served or in need of services by the public mental health system; 2) To disseminate public policy information, legislation, regulations, legislative proposals, research, case law and other information that will enhance the effective administration of public mental health programs; 3) To facilitate peer support and interaction in discussions and decisions made about the public mental health system; 4) To encourage and assist in the provision of training and technical assistance on current mental health issues for persons and agencies involved in the delivery of public mental health services; 5) To organize and implement regular meetings and conferences focused on issues in the delivery of public mental health services."

CMHDA Strategic Goals for 2008-2010: "1) Social Justice-CMHDA will advocate for equity and full inclusion of vulnerable populations and secure social justice as measured by access to necessary quality services that promote mental health, wellness, resiliency and recovery in our communities; 2) Policy-CMHDA will use the strength of the association to support and develop legislative and public policy agendas that lead to reducing disparities and increasing access to benefits, housing and income support; 3) Partnerships-CMHDA will foster and develop trust and rapport to establish, maintain and expand partnerships with all local, state and federal organizations/groups that

³¹ <http://www.cmhda.org/about/documents/CMHDA%20Bylaws%20Adopted%2003-13-08.pdf>

³² <http://www.cmhda.org/about/documents/Microsoft%20Word%20-%20CMHDA%20Strategic%20Plan%202008-2010%20Goals%20-%20Adopted.pdf>

impact, or will engage in joint ventures that increase quality of life for persons at risk of or experiencing mental illness; 4) Practice-CMHDA/CiMH will be the leaders in developing and advocating for best practices (including cultural specific) standards, measurable outcomes in behavioral health and efficient data collection and dissemination."

In addition the following *Goal Objective and Projected Activity* specific to the CMHDA OASOC Committee in the CMHDA Strategic Plan for 2008-2010³³ provides support to the Work Group's "Charge:"

Goal 4: Practice

CMHDA/CiMH will be the leaders in developing and advocating for best practices (including culture specific) standards, measurable outcomes in behavioral health and efficient data collection and dissemination."

Goal 4, Objective #7 : "Design an effective system of care: A. Pipeline and workforce development; B. Working with academic partners- "lreal-world" solutions have to be applied;
C. Working with the community- the natural environment. Change public mental health model (e.g., promotoras.)",

, Goal 4, Objective #7, Projected Activity #3: "Consider need for a specific white paper on workforce development for older adult mental health needs in California,"

³³[http://cmhda.org/go/Portals/O/CMHDA%20Files/Committees/OASOC/Handouts/OASOC_CMHDA_Strategic_Plan_w_Status_Update_\(8-26-08\).pdf](http://cmhda.org/go/Portals/O/CMHDA%20Files/Committees/OASOC/Handouts/OASOC_CMHDA_Strategic_Plan_w_Status_Update_(8-26-08).pdf)

Appendix II:

MHSA Policies Supportive of Mental Health & Aging Workforce Education/Training for the Public Mental Health Workforce and System Partners Working with Older Adults with Mental Health Needs

The following excerpts from MHSA policy documents support the provision of workforce education and training for the public mental health workforce and system partners who work with older adults with mental health needs, including those from diverse populations. MHSA policies also require that the MHSA WET community planning process includes stakeholders representing older adults and community partners who assist in the delivery of public mental services such as social services and others.

1. MHSA WET Component of the Three Year Program and Expenditure Plan for FY 2006-07. 2007-08.2008-09: ³⁴
 - a. MHSA WET Planning ProcessJpp.7-8): "In order to develop an effective Workforce Education and Training component stakeholder representatives are to be invited and encouraged to participate in the planning process. These include: 1) Representatives who can speak to workforce diversity needs and solutions, to include organizations representing underserved racial/ethnic communities; those who identify themselves as, gay, lesbian} bisexual and/or transgender; children} , youth and older adults; and urban and rural communities" (p. 7)"; 2) Educational entities to include high schools, adult education, regional occupational programs} community colleges, universities} trainers} consultants and professional organizations; 3) Community partners who assist in the delivery of public mental health services such 'as social services, behavioral health and vocational rehabilitation services." (p. 8)
 - b. Training and Technical Assistance (pp. 25-27): "This funding category is defined as events and activities in which individuals and/or organizations are paid with MHSA funds to assist all individuals who provide or support the Public Mental Health System in better delivering services consistent with the fundamental principles intended by the Act. These are: wellness, recovery and resilience; cultural and , linguistic competence; a client-driven and where appropriate, family-driven mental health system for older adults, adults and transition age youth and a family driven system of care for children and youth; an integrated service experience for clients and their family members throughout their interactions with the mental health system; community collaboration." (p. 25)

³⁴ http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-14_Enclosure1A.odf.

- i. "For this funding category audiences can include not only County staff and community based organizations delivering public mental health services, but also community partners in service delivery, such as criminal justice, social services, education, ethnic and cultural organizations, medical professionals, and other "first responders." (p. 27)

"Include local community educational entities and educators from universities, colleges, regional occupational programs, primary and secondary school education in the planning, delivery and evaluation of training and technical assistance." (p. 27)

- ii. Exhibit 3: Workforce Needs Assessment (pp. 11-12): "Specifically, this exhibit will depict ... A description of significant workforce shortages from the entire County system that surfaced in the Workforce Needs Assessment, to include issues of workforce sufficiency and access populations and communities that have not been identified in a countywide analysis of aggregated Populations and communities may include unserved or underserved urban and rural communities, immigrant and Native American populations, and special populations, such as at-risk youth and older adults.

2. MHSA Five-Year Workforce Education and Training Development Plan, April 2008-April 2013³⁵:

- a. Goals, Objectives and Actions (p. 7): "The objectives presented in this Five-Year Plan are intended to develop a mental health workforce trained to provide services to an ethnically diverse population across the lifespan that can respond to the unique of children and youth; transition aged youth, adults and especially those of older adults, who comprise an increasing percentage of the overall population."

- i. Goal #2 (p. 9): Increase the quality and success of educating and training the public mental health workforce in the expressed values and practices' envisioned by the MHSA

1. Objective G (p. 9-10): Expand the capacity of postsecondary education to meet the needs of identified mental health occupational Action (p. 10): Fund those portions of psychiatric residency programs that specialize in child or geriatric psychiatry, model a multidisciplinary team approach in a community public mental health setting, and/or focus on recruitment of who can meet diversity needs consistent with the vision and values of the MHSA.

³⁵http://www.dmh.ca.gov/Prop_63/MHSA/Workforce_Education_and_Training/docs/MHSA_FiveYearPlan_5-06-D8.pdf

b. Evaluating the Five-Year Plan (p. 12-13): "Measurement criteria and outcomes were developed with the understanding that education and training programs and activities will promote statewide applicability and equitable distribution of dollars, increase the diversity and cultural competence of the public mental health workforce and promote the participation of clients and family members. These programs and activities also serve to prepare the workforce to meet the needs of diverse ethnic/cultural populations heretofore unserved or underserved, including children, transition aged youth and older adults. Performance indicators and their measurement criteria and outcomes include":

i. Goal #2 (p. 14): "Increase the quality and success of educating and training the public mental health workforce in the expressed values and practices envisioned by the MHSOAC."

1. Performance Indicator #2 (p. 14): "An increase in the number of training and technical assistance events and activities that focus on the needs of un-served and underserved populations, especially older adults and transition aged youth." Measurement (p. 14): "The number and type of training and technical assistance events focusing on older adults and transition age youth will be compiled from Counties' Three-Year Program and Expenditure Plans, and will be compared to subsequent Three-Year Program and Expenditure Plans."

3. Mental Health Services and Oversight Accountability Commission Position Paper on Training and Education³⁶

a. Alleviate the shortages and maldistribution of mental health workers (p. 4): "There are urgent shortages of mental health practitioners with skills to work with such high-need groups as children, older adults and diverse populations. It is expected that there will be an increasing demand for practitioners with these competencies."

b. Adopt and implement major changes in the graduate education of mental health professionals to improve skills and enhance outcomes (p. 6):

i. "Practitioners are not taught to work effectively with {non-traditional providers of mental health services} including primary care. This is important since most people who seek help for mental health problems} especially people of color and older adults, do not seek help from their primary care physicians, who prescribe by far the majority of psychotropic medications and are not sufficiently prepared to do so."

³⁶[http://www.dmh.ca.gov\(MHSOAC/docs/TrainingEducationRolesPriorities_07Mar7Final.pdf](http://www.dmh.ca.gov(MHSOAC/docs/TrainingEducationRolesPriorities_07Mar7Final.pdf)

4. MHSA Prevention and Early Intervention (Pm,Funds for Training, Technical Assistance and Capacity Building Statewide Projects³⁷
- a. "The primary goal of the Statewide Training, Technical Assistance, and Capacity Building Project" is to improve the capacity of local partners outside the mental health system (Le., education, primary health care, law enforcement, older adult services) as well as County staff and partners who work on the development, implementation and evaluation of prevention and early intervention work plans and programs that will be funded through the PEI component of the County's Plan."(p. 2)
 - b. Increase the emphasis on prevention and early intervention in **workforce** training programs (p.15-16):
 - i. Enhance practitioner skills to work in and collaborate with diverse community settings and services, including education, medical care, social services, housing, criminal justice/probation, youth programs, elder programs and residences, and faith-based organizations.
 - ii. "Identify, train, and support community-based practitioners in diverse settings who are in a position to identify signs of mental illness and provide positive interventions."

³⁷ <http://www.dmh.ca.gov/DMHDocs/docs/notices08/08-37.pdf>

Appendix III: **System Partners**

The following are System Partners who are "partners in care" with public mental health providing health and human services for older adults with mental health needs and their family caregivers. These are service providers who would benefit from mental health and aging specialty training in collaboration with public mental health providers working with older adults.

Determining which System Partners could benefit from specific trainings depends on a variety of factors such as their job responsibilities and scope of practice, their training needs based on their knowledge and skill level, and the mental health needs of the older adults and family caregivers they work with. The decision as to who should be included in specific trainings would be the responsibility of the trainer, training coordinator, county mental health, system partners and others involved in coordinating county and regional Mental Health & Aging Workforce Education and Training.

1. Aging Services Providers (work with older adults with a range of mental health, medical and functional needs; require access to mental health services; low income) minority status).
 - a. Agencies on Aging and subcontractor community-based organizations (Home delivered and Congregate meals programs, Linkage Care Management, Information & Assistance, Family Caregiver Support Program, Senior Employment, other)
 - b. Multipurpose senior Services Program (MSSP)
 - c. Adult Day Health Care Centers (ADHC) and Adult Day Care Centers (Social Model)
 - d. Senior Centers and Community Centers
 - e. Transportation providers, including paratransit providers

2. Social Services Providers (work with older adults and adults with disabilities who need access to public mental health services; low income; minority status, high risk)
 - a. Adult Protective Services (First-responder, crisis intervention)
 - b. In Home Supportive Services (Personal care)
 - c. Community Care Licensing
 - d. Public Guardian

3. Alcohol/Other Drug Providers (work with older adults with co-occurring mental health, health and substance use needs)

4. Senior Housing (work with older adults with needs of mental health, medical and functional abilities)

5. Volunteer Programs
 - a. Senior Peer Counseling Programs

6. Law Enforcement
7. Code Enforcement
8. Healthcare Providers (work with clients who have medical and mental health needs and can benefit from integration of behavioral health and primary care; IMPACT Model)
 - a. Hospitals (Emergency Departments)
 - b. Paramedics (First Responders) :
 - c. Federally Qualified Health Centers (FQHC); Rural Health Clinics
 - d. Primary Care Providers (public and private)
 - e. Hospice'
9. Faith-based Organizations, Clergies/Faith Leaders
10. Community based organizations serving ethnically, racially and culturally diverse elders: Cultural Brokers
11. Family Members/Family Caregivers; Non-family paid caregivers (community-based, ' facility-based)

Appendix IV:

The Imperative for Mental Health & Aging Education/TraIning

"The of the baby boom population, combined with an increase in life expectancy and a decrease in the relative number of younger persons, will create a situation where older adults make up a much larger percentage of the U.S. population than has ever before been the case. While this population surge has been foreseen for decades, little has been done to prepare the health care workforce for its arrival."-- Institute of Medicine, "Retooling for an Aging America: Building the Health Care Workforce"

Demographics of Adults

According to the Administration on Aging, in 2006 there were 37.3 million persons 65 years older in the U.s., representing, 12.4% of the population-approximately one in every Americans.

- By 2030, there will be an estimated 71.5 million older persons, representing 20% of the population.
- The number of older adults in the United States will almost double between 2005 and 2030 and they becoming more racially and ethnically diverse 'as the overall minority population grows and experiences greater longevity.
- Between 2007 and 2030, the population 65+ is projected to increase by 68% compared with 184% for older including Hispanics African-Americans (126%), American Indians, Eskimos, and Aleuts (167%), and Asians and Pacific Islanders (213%).³⁸

California is projected to be one of the fastest growing States in the nation in total population. It has the largest population of persons over age 65 (over 3.9 million) and the largest population of ethnic elders in the nation.³⁹ According to the California state Plan on Aging (2009-2013)⁴⁰, California's elderly population is expected to grow more than twice 'as fast as the total population-an overall increase of 112% from 1990 to 2020.

- California's oldest old age group will increase at an ev'en faster rate, having an overall increase of 143% during the period from 1990 to 2020. The current size of the

³⁸ DHHS Administration on Aging, Older Adults and Mental Health: Issues and Opportunities, <http://www.aoa.gov>, pp.3-6.

³⁹ California Social Work Education Center (CaSWEC) Aging Initiative (AI), "CaSWECAging Initiative Regional Collaboratives", 7/14/08 <http://calswec.berkeley.edu/index/Age.html>.

⁴⁰ California Department of Aging, California State Plan on Aging, 2009-2013 (Draft), [http://www.aging.ca.gov/legislation\(California State Plan on Aging AoA 2009-2013 06-30-2009.pdf](http://www.aging.ca.gov/legislation(California%20State%20Plan%20on%20Aging%20AoA%202009-2013%2006-30-2009.pdf)

population age 85 and over and the projected increase is significant because those 85 years of age and older have a higher rate of severe chronic health conditions and functional, limitations that result in the need for more health} mental health and supportive services.'

California's older adults are' racially} ethnically, and culturally diverse and will become more , diverse in the future. While 61 percent of older adults will be White/Non-Hispanic in 2010, by 2050 the majority will be from groups formerly considered to be minorities. Because some population groups have been historically deprived of opportunities} or are now faced with the challenges of life in a new culture} diversity may translate into health and economic disparities that must be addressed.

- Older adults who are not White report poor or fair health more often than Whites/Non-Hispanics }
- Older Hispanics 'and those with English have the, worst health profiles compared to statewide averages.

California's lesbian, gay, bisexual, and transgender (LGBT) older adults are as diverse as their heterosexual counterparts and also experience disparities.

- Lifelong fears or experiences of discrimination have caused some of these older adults , to remain invisible, preferring to go without much-needed social} health, and mental health services.
- ' An estimated 3 to 8 percent of entire U.S. population is LGBT.' Although estimate may be low, applying this percentage to California's population of older adults suggests that there are approximately 177,000 to 473,000 older LGBT Californians. By 2030, this number is expected to nearly double.

Providing culturally appropriate outreach and assistance is essential to over'coming disparities in 'accessing health, mental health, and social services for California's diverse elderly population.

Shortage of Specialists

The Institute of Medicine (IOM) has raised awareness about the demographic imperative to train geriatric specialists in all professions because of the projected growth of the aging population and shortage of geriatric specialists: It recommends the following:

- Existing health care workforce geriatric specialty training and demonstrates competency in the care of older adults as a criterion of licensure and certification,

- Training standards be established for direct care workers such as home health, personal care and nurses aides,
- Patients and informal caregivers are integrated into the health care team-patients can learn self-management skills to improve their health, and informal caregivers can be trained to play a larger role in the delivery of healthcare services,
- Incentives such as loan forgiveness, scholarships and financial incentives are to be used for recruitment and retention of a trained workforce.
- "Principles of geriatric care such as patient education, care coordination and" interdisciplinary care must be integrated into service delivery and reimbursed by financing systems.⁴¹

The Eldercare Workforce Alliance, a group of 29 national organizations, joined together to address the following immediate and future workforce crisis in caring for an aging America:

- There are only 7,345 certified geriatricians practicing in the US, a 5.45 percent decrease from the 2000 and half the number currently needed. By 2030, when the last of the baby boomers turns 65 if recruitment into geriatrics continues at its current rate (in 2007, 264 residents chose to enter a geriatrics fellowship), shortfall will be 24,047. Similar shortages exist in other professions.
- By 2030, the U.S. will need an additional 3.5 million formal health care providers (a 35% increase from current levels) to meet the current demand of providers to the total population.
- By 2016 the U.S. will need 1 million more direct care workers yet these workers receive low hourly wages, limited access to employee benefits, and 25% of them have no health insurance coverage.
- Older adults use 48 percent of hospital days, 69 percent of home health services, and 83 percent of nursing home services-yet America is failing to train and support an adequate supply of geriatrics professionals, direct care workers and family caregivers.
- There are 3 million direct care workers - with an anticipated 1 million additional "workers needed within the next ten years - who provides 70 to 80 percent of the hands-on long term services and supports received" by Americans with disabilities or "living with chronic conditions.
- There are between 29 million and 52 million unpaid caregivers nationally, however the overall availability of informal caregivers is decreasing.⁴²

⁴¹ Institute of Medicine, op. cit., pp. 1-32.

⁴² Eldercare Workforce Alliance, www.eldercareworkforce.org. 2009.

The Administration on Aging (AOA) recognizes that there is an insufficient supply of trained professionals and paraprofessionals to provide mental health services to seniors. It calls for

- More geriatric mental health professional and paraprofessional personnel in the fields of medicine, mental health and social services;
- Increasing specialty training programs in geriatric mental health; integrating aging and mental health content into the curriculum of professional degree programs, including coursework and clinical training;
- Offering advanced workshops, continuing education, certification, and supervised experience for professionals and paraprofessionals;
- Offering incentives and practicum support for students;
- Targeting paraprofessionals and volunteers in settings such as senior centers or nutrition sites for training in basic communication and helping skills;
- Emphasizing interdisciplinary practice and multidisciplinary cross training between mental health, substance abuse, primary care, and aging networks.⁴³

The American Psychological Association acknowledges the severe shortage of qualified mental health and behavioral health professionals, including psychologists, to provide services to America's aging population and the growing number of racial and ethnic elders. Currently, only 3% of practicing psychologists viewed geriatric patients as their primary professional target.⁴⁴

In 2004, the California Social Work Education Center (CalSWEC), a catalyst to increase the number and quality of social workers in California, created an Aging Initiative (AI) to promote the development of a competent social work workforce to meet the needs of aging Californians and their families. It is comprised of representatives from 18 schools of social work, NA5W-CA, the California County Welfare Directors and the California Mental Health Directors Associations. CalSWEC AI has established "Aging Competencies" and "Curriculum Principles" aimed at developing workforce skills required to work with older adults at both the micro and macro levels of practice within health, mental health and human services systems.⁴⁵

The following Federal Legislation is to address geriatric workforce shortage issues:

- Retooling the Health Care Workforce for an Aging America Act 2009 (S 245 & HR 468),
- Caring for an Aging America Act 2009 (S 750)

⁴³ DHHS Administration on Aging, Older Adults and Mental Health: Issues and Opportunities, 2001, pp. 61-63.

⁴⁴ Multicultural Competency in Geropsychology, A Report of the APA Committee on Aging and its Working Group on Multicultural Competency in Geropsychology, <http://www.apa.org/pubs/multicultural-competency-geropsychology.odf>><http://www.apa.org/pubs/multicultural-competency-geropsychology.pdf>, p. 13.

⁴⁵ CalSWEC, AI, "CalSWEC Aging Curriculum Competencies," <http://calswec.berkeley.edu/CalSWEC/Aging-Competencies.html>

Appendix V:

Inventory of Mental Health & Aging Workforce Education/Training Resources

(Refer to Attachments for Appendix V for additional information)

- 1) Certificate in Geriatric Mental Health (Two Courses): Introduction to Older Adult Mental Health Issues; and Older Adult Mental Health and Recovery Services
 - a) Content: Training topics for both courses are listed in Attachment 1. (Some of the course training topics can be presented individually and are identified in the attachments.)
 - b) Target Audience: Mental health and system partners
 - c) Training Format: Face to face
 - d) Type of training: Certificated (CEU credits for BBS & BRN, CE credits for Psychologists, CME for physicians)
 - e) Contact Information/website: Training developed by Yang, PhD,
(iyang@cfar1.org) and Cynthia Jackson Kelartinian, PhD, The Heritage Clinic, Center for Aging Resources (CFAR) (www.centerforagingresources.org).
 - f) Cost: Fee for service unless funding is available. This certificate training is being provided to the Los Angeles and San Diego County Departments of Mental Health for its public mental health workforce and system partners working with older adults.

Attachment 1

- 2) Aging Certificate Program: Certificate in Mental Health & Aging' (Proposal developed, specifically for California); Online Courses - Boston University; Institute of Geriatric Social Work (IGSW)
 - a) Content: 50+ online courses; Aging Certificate Program; Mental Health and Aging Certificate Program for California (Proposal)
 - b) Target audience: Mental health and system partners
 - c) Format: Online or Blended
 - d) Type of training: Continuing Education, Certificated (Courses are accredited by the Association of Social Work Boards, California of Behavioral Sciences, National Association of Social Workers, Social Worker & Marriage and Family Therapist Board, Marriage and Family Therapists and Professional Counselors; Certified by NCCAP for Activities Directors.)
 - e) Contact Information/Website: <http://www.bu.edu/igsw>; Kathy Kuhn, MSW, LICSW, Director of Education and Training, IGSW (kkuhn@bu.edu)

2 Kathy Kuhn has offered to provide a free demonstration to the CMHDA OASOC Committee on the "Geriatric Assessment" or "Mental Health & Aging" online training programs. IGSW developed its on-line courses using the same competency resources from which CalSWEC derived its competencies.

- 3) Certificate in Aging (Pilot) - California Social Work Education Center Aging Initiative (CalSWEC-AI) in collaboration with Boston University, IGSW.
- a) Content: Five courses including Basic Issues in Aging, Geriatric Assessment, Mental Health and Aging Issues, Substance Abuse among Older Adults, and a Guide to the Aging Network. (Approximately 21 of training.)
 - b) Target audience: Piloted with APS and IHSS programs
 - c) Format: Online with Coach Facilitator.
 - d) Type of training: Continuing education, Certificated"
 - e) Contact Information/Website: <http://calswec.berkeley.edu/CalSWEC/indexAge.html>
Kathy Sniffen, Coordinator CalSWEC AI: Email: kasniffen@sbcglobal.net
 - f) **Fee:** Pilot project ended. Expansion dependent on funding and CalSWEC approval.

" Attachment 3 (*CalSWEC-IGSW Certificate in Aging Evaluation Report*)

Attachment 4 (*CalSWEC AI Competencies Progress Brief*)

- 4) Professional Program in Aging & Mental Health: UC Berkeley Extension
- a) Content: Refer to Attachment 5 "
 - b) Target audience: Mental health clinicians, nurses, social services professionals with graduate degrees
 - c) Format: Workshops (weekends)
 - d) Type of training: Continuing education; Certificate of Completion; CEUs psychologists, LCSNs, MFTs **R N S .**
 - e) Information/Website: www.unex.berkeley.edu/profseg/aging.html
 - f) . Cost: Fee (30 unit certificate: \$1800) "

Attachment 5

- "5) Certificate in Geriatric Mental Health; Certificate in Gerontology - University of Washington
- a) Content: Refer to Attachment 6
 - b) Format: Online and Classroom"
 - c) Type of training: Certificated
 - d) Contact Information/Website:
http://www.extension.washington.edu/ext/certificates/gmh/gmh_gen.asp

- 6) Adult Protective Services (APS) Training Project- Coordinated by the Bay Area Academy/Regional Training Academy Consortium
- a) Content: Core and Advanced training in abuse and neglect, and more
 - b) Target audience: APS providers and system partners .
 - c) Format: Face to face, Online training planned for Spring, 2010
 - d) Type of training: Continuing education
 - e) Contact Information/Website: Krista Brown, Coordinator (kbrown70@sfsu.edu or 510/419-3613/www.baa-aps.org)
 - f) "Cost: Free and fee for service

Attachment 6

7) Multidisciplinary Adult Services Training for Evaluation and Results (MASTER)-Academy for Professional Excellence

- a) Content: Core and advanced training in elder abuse and neglect investigations and interventions
- b) Target Audience: APS providers and system partners
- c) Format: Small group interactive, face to face and (in production) online training
- d) of training: Continuing education
- e) Contact Information/Website: Lori Delagrammatikas, Program Coordinator, ldelagra@projects.sdsu.edu
- f) Cost: Free and fee for *service*

Attachment 7

8) Depression Care Management Programs (www.cdc.gov/aging; www.chronicdisease.org)

- a) iMPACT (Improving Mood-Promoting Access to Collaborative Treatment)
 - i) Content: Depression screening, assessment and care management; Problem Solving Treatment
 - ii) Target Audience: Primary care and behavioral health clinicians
 - Hi) Training Format: Online, face to face
 - iv) Type of Training: Evidence-based program
 - v) Contact Information/Website: Implementation toolkit: <http://impact-uw.org/>
- a) PEARLS (Program to Encourage Active Rewarding Lives for Seniors)
 - i) Content: Depression screening, assessment and care management; Problem Solving Treatment; Physical and social activation;
 - ii) Target Audience: Clinicians and Care Management Staff
 - iii) Training Format: Implementation Toolkit and/or Face to face; Technical assistance consultation
 - iv) Type of Training: Evidence-based program
 - v) Contact Information/Website: <http://depts.washington.edu/pearispr/toolkit>
- b) Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)
 - i) Content: Depression screening, assessment and care management, Behavioral activation, referral and linkage to healthcare and mental health professionals
 - ii) Target Audience: Clinicians and Care Management Staff
 - iii) Training Format: Implementation Toolkit, Face to Face; Technical assistance consultation
 - iv) Type of Training: Evidence-based program
 - v) Contact Information/Website: <http://careforelders.org/default.aspx?menuitemid=290&AspxAutoDetectCookieSupport=1>

- 9) Older Adult Suicide Prevention Program-LivingWorks-"Implementing an Evidence-Based Suicide Prevention Model in the Aging Network" (Piloted by the Pima Council on Aging/Area Agency on Aging in Arizona and funded by the Regional Behavioral Health Authority for Pima County and Southern Arizona)
- Content: Recognition of signs/symptoms of depression, suicide risk assessment, crisis intervention, referral.
 - Target audience: Community gatekeepers, aging, social services, first responders
 - Training Format: Face to face, online, technical assistance consultation
 - Type of Training: Evidence-based program (LivingWorks suicide prevention training)
 - Contact Information/Website: <http://www.livingworks.net/>; Consultant: Donna Carender, MSG, Carender Consulting LLC] LivingWorks Master Trainer] Sahuarita] AZ (donna@carenderconsulting.com)
 - Cost: Fee or if funding available.

Attachment 8

- 10) QPR (Question, Persuade and Refer) Suicide Prevention Gatekeeper Training
- Content: Comprehensive prevention training program for general public, professionals institutions
 - Target audience: Community "gatekeepers"; System Partners
 - Format: Online and Face to Face
 - Type of training: Evidence-based
 - Contact information/website: www.gprinstitute.com ,
 - Cost: Fee or if funding is available
- 11) Peer Counseling/Peer Mentor
- Pennsylvania Peer Support Specialist statewide)
 - Pennsylvania Older Adult Peer Specialist Training (Certification statewide; Training developed by the University of Pennsylvania] funded by PA DMH) 9
 - College of San Mateo Peer Support Services Certificate
<http://cmhda.org/go/Portals/0/CMHDA%20Files/MHSA/WET%20Docs/College%20of%20OSan%20Mateo%20Peer%20Support%20Services%20Certificate%20of%20Completion.pdf>
<http://cmhda.org/bio/Portals/0/CMHDA%20Files/MHSA/WET%20Docs/College%20of%20OSan%20Mateo%20Human%20Services%20Course%20Overview.pdf>
 - DACUM Competency Profile for Behavioral Health Peer Specialist (California Community College Economic and Workforce Development Program Health Initiative Butte College)
<http://cmhda.org/go/Portals/0/CMHDA%20Files/MHSA/WET%20Docs/DACUM%20Behavioral%20Health%20Peer%20Specialist%202007.pdf>
 - Certified Psychiatric Rehabilitation Practitioner
www.uspra.org/i4a/pages/index.cfm?pageid=3925

- 12) Psychosocial Rehabilitation Practitioner Curriculum (CASRA)
<http://cmhda.org/go/Portals/0/CMHDA%20Files/MHSA/VIET%20Docs/CASRA%20Psychosocial%20Rehabilitation%20Certificate%20Program.pdf>
<http://cmhda.org/go/Portals/0/CMHDA%20Files/MHSA/WET%20Docs/Curdculum%20for%20the%20PSR.pdf>
- 13) Senior Peer Counseling (Training curriculum developed by Evelyn Freeman, PhD, Santa Monica Senior Peer Counseling ,
 a) Heritage Clinic-San Diego Peer Counseling Prograrri Attachment **10**
 b) Senior Peer Counseling Program-Wilshire Community Services, San Luis Obispo CA Attachment 11
- 14) Engaging Adults in Mental Health Services
 a) Health Literacy
<http://www.geronet.med.ucla.edu/center/s/cgec/healthliteracy.htm>
- 15) Wellness Recovery Action Plan (WRAP)-ad'apted for older adults
 a) Lynn Northrop, San Diego (Need resource information)
- 16) Alcohol,Drugs, Medication Misuse/Abuse: Get Connected Toolkit
 a) Content: Recognition of signs/symptoms of alcohol, drug, medication dependency, screening, brief interventionj referral/linkage
 b) Target audience: Older adult service providers, volunteers, community gatekeepers
 c) Format: Face to face; utilize Toolkit/Training
 d) Type: Get Connected Toolkit
 e) Contact Information/Website: Substance Mental Health Services Administration
<https://ncadistore.samhsa.gov/catalog/ProductDetails.aspx?ProductID=16523>
- 17) Alcohol, Medication and Other Drugs - American Society on Aging
 a) Content: Webinars on Alcohol, Medication and Other Drugs
 b) Target audience: Older adult service providers
 c) Format: Online webinars
 d) Type: Continuing education
 e) Contact Information/Website: American Society on Aging
<http://www.asaging.org/webseminars/>
- 18) Substance Use and Older Adults (SAMHSA)
 a) Older Americans Substance Abuse and Mental Health Technical Assistance Center
<http://www.samhsa.gov/OfderAdultsTAC/index.aspx>
 b) IIAlcohol, Medication and Older Adults"
<http://pathwayscourses.samhsa.gov/aaac/aaacintropg1.htm>
 c) IIAt Any Age, It Does Matter
<http://pathwayscourses.samhsa.gov/aaap/aaapintro.htm>

- d) Screening, Brief Intervention & Referral to Treatment (SBIRT)
<http://sbirt.samhsa.gov/index.htm>
 - e) Uncovering Substance Use & Elder Abuse: "Out of the Shadows"
<http://pathwayscourses.samhsa.gov/elab/elabintropgl.htm>
- 19) Substance Among Older Adults - Brown University's Distance Learning
- a) Content: Substance abuse, addiction treatment and prevention
 - b) Target audience: Addiction treatment providers, counselors, social workers, nurses, psychologists, physicians
 - c) Format: Online
 - d) Type: Certification, Continuing Education Credits (MFT, LCSW), California Board of Behavioral Sciences, American Psychological Association
 - e) Contact Information/Website: <http://www.browndlp.org/>
- 20) Stanford University Ethnogeriatric Training
<http://www.stanford.edu/group/ethnoger/index.html>
- 21) California Geriatric Education Center Training
<http://www.geronch.med.nyu.edu/centers/gerc/index.htm>
- 22) Social Inclusion and Trauma Informed Care: Substance Abuse Mental Health Services' Administration Resource Center to Promote Social Inclusion and Trauma Informed Care
<http://promoteacceptance.samhsa.gov/teleconferences/archive/training/teleconference09102009.aspx?printid=1&>
- 23) Impact of Trauma in Older Adults: Dr. Patrick Arbore, Institute on Aging
Attachment 12
- 24) **Stamp Out Stigma** (<http://www.w.stampoutstigma.org/>)
A community advocacy and educational outreach program dedicated to eradicating the stigma associated with mental illness.
- 25) Interviewing Skills for Working With Older Adults (Need resource information)
- 26) Institute on Aging Educational Programs: Professional Training Calendar
- a) Content: Variety of topics
 - b) Target audience: All aging service providers
 - c) Format: Workshops, webinars; presentations
<http://education.ioaging.org/cornerstones/capacity.html>
- 27) Family Advocate/Caregiver Training
- a) Catholic Charities of Santa Clara County (Need resource information)
 - b) Family Caregiver Alliance Workshops, Classes, Conferences
www.caregiver.org

- 28) CiMH Older Adult Prevention and Early Intervention (PEI) Webinar presented by Janet Anderson Yang, PhD, and James Cunningham, PhD
<http://www.cimh.org/Learning!Online-Learning!Webcasts!Prevention-and-Early-Intervention.aspx>
- 29) Essential Learning
- a) Content: Range of mental health topics (128 courses) on mental health, substance abuse, mental health recovery, medication information, peer professionals, older adults (elder abuse, older adults & mental health, older adults with psychiatric illness, overview of mental health issues in older adults, Alzheimer's Disease) and more
 - b) Target audience: Consumers, families, peer specialists, professionals
 - c) Format: Online
 - d) Contact Information/Website: www.essentiallearning.com
 - e) Cost: Fee
- 30) Pacific Clinics Training Institute
- a) Content: Variety of behavioral healthcare topics including older adult specific training (geriatric assessment, medication issues and older adults, HIV and older adults, community resources for older adults)
 - b) Target audiences: Mental health providers, system partners
 - c) Type of training: Pre-licensure and Re-licensure courses; Certification Courses, Continuing Education Credits (American Psychological Association, California Board of Behavioral Sciences, California Board of Registered Nursing, California Association of Alcoholism and Drug Counselors, California Association of Alcohol/Drug Educators)
 - d) Format: Face to face courses (range of hours)
 - e) Contact Information/Website: www.myPCTI.org
 - f) Fee (range in cost depending on course length); free to Pacific Clinics staff, interns, consumers, consumer family members.
- 31) Conferences:
- a) California Mental Health Directors Association (CMHDA) Older Adult System of Care Conference <http://clearning.networkofcare.org/CIMH/PackageOverview.asp?id=233262>
 - b) California Association of Area Agencies on Aging (C4A) <http://www.c4a.info!2007EventsHP.html>
 - c) California Association of Adult Day Services (CAADS) <http://www.caads.org/meetingsevents/conference.html>
 - d) American Society on Aging <http://www.asag-ing.org!index.cfm#>

Appendix VI:

Recommendations to Promote Planning, Funding, Implementation and Oversight of Mental Health & Aging Workforce Education/Training

- 1) Recommendations to the California Mental Health Directors/CMHDA:
 - a) Approve the CMHDAOASOC Committee WET Issue Paper and its key recommendations:
 - i) Identify the age-specific training needs of those working with older adults with mental health needs to promote a coordinated, collaborative and cost effective approach to geriatric mental health training in counties} regionally and statewide;
" Identify opportunities within the "framework of current and future county, regional and statewide MHSA WET Plans (or future Plans of other MHSA funding components) to: "
 - (i)" Support Mental Health and Aging specialty training for the existing mental health workforce;
 - (2) Invite county mental health and system partners to participate in joint mental health and aging continuing education opportunities;
 - (3) Promote geriatric specialization within mental health across disciplines in "post-secondary education and stipend opportunities.
 - . iii) Create a statewide "clearinghouse" for Mental Health & Aging Workforce Education/Training that includes the training resource information listed in Appendix V, to be updated as new training resources/opportunities are identified.
 - iv)" Identify funding support for a Mental Health & Aging Training Specialist to provide technical assistance to CMHDA} CiMH} County MHSA WET Coordinators and Training Directors, the MHSA Regional Partnerships} the California Mental Health Planning Council (CMHPC) and the "California of Health (DMH) and others to:
 - (1) Promote the planning, coordination} implementation and oversight of Mental Health & Aging Specialty Training at the "local} regional and level;
 - (2) Ensure coordination, cost effectiveness and efficiencies in the provision of geriatric specialty training.
 - b) Support the CMHDA Annual Older Adult System of Care Conference as a continuing education training opportunity for geriatric specialty training for the existing public mental health workforce including MHSA} WET and PEI Coordinators, Ethnic Services Managers} Training Directors, Consumer} Peer and Family Advocates. (December 1 & 2, 2009, Riverside, California) .
- 2) Recommendations to County MHSA Coordinators, Training Directors and other staff responsible for coordinating/implementing county mental health workforce education and training activities across funding sources:
 - a) Identify the training needs of the existing public mental health workforce including consumers} peers and family advocates serving older adults across all county mental

- health programs to determine gaps in knowledge and skills to work with older adults with mental health needs, and identify training resources to address needs.
- b) Invite system partners serving older adults with mental health needs to join the training provided to the public mental health workforce, appropriate to their skill level and scope of practice.
- 3) Recommendations to the California Institute of Mental Health (CiMH):
- a) with a Mental Health & Aging Training Specialist to provide technical assistance to CMHDA, CiMH, County MHSAs WET Coordinators and Training Directors, Regional Partnerships, CMHPC and DMH in the planning/implementation of older adult mental health specialty training; maintain the Mental Health & Aging Workforce Education & Training Inventory"; participate on CiMH planning committees for conferences/trainings to promote inclusion of older adult training topics/issues and identify potential presenters/panelists.
 - b) Include older adult issues in all CiMH conferences/policy forums that address workforce development, system of care development, MHSAs implementation and evaluation. The CMHDA OASOC Committee has requested representation on CiMH planning committees for public policy forums and MHSAs trainings.
 - c) Explore the potential for a statewide Clearinghouse for Mental Health & Aging Workforce Education/Training; Post Mental Health & Aging Training resources on the CiMH website.
 - d) Expand the CiMH Community Development Team Model: Supporting the Model Adherent Implementation of Programs and Practices to support evidence-based practice models appropriate for older adults.
- 4) Recommendations to the California Mental Health Planning Council and California Department of Mental Health:
- a) Review funding initiatives of the Five Year WET Development Plan relative to geriatric specialty training; Promote funding support for geriatric specialization within mental health training across disciplines in post-secondary education and stipend opportunities.
- 5) Recommendations to MHSAs Regional Partnerships/CiMH:
- a) Identify regional Mental Health & Aging training needs to coordinate training and promote cost effectiveness. For example several counties in a region may be funding similar older adult practice programs such as IMPACT, PEARLS, Healthy IDEAS or older adult suicide prevention training with aging services providers.
- 6) Recommendations to System Partners:
- a) Identify the "Mental Health & Aging" training needs of your workforce; Explore opportunities to partner with county mental health and other system partners for service collaboration and joint/cross-training.
 - b) Participate in the MHSAs community planning stakeholder process for all MHSAs funding components) including Workforce Education and Training (WET).

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CASRA Recovery Training Checklist
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ATTACHMENTS

Summary - Statewide **Training for** Adult Protective Services and Allied Partners; "
Project Master

Adult Protective Services (**APS**) Project Coordinator

Summary - Statewide Training for Adult Protective Services and Allied Partners

The Statewide APS Training Project which consists of the Regional Training Academy Consortium (RTAC) (members include: Bay Area Academy Northern California Training Academy} Central California Child Welfare Training Academy} and the Academy for Professional Excellence)) in partnership with Protective Services Operations Committee of CWDA and California Social Work Education Center (CalSWEC), provides advanced trainings each year in Adult Protective Services and collaborates on the development} pilot and evaluation of APS core curriculum trainings that utilize NAPSA and CalSWEC Aging Initiative core competencies and build critical knowledge} skills and abilities.

The regional training academies are affiliated with universities and have diversified their trainings to include other human service programs (e.g. APS and Mental Health). CalSWEC initiated an Aging Initiative which developed core competencies for aging curriculum and has conducted workforce development studies and projects with CA counties. CalSWEC is continuing its efforts to maintain and expand funding for the Aging Initiative.

To date} the Statewide APS Training Project has delivered nine (9) advanced trainings across California and developed} piloted} evaluated and finalized APS Case Documentation & Report Writing (Core Training)., Currently in development are Core Financial Exploitation modules that, utilize both in-class and online delivery. Further core training is planned but depends on available funding for the upcoming fiscal year FY 09-10 and beyond. Modules identified for development include: Sexual Abuse} Caregiver or Perpetrator Neglect} Mental Health Issues} Substance Abuse} Self Neglect} and Physical and Developmental Disabilities.

Project MASTER/Academy for Professional Excellence

Project MASTER is a program of the Academy for Professional Excellence and is funded by a grant from the Archstone Foundation to develop} pilot} evaluate and finalize two core competency modules per year over three years. MASTER is currently working on *Professional Communication, An Overview of APS} Case Management Regulations, and The Intake Process*. MASTER will be developing *Involuntary Case Planning and Intervention Process* and *Collaboration and Resources* next year. In addition, MASTER is developing the Transfer of Learning and piloting the NAPSA developed *Ethics, Values and Cultural Competence in APS* and *Assessing APS Decision-Making Capacity* this fall. In Phase One of MASTER's Archstone grant" a three day Advanced Series on Self Neglect was developed and those trainings continue to be statewide.

Both the Statewide APS Training Project and Project MASTER have joined together with the National Adult Protective Services Association (NAPSA) to create the National APS Training Partnership which works to strengthen the capacity of Adult Protective Service (APS) workers and their multidisciplinary partners to serve victims of elder abuse by, improving their knowledge} skills} and abilities through increased access to standardized} competency-based training curricula in California and nationally. Although the National Adult Protective Services Association's *Core Competencies for APS Workers (NAPSA Core Competencies)* form a national standard} funds to develop training curricula on each competency have been sorely lacking. At

present, there is no commonly accepted core curriculum in Adult Protective Services in the United States, despite its critical role in protecting vulnerable adults and seniors from abuse, neglect or harm. Compared to child welfare services, adult protective services have not received adequate support, funding or public recognition.

Overall Goal of Training .

The most important goal of the all Statewide Adult Protective Services Training is to help public agencies develop a more competent and effective workforce to meet the challenges of larger caseloads, increased case complexity (esp. financial abuse, mental health) self-neglect cases) and a growing and diverse population of California residents served by the APS program. This mission can be addressed through efforts to improve the quality of Adult Protective Services through professional, standardized training that builds greater knowledge, utilizes best practice and evidence-based content, and the fosters the acquisition of core and advanced practice skills. An important ancillary benefit is the inclusion of MDT partners, such as Aging, IHSS, Public Guardian, District Attorney/Law Enforcement or Behavioral Health, in APS training as a means of improving the overall delivery and coordination of services to the protective services population in California.

Adult Protective Services (APS) Project Coordinator

Duties and Responsibilities:

- Provide day-to-day program administration and management of the Statewide APS Training Project.
- Manage the development, delivery and evaluation of all APS training deliverables including Advanced and Core training modules.
- Strategic planning and independent implementation of APS training program goals and objectives, including developing a CQI plan.
- Coordination of subcontract agencies, consultants and various volunteer workgroups, including identification and negotiation of contracts.
- Arrangement of all training logistics (site location, hospitality, AV equipment, onsite support, etc.).
- Preparation and dissemination of various reports and support materials as required by the State of California, funders, and advisory groups.
- Draft routine reports, maintain timetables, and track completion of narrative grant reporting.
- Work with the Academy Fiscal Coordinator and Fiscal Assistant to develop and track budgets and to ensure that invoices are processed in a timely manner.
- Work with stakeholders to promote State and National level Aging and Adult Services policy and advocacy efforts.
- Participate in regional, statewide and national meetings and conferences, as needed, to advance the work of the APS training program.
- Supervision of project personnel and interns.
- Content development and management of APS Training Project website.
- Participate actively in Academy-wide staff meetings and member of Operations Team.
- Other duties as assigned by the Academy Director

ATTACHMENTS FOR APPENDIX V:
INVENTORY OF MENTAL HEALTH & AGING
WORKFORCE EDUCATION/TRAINING RESOURCES

Attachments 1-12