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Full service partnership (FSP) programs were designed under the leadership of the California Department of Mental Health in collaboration with the California Mental Health Directors Association, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, mental health clients and their family members, mental health service providers, and other key stakeholders of the mental health system. Although they have been in existence since 2005, full service partnership programs are continuing to develop the distinguishing characteristics that lead to good outcomes for mental health clients and their families.

The FSP Tool Kit is intended to provide FSP supervisors and team members with written guidance to support the ongoing development of the programs and integration of practices. This publication series encompasses a Tool Kit for each age group — children, transition-age youth, adults, and older adults — in recognition of the programmatic differences that exist across the four age groups.
The Tool Kit has numerous unique characteristics that include:

- Development with close involvement of diverse, statewide advisory committees that represented all of California’s public mental health constituents, including clients, family members, counties, and mental health service providers.

- Identification not only of service delivery models for age-specific full service partnerships, but also an overview of practices that can be integrated into full service partnerships.

- Reference and access to website links that offer additional in-depth information on the majority of practices included in the Tool Kit.

- Recommended resources to assist in the ongoing development of full service partnership programs that support clients in their recovery.
This Tool Kit is dedicated to all the people with lived experience, whether children and their families, transition-age youth, adults, or older adults, who continually demonstrate their belief in possibilities.

This project was funded through California’s Department of Mental Health (DMH). Creation of this Tool Kit resulted from the ideas, experience, and suggestions from many groups and people throughout California. Participants from the statewide advisory committee, age-specific committees, and the performance measurement subcommittee demonstrated tireless dedication to ensure a practical outcome. Representatives from all 58 counties — through county departments, regional networks, and partner agencies — participated via meetings, conference calls, and interviews.
Acknowledgements (cont’d)

Additional appreciation is extended to the staff and consultants at the California Institute for Mental Health (CiMH) for their excellent leadership and compassionate guidance in this visionary endeavor.

OLDER ADULT FSP TOOL KIT
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We appreciate that no one term may fit the same situation. The writers also realize that one term does not convey the same meaning across all age groups. However, to facilitate the writing of this project, selection of only one expression for certain concepts became necessary. We thank the committee members who, for the sake of clarity, guided us through this process.

For example, we designated the term “client” as the universal identifier for an individual with lived experience, even though we acknowledge that the term “consumer” or “person” may be more common in some areas or in some groups. Exceptions to this selected term may be found throughout the text if written within a direct quotation.
The *Philosophy* domain refers to the important background modes-of-thinking which inform implementation of full service partnerships for older adults. These include tools to help understand and implement the recovery model, a full service partnership model of service delivery, and 12 of the key tenets of an older adult FSP within the recovery model. This domain also includes tools related to understanding care for older adults.
Purpose

To understand the overarching parameters of full service partnerships that provide the structure upon which to build an FSP program.

Definition

*Understanding full service partnerships for older adults* encompasses gaining familiarity with the regulations and theory relevant to FSPs, to meet the needs of homeless and seriously mentally ill older adults. In addition to the homeless population, this includes older adults who are homebound and who have been inappropriately institutionalized.
Implementation Strategies

- Visit full service partnership, assertive community treatment, and AB 2034 programs to help gain firsthand knowledge of these programs.
- Network with program directors of older adult full service partnerships.
- Visit another older adult full service partnership program to learn how it operates.
- Read and gain an understanding of state FSP regulations and recovery model documents.
- Develop an understanding of local community needs. Work with organizations that perform services for minority and refugee communities, as a means to learn about the specific needs of older adults, the impediments they encounter, and the resources available to them in these groups.
Purpose

To help persons with mental illness achieve wellness, and recover from the effects of their mental illness.

Definition

*The recovery model* approach to change asserts that mentally ill persons can and do get well. The recovery model priorities emphasize client inclusion, hope, empowerment, choice, self-determination, self-responsibility, pursuit of quality-of-life goals, experiencing non-patient roles, cultural competency, and individualization of services.

*Recovery*, which in this context refers to full recovery from mental illness, may occur for some older adult clients. Alternatively, full recovery of one episode may occur, but because of further losses or illnesses, older adult clients may experience additional episodes or worsening of mental illness.
For some older adults who suffer from multiple additional social, medical, and/or cognitive onslaughts, words other than “recovery” may better describe the hoped-for outcome.

**Implementation Strategies**

- Learn about the recovery model, and train the staff in its use and benefits.
- Conduct discussions with staff members about how they understand recovery can occur among mentally ill older adults, and how they can encourage development of hopeful attitudes.
- Consider various components or qualities of recovery for older adults, such as habilitation, dignity, self-respect, meaning, quality of life, or healthy interdependence.
  - “Habilitation” may suggest that seniors might not recover 100 percent, but instead reach the best level that they can.
  - “Dignity,” “self-respect,” and “meaning” may suggest internally felt qualities, which may or may not involve complete absence of mental or medical illness.
  - “Increased quality of life” indicates improvement in a holistic manner in the person’s life, involving many spheres of life.
  - “Healthy interdependence” refers to recognition that full autonomy may not be the healthiest goal, and that learning how and being willing to receive help when needed may be of greatest benefit.
“Whatever It Takes”

Purpose

To guide the actions and motivation of full service partnership staff regardless of the array of services provided.

Definition

Whatever it takes means finding the methods and means to engage a client, determine his or her needs for recovery, and create collaborative services and support to meet those needs. This concept may include innovative approaches to “no-fail” services in which service provision and continuation are not dependent upon amount or timeliness of progress, or on clients’ compliance with treatment expectations, but rather on individual needs and individual progress and/or pace on their path to recovery. Clients are not withdrawn from services based on pre-determined expectations of response.
Implementation Strategies

- Understand each client holistically in order to fulfill whatever it takes to help a client recover. Recovery will include helping a client to reach healing in all areas of his or her life in which healing is needed. According to Maslow’s Hierarchy of Human Needs, a person may need help with physiological needs, security concerns, social issues, self-esteem and self-actualizing areas. Maslow’s hierarchy\(^1\) indicates the range of a person’s needs to which the FSP staff may need to respond.

Maslow’s Hierarchy of Human Needs

- Create a “no fail” rule in order for the staff to find ways to work with clients who face unique obstacles, yet need FSP assistance.

Implementation Strategies (cont’d)

- Do not place time limits on the engagement phase of the FSP services. Failure is not likely to occur as long as the staff keeps trying.
- In collaboration with clients, develop individual services and supports plans (ISSPs) that contain not only symptom reduction goals but also quality of life goals that focus on living arrangements, social supports, education, employment, volunteering and meaningful activities.
- Use the expertise of various team members when working with difficult-to-engage clients.
- Use a recovery scale to gauge progress toward recovery.
- Create an expectation at the beginning of the partnership that services will end as appropriate, and ask clients what goals they hope to achieve by that point. Periodically revisit these goals as services progress.
Purpose

To convey a sense of welcoming to clients that reflects the belief in recovery. The healing and recovery process will not truly begin until a client feels welcomed and accepted into the services and supports of an FSP team.

Definition

Welcoming refers to the positive and accepting attitude conveyed by team members. It also is an expression of the environment where the team provides services and supports and the degree to which team members believe in the recovery philosophy.
Consider the potential barriers that impede creation of a welcoming environment in the clinic setting, along with potential solutions that achieve the purpose the barrier served, yet contribute to a positive and accepting environment.

<table>
<thead>
<tr>
<th>POTENTIAL BARRIERS TO CREATING A WELCOMING ENVIRONMENT</th>
<th>POTENTIAL STRATEGIES FOR CREATING A WELCOMING ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having a security guard.</td>
<td>Creating a safe and secure environment is critical to any program’s success. The role of safety is not limited just to the presence of security guards. Staff and clients must be empowered to assume responsibility for ensuring a safe environment as well. If a county or agency must have security guards present, consider having the guards function as part of the overall team and knowing FSP clients by name. Ask clients what they like most and least about the presence of guards, and how they could be used most effectively.</td>
</tr>
<tr>
<td>Using metal detectors to provide environmental safety and security.</td>
<td>What is the purpose of the metal detector? Is it effective? How do clients and family members perceive it? How do team members perceive it? Can you devise a better way to achieve the purpose of the metal detector? Whether providing a service in the office or the community, consider the power of observation of team members and clients, coupled with a good therapeutic relationship or alliance, to determine when clients are acting in ways that might place themselves or others at potential risk.</td>
</tr>
<tr>
<td>Posting multiple signs depicting rules and regulations generally telling clients what they cannot do.</td>
<td>What does the team want to convey, and what is the best strategy to convey it? What is the role of peer specialists or peer greeters in conveying these messages?</td>
</tr>
<tr>
<td>POTENTIAL BARRIERS TO CREATING A WELCOMING ENVIRONMENT</td>
<td>POTENTIAL STRATEGIES FOR CREATING A WELCOMING ENVIRONMENT</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Locking a door that causes separation between team members, and clients between the entry or waiting room and service areas.</td>
<td>Determine which areas of the site require controlled access and why. Examine team beliefs regarding the need for separation between themselves and clients. If some restrooms are designated only for team use, why is that? What are the underlying assumptions and beliefs about sharing restrooms or space with clients?</td>
</tr>
<tr>
<td>Lack of cultural diversity among staff members</td>
<td>For many clients of diverse ethnicities, entering an agency in which the staff is composed primarily of a different ethnicity can be threatening and perceived as unwelcoming. The environment can be improved by: Increasing staff diversity and bilingual capabilities. Ensuring that language minority clients are respected and receive translation services promptly. Posting signs in several languages. Choosing décor reflecting diverse cultures. Advertising local cultural events. Providing waiting room materials (magazines, children’s books, videos) in several languages.</td>
</tr>
</tbody>
</table>

*Debbie Innes-Gomberg, PhD, District Chief – MHSA Implementation Unit, Los Angeles County DMH*
Implementation Strategies (cont’d)

- Adopt strategies for developing staff and client relationships and communication. Inherent in the name “full service partnership” is the partnership between the client and the team. As with any partnership, the client and team must make joint decisions. Developing a partnership involves:
  - Understanding the client’s culture, the way in which he or she makes decisions and the involvement of family members or community in the client’s recovery
  - Establishing an investment in a relationship that, at times, requires more from one partner than from the other partner
  - Knowing that although the healing or therapeutic relationship is equal, it may encompass hierarchical service aspects
  - Developing the capacity for team members and clients to share decision making with regard to care. In order to facilitate client self-responsibility and coordination, clients must be equal partners in treatment decisions
  - Instilling and maintaining hope for the client

- Consider transportation and field-based services that are particularly accommodating to the needs of older adults.

- Train the staff in developing comfort working with, and warmly accepting, older adults who may manifest qualities that may present difficulties for the service provider. An older adult may, for example, have a life-threatening medical illness that could elicit fear in the service provider. More frequently, bodily functions emerge as important topics of conversation (e.g., gastrointestinal and waste elimination problems), which can be awkward for a staff person. Accommodation of these needs requires careful hiring and training of staff members in ways to manage their personal feelings appropriately.

- Encourage the staff to consider the interplay between independence and dependence among aging persons. Train staff members to consider the appropriate times to accept the client’s decision to make independent choices that may include more risk.
Implementation Strategies (cont’d)

- Research how the interplay between independence and dependence may vary by culture. Integrate cultural differences in this area into service interventions, including respect for a client’s desire to remain engaged with family members or to separate from family members.

- Teach staff recovery principles of welcoming clients into the day-to-day workings of the program – for example, providing friendly, welcoming greetings to clients when they come into the clinic.

- Remember that for many clients of diverse ethnicities, entering an agency in which the staff is primarily non-Latino white and English-speaking can be threatening. The environment can be made more welcoming by:
  - Increasing staff diversity and bilingual capabilities
  - Ensuring that language minority clients are respected and receive translation services promptly
  - Posting signs in several languages
  - Choosing décor reflecting diverse cultures
  - Advertising local cultural events
  - Developing trust within communities by building partnerships with community leaders and community based organizations
  - Providing waiting room materials in several languages (e.g., magazines, books, videos)
Client-Centered Treatment Planning and Service Delivery

Purpose

To promote a foundation for healing through the relationship between the client and personal services coordinator (PCS) or FSP team.

Definition

*Client-centered treatment planning and service delivery* involves services that are individualized to the needs, interests, and strengths of each client. Under a client-centered approach, the relationship between provider and client is balanced and equitable. This type of relationship may be difficult to establish, especially if clients have the cultural expectation that providers are “experts.”
Implementation Strategies

- Take care when providing orientation to this approach — particularly for clients of diverse cultures, who may expect a more hierarchical relationship with their provider.
- Approach assessment and service delivery within the context of establishing and building a relationship that will result in healing and recovery.
- Conduct a thorough assessment of each client that results in the development of an integrated summary or clinical formulation based on the client data.
- In partnership with the client, develop a clinical formulation, assessment, and service plan based on the client’s unique cultural attributes, strengths, age, gender, sexual orientation, and readiness for change. Interventions are then based on the uniqueness of each client.
- Approach service planning and delivery as a collaboration between the personal services coordinator or other FSP staff person and the client.
- Have staff members who are interacting with older adults carefully consider the tension between safety and autonomy. When working with older adults, providers sometimes lean more toward safety, and may at times inhibit an older adult’s right to make his or her own choices. FSP staff members working with older adults must face and evaluate their own attitudes, as well as the attitudes of community partners.
- Consider that while services generally “end when the client manages their own life,”\(^2\) be sure to consider that older adults may need to learn to accept help, and it may be useful to consider the concept of healthy interdependence, rather than complete independence.

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Implementation Strategies (cont’d)

- Encourage consultation with knowledgeable persons (such as the client’s medical doctor) and recommend credible information sources (such as the “WebMD” website) when staff members perceive that an older adult client is making a risky choice (e.g., refusing to take a prescribed medication). Such resources may help determine whether the risk poses danger to the client or others or indicates the presence of a grave disability that requires crisis intervention, or whether the client is within his or her own rights to take risky action.

- Facilitate discussion in staff meetings and/or supervision to discourage the FSP program staff from acting within an “illness-centered approach,” and to suggest alternate, person-centered options. An illness-centered approach might manifest itself, for example, when a staff person pays more attention to symptoms of a diagnosis (e.g., delusions) than to noting changes in the client’s personal progress toward recovery (e.g., willingness to walk to the grocery market alone).

- The table below illustrates the differences between a client-centered approach and the more traditionally used illness-centered approach.

<table>
<thead>
<tr>
<th>ILLNESS-CENTERED APPROACH</th>
<th>CLIENT-CENTERED APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>The diagnosis is the foundation.</td>
<td>The relationship is the foundation.</td>
</tr>
<tr>
<td>It begins with an illness assessment.</td>
<td>It begins with welcoming — outreach and engagement.</td>
</tr>
<tr>
<td>Diagnosis and treatment are needed to determine the services provided.</td>
<td>Personal suffering and help needed determine the services provided.</td>
</tr>
<tr>
<td>ILLNESS-CENTERED APPROACH</td>
<td>CLIENT-CENTERED APPROACH</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Services work is defined within the context of illness reduction goals.</td>
<td>Services work is defined in terms of quality-of-life goals.</td>
</tr>
<tr>
<td>Treatment is symptom-driven, and rehabilitation is disability-driven.</td>
<td>Treatment and rehabilitation are goal-driven.</td>
</tr>
<tr>
<td>Recovery from the illness sometimes results after the illness and then the disability are treated.</td>
<td>Personal recovery is the objective of a client-centered approach from beginning to end.</td>
</tr>
<tr>
<td>Track illness progress toward symptom reduction and cure.</td>
<td>Track personal progress toward recovery.</td>
</tr>
<tr>
<td>Use techniques that promote illness control and reduction of risk of damage from the illness.</td>
<td>Use techniques that promote personal growth and self-responsibility.</td>
</tr>
<tr>
<td>Services end when the cure to the illness occurs.</td>
<td>Services end when clients manage their own life and attain meaningful roles.</td>
</tr>
<tr>
<td>The relationship exists only to treat the illness, and must be carefully restricted throughout to maintain a professional relationship.</td>
<td>The relationship may change and grow throughout the process, and may continue even after services end.</td>
</tr>
</tbody>
</table>

Source: Mark Ragins, M.D., Mental Health America of Los Angeles
Instilling Hope

Purpose

To understand how hope promotes the opportunity to make difficult changes possible and worthwhile.

Definition

*Instilling hope* means helping older adult clients believe that they can get better, feel good, and lead worthwhile lives.
Implementation Strategies

- Help staff members learn how to find hope in their work. When staff members have and convey hope, clients will be more able to gain hope for themselves. Helping the staff to nurture hope may involve helping them value small steps of change.

- Teach the staff about what older adults with mental illness can accomplish. The training sessions should explain how staff members can help older adults attain a new perspective about the life they are living (e.g., developing meaning in facing death).

- Support staff in the process of examining their own beliefs and feelings that may mirror the larger culture’s more negative perspective about older adults. As staff members examine and challenge their own discomfort about aging, and replace it with optimism, they will be more able to help their older clients develop hope.

- Help clients develop meaning in their lives, even when facing declining health, cognitive impairments, or other losses.

- Explore whether the older adult client has any spiritual or religious faith resources through which to develop and strengthen a sense of hope.

- Develop an understanding of the ways clients across cultures can experience hope and develop meaning in their lives. For example, cultural values may determine whether a client experiences meaning through relationships with others, spiritual enlightenment, mentoring, passing on traditions to youth, being physically active, or engaging in activities the client considers useful and productive. Instilling hope entails engaging clients in a manner that is culturally congruent and reflects their cultural values regarding meaning and fulfillment.
Client Goal-Driven Services

Purpose

To maximize a client’s independence or interdependence and investment in recovery.

Definition

Client goal-driven services are targeted actions chosen and set by the client to maximize his or her independence and/or interdependence and recovery. They must be realistic, attainable, and self-responsible.
Implementation Strategies

- Help staff and clients exercise patience and gain satisfaction with what may feel like small steps while helping clients pursue their own goals, with the understanding that setbacks related to medical issues and other aging-related losses may occur.

- Consider training for the staff to understand the gains that older adults can experience in later life. These may include developing deeper meaning in life, gaining greater self-reflection and self-acceptance, improved quality of life, increased wisdom, increased existential outlook and/or spirituality, and/or passing one’s legacy on to younger generations.

- Support and facilitate conversations with staff members who feel uneasy helping clients pursue their stated goals. Help the staff use a sensitive approach to formulating objectives and problem solving with clients when their stated goal may be self-harmful rather than self-responsible. Help the staff discuss ways to help the client identify recovery goals that achieve their long-term goal in self-responsible ways. For example, a client’s expressed goal may be advocacy by an FSP staff person to avoid eviction due to hoarding. In such a case, the staff member may need help from the treatment team or supervision to help the client develop strategies to take responsibility for his or her hoarding behaviors.

- Develop a peer counseling and/or peer-run “friendly visiting program” in order to meet client goals for increased socialization and volunteer opportunities. Such a program can both meet the social goals of homebound clients and the meaningful activity goals of more mobile clients.
Shared Decision Making

Purpose

To increase the client’s understanding, motivation, and collaboration with treatment.

Definition

*Shared decision making* means setting treatment goals through the collaboration between the client, the clinician and treatment team, and family as desired by the client.
Implementation Strategies

- Spend significant time listening, and gaining understanding of the client’s dreams, desires, and hopes, as well as understanding what the client fears and wants to avoid.

- Develop skills with a client-focused collaborative approach. While many mental health providers are skilled in setting goals and objectives for clients, they may need training in identifying goals and objectives with clients. Collaborating with clients may include listening to and considering goals that the staff person may be tempted to negate (e.g., continue drinking). Goals set collaboratively will be more likely to help the client to achieve what he or she wants, and more likely to gain the client’s motivation toward recovery and wellness.

- Consider training the client to use web-based software applications such as Common Ground, or similar programs that empower them to communicate with psychiatrists via shared decisions.

- Understand cultural expectations regarding the roles of the provider, client, and family in the decision-making process. Individuals from varying cultural backgrounds may expect the provider to take a more active role in leading the decision-making process. Ensure that the approach taken (whether collaborative or authoritative) is respectful of cultural expectations.

- Discuss the decision-making process with the client, and develop a plan that is comfortable for the client and respectful of cultural values and expectations. Consider that expectations regarding the decision-making role of family or other individuals close to the client may differ across cultures. In some cultures, an older son may take an active role, while in others community leaders may be involved in the decision making.
Integration of Services

**Purpose**
To improve access through collaboration of services, resulting in success of treatment.

**Definition**

*Integration of services* refers to the process of coordinating all of the interventions a client needs to achieve recovery and wellness.
Implementation Strategies

- Work with providers of medical and social services to perform all of the services in one location that may be a natural meeting point for elders.
- Conduct services through an “interdisciplinary team.” In an interdisciplinary team approach, service providers from different disciplines (e.g., physicians, psychotherapists, case managers, home health nurses, client, and family members) share the same goals for and/or with the client, and work in a coordinated manner to achieve success.
- Consider a “multidisciplinary team” approach when an “interdisciplinary team” is not possible. In a “multidisciplinary team,” different services providers collaborate, while each might be pursing their own goals for and with the client. Although a multidisciplinary team is not as fully integrated as an “interdisciplinary team,” it sometimes may be the best approach available, with clear and frequent communication among the various treatment professionals likely to help promote recovery. This clear and frequent communication should involve the client (and family as desired and appropriate), and can occur in person, by phone, or using other electronic technology.
- Be aware that across cultures, members of an interdisciplinary team may differ. For example, members may include a shaman, spiritual healer, community leader or elder, family member, or pastor, depending on the client’s culture and preferences.
- Observe and be respectful of differences in communication strategies and hierarchical relationship across cultures within multidisciplinary teams.
- Consider culturally influenced preferences when contemplating participation of family members in the team approach. In some cultures, inclusion of family members may be essential, whereas in other cultures, involvement of family members may contradict the client’s wishes.
Growth-Oriented Versus Care-Taking Approach

Purpose
To understand the distinction between growth-oriented and care-taking approaches, and their resulting impact.

Definition
A growth-oriented approach allows clients to complete tasks for themselves that they are capable of doing, in order to empower them to become as self-sufficient as desired. This can occur through learning and/or enhancing skills and abilities. The focus of a care-taking approach is letting providers perform functions that the client may be capable of doing.
Many mental health service providers have been working in an environment in which they have cared for, or taken care of clients. Similarly, many older adult service providers have used the care-taking approach with their older adult clients. While the care-taking approach may seem compassionate and oriented toward keeping the client safe, it may undermine the recovery model and the goal of increasing client empowerment and self-responsibility. FSPs for older adults within the recovery model need to recognize tendencies toward care taking, and pursue self-growth with the client as much as possible.

- Maintain a recovery focus on client empowerment, self-efficacy and self-responsibility. Help staff members identify any of their own predilections for completing tasks for older adult clients when the older adults could be encouraged to do perform such functions themselves. Identifying these tendencies can help the staff refrain from unnecessarily doing chores for clients. When clients learn that they are capable of acting on their own behalf, they can grow in their own self confidence and self-worth.

- Remind staff members to take note when they receive pressure from external older adult service agencies to perform functions that an older adult may be able to perform on his or her own.

- Help the staff identify, support, and build upon the strengths of the client – which the ability of the client to survive this far in life has made evident.

- Use reminiscence strategies that can enhance identification of strengths over the course of the client’s life.

- Use skill-building techniques to enhance social skill building, illness management skills, cognitive enhancement skills, and other strengths.

- Be aware of cultural differences in attitudes toward care taking and growth. In some cultures, children are expected to take care of their parents as they age. Be respectful of different cultural expectations regarding the care taking and growth-oriented approaches.
Purpose

To enable clients to live successfully in the community, as self-reliantly and independently as possible.

Definition

Building skills and supports helps clients learn new skills, renew old skills, and rally community supports in order to live with the highest quality of life possible. These capabilities encompass a wide variety of life management skills, as well as specific skills that are relevant to the specific goals and objectives of each client.
Implementation Strategies

- Help clients develop skills to manage various aspects of daily life, such as:
  - Finding and keeping appropriate housing
  - Gaining or re-gaining ability to manage finances
  - Learning anger management techniques to avoid conflicts and evictions
  - Developing approaches or finding supports to manage medication and other life regimens
- Help clients develop skills that will aid them in pursuing meaningful roles and worthwhile activities. Such functions may include job skills, educational skills, volunteer work skills, social skills, and recreational skills.
- Build supports to help clients acquire assistive devices or services that enable them to live more independently.
- Offer counseling or psychotherapy as necessary to enable clients to develop and maintain skills, and pursue growth and recovery.
- Seek information on-line or through various recommended agencies for:
  - Assistive devices
  - Disability products
  - Independent living products
Client-Run Services

Purpose
To help clients help themselves and other clients operate their own programs, enhance their self-esteem, and increase client engagement in services.

Definition
Client-run services are those that involve clients in provision of mental health services that support a culture of shared ownership. This approach encourages clients to help themselves and other clients while helping them feel appreciated and valuable by contributing their own efforts, thus enhancing self-esteem.
Feeling valuable and worthy of esteem is an important need for all people. Additionally, feeling able to influence what happens to and around oneself is a very human need. While older adult mental health clients often have been the recipients of services, they rarely have been able to make treatment decisions for themselves or create and influence their own services. Facilitating “client-run services” gives clients opportunities to control or influence the services they receive, to influence the services received by peers, and to gain personal value and self-esteem.

- Help clients obtain employment or volunteer opportunities by creating opportunities for them to work in the agency offering the FSP services. Clients who are employed as staff can contribute insights, perspectives and ideas about how to offer services.
- Consider exchanging client peers with another older adult FSP program so that clients can work or volunteer in a program other than the one in which they receive services.
- Help clients find employment or volunteer opportunities at other locations.
- Develop a peer counseling program and/or peer-run Friendly Visiting Program within your agency.
- Explore giving peer volunteers access to technology such as phone or a computer connection to use in their outreach to homebound older adults.
- Create a client-run center that would be an inviting place for clients to spend time while feeling comfortable and safe.
- Create programs that meet the diverse language and ethnic cultural needs of the FSP program’s clientele.
Engage in targeted efforts to identify and recruit minority clients to serve in peer-run programs. Remember that minorities experience barriers to obtaining services; therefore, identifying minority clients to serve in peer-run programs is often difficult.

Be aware that many minority clients find involvement in mental health services discomforting because of the stigma associated with mental illness. Broaden the definition of peer-run services to include gardening groups, grief support groups, craft groups, social activities, and other programs that support health and wellness without specificity to mental illness.

Ensure that these programs are culturally relevant to clients, reflecting the needs and preferences of their community.
Purpose

To present strategies for developing a culturally responsive approach for working with diverse clients in FSPs.

Definition

*Cultural responsiveness* means the ability to work effectively and sensitively within various cultural contexts. Ensuring cultural responsiveness entails promoting a set of congruent behaviors, attitudes, and policies in a system, agency, or among client providers, family member providers, and professionals, that enable them to work effectively in cross-cultural situations.  

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The effective engagement of diverse communities requires a dedicated, long-term, multidisciplinary approach. Some initial strategies for promoting cultural competence in FSPs at the organizational, systemic, provider, and client levels are listed below.

Organizational and Systemic Level

- Recruit and train, at all levels, a workforce that is reflective of the cultural groups in the county.
- Help employees from diverse cultural groups develop leadership capacity.
- Ensure that all materials are furnished in threshold and other languages, and that an effective and timely system for translation services is in place.
- Require contracting agencies to demonstrate a standard of cultural competence in service delivery.
- Collect statistics about race, ethnicity, language of clients, and other data to enable systems to identify unserved communities and address disparities.
- Involve target communities in leadership roles in planning, developing, and implementing FSP programs.

Provider Level

- Create opportunities and training for providers to develop:
  - Awareness — Providers must have an awareness of their own cultural experiences and background, and the ways in which these affect their beliefs, values, and behaviors in the clinical setting.
  - Knowledge — Providers must have knowledge about the historical background and cultural worldview of communities served.
  - Skills — Providers must have skills in communicating effectively, understanding nonverbal and verbal communication differences, and building rapport in cross-cultural interactions.
Implementation Strategies (cont’d)

Client Level

- Be aware that distrust and fear of mental health systems prevent many ethnic and cultural minority clients from seeking care and advocating effectively for the services they need.
- Empower clients of all cultures to be active participants in planning their care, and to obtain care that is consistent with their cultural values and beliefs.
- Develop strategies to assist clients in navigating systems of care, such as client navigator and parent partner programs (e.g., for grandparents who are raising their grandchildren).
Tailoring Service Coordination To Client Stage of Recovery

Purpose

To identify and to define levels of service and support that create a continuum of services based on the client’s stage of recovery, to ensure that clients are fully served.

Definition

*Tailoring service coordination* involves establishing a process for identifying a client’s level of recovery. Determining *stage of recovery* requires identifying degree of recovery, degree of risk of self or other harmful actions, engagement, skill mastery, and self-responsibility. While recovery scales vary on specific terms, they usually cover the same general areas. Services then focus on those recovery elements.
An overall framework must be established to indicate how services should flow from one level to the next. Levels of service refer to a guideline for determining the level of care that a client may need. The levels of service listed below constitute an example of a service continuum designed to meet clients’ needs as they recover.

- **Level 4:** Intensive services and supports for clients imminently at risk of institutionalization or homelessness.
- **Level 3:** Focused on strategic services for clients who generally engage at some level with the mental health system and natural supports, but are minimally to moderately coping.
- **Level 2:** Services geared toward self-management, with less reliance on the mental health system. Services are more peer-based and focused on wellness.
- **Level 1:** Community-based, often peer-run services, geared toward clients who have achieved relative independence from the mental health system.

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4 A guideline developed and adopted for use by the California Mental Health Directors Association (CMHDA) Adult System of Care Committee. The California Department of Mental Health has not sanctioned this policy guideline. Retrieved from [http://cmhda.org/committees/documents/ASOC/Handouts/0805_ASOC_documents_LOS_policy_and_guidelines_April_08.pdf](http://cmhda.org/committees/documents/ASOC/Handouts/0805_ASOC_documents_LOS_policy_and_guidelines_April_08.pdf)
Implementation Strategies (cont’d)

- Create a seamless set of services, at each level of service that focus on the milestones associated with each level of service.
- Obtain training for and use a recovery scale to assist FSP teams in determining a client’s level of recovery and associated services.
- Review client recovery scores at regular intervals, tracking client and program progress.
- Tailor services to client needs, interests, and level of recovery in the following ways:
  - **Clients at extreme risk**
    *Refer to Domain #2 — Service Array*
    - Reducing Involvement with the Criminal Justice System
    - Crisis Intervention and 24/7 Availability
    - Minimizing Psychiatric Hospitalizations
  - **Unengaged clients**
    *Refer to Domain #2 — Service Array*
    - Outreach and Engagement
    - Creating Welcoming Environments and Accessibility
  - **Clients who are building skills and mastery**
    *Refer to Domain #1 — Philosophy*
    - Client Goal-Driven Services
    - Building Skills and Supports
    - Client-Run Services
    *Refer to Domain #2 — Service Array*
    - Psychotropic Medications
    - Psychotherapy
    - Working with Grief and Loss
    - Integrated Services for Clients with Co-Occurring Substance Use and Mental Health Disorders
    - Successful Habilitation
Implementation Strategies (cont’d)

Refer to Domain #2 – Service Array (cont’d)
- Family Involvement
- Supporting Wellness and Recovery
- Employment and Volunteering
- Religious, Spiritual, and/or Existential Interventions

Refer to Domain #4 — Community Collaborations
- Community-Based Service Delivery
- Best Practices in Housing
- Integrated Services Between Behavioral Health and Medical Care
Purpose

To achieve as full a recovery as is possible.

Definition

Transitioning means that (1) clients move to a less intensive level of mental health services, or (2) clients move out of FSPs when they no longer need any mental health services.
The goal of mental health services is to help clients gain recovery and healing from their mental illness. Given that is most likely to occur in a progression, clients shall transition from a higher level of care to lower levels of care. They may transition from FSP services to less intensive mental health services, to client or peer-run services, and ultimately departing from mental health services.

- Develop, less intensive levels of services, either within the agency or in partnership with other agencies. These reduced service levels could include:
  - Client-run wellness or drop in centers or other peer services such as in-home visitation
  - Psychiatric medication
  - Counseling
  - Case management
- Provide field–based, less intensive services for homebound older adults.
- Establish a peer-run friendly visiting program, and/or virtual groups via telephone or the Internet.
- Develop strategies for individuals to be able to re-enter the mental health system if needed. Older adult clients may likely encounter additional life stressors due to life changes such as social, medical, cognitive, and/or financial losses. These may lead to increased risk for recurring mental illness, and therefore a need to reenter the FSP or lower-level mental health services.
- Ensure availability of an array of community services for clients to transition into the community. These may include socialization opportunities such as adult day care or adult day health care, friendly visiting, peer counseling and peer advocacy, transportation, help with housing stability, and/or steady medical attention.
Different Stages of Life and Quality-of-Life Goals

Purpose
To effectively serve older adults by understanding the different stages and expectations among older adults.

Definition
A person who is more than 60 years of age typically has life goals that may differ from those of an adult at age 25 or 45. Understanding the different stages of life and quality-of-life goals for older adults entails recognition that older adults may be classified among three groups: young-old (e.g., 60–64), middle-old (e.g., 65–84) and the old-old (e.g., 85+). Treatment goals may vary, depending on the age or developmental stage and the relative health of the client.
Issues that vary by developmental stage may include but are not limited to cognitive acuity, physical health, and number of interpersonal losses in one’s family and social network, one’s awareness of how much future is left, and awareness of approaching death.

**Implementation Strategies**

- Provide resources for the staff to learn about age differences between younger and older adults, and among older adults.
- Facilitate staff discussion to help staff members generate possible service objectives and therapeutic approaches for older adults at different stages. For example, consider active, outward-oriented goals for a younger cohort of older adults (work, volunteer opportunities), versus more internally oriented goals for an older adult in his or her 90s, who may be much lower on energy and more aware of the end of his or her life.
- Encourage discussion and sharing among staff members to promote increased understanding of age differences.
- Be aware of differences in the way age is conceptualized across cultures. In many cultures, age ranges for older adults may differ. For example, in the Hmong culture individuals are often considered elders at a much younger age than 60.
- Learn about different stage-of-life goals across cultures. When needed, engage cultural consultants to learn about cultural communities’ understanding of the aging process and the types of goals that are common for older adults across the cultures being served. In addition, engage clients and family members in discussions about their goals.
Be aware that for many immigrant and refugee clients, fulfillment of goals may be hampered by acculturation difficulties (e.g., difficulty reconnecting with family in the country of origin, or difficulty navigating the system to engage in productive activities). Explore ways that these clients can fulfill their goals despite the impediments they face.
Purpose

To develop an awareness of one’s own, and others’, prejudice about aging or older adults.

Definition

*Ageism* is “prejudice or discrimination against a particular age group and especially the elderly.”

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While many persons working with older adults may believe they do not hold ageist attitudes, ageism is deeply embedded in modern, particularly Western, culture and can impede treatment and recovery. Ageist attitudes can be observed among individual service providers as well as manifested in the ways in which agencies and the larger culture treat older adults. Seemingly harmless jokes in staff meetings – for example, “Don’t ask me how old I am; I’m getting old!” – suggest that becoming older in inherently bad. Another example is the tendency of older adults to receive less aggressive medical treatment for a condition than younger adults generally receives.

Assess, discuss and decrease ageist attitudes among staff by:

- Distributing pictures of older persons and asking for hypotheses about those persons; then giving pictures of younger persons and asking for hypotheses. Compare the responses.
- Assigning staff members to take Palmore’s aging quiz, then discussing their answers, and the assumptions underlying the answers.
- Asking staff members to bring in items from magazines, newspapers or other media depicting or discussing older people, and conducting a discussion about the underlying attitudes.

Facilitate staff members to examine their own attitudes about working with older people; encourage them to analyze how they feel about working with healthy older adults in comparison to physically ill older adults and older adults with dementia.

Conduct education and advocacy activities within the FSP program regarding ageism, as well as in the wider agency, the mental health system, the associated partner agencies, and the larger culture.
Facilitate a staff discussion about incidents involving ageism that the staff observed during interactions between the FSP team and older adults. A staff member who takes a client to the doctor and observes condescending treatment could initiate such a discussion. Discussion also might be appropriate when a staff member observes another service provider speak to a family member about the older adult, in front of the older adult.

Coach the staff in polite but assertive ways to advocate in these and other types of situations.

Be aware of the ways in which individuals across cultures experience and understand aging, and the manner in which immigration and acculturation may influence their experience and social status. Help clients recognize the importance of their contributions to family and community members. While in many immigrant and minority cultures older adults are respected and revered, acculturation pressures may result in decreases in social status for older adults. For example, older adults may be increasingly reliant on their children for assistance with transportation and interpretation. Such growing dependence often results in a shift in power relationships within families.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 59-66. This guide enables you to focus on the pertinent resources linked directly to each tool.

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</table>
✓ **Aging and Ageism Quizzes**


✓ **Articles**


Resources (cont’d)

✓ Articles


Resources (cont’d)

✓ Articles (cont’d)


✓ Assistive Devices

15. Seek information on-line or through various recommending agencies for the above resources.

✓ Books


Resources (cont’d)

✓ Brochure


✓ Disability Products

21. Seek information on-line or through various recommending agencies for the above resources.

✓ Independent Living Products

22. Seek information on-line or through various recommending agencies for the above resources.

✓ Policy Guideline


✓ Recovery Scales

Resources (cont’d)

✓ Recovery Scales (cont’d)


✓ Reports and Research Papers


Resources (cont’d)

✓ Reports and Research Papers (cont’d)


✓ Tool Kit


✓ Websites

33. Alzheimer’s Association: www.alz.org

34. American Association of Senior Peer Counseling: http://aaspc.com/

35. American Society on Aging: www.asaging.org


37. CalMEND – Resources for Mental Health Care Organizations and Providers of Mental Health: http://www.calmend.org
Resources (cont’d)

✓ Websites (cont’d)

38. Common Ground – Supported Recovery through Shared Decision Making (a web-based software application that empowers clients to communicate with psychiatrists via shared decisions):
   http://www.patdeegan.com/commonground/about

39. In-Home Supportive Services:
   http://www.dds.ca.gov/SupportSvcs/IHSS.cfm

40. John Hartford Foundation Geriatric Interdisciplinary Team Training:
    http://www.americangeriatrics.org/education/gitt/gitt.shtml

41. NAMI, Cultural Competence in Mental Health:

42. National Coalition on Mental Health and Aging:
    http://www.ncmha.org

43. Peer Counseling Program Model at WISE & Healthy Aging:
    http://www.wiseandhealthyaging.org/cms/1175.html

44. Stanford Geriatric Education Center’s web-based Ethnogeriatrics curriculum and resources (on-line resource with extensive, clinically relevant information about ethnicity and aging):
    http://sgec.stanford.edu/

45. Substance Abuse and Mental Health Services Administration:
    www.samhsa.gov

46. The State of Mental Health and Aging in America – Interactive Data:
    http://www.cdc.gov/aging/data/stateofaging.htm
Resources (cont’d)

✔ White Paper

Domain #2

Service Array

The Service Array domain describes 24 key service approaches of a full service partnership program for older adults. These include tools that are particularly beneficial for use with older adults (e.g., addressing death and dying, and intervening with cognitive impairment), as well as approaches for providing FSP services as adapted for older adults (e.g., field-based services).
Determining Eligibility

Purpose

To clarify what criteria FSPs need to follow in determining who they will serve in their program.

Definition

According to the California Code of Regulations (CCR), Title 9, Section 3200.230, determining eligibility of older adults for FSPs means deciding if clients who are 60 years of age and older, and who have a serious mental disorder, meet the criteria to receive services as set forth in the Welfare and Institutions Code, Section 5600.3(b).
The Code of Regulations specifies two determining eligibility factors:

- Their mental disorder results in substantial functional impairments or symptoms, or they have a psychiatric history that shows that, without treatment, they are at imminent risk of decompensation with substantial impairments or symptoms. Due to mental functional impairment and circumstances, they are likely to become so disabled they will require public assistance, services, or entitlements.

AND

- They are in one of the following situations:
  a. They are unserved and one of the following:
     i. Experiencing a reduction in personal and/or community functioning.
     ii. Homeless.
     iii. At risk of becoming homeless.
     iv. At risk of becoming institutionalized.
     v. At risk of out of home care.
     vi. At risk of becoming frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.
  b. They are underserved and at risk of one of the following:
     i. Homelessness.
     ii. Institutionalization
     iii. Nursing home or out-of-home care.
     iv. Frequently using hospital and/or emergency room services as their primary resource for mental health treatment.
     v. Involvement in the criminal justice system.

Typically FSPs serve older adults age 60 and older, while some serve persons 55 and older.
Implementation Strategies

- Determine from referral information if the older adult seems to have a serious mental illness, fits at least one of the risk categories, and meets age criteria.
- Follow up with an in-person assessment, often an informal assessment initially, to further determine meeting eligibility criteria.
- Determine if the client is receptive to outreach and engagement efforts.
- Make an initial informal assessment of the client’s cognitive ability to engage in and benefit from services.
- Follow up with a more formal assessment of cognition when and if possible and necessary.
Outreach and Engagement

Purpose
To form the foundation of a partnership by bringing clients successfully into an FSP as well as to retain clients in an FSP while they need services.

Definition
The process of outreach and engagement as codified by the CCR, Section 3200.240, means to “reach, identify and engage unserved clients and communities in the mental health system and reduce disparities identified by the county.”
Using the state’s definition as a starting point, FSP programs must practically apply the elements of reaching and identifying clients, and engaging them in services. Operationally, engagement involves establishing a trusting relationship, and is a critical component of the outreach process.

Further, outreach and engagement have been described as a dance, in the sense that each step in the outreach and engagement process is contingent upon the client’s response to the previous set of actions.⁶

### Implementation Strategies

- Identify the unserved and underserved older adults and older adults inappropriately institutionalized in skilled nursing facilities with serious mental illnesses who meet the eligibility criteria of candidates for outreach services in the community as indicated in the Welfare and Institutions Code (WIC) 5600.3(b). This eligibility list may include ethnic and cultural groups that have historically faced barriers to accessing services. It also includes homeless people, people cycling in and out of psychiatric hospitals or emergency rooms, those frequently incarcerated, or people living precariously with family members.

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Determine the key problems and needs, as well as the barriers faced by these groups, and create a plan for outreach services that includes:

- Deciding which staff members will conduct outreach services, and defining the role of peer outreach workers. Those with lived experience who are participating in outreach functions for specific populations are invaluable to the successful development and implementation of outreach and engagement. In addition, employing staff members who have constructive relationships with specific ethnic and cultural communities, and have bilingual capabilities that enable them to work with groups who have limited English proficiency, is critical for reducing barriers to engagement.

- Establishing which outreach staff members will maintain primary responsibility for outreach and engagement, or determining if they will follow clients into FSP services. The answer, in part, may depend upon the strengths and interests of outreach staff members. Some staff members have particular skills and are comfortable working in specific field-based environments.

- Minimizing changes between key staff with clients who are transitioning between levels of care is important.

- Specifying locations where teams will perform outreach.

- Being aware that some clients may not access services due to fear of disclosing their identities. For example, some clients may risk legal consequences if they access services. Other clients may face violence and harassment if their sexual identity is discovered. Efforts should be made to maximize client safety and confidentiality.

- Considering resources available and collaborations to develop and to ensure success.
Implementation Strategies (cont’d)

- Identifying existing community resources such as faith-based organizations, community-based agencies that have established relationships with target communities, and traditional or spiritual healers.
- Finding and obtaining resources needed to meet the basic needs of each population. This could include recommendations such as how to furnish an emergency shelter, as well as requirements for food, clothing, medications, or legal assistance before or after enrollment in an FSP.
- Using motivational interviewing (MI) to build rapport. MI is a “client-centered, non-directive, method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.”

Consider adopting the following outreach strategies by:
- Valuing the outreach client as a person.
- Understanding the cultural and belief system of each client. For example, homeless clients may feel safer and in control on the streets than in a shelter or in housing. Therefore, outreach strategies must take into account the beliefs the client has about mental illness, social services, and changes to one’s daily activities.
- Using an approach that is responsive to cultural differences. Understanding the ways in which culture may affect the client’s willingness to seek help, attitudes about his or her illness, and attitudes toward treatment.
- Displaying respect for the outreach environment and the clients for whom outreach services are designed.
- Having and expressing hope.
- Being patient, persistent, and non-threatening.

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Implementation Strategies (cont’d)

- Identifying client strengths, including survival skills.
- Creating opportunities for client empowerment and self-determination by presenting clients with choices.

Provide orientation and training to staff in the following areas:*

- Knowing field safety.
- Understanding the characteristics of the specific populations that are the focus of outreach, including ethnic and cultural minority groups.
- Recognizing co-occurring substance use and mental health disorders.
- Knowing the criminal justice system, public assistance benefits, and available resources in the community.
- Understanding abuse reporting laws (particularly when working with children, families, and dependent adults and older adults).
- Identifying engagement strategies and relationship development.
- Engaging community and family members in recovery planning and processes.
- De-escalating and establishing a framework for outreach services that includes boundaries and limits to the work.

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Field-Based Services

Purpose

To provide services for individuals who are unable or unwilling to come to a mental health clinic.

Definition

*Field-based services* are performed away from the agency, wherever the client is most comfortable and receptive to help and support. Such locations may include a client’s home, a street corner, a health-care setting, a skilled nursing or assisted living facility, a local coffee shop or restaurant, a church, or a senior center.
Implementation Strategies

- Leave the agency, go into client homes, and meet clients outside in places where they spend time.
- Train the staff to adapt decision-making guidelines to help them determine which roles and actions to undertake when in the field, and which roles and activities to avoid. These decision-making guidelines could include asking themselves the following questions:
  - What is the most clinically beneficial thing to do, including what is most empowering to the client?
  - Is the action I am considering within the scope of the client treatment plan?
  - Is the action I am considering ethical?
  - Is the action I am considering legal?
  - Is the action I am considering safe?
For example, if a bedbound client asks a clinician to cook breakfast for him, the clinician could determine if agreeing or declining would help the client most. Which action would empower or disempower the client? Is it ethical? Legal? Safe?
- Develop a safety protocol, and conduct staff training for field safety.
- Establish a staff support system for field service staff members who may become aware of and involved in overwhelming obstacles the client is encountering in addition to mental health issues. Treatment teams, supervisors, collegial peer support, and networking among agencies providing such services can be helpful.
Implementing Strategies (cont’d)

- Decide which rules to set, and which issues to leave to clinical judgment. For example, an FSP program might adopt a rule prohibiting staff members from accepting gifts, or instead might leave that decision up to the staff member’s clinical judgment at the time. Program administrators might consider enacting a rule to assign only same-gender staff members to clients who live alone, or instead may leave assignment of clients up to the judgment of the intake personnel.

- Determine when to serve clients in the field and when to see them in the clinic. For example, decision criteria might include the client’s physical abilities; they also might include the psychological conditions of the client (e.g., agoraphobia). Field-based services are useful for the homebound clients; they also are useful for outreach and engagement for clients who are hesitant to come to the clinic.

- Consider the range of services that FSP programs will conduct in the field. Ideally, for homebound clients, this range could include all services that the FSP offers, but such a comprehensive approach may be impractical for some agencies. They can also develop transportation and other options to enable clients to visit the clinic for certain services. Some options, such as medication services, could be expensive.
Purpose

To create an environment where clients are able to access services and supports, feel welcomed, accepted, heal, and recover.

Definition

Creating welcoming environments and accessibility means designing an inviting and convenient physical space, place or location where clients are served. The concept also refers to the positive and accepting attitude conveyed by team members. It is an expression of the environment where the team provides services and supports, and reflects the degree to which team members believe in the recovery philosophy.
Creating welcoming environments and accessibility requires FSP program personnel to assess barriers that are intrinsic to its system, and then to rectify those barriers. Inhibitors of a welcoming environment may include aspects of the physical environment as well as attitudes of the staff in the agency. Areas worthy of attention can include accessibility features of the building in which the program resides (e.g., doors wide enough for wheelchairs) as well as options for the program staff to physically go to the clients.

- Conduct field-based services at the homes and apartments of clients, as well as in assisted living, board-and-care, and skilled nursing facilities in which some may live. To connect with homeless older adults, agencies conducting field-based services may agree to seek and meet clients wherever they can be found (e.g., shelters, donut shops, or highway underpasses).
- Transport clients from their residences to clinic-based services.
- Offer a welcoming, accepting attitude by:
  - Helping the staff develop comfort working with and warmly accepting older adults who may be facing various emotional, mental, and physical health conditions, including nearing death.
  - Considering the need to require careful hiring and training. To engage field-based services effectively, FSP programs require staff members who are willing to leave the structured environment of the clinic, and venture into situations that are not controlled. Managers may want to assess potential staff for their flexibility and adventurous spirit. Programs also should prepare new staff members to make decisions quickly when faced with unusual situations (e.g., a client is sitting on the commode when the staff person arrives at the appointed time). Part of the training and ongoing supervision should consider the emotional responses of staff members when meeting with uncomfortable or unusual situations.
Training the staff to welcome clients and to accept the client’s right to make autonomous choices with which an assigned staff member may not agree.

- Examine the standard ways FSP programs operate. Clinics have sometimes developed rules and regulations that are more focused on creating safety and comfort for the staff than on working toward recovery for clients. While maintaining essential safety precautions, FSP programs can consider changes that can be made to create a greater sense of flexibility and welcoming.

- Engage older adult clients in helping the wider community develop welcoming environments, such as “one stop” centers where they can receive mental health attention, medical care, benefits assistance, social contact, and other services.

- Reconfigure the agency’s physical environment as needed. (Refer to Domain #1 – Philosophy, Tool: “Welcoming Environments”).

Implementation Strategies (cont’d)
Purpose

To obtain adequate information about the client in order to consider and plan for effective treatment.

Definition

Assessment is the process of gathering accurate information about each client in order to understand him or her as fully as possible, and using that information to determine the best way to work effectively toward recovery and wellness. The assessment process includes gathering the client’s perspectives on his or her history, hopes, and goals.
The FSP team must understand the client in a thorough and holistic way; that is critically important for all clients. Assessing an older adult client includes most of the same aspects as younger adults, but with special attention to a few factors, including medical conditions, medications, and cognitive status.

Complete a full assessment by obtaining adequate information about the client in order to consider and plan for effective treatment. Such an assessment would include the client’s:

- Goals
- Symptoms and own concerns
- Strengths
- Daily living needs (e.g., money, food, shelter, health care)
- History, including mental health and developmental history
- Medical status, medical history, medications, and sensory acuity
- Social and family network
- Co-occurring substance use problems, including those with prescription and over-the-counter medications, herbs, and other supplements
- Cognitive condition and current mental status, including differential diagnoses
- Spiritual and/or religious history, strengths, and concerns
- Suicidal and/or homicidal thoughts or actions
- Elder abuse, including self-neglect issues
- Cultural issues, including preferences, self-identity, acculturation, language preference, and ability
- Sexual dysfunctions
Implementation Strategies (cont’d)

- Determine an assessment protocol.
- Consider conducting only a minimal assessment during the initial encounter, guided by the degree of client engagement and openness to questioning; follow with additional, more probing assessment as possible.
- Collaborate with primary–care medical personnel.
- Develop relationships with local geriatricians and or a geriatric assessment team.
- Include client actively in collecting assessment data; ask the client which aspects of his or her life agency personnel must understand, including topics that have not yet been discussed.
Psychotropic Medications

Purpose
To assist clients who may benefit from psychotropic medications.

Definition
*Psychotropic medications* are drugs that are used to treat psychiatric disorders and are capable of affecting the mind.
Implementation Strategies

- Hire a psychiatrist who is:
  - Knowledgeable about or board-certified in geriatric psychiatry
  - Willing to travel to client’s homes
  - Knowledgeable about working with seriously mentally ill persons
  - Comfortable working with older adults
  - A team player
  - Able to understand and provide services within the recovery model
  - Experienced in delivering kind and compassionate services
  - Culturally proficient

- Consider the use of shared-decision models and decision aids in which the psychiatrist, other members of the FSP team, and the client interact in the process of educating the client to weigh risks and benefits. That ability to evaluate potential consequences enables clients to make responsible and informed choices regarding medication use. However, be prepared and respect the decision of a client who declines psychotropic medications.

- Create staff patterns that enable all team members, including the psychiatrist, to unify their approach to the clients.

- Take care to explore the attitudes of team members, including the client and his or her support network, regarding these approaches to treatment, and to respect the client’s experience and values. Remember that attitudes toward medication and psychotherapy vary across cultures.

- Present an orientation – when appropriate and particularly for those clients with little exposure to the mental health system – to the process, benefits, and risks of medication and psychotherapy.
Implementation Strategies (cont’d)

- Approach the subject of psychotropic medication with cultural minority clients using sensitivity, respect, flexibility, and understanding. Some individuals, particularly those from unserved groups, may consider the use of psychotropic medication oppressive or harmful. Marginalized communities historically have been subjected to harmful drug interventions. Consequently, consider enlisting the assistance of cultural brokers to help providers forge a better understanding of the client’s perspective, and to help the client better understand the provider’s perspective.

- Develop resources that would permit clients who do not speak English to work with a psychiatrist; consider bilingual psychiatrists or interpreters.

- Include traditional and spiritual healers or shamans, when appropriate, in team meetings to coordinate these approaches to integrate psychiatric care.
Purpose
To enable clients to benefit from psychotherapy.

Definition
_Psychotherapy_ is one of several treatment modalities that help clients heal internal psychological (of the mind) wounds, change behavior patterns, and develop new ways of being in the world.
Numerous evidence-based studies have shown that psychotherapy is an effective intervention in treating older adults for mood and anxiety disorders, and sleep disturbance. It also can be helpful for other psychiatric disorders, including late-life-onset psychotic disorders.\textsuperscript{9,10,11,12} Psychotherapy service can be performed by licensed therapists and graduate students in qualified courses of study who are supervised according to legal requirements.

- Offer supportive psychotherapy services. Much of the benefit of psychotherapy comes from the relationship that is built between the therapist and the client, including developing an interpersonal environment in which the client comes to trust that the therapist will listen non-judgmentally, compassionately, and helpfully.

- Listen to the client’s descriptions of what is occurring in his or her life, and support the client’s exploration of strategies to solve problems.

- Help clients develop and refine communication skills to enhance the relationships in their lives.

- Coach clients in achieving a more positive sense of themselves through life review and reminiscence.

- Consider cognitive behavioral therapy to help clients change undesirable ways of thinking and acting, and resolve problems that would otherwise interfere with daily living.


Implementation Strategies (cont’d)

- Evaluate use of Problem-Solving Therapy to help older adults’ depression improve.\(^\text{13}\)
- Consider applying behavioral activation interventions that help to increase clients’ activity level, as a means of diminishing their depression. \(^\text{14}\)
- Suggest depth-oriented psychotherapy to help clients resolve historical or developmental problems that interfere with optimal recovery.
- Consider pain management, mindfulness techniques, and relaxation training, which are often useful with older adults.
- Enlist licensed therapists to conduct family therapy to help clients resolve ongoing conflict, reconnect with estranged family members, and/or resolve unfinished issues.
- Provide training, along with follow-up consultation, in specific psychotherapeutic approaches before implementing them.
- Be aware that research identifying treatments that are effective with ethnic minority groups is limited. Most evidence-based practices have been tested primarily with non-Latino white populations. Therefore, caution is warranted when implementing evidence-based practices across cultural groups. Consider the following:
  - Theory and existing evidence may support the application of an evidence-based treatment for ethnic minority groups.
  - Adaptations must be made to some treatments to render them effective with particular groups.

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Implementation Strategies (cont’d)

- An alternative treatment should be sought when theory and/or research suggest that existing evidence-based practices are not appropriate and/or effective with clients of a particular culture. Consider applying an existing community-defined practice that holds promise for responding to the client’s concerns. Alternative treatments may be those with practice-based evidence or community-defined evidence. These are programs that have been used with success in communities but have not been formally validated by rigorous empirical study supporting their use.
Purpose

To help develop and maintain the highest level of mental health, older adults need to address issues related to grief and loss.

Definition

*Working with grief and loss* is a means of resolving painful feelings and experiences, in order to make peace with them and function optimally in the present.
Implementation Strategies

- Learn to identify losses, and to understand the grieving process and methods for working through it.
- Assist the staff in learning to help clients talk about their losses and begin the healing process.
- Provide grief counseling as needed by clients. Steps of grief counseling as indicated by J. William Worden\(^\text{15}\) include:
  - Establishing a therapeutic alliance
  - Ruling out medical problems
  - Assessing which tasks of mourning are incomplete:
    - Accepting the reality of the loss
    - Experiencing the pain of grief
    - Adjusting to the environment without the deceased
    - Withdrawing emotional investment and reinvesting
  - Reviving memories of the loss (i.e., help the client recall memories and feelings associated with the loss)
  - Dealing with affect and lack of affect, including anger, guilt, anxiety, helplessness, sadness, ambivalence, and other emotions
  - Helping the client learn to live with the loss of the deceased
  - Exploring and diffusing linking objects (identify specific items to which the client may be holding on as symbolic of the deceased person, if such items are inhibiting his or her moving through the grieving process). This fondness for symbolism could be manifested by, for example, keeping all of the deceased person’s belongings just as they were when the person was alive.

Implementation Strategies (cont’d)

- Acknowledging the finality of the loss
- Exploring client’s fantasy of what will happen if and when he or she stops grieving. For example, would he or she then have to face guilt for surviving – utter aloneness?
- Helping client say goodbye; use of ritual

- Be sensitive to the older adult’s preferred and the most healing approach to addressing grief and loss.
- Respect the degree to which to the client wants to talk about his or her feelings related to the losses.
- Develop an understanding of and respect for cultural differences in:
  - The manner in which grief and loss are perceived and understood
  - The ways in which individuals react and cope with grief and loss
  - Rituals and customs surrounding death and grieving
  - Willingness to share aspects of grief and loss with others

- Be aware of the diverse experiences of loss among cultural minority communities, and assist clients in coping with loss on these various levels:
  - Many immigrant individuals experience loss related to the circumstances of their immigration. Clients may experience grief related to the loss of their life in the country of origin and separation from loved ones.
  - Many refugee clients experience post-traumatic stress (either symptoms or the disorder) and grief related to traumatic experiences in war, including violent death of family members.
  - LGBTQ clients may experience grief related to rejection by family and community members.
Achieve the integration of substance use and mental health services into one treatment plan. This is critical to the recovery process for both disorders. The concept of "integrated services for clients with co-occurring substance use and mental health disorders (COD) means “providing both substance use and mental health interventions concurrently and in relation to each other, as part of one treatment plan provided by one team or within a network of services with shared goals. These integrated services must appear seamless to the individual and family participating in services.”\(^\text{16}\)

Implementation Strategies

Developing the Capacity for Integrated Services

- Consider hiring a substance use specialist who assists and leads the team in developing COD services.
- All team members should participate in specialized substance use recovery training initially and at least annually.
- All staff members should be trained in and practice motivational interviewing (MI) and stage-wise treatment.

Integrated Service Strategies

- Begin the integrated services process with an assessment of a client’s patterns of use of alcohol and other substances, and their impact on mental illness.
- Use a stages of change model, such as Prochaska and DiClemente’s stages of change model (see model below), or a similar model, as a way to match a client’s stage of change to intervention strategies. Approach services from the perspective of the client and his or her degree of perception that substance use is a problem and is crucial to address.

Prochaska and DiClemente’s Stages of Change Model

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Characteristics</th>
<th>Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation</td>
<td>Not currently considering change: &quot;Ignorance is bliss&quot;</td>
<td>Validate lack of readiness</td>
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<tr>
<td></td>
<td></td>
<td>Clarify: Decision is theirs</td>
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<td></td>
<td></td>
<td>Encourage re-evaluation of current behavior</td>
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<tr>
<th>Stage of Change</th>
<th>Characteristics</th>
<th>Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contemplation</strong></td>
<td>Ambivalent about change: &quot;Sitting on the fence&quot;</td>
<td>Validate lack of readiness</td>
</tr>
<tr>
<td></td>
<td>Not considering change within the next month</td>
<td>Clarify: Decision is theirs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage evaluation of pros and cons of behavior change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify and promote new, positive outcome expectations</td>
</tr>
<tr>
<td><strong>Preparation</strong></td>
<td>Some experience with change and trying to change: &quot;Testing the waters&quot;</td>
<td>Identify and assist in problem solving re: obstacles</td>
</tr>
<tr>
<td></td>
<td>Planning to act within 1 month</td>
<td>Help patient identify social support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Verify that patient has underlying skills for behavior change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage small initial steps</td>
</tr>
<tr>
<td><strong>Action</strong></td>
<td>Practicing new behavior for 3-6 months</td>
<td>Focus on restructuring cues and social support</td>
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<tr>
<td></td>
<td></td>
<td>Bolster self-efficacy for dealing with obstacles</td>
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<tr>
<td></td>
<td></td>
<td>Combat feelings of loss and reiterate long-term benefits</td>
</tr>
<tr>
<td><strong>Maintenance</strong></td>
<td>Continued commitment to sustaining new behavior</td>
<td>Plan for follow-up support</td>
</tr>
<tr>
<td></td>
<td>Post-6 months to 5 years</td>
<td>Reinforce internal rewards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss coping with relapse</td>
</tr>
<tr>
<td><strong>Relapse</strong></td>
<td>Resumption of old behaviors: &quot;Fall from grace&quot;</td>
<td>Evaluate trigger for relapse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reassess motivation and barriers</td>
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<tr>
<td></td>
<td></td>
<td>Plan stronger coping strategies</td>
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</tbody>
</table>

Implementation Strategies (cont’d)

- Coordinate and match interventions and services to the client’s readiness or willingness to change.
- Use MI, after identifying a client's stage of change. MI can serve as a strategy to stimulate conversation about readiness for change and therapeutic commitments. Consider helping the older adult to see the harmful effects of substance use on their health and longevity; that recognition often motivates them to begin to consider change.
- Offer an array of services options. Services should encompass outpatient individual and group COD services, 12-step programs, sober-living homes, and residential drug treatment programs. These options often are useful living arrangements as long as alignment exists between the client’s agreement to the approach and the treatment strategies.
- Develop integrated assessments, service plans, and crisis plans that promote recovery.
- Develop familiarity with the harm reduction approach. In this approach, staff members work with the client where he or she is, and problem-solve to help him or her gradually change behaviors in order to reduce the harmfulness of the addiction.
Establishing Social Connections

Purpose
To provide a sense of support and connectedness in the world.

Definition
Establishing social connections means helping clients develop relationships with other people who live in their world, outside of the mental health system.
Implementation Strategies

- Develop information on what opportunities exist for older adults in their communities. Find or make transportation resources, and help clients learn to use them.
- Help clients develop problem-solving and coping skills to deal with problems that often emerge when using para-transit transportation services.
- Develop referral resources through which older adults can be socially connected.
- Facilitate telephone or computer connections for or with home-bound clients. Older adults who are home-bound often find face-to-face social opportunities difficult to find and access. Telephone connections (e.g., telephone reassurance programs or similar programs) may be feasible. Computer options, such as chat groups, e-mail, Facebook, or Skype, can be explored.
- Help older adults who have physical disabilities find and obtain assistive devices to enable socialization.
Successful Habilitation

Purpose

To help clients to engage in activities that are meaningful, foster healthy interdependence, and/or give back to the community.

Definition

Successful habilitation is “a strength-based approach to skills development that focuses on maximizing an individual's functioning.”

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Initiating or increasing an older adult’s involvement in activities that they find satisfying, that promote healthy interdependence, or encourage giving back to the community are critical elements of recovery for the older adult client. Activities may include education, employment, volunteering, socializing outside the home, participating in family activities, or conducting individual, meaningful activities in the home. The services that clients require for their recovery and habilitation are unique to every older adult.

- Develop connections with various centers of activity that older adults could attend, such as a senior center, an adult day-care center or an adult day health-care center, places of worship, or faith and ethnic specific groups.
- Offer suggestions and gently coax clients through potential barriers; offer to go with them at first.
- Furnish or find transportation.
- Help clients develop, re-discover and/or continue meaningful activities within their homes.
- Encourage activities that encourage connections with the culture of origin and with other older adults. For many minority communities, this may be rewarding and may help decrease isolation. Working together in a community garden, for example, may enable Hmong older adults to connect with others in a culturally congruent manner. In addition, helping older adults work with youth to maintain cultural ties and connections may result in benefits for youth, older adults, and the larger community.
- Be aware that resources for older adults may be difficult to find in minority communities because these communities often have limited resources. Identify community assets and resources, and enlist the assistance of cultural brokers.
Family Involvement

Purpose

To have families involved in clients’ treatment and recovery in the most helpful way possible, including reconnecting, strengthening, and improving family ties.

Definition

*Family involvement* includes interaction with a variety of significant, involved others, including family members and friends who are committed to the care of the client.
Implementation Strategies

- Consider using an evidence-based practice such as family psychoeducation, which engages families and provides them with ongoing education about the client’s mental illness. It also helps them to develop problem-solving and coping skills and to create social supports.
- Honor the client’s right to decline involvement of family members in treatment.
- Revisit any initial decisions about family involvement to check about any changes in preference regarding establishment of a connection with family, or in favor of creating greater autonomy from family members.
- Help clients reconnect and rediscover a relationship with estranged relatives.
- Consider family therapy approaches through which older adults can focus on working with the family and manage unresolved differences that impede relationships with family members. Various approaches to family therapy can be useful.
- Provide conflict resolution and communication skills training.
- Pay careful attention to any possible signs of elder abuse:
  - When a family member refuses to leave the room during a staff member’s visit with an older adult, be sure to consider not only cultural preferences but also the possibility of elder abuse. Determine whether the decision maker is the older adult or another family member.
  - Be aware of other possible signs of elder abuse, such as timidity in the older adult, particularly when around certain family members; bruises on the older adult; vaguely stated concerns about family members; or excessive suspicion by family members about the services provided.
  - Because elder abuse is more frequent when an older adult is cognitively impaired, special awareness should be taken when an older adult is declining cognitively.
- Remember that the client continues to hold the legal right to make decisions for himself or herself in the absence of any legal document stating otherwise.
Implementation Strategies (cont’d)

- Train the staff to identify appropriate professionals (at the client’s request) to help with decisions such as arrangements for a conservatorship, power of attorney for health care, or power of attorney for finance if the client is making decisions that risk serious harm to the client or to others involved.
- Treat the client as an adult, not a child. Doing so can become difficult if the older adult is not objecting to adult children who are treating him or her like a child.
- Be aware of and respectful of cultural differences in family power structures and communication strategies.
- Remember that staff may encounter difficulty when attempting to facilitate family involvement for ethnic minority clients. For example, stigma of mental illness in some minority communities causes families to withdraw and isolate themselves. Fostering active family involvement in the client’s recovery may require psychoeducation for families to reduce stigma, protective isolation, and sensitivity.
- Provide technological means of communication (e.g., Skype) to circumvent geographic separation that may impede the efforts of immigrants to connect with their family members. Alternatively, the client may be encouraged to connect with other community support persons – extended family or close friends.
- Explore the possibility that LGBTQ clients may experience rejection by family involvement. In collaboration with the client, determine whether involving these family members is potentially helpful or harmful. If reconnecting with family is likely to produce further distress, identify ways to involve other individuals close to the client.
Suicide Prevention

Purpose
To intervene in situations that present risk of suicide, especially given that older adults have the highest rate of completed suicide in comparison with any other age group.

Definition
Staff members and community members can engage in suicide prevention measures to deter older adults from harming themselves, whether in active or passive ways. Passive suicide occurs gradually as a result of a client’s refusal to eat or take prescribed medications, or intentional failure to manage fragile medical conditions.
Implementation Strategies

- Recognize specific risk factors that may include, but are not limited to:
  - Depression
  - Social isolation, being lonely
  - Possession of a firearm
  - Recent loss
  - Physical illness
  - Pain
  - Substance abuse

- Assess potential suicidal risk in all older adults regularly.

- Consider outpatient treatment that can include:
  - Intensifying treatment through increased contact, in person or by phone
  - Removing access to means of self-harm
  - Resolving immediately pressing problems and long-term problems
  - Finding ways to increase hope
  - Facilitating an appropriate psychotropic medication regimen
  - Considering longer-term psychotherapy
  - Following up if someone drops out of treatment
  - Routinely monitoring and assessing ongoing suicidality including both direct and indirect markers of suicide potential
  - Maintaining a strong therapeutic alliance
  - Increasing social contact with supportive persons, including family members and/or friends
  - Enhancing financial security
  - Facilitating optimal physical health and independence
  - Encouraging alcohol abstinence
  - Developing favorably anticipated life events
Implementation Strategies

- Facilitating religious beliefs and values
- Providing practitioner optimism and concern, with regular appointments for ongoing care
- Treating depression, anxiety, insomnia, and pain

- Consider voluntary or involuntary hospitalization when necessary.
- Explore the cultural context for the client and the ways in which cultural values and beliefs can serve as buffers or supports in times of crisis. Attitudes regarding suicide vary substantially across cultural communities and are closely related to spiritual beliefs and values.
- Be aware of the prevalence of suicide in specific communities. For example, in recent years several suicides have occurred in the Hmong community in California. For communities in which the level of risk is particularly high, be sure to have a protocol in place to ensure individual safety and to mobilize support persons in the event of client suicidal ideation. Identify cultural brokers and community resources that can assist in these situations.
- Engage in broader community advocacy to educate communities about the risk factors and common signs for potential suicide. Identify and promote community-based activities such as social and recreational programs for older adults, which can prevent the isolation and despair that often lead to suicide in clients.
Purpose
To ensure that someone known to the client is available to respond during a crisis 24 hours per day, seven days per week.

Definition
Providing crisis intervention and 24/7 availability is the responsibility of the Personal Services Coordinator (PSC) and the entire FSP team. The team shares responsibility for each client but the PSC is immediately accountable for 24/7 response to client needs. The team approach ensures continuity of care for clients, and creates a supportive organizational environment for practitioners. The team ensures that a PSC is available 24/7 to respond to crisis needs if and when they arise. This team approach to around the clock availability helps to minimize the impact of staff absences or turnover and assure that a PSC, who is known by the client, is always available.
Implementation Strategies

- Identify, in team meetings, clients who are likely to need response during the workday or after hours.
- Ensure that bilingual staff members are available to meet the needs of clients with limited English-language proficiency.
- Consider use of 23-hour urgent-care centers associated with FSP programs to manage crises after hours. These programs can treat clients for up to 23 hours, 59 minutes, and can provide crisis services, medication, and linkage to immediate needs such as housing or outpatient mental health services. Be aware of language limitations at the centers, and prepare for potential linguistic complications before they occur.
- Consider creating crisis respite centers with staffs composed of peers who can furnish care support and housing during a mental health crisis.
- Train some staff members to qualify as Lanterman Petrus Short (LPS) Act designees, enabling them to evaluate a client’s need for involuntary hospitalization. A licensed clinician who undergoes such training and gains certification is able to consign a client to hospitalization involuntarily, in response to the client posing a danger to himself or herself or to others, or becoming gravely disabled.
- Develop a schedule giving LPS-designated staff members the flexibility and preparation to go to client homes or other places in the field, at any time, 24/7, to evaluate if involuntary hospitalization is needed.
- Develop plans with clients to reduce the need for after-hours crisis response, including:
  - Using Wellness Recovery Action Plans. (Refer to Domain #2 Service Array, Tool: “Supporting Wellness and Recovery.”)
  - Helping clients to identify positive and useful coping strategies.
  - Identifying early signs or precursors of an increase in symptoms.
  - Assisting clients in receiving support from other clients or peer providers.
Minimizing Psychiatric Hospitalizations

Purpose

To provide supports that can minimize psychiatric hospitalizations.

Definition

Minimizing psychiatric hospitalizations can be achieved by helping clients to resolve difficulties without admission to a hospital.
Implementation Strategies

- Make FSP services available 24 hours per day, 7 days per week, as a responsive resource that clients and their significant others can call, and thereby avert using a psychiatric hospital or emergency room for help.

- Use 23-hour urgent-care centers associated with FSP programs, which can be effective at managing crises after hours. These programs generally are open from 16 to 24 hours per day and can treat clients for up to 23 hours and 59 minutes, although the average length of stay is far less than that. These programs have the capacity to provide crisis services, medication, and linkage to immediate needs such as housing or outpatient mental health services.

- Consider crisis respite centers that also perform care during a mental health crisis.

- Make regular, reassuring contact with clients who go into crisis frequently – multiple times per week, if necessary, to help de-escalate building tension before a crisis erupts. Such consistent contact can help reduce crisis frequency.

- Help to break the crisis cycle by helping clients in:
  - Developing skills to take care of themselves.
  - Overcoming and healing from the factors that contribute to the cycle of crisis.
  - Changing traditional patterns within systems that contribute to the cycle. For example, clinics sometimes have become habituated to responding to clients only when in crisis, and not making time to help them develop skills that would help them avert the crises.

- Facilitate growth in clients rather than dependency and repeated crises by:
  - Stabilizing crises in a trustworthy and respectful way
  - Being involved with clients and developing and maintaining collaborative relationships when they are not in crisis
  - Enabling clients to receive the life supporting services they want and need, in a way that they are able to receive them
Implementation Strategies (cont’d)

- Working to change the factors that impinge on growth
- Devising ways to overcome factors that lead to crises, as a means of helping older adults avoid inappropriate psychiatric and medical treatment
Elder Abuse Prevention and Intervention

Purpose
To reduce presently occurring abuse as well as the potential for future abuse of older adults.

Definition
Elder abuse prevention means working with older adults, their families, and the community to prevent older adults from being abused financially, physically, or emotionally; from being neglected; or from neglecting themselves. Elder abuse intervention is the process of working to induce healing and to reduce the consequences of abuse of older adults.
Implementation Strategies

Elder abuse is becoming more recognized as a significant problem in the older adults’ community. Mentally ill older adults are at greater risk of being abused, and elder abuse can produce mental illness. Work with current clients is important as a means to avert elder abuse, as well to perform services for elders who have been abused.

- Conduct outreach with elder abuse victims gently and persistently, combined with relational advocacy, case management, and mental health services, to help reduce repeated Adult Protective Services (APS) involvement.
- Educate the staff to recognize the signs and causes of elder abuse.
- Train staff members on their mandated elder abuse reporting duties.
- Educate clients, family members, and caregivers about elder abuse, what happens when a report is made, and how elders can be helped.
- Intervene in reducing the causes and risks for abuse, including helping to reduce caregiver stress, reducing the level of dependency of a client on caregivers, and reducing the isolation of older adults. Mitigating the potential for these situations to occur can protect older adult clients.
- Educate the older adult victim, family members, and caregivers about what constitutes elder abuse, how to recognize abuse, and how to seek help.
- Conduct training on financial safeguards in collaboration with community professionals, bankers, and/or lawyers.
- Enlist isolation-prevention methods that include helping the older adult stay in contact with several types of people or programs. Such relationships allow others to observe potential causes for concern, and assist the client in making changes when a danger emerges.
- Coordinate community agencies to simplify the overall system so that help is readily available.
- Inform clients about the FSP staff’s legal reporting requirements.
Reducing Involvement with the Criminal Justice System

Purpose
To increase the client’s quality of life by minimizing his or her detention or other unwanted interactions with law enforcement personnel.

Definition
Reducing involvement with the criminal justice system means minimizing client contact with law enforcement agencies, including detention and arrests.
Implementation Strategies

- Determine, upon establishing a partnership with a client, whether he or she has any outstanding warrants or unpaid tickets that would result in an arrest. Assist the client in resolving these infractions to reduce the likelihood of criminal justice involvement for activities that occurred before the partnership began.

- Engage in proactive, advocacy-related work with the court when clients do become involved in the criminal justice system. Depending upon circumstances and history, judges may elect to suspend or reduce a sentence because the client is in an intensive care and treatment program.

- Establish relationships or partnerships with local probation offices. Such collaborations can identify individuals with a mental illness who have become involved in the criminal justice system but may benefit from a referral to an FSP team.

- Consider involving the probation officer as part of the FSP team.

- Issue identification cards to all FSP members, requesting law enforcement or psychiatric mobile response personnel to contact the FSP team if the client is in need or in trouble.

- Ask the client to sign releases of information and authorization, as a matter of practice, to help initiate comprehensive, integrated health and mental health treatment and to ensure that information on health and mental health care is shared appropriately. Authorizations should be specific to a primary-care physician to achieve coordination of care and in accordance with HIPAA regulations.

- Establish a close working partnership with the local or regional adult protective services agency and the office of the public guardian, and file the proper releases; work with these agencies to facilitate partnership understanding of the client’s specific conditions and needs.
Supporting Wellness And Recovery

Purpose
To promote and to model the belief in wellness and recovery.

Definition
Supporting wellness and recovery involves finding methods to enable the client to attain the highest level of functioning and optimal mental health possible.
Implementation Strategies

Supporting wellness and recovery may include complete resolution of the individual’s mental health symptoms, and/or it may involve living a full life while managing the mental health symptoms. With older adults who have co-occurring medical and/or cognitive conditions, wellness and recovery may not include recovery from those conditions, but can include optimal mental health while living with these conditions.

- Convey to the client that recovery can and does occur, and that the FSP team believes the client will recover.
- Develop a plan with the team and the client as partners.
- Consider some wellness strategies such as:
  
  - **Wellness Recovery Action Plan (WRAP)** – an approach to recovery self-management that helps clients develop daily maintenance plans, wellness toolboxes, the identification of early warning signs, trigger plans and plans for crisis and post-crisis.
  
  - **Illness Management and Recovery (IMR)** – an approach that teaches clients, individually or in groups, how to identify and manage symptoms effectively. Approaches include relapse prevention training, psychoeducation, coping skills training, and social skills training. Peers are often good facilitators for IMR.
  
  - **Peer Support** – an approach in which peers serve as outreach workers and welcome clients as they consider entering the mental health system. They may accompany clients to appointments; assist clients in obtaining needed services (e.g., looking for housing or grocery shopping); or assist clients in crisis by staffing warm lines, conducting peer counseling, and staffing crisis residential programs and other outpatient alternatives to hospitalization. Integrate and consider peers, especially those with a particular specialization or background, as equal partners within an FSP team.
Implementation Strategies (cont’d)

- **Support Groups** – may include general support groups or groups focused on particular topics. Support groups can decrease isolation, increase self-esteem, diminish depression, build coping skills, and benefit clients in other ways. Use chat rooms on the Internet for older adults who are homebound.

- **Enhancing Natural Supports** – a shift in client supports from the mental health system to supports in the community. As the community or the individual assumes more responsibility for daily life, the process fuels recovery. A client who begins to accept responsibility for making his or her own life work will experience increased self-esteem and empowerment. Greater involvement in the naturally occurring community rather than the mental health system will help reduce stigma and enhance self-esteem, as well.
Employment and Volunteering

**Purpose**

To help older adult clients progress in their recovery and achieve growth in self-reliance.

**Definition**

*Employment* means working productively for financial compensation. *Volunteering* is the act of performing productive service to other individuals or the community without pay.
Implementation Strategies

- Consider partnerships with state government agencies such as the Department of Rehabilitation to use MHSA funds as a local match for the federal funds received, thereby leveraging funding to support a client employment program.
- Develop a working relationship with public-service organizations that will help to find volunteer opportunities in the community.
- Help clients interested in a career within mental health—either as a peer specialist, peer advocate, or other position—use the following processes:
  - Developing a plan for peers to enter county or contract agency mental health programs as employees or volunteers, including specific positions and a career ladder
  - Developing and implementing training or certification for peers to gain the essential skills to enter the mental health workforce
  - Linking certification completion as a peer advocate or counselor with application for employment or volunteer positions, so that the client gains a meaningful role
  - Providing ongoing support for peers as they enter the mental health workforce, perhaps through the resources of the county’s workforce education and training (WET) plan
  - Establishing policies and parameters on employment of peers within the same setting where they received mental health services
  - Developing training and educational opportunities to enhance career development for interested peer staff members
Use of FSP Funds for Non-Mental Health Services and Supports

Purpose
To understand the Mental Health Services Act, California Code of Regulations, Title 9, Section 3620,(a)(1)(B), authorizing use of a portion of FSP funds for non-mental health services and supports. These funds are part of an approach to doing “whatever it takes” to help clients achieve their recovery goals.

Definition
Use of FSP funds for non-mental health services and supports can be allocated to food, clothing, and housing, including, but not limited to, rent subsidies, house payments, residence in drug or alcohol rehabilitation programs, and transitional and temporary housing; health-care treatment; and treatment for co-occurring substance abuse disorders, such as substance abuse and respite care. FSP funds also can subsidize items or other services needed to facilitate greater recovery.
Determine what portion of FSP funds should be dedicated for this purpose.

Balance the use of these funds with the ability of each client to provide for himself or herself. In using these funds, teams should help clients identify ways to attain self-sufficiency.

Consider the following key uses for these funds:

- Client housing support expenditures: housing subsidies, master leases, motel and other housing vouchers, rental security deposits, and first and last month’s rental deposits.
- Client flexible support expenditures: food; clothing; items necessary for daily living, travel and transportation; medication; respite services for caretakers; goods necessary for caretaking; medical and dental expenses; school or vocational supplies; furniture; and household products and appliances.
- Other non-Medi-Cal client support expenditures: costs of salaries and benefits for employment specialists, housing specialists, or peer support staff members who do not bill for their services.

Develop policies and procedures for making decisions with regard to client expenditures using these funds. Address in the guidelines questions such as:

- Who decides whether to make a particular expenditure – a clinician or the program administrator?
- If rent is being paid, what portion of the rent will be paid, and for how long will it be paid? What level of rent will a program fund or subsidize?
- How will staff members decide if a purchase is recovery-oriented and self-responsible (e.g., candy for a client who has diabetes)?
- What tracking procedure and receipts will be required?
- Should a program supply a client with cash for spending money?
- If a client has money but is not willing to spend it, will client support funds (flexible spending funds) be used?
- What constitutes an “emergency”? 
Addressing Issues of Cognitive Impairment

Purpose
To understand the challenges and provide services for clients with mental illness who also show cognitive impairment.

Definition
*Addressing issues of cognitive impairment* means helping older adults who have mental illness – as well as dementia, delirium, or mild cognitive impairment – achieve the maximum attainable recovery and quality of life, typically with the involvement of their families.
Implementation Strategies

- Obtain training and skills to assess and treat clients with cognitive impairment.
- Assess or obtain assessment of cognitive level upon intake, including normal age changes; mild cognitive impairment; and mild, moderate, or severe dementia and delirium.
- Consult with appropriate professionals (such as supervisors, a primary-care physician, geriatrician, neurologist, neuropsychologist, or pharmacist) when cognitive decline is evident in a client, at intake, as well as during the process of treatment.
- Train the staff to understand the criteria for a capacity declaration.
- Assess the immediate need for medical services to evaluate factors contributing to cognitive impairments and to resolve an acute medical condition that is possibly contributing to delirium or dementia.
- Know the community’s geriatricians and medical geriatric assessment teams.
- On intake, assess whether the client is exhibiting mental illness or only a form of dementia. If mental illness does not accompany the cognitive impairment, refer the elder to alternate services.
- Be aware of funding constraints; psychotherapy services are not covered when documentation indicates that dementia has produced severe cognitive impairment that would render therapy ineffective because of the client’s inability to establish a relationship with the therapist.
- Document the client’s cognitive level of functioning, to indicate that it is sufficient to allow the client to participate meaningfully in treatment; clients with insufficient cognitive function may have to be discharged from psychotherapy.
Implementation Strategies (cont’d)

- Know how to seek a probate conservatorship in your county, and understand the criteria for a medical declaration of incapacity.
- Consider facilitating a conservatorship if the client is cognitively incapable of taking care of himself or herself.
Purpose

To recognize other spiritual or existential interventions that can be especially important for older adults.

Definition

Religious, spiritual, and/or existential interventions help clients access satisfaction and quality of life by developing a metaphysical sense of self-awareness, participating in religious traditions, and/or connecting with supernatural powers in ways that lend enhanced meaning to existence.
Implementation Strategies

- Build or rebuild upon spiritual or religious resources that have provided strength throughout life for clients.
- Consider helping older adults seek new foundations of strength or meaning from spiritual or existential sources. Realize that for some older adults, religious concepts may not be of importance or interest.
- Assess the expectations of the client by asking questions such as:
  - “Are spirituality or religion important to you?”
  - “Do you have certain spiritual beliefs and practices that you find particularly helpful in dealing with problems?”
  - “Do you attend a church or some other type of spiritual community?”
  - “May I help you with any spiritual needs or concerns?”

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19 Joint Commissions on Accreditation of Healthcare Organizations (JCAHO) – Spiritual Assessment Recommendations (http://www.jointcommission.org/AccreditationPrograms/HomeCare/Standards/09_FAQs/PC/Spiritual_Assessment.htm).
Purpose

To become aware that mindfulness of death and dying is much greater for members of the elder population than it is among people of other age groups.

Definition

*Addressing death and dying* means helping and being receptive to older adults who choose to talk about their concerns, hopes, and fears regarding the process of dying, the point of death, and thoughts about experiences beyond death.
Implementation Strategies

- Encourage staff members to process their feelings about their own eventual death and the deaths of others, in order to be able to develop comfort with older clients who wish to talk about death and the process of dying.
- Train staff on when and how to consider approaching the topic of dying and death with their clients.
- Encourage the client to articulate his or her own feelings about the end of life, the process of dying, and what he or she believes will happen at the moment of death and after his or her own death. Help the client process feelings, and come to some level of acceptance of the approach of death.
- Assist the client in determining preferences for what should happen if he or she becomes unable to make medical decisions for himself or herself due to loss of consciousness. Help the client to determine what he or she wants to happen after death (e.g., burial or cremation; whether or not to have a funeral service).
- Be aware of the wide difference in beliefs and values regarding death across cultures. Respect these differences when exploring the clients’ ideas about death and when assisting clients in understanding and coping with feelings regarding death. Research suggests that individuals across cultures differ in:
  - The manner in which they communicate regarding end-of-life issues and the extent to which discussion of these issues outside of the family is acceptable.
  - The extent to which individuals believe end-of-life decisions should be made by the individual versus the family.
  - Levels of trust in providers, and willingness to discuss advance-care planning with providers.
Implementation Strategies (cont’d)

- Attitudes toward advance-care planning and end-of-life decisions; minority clients are less likely to complete advance directives and often are unaware of options regarding advance directives.
- Educate clients about advance care planning, and remain sensitive about their preferences. Do they prefer to communicate their wishes to family members? Do they trust providers to respect their wishes?
- Facilitate conversations whenever appropriate with family members regarding advance directives. Be sensitive to differences in preferences between clients and families, and assist them in engaging in healthy conversations regarding end-of-life decisions.
- Consider the impact of a client’s death to FSP staff and how to address those feelings.
Trauma-Sensitive Services

Purpose

To sensitively provide services to clients who have a history of traumatic experiences.

Definition

Trauma sensitivity is awareness of the attitudes and feelings of clients who have had traumatic experiences, as a means of devising useful treatment approaches for them.
Implementation Strategies

- Be sensitive that prospective clients may have undergone trauma previously, and approach them gradually and patiently when trying to engage them.
- Inquire about past traumas, as necessary; during early treatment, staff members may need to gather information about past traumas without actively probing vivid details of the client’s experiences.
- Offer encouragement and remain patient during middle phases of treatment. If a client appears ready to talk about the past trauma, that could help the client achieve some healing from it. Be prepared to revisit prior traumatic losses that may reemerge in conversation as the client begins to separate from current service providers and prepares to make the transition into a lighter level of care or into the community.
- Become knowledgeable about historical and cultural events that have traumatized certain generations of older adults, as well as different cultures and countries of origin of older adults.
- Become knowledgeable about ways in which memories and emotions relevant to past traumas resurface when older adults retire or become physically less active.
- Develop skills in helping reduce trauma feelings expressed by cognitively impaired older adults.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 137–155. This guide enables you to focus on the pertinent resources linked directly to each tool.

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<td>Reducing Involvement with the Criminal Justice System</td>
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<tr>
<td>Trauma-Sensitive Services</td>
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</tbody>
</table>
**Resources**

**Accreditation Organization**

1. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) – Spiritual Assessment Recommendations. Retrieved from [http://www.jointcommission.org/AccreditationPrograms/HomeCare/Standards/09_FAQs/PC/Spiritual_Assessment.htm](http://www.jointcommission.org/AccreditationPrograms/HomeCare/Standards/09_FAQs/PC/Spiritual_Assessment.htm)

**Articles**


Articles (cont’d)


✓ Articles (cont’d)


Articles (cont’d)


Resources (cont’d)

✓ Assessments

25. Activities of Daily Living Index (ADL):

✓ Assessments (cont’d)

26. An Array of Assessment Scales:

27. Assessment of Older Adults with Diminished Capacity:

28. Folstein Mini-Mental State Exam:

29. Geriatric Depression Scale:
Resources (cont’d)

✓ Assessments (cont’d)

30. **Geropsychological Assessment:**

31. **Instrumental Activities of Daily Living Scale (IADL):**

32. **Older Adult Psychological Assessment:**

33. **Patient Health Questionnaire (PHQ-9):**

✓ Assistive Devices

34. Seek information on-line or through various recommending agencies.
Resources (cont’d)

✔ Books


Books (cont’d)


Resources (cont'd)

✓ Booklet

58. Five Wishes – Provides a way for elders to control how they are treated if they become seriously ill. Retrieved from [www.agingwithdignity.org](http://www.agingwithdignity.org)

✓ Brochures


✓ Ceremony Guide

61. Service of Remembrance for Those Who Have Died – A sample ceremony to use to facilitate staff processing their feelings about client deaths. Retrieved from [http://www.heritageclinic.org](http://www.heritageclinic.org)

✓ Clinical Dementia Rating Scale

**Cognitive Impairment Assessments**

63. **Assessment of Organic Brain Deficit in Elderly Patients:**

64. **Clock Drawing Test:**

65. **Mini-Mental® State Examination:**

66. **Modified Mini Mental State Exam:**

67. **Saint Louis University Mental Status (SLUMS) Examination:**
Retrieved from [http://www.slu.edu/readstory/homepage/1294](http://www.slu.edu/readstory/homepage/1294)

68. **Short Mental Status Questionnaire:**
Resources (cont’d)

✓ Delirium Screening

69. **Confusion Assessment Method (CAM):**

✓ Fact Sheet


✓ Form

71. Physician’s Orders for Life Sustaining Treatment (POLST) – A means of documenting one’s requests for how medical care in conducted at the end of life. This can also facilitate a therapeutic conversation. Retrieved from http://www.capolst.org/

✓ Framework

Resources (cont’d)

✓ Handbook


✓ Manuals

74. **Procedure Manual:**

75. **.Restore, Empower, Mobilize (REM) Manual:**

76. **Substance Abuse Relapse Prevention Manual for Older Adults:**

77. **Treatment Manual:**
Resources (cont’d)

✓ Protocol


✓ Regulations


✓ Reports and Research Papers


Resources (cont’d)

✓ Reports (cont’d)


✓ Reference


✓ Research Paper


✓ Self-Help Guide


✓ Substance Abuse Assessments

87. CAGE Questionnaire:
Resources (cont’d)

✓ Substance Abuse Assessments (cont’d)

88. **MAST-G:**

✓ Toolkits


90. Get Connected! Toolkit: Linking Older Adults with Medication, Alcohol and Mental Health Resources. Retrieved from [http://store.samhsa.gov/product/SMA03-3824](http://store.samhsa.gov/product/SMA03-3824)


✓ Websites

93. Alcoholics Anonymous: [www.aa.org](http://www.aa.org)
✓ Websites (cont’d)

94. Alzheimer’s Association:  
   http://www.alz.org/

95. As You Age: A Guide to Aging, Medicines and Alcohol:  
   http://asyouage.samhsa.gov/

96. Best Practices: Using Harm Reduction:  
   http://www.agingincanada.ca/Best_3.pdf

97. Brief Intervention and Treatment for Elders (BRITE):  
   http://brite.fmhi.usf.edu/

98. County Offices: Public Guardian-Conservator-Administrator:  
   http://www.counties.org/default.asp?id=141

99. Elder Justice Coalition:  
   http://www.elderjusticecoalition.com/

100. Family Caregiver Alliance:  
    http://www.caregiver.org/caregiver/jsp/home.jsp

101. Medical and Medication Information:  
    www.webmd.com

102. Medicare:  
    www.medicare.gov.

103. National Alliance for Caregiving (conducts research, analyzes policy,  
     develops national programs, and increases public awareness of care-  
     giving issues):  
    http://www.caregiving.org/
Resources (cont’d)

✓ Websites (cont’d)

104. National Center on Elder Abuse – Administration on Aging:
  http://www.ncea.aoa.gov/ncearoot/Main_Site/index.aspx

105. National GAINS Center – U.S. Department of Health and Human Services, SAMHSA:
  www.gainscenter.samhsa.gov

106. PEARLS for Older Adults (Evidenced Based treatment for Depression in the Elderly):
  http://www.pearlsprogram.org/Our-Program/PEARLS-for-Older-Adults.aspx

107. Pleasant Events Schedule:
  http://www.healthnetsolutions.com/dsp/PleasantEventsSchedule.pdf

108. Practice Guidelines: Core Elements in Responding to Mental Health Crises:
  http://store.samhsa.gov/product/SMA09-4427

109. Suicide Prevention Action Network USA (SPAN USA):
  http://www(spanusa.org/

110. TIP 26 – Substance Abuse Among Older Adults (SAMHSA):

111. Wellness Recovery Action Plans:
  http://www.mentalhealthrecovery.com
Resources (cont’d)

✓ Workbooks


Team Structure and Staffing

The Team Structure and Staffing domain describes some of the ways in which older adult FSP teams may be structured, as well as some potentially useful approaches in transforming a more traditional service model into an FSP under the recovery model.
Purpose

To transform a traditional mental health delivery system into an older adult, recovery model FSP team and to resolve the challenges the transformation presents.

Definition

The basis of the FSP program is the recovery model. Traditional behavioral health systems will need to transform from a medical model to embody the person-centered recovery model. In the context of full service partnerships, *team transformation from traditional to recovery model* entails changing attitudes of the individual staff person, the agency, and the overall system to an approach in which treatment is centered on the client’s hopes and wishes, and the premise that mentally ill persons can and do become well. Transformation from a traditional model to a recovery model requires the administrators, providers, clients, and the community to embrace the recovery philosophy.
Implementation Strategies

- Adopt the new philosophy by learning the components of the recovery model (Refer to Domain #1 – Philosophy, Tool: “The Recovery Model”) and a new set of skills (Refer to Domain #1 – Philosophy, Tool: “Client Goal-Driven Services”).
- Instill hope for the older adult in the achievability of improved quality of life, of diminished mental illness, or the determination of meaning in his or her circumstances.
- Develop willingness and a comfort level sufficient to conduct field-based services. Be willing to let go of the client by helping him or her attain improvements, move on, and potentially cease being a “mental health client.”
- Help clients to secure recovery and gain wellness by empowering them to do all things for themselves that they are able to do. Help them recover by enabling them to end mental health services and meet their own needs through natural supports in the community.
- Consider which changes to the physical environment will facilitate a recovery orientation. Decrease manifestations of power differentials in the agency environment – for example, by relaxing a policy that previously required clients but not staff members to pass through a metal detector when entering the facility.
- Provide readings and training opportunities for the staff to learn more about the recovery model. Such a training program could include sending staff members to Mental Health America’s Village Immersion Training in Long Beach, California, or a similar training.
Purpose

To determine the most effective team model to meet the needs of the clients, the FSP team, and the agency in which the team is located.

Definition

*Team models* are varying approaches to team structure and the program’s team approach, giving the agency flexibility to adapt the most efficacious model for each program.
Implementation Strategies

- Decide which psychiatrists, nurses, social workers, mental health rehabilitation specialists, case managers, peer specialists, housing specialists, benefits specialists, psychologists, clients, and family members will compose the team.

- Decide how to organize the teams with regard to client interactions.
  - Under one team model, all staff members on a team perform service for each client, rather than assigning a “case load” to any individual team member. Whenever a client has a need, the team collaboratively decides which team member would most appropriately respond to the needs of the client.
  - A second team model pairs each client with one service provider who maintains all direct contact with the client, within the parameters of the staff person’s qualifications.
  - A third team model assigns one key staff person to perform most services, while one or two specialists are called upon for occasional care.

- Consider which team model might work best given the specifics of the client population, the community, and the preferences of the program staff. All models must include a staff member who meets the qualifications of CCR, Section 3620(i).
Each of the tools listed below has specific resources that you can locate in the general resource section on page 162. This guide enables you to focus on the pertinent resources linked directly to each tool.

<table>
<thead>
<tr>
<th>Name of Tool</th>
<th>Resource Number(s)</th>
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<tbody>
<tr>
<td>Team Transformation from Traditional to Recovery Model</td>
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</tr>
<tr>
<td>Team Models</td>
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</tbody>
</table>
Resources

✓ Articles


✓ Model

4. Assertive Community Treatment (ACT) Model: http://www.actassociation.org/actModel
Community Collaborations

*Community Collaborations* describe several of the essential aspects of working in the community, with community partners. This section describes tools to help in partnering with medical practices, housing agencies and owners, and other services providers.
Purpose
To emphasize a service delivery model that is community-based.

Definition
Fundamental elements of community-based service delivery include:
- Acknowledgement of the role of the community.
- Concerted and long-term efforts to establish trust and working relationships with individuals and agencies in the community, including performing services for community clients and helping community agencies to effectively provide services to older adults who are mentally ill.
- Collaboration with the community in developing a more effective service network.
Implementation Strategies

- Shift the perspective and efforts away from focusing solely on mental health service provision, and instead toward viewing mental health and recovery as integrally related with the entire community.

- Create strong relationships with community partners, including agencies that conduct services through the Older Americans Act and health-care partners to make community-based services successful. Potential partners are listed here:

<table>
<thead>
<tr>
<th>Potential Community Partners</th>
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<td>Supportive and independent housing sites</td>
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<tr>
<td>Supportive and independent employment or personal growth opportunities</td>
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<tr>
<td>Peer supports (e.g., peer recovery or habilitation network, drop-in centers, day centers)</td>
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<tr>
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<td>Chemical dependency treatment providers (residential and non-residential)</td>
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<td>Public guardian: LPS and probate conservatorships</td>
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<td>Residential care facilities for elderly</td>
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<td>Senior volunteer programs</td>
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<td>Shared housing</td>
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<td>Transportation services</td>
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</table>
Develop multi-disciplinary meetings that incorporate as many of the above-listed agencies as possible. Network with these service providers to develop effective interagency referral processes.

Offer consultation to these service providers about ways to increase their capabilities and patience in working with older adults with mental illness.

Work directly with clients to help them make successful connections with community services and agencies. Such involvement might include accompanying them to their first and perhaps subsequent meetings at such agencies.
Integrated Services

Purpose
To avoid being a “standalone” provider who attempts to treat clients in isolation, and instead strives to be a partner within the community, treating clients holistically.

Definition
*Integrated services* encompass a wide range of housing, economic opportunities, lifestyle supports, spiritual connections, medical health care, social interactions, and other services in a coordinated way, to help people change and grow. Mental health systems and the community must become integrated for mental health needs of older adults to be met fully.
Implementation Strategies

- Develop well-coordinated linkages between different types of services and levels of service.
- Network in the community. Offer education to the general population and partner agencies on strategies of working with mentally ill older adults.
- Build relationships and develop effective communication channels among mental health and partnering agencies.
Best Practices in Housing

Purpose

To improve the lives of clients by helping them secure safe, affordable places to set up households, and enjoy life more fully.

Definition

*Best practices in housing* are strategies for providing a full array of housing options that will work for a variety of clients, at various stages of recovery and in various degrees of health.
Implementation Strategies

■ Recruit and train for the FSP team a dedicated housing specialist who develops community housing options. This staff person would be responsible for:
  ➢ Developing relationships with property owners interested in renting to mental health clients, as well as working directly with clients on obtaining housing. The housing specialist would help the client complete rental assistance and other housing applications, including Section 8 housing vouchers and Shelter-Plus Care Program vouchers.
  ➢ Obtaining information about board-and-care facilities and assisted-living facilities in which older adults with mental illness can receive needed supports.
  ➢ Providing consultation and support to enable facility operators to gain and maintain skills in serving mentally ill older adults.
  ➢ Becoming knowledgeable about emergency housing such as shelter beds and motels.

■ Recruit peers, who often make excellent housing specialists because they act as sources of hope and models for other clients to emulate. Peers also uniquely understand the barriers to housing, and strategies to overcome them.

■ Use flexible funds when financial barriers emerge, including rental assistance and assistance with housing supports (for example, utilities, rental deposits, and basic necessities).

■ Be ready to provide clients with immediate permanent housing at the time of the client’s self-responsible request.

■ Identify opportunities to collaborate with housing developers to create additional housing that would be especially oriented to mentally ill, older adults’ needs.

■ Identify the number of clients who live in board-and-care, skilled nursing, and assisted living facilities, but who could make the transition to independent living or a lower level of care with appropriate supports.
Implementation Strategies (cont'd)

- Develop a clinical and a fiscal plan to facilitate independent living transitions.
- Create roommate groups or networking opportunities for clients interested in congregate or completely independent living.
- Assist the client in obtaining safe and stable independent permanent housing at the level of independence or interdependence needed, regardless of the client's level of recovery as noted in both supported housing and housing first models. Both models emphasize creating normalized living environments for clients that involve becoming a tenant, neighbor, and community member, and require collaboration between the client, FSP team, and landlord.
Purpose
To achieve optimal mental health recovery by integrating mental health care with medical care.

Definition
*Integrating services between behavioral health and medical care* is the process of moving away from the traditional model of separate silos of treatment, and instead finding ways to coordinate and/or work together to treat clients.
Implementation Strategies

Behavioral health care and medical health care traditionally have been conducted through separate institutions. With such separation of services, each provider may pursue different and sometimes competing goals – an approach that often is less effective than coordinated services in actively moving a client toward recovery and wellness. Integration of behavioral and medical health care can improve services and outcomes, and potentially be more cost effective. The American Psychological Association Presidential Task Force on Integrated Health Care for an Aging Population identified eight basic principles of integrated healthcare:

1. Sensitivity to ageism;
2. Familiarity with the roles of other health-care team members;
3. Respect for differences in health-care processes and beliefs among team members;
4. Awareness and productive treatment of conflict among team members;
5. Use of conflict resolution skills;
6. Receptivity to increasingly diverse forms of communication (e.g. virtual teams) within health-care teams;
7. Sensitivity to issues of multicultural diversity and marginalization; and
8. The need to offer ongoing assessment of treatment and treatment outcomes.20

While an FSP program is not usually operating in a system that fully integrates medical and behavioral health services, several strategies can create some degree of integration.

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Implementation Strategies (cont’d)

- Develop abilities to evaluate the presence of medical conditions as well as side effects of medications, to refer clients to medical care, and to work collaboratively with medical providers.
- Consider developing an integrated service delivery system that is co-located in medical offices that perform primary care.
- Train the staff in how to communicate with primary-care physicians.
- Promote high-quality communication and multi- or inter-disciplinary collaboration between mental health providers and medical providers.
- Hire medical providers and use them in the FSP treatment team. Such medical professionals might be physicians, nurses, nurse practitioners, or physicians’ assistants.
- Be active over the telephone and/or other means of communication, such as fax or secure email, with client’s medical providers to facilitate collaboration.
Purpose

➢ To assist clients in managing and living productive lives in their community.
➢ To reduce unnecessary client reliance on the mental health system.
➢ To increase capacity within the system to serve new clients.

Definition

Community capacity development is the process of strengthening the “ability of community members to use the assets of its residents, associations, and institutions to find or create opportunities where clients, as they recover, can rely on services and supports from the community rather than the mental health system to improve quality of life.”

When pursuing recovery for and with a client, the agency must encourage the client to become as involved as possible in the natural, non-mental health system community. This involvement presumes that the community has services and activities with which the client can become involved. Sometimes, however, such services do not exist. For example, homebound older adults seeking socialization opportunities may need a home visitor or a friendly visiting program. An FSP program should become involved in community capacity development in order to establish the needed services.

Generally, community capacity building has five elements:  

1. Knowledge building within the community – the ability to enhance skills, use research and foster learning.
2. Leadership – identification and support of a collective vision and interest of all community stakeholders, and development of a strategic direction.
3. Network building – formation of partnerships and strategic alliances for the benefit of the community.
4. Valuing of community – the value placed on the distinctive qualities of the community that support an investment of effort to work together.
5. Supporting information and analysis – reporting on data and outcomes of community integration efforts and the mental health program.

FSP programs may need to do community capacity development along these principles in order for clients' needs to become met in the community.

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Implementation Strategies

- Educate the community about mental illness, offering resource information and a speakers’ bureau composed of clients, family members, and non-clients, to illustrate inclusion and recovery.
- Collaborate with Prevention and Early Intervention (PEI) programs targeting prevention and early intervention programs, and with non-mental health community-based agencies, programs and faith-based groups.
- Debunk myths that persons diagnosed with mental illness are violent or unpredictable, in order to facilitate their acceptance and involvement in community activities.
- Establish partnerships between mental health programs and community organizations, including senior centers, senior residences, medical clinics, churches, temples, and other faith-based organizations, transportation services, and the area agency on aging.
- Consider offering free classes on non-threatening topics such as “building self-esteem” and “improving communication skills.”
- Establish a positive presence by becoming partners within the community.
- Consider participating in cross-agency, cross-disciplinary work groups and projects.
- Join and support area agencies on aging projects, and/or adult protective services’ multi-disciplinary programs.
- Assist in establishing community “safety nets” for residents and clients.
- Participate in establishing, developing, and supporting community or neighborhood coalitions that are empowered to solve community-level shortcomings and barriers.
- Identify existing official and “non-official” resources in communities, and make that information widely available and easily accessible.
- Create networking opportunities for existing resource providers to encourage warm hand-off referrals from resource to resource.
Purpose
To improve the capacity to fully serve older adults.

Definition
Advocacy and planning involve working at a public policy and systems level to build an older adult system of care and enhance the society’s ability to fully serve older adults who have mental illness.
Implementation Strategies

- Help the system by advocating for more articulated policy guidelines for levels of service in the older adult system of care.
- Develop appropriate modification of recovery instruments that can help with assessment, clinical decision-making, and administrative decision supports for older adults.
- Develop a model for services across the recovery spectrum, and advocate for more continuous service gradients.
- Campaign on behalf of more services specifically tailored for older adults, to become more proportional to their percentage of the population.
- Advocate for further training and development of a workforce with older adult expertise.
- Engage in needs assessments and program development efforts that specifically cater to cultural minority communities. Many cultural minority older adults live in isolation, and documentation about the specific needs of these communities is sparse. Cultural minority older adults often have access to fewer resources in health care, financial institutions, legal and immigration resources, recreational activities, social activities, and other functions. Advocate for increased resources in these communities.
- Ensure that language minority adults receive appropriate and timely interpreting services.
Each of the tools listed below has specific resources that you can locate in the general resource section on pages 181–184. This guide enables you to focus on the pertinent resources linked directly to each tool.

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<thead>
<tr>
<th>Name of Tool</th>
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<tr>
<td>Best Practices in Housing</td>
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<tr>
<td>Advocacy and Planning</td>
<td>1</td>
</tr>
</tbody>
</table>
Resources

✓ **Article**


✓ **Book**


✓ **Handbook**

Models for Collaboration Between Mental Health and Medical Care


Newsletter


Report


Resources (cont’d)

✓ Websites

9. Administration on Aging (AoA):  
   http://www.aoa.gov/

10. Area Agencies on Aging:  
    www.aging.ca.gov

11. California Commission on Aging:  
    www.ccoa.ca.gov

12. California Department of Aging:  
    www.aging.ca.gov

13. Center for Substance Abuse Treatment:  
    store.samhsa.gov/pages/searchResult/treatment:+csat

14. Community Capacity Building:  
    www.aare.edu.au

15. Community Integration for Older Adults with Mental Illnesses:  
    Overcoming Barriers and Seizing Opportunities:  
    http://store.samhsa.gov/product/SMA05-4018

16. Eldercare Locator – U.S. Administration on Aging (This resource can help  
    identify home and community-based services, including  
    transportation, meals, home care, and caregiver support services):  
    www.eldercare.gov

17. Housing First:  
    www.beyondshelter.org

18. National Coalition on Mental Health and Aging:  
    http://www.ncmha.org/resources.php
Resources (cont’d)

 Websites (cont’d)

19. Social Security Online:
    www.ssa.gov

20. Substance Abuse and Mental Health Substance Abuse:
    www.samhsa.gov

21. Supported Housing:
    www.csh.org
    www.bazelon.org
This appendix includes a list of general resources for older adults encompassing the national, state and local levels. Resources are also listed by topics.
General Resources

Resources by Area Level

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General Resources

✓ National Resources

American Society on Aging:
   http://www.asaging.org

APA Handbook -- Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists:
   http://www.apa.org

Association for the Advancement of Retired Persons:
   http://www.aarp.org

Department of Health and Human Services - Older Americans Act:
   http://www.aoa.gov

Leadership Council of Aging:
   http://www.lcao.org

National Council on Aging:
   http://www.ncoa.org

Profile of Older Americans (2009):
   http://www.aoa.gov

Social Security Online:
   http://www.ssa.gov

White House Conference on Aging:
   http://www.whcoa.gov
General Resources (cont’d)

✓ **State Resources**

California Association of Area Agencies on Aging:  
http://c4a.info

California Council on Gerontology and Geriatrics:  

California Department. of Aging: State Plan on Aging  
http://www.aging.ca.gov

California Institute for Mental Health (CIMH):  
http://www.cimh.org

Graying in the Golden State:  
http://www.ppic.org

University of California - The growth and aging of California's population:  
http://repositories.cdlib.org

✓ **Local Area Resources**

Local Area Agencies on Aging:  
http://www.aging.ca.gov
General Resources (cont’d)

✓ Alzheimer’s Disease

Alzheimer’s Disease Facts and Figures (2009):
http://www.alz.org

Alzheimer’s Disease Education and Referral Center
http://www.nia.nih.gov

Alzheimer’s Family Centers
http://www.alzheimerhelp.org

Alzheimer’s Foundation of America:
http://www.alzfdn.org

Family Caregiver Alliance:
http://www.caregiver.org

Information about Dementia:
http://www.alzbrain.org

National Association of Professional Geriatric Care Managers
http://www.caremanager.org

The Forgetting: PBS video about Alzheimer’s
http://www.pbs.org

✓ Arthritis

Arthritis Foundation
http://www.arthritis.org
General Resources (cont’d)

✓ Assistive Devices

Abilities Expo:
   http://www.abilitiesexpo.com

Ability Center:
   http://www.abilitycenter.com

Adaptive Computer Empowerment Services (ACES):
   http://www.adaptive.org

Assistive Devices Network:
   http://www.assistivedevices.net

Disability Products:
   http://www.disabilityproducts.com

Dr. Leonard’s - Discount Healthcare Products:
   http://www.drleonards.com

Functional Solutions:
   http://www.beabletodo.com

Hopkins Medical Products:
   http://www.hmponline.com

Independent Living Products:
   http://www.ilponline.com

Rehab Mart:
   http://www.rehabmart.com
General Resources (cont’d)

✓ Assistive Devices (cont’d)

Public Library Services for People with Disabilities:
http://www.sandiego.gov

Specialized Transportation for Elderly and People with Disabilities:
http://www.stridesd.org

Spoke Shop:
http://www.spokeshopsd.org

Yes I Can:
http://www.yesican.com

Wheelchairs:
http://www.1800wheelchair.com

✓ Brain Injuries and/or Impairments

American Parkinson Disease Association:
http://www.sd-pc.com

Multiple Sclerosis Society:
http://www.mssd.org

✓ Caregiver Information

Caregiver Health:
http://www.ama-assn.org

Family Caregiver Alliance:
http://www.caregiver.org
General Resources (cont’d)

✓ Caregiver Information (cont’d)

Family Care and Alzheimer’s Caregiving in the U.S:
   http://www.caregiving.org

Family Caregiving and Public Policy: Principles for Change:
   http://www.caregiving.org

Foundation for Health in Aging:
   http://healthinaging.org

Health and Age Centers:
   http://www.healthandage.com

Medicare Video for Caregivers:
   http://www.youtube.com/watch?v=IZa5m9kd_z4

New CMS Initiative:
   http://www.cms.hhs.gov

Resource Guide for Caregivers:
   http://www.medicare.gov

✓ Diabetes

American Diabetes Association:
   http://www.diabetes.org
General Resources (cont’d)

✓ Elder Abuse

Barriers to Promising Practices for Collaboration between Adult Protective Services and Domestic Violence Programs:
http://www.ncea.aoa.gov

Domestic Violence in Later Life: A guide to the Aging Network for Domestic Violence and Victim Service Programs:
http://www.ncea.aoa.gov

Elder Abuse Resources:
http://www.abanet.org

Elder Abuse and Neglect Information Kit (2007):
http://www.ageconcern.org

Elder Abuse and Neglect: In Search of Solutions:
http://www.apa.org/pi/aging/eldabuse.html

http://www.owl-national.org

NCEA Fact Sheet: Elder Abuse Prevalence and Incidence:
http://www.ncea.aoa.gov

✓ Hearing

Better Hearing Institute:
http://www.betterhearing.org

Starkey Hearing Foundation:
http://www.sotheworldmayhear.org
General Resources (cont’d)

✓ Heart

American Heart Association:
http://www.americanheart.org

National Heart, Lung and Blood Institute:
http://www.nhlbi.nih.gov

✓ Kidney

National Kidney Foundation:
http://www.kidneysocal.org

✓ Liver

American Liver Foundation:
http://www.liverfoundation.org

✓ Long Term Care

Across the States: Profiles of Long-Term Care and Independent Living (2006):
http://assets.aarp.org

Consensus Statement on Improving the Quality of Mental Health Care in U.S Nursing Homes: Management of Depression and Behavioral Symptoms Associated with Dementia:
http://www.americangeriatrics.org

Nursing Home Abuse Risk Prevention Profile and Checklist:
http://www.ncea.aoa.gov
General Resources (cont’d)

✓ Lungs

American Lung Association:
  http://www.lungusa.org

✓ Medicare

California Health Advocates:
  http://www.cahealthadvocates.org

California Medicare Information - Consumer Reports:
  http://www.calmedicare.org

Medicare and Your Mental Health Benefits:
  http://www.medicare.gov

State by State Fact Sheets on Medicare Prescription Drug Coverage:
  http://www.aarp.org

Health Advocates:
  http://www.cahealthadvocates.org

✓ Mental Health Information

Depression in Older Adults Fact Sheet:
  http://www.mentalhealthamerica.net

Geriatrics and Mental Health – The Facts:
  http://www.aagponline.org

Good Mental Health is Ageless (SAMHSA):
  http://kap.samhsa.gov
General Resources (cont’d)

✔ Mental Health Information

Hoarding:
   http://understanding_ocd.tripod.com

Mental Health - A Report of the Surgeon General:
   http://www.surgeongeneral.gov

Mentally Healthy Aging - A Report on Overcoming Stigma for Older Americans (SAMHSA):
   http://download.ncadi.samhsa.gov

MINDALERT Database on Mental Fitness and Aging:
   http://www.asaging.org

National Coalition on Mental Health and Aging;
   http://www.ncmha.org

Older Adults: Depression and Suicide Facts:
   http://www.nimh.nih.gov

Older Adults and Mental Health - Issues and Opportunities:
   http://aoa.gov

Psychology and Aging Addressing Mental Health Needs of Older Adults:
   http://www.apa.org

Suicide and Older Adults Resources:
   http://www.spanusa.org
General Resources (cont’d)

✓ Prescriptions

Prescriptions:
http://www.helpingpatients.org

Needymeds:
http://www.needymeds.com

Rx Help for Californians:
http://www.rxhelpforca.org

RxList:
http://www.rxlist.com

Suddenly Senior Drugstore Discounts:
http://www.suddenlysenior.com

✓ Stroke

American Stroke Association:
http://www.strokeassociation.org

National Institute of Neurological Disorders and Stroke:
http://www.ninds.nih.gov

National Stroke Association:
http://www.stroke.org
General Resources (cont’d)

✓ Substance Abuse

Addiction Technology Transfer Center Network:
http://www.attcnetwork.org

Aging, Medicines and Alcohol (SAMHSA):
http://kap.samhsa.gov

Get Connected! Toolkit: Linking Older Adults with Medication, Alcohol and Mental Health Resources (SAMHSA, AoA and NCOA):
http://download.ncadi.samhsa.gov

Older Adults: Substance Use and Serious Mental Illness Data Reports:
http://oas.samhsa.gov

Promoting Older Adult Health: Aging Network Partnerships to Address Medication, Alcohol and Mental Health Problems:
https://www.ncoa.org

Substance Abuse Relapse Prevention Manual for Older Adults - A Group Treatment Approach:
http://kap.samhsa.gov

TIP 26: Substance Abuse Among Older Adults:

✓ Vision

Braille Institute:
http://www.brailleinstitute.org

Braille Library:
http://www.braillelibrary.org
General Resources (cont’d)

✓ Vision (cont’d)

   Canine Companions:
       http://www.caninecompanions.org

   Eye Care America:
       http://www.eyecareamerica.org

   Foundation Fighting Blindness:
       http://www.blindness.org

   Guide Dogs for the Blind:
       http://www.guidedogs.com

   Guide Dogs of America:
       http://www.guidedogsofamerica.com

   Library of Congress - Books in Braille:
       http://www.loc.gov

   Lighthouse:
       http://www.lighthouse.org