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MENTAL HEALTH TREATMENT FOR THE ELDERLY COMMUNITY
IN A CENTRAL CALIFORNIA REGION

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
John Lewis Klevins

June 2018

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ABSTRACT

There is a national, state and local concern that focuses upon the rapid growth of our elder population as well as those within the cohort that suffer with mental illness. However, other than the numerous Alzheimer's related headlines, there is little national or state consideration being given to non-dementia-related elder mental illnesses. The lack of existing mental health service programs to assist the elderly community merits attention. The Constructionist paradigm was the basis for this study, due to its reliance upon recognized leaders in the field engaging in an interactive group process. These leaders included politicians, governmental agencies, non-profit organizations, and other community leaders. Outcomes from this study produced five action oriented initiatives: Leadership, Funding Campaign, Elder Sensitivity Campaign, Enhancement of Existing Programs, and New Program Expansion. These initiatives, if implemented, could drive change and positively affect the elderly population with mental illness within this central California county research site.

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CHAPTER ONE

ASSESSMENT

Introduction

The focus of this research project is on the mental health programs for the geriatric community within a central California county region. The assessment phase of this study began with an exploration of the topic related existing research and then proceeded to state the reasons for using the constructivist paradigm. In order to provide an overview of the topic this study first described the use of the literature review within the constructivist approach and then followed with a summary of the available peer reviewed research articles. Next, a summary of how the theoretical orientation is used somewhat differently in the constructivist paradigm, followed by a review of the two theories that are fundamental to this research. Finally, an explanation is given as to how this study will have a positive impact on the micro and macro social work practice as a whole.

Research Focus: Problem Statement

There is a national, state and local concern that focuses on the rapid growth of our elder population as well as those within the cohort that suffer with mental illness. According to the Administration on Aging (2017), there are currently over 46.2 million people (as of 2014) aged 65 years and older who reside in the United States, of which approximately 20%, or over 9 million elders,

suffer with psychiatric symptoms. In the next 20 years, people aged 65 or older will make up approximately 20 percent of the U.S. population (Stephens & Flick, 2010). These numbers have already challenged health care systems, governmental agency programs, service providers, family structures, as well as local, state and national economies, and the worst effects are yet to come (Morris et al, 2010).

However, other than the numerous Alzheimer's related headlines (whose numbers will triple by the year 2050), there is little national or state consideration being given to non-dementia-related elder mental illness such as depression or anxiety (Bor, 2015). This lack of focus remains even though elder mental illness has been identified as a leading cause of disability worldwide (Callahan et al, 2005). The disability associated with mental illness, specifically depression, is often created from declines in emotional, cognitive and physical functioning (Callahan et al, 2005). Older adults with mental illness describe greater functional impairment than those without, and unfortunately this condition endures over time (Bor, 2015). To compound this effect, older adults often suffer from comorbidity (simultaneous multiple diseases and/or conditions), with medical, physical and mental ailments plaguing their ability to remain independent (Bor, 2015).

Even in light of this information, there are few governmental agency resources in central California dedicated to the treatment of mental illness, and certainly none with a focus upon the elderly population. Given this apparent

oversight of dedicated services, the problem statement of this research project is the lack of existing mental health service programs to assist the elderly community within this central California research site.

Rationale for Chosen Paradigm

This research project has been conducted utilizing the constructivist paradigm. This approach was selected since it is the most appropriate worldview from which to gain a credible understanding of an existing apparent need, by understanding current programming from engaged professional practitioners, and then proceeding with an action orientation to arrive at programs, policies or processes that meet those community needs. The constructivist paradigm suggests that the only true way of understanding and improving any human circumstance is to use a qualitative data gathering approach to study the subjective perspectives of the stakeholders involved in the subject topic and then move to use this knowledge to improve the existing system. The purpose of this constructivist research study was to subjectively seek out a group of key stakeholders who understood the mental health needs of the aging cohort in central California, review existing programs, then develop an understanding of future programs or interventions that may assist with providing solutions to meet that cohort's specific needs.

In keeping with the constructivist paradigm, this study has created a credible group consensus that may lead to an ongoing commitment toward community action. In order to achieve this high level of group interaction this

study has again followed the constructivist approach and assembled a hermeneutic dialectic circle (HRC) in order to build a qualitative body of research data through both individual and group constructs. In practice, the HRC group as assembled, preferred to refer themselves as the Advisory Committee (AC). Since the processes and procedures used in the assembly and management of the Advisory Committee, coupled with the recording and reporting of the results, were handled in a reliable and credible fashion, the constructivist approach has created usable and verifiable community action oriented results.

The qualitative and subjective nature of constructivism not only met the needs of this study from a logistic perspective, but just as importantly, from a philosophical one. The constructivist paradigm offers a goal orientation characteristic that leads to the gathering of inspired action oriented suggestions, which fit within the research and implementation aspirations of this study. The constructivism paradigm is distinctive, overcoming societal based concerns through subjective research that is produced within a community minded, individual and group construct building atmosphere.

This study has benefited from assembling a group of stakeholders with the sole purpose of gathering, developing and sharing individual and group research topic constructs. Another area where the constructivism approach has benefited the research of this problem statement is in its flexibility, in that it anticipates that not only will the participants change over time, but also the framing and content

of the research topic itself may be altered based on the data collected through the combination of individual and group constructs.

Morris (2013), sites a mapping metaphor, which depicts the constructivist researcher as an explorer who sets out on a research journey with map in hand, yet knowing that the map will change due to the variability of the existing terrain. Much like unexplored land, our local communities are comprised of extremely unique individuals that are interacting within systems that tend to be inherently inconsistent due to relentless societal change. Within this dynamic system of interactivity, the constructivist world view seems well suited to study a group as diverse as the baby boomers, within a society that prides itself on individual adaptation and communal change.

Literature Review in the Constructivist Paradigm

Unlike the literature reviews of other research paradigms, the constructivist's review of the prevailing peer reviewed literature has been considered as just one of several resources used in gaining an understanding of the problem statement. For the constructivist, the literature does not drive the research focus, it merely enhances the progress of the information gathering in partnership with the study participants. The constructivist views the literature as an integral element of the research project, using the knowledge within a dynamic environment that has the capacity to change based on the impacts of the study parameters.

Literature Review

From a review of existing peer reviewed literature, it appears that there is an increased need of mental health related services for the elderly population not only in central California, but across the nation. According to the Administration on Aging (2017), there are currently over 46.2 million people (as of 2014) aged 65 years and older who reside in the United States, of which approximately 20%, or over 9 million elders, suffer with psychiatric symptoms (AofA, 2017). With such an overwhelming need, the reasons for inaction may stem from a form of subtle bias. This lack of prioritization has been given a name: ageism. Like racism and sexism, ageism is based on discrimination, yet in this context it relates to a wide acceptance of negative feelings and beliefs regarding our senior population (Stephens & Flick, 2010). Ageism arises from a lack of respect, which diminishes the potential for a better quality of life for members of this older cohort (Stephen & Flick, 2010).

If our society can rise above such harsh judgment, it is clear that geriatric behavioral health experts are convinced that mental illness is just as treatable in the elderly as in younger adults, but it takes specially trained skills to recognize and understand the nuances of diagnosing and treating the elderly population (Bor, 2015). There is credible evidence that interventions should involve public health education and tailored treatment settings, which would include primary care settings, specialty mental health settings, nursing homes and home-based care (Zivin & Kales (2008).

Increasing Need of Services

Since the end of the baby boom generation, decreasing fertility rates and increasing lifespans have resulted in an unprecedented worldwide elder population growth, leading to an estimated size of approximately 450 million older adults (Morris et al, 2010). According to Schnittker (2004), life expectancy in the United States has dramatically increased in the 21st century due to health-related improvements such as medical treatment, preventative practices and living standards. In the next 20 years, people aged 65 or older will make up approximately 20 percent of the U.S. population (Stephens & Flick, 2010). These numbers have already challenged health care systems, governmental agency programs, service providers, family structures, as well as local, state and national economies, and the worst effects are yet to come (Morris et al, 2010).

Mental Illness and Aging

There are accounts of rising numbers of seniors with diabetes, heart disease, and other chronic illness, not to mention the associated costs and the limited geriatric workforce that are struggling to even meet present needs, much less those of near future (Bartels & Citters, 2005). However, despite the headlines relating to the sharp increase of Alzheimer's disease (whose numbers will triple by the year 2050), there is little consideration being given to non-dementia-related mental illness, such as depression and anxiety (Bor, 2015). According to Bartels & Van Citters (2005), anxiety and depressive disorders are the most prevalent mental illness issues facing the older adult population.

Mental illness is a leading cause of disability worldwide, most especially in our aging populations (Callahan et al, 2005). The disability associated with depression is often created from declines in emotional, cognitive and physical functioning (Callahan et al, 2005). Older adults with mental illness describe greater functional impairment than those without and unfortunately this condition endures over time (Bor, 2015). To compound this effect, elder adults often suffer from comorbidity (simultaneous multiple diseases and/or conditions), with medical, physical and mental ailments plaguing their ability to remain independent (Bor, 2015). According to Bor (2015), in a 2012 report by the Institute of Medicine (IOM), it was estimated that 5.6 – 8 million senior citizens had one or more mental or substance abuse conditions, with that number forecasted to increase to 10 to over 14 million by 2030. Bor (2010) further points out that the IOM stated that there is no single federal agency that is responsible for the plight of older adults with mental illness. Yet, as Bor (2015) mentions, mental health services accounted for only 1 percent of Medicare spending, despite clear evidence that older adults with mental illness have much higher rates of hospitalization and emergency department visits than those with physical illness alone.

Another area of interest is the study of late-onset mental illness. According to a Delphi study undertaken by Van Alphen et al (2012), where they questioned 35 Dutch and Belgian geriatric experts in the field of mental illness, it was agreed that late-onset personality disorder is a useful construct within

geriatric psychiatry. This provides the basis for discussions not only about aging adults with a life long history of mental illness, but also mentally stable adults who progress to older age and develop a personality disorder.

Ageism

There is a negative sentiment concerning the size of our aging population that oftentimes is described in terms of fear and loathing through the use of such metaphors as “time bomb”, or “tsunami” or even the “tidal wave” of old people that are about to engulf our communities (Stephens & Flick, 2010). This fear tends to be based on the assumption that our elders do not contribute, are dependent and will generally cost a great deal of society’s money for health care. This form of ageism can lead to the neglect and exclusion of our community’s elders as an unwanted or unneeded by-products of the aging process. As illustrated by Schnittker (2004), even practitioner’s that work with senior citizens tend to focus on “depletion” in later life, rather than in “maturity” or “insight”. According to Stephen & Flick, 2010, many times there can develop a tendency toward non-treatment, arising from a position of a lack of care and respect, which neglects the potential for a better quality of life for the older cohort.

If we are to overcome ageism and take a positive approach to ageing in America and celebrate the contributions of our elders, while simultaneously taking the responsibility of caring for seniors that are frail and vulnerable, we must undertake to change many deeply held beliefs of our elders (Stephens & Flick, 2010). One of the first tasks will be to move our societal focus from deficit

and lack, to well-being and contribution by recognizing that there are numerous ways that people age (Stephens & Flick, 2010). As clearly depicted in the work of Rowe & Kahn (1998), if understood by society, there are models of “successful aging” that can produce low disease, high function and active engagement, which are clearly at odds with the discriminatory concept of ageism.

Stigma of Mental Illness

Beyond a negative societal perception of our ageing population, another significant barrier that must be overcome is a common belief (even amongst seniors themselves) that there is a stigma against individuals who seek out services for the treatment of mental illness (Zivin & Kales, 2008). Geriatric experts contend that psychiatric care tends to work better in a primary care setting, since many older adults fear that by visiting a specialized clinic they will be labeled as a psychiatric patient, which for many comes with severe shame (Bor, 2015).

According to Jimenez et al (2013), there is a significant stigmatizing attitude toward mental illness among various racial groups of advancing age. Elder African-Americans and Latinos expressed a higher level of comfort when talking to primary care physicians or mental health professionals relating to their mental health compared to Caucasians (Jimenez et al, 2013). Yet those same Latinos, along with Asian-Americans expressed greater shame and embarrassment about having a mental illness than Caucasians. Of the various racial groups surveyed, Asian-Americans expressed the greatest difficulty in

seeking or engaging professional mental health treatment (Jimenez, et al, 2013). Jimenez et al, (2013) concluded that within the aging community, there are significant differences in the way various racial groups respond to mental illness as well as its treatment.

Health care systems will also have to grapple with the logistics of rising numbers of ethnic minorities in the elder population, particularly Hispanics and Asians. Census projections illustrate that the proportion of older adults who are non-Hispanic whites will decline to 72 percent by 2030, a 9 percent decline since 2003 (Bor, 2015). This information is key when it comes to the implementation of any mental illness treatment program, in that, program outreach will need to be specifically tailored to the racial populations that reside within the municipality.

Housing of Elder Mental Illness

Although most of the elderly population with mental illness reside within the community, individuals with the most severe psychiatric disorders are served in institutional settings such as nursing homes (89%), or in state, county or Veterans Administration facilities (11%) (Bartels & Van Citters, 2005). Nursing homes provide residential care to approximately 1.6 million older adults in the U.S., of which nearly two thirds of these residents have a mental illness (Bartels & Van Citters, 2005).

To add historic perspective, in 1955 the number of state psychiatric hospital beds exceeded the total number of all medical beds combined, which according to the census of psychiatric hospitals was approximately 560,000

patients (Bartels & Van Citters, 2005). Due to deinstitutionalization, by the year 2000 progressive downsizing and the closure of state psychiatric hospitals across the country, the total population of mentally ill persons in state hospitals decreased to roughly 57,000, a decrease of almost ninety percent (Bartels & Citters, 2005). This era of deinstitutionalization was ushered in by several events, first of which was the introduction of new antipsychotic medications that made community care more viable. Second, under the Kennedy Administration, the 1963 Community Mental Health Center Act, sought to reduce the costs associated with large state-run facilities and began funding construction and staffing of community-based mental health centers throughout the states. Third, in the mid 1960's, Medicaid and SSI (Supplemental Security Income) programs were established with financial incentives for community-based care. Finally, it was common practice amongst advocacy groups to promote the care of mental illness in the least restrictive setting as possible (Bartels & Citters, 2005).

However, local governmental agencies were ill prepared to provide community-based alternative placements from this rash of state hospital closings (Bartels & Citters, 2005). This led to the advent of the court and prison systems having to replace one institutional setting for another as it pertained to the custodial care of younger adult mental illness (Bartels & Citters, 2005). Whereas prisons have become the de facto psychiatric institutions for the younger person, the nursing home has taken on this responsibility for the elderly mentally ill (Bartels & Citters, 2005). This transpired due to many states unintended use of

Medicaid and Medicare to shift costs to the federal government by placing older mentally ill patients in nursing homes instead of local community based settings (Bartels & Citters, 2005). To combat this the U.S. Supreme Court ruled in the Olmstead Decision that it was discriminatory and thus unlawful to institutionalize a person who is disabled yet wishes to live in the community (Bartels & Citters, 2005). With limited federal and state funding, implementing the intent of the Olmstead has been challenging, leaving the care of elderly mental illness to nursing homes, assisted living, board and care, adult foster care, home health providers and agency run community mental health centers (CMHC's) (Bartels & Citters, 2005).

Apprehension and Intervention

Despite having high needs, it is sad but undisputable that our elder population greatly underutilizes what nominal amount of mental health care services that are available to them (Segal et al, 2004). There are two primary reasons that make our elder population understandably unwilling to seek psychological assistance, first, as previously mentioned is the stigma that many in society place on those with a mental illness, and second, is the shame they internalize for admitting to psychiatric problems (Segal, et al, 2004). To compound this under-utilization of treatment there are other obstacles inherent in mental health treatment for the elderly to include: some primary care physicians are not adequately trained to recognize mental illness in the elderly; patients are often hesitant to discuss their emotional difficulties with their primary care doctor;

and finally, some even blame themselves for not being in a more stable emotional state (Bor, 2015). What is even more damaging is that in a recent IOM report it was noted that our nation does not have sufficient numbers of trained professionals to diagnose and treat seniors with mental illness (Bor, 2015). This same IOM report called for increased training of not only geriatric specialists, but also direct care workers and peer support providers who can be involved in various forms of intervention (Stephens & Flick, 2010).

In a recent article by Zivin & Kales (2008) they summarized key factors associated with adherence to depression treatment among older adults. In their review one of the categories they focused upon was the “modifiable” traits of our elder population as it relates to their apprehension to adopting treatment interventions. Some of the more prominent forms of modifiable characteristics included social norms (stigma), detrimental effects of polypharmacy (taking multiple medications), lack of social support, spiritual beliefs and the overall cost of treatment (Zivin & Kales, 2008). In a meta-analysis by Pincus et al (2006) they compared several types of treatments to include: behavior therapy; cognitive behavioral therapy (CBT); psychoeducation; reminiscence/life review; brief psychodynamic therapy; interpersonal therapy; supportive interventions; physical exercise. They concluded that psychotherapeutic interventions, particularly CBT and reminiscence, are very effective in reducing depressive symptoms in the elderly population (Pincus et al, 2006). Zivin & Kales (2008) also stated that evidence based interventions should involve public health education and tailored

treatment settings, which would include primary care settings, specialty mental health settings, nursing homes and home-based care. Segal et al, (2004) was in alignment with this notion given their suggestion that primary care settings should be targeted as an important area of growth for mental health services for older adults.

According to Stephens & Flick (2010) another psychological factor that has been illustrated to support physical health, cognitive health, mental health and longevity among the elderly population is social engagement, which includes the related notions of social networks and social support. The focus of this research highlights the particular social support needs of the elder and their short and long-term impact on wellbeing (Stephens & Flick, 2010). This research supports the development of interventions to improve social support, while counteracting social exclusion and loneliness, such as community arts projects, group music and reading activities to inspire the building of an aging community integration concept (Stephens & Flick, 2010).

A study performed by Callahan et al (2005), divided 1,800 elder participants into an intervention group and a control group throughout 18 primary care clinics in five states. The intervention group was treated through a model called Improving Mood: Promotion Access to Collaborative Treatment (IMPACT), which used a team of specifically trained, medical and psychological personnel, whereas the control group used a more contemporary form of one-on-one primary care/referral doctor treatment. The results were clear, those within the

IMPACT collaborative care intervention group experienced a lower self-reported sense of depression, as well as testified to a better physical functioning over the one year of treatment than did the control group. According to these findings, collaborative care management for late in life depression, improves both mental illness and the physical function to a greater degree than what is customarily provided by contemporary treatment (Callahan et al, 2005).

There is common notion that many seniors tend to use their primary care physician as their default mental health practitioner, which suggests that primary care settings can and should be targeted as an important area of growth for mental health services for older adults (Segal et al, 2004). Segal et al (2004) went on to support the innovative, emerging and important U.S. trend of integrating mental health care within primary medical care for older adults through the use of specially-trained practitioners who work closely with the primary physician to implement all-inclusive step-by-step intervention/treatment programs for elders with depression. According to Bor (2015), 45 percent of patients assigned to integrated care had a 50 percent or greater reduction of depressive symptoms compared to 19 percent of patients who either sought direct psychiatric care or non-integrated mental health care, from their under trained primary doctor. The Van Alphen et al (2012) Delphi Study concurred with this notion, in that the panel of experts confirmed that an integrated, multi-disciplinary “specific mental health program” is useful to refine the diagnostic assessment and treatment in older patient with a condition of mental illness.

These findings are enormously important for elder care, in that not only does it add credibility to the merits of the collaborative care model, but more importantly illustrates that certain mental and physical functional declines are reversible (Callahan et al, 2005).

Literature Review - Conclusion

From a review of this peer reviewed literature it seems clear that due to a historically high increase in both the elder population as a whole, and those older adults with mental illness, there is an associated increase in the need for geriatric mental health related services. It is also apparent that this need has already challenged health care systems, governmental agency programs, service providers, family structures, as well as local, state and national economies. Once the American public transitions beyond ageist judgments, it will then take specifically designed intervention programs along with trained personnel to recognize and understand the nuances of diagnosing and treating this population (Bor, 2015). There is credible evidence that interventions should involve public health education and tailored treatment settings, which would include primary care settings, specialty mental health settings, nursing homes and home-based care (Zivin & Kales (2008).

Intervention models can be used with our aging population, which will produce degrees of success if the local municipal jurisdictions, non-profit organizations and private sector companies will take it upon themselves to explore new forms of care and treatment to this specialized population.

Regardless of the genesis of this dilemma, the main issue remains the same; our aging population with mental illness is growing and despite the numerous barriers to proper treatment, our society needs to design interventions that can aid in the treatment process.

Theoretical Orientation

The constructivist takes a slightly divergent approach, in that they see the vast array of applicable theories as important, but no more so than other available resources. Theories are simply added to the array of other pieces of information and distributed to the stakeholders for their consideration and comment. The constructivist assumes that the research project will not be guided by a particular theoretical orientation, but will in effect include the theoretical content into the development of the individual and joint constructs.

Even though this constructivist research has not been guided by a particular theoretical orientation it is important to provide all participants an understanding of the theoretical orientation that will act to support the targeted risk group of our community, that being the mentally ill elderly. There are however a large array of philosophies, theories, models and perspectives that could be interpreted as having impact on the content and direction of this study. Given this variation, this study will choose to be primary based on two theories, Erikson's Theory of Psychosocial Development and the Activity Theory. As the research study got underway, each of the seventeen (17) Advisory Committee

participants were given the option to review and discuss these underlying theoretical perspectives.

In the mid twentieth century, Erik Erikson proposed a theory of psychological development comprising of eight stages. His theory focuses on how people progress throughout the life cycle as a result of interaction between biological evolution and the demands of society (Zastrow & Kirst-Ashman, 2016). Erikson's focus was on the role of the social environment in personality development. Erickson postulated that one's society makes certain psychic demands (called crises) at each of his eight stages. During each of these psychosocial stages the person must adjust to the stressors and conflicts inherent in these crises. The individual that copes well with each crisis will be better prepared to meet the next stage with its set of crisis. Ultimately, a person's resolution of each crisis is the ideal, yet not necessarily a reality. Not overcoming a crisis in one stage will eventually lead to prolonged crisis in later stages. If the subject appreciates their life and are content with their accomplishments Erickson believes they achieve ego integrity, which he believes is the ultimate form of identity integration. People with ego integrity enjoy a sense of peace and accept life, others who have failed to cope successfully with past life crises will fall into regret and despair. The psychosocial theory presented by Erickson will help to understand the role of responding to crises throughout the lifespan, while helping the research participants to qualify their

reactions to a segmented hierarchical approach to the psychology and sociology of aging.

A second theory that this research study will utilize in its communication with participants is known as “Activity Theory”. Formally stated in the 1960s, this theory postulates that apart from biological changes in one’s physical self, older people are similar to middle-aged people in many ways. They tend to have the same psychological and social needs and will benefit from staying active and resisting isolation. Activity Theory stresses that through continued activity (mental, physical, social, spiritual) that older adults maintain their skills and their sense of social and professional value (Zastrow & Kirst-Ashman, 2016).

The overall study of aging cannot and should not be represented by one or two categories of thought. That is not the intent in the identification of these two theories. These theories are presented in order to potentially stimulate discussion and enlist further theoretical exploration by its participants. These two theories directly relate to the aging population and will provide an adequate foundation from which to research and study the elderly cohort in this central California region.

Contribution to the Social Work Practice

In reaction to the needs of our overwhelmingly large aging population, we are, as a society, woefully unprepared for the onslaught of their retirement and in effect their physical, emotional and mental support and care giving (AofA, 2017). As Bor (2015) points out, in a recent IOM report it was noted that our nation does

not have a sufficient number of trained professionals to diagnose and treat seniors with mental illness. This same IOM report called for increased training of not only geriatric specialists, but also direct care workers and peer support providers who can be involved in various forms of intervention (Stephens & Flick, 2010).

According to Segal et al (2004) the social service industry should undertake a large-scale, multi-faceted, fully integrated, intervention campaign assisting our aging cohort in its understanding of the types of mental health concerns that clinicians can assist with; outlining the mental health services available; outlining the means of access to those services; the details of insurance cost coverage; and finally, education on the general effectiveness of psychotherapeutic treatments. In short, the social service industry, including social work practitioners, needs to create policies and procedures which design and support treatment planning interventions that are specific to our senior population. In order for our communities to be able to provide robust programs and services for our aging population, the conclusions reached as a result of our social work-related research must be adopted by its practitioners into informed interventions.

In relation to micro social work, the results of such focused research can be incredibly informative and extremely practical when it comes to the relative success and potential benefits of various intervention strategies for the aging population with mental illness. Through the dissemination of this research

information, a social worker can implement either all or certain aspects of the researched intervention into their own practice. The conclusions reached by this study can be readily transferable to the practice of social work since the outcomes will be trustworthy, credible and dependable due to the rigorous subjective research methodology of the constructivist paradigm.

Chapter Summary

As stated, the focus of this research project is on the mental health programs for the geriatric community within a central California region. The content of this assessment phase of this research study began with an exploration of the existing peer reviewed research that related to this topic and then moved to state the reasons for using the constructivist paradigm. Next, a review was given of the two theories that will be fundamental to this research, first Erickson's Psychosocial Theory and next the Activity Theory. Finally an explanation was given as to how this study will have a positive impact on the micro and macro social work practice as a whole.

CHAPTER TWO

ENGAGEMENT

Introduction

The constructivist paradigm is the only one of the four research study methods that does not assume an objective reality, but instead proposes that human experience can only be studied and comprehended as a subjective reality. This has major implications for the constructivist's engagement phase of the research study in that it supposes that no one can stand outside human experience and observe laws and the regulatory process, independent of experiencing those aspects oneself. Constructionists believe that in order to collect data, they must collaborate with those participants involved in the subject experience in order to build a valid, authentic, and shared construct that may lead to positive action steps. This process required numerous steps to include the identification of the various subject sites, engaging with the subject site's gatekeepers, identifying willing participants, developing various procedural plans, taking into consideration diversity, ethics and political issues and finally the appropriate use of technology.

Study Sites

The first step of this engagement segment was to set a strategy to gain access to a variety of study sites within the overall research site of the central California county region. The study sites are in effect, the places where the

gatekeepers and stakeholders are employed or active, and where the researcher can engage with them while observing ongoing programs that may support the mental health of the aging population. The gatekeepers provided introduction to the hermeneutic dialectic circle (HDC) participants, or in the case of this study the Advisory Committee (AC) members, who were agreeable to participate and were viewed as critical components of this research project. In order to select study sites within the research site, this study explored various professional and educational networks to gain access to the gatekeepers and AC participants. The networks that were used to generate participants included the university system, governmental agencies, non-profit and private sector organizations that serve the elderly community, and most importantly, professional referrals that were provided during the networking process. The goal of the engagement phase of this constructivist research study was to identify who the key policy decision makers were and find methods to gain access to them in order to secure a commitment of participation on the research study's Advisory Committee.

The following list of study sites represents the initial summary list that was assembled by the researcher of the agencies and organizations that provide social services to the research site's aging population. The researcher endeavored to contact each of the below listed agencies and organizations, yet not all of these sites were able to commit to the study.

- Elected Municipal or County Officials
- Adult Protective Services

- County Mental Health agency
- County Department of Social Services
- Municipal Senior Centers
- National Association of Social Workers
- Area Agencies on Aging
- Centers of higher education (universities, colleges)

Engagement Strategies

According to Erlandson et al (1993), the researcher needs to consider several plans prior to moving forward with implementation. One of these plans is termed the Plan for Engagement (Appendix E), which includes the various mechanisms that will be used to engage the gatekeepers and study participants within the research settings. In actual practice the engagement was accomplished via a combination of e-mail, phone calls and personal connection with trusted key players that had connection with the various institutions providing services the elder community in the research site. The search process objective was to secure one person or site at a time, always requesting appropriate referrals. Each contact then led to the next gatekeeper or research site; the process required professionalism, tenacity, stamina, and accurate record keeping. The implementation chapter will go into greater detail on this topic and will provide a sample solicitation letter and follow-up email.

Self-Preparation

In adopting the constructivist approach, this study assumed a more interactive and arguably more personal form of research. In order to prepare for this endeavor, this study incorporated the various preparation plans (Appendix E) established by Erlandson et al (1993). As with many constructivist research studies, after the engagement process commenced, some of the identified plans needed minor adjustments in order to meet changing circumstances.

The first of this study's preparation plans was the Plan for Purposive Sample Selection. In order to provide a strategic approach to the selection of these participants, this study used Patton's "purposeful sampling" strategies (2002). The Patton strategies aided this researcher in purposefully choosing study participants who were able to provide the most thorough data about the research study focus. After a thorough review of Patton's various purposive sampling methods, this study identified four of these strategies to use in unison, which will be thoroughly reviewed in the following chapter on implementation.

The second preparation plan, was the Plan for Engagement for the various study sites, gatekeepers and AC participants. As mentioned above the plan of engagement that was actually implemented was a compilation of e-mails, phone calls and in-person interactions that solicited participation as either a study site, a gatekeeper or an AC participant. The plan for engagement is more specifically detailed in the implementation chapter that follows.

The third preparation plan was the Plan for Negotiation of the site and all participants. Once the initial contact was made and there was interest on the part of the agency or organization to act as either a gatekeeper or AC participant, this study followed the six Guba and Lincoln (1989) negotiated conditions for AC participation. This study requested that each AC participant review and sign a Participant Agreement letter (Appendix F), illustrating that they agreed to each of the six Guba and Lincoln conditions of participation.

The fourth preparation plan was the Plan for Data Collection. For this study, the primary means of data collection was both the one-on-one interviews, as well as the Advisory Committee member check meeting. Since the researcher in this study has only recently taken up residency in the research site area, and has not yet developed a deep knowledge base of existing programs available to the elder population, the study used participant interviewing, organizational websites and the member check meeting as the primary sources of data collection.

This study's interview process started where the participant was, and respected their perception of the proposed problem statement (Morris, 2013). The study also used listening and attending skills to obtain the participant's experiences, issues and concerns with the problem statement, as well as effective questioning skills using open and closed-ended questions to enlist the participant's responses.

The fifth preparation plan was the Plan for Data Analysis. Being a constructivist study it used the framework of a qualitative analysis. The data analysis for this study will be more thoroughly discussed in the implementation section in reference to the process of building units of information leading to individual and joint constructions, as well as the timelines of this study.

The sixth preparation plan was the Plan for Study Accuracy, Trustworthiness and Authenticity. Since this study was not funded, the option of an outside auditor was deemed impractical. The accuracy, trustworthiness and authenticity of this study has been audited by the university based research advisor.

The final strategy was the Plan for Data Dissemination and Reporting. The study's findings will be disseminated by the researcher to the AC participants, gatekeepers and their associated agency organization. It is anticipated that there may be various audiences who will be interested and could benefit from the findings. Once those audiences become apparent, presentations will be provided to them on an as needed basis. The researcher will ensure that any dissemination of this project's outcomes will be in keeping with university standards. Further details of this plan will be provided in the implementation section.

Diversity Issues

This project has acknowledged and engaged in the diverse characteristics and contexts of not only the gatekeepers and AC participants at the micro,

mezzo and macro levels, but also the content of the literature used throughout the study. In reference to the individuals involved in this study, which can be viewed as “sources of data”, this study acknowledges that they have unique demographic characteristics, and that special care was taken to ensure that these issues were considered. In keeping with the information presented by Farmer and Bess (2010), the social work research performed in this study was not built upon the limitations of our minority participants, but focused on their strengths and resiliencies.

In order to accomplish this goal on the micro level of human interaction, the researcher has implemented advice provided by Morris (2013) in the “micro-counseling approach”. This approach suggests that a person can attain a higher level of cultural competency by implementing certain attending and listening skills. For example, in relation to eye contact, the European North American norm of eye contact is considered rude in some cultures, such as in many Native American and Latino cultures. According to this approach, a person should gaze at a speaker and avoid eye contact when listening. Another example of this approach that was used in this study was remaining cognoscente of physical space. Some cultures requires an arms distance, where in others, such as those of Arab descent, are fine with distances as close as 6 to 12 inches. Another cultural difference that was noticed in this study was in relation to verbal following, where Chinese Canadians and Japanese Americans may not react well if a listener repeats back what they have heard. The take-away here is to be

cognoscente of cultural reactions, and be willing to make changes in ones mannerisms in order to make others feel comfortable, respected, and accepted as a group member.

From a macro perspective, this researcher followed the recommendations outlined by Morris (2013) in the community-based research (CBR). One of these recommendations is to acknowledge the diversity within the study group, by being attentive to its cultural heterogeneity. Another major tenant of CBR is the process of active listening and paying close attention to both hidden and public transcripts. This researcher maintained a high degree of attention on both micro and macro cultural competency through the use of both the topics contained in CBR as well as the micro-counseling approach.

During the engagement process of this study there was a significant focus on a variety of diversity issues with the gatekeepers as well as the AC participants. Diversity distinctions that were noticed included issues such as the differences in appearance, power, assumptions/norms, perspective, language, vocabulary and cultural history. Other more specific multi-cultural topics that were identified were ageism, stigmas, internalized shame, medication compliance and affordability of treatment. Naturally the discussion of these topics changed as various ethnic backgrounds and their associated cultural aspects were considered by the AC participants. Given the openness of the constructivist process, issues of diversity were acknowledged throughout the study, and met with a high degree of sensitivity to cultural competence.

Ethical Issues

This study understood and anticipated the potential harm that gatekeepers and AC participants could suffer based on a breach of confidentiality. Confidentiality was so critical to this research study that it asked each member to sign a Participant Agreement and a Notice of Consent (Appendix F & G) in order that all participants had a clear understanding of the study's processes and safeguards. The researcher as well as the university based research advisor, ensured that there were no unintended ethical consequences that resulted from this proposed research. In order to comply with all applicable ethical standards and federal guidelines, this researcher obtained approval of the proposal application from the Human Subjects Review process, managed by an Institutional Review Board (IRB) on the campus of CSUSB. In addition to not harming, nor coercing study participants, this constructivist research study assured that all participant's privacy, confidentiality, anonymity and basic informed consent concerns were met by obtaining a signed Participation Agreement, and Letter of Informed Consent (Appendices F & G).

With the constantly changing processes of the constructivist paradigm, the desire to develop credible constructs for each participant, along with the goal to share those constructs, created a burden on the confidentiality and informed consent procedures. In order to eliminate this ethical issue, this constructivist study openly discuss the concern for anonymity and confidentiality with each AC participant, so that they were able to make a decision on their continued

involvement. All twelve of the AC participants signed both the Participation Agreement as well as the Letter of Informed Consent; however, one participant did not want to be tape recorded.

Political Issues

From the outset, there was a strong commitment by this constructivist researcher to sharing of political power as well as a high degree of honesty and transparency. Fundamental to this study was the development of true partnerships with study gatekeepers and AC participants, as well as a commitment to ensure that all processes and products (constructs) were discussed and agreed upon at the initial stages of the study's interpersonal interactions.

The Role of Technology

Even though trust and project commitment are largely built upon interpersonal communication as the center stone of the constructivist paradigm, technology does play a role in the engagement process. The researcher in this study used a smart cell phone, laptop and iPad to gather, retrieve and store information and maintain schedules. The data gathered from the individual meetings was digitally recorded on the researcher's iPad device, as well as on their cell phone as a back-up. Once the individual AC participant meetings were completed, the researcher used an online service in order to obtain written transcriptions of each hour-long meeting. After the individual AC participant

interviews were completed the researcher download the written transcriptions into the Atlas.ti software in order to capture the units of information using both open coding, as well as arranging larger categories of information using axial coding.

Chapter Summary

This chapter contained the manner in which this constructivist research study has conducted the engagement portion of this project. The elements of that process included various plans to identify the subject sites; plans to engage the subject site's gatekeepers and Advisory Committee participants; methods of how the study will develop various self-preparedness procedural plans; the procedures relating to issues of diversity, ethics and politics; and finally, how the study used technology to simplify certain project related tasks.

CHAPTER THREE

IMPLEMENTATION

Introduction

This chapter outlines the specific steps that were used to carry out the implementation of this project on mental illness focused, social service programs for the aging community, in a central California county region. This chapter will address the key implementation topics to include the participant selection process and procedures, identifying potential study participants, the methods used in data gathering, recording and analyzing, the termination and follow-up of the study and finally, the techniques used for the communication and dissemination of the results.

Selection of Participants

Within the constructivism paradigm the selection process may seem like a somewhat random process of identifying subject matter experts and then verifying their willingness and availability to participate. In order to provide a more strategic approach from which to form the list of study sites as well as Advisory Committee (AC) participants, this study selected from Patton's "purposeful sampling" strategies (Patton, 2002). After a thorough review of Patton's sampling methods, this study actually implemented four of these strategies in unison. These four strategies make up this study's Plan for Purposive Sample Selection (Appendix E), which achieved a well-rounded and

effective AC selection process. The first such sampling method was the “homogeneous sampling” of organizations that provide social services to the elderly population within the research site area. The organizational listing provided in Chapter 2 is such a homogeneous sampling, in that each of those organizations or public agencies impact the elder community in the research site’s geographical territory. That listing was used to start the identification process for the organizations and agencies amenable to providing a representative willing to participate as either a gatekeeper or AC member.

The researcher contacted each of these organizations or agencies using a three-step process. First, the researcher sent out a letter of solicitation to an identified upper level manager via certified mail with signature receipt. An example of the form letter that will be used is attached as Appendix A. If the intended manager did not respond to this solicitation letter within 4 business days, the researcher then moved to the second step of the three step Plan for Engagement, that being a follow-up e-mail. A sample of the follow-up solicitation e-mail is attached as Appendix B. If there was still no response after a three-day period, then a final attempt at a connection was made via phone call directly to the manager. These phone contacts were maintained on the HDC/AC Member Call Log depicted on Appendix C. If this third step elicited no response, then that particular study site was either crossed off the list, or depending upon the researcher’s opinion of the importance of the organization or agency, another upper level manager was identified and the three-step process began again.

The second sampling method that was applied to this study was the “snowball or chain sampling” process. In practice, this method aligned well with the information gathering premise of constructivism, in that as the study unfolded the researcher was led to various study sites, via referrals, that blended with the existing AC members. The premise here was to apply the maximum amount of search parameter flexibility as possible when moving through the study site search process. When using this chain sampling method, the researcher either contacted the referral direct via telephone, or used the same three step connection process as mentioned above. As the researcher met with and developed working partnerships with various gatekeepers or AC participants, a request was made for referrals or suggestions of additional participants that were appropriate additions to the team of professional advocates.

The third purposeful sampling method that was used was “opportunistic” or “emergent sampling”, which provided the researcher the ability to make an on-the-spot decision to incorporate a particular person, agency or organization into the three-step connection outreach process, or to make an impromptu face-to-face presentation of the research study and to directly request participation. This opportunistic sampling style provided the researcher the ability to immediately capitalize on the availability or interest of a particularly strong candidate.

The fourth and final sampling method was the “politically important case” sampling, which used the politics of the setting to decide on whether to incorporate a potential candidate, agency or organization as gatekeeper or an

AC participant. In this study, an example of this method was the decision to solicit, and finally obtain participation from both a county politician, as well as high ranking agency manager; both of which dramatically effected other agency and organizational managers in their decision to participate.

Study Participants

This section goes into greater detail on the necessary steps for connecting, negotiating and partnering with the various study sites, gatekeepers and AC participants located within this research site. Inherent in the constructivism paradigm is the notion that the listing of study participants builds over time, as new information, relationships and referrals are acquired. This optimal flexibility permits the expansion of various study sites, their gatekeepers, and the AC participants, in a dynamic, seemingly self-fulfilling manner.

Other than the participant sampling methods mentioned in the previous section, this study also identified key study sites, then worked to augment the AC participant list based on a combination of their potential impact, their availability and their willingness to participate. In order to select study sites within the research site, this study explored various professional, educational and social networks. These networks included contacts gained within the university system, those who worked in social service governmental agencies, managerial employees of non-profit and private sector services to the elderly community, and most importantly, professional referrals that were provided during the networking process. This identification process sought a high level of professionalism, those

with a significant level of knowledge, experience, connection or political savvy within the area of mental health services and/or the elderly population. The goal was to identify who the key policy decision makers were and find methods to gain access to them in order to secure a commitment of participation either as a study site, gatekeeper or AC participant.

Once the study sites were identified, the commitment of participation would require high amounts of interaction over prolonged periods of time. So naturally trust was a vital component to maintaining the relationships with the gatekeepers and AC participants. These participants were vital members of the stakeholder group since they have strong influence on future policy decisions or programmatic interventions within the community.

As a matter of practice, the overall list of both the study site gatekeepers as well as the AC participants expanded and contracted over the length of the study through additional need, withdrawal, and referral. The following is the final list of AC participants (specific names removed for confidentiality), which was comprised of seventeen (17) local executive level leaders representing twelve (12) organizations or government agencies that provide social services to the aging population of the subject research site. Of note, not all seventeen of those that participated in the individual construct building process were able to attend the joint member check meeting. Yet, this study was extremely fortunate in that every study site was represented at the member check meeting, and all

participants had high level managerial decision making authority for their associated organization or governmental agency.

Elderly Mental Illness Research Project: Advisory Committee

1. Captain, County Sheriff's Office
2. County Supervisor, Board of Supervisors
3. Director, Commission on Aging
4. Director, Alzheimer's Association
5. Executive Director, Transitions Mental Health Association
6. Executive Director, Area Agency on Aging
7. Director, Transitions Mental Health Association
8. Executive Director, Long-Term Care Ombudsman
9. Director, Community Action Partnership
10. Executive Director, Wilshire Community Services
11. CEO, California Association of Adult Day Services, Sacramento
12. County Sheriff, County Sheriff's Office
13. Division Manager, Department of Social Services
14. Department Manager, County Adult Protective Services
15. CEO, Community Action Partnership
16. Chairman, NASW; LCSW, County Mental Health Services
17. Division Manager, County Mental Health Services

Data Gathering

Once the researcher had enlisted AC participants, the study then entered the data collection process by implementing its Plan for Data Collection, illustrated within Appendix E. This process occurred through face-to-face interviews with each of the AC members individually, and then subsequently with all AC members at the member check meeting. In order to establish basic participant ground rules, the researcher implemented the Plan for Negotiation (Appendix E), by requesting participants sign both a Study Participation Agreement (Appendix F) as well as a Letter of Informed Consent (Appendix G).

As an organization tool specifically designed for the one-on-one individual meetings the researcher instituted a four-step participant interview process. The first step was one of preparation for both the researcher and the interviewee. This step entailed completion of the following: first, the researcher ensured that the interviewee (AC participant) had reviewed and signed both the Participation Agreement and the Letter of Consent; next, the researcher updated and maintained the study's research journal; then, the researcher reviewed the most recent information on the study site and interviewee; and finally, the researcher attended the scheduled interview. In reference to the research journal, the researcher maintained a single journal that contained both the narrative account of what was occurring during the study as well as any reflective notes regarding research rationales, data collection issues/results and analysis decisions.

The second step was to ensure that the content of the discussion was recorded for future use. The researcher also made hand notes that were later placed into either the research journal, the written transcription summary or the Atlas.ti software.

The third step was the one-on-one interview itself. During the interview, the researcher focused on building trust, comfort and familiarity using elements of engagement, then by using the pre-prepared questions (Appendix D) developed a focus, which was maintained through the termination phase. Of course, as with any conversation, the researcher remained flexible with this process, with the intention of being culturally competent and socially responsible, while still obtaining the research data that was needed. These interviews took from 45-60 minutes and were conducted in a question, answer and general discussion format. In keeping with the flexible nature of the constructivist approach, the interview questions were updated over time.

The fourth and final step of the interview process was the termination of the interview, which was signaled by the researcher offering a summary of the discussion, asking the interviewee for additional feedback, and then addressing any questions or concerns that were brought up. The final comments of the researcher provided details of next steps to include the transcription phase, presentation of a draft individual construct to the interviewee, completion of any required edits and finally a discussion of the member check meeting.

Data Recording

The raw data received from the individual one-on-one interviews as well as the member check meeting was collected by the researcher via digital recording and hand notes. For the individual interviews, the recording was done both by a digital recording device (iPad computer) as well as on the researcher's cell phone as a back-up device. However, when it came to the member check meeting it became clear that the audio recording devices that had been used for the individual meetings was insufficient for the large group conference room. The researcher had to hire a professional audio technician to record the large joint member check meeting. This technician used a mixing board with multiple microphones in order to adequately separate the various member's voices and to obtain a clear enough recording that could subsequently be transcribed into written format.

Data Analysis

The data analysis of this constructivist study used a typical qualitative analysis framework. This study's Plan for Data Analysis (Appendix E) illustrates that the data received from both the digitally recorded one-on-one AC member interviews, as well as the member check meeting were transcribed by an on-line service and then uploaded into the Atlas.ti software for continued analysis. Within this software, the researcher utilized open-coding to break down the narrative of these interviews into categories that were used in microanalysis. In this process the researcher took chunks of narrative data that seemed to have

intrinsic links and developed important conceptual themes or categories. The researcher then took this process one step further and engaged in axial coding; a procedure for linking these evolving categories and making statements about the relationships between these categories and their dimensions. This type of data analysis assisted the researcher in the drafting of both the interviewee's individual construct as well as the initial AC joint construction.

Termination and Follow-up

The AC joint member check meeting with its finalization of the initial joint construct was the project termination as it related to the AC participants as a group. The function of this meeting was to guarantee the credibility, dependability and conformability of the shared draft joint construction. In order to add structure to the meeting, the researcher created a meeting agenda (Attached as Appendix H) that was distributed via e-mail well in advance to all of the AC participants, with a request for review and input prior to the joint member check meeting. At this meeting, the researcher became not only the reporter of data, but also the group facilitator in order to ensure that all revisions were adopted into a revised joint construct and that AC members took ownership of the study's task oriented planning phases. As a facilitator, the researcher worked to assist with the understanding of the initial joint construction's content, but also motivated the AC members to collaborate in taking an active commitment in continuing the project's action steps. There was discussion on the follow-up procedures that could bring the AC members back together, yet it was concluded

that while the meetings content warranted additional discussion, it would better serve the members to address the issues at one of the more well-established public meetings.

The importance of this meeting cannot be overstated, it was the cornerstone of this constructivist paradigm project; it was where the initial joint construction was first discussed, and where action oriented tasks were considered and tentatively planned. The termination phase included a commitment by the researcher to maintain close connection with each AC participant, and to forward the revised joint construct to all attendees. In practice, the participants understood the meeting's content, took ownership of the initial joint construct and were looking forward to receiving the revised joint construct.

Communication of Findings and Dissemination Plan

After the university has reviewed and approved the content of the completed project, the distribution of the revised joint construct along with the project's findings will be undertaken by the researcher. Since the researcher is not a long-time resident of the research site, he will look for direction from the AC members as to an appropriate dissemination plan that will be appropriate to the research site. This plan will undoubtedly consist of an e-mail distribution of the joint construct to all AC participants, face-to-face executive summary discussions with gatekeepers of various interested organizations or agencies, and scheduled formal presentations to various local board meetings, interest groups, organizations or agencies. The researcher will also provide CSUSB's social

work department with a digital presentation that can be used during their project presentation day ceremonies.

Chapter Summary

This chapter has outlined the specific steps necessary to carry out the implementation of this project on mental illness focused, social service programs for the aging community, in a central California county region. The constructivism paradigm was used due to its hermeneutic dialectic circle orientation of obtaining a mutually agreeable, subjective joint construct. This chapter has addressed the key implementation topics, which included an initial listing of potential study participants, the participant selection approaches, the various methods of data gathering, collecting, recording and analyzing, as well as the termination and follow-up of the study, and finally, the techniques used for the communication and dissemination of the results.

CHAPTER FOUR

EVALUATION

Introduction

This chapter focuses on the evaluation of data received during the research portion of this project. After each of the twelve (12) meetings that included all seventeen (17) Advisory Committee (AC) members, the audio recordings were sent for transcription. Upon receipt of the written transcriptions, the researcher forwarded the transcripts to those attending the confidential meetings for review, editing and approval. Authenticity and credibility of the interview process, transcription review, participant confidentiality, data analysis and the implementation of the joint member check meeting was ensured through CSUSB facility advisor oversight.

The transcripts were then analyzed using a bottom-up approach via open coding, through which categories or themes of information were shaped in order to give the initial dimensional view of each interview narrative. Once this open coding process was completed for all twelve narratives, the researcher undertook further analysis using the axial coding process, which resulted in the identification of relationships between the categories. At this point The Advisory Committee's initial joint construct for the elderly mental illness service programs in this central California region was reviewed and suggestions for edits were received during the member check meeting of September, 28, 2017.

The information gleaned from the axial coding process as well as the member check discussion became the source data for the generation of five action oriented initiatives, as well as the overall revised joint construct. These documents establish a credible summary or inclusive interpretation of the emerging conditions surrounding elder mental illness services in this central California region's organizations and government agencies.

Open Coding

With the assistance of the Atlas.ti software, the researcher used the microanalysis tool of open coding to transform the participant approved, transcribed written interviews into chunks of data. After much aligning and realigning, the specific core themes were ultimately identified as: 1) general information; 2) existing programming; 3) lack of funding; 4) sensitivity to aging and mental illness; (5) leadership and (6) service gaps. Each of these six patterns represented the major conceptual elements that were key to the communication that transpired within the participant interviews.

This process provided the researcher with a more in-depth and rich perspective of the interview, which then lead to the generation of the participant's individual construct. The initial draft of the individual construct was then forwarded to the participant(s) of the interview in order to obtain their review, potential edits and final approval.

General Information

Of the six comprehensive themes or categories that emerged from the open coding process, the general information theme was not only the broadest in nature, but more importantly set the stage for more focused analysis within the axial coding process that followed. This code represented specific segments of data that assisted by defining elements of the elder mental illness research topic in this central California county. This code represented eighteen (18) separate segments of data, which included either specific facts or a more broad based discussion topic. For example, a brief data set included information such as 16%, or approximately 44,650 of the research site's population were seniors. Another more specific data set represented that the current approved county budget encompassing the research site, allocated only 7.8% or \$153,000 of the available discretionary funds (\$1.9 million) toward elder programing.

On the other end of this data set spectrum were summaries of factual information that tended to lead to more broad based discussions. One example of this is that the county represented by the research site is not only the fastest growing county in the state of California, but also is ranked #2 in the state for counties with the least amount of poverty. Another hotly debated topic represented as a key data set within this general information code, is the fact that the county agencies responsible for mental health within the research site, will not provide treatment for patients with either Alzheimer's or any form of dementia, since they deem these conditions as not being a mental illness.

Other data set examples include an enduring negative stigma mental illness and the aging process in general, and the severe lack of affordable senior housing within the county.

Existing Programing

The Existing Programming code was the largest data set, containing 44 separate coded data segments. Similar to the General Information code above, the Existing Programing open code contained data summaries representing broader based discussions of existing non-profit and governmental agency programming, as well as specific, fact based data sets, which helped to understand the research site's achievements as well as struggles providing service to various segments of the elderly community.

In relation to broader based discussion topics within this code, one which came up in numerous interviews was the issue of the County Sheriff's jail being used as the default mental health housing agency: over 40% of the inmate population are prescribed with psychotropic medications, requiring staffing and resources to care for these mentally ill inmates. Another broad topic is the relatively small number of elderly mentally ill patients that are served by county agencies. The county's main program that services senior mentally ill patients is the Full Service Partnership (FSP), which in 2016 served less than 20 patients. Other broad topics are the need to increase the number and scope of Psychiatric Health Facility (PHF) units and Adult Day Care facilities.

Also within the Existing Programming code is a data set that can be viewed as more specific information that relates to either individual programs or service needs. An example of such data would be the “211” phone information resource line that has been a good community service to the elderly population, providing adequate definition of and referrals to various senior services. Additional examples are the Area Agency on Aging’s *Senior Information Guide*, which could only be improved through funding for a broader distribution, and that the senior population within the research site is due to suffer a 63% increase in cases of the Alzheimer’s disease within the next decade.

Lack of Funding

This code was the single most identified issue throughout all of the AC member discussions as well as the member check meeting. However, even though it was clearly the most impactful topic, it was also the subject with the least number of solutions. When the topic was broached by the researcher, it was usually placed into the broad categories of increased governmental funding intervention, tapping into new philanthropic resources, or an overall increase in societal willingness to assist the elder population. The underlying element seemed to return to the prevailing stigma of ageism. Many of the AC members noted that it is easier to raise budgetary funding for causes such as children and animals than it is to gain financial momentum for our aging cohort.

Sensitivity to Aging/Mental Illness

As mentioned above there is a substantial stigma to the process of aging, yet the topic of this research also layers on another equally distasteful societal subject, that of the condition of mental illness. As the literature review mentioned, among numerous cultures around the world, the often taboo topic of mental illness tends to be shameful to families, as well as awkward for the patients themselves. Yet, as in the context of this research, when the topic of discussion combines these equally subjects, the unfortunate societal reaction is not one of empathetic project creation or financial support.

Much the same as in the Lack of Funding code, this Sensitivity to Aging and Mental illness code presented a great deal of acknowledgement, yet little in the way of future planning or solutions. One glaring exception is the description of the County's mental illness stigma campaign that used MHSA funding to deliver a multi-layered public outreach program to help reduce the distain that many attach to the topic of mental illness. This program entailed several levels of advertising along with a staff driven educational outreach, which included speaking engagements, classes and group sessions. This campaign did not focus on one particular age group, but from the perspective of those County staff involved, it was well received by the community at large. It has been over a decade since this work was undertaken, so the timing of this material is somewhat dated, yet there is clearly a regional precedent that has been set on this issue.

Another data set that belongs to this topic of stigma is the reluctance of self-reporting when it comes to aging mental illness. For an aging person in today's society there are numerous reasons to suffer from depression, anxiety and stress. However, according to this data set a large percentage of these cases go unreported due to stigma related judgment from others or that is self-generated.

Service Gaps

The service gap code was a close second to existing programming, with forty (40) individual data sets that were identified within the open coding process. This number is noteworthy in that decision making AC participants were as quick to discuss aspects of their existing programs, as they were to not only admit that service gaps exist within the community at large, but were willing to openly discuss where and how these gaps could be overcome with sufficient time and resources. The service gap open code was viewed by AC participants as critical data sets since each represented a component of future community improvement. Given this emphasis, the service gaps open code was also ranked by the number of times each was repetitively coded within the Atlas.ti software. Since there was a large number of open codes within this grouping, various AC participants suggested to initially focus on the top ten service gaps. This listing begins with the service gap that had the highest level of repetitive codes: 1) Alzheimer's/dementia as a mental illness; 2) Affordable housing; 3) Affordable transportation; 4) Additional adult day care centers 5) Psychiatric Health Facility

(PHF) expansion in number and scope; 6) Full Service Partnership (FSP) efficiency; 7) Mental illness/aging stigma; 8) Lack of Geriatric Psychiatrists; 9) Remove law enforcement from mental illness equation; 10) Centralize county senior care.

Due to the large number of data sets only a few examples will be provided here, but during further analysis all of the information within these data set was used to help arrive at initiative action steps. One preeminent, often mentioned service gap was the overwhelming lack of affordable housing. For a county such as this research site, the most plausible solution is for the governmental agencies or non-profit organizations to work in tandem to create projects that combine Federal, State and local funding, along with tax incentives and zoning regulation flexibility to create subsidized, affordable housing projects available to the senior population. Similar project partnership could be established to help fund and maintain other senior oriented facilities such as independent care, adult day care and the more intensive care of nursing homes.

Another topic often mentioned was the expansion in both the number and scope of the Psychiatric Health Facilities (PHF) in the research site. Currently there is only one sixteen (16) bed facility that has severely constrained admissions criteria that all but eliminate many elderly patients.

On a more local scale is a gap that was also brought up numerous times, the management of their Full Service Partnership (FSP) program. This program is funded with \$450,000 of Mental Health Services Act funding, for which less

than twenty (20) seniors with mental health were served in 2016. The concern raised by several AC participants was that over \$22,500 per patient seems to be an over allocation of scarce funds.

Leadership Opportunities

This open code data set was not one of the largest, yet once the researcher began to observe the interrelationships between the high number of service gaps, lack of funding issues and existing programming constraints within the research site, it became clear that the momentum generated through solid leadership was an important topic.

For this open coding section, specific examples of leadership opportunities are as varied as many of the open coded data sets. This study will point to leadership initiative opportunities that community decision makers can focus upon in order to make progressive strides for long-term solutions.

Axial Coding

Once all the interviews and individual approved constructions had been completed, the researcher undertook the axial coding portion of the analysis. With this continued analysis, the researcher noticed that five action oriented topics emerged, representing the areas where the local governmental and organizational decision makers might want to focus their attention.

Rather than limit the discussion of these initiatives to a linear dimensional framework with a protracted narrative, the researcher chose to use visually descriptive flowchart illustrations (conditional matrices) to more succinctly

represent these five action oriented initiatives. Below is both a brief narrative description of each of the five initiatives, as well as their individual EMHI flowchart (Elder Mental Health Initiative Flowchart). In an attempt to provide a visual standard for all five initiatives, an eco-map legend with its common structural components is provided below as figure 1.

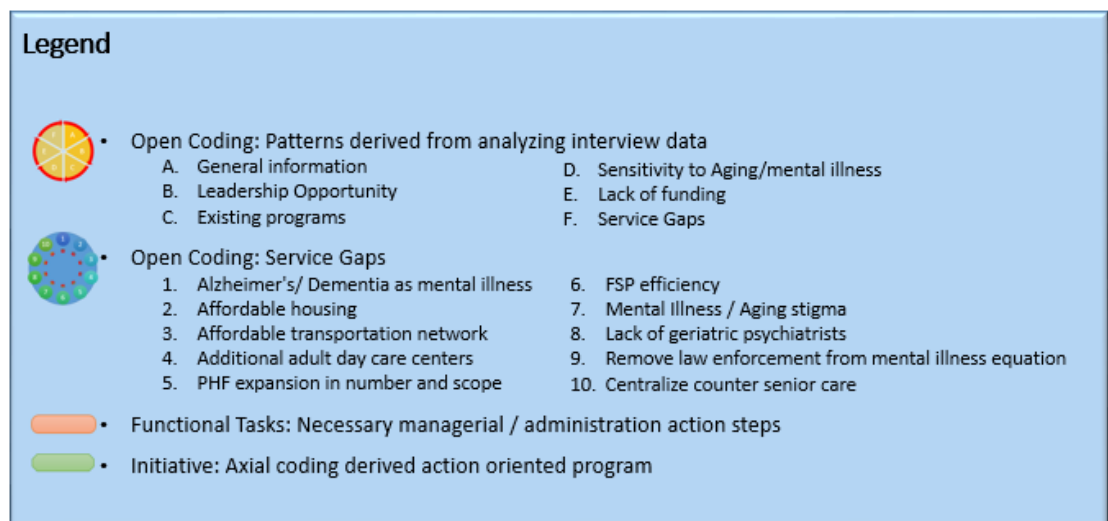


Figure 1. EMHI Flowchart Legend

As can be seen within the figure 1 legend, each flowchart contains a series of structural component icons that represent data sets, functional task steps and information directional flow that culminate in the progression of the subject initiative. Figure 1 helps to define these icons and direction flow arrows with brief narrative descriptors, which support the flowcharts in their effort to

depict the flow of open coded data sets, through the managerial and administrative functional tasks and ending with the process of undertaking the subject initiative. Beyond the open coding references, each flowchart is meant to illustrate the constructivist's axial coding process, as well as the AC participants description of necessary functional steps that lead to the introduction of the five action oriented initiatives described below.

Elder Mental Health Initiatives

Leadership. Figure 2 represents arguably the first action oriented initiative that needs attention. After reviewing the interrelationships between the open coding data sets, particularly those found within the service gap data set, it was clear that there are a large number of outstanding services that need appropriate leadership in order to gain political, monetary and community support-related momentum.

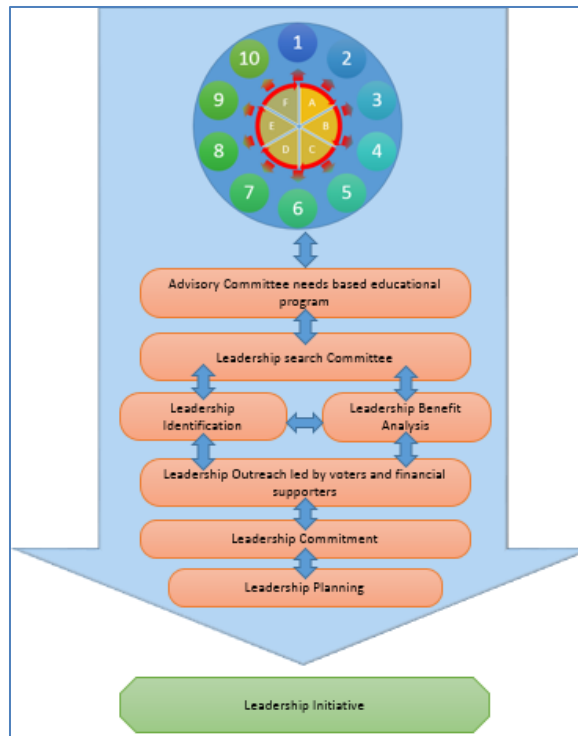


Figure 2. EMHI Flowchart: Leadership

At the top of figure 2 is a diagram illustrating an inner circle of descriptive and informational open codes, with an outer circle of the top ten service gaps. As can be seen, there is an abundance of interrelated informational transfer, denoted as incoming and outgoing arrows between all of this data. This pictorially represents the interplay between the information contained within these data sets, as well as the continued future interplay between the AC participants who originally supplied those data sets. As one progresses down the page the arrows illustrate that there continues to be a give and take relationship between coded data sets and the functional tasks.

The first functional task of figure 2 illustrates that in order for the AC participants to recruit initiative leaders, they will need to generate a needs-based educational program to illustrate the necessity for the improvement of services for the elderly mentally ill community. Some of this educational outreach will be performed as an element of this research study, which is outlined in the next chapter on Termination and Follow-up. While the community at large as well as its leaders are being convinced of the need for action, AC participants will initiate a leadership search committee in order to identify proven leaders, as well as gain an understanding of what may motivate these leaders to commit their energy, time and resources to these initiatives. Once these leaders have been properly motivated to assume leadership roles, the AC participants will engage in the leadership planning phase in order to best utilize this newly developed team of decision making leaders.

Funding Campaigns. As can be seen from the Fundraising Campaign(s) Initiative flowchart depicted in figure 3, the researcher took data sets from the open coding process, particularly those from the service gap data set, to arrive at numerous funding needs, initiative-wide. From that point the flowchart illustrates what certain AC participants felt were the necessary functional steps in order to arrive at a fundraising campaign initiative.

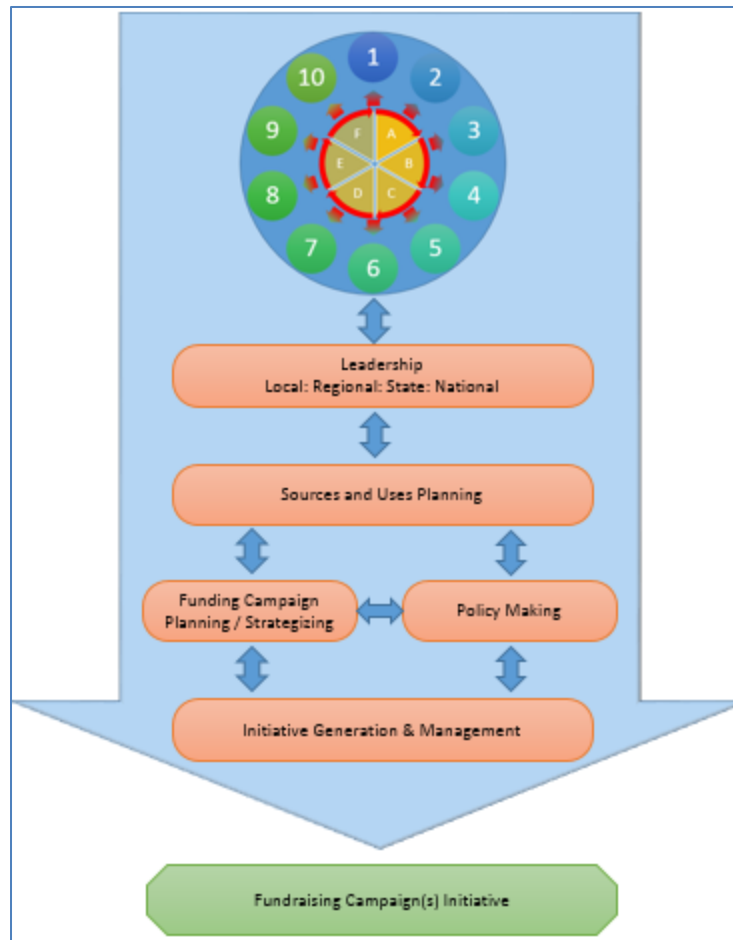


Figure 3. EMHI Flowchart: Funding Campaign(s)

Figure 3 illustrates that the first key element in this initiative will be the gathering and commitment of appropriate local, regional, state and national leaders that share interest in a specific initiative or an initiative-wide effort. In the sources and uses of funds planning stage, these leaders will need to understand and share available existing funding sources (State, Federal, Private Foundation, Corporate Foundation and interagency) as well as potentially plan for the self-

funding through community-wide tax levies. At this source and use level, these leaders will need to agree upon program prioritization for funding, along with amounts needed for each program or initiative. As represented in Figure 3 this initiative will continue with planning, strategizing, policy making and finally with the generation of specific action steps for either individual initiatives or initiative-wide campaign implementation.

Elder Sensitivity Campaign. Recognized as one of the top ten service gaps, the importance placed on the improvement of the existing mental illness and aging-related stigmas is of great importance to the AC participants of this study. The focus of this action oriented initiative would be to combine the topics of aging and mental illness to create a community campaign with the objectives of topic education, symptom acceptance, service awareness, leadership-champion identification and public recognition and support.

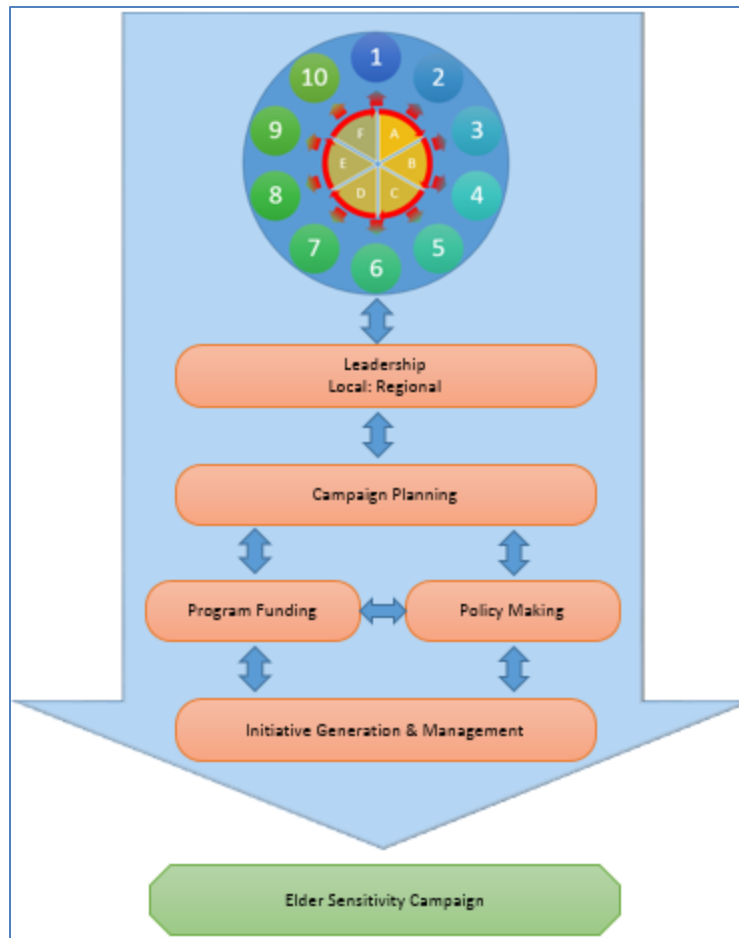


Figure 4. EMHI Flowchart: Elder Sensitivity Campaign

Figure 4 graphically illustrates that once the distinct pattern of the elder sensitivity campaign was identified, then certain managerial tasks were undertaken in order to implement the initiative. As with other initiatives, the local and regional leadership component would be the first action oriented task, following by campaign planning, program funding, policy making and culminating in the initiative's generation and management.

Enhancement of Existing Programming. Once the researcher analyzed the existing programming and service gap open coding, it became evident that certain community service shortcomings could be effectively handled by enhancing existing programs, rather than creating new ones. This was immediately apparent in several governmental agency and non-profit organizational programs. Figure 5 illustrates the axial coding and functional tasks necessary to assist with existing program enhancement.

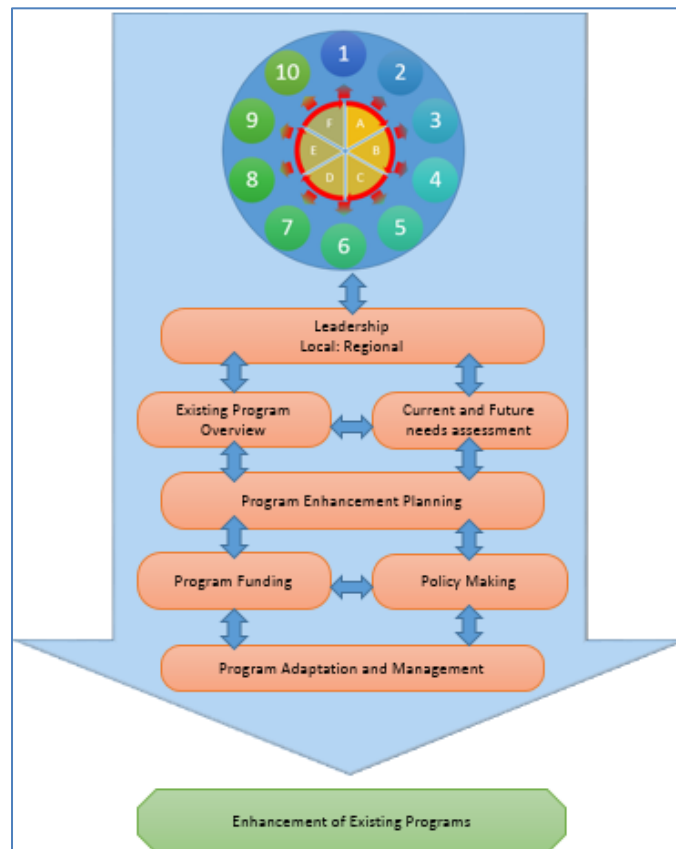


Figure 5. EMHI Flowchart: Enhancement of Existing Programs

This initiative will require supportive resources from some of the other five initiatives, most pointedly leadership, fundraising and the elderly sensitivity campaign. With the influx of renewed public interest (sensitivity campaign), additional funding and committed leadership, existing programs that may have struggled due to a lack of resources, may find the ability to transform into efficient and effective public services. Figure 5 demonstrates that local and regional leadership must understand the dynamics of existing programs as well as assess future programmatic needs. Then, program and community leadership will attain program funding, help set new policies and continue to adapt and manage the program to maintain superior service to the community of mentally ill elderly patients.

New Program Expansion. Much like the previous initiative, the new program creation works with the open coded information for both existing service needs, along with a certain amount of informed speculation on future circumstances, to arrive at programmatic solutions to community needs. Represented in Figure 6 is the new program expansion initiative, which requires strong leadership to provide momentum on topics such as existing programming overview, needs assessment, program funding and policy creation. Once these issues have been analyzed, directional decisions made and program creation and roll-out underway, then comes the administrative tasks of program management and follow-up.

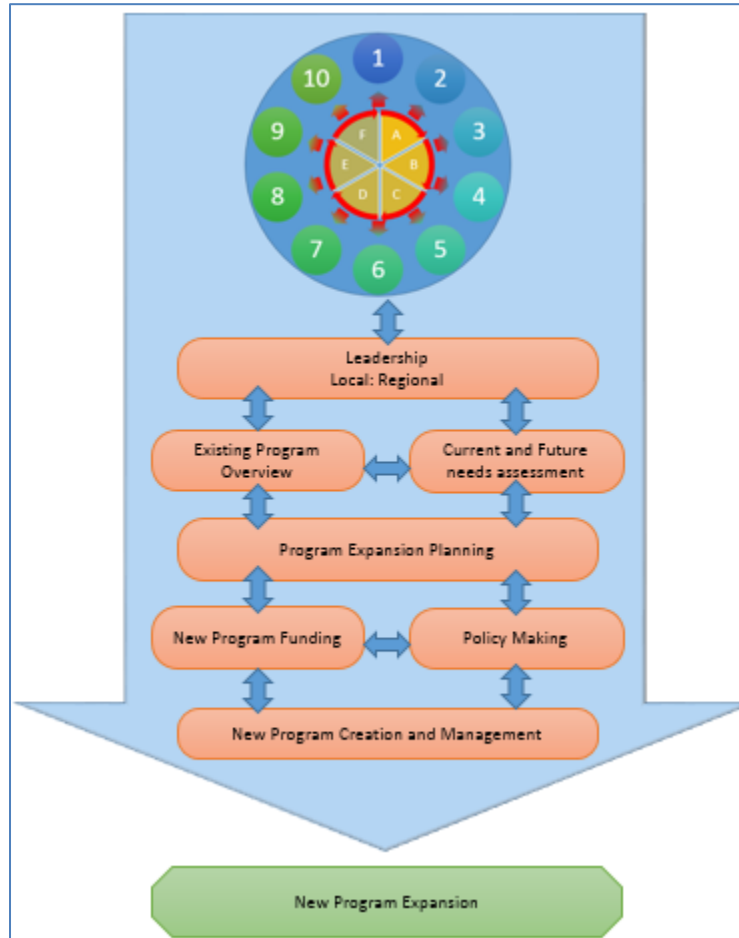


Figure 6. EMHI Flowchart: New Program Expansion

Overall Initiative Implementation

Once all five of the above initiatives were individually created, the thought process then shifted to how best to implement the overall initiative. Like fingers on a hand, the five initiatives are more useful if thought of in the aggregate, and

used like a macro intervention tool. However, once AC participants reassemble and begin to strategize how best to begin, they will be faced with the dilemma of which initiative takes precedence. Regardless of which measure is the impetus for programmatic expansion, the fundraising campaign initiative will be an imperative element of the future success of the elder mental health initiatives within the research site.

Implications of Findings for Micro and Macro Practice

This research study contributed to the knowledge of the social work practice at both the micro and macro levels of human social service organizations and governmental agency practice. The preceding chapter on assessment pointed out that in light of the tremendous number of seniors nationwide due to the baby boom generation, there are still few governmental agency resources (macro environment) in central California dedicated to the treatment (micro environment) of mental illness, and certainly none with a focus upon the elderly population. This study's research provided a large number of solution based data sets that could be applied within both the macro and micro environments. However, the five action oriented initiatives provide direct micro and macro interventions that will impact the research site within a central California municipal county region.

Micro Practice Implications

This research study augmented micro social work through both direct and indirect mechanisms. Through interviews with AC participants, a large number of

data sets (over 80) provided detailed information on existing service programming and service gaps that directly pertain to individual or group therapy intervention. Specifically, the content related to the types of client-centered services provided within the County's Full Service Partnership (FSP) program, the explicit services available for county residents afflicted with Alzheimer's or Dementia, or the mental illness patient directed services that are provided by local law enforcement agencies. This study has identified both existing micro program interventions and well as desperately needed programs that would bring particular client focused services to the elderly population with mental illness within the research site. From the service gap data sets it is clear that the elderly mentally ill community is in strong need of specific service interventions where their defined needs are addressed. Some of these needs include affordable treatment managed housing, subsidized transportation and additional, affordable geriatric psychiatrists in order to provide medication management.

Macro Practice Implications

Since the AC participants were all leaders within the regional elder services segment, a large portion of the programmatic issues and solutions that were discussed focused on the macro processes of change. The five initiatives were a testament to this trend, in that they are community based campaigns that require extensive inter-governmental and organizational collaboration. As mentioned, the macro components of each of these initiatives will require continued committee based strategy sessions in order to decide upon the most

effective course of action for successful implementation. In order to proceed, AC participants will need to jointly assess numerous issues to include: the sources and uses of funds, how best to generate community support, which leaders will be most instrumental in lobbying for political backing, how best to attract the commitment of these leaders and how best to expand existing programs or develop new ones. In order for the five initiative programs to be effective, the AC participants will need to manage these macro system elements in order to produce the community's desired micro interventions.

Chapter Summary

This chapter has summarized the evaluation process that was performed on the research data gathered from the AC participants. From the transcripts of each of the twelve (12) meetings with all seventeen (17) Advisory Committee (AC) participants, came the open coded analysis that was derived through the use of the Atlas.ti software program. This bottom-up coding process produced categories or themes of information which shaped the initial dimensional view of each interview narrative. These open codes formed the basis for further analysis using the axial coding process, which resulted in the identification of relationships between the categories. The information gleaned from this exercise produced the twelve individual constructs, as well as the initial overall joint construct that was reviewed at the member check-in meeting and will be discussed in the following chapter. After the conclusion of the interactive, discussion based member joint check-in meeting, a network of evolving action oriented initiatives

later became apparent to the researcher, from which the five (5) illustrative flowcharts were assembled. As mentioned, these conditional matrices or flowcharts, include the themes, patterns and interrelations that were the result of the AC participant meetings, the Atlas.ti open and axial coding, as well as the researcher's ability to connect the aggregate of this data into a synthesis of action oriented tasks and pertinent information.

CHAPTER FIVE

TERMINATION AND FOLLOW UP

Introduction

This chapter identifies the termination and follow-up that the researcher undertook in order to develop the set of five action oriented initiatives from this constructivist based research project. One of the final tasks of the collaborative working relationship between the researcher and the AC participants was to plan, schedule and implement a formal member check-in meeting. During this meeting the researcher used a prepared agenda to guide the AC participants through a review, discussion and an editing process of the initial draft joint construct.

During the AC member check meeting the initial joint construct was reviewed, analyzed, edited and an agreement was reached to have the researcher pull together a revised joint construct. The previously mentioned five action oriented initiatives, along with their respective flowcharts, were created subsequent to the member check meeting and will be incorporated into the revised joint construct and distributed to AC participants upon university review and approval of this project document. These finalized documents establish a credible summary or inclusive interpretation of the emerging conditions and potential solutions that surround elder mental illness services in this central California region's organizations and government agencies.

Communication of Findings

This study was extremely fortunate in that the researcher was able to assemble a hermeneutic dialectic circle, or as the participants referred to it, the Advisory Committee (AC), made up of top level leaders representing the fields of senior care, mental illness, political leadership and law enforcement. This high level of seasoned expertise was vital in producing such a broad range of insightful data. Communications needed to be professionally succinct and overall program expectations clear at the onset, with little room for changes or interruptions during the process. With these understandable constraints in mind, it was determined that once the individual constructs were approved by each interviewee, the researcher would then develop an initial draft joint construct, present it to all participants individually via e-mail, and then discuss the edited draft at the AC member check meeting.

The initial joint construct was forwarded to all participants in preparation for the scheduled member check meeting. This all participant meeting was held on September 28, 2017 and consisted of twelve of the seventeen interviewed AC members. Even with a few members unable to attend due to scheduling conflicts, every agency and organization had representation and was able to comment on the initial joint construct.

For this meeting, an audio-visual consultant was hired to record the meeting, and the use of a conference call-in function was used for an out-of-town subject matter expert and one AC participant who was based in a remote

location. The subject matter expert was from the UCLA Center for Health Policy Research, a doctoral professor and co-author of the California Mental health Older Adult System of Care Project. Her role was to call into the meeting, deliver vital statewide research based information on the subject of elderly mental illness programming, be available for a brief question and answer session with the AC participants, and then exit the meeting to leave the participants to discuss their initial joint construct.

The meeting was facilitated by the researcher using the agenda as illustrated as Appendix H. The purpose of the check-in meeting was to gather together as a hermeneutic dialectic circle, review the initial joint construct, gather and discuss additional information, obtain edits or additional comments on the construct and discuss next steps for the group. All of these tasks were accomplished pursuant to the agenda and a commitment was made by the researcher to redraft the joint construct as an element of the completion of this five chapter research project. The researcher committed that all findings would be provided to the participants, including a revised joint construct, after the project's final document was approved by the university.

Study Termination

From the initial introduction of this research study to the various AC participants, the researcher set the expectation that participants were committing to a research process that entailed four components: an initial in-person recorded interview, co-development of their individual construct, their review of a

digital draft initial joint construct, and their attendance at a final member check meeting in order to provide final input on an initial joint construct. The participants were informed that if after receiving the final project summary documentation they wanted to meet with the researcher to discuss the project's outcomes, that request would be happily granted.

During the meeting, it became clear that the initial joint construct would require editing in order to incorporate the various discussion topics that had been considered during the meeting. During the conclusion of the meeting, the researcher modeled the constructivist paradigm and encouraged the participants to use the information contained within both the initial joint construct, as well as the open discussion of the check-in meeting, to further assist the mental ill elderly within the research site. The member check meeting concluded with a commitment by the researcher to connect with several organizations for project presentations once university approval was granted, and maintain connection with the AC participants through the completion of the project and university approval. After the meeting concluded, a strong majority of the participants remained to continue the discussion and conduct further networking.

Ongoing Relationship with Advisory Committee Participants

The topic of next steps for the Advisory Committee was discussed as an element of the agenda. The conclusion reached by the AC participants was that there were existing committees and independent meeting groups that focused on the issues raised within the initial joint construct (Commission on Aging, Agency

on Aging etc.), so a continuation of the AC meetings would not be necessary. However, it was widely recognized that the depth of content achieved from this project was substantial, and its content should be shared. Toward the conclusion of the member check meeting several participants suggested organizational forums where the researcher should make formal presentations.

Chapter Summary

This chapter has identified the termination and follow-up that this researcher undertook in order to develop the set of five action oriented initiatives from this constructivist based research project. As discussed, one of the final tasks of the Advisory Committee was to plan, schedule and implement a formal member check-in meeting. During this meeting the initial joint construct was reviewed, analyzed, edited and agreement was reached to have the researcher pull together a summarized findings document to include the revised joint construct. These finalized documents establish a credible summary or inclusive interpretation of the emerging conditions and potential solutions that surround elder mental illness services in this central California region's organizations and government agencies.

APPENDIX A
FORM LETTER OF SOLICITATION



College of Social and Behavioral Sciences
School of Social Work

April 15, 2017

ABC County
Department of Mental Health
Attn: Ms. Judy Jones
Division Manager
1234 Happy Street
Somewhere, CA, 00000

Re: Request for Participation

Dear Ms. Jones,

Jim Johnston of ABC County, Adult Protective Services, suggested that I contact you in reference to short-term participation in my research study. I am a Master of Social Work student undertaking a research project on elderly mental healthcare in our county.

I have contacted you due to your professional background within the field of adult mental health. My research will be performed from the constructivist paradigm, which assembles a dream team of influential professionals in order to gain their insights, first as individuals and then as a collective group on the topic of elder mental health.

Since your time is extremely valuable, my goal is to limit your participation to just two meetings. The first will be between the two of us at a convenient location. The second will be at a mutually convenient location for the entire group of participants. Due to regulatory compliance, this study will strictly adhere to issues of confidentiality, both in terms of involvement, as well as statements made.

909.537.5501 · 909.537.7029

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393



College of Social and Behavioral Sciences
School of Social Work

It is my sincere hope that the future of elderly mental healthcare is as important to you as it is to me, and that you take this opportunity to be a part of this action oriented research study. I will be contacting within the next week to discuss your participation.

Warm Regards,

John Klevins
MSW Student
California State University, San Bernardino
johnklevins@gmail.com; (805) 792-0019

909.537.5501 · 909.537.7029

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

The California State University · Bakersfield · Channel Islands · Chico · Dominguez Hills · East Bay · Fresno · Fullerton · Humboldt · Long Beach · Los Angeles · Maritime Academy · Monterey Bay · Northridge · Pomona · Sacramento · San Bernardino · San Diego · San Francisco · San Jose · San Luis Obispo · San Marcos · Sonoma · Stanislaus

APPENDIX B
FOLLOW-UP SOLICITATION E-MAIL

Hello Ms. Jones,

Last week I mailed you a letter requesting your participation in a research study on the topic of elderly mental healthcare. Jim Johnston of ABC County, Adult Protective Services, had suggested that you would be a great resource for my short-term research.

I had contacted you due to your professional background within the field of adult mental health. It is my sincere hope that the future of elderly mental healthcare is as important to you as it is to me, and that you take this opportunity to be a part of this action oriented research study.

Within the next few days, I will call you to discuss your participation.

Warm Regards,

John Klevins

APPENDIX C
HERMENEUTIC DIALECTIC CIRCLE /ADVISORY COMMITTEE MEMBER
CALL LOG

HDC Member Call Log

Contact information				Contact dates:			Notes	
Date	Name	Organization	Contact Num	Letter	Email	Call	Comments	Follow-up

APPENDIX D
ADVISORY COMMITTEE PARTICIPANT QUESTIONS

AC Participant Questions

by John Klevins

1. What is your experience with elder mental healthcare? What do you do each day in relation to elder mental healthcare?
2. Other than Adult Protective Services and Senior Center related leisure time and recreational activities, what elderly focused services are you aware of that are available in this county?
3. Do any of your agency's or organization's services pertain to elder mental health?
4. What types of mental health services do you feel that need to be added to help this county's senior population?
5. What are the governmental agencies and non-profit organizations that provide free public mental health services for the elderly?
6. Are there private pay mental health services for the elderly that could or should be provided either free of charge or insurance reimbursed (MediCal/MediCare)?
7. What have been your experiences with mental illness treatment for the elderly population in the county?
8. What are your experiences with the treatment of mental illness resulting from aging?
9. What programs are in place that provide medical and/or therapeutic solutions to ease, heal or cure mental health issues resulting from aging?
10. What are your experiences with the treatment of pre-existing mental illness that has been compounded by aging?
11. What senior related programs are (or should be) in place that provide medical and/or therapeutic solutions to ease, heal or cure pre-existing mental health?
12. What programs are (or should be) in place to assess mental health issues for seniors living at home or in various forms of residential care?
13. What educational programs are (or should be) in place to assist family members and/or caregivers to identify mental health issues and provide the necessary care?

14. What are your thoughts regarding elderly mental healthcare being provided in separate facilities with age specific interventions?
15. Within an elderly mental illness program, what would be the distinctive elements that would relate to older adults as opposed to middle aged adults?
16. What are the funding sources (governmental, insurance, non-profit grants) to assist the elderly with mental illness in this county?
17. If funding was not the issue, what type of elderly population focused mental illness program would you support?
18. Would you be willing to provide the name of one of your colleagues that might be a beneficial addition to the study's AC?
19. Is there an organization or governmental agency that I should contact that would be a beneficial addition to the study's AC?
20. Are there any questions or concerns regarding this issue that I have overlooked or that you want to add?

APPENDIX E
PREPARATION PLANS

Project Preparation Plans

1. Plan for Purposive Sample Selection: Based on Patton (2002)
 - a. Homogeneous sampling
 - b. Snowball or chain sampling
 - c. Opportunistic or emergent sampling
 - d. Politically important case
2. Plan for Engagement of the various study sites, gatekeepers and AC participants:
 - a. Three step process of solicitation letter, e-mails and follow-up telephone call
 - b. In-person interaction if an opportunity presents itself
3. Plan for Negotiation of the site and all participants: Based on Guba and Lincoln (1989)
 - a. Request each AC participant to sign a Letter of Involvement:
 - i. Participants are committed to working from a position of integrity, in effect participants agree to tell the truth and be honest.
 - ii. Participants must have minimal competence to communicate verbally and in written form. To clarify, those who are severely developmentally delayed, or severely mentally ill will not be able to participate.
 - iii. Participants must have a willingness to share power with other participants. One participant's individual construct will be seen as equal to all other individual participant's constructs.
 - iv. Participants must have a willingness to reconsider their perspectives. Each HDC participant will hear other participant's constructs and should be amenable to changing their ideas if persuaded by another point of view.
 - v. Participants must have a willingness to make the time and energy commitment needed for this constructivist research study.
 - b. Request each AC participant to sign a Letter of Consent
4. Plan for Data Collection:
 - a. One-on-one interviews with AC members to build individual construct
 - b. AC/HDC member check meeting to build combined all member joint construction.
 - c. Obtain permission to record interviews and member check meeting
5. Plan for Data Analysis:
 - a. Transcribe digital recordings from one-on-one participant interviews
 - b. Build units of information with content of interview transcriptions
 - c. Perform Open and Axial Coding from interview transcriptions using Atlas.ti software

6. Plan for Study Accuracy, Trustworthiness and Authenticity:
 - a. Elimination of outside auditor
 - b. Accuracy, trustworthiness and authenticity of this study will be audited by the university based research advisor.
 - c. Discussed with the advisor after approval of the proposal and before implementation

7. Plan for Data Dissemination and Report:
 - a. The final dissemination plan will be appropriate to the research setting and in keeping with University guidelines. The dissemination of the study findings and action steps will be discussed at the AC member check meeting once the joint construction has been concluded.

APPENDIX F
PARTICIPATION AGREEMENT

College of Social and Behavioral Sciences

School of Social Work

This study is being conducted within the constructivist research paradigm, which is based on an open and considerate exchange of ideas between a chosen group of professionals and the attending researcher. A component of this study will be to assemble a group of professionals and task them to work together as a cohesive unit to develop what is known as a joint construct. This construct is a mutually agreed upon body of information including action items, that pertains to mental illness healthcare for older adults living in this central California county.

In order for this research study to be a success, it is important that each member agree to the following rules of engagement.

1. **Integrity:** Participants are committed to working from a position of integrity, in effect participants agree to tell the truth and be honest.
2. **Competence:** Participants must have minimal competence to communicate verbally and in written form. To clarify, those who are severely developmentally delayed, or severely mentally ill will not be able to participate.
3. **Consideration:** Participants must have a willingness to be considerate of the position of others, in effect sharing power with the other participants. One participant's construct will be seen as equal to all other participant's constructs when developing the joint construct.
4. **Open to Suggestion:** Participants must have a willingness to reconsider their perspectives. Each participant will patiently listen to other participant's constructs and should be amenable to changing their ideas if persuaded by another point of view.
5. **Time Commitment:** Participants must have a willingness to make the time commitment needed for this constructivist research study.
6. **Confidentiality:** Participants will maintain a high degree of confidentiality when it comes to the identity of fellow participants as well as their personal views on the subject matter.

College of Social and Behavioral Sciences
School of Social Work

7. **Meeting Recording:** Participants agree to allow researcher to use a digital recording device during both the one-on-one individual meeting as well as the HDC member check meeting. These confidential recordings will be transcribed to written form and subsequently erased.

By signing below I agree that I have read, understood and will follow the aforementioned ground rules of this research study.

Participant Name

Date

APPENDIX G
LETTER OF INFORMED CONSENT

College of Social and Behavioral Sciences
School of Social Work

Informed Consent Form

This study in which you are being asked to participate is designed to investigate the mental illness healthcare programs for older adults living in our county. The study is being conducted by John Klevins, an MSW graduate student, under the supervision of Dr. Herbert Shon, Assistant Professor in the School of Social Work at California State University, San Bernardino. This study has been approved by the Institutional Review Board Social Work Sub-committee, California State University, San Bernardino.

PURPOSE: The purpose of this study aims to identify the current mental illness healthcare programs for the elderly population within our County, as well as explore any new programs that could be implemented over time.

DESCRIPTION: By taking part in this study, participants will be asked questions relating to the mental illness healthcare programs for the elderly population within our county, as well as question to explore the potential of new programs that could be implemented in the future. In the meetings where the participants will be asked questions, digital recordings will be made so that the student can refer to the content of these discussions for transcription and analysis at a later time.

PARTICIPATION: Participation in the study is totally voluntary. Participants have the right to withdraw from the study at any given time without consequence.

CONFIDENTIALITY OR ANONYMITY: Information provided during this study will remain confidential. All information gathered for this study will be destroyed at the end of the study.

DURATION: This study will entail two face-to-face meetings. The first, a one-on-one meeting will take approximately 30-60 minutes. The second, a group meeting, will take as much as 90 minutes to two hours depending on the participant's wants and needs.

RISKS: There are no foreseeable risks to the participants.

BENEFITS: There are no direct benefits to the participants of this study.

CONTACT: If you have any questions or concerns regarding this study, you may contact Dr. Herbert Shon at (909) 537-5532.

RESULTS: Results from this study can be obtained at Pfau Library ScholarWorks database (<http://scholarworks.lib.csusb.edu/>) at California State University, San Bernardino after July 2018.

By signing below, I agree that I have read the above information and am giving my consent to take part in the study. By signing below, I also agree that I am at least 18 years of age or older.

909.537.5501 • fax: 909.537.7029 • <http://socialwork.csusb.edu/>
5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

Place an X mark here

Date

I agree to be digitally audio recorded: _____ Yes _____ No

APPENDIX H
ADVISORY COMMITTEE AGENDA

Decision Makers Advisory Committee (D-MAC)
 Senior Mental Illness Services Discussion
 September 28, 2017, 9:00 am

Agenda Items:

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| I. | Welcome and Housekeeping | Klevins |
| II. | Brief Self-Introductions: | Group - 5 min |
| III. | UCLA Research Overview:
“California Mental Health Older Adult, System of Care Project”
➤ Brief Project Description
➤ Summarize Project Deliverables
➤ High Level Overview of Project Recommendations | Dr. Frank - 10 mins |
| IV. | UCLA Research Project-Group Q&A: | Dr. Frank - 15 mins |
| V. | Brief Overview of Advisory Committee Joint Construct
➤ Discuss Committee Member Findings
➤ Review Committee Member Service/Needs Gaps | Klevins - 10 mins |
| VI. | Group Discussion:
➤ Brief input on Edits to Joint Construct
➤ Discuss Findings and Service/Needs Gaps
➤ Brainstorm Program Alterations/Additions | Group - 45 mins |
| VII. | Next Steps: | Group - 5 mins |

Distribution (alphabetical):

Captain, County Sheriff’s Office
 Board Supervisor, County Board of Supervisors
 Central Coast Commission on Aging
 Director, Alzheimer’s Association
 Executive Director, Transitions Mental Health Association
 Executive Director, Area Agency on Aging
 Professor, UCLA Center for Health Policy Research, Los Angeles
 Executive Director, Transitions Mental Health Association
 Executive Director, County Long-Term Care Ombudsman
 Director, Community Action Partnership
 Executive Director, Wilshire Community Services
 Executive Director, California Association of Adult Day Services, Sacramento
 Sheriff, County Sheriff’s Department
 Division Manager, County Department of Social Services-APS
 Department Manager, County Department of Social Services-APS
 CEO, Community Action Partnership
 Chairman, NASW; LCSW, County Mental Health Services
 Division Manager, County Mental Health Services
 Director, Community Action Partnership

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