Behavioral Health Network
Of Greater St. Louis

ABC Systems Agency Assessments Report

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Introduction

Older adults face several challenges when accessing behavioral health services, many of which are rooted in systemic, cultural, and practical barriers. One significant obstacle is the pervasive stigma surrounding mental health, particularly among older generations who may have grown up with the belief that psychological issues should be kept private or are a sign of personal weakness. This stigma can prevent them from seeking help or even recognizing the need for support. Additionally, behavioral health symptoms in older adults are often misattributed to normal aging or physical health conditions, leading to underdiagnosis and undertreatment of issues like depression, anxiety, or substance use.

There is also a shortage of mental health professionals trained to work with older adults, especially those who understand the unique interplay between cognitive decline, physical health, grief, isolation, and mental well-being. Practical barriers, such as limited transportation, financial constraints, and a lack of access to technology, further complicate service use, particularly for those in rural or underserved communities. Finally, fragmented healthcare systems often separate mental and physical healthcare, making it difficult for older adults to navigate referrals and receive coordinated, holistic care. Together, these challenges contribute to significant unmet behavioral health needs among aging populations. The Systems Aging and Behavioral Health (Systems ABC) project, funded by the Missouri Foundation for Health, aims to begin addressing these challenges by building intentional efforts to integrate aging and behavioral health systems into coordinated care. Existing literature highlights what is already known about the facilitators and barriers to promoting systems of change work (see Table 1).

Table 1. Summary of the literature on facilitators and barriers in systems of change work

Facilitators	Barriers
Strong leadership commitment and resource allocation.	Limited funding and competing organizational priorities.
Cross-sector collaboration between aging services, behavioral health, and community partners.	Workforce shortages and a lack of staff trained at the intersection of aging and behavioral health.
Staff training to build competencies in aging and behavioral health.	Stigma surrounding mental health among older adults.

Integrated assessment tools and coordinated referral pathways.	Fragmented systems of care that hinder coordination and follow-up
Inclusion of older adults' lived experiences in planning and evaluation	Resistance to change due to entrenched practices or staff burden
Feedback loops and ongoing communication across disciplines	Lack of standardized tools or shared frameworks for integration
A culture that embraces innovation, openness, and continuous improvement	Organizational silos that discourage collaboration

(see Elshaikh et al., 2023; Seegan & McGuire, 2024; Tian et al., 2024; Fleet et al., 2024; Cheung et al. 2019; Horgan et al., 2024)

Methods

This report has been prepared by Saint Louis University faculty consultants and graduate student researchers for the Behavioral Health Network of Greater St. Louis to summarize the findings from the 12 agency assessment consultations as part of the ABC Systems project. Through our partnership with the Behavioral Health Network of Greater St. Louis and Illume (Places for People), we concluded a three-year system of change effort where we evaluated 12 aging and behavioral health organizations across the city and surrounding areas. The 12 agencies that participated in consultation included six primarily aging-focused organizations and 6 primarily behavioral health-focused organizations: Aging Ahead, Behavioral Health Response (BHR), Cardinal Ritter, Cardinal Ritter Senior Services, Jewish Family Services (JFS), Memory Keepers, National Alliance for Mental Illness (NAMI), Provident, Places for People, St. Patrick's Center, University of Missouri at St. Louis (UMSL) Counseling Center, and VOYCE (Long Term Care Ombudsman Program).

The agency assessments included having agencies complete an agency pre-questionnaire and participate in an agency assessment meeting with Saint Louis University, Illume, and Behavioral Health Network of Greater St. Louis consultants, which produced a written list of recommendations. From that list, agencies selected one to three recommendations to implement. One year following their consultation, they were invited to complete a post-questionnaire about systems change work and participate in a systems change exit interview. Copies of these instruments are provided in the appendix of this report.

Saint Louis University faculty and graduate students conducted a de-identified thematic analysis, following recommendations of Braun & Clark (2006), of these documents to explore the 1) progress made towards systems of change work, 2) what facilitators aided success in systems of change research efforts, and 3) what challenges agencies continue to experience in their systems of change efforts. The following are the thematic findings from analyzing the four documents of each agency. We also present a few case examples of the successful implementation of system change adoption.

Results

Systems of change work progress

Of the 12 agencies, all 12 participated in completing the pre-questionnaire, initial consultant visit, selecting recommendations, post-questionnaire, and exit interview.

Agencies selected implementing new assessment instruments (n=9; 75%) and staff training as a recommendation to implement (n=6; 50%). Among the 12 agencies, only half of the organizations (n=6; 50%) were widespread in their adoption (required for the majority of front-line or clinical staff).

Recommendations included training for Older Adult Mental Health First Aid, Older Adult Trauma Informed Care, Older Adult Question, Persuade, Refer (QPR) Suicide Prevention Training, RUSH University's Center for Excellence in Aging's Foundational Competencies in Older Adult Mental Health Online Certificate Program Non-CE training, and training offerings on various assessment tools. Assessment instruments included cognitive screenings (i.e., Rapid Cognitive Screening [RCS] and Saint Louis University Memory Screening [SLUMS]), Rapid Geriatric Assessment (RGA), loneliness (ALONE), and depression (AM-SAD). All 6 behavioral health organizations pursued recommendations that pertained to the aging population. Only 4 of the 6 aging organizations pursued recommendations that pertained to behavioral health issues. These results are summarized in Table 2.

Table 2. Selection of adopted recommendations

Older Adult Mental Health First Aid Training	3	25.0%
Older Adult Trauma-Informed Care Training	1	8.3%
Older Adult Question, Persuade, Refer Suicide Training	1	8.3%
RUSH University's Excellence in Aging Foundational Competencies in Older Adults Mental Health Online Certificate Training	2	16.6%
Cognitive Screening Adoption	3	25.0%
Rapid Geriatric Assessment Adoption	4	33.3%
Loneliness Screening Adoption	1	8.3%
Depression Screening Adoption	1	8.3%

At the one-year follow-up, all 12 organizations had made progress on the adoption of their recommendations. However, 4 (25%) were still in the process of completing their recommendations one year in. **When organizations were asked to rate their achievement in becoming a more Aging and Behavioral Health Friendly agency by completing the Agency Assessment and following up on Consultant Recommendations, the majority felt they had achieved the goal (n=7; 58.3%) and 5 (41.7%) reported they "achieved somewhat more than the expected outcome".**

The geriatric competencies instrument was used as part of the pre-questionnaire and post-questionnaire process with an intention to show how competencies grew over the one year However, due to agencies not being familiar with the tool and/or competencies specific to older adults, or having different staff complete the pre-assessment and post-assessment questionnaire, it did not yield meaningful results to interpreting systems of change and was not be included in this report.

Facilitators of systems of change work

Systems change work within organizations is facilitated by a combination of leadership commitment, cross-sector collaboration, and a willingness to adapt existing structures to better meet the behavioral health needs of older adults. Change becomes possible when organizational leaders champion inclusion and allocate resources toward staff training, integrated assessment tools, and streamlined referral processes that address both physical and behavioral health. Collaboration with behavioral health providers, community organizations, and older adults themselves ensures that the system reflects lived experiences and addresses real barriers to care. Additionally, creating feedback loops, building trust across disciplines, and fostering a culture of openness to innovation help sustain momentum. Together, these elements cultivate a foundation where aging organizations can more effectively integrate behavioral health supports and deliver holistic, person-centered care. Themes we saw demonstrated throughout the 12 agency assessments that appeared to facilitate systems of change work included the following:

- **Proactivity** – Organizations that were goal-oriented, insightful of their own organization's capacity and limitations, and had an awareness of clients' needs (including unmet needs) were more likely to adopt systems of change practices.
- **Qualified staff** – Organizations that had qualified professional staff to conduct assessments, recognized opportunity for interprofessional collaboration, and the benefits of coordination of care (both within one's own organization and between agencies) were more likely to adopt systems of change practices.
- **Cross-training** – Organizations that were willing to pursue training outside of their organization's focus (i.e., aging providers that pursued behavioral health training; behavioral health providers that pursued aging training) were more likely to complete their selected recommendations and were more likely to adopt systems of change practices.

- **Consistency** – Organizations that have more consistent, standardized protocols or processes for each client, as opposed to only sometimes implementing a behavioral health assessment or only sometimes asking about a history of dementia diagnosis, were more successful in adopting system of change practices.
- **Agency's structure** – Organizations that offered a broader range of services (i.e., more comprehensive services) appeared to have an easier time identifying strategies to engage in systems of change practices.
- **Organizational buy-in** – Organizations that had buy-in from across the agency (i.e., administration/leadership, front-line staff, etc.) were more likely to complete their recommendations and were more likely to adopt systems of change practices.
- **Affordability** – Organizations noted they were more likely to adopt recommendations for systems of change if the recommendation was affordable in cost or available for free.
- **Expanding services** – Several organizations expanded their service offerings to be more comprehensive of older adult behavioral health needs as a result of participating in the systems change initiative.
- **Expanding partnerships** – While many organizations spoke about already existing partnerships (formal and informal) they held with other organizations, several participating organizations expanded their formal partnerships to offer more comprehensive older adult behavioral health services (or specifically, linkage and referral) as a result of participating in the systems of change initiative.

Barriers to systems of change work

Barriers to systems change work in aging organizations often stem from structural, cultural, and resource-related challenges. Many organizations face limited funding and staffing shortages, which make it difficult to prioritize behavioral health integration alongside already pressing demands. Workforce gaps are especially pronounced, as few professionals are trained at the intersection of aging and behavioral health, leaving staff underprepared to address complex needs. Culturally, stigma surrounding mental health in older adults can discourage open conversations and prevent organizations from fully embracing change. Fragmented systems of care—where aging services, primary care, and behavioral health providers operate in silos—further complicate coordination and create gaps in referrals and follow-up. Additionally, resistance to change within organizations, whether due to entrenched practices or fear of overburdening staff, can slow progress. These barriers make it challenging for aging organizations to evolve toward a truly integrated model that addresses the whole person.

- **Financial capacity** – Barriers to adopting a system of change often included recognition of financial capacities. Agencies discussed challenges, including lack of funding for staff or services, difficulty identifying appropriate grants or grant writing, getting financial buy-in from the organization or funder, cost of expanding services or training, and general concerns about economic capacity and insecurity in the current climate.

- **Staffing challenges** – Barriers to adopting systems of change included issues with staffing. Issues reported include staff turnover, limited staff dedicated to expanding services, and the time staff take to complete additional assessments.
- **Lack of staff training** – While related to staffing challenges, training itself was a frequent discussion point for barriers to adopting systems change. Organizations discussed the difficulty of training staff due to limitations on staff's time, inability to make training a requirement, and lack of access to training (whether because they didn't know where to get staff training or were unsure if such training existed).
- **Lack of engagement/outreach with clientele** – Some organizations recognized they had limited capacity to identify older clients with behavioral health issues because those weren't the type of clients they were seeing in their agency setting. They attributed this to a lack of engagement or outreach to these clients, in that they might not associate their organization with serving that sector of the population. Clients or caregivers of clients may be unaware that they offer such services.
- **Administrative challenges** – Many organizations spoke about difficulties in adopting systems of change work due to administrative challenges. Some organizations acknowledged they were unaware of their staff's needs when it came to offering coordinated care or their training needs. Other organizations recognized a lack of buy-in from administration, which limited factors such as conducting consistent assessments or a lack of widespread adoption of staff training. Some organizations indirectly recognized their agency lacked motivation to conduct systems change work, given competing priorities.
- **Stigma** – Some organizations reported stigma and client resistance from those not wanting to adopt behavioral health services or being resistant or fearful of being labeled. This was especially a common concern within the context of cognitive assessments.
- **Client has unmet need** – Some organizations recognized that there was a lack of utilization of standardized aging behavioral health assessments, clients weren't being identified as having a particular need, which prevented them from being able to intervene, or link and refer for intervention.
- **Scope of the agency** – The scope of the agency also impacted the ability of an organization to engage in systems of change work. Organizations that identified as rigid in their scope of services struggled to adopt systems of change practices and discussed this as feeling misaligned with the system of change efforts.

Limitations

With any data analysis, there are numerous limitations that we should consider. First, staff participating in the agency assessments may have differed between the pre-questionnaire to the post-questionnaire, and the exit interview. Staff turnover was an issue reported by numerous organizations, and so we cannot assume that the person completing the pre-questionnaire is the

same respondent who participated in the exit interview or the post-questionnaire. The interpretation of results, such as the pre-test post-test of the geriatric competencies, has limited generalizability due to the small sample size. While steps were taken (i.e., peer review, consulting system change expertise) to limit the potential of bias in the study design and thematic analysis, questions on the questionnaires or exit interviews may still be too broad in guidance or so specific that some nuisance context was lacking.

Case Examples

One behavioral health-focused organization continues to think about systems of change work. After their initial consultation, they recognized they wanted their staff to be able to conduct cognitive assessment training to identify potential concerns for dementia. After participating in the training, staff communicated that they felt they also needed an overall dementia training course, which was then also provided. After the one-year follow-up interview, the organization recognized its staff needed a better understanding of how to facilitate group intervention for older adult clients and reached out to pursue additional training on this topic from a University partner.

One aging-focused organization implemented a requirement that all of their employees, including new hires, would be required to complete the Foundational Competencies in Older Adult Mental Health Online Certificate Program Non-CE training, which is a 16-module course offered for free by RUSH University's Center for Excellence in Aging.[1]

A group of organizations participating in the ABC Systems change has developed a new formal partnership with one another and plans to jointly pursue funding to offer more coordinated care.

Further Recommendations

The next steps in these systems of change efforts should look to improve service coordination for older adults with behavioral health needs by focusing on building integrated, person-centered care systems. This means strengthening partnerships between aging services, healthcare (i.e., primary care), and behavioral health providers so that referrals are not just made but actively coordinated and followed through. Developing shared assessment tools, care plans, and communication platforms can reduce fragmentation and ensure providers are working from the same information. Expanding workforce training in geriatric behavioral health is also critical, so staff across sectors have the skills to recognize and address both cognitive and emotional needs.

[1] RUSH University's Center for Excellence in Aging's Foundational Competencies in Older Adult Mental Health Online Certificate Program Non-CE training is available at https://learning.rushaging.com/content/foundational-competencies-older-adult-mental-health-online-certificate-program-non-ce#group-tabs-node-course-default2

Policy and funding shifts that incentivize collaboration—rather than siloed service delivery—will also be necessary to sustain change. Finally, including older adults and their caregivers in designing and evaluating services helps ensure coordination efforts are practical, accessible, and responsive to real-world needs. Taken together, these steps can help create a more seamless system where behavioral and physical health are addressed in tandem, improving both outcomes and quality of life for older adults (reported in Table 3).

Table 3. Next steps for systems of change work

Build Strong Cross-Sector Partnerships	Establish formal partnerships (e.g., MOUs) between aging services, healthcare, and behavioral health providers to define roles, responsibilities, and referral processes.
Standardize Assessments and Communication Tools	Adopt shared screening tools for behavioral health needs and create secure communication platforms that allow providers across sectors to share information and track follow-up.
Strengthen Workforce Training	Provide ongoing training for staff at all levels to recognize behavioral health conditions in older adults, understand dementia-related behaviors, and know when and how to make appropriate referrals. Solicit feedback about what outstanding training organizations feel they need and ensure they can access such information.
Create Coordinated Care Plans	Develop care plans that include input from medical providers, social workers, behavioral health professionals, and family caregivers to ensure services are aligned and not duplicated.
Secure Sustainable Funding	Pursue funding streams and policy incentives that reward integrated, team-based approaches rather than siloed service delivery, making coordination financially feasible.
Center Older Adults and Caregivers	Engage older adults and their caregivers in co-designing services, advisory councils, or feedback groups to ensure coordination efforts reflect lived experiences and actual needs.
Monitor and Evaluate Progress	Use data tracking and feedback loops to measure outcomes, identify service gaps, and adjust coordination strategies in real time.

Conclusion

Systems of change work is an ongoing process: populations change, policies evolve, new evidence emerges, and community needs shift over time. What works today may not be effective tomorrow. Systems change requires continuous reflection, adaptation, and collaboration to

respond to these evolving conditions. The goal is not to *fix* a problem once and for all, but to build more robust, flexible, interconnected, and resilient structures that can sustain progress and address challenges as they arise. This requires coordinated shifts across multiple parts of the system, including funding streams, workforce practices, organizational culture, policies, and community engagement. Without this broader lens, efforts tend to be fragmented, short-term, and often less effective.

The ABC Systems initiative was largely successful in its broader application because it initiated a cultural shift that might otherwise never have happened. Individual organizations, through participation in the initiative and the agency assessment, shifted their awareness of older adults' behavioral health needs. The broader ABC systems initiative was also successful for the essential reason that it created an intentional effort to get two groups of service providers into the same room, whereas they otherwise would never have connected, and engaged them in ongoing regular communication. This itself is the catalyst for beginning a system of change. These communications have led to new programs, new partnerships, and more coordination of care among the older adult residents of St. Louis. While there is still much work to be done to reduce fragmented, less efficient services, St. Louis is forging a path in the right direction.

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Appendix

I. Pre-Questionnaire

<u>Assessment Preparatory Questionnaire:</u>

Part 1: General Agency Information

Person(s) completing this questionnaire (Please list names and titles)

Please respond to the following items related to current practices and perspectives within your organization:

1. Goals for participation in this self-assessment process:

2. Current practices related to behavioral health:
    a. Screening tools used (please list all and add lines as needed)
        i. Name of tool:
        ii. Reason for administering:
        iii. Discipline or position of person(s) responsible for administering:
        iv. The point in the assessment/intervention process tool is administered:
        v. Frequency of administration:
        vi. Required by external group (Funder, accreditor)? Internal group (Company preference)?
        vii. Action taken following the completion of the tool:
    b. Services provided (please attach organizational chart):
        i. General –
        ii. Behavioral Health –
    c. Staffing: Please describe staffing practices related to addressing behavioral health issues (e.g., are specific staff identified to provide these services, or do all service staff provide the services).
    d. Trainings offered:
        i. General aging –
        ii. Behavioral Health specific – n/a Some staff have had QPR and some have had Mental Health First Aid, VA-Suicide Prevention. We have staff who have worked in other agencies providing Behavioral Health services.
        iii. Other
    e. Linkage and Referral—Describe processes for:

i. Identifying a provider for a client need beyond what your agency delivers
ii. Linking and/or referring clients to behavioral health services
iii. Communicating with these organizations

3. Collaborations with Behavioral Health organizations: Describe formal and informal collaborations your organization has with behavioral health organizations.

4. How are older adults experiencing behavioral health issues viewed by the staff (e.g., same as all clients, differently, or not sure)?

5. Does your organization use the same or different measures (screeners & assessment tools) for older adults experiencing behavioral health challenges? Provide an explanation for the practice you use.

6. Describe the strengths and areas for growth and change related to behavioral health assessment and service provision:

a. Strengths or current approach:
b. Areas for growth and change:
c. Challenges to achieving growth and change:

Part 2: Geriatric Behavioral Health Core Competencies

Using the attached Geriatric Behavioral Health Core Competencies (Partnership to Improve Behavioral Health for Older Adults and People with Disabilities, 2021), rate your organization's overall knowledge and skills in the following areas of service on a continuum

Please define who is answering this question. Please list Person(s) completing this portion:

0 = Do not address in assessment or intervention

1 = Include in assessment but do not address in the intervention

2 = Include in assessment and make appropriate referrals

3 = Include in assessment and intervention at a minimal level

4 = Include in assessment and intervention at an optimal level

	0	1	2	3	4
Medication and Polypharmacy: medications can cause/exacerbate chronic conditions. Do you assess number and type of medications and complete a medication reconciliation?					
Suicide: Risks and Prevention in Older Adults—do you assess for suicide risk in older adults with tools validated for the population? Do you offer interventions for prevention and safety planning?					
Elder abuse and elder rights—do you assess for elder abuse, neglect, and exploitation, including risk and protective factors?					
Somatic/medical comorbidity and impact on well-being and mental status—do you assess for chronic conditions that place older adults at risk for or exacerbate depression, cognitive impairment, etc.?					
Health disparities and inequities—do you assess for social determinants of health and/or practitioner and data bias?					
Culture, race/ethnicity, and mental health—do you adapt traditional (i.e., developed for Anglo-Saxon groups) evidence-based mental health interventions for specific racial/ethnic groups?					
Positive aging and reframing aging—are your staff aware of age-related biases and practices?					
Social determinants of health for older adults—specifically, do you assess for transportation, housing, nutrition and their impact on older adult well—being?					
Advance care planning/end-of-life—do you assess for older adults' advance care planning and end-of-life wishes? Do you help older adults complete the appropriate documents?					
Age-friendly infrastructure—do you use IHI and/or WHO age-friendly standards for guiding service provision?					
Normal aging—does your staff receive training on normal (vs. abnormal) aging?					
Comprehensive geriatric assessment—does your staff conduct comprehensive geriatric assessments (e.g., physical, emotional, spiritual, and social)?					

Geriatric syndromes—does your staff receive training on common geriatric syndromes (e.g., cognition, frailty, mood disorders, etc.)?					
Cognition and cognitive assessment—do you assess for cognitive function? Does your staff know how to interpret the findings?					
Risk assessment and capacity—do you assess for older adults' capacity for decision-making?					
Dementia 101 and differential diagnoses regarding different types of dementia—does your staff receive training on the dementias and diagnostic strategies?					
Delirium—do you assess for delirium in older adults? Does your staff receive training on delirium?					
Depression in older adults—do you assess for depression in older adults? Does your staff receive training on depression in older adults?					
Serious mental illness and aging—do you assess serious mental illness in older adults? Does your staff receive training in serious mental illness?					
Serious mental illness and co-occurring dementia—does your staff receive training in intervening with older adults experiencing serious mental illness and co-occurring cognitive impairment?					
Substance abuse disorder—do you assess for substance abuse disorder with tools specifically validated for older adults?					

Additional comments:

Part 3: Age-Friendly Health System Framework

Age-Friendly Care: In 2017, The John A. Hartford Foundation, Institute for Healthcare Improvement, American Hospital Association, and Catholic Health Association of the United States, developed a framework for age-friendly care that is conceptualized as: being evidence-based, causes no harm, and aligns with What Matters to the older adult and their family or other caregivers. Becoming an Age-Friendly Health System entails reliably providing a set of four evidence-based elements of high-quality care, known as the "4Ms," to all older adults in your system. When implemented together, the 4Ms represent a broad shift to focus on the needs of older adults. For more information, visit: http://www.ihi.org/AgeFriendly

1. Based on your knowledge of the Age-Friendly Health System Framework (Institute for Healthcare Improvement, 2017), rate your organization's practices in the assessment of the "4 Ms" (i.e., what matters, medications, mentation, and mobility):

0 = Do not address in assessment or intervention

1 = Include in assessment but do not address in the intervention

2 = Include in assessment and make appropriate referrals

3 = Include in assessment and intervention at a minimal level

4 = Include in assessment and intervention at an optimal level

	0	1	2	3	4
What Matters: Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.					
Medications: If medication is necessary, use age-friendly medications that do not interfere with what matters to the older adult, mobility, or mentation across settings of care.					
Mentation: Prevent, identify, treat, and manage dementia, depression, and delirium across care settings.					
Mobility: Ensure that older adults move safely every day in order to maintain function and do what matters.					

Additional comments:

2. Describe in detail those areas in which you feel training is needed. Please check all that apply and provide additional suggestions:

Age-Friendly Health Systems Overview	Need High	Moderate	Low	Priority High	Moderate	Low
1. What Matters						
Please explain:						
2. Medications						
Please Explain						
3. Mobility						
Please Explain:						
4. Mentation (i.e., Dementia, Delirium, and depression =)						
Please Explain:						
	Need High	Moderate	Low	Priority High	Moderate	Low
Mental Health Assessment in Older Adults						
Please Explain:						
Memory Assessments						
Please Explain:						
Fall Risk in Older Adults						
Please Explain:						
Working with Caregivers in practice?						
Please Explain:						
Other:						
Please Explain:						

3. How can the Systems ABC grant staff and consultants help your organization improve the quality of services provided to older adults in the area of behavioral health?

Part 4: Trauma-informed culture assessment

This section asks about five domains relevant to trauma-informed cultures (TIC): *Safety*, *Trustworthiness*, *Choice*, *Collaboration*, and *Empowerment*.

Please see the below for guiding questions relevant to each domain. Please include stakeholders with diverse perspectives (e.g., program staff, clients, administrators) when rating your agency's ability to demonstrate each domain.

We will support agencies in assessing their strengths and areas for growth as it relates to each domain. We can assist in setting and monitoring simple, concrete goals to make meaningful change in the areas the agency selects. Areas for growth should be concordant with existing program goals and strengthen the existing work of the organization in serving older adults.

Guiding questions for each domain

Physical and emotional Safety: To what extent do the program's activities and settings ensure the physical and emotional safety of female and male consumers and staff members?

Trustworthiness: To what extent do the program's activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency and transparency in practice, and by maintaining boundaries that are appropriate to the program?

***Choice for consumers and staff*:** To what extent do the program's activities and settings maximize consumer and staff experiences of choice and control?

Collaboration for consumers and staff: To what extent do the program's activities and settings maximize collaboration and sharing of power between staff and consumers? Between staff and supervisors and administrators?

***Empowerment for consumers and staff*:** To what extent do the program's activities and settings prioritize consumer and staff empowerment and growth?

Reflecting on the past month, to what extent are the following domains achieved within your organization?					
	Never	Rarely	Sometimes	Usually	Always
Consumers					
Safety - Physical					
Challenges					
Strengths					
Safety - Emotional					
Challenges					
Strengths					
Trustworthiness					
Challenges					
Strengths					
Choice					
Challenges					
Strengths					
Collaboration					
Challenges					
Strengths					
Empowerment					
Challenges					
Strengths					
Staff					
Safety - Physical					
Challenges					
Strengths					

Safety - Emotional					
Challenges					
Strengths					
Trustworthiness					
Challenges					
Strengths					
Choice					
Challenges					
Strengths					
Collaboration					
Challenges					
Strengths					
Empowerment					
Challenges					
Strengths					
Additional comments:					
Adapted from Harris & Fallot (2001) *Creating Cultures of Trauma-informed Care: A Self-Assessment and Planning Protocol*.					

II. Post- Questionnaire Assessment

Agency Assessment Post-questionnaire

Part 1: Geriatric Behavioral Health Core Competencies

Using the attached Geriatric Behavioral Health Core Competencies (Partnership to Improve Behavioral Health for Older Adults and People with Disabilities, 2021), rate your organization's overall knowledge and skills in the following areas of service on a continuum

Please define who is answering this question. Please list Person(s) completing this portion:

0 = Do not address in assessment or intervention

1 = Include in assessment but do not address in the intervention

2 = Include in assessment and make appropriate referrals

3 = Include in assessment and intervention at a minimal level

4 = Include in assessment and intervention at an optimal level

	0	1	2	3	4
Medication and Polypharmacy: medications can cause/exacerbate chronic conditions. Do you assess number and type of medications and complete a medication reconciliation?					
Suicide: Risks and Prevention in Older Adults—do you assess for suicide risk in older adults with tools validated for the population? Do you offer interventions for prevention and safety planning?					
Elder abuse and elder rights—do you assess for elder abuse, neglect, and exploitation, including risk and protective factors?					
Somatic/medical comorbidity and impact on well-being and mental status—do you assess for chronic conditions that place older adults at risk for or exacerbate depression, cognitive impairment, etc.?					
Health disparities and inequities—do you assess for social determinants of health and/or practitioner and data bias?					

Culture, race/ethnicity, and mental health—do you adapt traditional (i.e., developed for Anglo-Saxon groups) evidence-based mental health interventions for specific racial/ethnic groups?					
Positive aging and reframing aging—are your staff aware of age-related biases and practices?					
Social determinants of health for older adults—specifically, do you assess for transportation, housing, nutrition and their impact on older adult well—being?					
Advance care planning/end-of-life—do you assess for older adults' advance care planning and end-of-life wishes? Do you help older adults complete the appropriate documents?					
Age-friendly infrastructure—do you use IHI and/or WHO age-friendly standards for guiding service provision?					
Normal aging—does your staff receive training on normal (vs. abnormal) aging?					
Comprehensive geriatric assessment—does your staff conduct comprehensive geriatric assessments (e.g., physical, emotional, spiritual, and social)?					
Geriatric syndromes—does your staff receive training on common geriatric syndromes (e.g., cognition, frailty, mood disorders, etc.)?					
Cognition and cognitive assessment—do you assess for cognitive function? Does your staff know how to interpret the findings?					
Risk assessment and capacity—do you assess for older adults' capacity for decision-making?					
Dementia 101 and differential diagnoses regarding different types of dementia—does your staff receive training on the dementias and diagnostic strategies?					
Delirium—do you assess for delirium in older adults? Does your staff receive training on delirium?					
Depression in older adults—do you assess for depression in older adults? Does your staff receive training on depression in older adults?					
Serious mental illness and aging—do you assess serious mental illness in older adults? Does your staff receive training in serious mental illness?					

Serious mental illness and co-occurring dementia—does your staff receive training in intervening with older adults experiencing serious mental illness and co-occurring cognitive impairment?					
Substance abuse disorder—do you assess for substance abuse disorder with tools specifically validated for older adults?					

Additional comments:

Part 2: Goal Attainment

Please rate your achievement in becoming a more Aging and Behavioral Health Friendly agency by completing the Agency Assessment and following up on Consultant Recommendations.

1: Achievement of much less than expected goal

2: Achievement of somewhat less than expected goal.

3: Achievement of goal.

4: Achieved somewhat more than expected outcome

5: Achievement of much more than expected goal

Agency Rating & Explanation:

Part 3: Sustainability

Please give a brief description on how your agency plans to sustain the aging & BH-friendly practices introduced by the Agency Assessment:

Any Additional Comments:

We appreciate the opportunity and the feedback.

{END} Thank you for your participation in the Systems ABC Agency Assessment

III. Follow Up Interview

Agency 1-year Follow up

Agency:

Initial Meeting date:

Selected Recommendations:

Open Dialog questions:

Why did you choose the recommendation(s) that your agency did?

What other recommendations did you consider implementing and why did you rule them out?

Who makes the decisions about what recommendations you'll choose? Whether and what you'll continue? Or will you discontinue?

Are you currently still implementing the recommendation?

If so, how is it going?

If not, what caused the difficulties?

Did you adapt the recommendations to fit your needs? How? Why? How did it go?

Were there any unintended consequences?

Has your agency followed up on any other recommendations not selected for this project?

Did any of the work influenced by this project expand beyond the initial scope?

What did you learn about your counter partner organizations (aging services or BH services)? How did your relationship change?

Do you have any plans for sustainability, either for a selected recommendation or in the realm of OABH?

Brainstorming ideas for additional help and/or resources.