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Strengthening Psychology's Workforce for Older Adults:

Implications of the Institute of Medicine's Report to Congress

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Abstract

Professional psychology faces an urgent crisis, which the following facts paint in stark relief. Adults over age 65 will rise to 20% of the U.S. population over the next 15 years and already account for a third of the country's health care expenditures. Up to 8 million older adults experience mental health and substance use conditions in a given year, yet most psychologists receive no training in their assessment and treatment. No more than an estimated 4%, or 3,000, psychologists nationwide specialize in geropsychology; a ratio approaching 3,000 to 1. A small group of advocates within the profession have sounded the alarm and worked to strengthen geropsychology as a specialty, but this has had very limited impact on the actual supply of psychologists qualified to provide services to this population. In 2012, an Institute of Medicine (IOM) committee released a report on the crisis regarding the mental health and substance use workforce for older adults. Drawing on that report, a team composed of geropsychologists, along with psychologists who served on the IOM committee, identifies in this article priority areas for workforce development. The authors assess the progress of psychology in each of these areas and offer a set of recommendations for future efforts by this profession to develop its own workforce and to strengthen the ability of other caregivers to address the behavioral health needs of older adults. Strengthening its own workforce and responding to the needs of this population is imperative if psychology is to maintain its relevance as a health profession and meet its ethical obligations to an increasingly diverse society.

Keywords

older adult; mental health; substance use; geropsychology; workforce development

Psychology as a profession is simply not prepared to meet the behavioral health needs of America's aging population. Although the demographics of the country are shifting rapidly, the overall preparation of the profession's workforce to care for an aging society has shifted almost imperceptibly. Drawing from a recent report by the Institute of Medicine (IOM; Institute of Medicine, 2012), this article makes the case for a bold response by psychology in the form of eight practical steps to better prepare the nation's workforce.

Currently, 13% of the U.S. population is age 65 and older, but this figure is projected to swell to 20% by 2030 (Centers for Disease Control and Prevention & The Merck Company Foundation, 2007). Older adults are significant consumers of health care, currently responsible for 36% of all health related expenditures (Institute of Medicine, 2012). They experience a wide range of mental health and substance use problems, including those developed earlier in life that persist into or recur in old age, as well as late onset disorders. The IOM estimated that each year 5.6 to 8.0 million older adults in the United States experience one or more behavioral health conditions (Institute of Medicine, 2012).

A range of evidence-based treatments is effective for treating behavioral health problems in older adults. Research has shown that without adequate treatment, behavioral health problems within this population can lead to serious public health consequences, including increased mortality, comorbidity of chronic conditions such as cardiac illness, unnecessary suffering, and additional burden to family caregivers (Manthorpe & Iliffe, 2010; Reynolds et al., 2012; Sayers et al., 2007; Win et al., 2011). The cohort over age 85 will grow significantly after 2030 as surviving baby boomers continue to age, with high rates of dementia and other forms of morbidity that will make the clinical challenges even more complex (Vincent & Velkoff, 2010). Men aged 85 and older have the highest suicide rate of 44.27 per 100,000, compared to an overall rate of 20.23 per 100,000 for all ages (National Center for Injury Prevention and Control, 2011).

Compelling evidence exists that today's workforce is seriously insufficient in number and in preparation to meet the current mental health and substance use treatment needs of older adults (Bartels & Naslund, 2013). This applies to behavioral health professionals and to other health care professionals, such as primary care providers, to whom older adults often turn first when experiencing a mental health or substance use condition (Institute of Medicine, 2012). The situation will become more critical as the proportion of older adults in the population rapidly increases (Hoge et al., 2013).

Concerns about the size and preparation of the work-force qualified to care for older adults are highly applicable to psychology. As this analysis will show, the psychologists specializing in geropsychology are but a small percentage of the profession and there has been marginal growth in their numbers (see Figure 1). While many psychologists provide services to a limited number of older adults, they often do so without any specific training in the care of this population. The profession has made advances with respect to older adults,

such as the development of practice guidelines and competencies, recognition of geropsychology as a specialty, and some growth in specialty training programs. However, these efforts, which have created an important foundation, simply have not yielded substantial growth in the number of psychologists prepared to care for this segment of the population.

In 2012, the IOM released the report *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* (Institute of Medicine, 2012). The U.S. Congress commissioned this review in response to advocacy by the American Psychological Association (APA) and other professions concerned about inattention to behavioral health in an earlier IOM report on the health care workforce for an aging America (Institute of Medicine, 2008). The 2012 report did examine the service needs of older adults with mental health and substance use conditions, reviewed the models of care for meeting those needs, and provided a detailed analysis of the current workforce available to care for these older adults.

The IOM, which is part of the National Academy of Sciences, is a nonprofit organization that provides unbiased information and advice to policymakers and to the public about health and health care (www.iom.edu). Congress commissions many of the IOM reports and, although it does not mandate that their recommendations be followed, the reports have had considerable influence on health care policy and practice within the United States and abroad. The reports on the safety of health care (Institute of Medicine, 2000) and quality of care (Institute of Medicine, 2001) are two examples that have had major impact.

Formal recommendations in IOM reports tend to be relatively few in number. Four of the five recommendations in the 2012 report focused principally on federal action. However, embedded in the body of the report were descriptions of priorities for action in building a workforce that is sufficient in size, diversity, and skill to meet the mental health and substance use treatment needs of older Americans. These priorities constitute a blueprint for action by any profession involved in the prevention and treatment of behavioral health problems.

This article distills priority areas from the IOM report and applies this framework to psychology, documenting the profession's progress to date in these areas and identifying priorities that have been insufficiently addressed. This analysis yielded eight high-priority recommendations for action by psychology to shape the workforce to meet the needs of older adults. The authors identify psychology organizations that are well positioned, by virtue of role, capacity, or prior work, to lead, collaborate on, or fund each activity.

In formulating the recommendations, the team of authors drew on their relevant experience: two are psychologists who served on the IOM committee that issued the report and three are geropsychologists who have been extensively involved nationally and locally in training and education, clinical care, and policy related to the care of older adults. In addition to synthesizing the published literature related to this topic, the paper was informed by communications from education, policy, and scientific leaders in geropsychology who have knowledge of the field that is not documented in the published literature.

Other psychologists have called on the profession to address the needs of our aging population (APA Presidential Task Force on Integrated Health Care for an Aging Population, 2008). The authors conclude this article by examining why the response to date has not been more substantive. They argue that fundamental shifts in population demographics and in the repositioning of psychology as a health services profession set the stage for concerted action on this agenda.

Workforce Priorities and Progress in Psychology

Estimate Supply and Demand

IOM perspectives—For health care professions to remain relevant, they must shape their workforce to address the population and its needs. However, when examining the *need* for and *supply* of a workforce qualified to address the behavioral health problems of older Americans, the IOM committee noted the absence of reliable information on supply or demand (Institute of Medicine, 2012). No national database exists that captures the supply of the mental health and substance use workforce, nor have professional associations agreed on a standardized dataset to assess and compare the size and characteristics of their membership. The Health Resources and Services Administration (HRSA) periodically funds estimates of mental health workforce shortage areas; however, these studies have not examined supply or demand issues related to older Americans. Inherent in the task of estimating supply are challenges in defining the qualifications and roles of those providers who are prepared to meet the needs of the older adult population.

The absence of data on workforce demand is even more striking. The IOM committee identified the many complexities involved in estimating demand and concluded that compelling evidence exists of a high level of behavioral health service need among older Americans, but could find no solid estimates of the size and composition of the workforce required to meet that need. In both policy and professional arenas, advocacy initiatives to make the case for developing the behavioral health workforce for older Americans are hampered by the lack of estimates derived from methodologically rigorous procedures.

Progress in psychology—Efforts to delineate the geriatric workforce supply within psychology include a 2002 survey (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002) and a 2008 survey (APA Center for Workforce Studies, 2010) of APA members. These studies were consistent in finding that only 3% to 4% of survey respondents, or an estimated 3,000 psychologists nationally, viewed older adults as their primary focus (Qualls et al., 2002). This available workforce is obviously dwarfed by the size of the older adult population.

Although few psychologists viewed older adults as their primary focus, a large percentage did report having *a few* older adults in their caseloads, ranging from 39% of psychologists surveyed (APA Center for Workforce Studies, 2010) to 69% (Qualls et al., 2002). The studies, along with a subsequent survey by Segal and colleagues (Segal, Qualls, Grus, & DiGilio, 2012) found that the dominant service model is one in which psychologists, who likely have had no formal training for work with this population, see a couple of relatively young older adults each week to whom they mainly provide psychotherapy. This is in

contrast with the more comprehensive and complex assessments and interventions tailored to older adults that are offered by specialists in geropsychology.

With respect to demand, Qualls and colleagues (2002) reported that there have been at least two somewhat dated attempts to predict the need for psychologists to treat older Americans. The first analysis estimated that 5,000 geropsychologists were required and the second increased the estimate to 7,500. In their review, Qualls and her colleagues concluded that existing psychologists could meet about half of the estimated need. The validity of these estimates, like the validity of many workforce projections, was somewhat questionable as the estimates were built on multiple assumptions, including the level of clinical need within the older adult population, the services to be provided, the amount of time required to deliver those services, the role of psychologists in integrated and interprofessional care models, and the number of psychologists currently qualified to provide the services.

Recruit and Retain the Workforce

IOM perspectives—A fundamental challenge for each profession is to interest its members in developing skills related to older adults and to maintain that interest over time (Institute of Medicine, 2008, 2012). The IOM committee identified a range of strategies that have been used as part of recruitment efforts across disciplines. An initial approach includes *early exposure* during training to older adults who are healthy so that students can better understand normal aging, as well as exposure to those with medical illnesses, problematic health-related behaviors, mental illnesses, and substance abuse. As an example, the GeriEd program at the Albert Einstein College of Medicine provides medical students with classroom and clinical exposure to older adult populations prior to selection of a medical specialty (Ehrlich & Jacobs, 2004). Evidence suggests that organized, learning-focused contact with stigmatized populations, including those who are elderly or mentally ill, can improve negative attitudes toward these populations (Institute of Medicine, 2012).

Scholarships and loan forgiveness, often tied to postgraduate service commitments, have been funded by federal agencies such as HRSA and by the states. Professional associations and foundations have had initiatives to provide *mentoring* to young students in social work and geriatric psychiatry through individual contacts with working professionals and participation in professional communities committed to caring for older adults with mental and substance use conditions. The students may become members of a professional geriatric society, attend professional meetings focused on this population, and learn about clinical and research career options (American Association of Geriatric Psychiatry, 2013; Association for Gerontology Education in Social Work, 2013).

Progress in psychology—Psychology has made efforts to increase early exposure to this population as a means to influence career interests and potential downstream recruitment into geropsychology or related fields. One strategy has involved infusing the topic of aging into high school and undergraduate education. For example, geropsychologists provided aging content into several standard-setting curricula guides, such as National Standards for High School Psychology Curricula (APA, 2011), *Guidelines for the Undergraduate Psychology Major* (APA Board of Educational Affairs Task Force on Psychology Major

Competencies, 2013), and *Toward an Inclusive Psychology: Infusing the Introductory Psychology Textbook With Diversity Content* (Trimble, Stevenson, & Worell, 2003). No evidence is available on the impact of these efforts.

Similarly, at the secondary school and undergraduate level, geropsychologists have provided educators with model course syllabi, teaching tips, and recommended educational videos and textbooks (<http://www.apa.org/ed/precollege/topss/about/index.aspx>; <http://www.apadivisions.org/division-20/education/index.aspx>). To complement these early exposure efforts, the APA Office on Aging has worked to further reduce barriers to recruitment by directly confronting stigma regarding older adults through media outreach to both the general public and psychologists (www.apa.pi/aging). Each of these efforts to disseminate information has a clear rationale. However, data are simply not available regarding their impact on career choices and professional practice.

A substantial number of federally funded health profession workforce programs currently focus on older adults, including loans and scholarships, which are funded under Title VII of the Public Health Service Act and are managed by HRSA (<http://bhpr.hrsa.gov>). APA advocacy has led to psychology's eligibility under a number of the provisions (<http://bhpr.hrsa.gov/grants/geriatricsalliedhealth>). However, awareness of these programs within the profession is less than optimal. Even seasoned geropsychologists find it difficult to understand which awards are applicable to older adults, which include a focus on mental health and substance abuse, which deem psychologists or psychology programs as eligible, and which are not only authorized by Congress but have had funds appropriated to support awards. For example, psychologists are eligible for Geriatric Career Incentive Awards, but Congress has not appropriated funds to support this program. Funds have been appropriated for Geriatric Academic Career Awards, but only one psychologist has been selected nationally. Although psychology graduate programs are eligible for Graduate Education Center Awards, no psychology programs have received them, though individual psychologists may have received some training through Center grants awarded to other types of university-based organizations (personal communication, K. Studwell, December 23, 2013). In sum, it is not easy to ascertain the extent to which psychologists have competed for these awards, but it is clear, given the relatively few number of awards, that the overall impact of these federal programs on geropsychology has been quite small.

With respect to mentoring, Psychologists in Long Term Care (PLTC; <http://www.pltcweb.org>), the Society of Clinical Geropsychology (APA's Division 12:2), and the Department of Veterans Affairs have mentoring arrangements in which professionals seeking ongoing guidance and support are connected with more experienced psychologists who have volunteered as mentors. The Society of Clinical Geropsychology, APA's Division of Adult Development and Aging (Division 20), PLTC, and the Council of Professional Geropsychology Training Programs, which is described later, maintain active listserv communities to provide forums for psychologists to get rapid input on issues related to clinical care, training, and practice administration. The mentoring opportunities are likely valued by those being mentored, though impact has not been formally assessed.

Declining reimbursement under Medicare has reduced the economic incentives for psychologists to serve older adults. A large percentage of these adults are covered by this government administered health plan. Psychologists provide an estimated 40% of outpatient and 70% of inpatient psychotherapy services to Medicare beneficiaries. However, their reimbursement for a 45-minute psychotherapy session has declined by 37% over the past 12 years when adjusted for inflation (Hartman Stein, 2013; Nordal, 2013). The APA Practice Organization (APAPO; <http://www.apapracticecentral.org>) and other groups, such as PLTC, have advocated extensively with the Centers for Medicare and Medicaid Services (CMS) to prevent further cuts and to restore previous cuts to psychologist reimbursement under Medicare (Hartman Stein, 2013). Some modest and selected improvements were achieved in the 2014 Medicare fee schedule (APAPO, 2013). However, Nordal (2013) described the recent results from an as yet unpublished Psychologist Payment Survey of 5,000 APA members, which raises serious concern about older adult's access to mental health services from psychologists. Among the respondents, 70% of these practicing psychologists had participated in Medicare as providers, but 26% left the program, principally because of low reimbursement rates.

Difficulty recruiting persons who represent *diverse* racial and ethnic groups has been a problem within geropsychology, as it is within the profession at large. Such recruitment is important because professionals of color are more likely to provide services to persons of color, develop stronger therapeutic alliances with them, and retain them in treatment at higher rates (Chao, Steffen, & Heiby, 2012; Field & Caetano, 2010). The National Institute of Health operated the Institute for Research, Minority Training on Mental Health and Aging program to engage more minority early investigators in geriatric mental health and substance use research. This initiative trained 11 psychologists, but then was discontinued (personal communication, A. Austin-Dailey, August 20, 2013). With the same objective, the National Institute on Aging funded an APA Minority Aging Network in Psychology, which trained 65 psychologists before the program was eliminated.

The Veterans Health Administration within the Department of Veterans Affairs (VA) has created various structures and requirements to recruit and retain psychologists to work with this population. An increasing number of internship positions provide exposure to and training with older adults and there are approximately 20 VA postdoctoral fellowship programs that offer advanced geropsychology training. The VA has hired a large number of psychologists to work with older adults, and most of these psychologists were VA trained. For example, every home-based primary care program is required to have at least one mental health professional who must be a psychologist or a psychiatrist, and most of these professionals are, in fact, psychologists. This represents approximately 200 positions across the VA system. In addition, long-term care settings in VA, known as community living centers, are required to maintain a ratio of one full-time psychologist for every 100 residents. Palliative care programs, including hospice programs and outpatient palliative care, also are required to have a psychologist on their teams.

Identify and Strengthen Competencies

IOM perspectives—The IOM committee endorsed the notion that essential workforce competencies must be identified and defined in order to advance the care of older adults with mental and substance use conditions (Institute of Medicine, 2012). Competencies, which involve knowledge, skills, and attitudes, are ideally the foundation for initial professional training, continuing education, licensure and certification, and the assessment of workforce performance. The IOM committee noted important distinctions between *specialty competencies* for professionals who dedicate a significant portion of their time to caring for older adults versus *competency enhancements* for other individuals in the workforce who, though not specialists, have some role in providing services to this population. It also noted the importance of interprofessional efforts to identify geriatric competencies that are common across professions, which could facilitate collaboration in interdisciplinary teams.

Progress in psychology—In 2006, a national conference led to the development of the Pikes Peak Model for Training in Professional Geropsychology (Knight, Karel, Hinrichsen, Qualls, & Duffy, 2009). This model, which drew extensively on an early version of the APA Guidelines for Psychological Practice with Older Adults (APA, 2004), delineated attitude, knowledge, and skill competencies for the entry-level geropsychology specialist. It included basic elements, such as knowledge about normal adult development and aging, as well as knowledge and skills regarding behavioral health assessment, intervention, and consultation with older adults, families, and the systems in which they receive care. There has been some interest in developing a set of competencies for work with older adults that targets the large number of nonspecialists in psychology who provide some services to older adults. A recent survey of a small number of training programs gathered preliminary input on potential competencies for this segment of the psychology workforce (Casciani, 2012),

The Pikes Peak Model served as the foundation for development of the Geropsychology Knowledge and Skill Assessment Tool (Karel, Emery, Molinari, & the CoPGTP Task Force on the Assessment of Geropsychology Competencies, 2010), which fosters self-assessment or a supervisor's assessment of professional competence with older adults (<http://www.gerocentral.org/copgtp/ppcat.php>). A preliminary validation study of this tool with 75 psychologists and 34 trainees found good reliability in terms of internal consistency across and within subscales (Karel et al., 2012). In multiple regression analyses, self-rated competencies were associated with receipt of formal clinical training with older adults and higher proportions of geriatric-focused practice, but *not* with levels of prior graduate coursework or continuing education on the care of older adults.

Provide Advanced Training and Certification of Specialists

IOM perspectives—The traditional approach to meeting the needs of unique populations has been to develop training and certification for specialists. The IOM report concluded that relatively few opportunities exist for advanced training and certification of expertise in the behavioral health care of older adults. Historically, social work, psychiatry, and professional mental health counseling (distinguished from counseling psychology) have been the only disciplines that have offered certification in this specialty. Since 2006, psychiatry has been unable to fill half of its geriatric fellowship slots due to a lack of applicants, while the field

of professional mental health counseling abandoned both program accreditation and professional certification initiatives due to lack of interest within its profession (Institute of Medicine, 2012). Nonetheless, every year a small cadre of specialists across different professions are developed in training programs focused on older adults. The typical approach involves at least 1 year of didactic instruction combined with clinical experience and supervision from a qualified mentor. The costs of education have been covered through various sources, including federal and foundation grants and institutional training funds, such as those available in the VA.

Progress in psychology—In 2010 APA recognized professional geropsychology as a specialty within psychology, building on the critical groundwork of the Pikes Peak competencies and training model and the APA Guidelines for Psychological Practice with Older Adults (APA, 2004). In order to create a mechanism for certifying specialists in geropsychology, leaders in the field formed the American Board of Geropsychology (ABGERO). In 2013, ABGERO entered the implementation phase of affiliating with the American Board of Professional Psychology (ABPP). The examination in geropsychology has been developed and ABGERO examined the founding board members and more than 30 additional candidates, which was a prerequisite to creating a formal, full affiliation with ABPP in the specialty of geropsychology. In December 2014, the Board of Trustees of ABPP formally approved geropsychology as an ABPP member specialty board.

Board certification requires evidence of specialized education and training. Within psychology, there are multiple pathways to geropsychology competence. Specialized training within graduate schools, internships, and postdoctoral fellowships typically involves coursework, supervised clinical experience, and/or research training related to older adults. In contrast, continuing education usually is much less structured, less intensive, and relies almost exclusively on brief didactic instruction or self-study. Continuing education opportunities to receive clinical supervision or consultation are rare. Therefore, postlicensure specialization in geropsychology is theoretically possible, but the continuing education structures are not yet adequate to support this pathway to geropsychology specialty competence for most psychologists.

Of particular concern is the general absence of federal non-VA support or foundation funding for training initiatives in psychology as compared to other disciplines. Beginning in FY 2002 HRSA allocated funds for psychology training under the federal Graduate Psychology Education (GPE) program. In FY 2003, a separate grant announcement was issued, dedicated to funding geropsychology training. Seven 3-year programs were funded nationwide that year, briefly providing a surge in geropsychology training opportunities. Subsequently, the funding opportunity specific to geropsychology training was eliminated. Although geropsychology training programs were eligible for the general GPE funding opportunities, the elimination of the dedicated grant announcement led to geropsychology program reductions and outright closures (Institute of Medicine, 2012). The federal government has continued to fund and, most recently, expand the GPE program, but no longer allocates funding dedicated exclusively to geropsychology training.

The Council of Professional Geropsychology Training Programs (CoPGTP) was formed in 2007 to recognize and support postdoctoral residencies, internships, graduate programs, and continuing education providers dedicated to professional geropsychology. As of this writing, CoPGTP has 15 member postdoctoral programs that provide training consistent with the Pikes Peak Model, as well as 14 internship programs and 14 doctoral programs. Using a different methodology, the Association of Psychology Postdoctoral and Internship Centers (<http://www.appic.org>) lists 68 postdoctoral programs that self-identify as offering “geropsychology” training, though how extensive such training is in geropsychology is essentially unknown. In contrast to geriatric psychiatry, professional geropsychology is generally able to fill all available postdoctoral training positions.

Provide Basic Training on Older Adults to All Health Care Professionals

IOM perspectives—Given the dearth of specialists in this field, the IOM committee concluded that *all* health care professionals should be trained in basic assessment and intervention skills with older adults. This applies not only to physicians, physician assistants, nurses, and pharmacists, but to individuals in the mental health and substance use professions who choose not to specialize in the care of older adults. Among the professions, training content for this purpose does exist. As one example of innovation, the Geropsychiatric Nursing Collaborative identified and disseminated different sets of recommended competency enhancements to guide curriculum, including one set for generalist entry-level nurses (Beck, Buckwalter, Dudzik, & Evans, 2011). However, with few exceptions, accreditation or licensing bodies have not mandated substantive content on aging in either required curricula or in licensing exams.

Progress in psychology—At present, the educational standards issued by the APA Commission on Accreditation require that all psychologists develop competence in issues related to diversity, and age can be considered one element of diversity. However, this requirement is very general. As it has been interpreted and enforced, basic competencies to assess and treat older adults are not required for all psychologists.

When APA recently invited comment on its *Guidelines and Principles for Accreditation* (<http://www.apa.org/ed/accreditation/accreditation-roadmap.aspx>), five professional groups partnered to submit input about the need for all psychologists to have exposure to work with older adults during the course of their doctoral training. These included APA’s Office on Aging, APA Division 12:2, APA Division 20, CoPGTP, and PLTC. Unfortunately, the subsequent draft revision of the *Guidelines and Principles* does not specify training in aging beyond the general diversity requirement (<http://www.apa.org/pi/oema/resources/communique/2014/06/health-service-psychology.aspx>). The implementing regulations for the revised standards have yet to be released.

There have been efforts to reach the postgraduate workforce through continuing education, such the annual APA convention workshop, What Psychologists Need to Know About Working With Older Adults (now online at www.apa.org/education/ce/aoa0009.aspx), and the annual 3-day-long geropsychology conference hosted by the University of Colorado, Colorado Springs. The GeroCentral Web site (<http://gerocentral.org/>) represents a joint effort

of numerous professional groups to consolidate educational resources to support geropsychology practice, and it includes a clinical toolbox, competency self-assessment, information on reimbursement, and a library of readings that link to each knowledge competency in the Pikes Peak Model. Similar resources exist for VA clinicians who can access the department's internal learning management system to receive online education on topics such as suicide prevention with older adults and cognitive evaluation of older adults in primary care.

These creative and collaborative educational activities have been important within geropsychology. From a larger workforce perspective, however, the profession has reached very few psychologists through these efforts and data on the impact does not exist. Controlled research studies have repeatedly shown that single session continuing education has little, if any, impact on the subsequent professional skills or behaviors of participants (Davis et al., 1999; Institute of Medicine, 2010). The most intensive continuing education event focused on geropsychology, the Colorado Springs conference, was discontinued after 5 years when foundation support expired and no source for sustainability could be identified (S. Qualls, personal communication, August 23, 2013).

Promote Integrated Care

IOM perspectives—The IOM committee concluded that for two common disorders among older adults, depression and at-risk drinking, strong research evidence has demonstrated the superior effectiveness of integrated, continuous care models. These approaches involve diverse providers working as a coordinated team to conduct out-reach, teach clients self-management strategies, track outcomes, and provide relapse prevention (Institute of Medicine, 2012). The implication is that behavioral health professionals serving older adults require training in these models of care, which typically involve a role for them as consultants, as opposed to primary providers, and require a degree of comfort working in settings such as primary care offices, rather than behavioral health treatment programs and private practices. Other health care providers also require training in integrated care models, interprofessional practice, and in the screening, brief treatment, and the collaborative care of persons with mental and substance use conditions.

Progress in psychology—Psychology's interest in integrated care has grown significantly in recent years as evidenced by APA's new Center for Psychology and Health (<http://www.apa.org/health/>), which was established in 2013. Its focus is on expanding the use of psychological knowledge within evolving health care settings and preparing psychologists to use their expertise in such settings. Concurrently, APA has advanced a number of critical initiatives. It defined guidelines for psychological practice in health care delivery systems (APA, 2013b) and developed competencies for psychology practice in primary care (APA Interorganizational Work Group on Competencies for Primary Care Psychology Practice, 2013).

Geropsychologists have long promoted integrated care, because older adults often present with multiple medical morbidities, and because medical conditions and treatments often have consequences, like pain or insomnia, that psychologists can address (Areán & Gum,

2013; Karlin & Zeiss, 2010; Kearney, Post, Pomerantz, & Zeiss, 2014). In addition, physical complaints often have a psychological contribution to their origin. An integrated approach to service delivery improves access to behavioral health care and provides a structure for addressing multiple chronic illnesses and complex social circumstances. A contemporary model of integrated care in geropsychology was articulated in *Blueprint for Change: Achieving Integrated Health Care for an Aging Population* (APA Presidential Task Force on Integrated Health Care for an Aging Population, 2008). At the national level, psychology contributed to two initiatives on integrated care for older adults sponsored by The American Geriatrics Society through its Partnership for Health in Aging. These included development of the Multidisciplinary Competencies in the Care of Older Adults at the Completion of the Entry-Level Health Professional Degree (http://www.americangeriatrics.org/about_us/partnership_for_health_in_aging/multidisciplinary_competencies/) and the Position Statement on Interdisciplinary Team Training in Geriatrics: An Essential Component of Quality Health Care for Older Adults (http://www.americangeriatrics.org/files/documents/pha/PHA_IDTStatement.pdf).

Strengthen Caregiving Roles of Direct Care Workers, Older Adults, and Family Members

IOM perspectives—Graduate-degreed health care professionals are not the only type of caregivers for this population. The IOM report described direct care workers, including aides, home health workers, and community health workers, as the largest group of health care providers for older adults. There will be a significant increase in demand for these workers as the U.S. population ages (Institute of Medicine, 2012). The committee identified a crucial need to strengthen the role of these providers, who typically receive little training, have low wages and high turnover, are seldom credentialed, and have few opportunities or incentives to improve their skills.

Through self-care and peer support, older adults also play a major role in caring for themselves and each other. Similarly, family members constitute a very large group of caregivers for older adults with mental health and substance use conditions. To maximize the effectiveness of these caregiving resources, the IOM committee (Institute of Medicine, 2012) emphasized the need to promote: an expansion of self-care and peer-led interventions for older adults, greater consumer and family involvement in the process of care, and strategies to strengthen families' skills in caring for older adult relatives, while managing the personal stress inherent in the family caregiver role (U.S. Department of Health and Human Services, 2013).

Progress in psychology—Within geropsychology, particular attention has centered on increasing the skills of *direct care workers* in long-term care settings to work with older patients with dementia (Cohen-Mansfield, 2003; Teri, Logsdon, & McCurry, 2002). Such approaches often involve psychologists teaching management techniques for behavioral symptoms of dementia, with a focus on assessing the etiology of disruptive behaviors, matching interventions to individual needs, and increasing positive stimuli (Cooper et al., 2012). Psychologists, in collaboration with professionals in other disciplines, have developed or implemented *peer-led* programs for older adults residing in the community (Chapin et al., 2013) and in long-term care settings (Camp & Skrajner, 2004; Rook &

Sorkin, 2003; Winningham & Pike, 2007). With respect to *self-care*, psychologists also have contributed to efforts to develop and test self-management programs for older adults with depression (McKendree-Smith, Floyd, & Scogin, 2003; Moss, Scogin, Di Napoli, & Presnell, 2012), anxiety, and comorbid mental health and medical conditions (Fisher et al., 2013; Wetherell et al., 2011).

Psychologists have made important contributions to the development and testing of interventions to teach the *families* of individuals with dementia to manage behavioral problems, while providing support to and ameliorating depression among family caregivers (Bass et al., 2013; Belle et al., 2006; Gallagher-Thompson et al., 2012; Kajiyama et al., 2013; Sörensen, Pinquart, & Duberstein, 2002).

In 2010, APA president Carol Goodheart convened a task force to develop an online Family Caregiver Briefcase (<http://www.apa.org/pi/about/publications/caregivers/>), which includes focused attention on older adults. This serves as a tool for psychologists assisting family members and also addresses the role of psychologists in graduate education, research, and advocacy related to family care-giving.

Recommendations

Analyzing workforce priorities in the IOM report and the progress by psychology in each of these areas yields a long list of possible recommendations for the profession as it moves forward. Because resources are limited and many workforce interventions would likely have uncertain or, at best, modest influence, selecting a small number of potentially high impact interventions is important. Eight high priority workforce strategies are recommended below as a guide to action by the profession (see Table 1).

Mindful of the relatively small number of specialists in geropsychology and the limits on their volunteer activities to accomplish the recommendations, potential funding sources to support these activities are suggested. An overarching assumption is that accomplishing these diverse workforce objectives will require more assertive action by APA leadership than it has historically exercised in shaping the psychology workforce. Geropsychology professional associations are active and innovative, but small. Substantive change in the capacity of the profession to meet the needs of older adults will be dependent on APA driving that change.

1. Identify for All Psychologists an Essential Set of Core Competencies and a Minimum Level of Graduate Training in the Care of Older Adults

Specialization in geropsychology has been well defined through specification of the Pikes Peak Competencies and the requirements for the newly created ABPP Board Certification. While it is important to grow these efforts, it is clear that the small group of geriatric specialists in this nation, including geropsychologists, will never be sufficient in number to meet the majority of behavioral health needs of older adults. Because this demographic group will soon be 20% of the population and because the majority of practicing psychologists appear to be providing some services to older adults, psychology has an obligation to specify a core set of competencies and the training in those competencies that

should be acquired by all individuals entering the profession. With financial and organizational support from APA, geropsychology training and practice organizations, such as Division 12:2 and CoPGTP, have the knowledge base and professional relationships necessary to convene a panel of experts to accomplish these tasks.

2. Incorporate the Minimum Competency and Educational Standards Into the APA Guidelines and Principles for Accreditation

Recommendations regarding core competency development and minimum levels of training related to older adults are unlikely to be met with voluntary compliance by graduate programs. Large-scale competency adoption and curriculum reform will require incorporation of these requirements into the profession's standards for accreditation. Responsibility for this action clearly falls to the APA Commission on Accreditation as it revises *Guidelines and Principles for Accreditation* and develops the corresponding implementing regulations.

3. Expand Content on Older Adults in the Examination for Professional Practice in Psychology

The national licensing examination for the profession should reflect the competencies needed for licensed practice, which, given the demographic shift, will include some practice with older adults for the majority of psychologists. Moreover, educators often do, in fact, "teach to a test." Therefore, shaping this exam is yet one more way to ensure that educational programs adequately prepare their students on essential topics related to aging. Responsibility for changes to the content of this national exam lies squarely with the Association of State and Provincial Psychology Boards (ASPPB).

4. Develop and Promote Adoption of a Graduate-Level Model Curriculum on Older Adults

Competency and training standards should be complemented by the development of resources that graduate programs can use to meet these new requirements. The curricula should include exposure to normal development in aging and to the prevention, assessment, and treatment of behavioral health conditions in older adults. An emphasis in the curricula on team-based practice and integrated care would serve to educate students about evidenced-based approaches to the treatment of older adults, while also promoting the profession's objective to play a larger role in interprofessional practice within health systems (American Psychological Association, 2013a; Steffen, Zeiss, & Karel, 2014). Such resources may be of value within internship sites, as well.

APA should lead the effort to arrange the essential financial support for these initiatives, either providing it directly or securing it through federal agencies and foundations. Once the financial resources are available, the leadership of APA Divisions 12:2 and 20, along with representatives of CoPGTP, are well positioned to create the curriculum resources and a structure to promote their dissemination and adoption. Consultation to and mentoring of training faculty will be essential given the current dearth of faculty with expertise in geropsychology.

5. Establish an Evidence-Based Continuing Education Pathway in Geropsychology

The four recommendations above deal with the pipeline of newly trained psychologists. However, opportunities are needed for practicing psychologists to obtain skills in working with older adults. Educational leaders within CoPGTP, Divisions 12:2 and 20, and PLTC should convene workgroups to organize evidence-based teaching programs that will be the foundation of continuing education initiatives in geropsychology and a pathway to competence for the existing workforce. This would include the use at regional locations of longitudinal and sequenced problem-oriented educational approaches that incorporate modeling of skills, observation of learner practice, coaching and feedback, and integration of learning into the flow of routine activities using work-based learning strategies (Institute of Medicine, 2010). Funding from multiple sources, including the Department of Health and Human Services, foundations, and APA is needed to develop the teaching programs and underwrite broad scale offerings of effective continuing education on the behavioral health care of older adults.

VA could also play an important role in the development of new evidence-based continuing education. It currently has a well-developed program to train staff in evidence-based treatments, with some content on adaptations of treatments for use with older adults (Ruzek, Karlin, & Zeiss, 2012). With direction from VA leadership and support from Congress, the content on older adults within this system could be significantly expanded.

6. Develop the Caregiving Skills of Other Professionals, Direct Care Workers, Older Adults, and Their Families

Workforce development within psychology, as described in these recommendations, is a necessary, but not sufficient strategy, to meet the needs of older adults. Drawing on the core competencies and training curriculum referenced above, the profession should expand its efforts to educate other health professionals about the prevention, assessment, and treatment of behavioral health conditions in this population, with a special emphasis on team-based, integrated care models. Although psychology, in general, has not been promoting a terminal masters degree as a career path within its own field, psychologists can play an enhanced role in training, mentoring, and supervising master's-level clinicians from other disciplines in the care of older adults. Similarly, the profession should expand efforts to: train and consult with nondegreed, direct care workers who serve this population; develop and teach self-care to individuals over age 65; and support the development of caregiving and self care skills among family caregivers. APA Divisions 12:2 and CoPGTP could plan and coordinate the expansion of these efforts, in collaboration with the similar groups from other professions. In order to accomplish this goal it will be necessary to secure federal, state, and foundation support to mount initiatives of significant size to make an impact.

7. Advocate for Expanded Federal Financial Incentives for Work With Older Adults

The recommendations listed here focus on increasing the size of the workforce skilled in caring for older adults. However, health care financing impacts workforce recruitment and retention within this and other areas of practice. Efforts to increase financial reimbursement for services delivered to older adults face enormous obstacles and generally yield, at best, modest changes after long periods of advocacy. However, reimbursement guidelines and

rates appear to have such a large influence on practice patterns that APAPO, in partnership with geropsychology professional groups, should redouble its efforts to encourage Congress and CMS to significantly enhance reimbursement of services provided by psychologists under Medicare and to modernize reimbursement guidelines to compensate for the delivery of integrated care. As reimbursement policies shift under the Affordable Care Act, APAPO must be poised to advocate for psychological care for older adults, like all populations, as integral to overall health care quality.

8. Create a Supply and Demand Analysis for Psychologists Qualified in the Care of Older Adults

Psychology aspires to be a data driven profession in its diverse activities, but does not craft its training and accreditation based on data regarding population health needs. As one aspect of the profession's efforts to ensure that its workforce has relevant preparation for practice, it should establish a rigorous methodology for estimating the *demand* or need for psychologists capable of providing services to older adults and the *supply* of such psychologists at any given point in time. Such analyses would undoubtedly be used to advocate for federal and foundation funding to support the development of this workforce, but should also yield targets to which the profession holds itself accountable. Conducting these analyses will not have an immediate impact on the workforce. However, it creates an essential foundation for a data driven approach to future planning and recommendations regarding these workforce needs.

Estimating current and future demand involves drawing on the best available evidence of clinical need, probable service models, and the likely role of psychologists in the rapidly evolving American health care system. The numerous assumptions that must be made in such modeling about demand, service types, service volume, and the pipeline of future psychologists should be clearly articulated so that they can be periodically revisited and updated. Generating estimates of supply will require surveys of both APA and non-APA members, and collaboration with the ASPPB to standardize data on workforce supply. Conducting such workforce analyses clearly falls within the mission of the APA Center for Workforce Studies (<http://www.apa.org/workforce>), which, in conducting these analyses, would undoubtedly draw on the Minimum Data Set that APA and ASPPB developed with the HRSA National Center for Health Workforce Analysis (<http://bhpr.hrsa.gov/healthworkforce/data/minimumdataset/index.html>).

The Process of Change

The logical sequence into which the recommendations are organized involves improving the ability to care for older adults among three groups: the pipeline of new psychologists being trained (Recommendations 1–4); practicing psychologists (Recommendation 5); and other professionals, direct care workers, older adults, and their families (Recommendation 6). There is an inherent stepwise order in which competency identification (Recommendation 1) lays the foundation for strengthening accreditation standards and licensing exam content (Recommendations 2 and 3), which, in turn, create the demand for and adoption of graduate curricula on older adults (Recommendation 4). The graduate-level resources, once

developed, would have utility in educating other portions of the workforce (Recommendations 5 and 6).

The process of change, however, is seldom orderly. With relative ease and with modest resources, APA could commission concurrent work on the core competencies, graduate-level curricula, and continuing education initiatives. These should be immediate priorities. Building a supply and demand analysis is quite feasible but very complex. Thus, it should be considered an intermediate term goal. Other recommendations, such as changing educational standards, licensing exam content, and federal financial incentives are equally essential, but require a longer time horizon given the practical and political obstacles.

Discussion

The analysis above suggests that psychology has made some significant strides over the past decade in its efforts to strengthen the ability of the profession and the professionals within it to respond to the needs of older adults. Experts in the care of older adults created a set of core geropsychology competencies that are now widely recognized in the field. APA has recognized geropsychology as a specialty and a process for board certification has been developed. Leaders within the profession have formed a council to promote training in geropsychology at the graduate, internship, and postdoctoral level, and the number of programs that offer curricula and supervised experience with older adults has increased. Mentoring and loan repayment programs have been used to attract psychologists to this work and federal initiatives were launched to develop young researchers. A directorate within APA has established an office to advocate in diverse forums for geropsychology and the service needs of older Americans.

These accomplishments have created an essential foundation for geropsychology within this profession. However, there remain many reasons for concern. Only a *very* small fraction of psychologists have specialized in the care of older adults despite both the large and rapidly growing percentage of individuals over 65 in the U.S. population and their heavy use of health care services. A majority of psychologists are involved in providing some very limited services to a very small number of older adults, but with no apparent training regarding the issues unique to assessing and treating this population. In the educational pipeline of new psychologists there are no requirements that students receive any training in the care of older adults. Few trainees are systematically exposed to the older adult population, to services tailored to that population, or to geropsychologists as role models and mentors. If such training were mandated, there is no recognized set of core competencies by which this majority could obtain some skill enhancements to prepare them for this work. Although the profession has made progress in defining psychologists' roles on interprofessional teams—a frequent site of care for older adults—it has lost ground over the past decade in reimbursement for its services under Medicare, which undermines both recruitment and retention of these essential professionals. In light of these many limitations, psychology is not widely viewed as a core health profession for older adults.

Other professionals have called previously for psychology to better address the needs of this population. Numerous factors have undermined the possibility of change, such as stigma and

discrimination toward older adults and a professional training system that is shaped more by student and faculty interests than by population needs. However, many historical trends are giving way to new forces that set the stage for a more significant response from the profession in the near future, as detailed here:

- Older adults have been considered a significant, though not dominant, sector of the U.S. population. But of late, they have risen prominently in this country's awareness as a rapidly growing demographic that will reshape significant elements of American society and its health care system. The impact is now *almost* impossible to ignore.
- Historically, psychology has defined itself as a *mental health* profession. But, quite recently, it has begun a major and quite public effort to redefine itself as a *health service* profession, attempting to strengthen its position in the mainstream of health care providers and health care systems. This important objective, set forth by APA, can only be achieved if psychology has a workforce of demonstrated competence in caring for the subgroup of the U.S. population that utilizes the highest level of health care services, namely older adults.
- The traditional response of psychology and other professions to the needs of unique populations has been to train specialists. However, most contemporary models of health care delivery now rest on the assumptions, supported by data, that the number of specialists is and will continue to be very small and that few individuals will receive services from them. Fueled by numerous provisions within the Affordable Care Act, the emphasis on specialization is giving way to integrated care models in which behavioral health professionals, through collaborative and consultative service models, are expected to have broad competence in working with diverse populations across the life span.
- Establishing a new specialty within a discipline is both a professional and a political process. Geropsychology interest groups, in their historical efforts to establish their specialty, have been very careful *not* to insist that all psychologists providing services to older adults, no matter how few older adults, have specific training and skills to work with this population. However, all professions, including psychology, have been placing much greater emphasis on identifying, assessing, and requiring workforce competencies. The notion of a professional serving a major segment of the population, such as older adults, without the training or demonstrated competence to do so is becoming increasingly untenable in organized systems of care.
- In the absence of data, there have been few metrics and only a couple of relatively obscure surveys available to judge the extent to which psychology as a profession has had a workforce to meet the needs of older adults. With the establishment by APA of its Center for Workforce Studies, which occurred just several years ago, more reliable and much more public data is likely to be generated over the next decade about the disconnect between the size of the older adult population in the United States and the lack of preparation among most psychologists to meet their needs. The visibility of this information will make the current absence of an

adequately prepared workforce increasingly unacceptable to the profession, to payers, and to accrediting and licensing bodies.

Psychology has often looked outward, to the government, to foundations, or to the IOM, to address workforce needs and imbalances related to older adults. Internally, it has relied on the efforts of a small and committed group of geropsychologists whose numbers and resources are dwarfed by the size of the challenge. Remarkable shifts are occurring in the composition of the U.S. population leaving psychology, as an organized profession led by APA, with an ethical responsibility to use all the levers at its disposal to shape its workforce to meet the needs of the changing population. It risks becoming largely irrelevant within the nation's health care system if it fails to act decisively.

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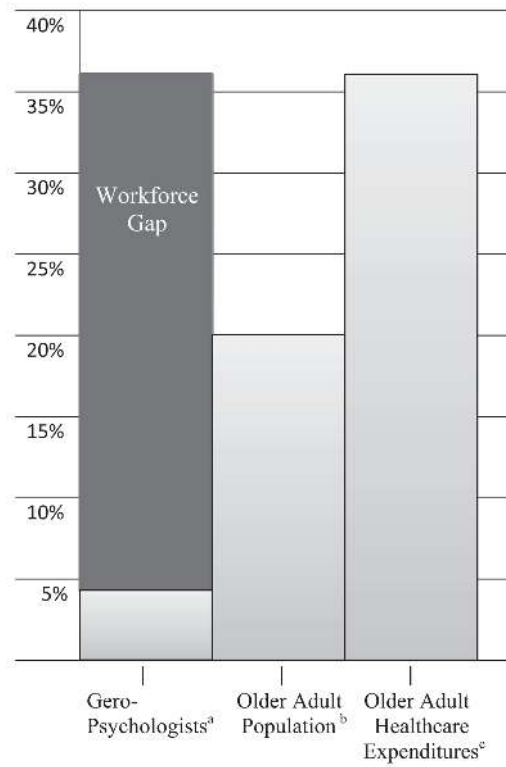


Figure 1.

The Psychology Workforce Gap for Older Adults

^a Only 4% of the psychology workforce has received specialized training in geropsychology. ^b By 2030, 20% of the U.S. population will be older. ^c Currently 36% of health care expenditures are for older adults, a number that will rise as the population ages.

Table 1**Recommended Actions: A Workforce Blueprint for Psychology**

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- 1 Identify for *all* psychologists an essential set of core competencies and a minimum level of graduate training in the care of older adults.
 - 2 Incorporate the minimum competency and educational standards into the *APA Guidelines and Principles for Accreditation*.
 - 3 Expand content on older adults in the Examination for Professional Practice in Psychology.
 - 4 Develop and promote adoption of a graduate-level model curriculum on older adults.
 - 5 Establish an evidence-based continuing education pathway in geropsychology.
 - 6 Develop the caregiving skills of other professionals, direct care workers, older adults, and their families.
 - 7 Advocate for expanded federal financial incentives for work with older adults.
 - 8 Create a supply and demand analysis for psychologists qualified in the care of older adults.