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California's Behavioral Health Services Workforce Is Inadequate for Older Adults

Janet C. Frank, Kathryn G. Kietzman, and Alina Palimaru

“Older adults ... require a well-trained workforce with geriatric behavioral health expertise.”

SUMMARY: The Workforce Education and Training component of California's Mental Health Services Act, which passed in 2004, has infused funding into the public mental health system. However, funding has not kept pace with an existing behavioral health workforce shortage crisis, the rapid growth of an aging population, and the historical lack of geriatric training in higher education for the helping professions. This policy brief draws on recent study findings, state planning documents, and

a review of the literature to describe gaps and deficiencies in the behavioral health workforce that serves older adults in California. The brief offers recommendations to the following specific audiences for improving workforce preparation and distribution: state policymakers and administrators; educational institutions, accrediting bodies, and licensing boards; and county mental health/behavioral health departments and their contracted providers.

Older Adult Behavioral Health Care Needs

Despite over two decades of reports documenting the inadequate number and preparation of workers trained to serve the unique behavioral health needs of older adults, this critical deficit remains unaddressed.^{1, 2} According to a 2012 Institute of Medicine and National Academies Report, “The workforce is not prepared—in numbers, knowledge and skills—to care for the mental health and substance use needs of a rapidly aging and increasingly diverse older adult population.”¹

Unfortunately, this statement mirrors the experience in California, as shown in findings from the 2017 California Mental Health Older Adult System of Care study,³ as well as in a review of planning activities currently underway at the California Office of Statewide Health Planning and Development (OSHPD) and the California Behavioral Health Planning Council (CBHPC).

Older adults have important needs in mental health and substance abuse/misuse (behavioral health) that require a well-trained workforce with geriatric behavioral health expertise in the areas noted below.

Suicide Prevention

The incidence of suicide is particularly high among older males, and the suicide rate among older white males (ages 85+) is more than four times higher than the overall rate in the nation.⁴ Suicide attempts are often more lethal in older adults than in younger adults. Compared to adults under 60 years of age, older adults who attempt suicide are often more frail, more isolated, more likely to have a suicide plan, and nearly twice as likely to use firearms as a means of suicide.⁴

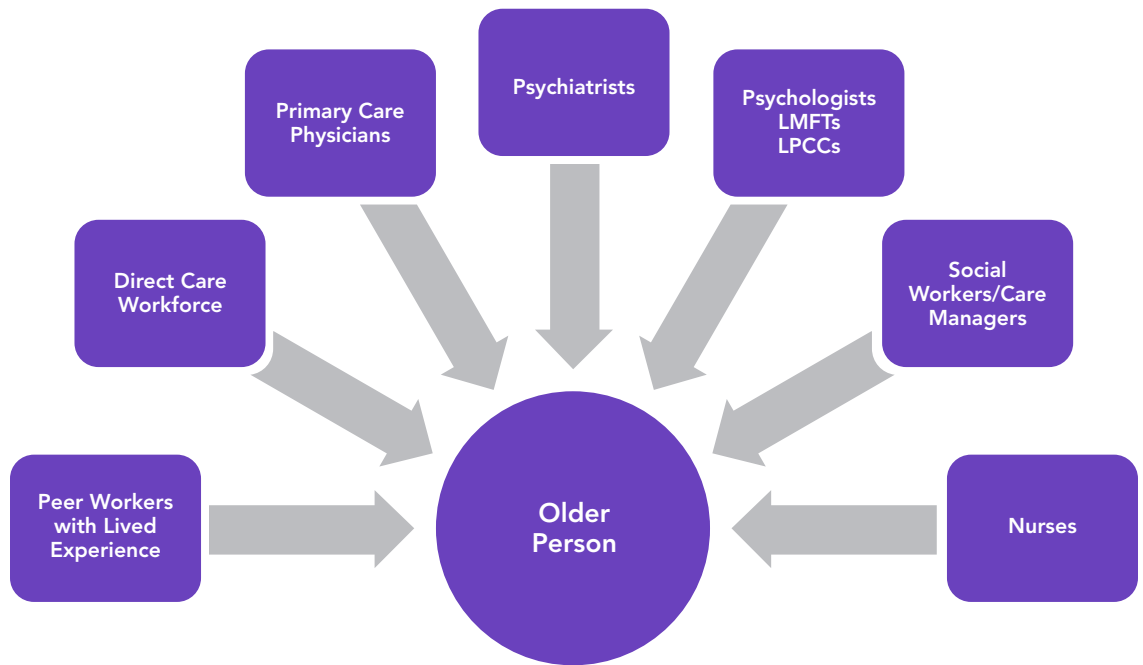
Depression and Anxiety

Depression is the most common mental illness in late life and decreases quality of life.⁵ Nationally, between 8 and 16 percent of community-dwelling older adults have depressive symptoms, and rates are



Exhibit 1

California's Behavioral Health Workforce for Older Adults



“In 2016, California had more than 80,000 licensed behavioral health professionals ... but very few had specialized training in geriatrics.”

substantially higher among older adults with medical illnesses.⁶ A recent study of people receiving community-based aging services in New York state found that more than one-quarter (27 percent) met the criteria for having current major depression, and nearly one-third (31 percent) had clinically significant depressive symptoms.⁷

Older adults also experience anxiety disorders: between 3 and 14 percent meet the diagnostic criteria, and even more have clinically significant anxiety symptoms that impact their functioning.⁸ Unfortunately, depression and anxiety disorders are often unrecognized and undertreated in older adults. Detection and diagnosis are often complicated by medical comorbidity, cognitive decline, and changes in life circumstances among this age group.⁸

Alcohol and Substance Misuse/Abuse

Recent community surveys have estimated that as many as 16 percent of older adults are at risk of developing drinking problems or are already problem drinkers. Substance abuse—particularly of alcohol and prescription drugs—among adults 60 years and older is one

of the fastest-growing health problems in the country.⁹ According to the Substance Abuse and Mental Health Services Administration (SAMHSA), over 60 percent of the 1.1 million emergency department visits for adverse drug reactions in 2012 involved an older adult, and nearly 25 percent of these emergency visits involved narcotic and nonnarcotic pain relievers.¹⁰ Further complicating treatment of older adult substance abusers is the fact that these individuals are more likely to have undiagnosed psychiatric and medical comorbidities.

Behavioral Health Workforce in California *The Numbers*

California's behavioral health workforce includes people in various occupations, with different scopes of work and training requirements (see Exhibit 1). In 2016, California had more than 80,000 licensed behavioral health professionals in a variety of disciplines,¹¹ but very few had specialized training in geriatrics.¹

There are more than 3,000 psychiatrists in California, but the number with specialty geriatrics training could not be located.

According to the American Association of Geriatric Psychiatry, there are fewer than 1,800 geriatric psychiatrists in the entire U.S. today.¹²

Very few nurses (an estimated 1 percent), psychologists (estimated at 4 percent), or social workers (4 percent) have training in and/or specialize in geriatrics, and only about 3 percent of medical students take any geriatrics electives during their training.¹ Medical residents are required to take one 30-day rotation in geriatrics, typically in a hospital setting. Currently, there are 721 certified geriatricians in California—far below the number needed. The Institute of Medicine (IOM) has estimated that the U.S. will need nearly fivefold more geriatricians by 2030 (about 36,000), while the current pipeline is expected to produce only 7,750 (about one for every 4,254 older Americans).^{13, 14}

Data do not exist on the numbers of primary care providers who have had specialized training in behavioral health for older adults, because they do not have recognized credentials and are difficult to track.¹ Nonlicensed peer workers—people with lived experience, meaning they have or have had a mental illness or a history of alcohol and/or drug abuse—are an important part of the behavioral health workforce. There are a number of peer-training program models (e.g., peer support specialists) that have added important resources to behavioral health services.¹ However, despite recent legislative efforts, California lacks a peer certification process that could further promote this vital segment of the behavioral health workforce.¹

Workforce Characteristics

There is mounting concern that the behavioral health workforce shortage crisis will become even more acute due to the aging of the workforce and the lack of trainees in the pipeline to replace these workers.¹³ Of particular concern in California is the lack of representation of ethnic and racial minorities; African-Americans and Latinos are underrepresented in psychiatry and psychology,

and Latinos are also underrepresented in counseling and social work.²

There are also rural/urban geographic disparities in the distribution of the behavioral health workforce across California. Exhibit 2 illustrates the extent of public behavioral health workforce shortages and disparities in California, with 207 defined geographic areas federally designated as having workforce shortages.

California Mental Health Older Adult System of Care Study

The California Mental Health Older Adult System of Care (OASOC) study was the first evaluation of how California's public mental health delivery system has served older adults (60 years of age and over) since the passage of the MHSA in 2004. The study documents unmet needs among older adults with behavioral health conditions, along with deficits in the representation of older adults in required MHSA planning processes, outreach and services, workforce development, and outcomes measurement and reporting.³ The following section summarizes findings related to workforce development, with particular attention to the use of Workforce Education and Training (WET) funds.

Workforce Education & Training (WET) Funding Impact

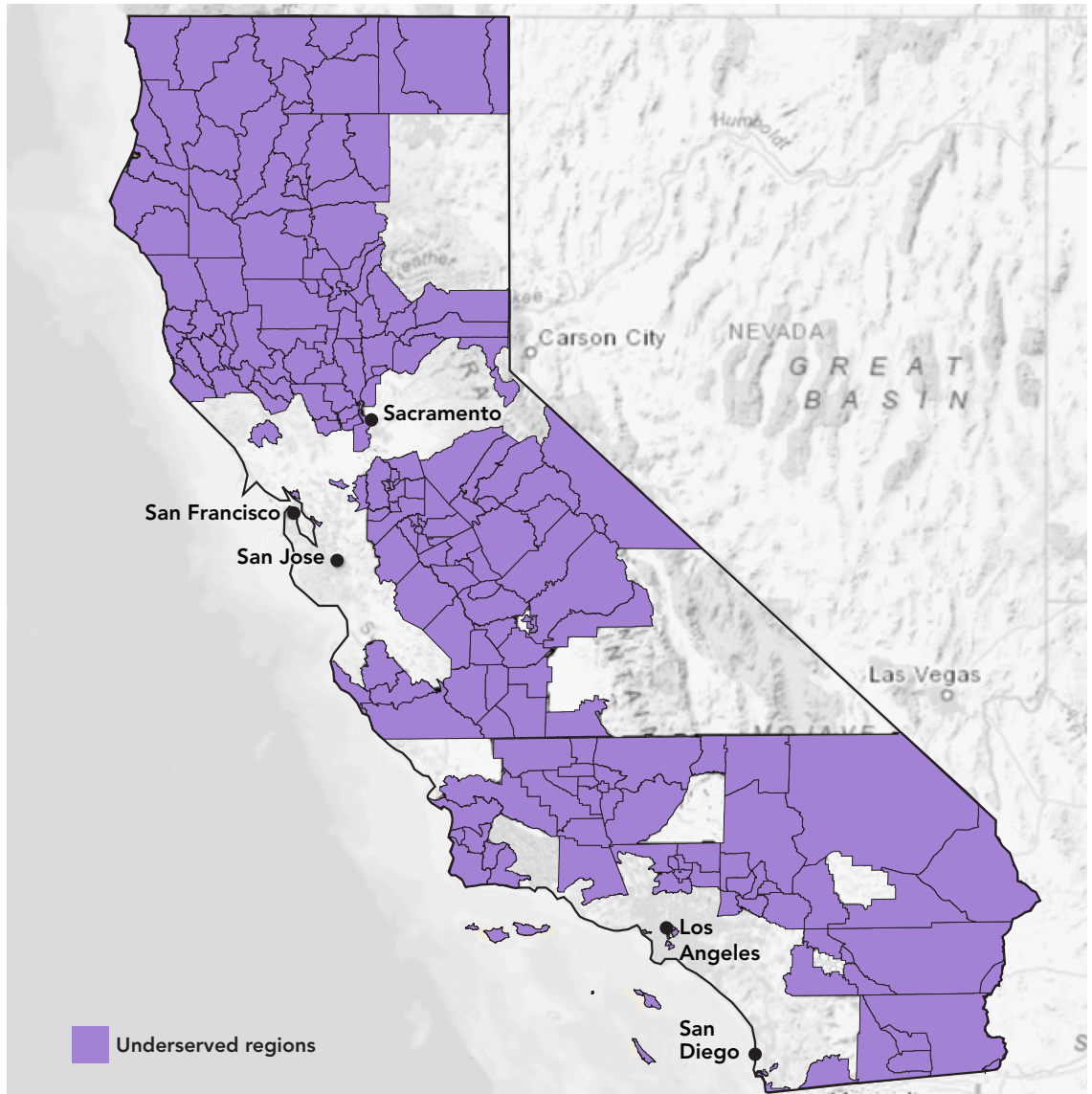
WET infused resources into the California public mental health system with the goal of developing a diverse workforce and providing services that are linguistically and culturally competent, as well as relevant to client needs. Key informants from the OASOC study reported that WET resources have had a noticeable impact on county capacity to support workforce training and education related to older adult behavioral health care, yet gaps remain.³

WET funds have been utilized for programs that have increased both the educational capacity of professionals and the training

“The behavioral health workforce shortage crisis will become even more acute due to the aging of the workforce and the lack of trainees ... to replace these workers.”

Exhibit 2

California: Mental Health Professional Workforce Shortage Areas



Source: California Health and Human Services Agency, Office of Statewide Health Planning and Development

“Understaffing and inadequate geriatric and behavioral health training are problems in all counties.”

and employment of consumers and family members* within the public mental health care system.³ However, many challenges still remain as a result of the rapid growth of an aging population and the historical lack of geriatric training in higher education for the helping professions, combined with an existing behavioral health workforce shortage

* Consumers with serious mental illness (and their family members) who have “lived experience” can be trained and hired to be peer /family support specialists within the public mental health system. Peer support specialists engage in a relationship without the constraints of the traditional expert/patient or expert/family member role and promote therapeutic interactions with others who share a “lived experience” of mental illness or substance abuse. In addition to helping support the recovery of others, the provision of peer support typically becomes part of the consumer’s own continuing recovery process.

crisis. Understaffing and inadequate geriatric and behavioral health training are problems in all counties, although some larger counties have provided more geriatrics training to agency staff and providers, compared to smaller and predominantly rural counties. Even with WET funding, rural counties have critical recruitment and retention issues, and these counties often rely on trainees’ receiving WET stipends and loan forgiveness for staffing clinical services.³

It is not possible to quantify how WET funds have been used across counties for preparing the workforce to appropriately serve older adults with serious mental illness (SMI) and

behavioral health problems. The state collects information on the demographics of participants in the stipend programs, but not on the type, content, or quantity of training received. While some counties do report the types of training provided, this is not a state requirement. Although WET funds are often used by counties to support loan forgiveness and to provide stipends for social workers and psychologists, the extent to which counties have prioritized the needs of older adults is unknown.³

Key informants from the OASOC study reported that there is a need across counties for geriatrics training in all behavioral health clinical care areas and related settings, such as in residential care. Some counties had no providers who were formally trained in older adult behavioral health care, and they cited the need for training in older adult suicide screening and in the differential diagnosis of mental illness and dementia. State stakeholders acknowledged that training in medication management and drug interactions is another especially important area of education for providers serving older adults.³

Challenges to Developing Geriatric Workforce Capacity

The OASOC study identified challenges related to workforce capacity, including staff shortages and the high turnover of clinical staff in general, and particularly of staff with geriatric training.³ Lack of case management staff overburdens clinicians and licensed providers. In one rural county, recruitment and retention of high-level agency administrators was also difficult. Informants reported that in addition to a lack of funding and to retirements, staff experiences the burdens of large caseloads and required reporting. Rural counties are at a severe disadvantage for recruiting and retaining clinicians, and they often rely on trainees who are receiving state WET stipends and loan forgiveness. One provider participant described these disparities as a “zip code lottery,” meaning that the services an individual has access to and the availability of providers depends on where

that person lives.³ One administrator from a large rural county noted that when trainees have completed their education, they often move to other counties or take positions that offer higher pay. The almost constant turnover of clinical staff is very problematic, as it impedes the development of clinical rapport, disrupts continuity of care, and results in a less experienced workforce.³

A major barrier to workforce development in older adult behavioral health care is that there is no state guidance, with counties having sole discretion over how they use their WET funds. This results in very little focus in many counties on the mental health needs and complexities of older adults with serious mental illness in sponsored education and training programs.³ The availability of funding for state-administered WET projects ended in 2018, and while the requirement for the development of a five-year Workforce Training and Development Plan continues, no new MHSA funding has been allocated for this purpose. Counties can redirect a limited percentage of service dollars to training, but few do so.

Improvement Strategies and Policy Recommendations

A number of national groups have identified improvement strategies and made recommendations to address behavioral health workforce deficits, and the geriatric workforce crisis in particular.^{1, 15} This policy brief builds on and identifies the action steps needed to implement these recommendations in California. The recommendations are tailored for three major spheres of influence: the California legislature, state agencies, and policymakers; institutions of higher education, accreditation bodies, and licensing boards; and county mental/behavioral health departments and contracted service providers.

California Legislators, State Agencies, and Policymakers

Several statewide groups, such as the California Behavioral Health Planning Council and the California Council of Community Behavioral Health Agencies,

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have been working together to advocate for one year of gap funding for the existing five-year WET plan, as well as for a stable and sustainable funding source for local and statewide WET activities moving forward.

OSHPD is currently going through a planning process to develop the next WET five-year plan, without the benefit of knowing what funding may be available. Planning efforts to date have focused generally on the behavioral health workforce, with little attention to the unique issues associated with service delivery to older adults and people with complex medical needs.

Many stakeholders are advocating for legislation to continue the stipend and loan forgiveness programs previously supported at the state level by WET. Loan forgiveness for psychiatrists and other licensed clinical providers (e.g., social workers) has previously been provided by WET to incentivize clinicians to work in medically underserved regions and take hard-to-fill/retain positions. In Los Angeles County, the Mental Health Department included an “older adult” category in the criteria for award consideration; there is no statewide data-reporting requirement in place to determine whether other counties do this as well.

Recommendation 1: In its next five-year WET plan, OSHPD should include a requirement for counties to designate priority slots in future loan forgiveness and stipend programs for trainees who are interested in geriatric behavioral health services. The percentage of slots so designated should be consistent with each county’s prevalence of older adults with behavioral health needs. Data reporting on this requirement should be mandatory.

Recommendation 2: To address the needs of small, rural, and frontier counties, the next WET plan should include special considerations for promoting the geriatric behavioral health workforce—for example, designated funding allocations and a streamlined application process.

Recommendation 3: California’s outgoing governor recently vetoed a bill that would have established standards and a certification process for peer-support specialists. California’s incoming governor should consider and sign future legislation following the direction of the other 47 states that have already created a standardized peer-support specialist certification system.

Recommendation 4: The California Mental Health Oversight and Accountability Commission and OSHPD should develop a more robust data-collection system that tracks the current and projected status of the behavioral health workforce as well as related activities funded through the MHSA. The Board of Behavioral Health Sciences could lend its support to these additional data-collection efforts. Data collection should include specifics about the availability of provider types and specialties, MHSA-funded geriatric behavioral health education and training programs, demographic and professional attendee characteristics, the number of people who attended the programs, and trainee and organizational outcomes for the programs.

Recommendation 5: The Department of Health Care Services (DHCS) currently administers a multimillion-dollar contract with the California Institute for Behavioral Health Strategies (CIBHS) to provide training to counties. DHCS could direct CIBHS to utilize some of that funding to develop and deliver a geriatric curriculum to the existing behavioral health workforce in order to inform and better prepare their work with older adults.

Institutions of Higher Education, Accrediting Bodies, and Licensing Boards

Recommendation 6: California’s higher education programs for the disciplines in the behavioral health workforce (see Exhibit 1) should ensure that geriatric topics are included in the core curriculum, and that geriatric behavioral health elective courses for specialization are available and are promoted to students.

Recommendation 7: Accrediting bodies and professional organizations should include geriatric behavioral health competency expectations as a component of curriculum review and set standards for prioritizing this area of expertise within programs.

Recommendation 8: Licensing boards (e.g., psychiatry and clinical social work) should include questions about key content in geriatric behavioral health linked to competency standards on all behavioral health profession licensing examinations.

Recommendation 9: Community colleges and university extension programs should develop career technical education programs and peer education programs to support the development of paraprofessionals in geriatric behavioral health.

County Behavioral Health Departments and Contracted Service Providers

Recommendation 10: All counties should develop and implement incentive programs to ensure that they have sufficient staff to plan and deliver culturally competent behavioral health services to older adults and clients with complex medical needs. This can be done through priority hiring of well-trained professionals with this expertise and/or through utilizing model professional development programs for current employees.¹⁶ A higher salary classification for older adult specialists across provider categories would help efforts to fill these positions.

Recommendation 11: All counties should develop peer-training programs that involve people with lived experience to provide culturally appropriate auxiliary or additional behavioral health services for older adults and others with complex medical needs.¹⁷

Conclusions

Addressing the deficiencies in California's geriatric behavioral health workforce will require a concerted, multipronged approach. Although the problems have been identified for decades, there has been very little, if

any, improvement, even with the infusion of MHSA WET support. The expected increase in the number of older adults, who will represent nearly 20 percent of the state's population by 2030, necessitates action for improvement now. Political will is needed to accomplish the recommended course of action.

“Political will is needed to accomplish the recommended course of action.”

Data Source and Methods

This policy brief utilizes data from a six-county study of public mental health services for older adults. For more information on this evaluation and to see all related publications, please visit <http://www.healthpolicy.ucla.edu/Older-Adult-Mental-Health>.

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Author Information

Janet C. Frank, MS in Gerontology, DrPH, is an adjunct associate professor at the UCLA Fielding School of Public Health and a faculty associate at the UCLA Center for Health Policy Research. Kathryn G. Kietzman, PhD, MSW, is a research scientist at the UCLA Center for Health Policy Research and an assistant researcher at the UCLA Fielding School of Public Health, Department of Community Health Sciences. Alina Palimaru, MPP, PhD, is an associate policy researcher at RAND Corporation.

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10960 Wilshire Blvd., Suite 1550
Los Angeles, California 90024



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Editor-in-Chief: Ninez Ponce, PhD

Phone: 310-794-0909
Fax: 310-794-2686
Email: chpr@ucla.edu
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- 16 Several well-tested models currently exist for in-service and professional development programs. Cross-training programs and training programs that focus on interprofessional team training and integrated care delivery are especially helpful for addressing the complex care needs of older adults and others with multiple medical problems.
- In San Diego, the department of behavioral health offers a Geriatric Certificate Program. The UCLA Geriatric Psychiatry Fellowship at the Los Angeles County Mental Health Department (LACDMH) consists of two fellows each year for two days a week, six months each.
- The SAMHSA and HRSA Center for Integrated Health Solutions offer principles to guide such efforts: https://www.integration.samhsa.gov/workforce/Guiding_Principles_for_Workforce_Development.pdf
- 17 In Monterey County, MHSA has supported the Senior Peer Counseling Program (SPC), which provides no-cost behavioral health interventions and emotional support to older adults suffering from depression, anxiety, grief, loss, adjustment to chronic illness, and other stressors that can occur in later life. In Alameda County, MHSA has provided funding to the Afghan Elderly Association (AEA), which works to improve the well-being of Afghan elders in the Bay Area.