

Episode: *Ethics Talk: Where Are All the Geriatric Psychiatrists?*

Guest: Steven Starks, MD

Host: Tim Hoff

Transcript by: Cheryl Green

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TIM HOFF: Welcome to Ethics Talk, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. There were nearly a million physicians of all specialties in the US in 2021. At a person-per-physician level, this is about one physician per 344 people. Let's use that ratio as a starting point to contextualize physician workforce capacity now, for a specific group of US residents older than 65. In 2021, there were just over 6,000 geriatricians in the US. That's nearly 12,000 people per geriatrician. By 2040, one in five adults will be older than 65 years. Although care needs among older people vary, at least 80 percent of US residents in this age group currently have at least one chronic condition.

If we add 25,000 geriatricians to the US health care workforce by 2025, we might have one geriatrician caring for about 700 people, a number that the American Geriatrics Society suggests is reasonable. But with around 20,000 medical students matriculating to US schools each year and with less than one half of 1 percent of first-year resident physicians specializing in geriatrics, the numbers just don't add up. And the physician workforce is expected to be far under capacity to meet the health needs of US older adults.

What is needed to meet today's demand is cross-specialty training to prepare every physician to care for geriatric patients. Academic health centers have duties to equip US health care to avoid shortfalls, yet only 45 percent of medical schools have required geriatric clinical learning activities. There's also a lack of curricular standardization across US medical schools. Today's guest, Dr Steven Starks, also points to the roles of ageism and stigma as reasons that US health system capacity is not well-situated to meet the health needs, especially the mental health needs, of older adults.

DR STEVEN STARKS: When I actually first chose to specialize in geriatric psychiatry, when I was mentioning to some of my supervisors, they would always ask me, why would I want to do that, right? I was, you know, they thought I would be a great therapist. And for some reason, I think in their mind, [laughs] you can't do effective therapy with older adults. And so, even within a specialty that faces a lot of stigma, even caring for older adults is stigmatized as well.

TIM HOFF: Dr Starks is a clinical assistant professor at the Tilman J. Fertitta Family College of Medicine, and he joins us today to talk about what clinicians need to know about caring for the mental health care of older adults and what educators and schools

need to do to prepare the clinician workforce for the growing population of patients who are older adults.

STARKE: Thank you for having me join and share my perspective. [music fades]

TIM HOFF: Providing mental health care to geriatric populations requires adapting that care to many different kinds of clinical environments. There's home-based care, there's long-term care facilities, primary care settings. The list goes on. So, what should listeners know about the unique challenges of providing care in these settings, perhaps especially as patients move from one to another as they age?

STARKE: Yeah. Great question. Well, your listeners, particularly those who have maybe kind of sought out mental health care for their own or assisted others, like family, friends, or loved ones, and locating mental health services may already have an idea about some of the challenges. So, they may run into issues finding a psychiatrist or other mental health professional. They may've experienced difficulty utilizing their insurance coverage if they even have coverage at all. And if they lacked insurance, their ability to afford the visits or treatment may've been a particular barrier to care. So, I think in geriatric mental health, again, we see the same things. They've also found it difficult to access certain types of care, like the care they would prefer. Sometimes patients often prefer psychotherapy or counseling services, which are hard to come by, and additionally, they may have faced stigma or other impediments that delay their care. So unfortunately, in our fragmented mental and behavioral health system, those are the challenges that many Americans face. And I don't think it's unique for older adults. So, not necessarily unique, but I think things are a little bit more complicated or exacerbated by the need for more specialized geriatric care. And we see that throughout geriatric care, so not just in geriatric mental health settings. We see that in primary care and finding a geriatrician.

I think what makes it unique for older adults is since Medicare provides insurance coverage, I think the assumption is that there shouldn't be a significant barrier in paying for care or accessing care, but that's also not true. So, older adults run into the issue of finding clinicians who take Medicare. There are few mental health professionals who do so, given the rates of reimbursement that are typically seen. And oftentimes, it's not really a lot of incentives to participate in that program. And so, finding a professional is compounded not only by finding someone who takes Medicare, but also finding one who's specialized and trained and has trained in the area to meet the needs of the patient. There are workforce shortages, broadly, in primary care and mental and behavioral health, and there are a dearth of physicians and clinicians who specialize in geriatrics. So, older adults often have challenges in receiving effective mental health care throughout the entire continuum.

There are policies currently that've tried to integrate mental health into primary care settings to kind of bridge gaps, and your audience might be aware or may not be aware that three-quarters of mental health services are delivered in primary care settings. So, there are very few patients who want to access, or stigma does prevent patients from seeking out specialty care. I think there's a particular challenge that we see in long-term

care settings. So oftentimes, mental health services are nonexistent or inconsistent, leading older adults in those environments to have much poorer mental health outcomes. And throughout the continuum of health care settings, it can be particularly difficult for older adults with neurocognitive disorders. So, dementia, individuals with dementia often have co-occurring psychological and behavioral issues in addition to the problems that they face with their memory and thinking. And so, a lot of challenges out there, but I do believe that there are opportunities for policy reforms to create an age-friendly environment. And so, I do tend to remain optimistic on the front of geriatric mental health.

HOFF: What would you say is the type of mental health care that older adults are looking for that is currently most underserved? So, in other words, where's the gap between the current clinician workforce capabilities and capacity and patient needs?

STARKS: I think definitely the biggest gap is with dementia-related care. So, like I'd mentioned before, patients with dementia, or what we call major neurocognitive disorders, often face issues in terms of their psychological symptoms and behavioral symptoms. And so, oftentimes, before someone really recognizes an individual has dementia, there is oftentimes maybe a late-life anxiety or depression or other psychiatric symptoms that manifest. And I think there's a particular challenge for individuals with dementia and their caregivers to locate mental health services and treatment. There are very few specialists, very few geropsychologists and very few geriatric psychiatrists to offer care and support to individuals living with dementia.

HOFF: So, as we mentioned in the introduction to this podcast, the US population is rapidly aging. So, in anticipation of this trend, which policies or regulatory efforts exist aimed at caring for the mental health of this growing group of people?

STARKS: The Older Americans Act was the original legislation that authorized states to, or grants to states, for coordinating community planning and social services kind of needed for older adults. And it also enables research and development projects and is focused on workforce and personnel training broadly within the field of aging. And the federal government can only do so much through those programs and through the kind of typical appropriations process. More recently, though, there have been some states who have forged new efforts to address gaps in programs and services, and they've done so through state plans or master plans on aging. So, states like California, Colorado, Massachusetts, Minnesota, Texas, and Vermont have developed these state plans or master plans, and a few other states have elements that perhaps aren't as comprehensive but align with the aims of these state plans.

And so, what the plans are, is states have recognized that it's critical, given these aging populations, to identify solutions and to coordinate federal, state, and local programs. That's oftentimes the gap there. So, to build an effective state plan, states are looking to collect data and to identify long-term strategies. And these strategies with these state plans, these master plans, have to be at least ten years, right, to really fully support effective implementation. And they not only target older adults because they're state plans for aging. So, it's everybody who is an older adult and everybody who wants to

become old, so everybody. And the goal is, of course, to ensure positive health, vitality, and independence. We want people to be able to age in their chosen place.

And just in general, in many states, the programs that address the needs of older adults tend to be siloed and segmented. And so, if you think about health care or food and nutrition or housing, right, they're often not communicating with each other, and that's to the detriment of older adults. And so, the master plans are intended to be holistic and to integrate programs, services, policies, just to create that better alignment between state and local governments and their departments and agencies. They rely strongly on partnerships, and the partnerships are broad, so community-based organizations, community members, research, philanthropy, the private sector, through public/private partnerships. In many of these state plans, while the primary focus is not on mental health, it's of course, mental health services are a large part of many of the state plans, so mental health services, dementia care services, etc.

Aside from that, I think your listeners should also be aware of efforts to support family caregivers. So, the RAISE Act was passed in 2018, RAISE Family Caregiver Act, and RAISE just stands for Recognize, Assist, Include, Support, and Engage. It's a little bit more indirect in terms of its impact on the mental health of older adults because family caregivers can be a broad group. It can include, obviously, those who are caring for older adults and those who are partnering with someone with a mental health disorder. But it's not limited to that, right? Family caregivers can also be older adults or individuals who are living with a mental health disorder. And so, the RAISE Act, as a result of that, there is a broader national strategy and a action plan that's tied to legislation that targets caregiver supports and services or caregiver financial security and caregiver job security, and of course, the mental health of caregivers and the mental health of those who partner in care.

In terms of, I guess, COVID policy, so COVID did expand Medicare coverage for telehealth services during the public health emergencies, and that will continue now that the public health emergency is over. And that's been tremendous, though I would still like to see a larger focus on the administration's plan for the mental health of older adults, particularly those in nursing home settings. I definitely applaud the Biden administration's efforts to address mental health needs of children and adolescents, which much of the efforts have been addressing the health of youth in homes and in school. But I often like to remind folks about what occurred in nursing homes during the pandemic, right? Lots of loss, morbidity, mortality, workforce issues. And again, I think those impacts continue in that realm of long-term care.

And we do know that the treatment of depression in long-term care often fails to meet the needs of those individuals who reside in those facilities, and the prevalence of dementia for those populations often exceeds what we see with older adults living in community settings and those who receive their care in primary care settings. The prevalence of depression in nursing home residents over the age of 65 is estimated to be nearly a third or nearly one half, and it contributes to a significant disability in a population that's made vulnerable by these systemic factors. And so, I think accessing mental health services is difficult and often variable for older adults in nursing homes,

varies by state, varies by locality, and oftentimes, depends a lot on state and local mental health authorities for support. And I'm just hopeful that we'll start to see more policies and solutions that address depression prevention strategies in nursing home settings.

HOFF: Hmm. Yeah, you mentioned the goal of allowing people to age in a place of their choosing, and that leads, unfortunately, well into this next question. So, some estimates suggest that as many as 50 percent of unhoused people are over 50 years of age, and that's up from 37 percent in the early 2000s. A 2022 report found that, "Eighteen out of every 10,000 Americans are homeless, and that number jumps to 52 for Black Americans, 45 for Native Americans, and 109 for Pacific Islanders." These two facts in tandem suggest a looming crisis in mental health care equity for people of color suffering from the dual problems of inadequate mental health care and houselessness. So, are there legislative efforts to address this problem specifically that listeners should be aware of? And what might individual clinicians do to help these patients?

STARKS: Yeah, that's an incredible challenge, aging in place. I think the bottom line when it comes to individuals who are unhoused is literally the bottom line. It's a matter of funds. And we've left our older adults with more economic uncertainty than they've experienced in the past. There's been a loss of certain assurances and certain safety nets. So, I remember my grandparents distinctly. They had access to pensions. It was a defined benefit pension that guaranteed them this lifelong income, right? And I think as employers have shifted to 401(k)s and a defined contribution and retirement plans that rely on individuals to kind of opt in and to select the product, we're starting to see more financial insecurity in older adults. And so, older adults are at greater risk, and Social Security benefits for those who have work histories are not substantial enough to support most people's monthly expenses. We've had the housing crisis, past and current recessions that also contribute to what we see today.

I think there's the factor also related to the employment of older adults, right? We don't talk a lot about age discrimination in the workplace, but how easy is it for an older adult to find a job if they wanted to work? And many do want to work. The work schedule and their preferences for types of work may be different, but I certainly know older adults who want to be a part of the workforce and feel like they've been shut out. And I think we also have to put it in the perspective of the social changes that we see. So, declining birth rates, the role, changing role of children in caring for their parents who make it to old age. We have individuals are not necessarily coupling, partnering, or marrying as much as they had in the past. And there also is the impact of family estrangements. And so, it's a lot going on here. And a person's adult child may not live in the same neighborhood, community, town, or state that they, like they would've in the past. And our older adults are oftentimes much more isolated from social connections.

To your point about the, I guess, equity issue, particularly as it comes to racialized and minoritized groups, I think we're seeing, and particularly in major cities, the impact of increased housing and rental rates and the effects of gentrification. We do know for older adults of color from communities that've been marginalized, you have disparate rates of home ownership or home equity. There's income inequality and wealth gaps

that definitely contribute to the disproportionate figures that we see in terms of unhoused individuals. So, there's a lot at play in that regard. And when I always think about unhoused individuals and health and their mental health, I think the bottom line is that we know that safe, stable, and affordable housing is critical in improving both physical health and mental health outcomes. Of course, states and the federal government play a role in addressing the housing issue for older adults. It's the US Department of Housing and Urban Development that administers the housing programs. And most of that, particularly the strategy for the housing for the elderly, comes under Section 202 of the National Housing Act. And there are continual budget proposals that the president submits in congressional appropriations that are pretty stable in terms of funding. So, it's a little, yeah, don't have much of a solution there.

And definitely, more work could be done in that area in terms of what clinicians can do. I think the best thing that we can do in practice is to identify those individuals at risk, right? To ask our patients, to talk to them about what they're experiencing in their day-to-day lives. There's a lot of information, the Agency on Healthcare Research and Quality, AHRQ, does have information on toolkits to address patient social risk and patients' needs. And I think those types of things are critical to kind of identify where our patients might be made vulnerable. And in addition to obviously screening, asking the right questions is just being knowledgeable about what resources might be available in your area. So, I know in practices that I've been in, I've not always had easy access to a social worker or a patient advocate or a community health worker, and so being knowledgeable and being kind of connected to community and local resources, I think, is important so that we're able to intervene when patients do express these concerns about their housing or other issues.

HOFF: So, I want to turn to some of your previous work as a health and aging policy fellow focused on community-based solutions to marginalization. What roles do community partnerships have in expanding health system capacity to reach vulnerable patients and perhaps especially communities of color? And how might clinicians engage with these types of organizations?

STARKE: Yeah, that's a great question. I think expanding the reach of health services, yeah, relies strongly and very heavily on effective community engagement strategies. Community partnership has always been paramount. It's been, I think, troubling for academic health systems, health centers, health systems to really address it, but I do think the COVID-19 pandemic response has elevated that framework, right? And so, with the COVID response, we saw the immediate impact of community-based strategies when it came to outreach and awareness, right? Particularly with the vaccine implementation strategies that relied heavily on community-based organizations in BIPOC communities for their success. And I think similar strategies are needed to effectively address mental health and substance use disorders. I do see American health care is moving slowly in the direction of addressing the social and political drivers of health. And I think there's a challenge of identifying meaningful outcomes, or the challenge of finding the right incentives or really financing programs, right? So, how do you finance a program that partners with a community-based program?

I think specifically for mental and behavioral health care, I think we also have to recognize the role of environment and community, just as one thing I think about is just adverse childhood experiences. So, in geriatric mental health, we do know that those early life experiences continue to have an impact on the physical and mental health of older adults, and we do know that individuals from minoritized groups are disproportionately impacted by adverse childhood events. And so, I think it's important, again, for health systems, community health centers, local mental health authorities to develop effective partnerships with community-based organizations.

I think one way that we know, one thing that we do know is patients like access to care in their homes and in their neighborhoods. There are a lot of reasons why they don't want to seek out care in clinical settings because of historical harms that have, and present-day harms that continue, to take place in these environments. We see the gaps in terms of health care disparities and poor outcomes and individuals feeling unheard and unseen by clinicians that they work with. And so, I think we can do more to work in neighborhoods and in communities. And I think telehealth has given us one signal for that. So, that's an innovation, I think, that highlighted the role of, okay, we need to get out of our comfort zone and get in spaces where patients want to see us.

And I think clinicians can start by seeking out local partnerships. So, what are the community organizations that your patients identify as trusted and reliable resources, and what can you do to effectively learn more about the programs and services that they offer? And how can you align those resources with your practice? It's also, I think, important for clinicians to investigate the successful state programming that relies heavily on community partnerships. So, nationally, people should be aware that there is an Administration on Community Living and an Administration on Aging that have vast networks. And many of those services that provide supports for older adults are distributed through what we call Area Agencies on Aging, so Triple As, and they can be public or non-profit, private non-profit agencies, again, that implement state services and supports. And so, clinicians should be aware that that model is already out there and should be able to identify some type of alignment to help fill gaps and expand capacity in addressing the needs of older adults.

HOFF: Mmhmm. So, we've talked throughout this podcast about expanding the clinician workforce to meet the growing population of older adults in the US. So, how should health professions educators, and schools specifically, ensure that enough clinicians are adequately trained to respond with care to our elders' needs?

STARKE: Yeah. The workforce issue really is the crux of the matter, and it's one where, unfortunately, it's easy for even me to lose a little optimism sometimes because the numbers simply don't add up now, and I don't think they'll add up based on the forecast projections and proposed targets that we have for the next decade and the decades to come. More than a decade ago, the National Academies had a committee on the mental health workforce for geriatric populations that published a report called *In Whose Hands?* in 2012. And that was in hopes of addressing the challenges and vulnerabilities of older adults with mental health and substance use disorders. But unfortunately, even after a decade, not a lot has changed. When I look at my own specialty over the past

decade, the number of residents who enter fellowship training in geriatric psychiatry has shrank, so, from the mid-60s now to the mid-40s, and the number of active geriatric psychiatrists has remained pretty flat. Trainees in geriatric medicine haven't seen the same levels of decline, but decline is still apparent, particularly when you take into account the subtle growth in the number of medical schools and medical students, residency training slots in accredited fellowship programs in geriatric medicine or in geriatric psychiatry. And I think while there is kind of unpredictable demand for services, right, there's certainly an unmet need for older adults who are seeking out mental health care. And so, if learners aren't seeking out certifications for whatever reason, or if they aren't seeking out added qualifications or choosing to specialize in geriatrics, I think we drastically need to consider education, training, and lifelong learning of all the professionals involved in the care of older adults. And so, it's a big group there: physicians, nurses, nurse practitioners, social workers, physician associates, pharmacists, psychotherapists, counselors, dentists, dental assistants, occupational and physical therapists, certified nursing assistants, and caregivers, family, so individuals who are both paid and unpaid. There has to, we have to figure out a way to develop a skill set and an expertise broadly throughout the full lens of those who provide care.

I think the core competencies and program objectives of the curriculum of health professions and allied health schools should be in line with the highest standards that ensure that everyone who graduates is able to ensure the health and safety of the older adults that they'll care for in their careers. I think hospitals and health care systems also have a role, right, in many cases. Obviously, they set up the environment that learners are exposed to throughout their professional journeys. And as learners transition into clinical practice, these are the environments where they get their first signals and impressions about what the care of older adults should be. And so, those settings should be age friendly.

This is a question I like because as a faculty member at a medical college, I think a lot about how are we designing our curriculum in ways that ensure that my students can effectively take care of my mother if she was in a bind? And I had to do my own investigation just to look at what are the general competencies that we look for in medical education, and I did learn about a particular program in that investigation, a project called Project EDGE. EDGE just stands for Education in Geriatrics. That was a collaboration with the American Geriatrics Society, Harvard Medical School, and the New England VA's GRECC, their Geriatric Research, Education, and Clinical Center. And it aims to keep the standards in medical education high and was actually an update of a 2007 Consensus conference that was called Keeping Granny Safe. Great concept there. That was sponsored and through the AAMC in Mount Sinai School of Medicine and funded by the Dannie Hartford Foundation and the American Geriatrics Society.

I think there's, more importantly, definitely kind of opportunities and avenues for interprofessional development. Those of us who are in geriatric recognize the importance of collective impact and recognize the importance of team-based treatment and team-based learning. And I think looking for a comprehensive strategy that's interdisciplinary, that focuses on career development in students, that focuses on faculty development and training teachers to best educate individuals is important. [theme

music returns] And ultimately, in terms of workforce, there has to be some incentive at the state or government level to fund, whether it's specific training grants that are funded, maybe education, debt repayment programs. Something has to be done because we definitely don't have enough clinicians to respond to the current need.

HOFF: Dr Starks, thank you so much for your time and expertise on the podcast today.

STARKS: Oh, thank you so much for the invitation.

HOFF: That's our episode for today. Thanks to Dr Steven Starks for joining me. Music was by the Blue Dot Sessions. To read our full issue on Geriatric Psychiatry and for early access to this month's author interview podcasts, visit our site, journalofethics.org. Those episodes will be available later on streaming platforms on the 15th. For all of our latest news and updates, follow us on [Twitter @journalofethics](https://twitter.com/journalofethics). And we'll be back next month with an episode on Loneliness and Health. Talk to you then.