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Authors
Joo, Jin Hui
Jimenez, Daniel E
Xu, Jiayun
et al.

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Perspectives on training needs for geriatric mental health providers: preparing to serve a diverse older adult population

J. Joo[1], **D. Jimenez**[2], **J. Xu**[3], and **M. Park**[4]

[1]School of Medicine, Johns Hopkins University Baltimore, Maryland [2]School of Medicine, Miami University, Miami, FL [3]School of Nursing, College of Health and Human Sciences Purdue University, West Lafayette, IN [4]School of Nursing, University of California, San Francisco, CA

Abstract

An increasingly diverse population of older adults requires a workforce trained to address the situation of differential health care access and quality of care. The purpose of this article is to describe specific areas of training focused on addressing health disparities based on ethnic differences, while recognizing that other factors such as gender and socioeconomic status also contribute to disparities among older adult populations. Training is critical at multiple levels: at the level of the patient, provider and patient and the health system. Cultural competency training can be effective as a part of general clinical training. Clinicians should be trained in cultural competency skills that include effective communication, development of appropriate attitudes and knowledge that are relevant to caring for ethnically diverse older adults. Additionally, the mental health workforce needs to become skilled in working within different models of mental health service delivery. Evidence-based service delivery models such as the collaborative care model and the use of lay health workers (i.e. community health workers and peers) are becoming common in health care organizations and have potential to address disparities in mental health care. These models are associated with specific training needs such as interprofessional collaboration, education, and supervisory skills needed to work effectively with a lay workforce. We are at the intersection of a growing and diversifying population of older adults and a rapidly transforming healthcare system with new models of care that will require training to achieve equitable and quality mental health care.

Corresponding Author: Jin Hui Joo, MD MA, Department of Psychiatry, School of Medicine, Johns Hopkins Bayview Medical Center, 5300 Alpha Commons Drive, Room 427, Baltimore, Maryland 21224, Phone: 410-550-2282, Fax: 410-550-1407, jjoo1@jhmi.edu.

Mijung Park, PhD MPH RN, School of Nursing, University of California, San Francisco, 2 Koret Way, Rm 405J, UCSF Box 0606, San Francisco, CA 94143, Phone: 415-502-5628, Fax: 415-476-6042

Daniel E. Jimenez, School of Medicine, University of Miami, Coral Gables, FL, Phone: 305-243-6732

Jiayun Xu, PhD, RN, Assistant Professor, Purdue University School of Nursing, 502 N University Street, West Lafayette, IN 47907-2069, Phone: 765-494-4017, Fax: 765-494-6339

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Keywords

training; healthcare; cultural competency; paraprofessionals; mental health; geriatric; older adults

Increasing diversity of the population and a homogeneous workforce

The diversity of older adults is increasing. The total population of older adults aged 65 and over in the United States is projected to rise to nearly 24% of the population by 2060, with older ethnic minority adults representing nearly 50% of the older adult population. [1,2] The current mental healthcare workforce, however, does not reflect the ethnic diversity of the adult population. Approximately 40% of the U.S. population identify as ethnic minority[3] yet underrepresented minorities, the majority of whom are African American, Hispanic American, and Asian, account for approximately 9% of practicing physicians according to a 2014 AAMC report.[4,5] Precise figures for the geriatric mental health workforce are lacking; however, estimates project less than 2,000 geriatric psychiatrics currently, with only one for 20,000 older adults by 2030.[6] The ethnic diversity of medical trainees (eg. African American) has increased from 2011 to 2015, although data specific on geriatric mental health is lacking.[5]

Disparities in access to and adequacy of treatment for mental and behavioral health disorders by ethnicity have been documented extensively[7,8]. Up to 70% of ethnic minority older adults with mood disorders do not receive any mental health care.[9] Inequitable mental health care services result in poor health outcomes for diverse groups and also contributes to significant societal costs such as increased utilization of health services and economic burden of over 200 billion dollars that can be reduced by addressing issues such as access to care.[10,11]

Since multiple factors contribute to differential access and quality of care that in turn lead to healthcare disparities, using a health disparities framework is useful in conceptualizing where interventions should be targeted. This then can inform training needs for the mental health workforce. Numerous multilevel factors that span the person, health care systems and policy contribute to mental health disparities. Alegria et al. provide a conceptual framework that describes the micro level, involving health provider and patient interactions, the meso level that includes healthcare organizations, lay sectors and communities, and the macro level that involves health care policy and environmental context. These factors can take the form of a person's self-stigmatizing attitudes that prevents help seeking for emotional problems to limited communication training for mental health providers when caring for minority patients. Many efforts to reduce mental health disparities are aimed at the provider-patient level; however, there is recognition and funding to transform healthcare services that emphasize the critical nature of sociocultural factors in determining access to health care that can result in disparities. Disparities can be due to resource-poor neighborhoods at the community level and exist even more broadly at a macro level where policies perpetuate inequalities in insurance coverage.[12,13] Mental health policies at the local, state, and federal level can directly impact disparities through changes in factors such as mental health care access. Further complicating the multitude of factors is that these factors typically intersect and change over time.

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When discussing health disparities, a focus on ethnicity is common; however, disparities are due to cultural factors such as belonging to a specific generational cohort that can influence an older adult's social norms and help-seeking behaviors that in turn can lead to health disparities. Ethnicity also intersects with other factors such as gender, disability and socioeconomic status, for example, such that the impact of ethnicity may not be the prevailing factor leading to disparities in help-seeking for mental health care.

Given intractable healthcare disparities in mental health, there is a need to better prepare the geriatric mental health workforce to address the needs of a diverse older population. In this article, we present an overview of three specific training needs: 1) cultural competency and communication training for providers and 2) preparation of the mental health workforce in team-based care relevant for collaborative care models and 3) training professionals to work effectively with non-professional lay health workers.[13]

1. Cultural competency and communication training for mental health providers

Cultural competency is defined as the ability to be respectful and responsive to the health beliefs and practices of diverse populations.[14] Medical education is putting greater emphasis on training professionals to provide more culturally responsive and effective quality mental health care. Beginning in July 2007, the Accreditation Council on Graduate Medical Education required that medical trainees demonstrate cultural responsiveness as part of developing their competency as a healthcare professional.[15] Among approximately 8,000 graduate medical educational programs in the United States, 50.7% offered cultural competency training in 2003–2004 and the degree to which programs met the required competency domains was variable.[16,17] Some States such as New Jersey, Washington, and California are making physician cultural competency training a condition of licensure or a requirement in all CME activities.[18]

Core competencies for graduate medical training for geriatrics have been formulated that take a relationship-focused training approach to develop attitudes, knowledge, and skills in the care for ethnically diverse older adults. Diverse training methods such as case studies, cultural competency workshops and peer teachers are recommended.[19] The benefits of interactive educational methods such as self-reflective journal assignments and making cultural competency training a part of general clinical training rather than teaching in discrete workshops have been emphasized.[20]

At the individual provider level, cultural competency training is commonly perceived as a body of knowledge that can be mastered, consisting of characterizations of ethnic groups such as African American, Latino and Asian persons. The dangers of such an approach is misguided stereotyping of minority or other social groups that may not add value to clinical management and can be counterproductive. Alternatively, others perceive cultural competency as an attitude toward clinical care. The focus can be on acknowledging the patient's self-knowledge and on clinicians developing a responsive attitude and effective skills to exchange mutually beneficial information during mental health appointments. Training of this type may include learning how to tailor communication styles and language

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to meet the patient's learning style especially if the older adult is already cognitively impaired. Training can also include becoming aware of different decision-making preferences for the patient and family about potentially stigmatizing mental health disorders, and sensitivity to sexual and gender issues.[21] Rather than learning a concrete body of knowledge, healthcare providers can learn how to avoid making a priori judgments based on the patient's ethnicity for instance, and assume an attitude of cultural humility.

The term "cultural humility" describes the process of relating to the patient by using patient-focused interviewing and care.[22] A culturally humble approach entails the provider facilitating the expression of patient needs and goals rather than the doctor leading the conversation.[13, 23] Physician-centered interviews are the standard format that is taught during medical training, i.e. from history of present illness to a review of symptoms in order to arrive at a diagnosis and recommendations for treatment. A patient-centered approach uses open-ended, non-focused questioning to elicit the patient's perspective, integrates empathy, and pays attention to patient understanding of topics presented in the interview. This approach is characterized by the provider including psychosocial topics in contrast to focusing predominantly on biomedical topics, eliciting questions and including patients in decision-making.[24]

Patient-centered communication training needs that are specific to the geriatric mental health population may include: 1) consideration of existing or expected changes in cognition, 2) accounting for medical conditions in older adults that may change how mental illness manifests, 3) inclusion of family in goals of treatment and care planning, and 4) assessing for life events that may be a trigger for mental illness such as the death of a loved one. For patients who may have different explanations of their symptoms due to ethnicity or age, use of patient-centered interviewing may help the healthcare provider better understand the meaning of a mental health condition for the patient and ultimately improve engagement in care. The value of patient-centered communication has been shown to increase patient satisfaction, adherence to treatment, decreased need for referrals and testing and patient health outcomes.[25–28]

A patient-centered orientation is key because patients cannot be defined by one social trait such as ethnicity. A mental health care delivery approach that accounts for multiple social traits is more likely to be accurate and appropriate upon which to base clinical decisions. For example, an older adult may identify as a Latina, a mother, wife, undocumented resident, Catholic, and resident of an urban city. A knowledge-based approach can easily lead to stereotypical thinking of these social traits; however, an approach that is culturally humble will enable the patient to describe the meaning of these traits in all its complexity, some of which may defy stereotypes altogether. [29]

Finally, despite the importance of micro-level approaches, it is recognized that cultural competency is necessary but insufficient to address health care disparities. The micro-level approaches place the burden of change upon the individual when the weight of the problem may be far greater than an individual approach can achieve. Systems level changes that encourage cultural competency at the healthcare delivery level also need to occur.[30]

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2. Preparation of the mental health workforce in team-based care relevant for collaborative care models

The emergence of the integration of behavioral and physical health services has promise in having a positive impact on disparities, and training around this is full of potential and challenges. Several programmatic trials have demonstrated that integrating psychiatric care with primary care can significantly improve quality of care for depression and anxiety among minority older adults. [31–34]

Collaborative care models with behavioral and physical health have the potential to reduce mental health service disparities in minority older adults for two reasons: (1) primary care is where the majority of minority older adults receive their mental health care. Therefore, improving the overall quality of mental health services in primary care may benefit minority older adults. For example, studies have shown that collaborative care models for general primary care settings have benefited minorities. In the IMPACT study, a large trial to improve the quality of care for older adults with depression, the quality of care improved similarly for Black, Hispanic, and White patients.[35] Another study in a managed care setting found that clinical outcomes one year later were better for Latinos and Blacks than for Whites.[36] Studies have shown that racial and ethnic minorities has less likely to have access to specialty mental health care, and collaborative care model may have improve the access to depression care, and subsequently better outcomes in these populations. (2) Collaborative care, which comprise of multidisciplinary team members, can maximize and optimize limited cultural and linguistic resources. Culturally tailored collaborative care models have been efficacious in treating depression among Asians [37] and Hispanics.[33] In these cases, the care team included multi-lingual and multi-cultural providers, but not exclusively. In those studies, contents of educational materials and of Problem Solving Therapies were tailored to cultural expectations (e.g., idiomatic contents)

Despite its potential for improving mental health care for minority older adults, workforce development and training to prepare providers to work in collaborative care has been challenging. The traditional education for health professionals has been organized by discipline, and emphasizes separate, specialized training. Unfortunately, such siloed approaches do not prepare the future generation of health care providers for “real-world” health care practice that is increasingly team-based, collaborative, and patient-centered. Consequently, a major barrier to implementing interdisciplinary, team-based collaborative care is the inability of providers from different disciplines and/or specialty areas to cooperate and trust one another.[38] Furthermore, existing modules for collaborative care have been developed for specific disciplines. Consequently, providers learn the most important skills for collaborative care (e.g. communication, role delegation, conflict management, and trust) on the job.

Interprofessional education (IPE)—a pedagogical philosophy and an instructional approach —has potential for improving the existing siloed educational model and addresses the lack of training opportunities for collaborative care models. IPE occurs “when members (or trainees) of 2 or more professions associated with health or social care engage in learning with, from, and about each other to enable effective collaboration and the delivery of health

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care ." [39] By definition, IPE is built on the principles of cooperation and coordination among all providers. Three potential contributions of IPE to workforce development for collaborative care are the following: (a) provides trainees with an understanding of the roles and responsibilities of other health professions, (b) helps trainees develop skills and techniques that are vital to be a functioning member in a care team, and (c) increases trainees' cultural awareness and responsiveness. A recent meta-analysis of IPE in mental health practice has shown that IPE interventions may have a greater impact on developing positive attitudes toward other professions and increased knowledge of and skills in collaboration, compared to conventional clinical trainings.[40] Furthermore, evidence suggests that the earlier trainees are exposed to interdisciplinary collaborative practice models, the more likely they are to practice within an interdisciplinary model following graduation.[41] Finally, IPE may be more effective in increasing trainees' cultural sensitivity than traditional discipline-based cultural competency training models. [42]

Recently, there have been coordinated efforts to develop and implement IPE curriculums for geriatric mental health training programs. Examples of such programs include Health Resources and Services Administration's Geriatric Workforce Enhancement Programs (GWEP), and the Veterans Affairs' Center for Excellence in Primary Care Education. For example, between 2015–2016; the GWEPs have provided 1,650 different continuing education courses related to health care for older adult to older adults to approximately **94,000** health care professionals and students from disciplines including medicine, nursing, allied health, health services administration, social work, and psychology. Among these programs are didactic and clinical training opportunities in geriatrics for health professional students and promotion of interprofessional, team-based approaches to care and care coordination; and 160-hour interprofessional Faculty Development Programs to prepare faculty to teach geriatrics and interprofessional team-based care.[43]

Successful IPE programs for geriatric mental health have incorporated case studies and service learning components.[44] Despite advances in IPE curriculums within academic health science programs; they may not include content on mental health challenges unique to racial and cultural minority older adults. For example, we need to develop contents related to the cumulative consequences of life-long experience of oppression, discrimination, and violence in assessing and treating depression among older adults. Therefore, there is a need to develop and implement IPE cultural competency modules for diverse minority older adults. Another limitation of existing IPE curriculums for geriatric mental health training is that few programs include content about geriatric mental health service delivery. Recently, the Institute of Medicine (IOM) recommended that health profession educators and health system leaders collaborate to integrate IPE within healthcare delivery systems.[43] However, there is currently lack of needed buy-in from the health system and not enough health care providers who are able and willing to model interprofessional team-based attitudes and workflows that encourages trainees to value team-based care as important for their education.[45]

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3. Training professionals to work effectively with non-professional lay health workers

The use of lay health workers (eg. community health workers, peer specialists, promotoras) is emerging and has potential to address health service delivery challenges for underserved older adults. In the US, the number of specialty mental health providers (e.g. psychiatrists, psychologists, nurses, social workers) that can provide linguistically and culturally appropriate care is insufficient to address the needs of vulnerable populations.[44] The lack of a bilingual and bicultural mental health workforce plays a significant role in disparities across all three key areas of mental health care service delivery: a) availability of; b) meaningful access to; and c) provision of quality care.

Findings from Lower and Middle Income Countries (LMICs) has shown that community health workers in LMIC countries can effectively deliver evidence based mental health treatments.[45] Evidence exists to support the use of peer-delivered interventions to provide depression care in addition to various services such as socialization and case management and decrease inappropriate health service utilization.[46,47] Lay health worker roles and responsibilities could be expanded to meet the needs of communities with mental health access and utilization disparities. Potentially, lay health workers may be mobilized to step into the role of primary providers of evidence based treatments (EBTs) in settings with severe professional mental health provider workforce shortages, but even in higher resource settings they may be involved in EBT delivery for individuals with lower levels of need (e.g. those benefiting from prevention services).[48] Lay health worker delivery of prevention and early intervention services would allow trained mental health professionals to focus their expertise on individuals who require more intensive services.[49]

Although the use of lay health workers in mental health is increasing, many mental health providers may be unfamiliar with these individuals and what their roles are in the mental health care system. Therefore, education is required to broaden mental health providers' expectations regarding who can provide mental health services, and how lay health workers can complement what they do.[37] Well-prepared health professionals, program managers, and supervisors who understand and support lay health workers will have to be developed and trained. Training that is content-based or experiential can help professional mental health providers understand how to collaborate and integrate lay health workers successfully into healthcare teams.[46,50–54] This training should focus on three factors: why lay health workers are effective, communication, compensation that enable their inclusion in the healthcare system, and supervision requirements.

Why lay health workers are effective

Lay health workers are assumed to be effective because they are part of the communities in which they work – ethnically, socioeconomically, and experientially, and can bring many benefits to a clinical team. They possess an intimate understanding of community social networks, strengths, and health needs; communicate in a similar language; and recognize and incorporate culture to promote improved mental health outcomes.[55] They empower community members to identify their own mental health needs and implement their own

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solutions, leading to improved personal and community self-efficacy.[56] As members of the communities they serve, lay health workers are uniquely positioned to build trust and address barriers to seeking care among traditionally underserved communities.[57] Relatedly, lay health workers reduce the stigma associated with receiving mental health care, increase service engagement and serve as an effective link between mental health facilities and communities, and they can provide services to difficult-to-reach populations.[58,59] Previous studies have found teaching by lay health workers such as peers may be preferred by minority patients compared to health education provided by professionals [60,61] and lay health workers can lower attrition and increase the number of sessions attended by patients. [62] The use of lay health workers might also effectively engage ethnic minority older adults since they are less likely than their White counterparts to seek care from conventional mental health providers.[63] Use of lay health workers may address the distrust of minority communities for mainstream health services. Factors such as language can also be overcome by using lay workers who speak the patient's preferred language.

Communication

Training that prepares professional mental health providers to collaborate effectively with lay health workers will need to include training in teamwork and communication as well. At the healthcare system level, traditional teams may be multidisciplinary but typically work in parallel rather than in an integrated fashion. For example, psychiatrists and psychologists may be accustomed to directing unlicensed workers rather than including them as team members with unique roles and contributions that complement professional care. Education that focuses on team building to provide the mental health care rather than strictly on professional/nonprofessional distinctions between team members will be needed.[64,65]

Compensation that enables their inclusion in the healthcare system

Lay health worker services are commonly delivered by organizations that are not integrated with the health care system (church-based programs, senior centers, etc.). Without formal linkages to clinical providers, these programs face many limitations and may produce disappointing results.[59,66] For example, task-shifting non-clinical work to CHWs is more difficult or clinicians may not recognize the value of CHWs if they do not work together.

Given that clinicians do not often work with lay health workers, they may not recognize the value of these lay health workers and are therefore less willing to finance these programs. Although it's important for lay health workers to maintain their community-based identity, they also need to be integrated into care teams. Compensation (e.g. salaries, financial incentives, or income from selling commodities) and non-monetary incentives (e.g. respect, trust, recognition, and opportunities for personal growth, learning, and career advancement) are important motivators for lay health workers.[67] Satisfaction (or dissatisfaction) with incentives are closely linked to lay health worker motivation and performance. Improved financial remuneration can reduce attrition among lay health workers. Furthermore, adequate compensation can lead to lay health workers feeling as if they are integrated into the health care delivery team.[68]

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Supervision requirements

Another key element for geriatric mental health providers working with lay health workers is the importance of effective supervision.[50,53] Effective supervision is critical to maintain quality and motivation and improve patient outcomes.[69] However, it is often one of the "weakest links" in a lay health worker program. Inadequate attention given to ensuring high-quality supervision[70] can undermine community embeddedness and reduce lay health worker motivation.[71] Few supervision strategies have been rigorously tested and data on CHW supervision is particularly sparse.[72] However, there is evidence to suggest that improving supervision quality has a greater impact than increasing frequency of supervision alone. Supervision that focuses on supportive approaches, quality assurance, and problem solving may be most effective at improving CHW performance (as opposed to more bureaucratic and punitive approaches).[69] Additionally, some strategies are more appropriate for specific settings. For example, group and peer supervision may be most appropriate in settings where supervisors have long distances to travel.[73] Lay health workers will be most effective with a high level of support with ongoing supervision and consultation, as this is also required for mental health professionals to deliver EBTs with competence.[74] It is in these supervision meetings that lay health workers can communicate the perspective of the patient with either the psychiatrist or psychologist. In addition, psychiatry and psychology training programs can incorporate supervisor training into their curricula in the same way that internal medicine programs train residents to work with nurse practitioners and physicians' assistants.

There are numerous nuances to working as a team, with professionals and non-professionals each contributing their expertise, from psychiatric diagnosis to lived experience of managing a mental health condition successfully. The idea of interprofessional training is relevant due to the dissemination of collaborative care models but the training will need to be expanded to include lay health workers such as community health workers and peer specialists. As mentioned already, education about the uniqueness of lay health workers, whose effectiveness may be associated with their knowledge and understanding of the community will be needed. Also, that regulations and institutional processes associated with being part of a healthcare team may overshadow the unique strengths that lay workers can offer should be recognized.[52]

Implementation of lay health worker programs face many challenges. Political endorsement is often weak; financing is problematic; supervision is fragmented; and mental health providers are over-burdened by trying to meet the patient and regulatory (i.e. continuing medical education, administrative, etc.) demands.[75–78] In addition, lay health workers function at the intersection of two dynamic and overlapping systems – the formal health system and the community. Each system typically supports lay health workers; their support, however, is not necessarily strategic, collaborative or coordinated. Nevertheless, policy makers, mental health providers, and other stakeholders need guidance and practical ideas for how to collaborate with, support, and integrate lay health workers in large-scale programs. The Patient Protection and Affordable Care Act's (PPACA) emphasis on community-based initiatives affords a unique opportunity to disseminate and scale up evidence-based integration of lay health workers within health care delivery teams and

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programs.[65] PPACA and current payment structures provide an unprecedented and important vehicle for integrating and sustaining lay health workers as part of these new delivery and enrollment models.[65]

Conclusion

To address the disparities and inequities in mental health care, training professional mental health providers in specific skills such as cultural competency, IPE and collaborative team care, and knowledge and skills working with lay health workers are needed. At the patient-provider level, provider cultural competency can initiate a deeper understanding of the interplay between different social traits and reduce stereotypes based on a social identity such as ethnicity. With a patient-centered approach, we can attempt to provide mental health services in a thoughtful and meaningful way to reduce disparities. At the health systems level, new care delivery models such as collaborative care and integration of lay health workers into mental health care are promising and can further address disparities. To function effectively in these contemporary mental health service delivery models that are growing in popularity, the professional and lay mental health workforce will need to become familiar with each other's roles and learn how to work together collaboratively with the patient as the focus.

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Highlights

- What is the primary question addressed by this article? Given the differential access to mental health care and the quality of care for diverse populations, the purpose of this article is to describe specific areas of training for the geriatric mental health workforce needed to address this problem.
- What is the main finding of the article? To deliver care to a diverse older adult population, cultural competency and communication skills, interprofessional training relevant to collaborative care, and skills to work effectively with a lay workforce are needed.
- What is the meaning of the finding? We are at the intersection of a growing and diversifying population of older adults and a rapidly transforming healthcare system with new models of care that require training the mental health workforce to achieve equitable and quality mental health care.