

## GUEST EDITORIAL

# The baby boomers are nearly here – but do we have sufficient workforce in old age psychiatry?

In 2011, the baby boomer generation officially commences its residency in the 65 years and over age group (U.S. Census Bureau, 2006). The much anticipated rapid growth in the population aged 65 years and over between 2011 and 2030 will challenge health care systems worldwide. Mental health services for older people will need to prepare for a near doubling of possible demand based upon estimates of the increase in prevalence of mental disorders in late life in this period in the developed world, with the increase likely to be greater in low and middle income countries (Bartels, 2003; Alzheimer's Disease International, 2009). The pressures that this will place upon the old age psychiatry workforce has contributed to the impetus for the Faculties of Psychiatry of Old Age of the Royal College of Psychiatrists and the Royal Australian and New Zealand College of Psychiatrists to prepare a 'Joint Statement on Specialist Old Age Psychiatry Workforce and Training' (see Appendix).

The Joint Statement emphasizes the importance of having an appropriately trained old age psychiatry workforce and the need to better understand incentives and barriers to recruitment, training and retention of old age psychiatrists. The same situation exists for psychologists, nurses, social workers and occupational therapists. Without such action there is concern that there will be insufficient old age psychiatry workers and that the quality of mental health care for baby boomer elders will be compromised.

Old age psychiatry is still a young subspecialty with its training guidelines and curricula being developed in Europe, North America and Australia/New Zealand over the past 20 years (Draper, 2003). A World Psychiatric Association survey of teaching and training in old age psychiatry found that old age psychiatry was regarded as a subspecialty in only 27% of responding countries worldwide, including only 18% of European countries (Camus *et al.*, 2003). Yet, the European health strategy identifies the development of age-related medical specialties as a priority, requiring an average 25% increase in health spending by 2050 to meet the need of an aging population (Commission of the European Communities, 2007).

But even in countries that have recognized old age psychiatry as a subspecialty there are

concerns about the workforce. In the U.S.A. the number of geriatric psychiatrists has decreased from 2508 in 2000 (1.5 geriatric psychiatrists per 10,000 population aged 75 years and over) to an estimated 1738 practicing in 2010 (0.9 per 10,000 population aged 75 years and over) (ADGAP, 2008). Projections based upon current training numbers indicate a continuing decrease over the next 20 years so that by 2030 there will only be 1659 geriatric psychiatrists (0.5 per 10,000 population aged 75 years and over) (ADGAP, 2008). In Australia in 2003 the number of old age psychiatrists varied across the states from 0.20 to 0.59 per 10,000 persons aged 65 years and over, while New Zealand had 0.49 per 10,000 persons aged 65 years and over (O'Connor and Melding, 2006). In 2008 there were 191 old age psychiatrists in Australia (0.69 per 10,000 persons aged 65 years and over) (Australian Bureau of Statistics, 2009) and 29 in New Zealand (0.55 per 10,000 persons aged 65 years and over) (Statistics New Zealand, 2007). Of concern, over the last decade the number of trainees completing advanced training in old age psychiatry in Australia and New Zealand has dropped from around 11 per year (2002–2005) to just over 6 per year (2006–2009). In the U.K. and Ireland the number of old age psychiatrists has increased but substantial investment in mental health services has excluded older people (Anderson *et al.*, 2009).

There is already evidence that older persons are in receipt of relatively few specialist psychiatric consultations. Medicare data from Australia indicate that persons aged 65 years and over have about one-third the chance of receiving a specialist psychiatric consultation compared with younger adults (Draper and Koschera, 2001). In the U.S.A. geriatric psychiatry has lower consultation rates than other medical specialties for those aged 85 years and over (ADGAP, 2008). In the U.K., younger adults with depression are eight times more likely to be referred to a psychiatry service than older people and only 1 in 6 older people with depression receive treatment of any sort (Age Concern, 2007). Within countries there is also a geographical maldistribution of the workforce. An old age psychiatry workforce survey undertaken in Australian and New Zealand in 2008 by the Faculty of Psychiatry of Old Age found that 82% of clinical time was spent in urban settings (Draper *et al.*,

2010), while in the U.S.A. areas of low population have fewer geriatric psychiatrists (ADGAP, 2008).

Concerns in the U.K. have resulted in a policy position statement by the Royal College of Psychiatrists (2009) and the issues of discrimination and the special nature of older peoples mental health have been discussed in more detail (Anderson *et al.*, 2009). The different needs of older people must be reflected in the competencies of specialist mental health services for older people and without these services there will continue to be age discrimination.

These shortcomings are likely to worsen unless initiatives to increase the old age psychiatry workforce are put into place promptly. This joint statement is intended to be a reference point for such efforts.

### Conflict of interest declaration

The authors are executive members of the Faculty of Psychiatry of Old Age in the Royal College of Psychiatrists (DA) and the Royal Australian and New Zealand College of Psychiatrists (BD) and represent the interests of old age psychiatrists in their respective countries.

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### Appendix

#### Joint Statement on Specialist Old Age Psychiatry Workforce and Training

#### Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists and Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists

Populations are aging worldwide and although many persons are reaching late life in better health than past generations, they are also living longer with disabilities. It is expected that these demographic changes will result in the incidence and prevalence of mental disorders in late life increasing in coming years. There will need to be a skilled old age psychiatry workforce available with the right knowledge and positive attitudes to address this inevitable demand.

This joint statement focuses on workforce and training issues and is guided by the principles espoused in the 1998 WHO Technical Consensus Statements on Psychiatry of the Elderly. The intent is to outline the broad agreement between the Faculties on key parameters and to facilitate cooperative initiatives in workforce and training.

1. Old Age Psychiatry is the field of psychiatry that specializes in the mental health of older people. Although in many jurisdictions the age of 65 years is used to determine the boundary between adult psychiatry and old age psychiatry, there are circumstances where this age might vary. For example, a younger age might be appropriate for some cultural groups or persons with younger onset dementia while an older age might be appropriate for persons with chronic mental disorders being managed long term in an adult service.
2. The effects of aging and age-related disorders upon mental health results in different and varied epidemiology and presentations of mental disorders in old age compared with younger adults. This has a significant impact upon the appropriate treatment and care of older persons with mental disorders including the effects of physical comorbidity and altered pharmacokinetics. Specific skills, knowledge and attitudes are required in a psychiatrist in order to provide best practice assessment, treatment and care for older people.
3. The training of all psychiatrists should include specific modules related to old age psychiatry including a training rotation within a dedicated old age psychiatry service.
4. The training of old age psychiatrists should be of sufficient duration to enable trainees to demonstrate competency in core areas of old age psychiatry. These include but are not limited to demonstrating:
  - a. knowledge of aging and age-related mental and physical disorders;
  - b. knowledge of psychological, social, cultural aspects of aging;
  - c. knowledge of and ability to apply relevant policy and legislation in the care of older people;
  - d. knowledge and skills to interpret and generate the research evidence base for old age psychiatry practice;
  - e. skills to conduct a comprehensive psychiatric assessment in an older person and their carer(s);
  - f. skills to develop and implement appropriate evidence-based interventions in collaboration

with the older person and their carer(s) that take into account their life history, cultural values, needs and strengths;

- g. interpersonal and communication skills that result in effective and empathic information exchange with consumers and carers and collaboration with all stakeholders;
  - h. ability to work effectively and take a leadership role within a multidisciplinary team and in private practice;
  - i. positive attitudes towards older people and their care.
5. The key competencies of Faculty subspecialty training requirements should aim to be compatible and as equivalent as possible to facilitate mutual recognition of subspecialty (Specialist/Advanced) training between the Colleges and countries.
  6. Each geographical region of a country should have equitable access to old age psychiatrists preferably in association with a comprehensive multidisciplinary old age psychiatry service. Gaps in rural and regional areas of each country are already present and are likely to worsen with the population increase.
  7. Recruitment and retention of the old age psychiatry workforce is crucial. There is a need to identify incentives and barriers to recruitment, training and retention in each country at undergraduate, postgraduate and mid-career level.
  8. The Faculties recognize that workforce development and retention will be enhanced by opportunities to work in each other's jurisdictions. To this end the Faculties undertake to encourage and support old age psychiatry job exchanges, temporary appointments and sabbaticals between UK and Australasia, at both academic and clinical levels.
  9. The Faculties support and encourage the recruitment, training and retention of health workers into other disciplines involved in old age psychiatry services including but not limited to nurses, psychologists, social workers and occupational therapists.

## Reference

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