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COMMENTARY

Tackling the Geriatric Psychiatry Workforce Shortage Through the Development of Concentrated Training Experiences

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The U.S. Census Bureau estimates that the number of Americans over the age of 65 will nearly double from 40.3 million in 2010 to a projected 72.1 million in 2030, and the Institute of Medicine has estimated that, by 2030, 10.1 to 14.4 million Americans aged 65 or older will have mental health or substance use disorders [1, 2]. The COVID-19 pandemic also significantly impacted the mental health of older adults, with data showing that the negative effects remain evident and may continue to worsen over time without the implementation of effective interventions [3]. Despite these trends, our society remains woefully underprepared to care for the growing number of older adults who struggle with mental health and addiction problems [4].

Based on the 2022 American Psychiatric Association (APA) Resident/Fellow Census, from 2017 to 2021, geriatric psychiatry fellowship programs had the lowest average enrollment rate compared to the other psychiatry subspecialty fellowship programs at 33.5% [5]. Moreover, the shortage of geriatric psychiatrists is anticipated to become even more pronounced due to the upcoming retirement of current geriatric psychiatrists and the relatively low rate of recruitment into the field [6].

These numbers suggest that we are facing a public health crisis and desperately need alternative strategies to increase the number of psychiatrists trained to care for older adults with mental health and addiction problems. With this need in mind, a group of geriatric psychiatry fellows and fellowship program directors from six West Coast programs met from 2023 to 2024 with support from a grant from the Archstone Foundation. The goals of these meetings were to develop initiatives that increase the recruitment and retention of psychiatrists into the specialty of geriatric psychiatry and to better leverage the expertise of geriatric psychiatrists currently. In this commentary, we describe one of these initiatives, which is a proposal for a concentrated training model that provides an enhanced level of training in geriatric psychiatry within the structure of a general adult residency program.

A Strategy to Increase Preparedness in Caring for Older Adults

The Archstone Learning Collaborative consisted of geriatric psychiatry fellows and fellowship directors from the University of Washington, Oregon Health Science University, Stanford University, University of California San Francisco, University of California Los Angeles, and University of California San Diego who met monthly during the 2023–2024 academic year. During these meetings, barriers to entry into geriatric psychiatry fellowship training were discussed. It was postulated that there exist psychiatry residents who have a professional interest in geriatric psychiatry, but for whom the added geriatric psychiatry fellowship training year is not feasible, for reasons such as family obligations, financial constraints, or training fatigue.

When considering how to augment this group of residents' training in geriatric psychiatry, we recognized that there have been past proposals focused on this topic. For example, in 2015, Kirwin et al. proposed restructuring general and subspecialty psychiatry training, allowing a resident to meet general adult psychiatry graduation targets within 3 years, followed by subspecialty geriatric psychiatry fellowship training in the 4th year [7]. This proposal's ultimate

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goal was to graduate residents who would be American Board of Psychiatry and Neurology (ABPN) board eligible for both general adult and geriatric psychiatry certification at the end of training. Another model was proposed by Balon in 2017 [8] and later by Duffy and colleagues in 2019 [9] and described as "mini-fellowship" track experiences [10]. These involve a 6-month-long 4th-year elective that provides cohesive training in geriatric psychiatry for residents [9, 10].

When thinking about how to build upon prior proposals, our conversations led to the concept of developing a concentrated training model that has a level of educational attainment similar to the 1 year of geriatric psychiatry training proposed by Kirwin et al., but completely within the structure of a general adult psychiatry residency. In other words, residents would have training almost to the standards of a geriatric psychiatry fellowship, but the model would have the flexibility needed to remain fully integrated in the mission and organization of their general adult residency. Subspecialty certification is not a planned result, but we recognize future potential to achieve this, as medical education moves towards competency-based and time-variable outcomes, rather than time-based outcomes. For example, programs that have a concentrated training model would be well positioned to pivot to "Promotion in Place," where residents who meet general adult competencies faster than 4 years could then engage in subspecialty training until graduation, and thereby meet competencies for both the general adult and subspecialty competencies at the end of the 4-year timeframe [11].

The Concentrated Training Model Description

The proposed concentrated training model resembles many aspects of a geriatric psychiatry fellowship, but with some key differences. In Table 1, we describe what we anticipate would be involved in such training programs and how such curricula compare to the standard pathway to geriatric psychiatry fellowship.

Regarding the structure of the model, it is intended to be part of and under the authority of the general adult psychiatry residency program, so there needs to be flexibility around implementation. For example, some programs may wish to develop geriatric psychiatry tracks that start in the first year of residency, while others may find it advantageous to focus on highly enriched time positioned only during the 4th year of residency. Some may designate a title, such as Chief Resident in geriatric psychiatry. Different programs will have differing selection criteria and will be able to accept differing numbers of trainees. Development of these programs will be done in partnership with and in line with the goals of their respective general adult psychiatry residency program directors.

While we expect that implementation specifics will differ amongst programs, we are anticipating that this model of training will involve core features. As described in Table 1, core education will include topics such as normal aging, cognitive assessments, caregiver considerations, and treatment considerations more common or specific to older adults. Assessments of resident progress will mirror the assessments used in geriatric psychiatry fellowships, which currently focus on advancement through Geriatric Psychiatry Milestones. As entrustable professional activities (EPAs) develop for use in geriatric psychiatry, this model would be poised to adapt those, as well.

The Advantages and Challenges

We believe that providing the opportunity to complete concentrated training in geriatric psychiatry during residency will increase access to psychiatrists with specialized training in the care of older adults. While our proposed training model would not increase the number of psychiatrists with board certification in geriatric psychiatry, this formalized option may attract more individuals who would have otherwise not completed a year of fellowship after residency. Completing a concentrated training program could also motivate more residents to do fellowship in geriatric psychiatry since, at this time, residents often do not feel as though they have enough exposure to specialty populations to make an informed decision about whether to enter fellowship, especially as the Accreditation Council for Graduate Medical Education (ACGME) only requires a 1-month full-time equivalent experience in geriatric psychiatry at this time [10, 12–14]. Overall, implementation of this approach on a larger scale should allow for the aging population to have improved access to psychiatrists with specialized training in the care of older adults while still preserving the availability of the formal geriatric psychiatry fellowship for those interested [9].

We also recognize several challenges likely to be associated with the implementation of such concentrated training curricula. First, such concentrated training programs could only be implemented in programs that have geriatric psychiatry faculty and clinical resources, and even in those programs, they may involve only a handful of trainees per year. Also, psychiatry residency programs without such concentrated training experiences may have concerns about how recruitment to their programs would be affected. It is also possible that the implementation of such concentrated training programs could reduce the number of senior residents available for such duties as coverage for longitudinal outpatient clinics, chief residency positions, or other roles that have been traditionally occupied by trainees during the last

Table 1 Proposed concentrated training model compared to the standard pathway

Training components	Concentrated training in geriatric psychiatry	Standard training involving geriatric psychiatry fellowship
Description of pathways to geriatric psychiatry	Geriatric psychiatry training curriculum dedicated during elective time	1-year fellowship following 4 years of general psychiatry residency training
Total duration of training in psychiatry	4 years	5 years
Current ACGME approval status	Not approved	Approved
Geriatric psychiatry curriculum	Conducted during elective time	Conducted during the 5th year of training
Didactics curriculum	Geriatric psychiatry didactics in addition to general psychiatry didactics	Geriatric psychiatry curriculum during fellowship
Clinical rotations	Potential clinical rotations include inpatient geriatric psychiatry; outpatient geriatric psychiatry; memory disorders clinic; geriatric psychiatry consultation (inpatient and outpatient); geriatric psychiatry in subacute rehabilitation or long-term care; electroconvulsive therapy; home visits; neurology; and palliative care	As per the ACGME guidelines for geriatric psychiatry fellowship training
Supervision	Dedicated supervision by geriatric psychiatry and neuropsychiatry faculty	Dedicated supervision by geriatric psychiatry and neuropsychiatry faculty
Board certification pathway	ABPN General Psychiatry Certification after the 4th year; ABPN Geriatric Psychiatry Certification not approved	ABPN General Psychiatry Certification after the 4th year and ABPN Geriatric Psychiatry Certification after the fellowship
Pros	Subspecialty training for interested candidates over a shorter duration of time	Subspecialty training and certification; established pathway, with current ACGME and ABPN approval status
Cons	Lack of ACGME and ABPN accreditation processes, interference with specific programs' needs for house staff, need for geriatric psychiatry faculty	Longer duration of training, limited number of interested candidates, limited financial gains

Abbreviations: *ACGME*, Accreditation Council for Graduate Medical Education; *ABPN*, American Board of Psychiatry and Neurology

year of residency. Making such concentrated programs available might cause concern for reducing the pool of residents who pursue training through ACGME-accredited geriatric psychiatry fellowship programs, although one could argue that greater visibility of such educational opportunities could increase overall interest in the field. We also acknowledge that a concentrated experience to train more psychiatrists in the field of geriatric psychiatry would not address other important barriers, such as the stigma of aging and financial disincentives involving lower reimbursement rates [4]. Finally, all residents will graduate board eligible for general adult psychiatry certification, but the geriatric psychiatry training may be variable, as this model is not being developed under the auspices of a formal oversight body. Residents who complete a concentrated training program but do not complete the geriatric psychiatry fellowship may have a lesser degree of expertise, experience, and clinical confidence. However, we envision collecting outcomes and disseminating our experiences in order to improve upon the model and contribute to formalization efforts in the future.

The Next Steps in Implementation

After the Archstone Learning Collaborative stopped meeting in 2024, we as a subgroup of geriatric psychiatrists, including partners in six geriatric psychiatry fellowship programs, have continued working to develop this model. We continue to refine the components and invite dialogue from educational colleagues, with a goal to have one or more of our participating institutions pilot a concentrated training model in the near future. We plan to collect data to demonstrate feasibility, refine the model, and show outcomes, such as participants' achievement of competencies in both general adult psychiatry and geriatric psychiatry and practice areas after graduation. Over time, we may propose that if data on feasibility and outcomes are favorable, especially as medical education moves towards competency-based outcomes, this model could be considered for ACGME and ABPN approval for board certification in geriatric psychiatry. For now, however, we hope that creating concentrated training programs in geriatric psychiatry will allow for a greater number of psychiatry residents

to become better prepared for caring for older adults and, in turn, better meet the needs of our aging population.

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Declarations

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