Subspecialty Training and Certification in Geriatric Psychiatry: A 25-Year Overview

Dorthea Juul, Ph.D., Christopher C. Colenda, M.D., MPH, Jeffrey M. Lyness, M.D., Laura B. Dunn, M.D., Rita Hargrave, M.D., Larry R. Faulkner, M.D.

The Institute of Medicine estimated that by 2030, from 10.1 to 14.4 million Americans aged 65 years or older will have mental health or substance use disorders. This article reviews the history and current status of training, certification, and practice in geriatric psychiatry against the backdrop of this "silver tsunami." The American Board of Psychiatry and Neurology (ABPN) administered the first subspecialty examination in geriatric psychiatry in 1991, and through 2015 3,329 certificates were awarded. The Accreditation Council for Graduate Medical Education approved the training requirements in 1993. After a surge in programs and fellows, the numbers appear to have stabilized at about 57 programs and 60–65 trainees per year with fewer than half of the positions filled each year. The majority of graduates seeks and obtains ABPN certification, and the majority of those who were fellowship trained have maintained certification.

Despite the unprecedented demand for mental health services for older adults, it must be acknowledged that not enough geriatric psychiatrists can be prepared to meet the needs of an aging U.S. population. Strategies for addressing the shortage are discussed, including undertaking subspecialty training in the fourth year of psychiatry training, increasing the time devoted to the care of older adults in undergraduate and graduate medical education, and developing alternative training pathways such as mini-fellowships. It is not clear whether more favorable Medicare reimbursement rates for those certified in geriatric psychiatry would increase the numbers seeking fellowship training. (Am J Geriatr Psychiatry 2017; ■■:■■–■■)

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The Institute of Medicine estimated recently that by 2030, from 10.1 to 14.4 million Americans aged 65 or older will have mental health or substance use disorders.[1] The "silver tsunami" is bringing with it an unprecedented need for mental health services for older adults, yet, as a society we remain woefully underprepared for this need.[2] Currently, only one month of geriatric training is required in general

Received May 3, 2016; revised December 22, 2016; accepted December 23, 2016. From the American Board of Psychiatry and Neurology, Inc. (DJ, LRF), Buffalo Grove, IL; The West Virginia University Health System (CCC), Morgantown, WV; Department of Psychiatry and Neurology (JML), University of Rochester School of Medicine and Dentistry, Rochester, NY; Department of Psychiatry and Behavioral Sciences (LBD), Stanford University, Stanford, CA; and Department of Psychiatry and Behavioral Sciences (RH), University of California, Davis, Sacramento, CA. Send correspondence and reprint requests to Dr. Dorthea Juul, American Board of Psychiatry and Neurology, Inc., 2150 East Lake Cook Road, Buffalo Grove, IL 60089. e-mail: djuul@abpn.com

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psychiatry residency programs (a recent modification to the residency training requirements).[3] Subspecialty training and certification in geriatric psychiatry date to the late 1980s and early 1990s, with the first certification examination in geriatric psychiatry administered by the American Board of Psychiatry and Neurology (ABPN) in 1991.

Given the major demographic shifts that are occurring, the purpose of this article is to describe the history and current status of training and certification in geriatric psychiatry. The significant workforce issues confronting the subspecialty and the strategies that have been proposed for addressing them are also discussed. This article provides an update on some of the issues addressed in the May–June 2003 issue of this journal, which featured a number of articles on training in geriatric psychiatry,[4] and in a report on trends in psychiatric subspecialties by Faulkner and colleagues.[5]

FELLOWSHIP PROGRAMS, CERTIFICATION, AND RECERTIFICATION IN GERIATRIC PSYCHIATRY

History, Fellowship Match Rates, Clinical Training Requirements

The emergence of geriatric psychiatry as a subspecialty is described by Reifler et al.,[6] who linked it to increasing recognition of the clinical importance of often complex neuropsychiatric conditions in a burgeoning older population and the key role that psychiatrists could play in understanding and treating them. In early 1989 the ABPN applied to the American Board of Medical Specialties (ABMS) for recognition of the subspecialty. The ABMS granted approval later that year, and the Accreditation Council for Graduate Medical Education (ACGME) approved the training requirements in 1993. At the time that the geriatric psychiatry subspecialty was approved, the only other ABPN subspecialty was child and adolescent psychiatry, which had its inaugural examination in 1959. Geriatric psychiatry was quickly followed by several other subspecialties, including more recently the multidisciplinary subspecialties of pain medicine, sleep medicine, hospice and palliative medicine, and brain injury medicine.

At the time of application to the ABMS, there were 29 unaccredited programs in geriatric psychiatry; the number of fellows was not specified. By academic year 2000–2001, there were 62 accredited programs with 104 filled positions.[6] A decade later (academic year 2010–2011), the number of programs decreased to 56 and the number of filled positions to 57.[7] Since 2006, fewer than half of the fellowship positions have been filled, and the fill rate has declined.[1] Currently (academic year 2016–2017), there are 57 programs; about half of them (N = 27) have two positions, and about a fourth (N = 13) have three. The size of the rest ranges from one to seven. Of the 153 positions, 61 (or 40%) were filled. A third of the programs (19 of 57) had no filled positions, and 9 (16%) filled all positions.[8]

The trajectories for forensic and addiction psychiatry were similar in that in the first decade after ABPN/ACGME recognition the numbers of programs and trainees expanded, although neither one reached the number of programs that geriatric psychiatry did. Unlike geriatric psychiatry, however, neither of those subspecialties experienced a decrease in the number of programs and trainees in their second decade.[5] Psychosomatic medicine was approved about a decade after these three subspecialties, and the numbers of programs and trainees are still increasing. In terms of fill rates, for academic year 2016–2017, geriatric psychiatry had the lowest fill rate (40%). The fill rates for the other subspecialties were child and adolescent psychiatry 86%[9] (128 programs, 871 on-duty residents), psychosomatic medicine 72%[9] (58 programs, 85 on-duty residents), addiction psychiatry 70%[10] (46 programs, 92 on-duty residents), and forensic psychiatry 56%[11] (44 programs, 65 on-duty residents). These data suggest that geriatric psychiatry may be less appealing to residents than the other psychiatry subspecialties.

The current requirements for the one-year fellowship program in geriatric psychiatry include clinical experience in longitudinal care, geriatric psychopharmacology, electroconvulsive therapy, individual and group psychotherapies, interdisciplinary geriatric care team, geriatric psychiatry consultation, and experiences that enable fellows to become familiar with the organizational and administrative aspects of home health care services, outreach services, and crisis intervention services in both community and home settings.[12]

Significant changes in the program requirements resulted from the ACGME's Outcome Project, initiated in 1998, to move accreditation from a process-based