American Association of Directors of Psychiatric Residency Training

Committee Spotlight

Name: Workforce

Chair: Rebecca Lundquist, MD

Charge:

Background

The United States has a psychiatrist workforce problem. Between 1995 and 2014, although the population increased by 37% and the number of physicians grew by 45%, the number of psychiatrists increased by only 12%. In 2017, 61% of psychiatrists were 55 or older and thus approaching retirement. A 2018 population analysis projected that the US psychiatrist workforce would contract to a low of about 39,000 by 2024, with an ongoing shortage through at least 2040. The current psychiatric and mental health workforce is insufficient to meet the nation's mental health needs, with less than half of US adults with a DSM disorder receiving any care, only 12% seeing a psychiatrist, and 96% of US counties having unmet need for psychiatric prescribers. The problem affects subspecialists as well, with shortages of child and adolescent, addiction, and geriatric psychiatrists.

In response to these shortages, the American Association of Directors of Psychiatric Residency Training (AADPRT) convened a Workforce Task Force in 2019. The task force was charged with studying obstacles to increasing the psychiatrist workforce and the feasibility of potential strategies and solutions. In 2022 the task force provided the executive committee a range of recommendations, leading to formation of a workforce committee to continue this work.

Purpose

There is a clear and urgent need for an increase in the number of psychiatrists available in the United States. While we need to sustain interest in psychiatry, at this time there continue to be more medical students interested in psychiatry than available residency positions. Successful and sustained expansion of residency training slots needs to be an urgent priority. To do so effectively, current and prospective program directors need easily accessible resources and mentoring specific to their needs.

In addition to expanding the pool of general psychiatrists, we need to address the significant shortage of sub-specialists in psychiatry. A two-pronged approach would be first to ensure that all general psychiatrists are well trained to treat all specific subpopulations and second to implement strategies to increase the number of trained subspecialists.

Recruitment and retention of teaching faculty are areas that need sustained attention. A simple increase in the number of psychiatrists available is not sustainable without having dedicated and enthusiastic teaching faculty. Salary disparities between private settings and academic work, which requires time for faculty to teach and supervise, is an important issue that is difficult to address and will need national level advocacy efforts. It will also require providing program directors and faculty with tools to be able to make a business case at their institutions. Burnout among both program directors and faculty members that leads to attrition is a significant barrier to the sustained expansion of residency and fellowship slots in psychiatry.

It is also worth exploring other options with the end goal of meeting the growing psychiatric needs of the patient population. The workforce can be augmented with Nonphysician Providers (NPPs). Effective use of hybrid teams with NPPs and psychiatrists hinges on understanding the training and education of NPPs and learning effective ways to work jointly with them. It also requires psychiatrists being trained in leading hybrid teams. As NPPs are increasingly present in clinical settings where residents and fellows work, it is important to develop best practices for the co-work of residents and fellows with NPPs.

Incorporation of collaborative care and telepsychiatry may help us more effectively provide psychiatric care to our patients. Training residents and fellows on ways to leverage psychiatrist time using collaborative care models, to provide effective telepsychiatry may also help alleviate the shortage.

Finally, it may be time to re-evaluate psychiatric training, look at all aspects critically and explore whether all the current requirements are still relevant. For example, are there effective ways to shorten training or provide fast tracking to fellowships other than CAP? Are there alternate pathways to subspecialty certification that should be considered again? Are there additional areas of training that are currently missing such as how to effectively lead a hybrid team, understanding the finances of patient care and the role of advocacy, that should be included and if so, what are the current requirements that can be taken off?

In order to move the above forward, we will need to advocate for them. Advocacy will have to be from all levels of psychiatric education: residents, faculty, program directors and chairs and will have to be at the local, state, and national levels. It is clear that there is an imperative need for more psychiatrists, and we need more psychiatry residency positions and to do this we need federal funding, not just the hodge-podge of local/state funding that has allowed some programs to start/expand -- i.e., we need a coherent national policy and funding. Thus, advocacy is going to be a key factor in our future efforts.

Tasks

1. Expansion of residency slots
    a. Revise the document entitled *Creation of a New Program or Track or Expansion of a Program Resource Guide* developed in 2020. Consider adding a set of basic documents (policies, etc.) needed when developing new programs as a resource for new programs as well as keeping a list of consultants available to institutions wanting to start new programs.
    b. Align with mentorship committee to provide opportunities for mentoring and or/access to consultants with experience starting or expanding a program
    c. Developing an understanding of the barriers to new training programs and to the expansion of existing training programs.
    d. work with the rural programs, new programs and community caucuses to understand what is needed to support residency slot expansion efforts in AADPRT
2. Address significant shortage of sub-specialists in psychiatry.
    a. Improve/expand categorical subspecialty training so that residents graduate from general psychiatry residency prepared to take care of a full spectrum of patients - analysis of current subspecialty training FTE requirements and alignment with taskforce recommendations e.g. addiction taskforce recommendation to increase addiction psychiatry training to 2 FTE months
    b. Explore options to increase the number of trained subspecialists
    c. Explore innovative programs and/or shortened training pathways
    d. work with the subspecialty, triple board, combined programs, CAP caucuses, addictions committee to coordinate efforts on these issues with them

3. Faculty recruitment/retention
    a. Obtain baseline analysis of workloads and patient volumes for teaching faculty
    b. Liaise with Justice, Equity, Diversity and Inclusion Committee to develop support for and expand teaching faculty from diverse backgrounds
    c. Initiate and sustain educational advocacy efforts with national organizations (e.g. ACGME/APA)
    d. Develop tools that enable PD's/chairs to develop effective business cases that support faculty recruitment and retention.
    e. Work with the wellbeing/burnout committee to understand and make mitigation strategies for faculty retention/recruitment barriers
4. Working with NPP's
    a. Publish results of survey of PD's that focused on the impact of NPP's on Graduate Medical Education (GME) in psychiatry
    b. Complete Best Practice resource regarding interaction of GME in psychiatry with NPPs and NPP trainees
5. Leveraging psychiatric expertise
    a. Align with integrated care caucus and curriculum committee to disseminate newer models of care (e.g. telepsychiatry, integrated care) to reach patients in rural/underserved areas and address workforce maldistribution.
    b. Explore models of resident supervision and training of residents in under resourced areas
6. Re-evaluate psychiatric training
    a. Explore whether all the current requirements are still relevant, whether new requirements should be included and whether some requirements could be removed.
    b. Develop ACGME recommendations in collaboration with curriculum committee
7. Advocacy - Local institution, State and National
    a. Liaise with APA and other organization interested in the psychiatry workforce
    b. Develop funding advocacy tools to include federal, state, institutional, insurance options

Email Rebecca to join the committee.