Improving Child and Adolescent Psychiatry Education for Medical Students:

An Interorganizational Collaborative Action Plan

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Abstract:

***Objectives*: A new Child and Adolescent Psychiatry in Medical Education (CAPME) Task Force, sponsored by the Association for Directors of Medical Student Education in Psychiatry (ADMSEP), has created an interorganizational partnership between child and adolescent psychiatry (CAP) educators and medical student educators in psychiatry. This paper outlines the task force design and strategic plan to address the long-standing dearth of CAP training for medical students.**

***Methods*: The CAPME ADMSEP Task Force, formed in 2010, identified common challenges to teaching CAP among ADMSEP members, utilizing focus group discussions and a needs assessment survey.**

***Results*: The Task Force was organized into five major sections with interorganizational action plans to address identified areas of need, such as portable modules and development of benchmark CAP competencies.**

***Conclusions*: The authors predict that all new physicians, regardless of specialty, will be better trained in CAP. Increased exposure may also improve recruitment into this underserved area.**

Key Words: child and adolescent psychiatry, medical student education

Introduction

Child and adolescent psychiatry (CAP) remains among the most underserved specialties in medicine, as highlighted in multiple white paper and policy statements from CDC, APA, WHO, American Academy of Pediatrics, the U.S. Surgeon General, and others (1,2). An entire 2008 issue of Academic Psychiatry was dedicated to strategies to improve CAP pedagogy and recruitment (3).

There remains a frustrating gap between the call to action versus implementation**.** Despite ongoing efforts to address CAP workforce issues (4), the number of applicants remains insufficient. From 2006-2011, 35% of CAP programs and 16% of positions did not fill in the Match (5). In part due to the CAP shortage, most children receive mental health treatment from primary care providers or general psychiatrists (6). This reality makes it imperative that all medical students receive a foundation in CAP education, regardless of specialty choice. Unfortunately, CAP exposure in most medical school curricula

is limited (7). Integrating CAP topics into an increasingly packed four-year medical school curriculum is challenging.

A key overlooked fact is that most psychiatric educators are not themselves child psychiatrists. The authors propose that this discrepancy is partly responsible for the dearth of CAP representation in the medical school curriculum, and contributes to difficulties with recruitment into the field. New alliances need to be forged to truly address the problem.

Organizational Analysis, Hypothesis, and Plan

In order to effect changes in medical school CAP curricula, collaboration between psychiatric medical student and CAP educators is needed. However, these two key groups of educators rarely interact at a national level. At the ADMSEP Annual Meeting, CAP presentations have been few in number and sparsely attended. In June 2009, only 14 out of 163 ADMSEP members had CAP training. Many psychiatric educators report limited access to local CAP faculty resources.

In a parallel problem, the majority of CAP educators are primarily focused on CAP fellowship or general psychiatry residency training. CAP training directors convene at the American Academy of Child and Adolescent Psychiatry (AACAP) Annual Meeting and at the American Association of Directors of Psychiatry Residency Training (AADPRT) meeting. Although problems with CAP recruitment are perennially bemoaned in these settings, efforts to improve curricula have remained primarily focused on residency and fellowship.

Another contributing factor is that the priorities of the various organizations are significantly different. ADMSEP's primary mission is to provide excellent psychiatric education to all medical students, regardless of their future specialty. Since roughly 95% of medical students do not choose psychiatry, educators must ensure that the fundamentals of psychiatry are learned by every future physician. Recruitment into psychiatry is secondary to this goal (8). Therefore, medical student educators in psychiatry actively resist the tendency of their chairs to gauge success by the percent of the graduating class selecting psychiatry. Instead, they rightly emphasize the primacy of providing excellent general psychiatric education to 100% of medical students (9). In contrast, both AACAP and AADPRT expend significant energy on recruitment and workforce issues. Job performance of general and CAP training directors is in part judged by their ability to recruit excellent candidates.

In the authors' opinion, these organizational factors, combined with the shortage of academic child psychiatrists, have conspired to create obstacles to improving CAP education for medical students. The educators who are passionate about medical student education as their primary mission are usually general psychiatrists, while the CAP education experts are usually focused on post-graduate training. Given the limited opportunities for interaction and collaboration for these educators, it is not surprising that CAP offerings in the average medical school curriculum leave significant room for improvement.

If this formulation is correct, then the solution is to increase collaboration between CAP educators and medical student educators in psychiatry. Full interorganizational collaboration should lead to significant improvements in CAP education for medical students.

In 2010, the ADMSEP Task Force on Child and Adolescent Psychiatry in Medical Education (CAPME) was created. Importantly, participants included both CAP and non-CAP psychiatric educators. In order to identify areas of need and potential solutions, the group conducted an ADMSEP meeting brainstorming session, an ADMSEP listserve electronic survey, and focus groups with medical educators. Overall, many participants noted that they had limited resources for teaching CAP. The majority of participants were interested in seeing benchmark competencies in CAP developed for medical students. The competencies suggested were wide ranging and often very basic, such as recognizing when a child needs further mental health assessment, knowing how to obtain a CAP history, knowing the criteria for major CAP disorders (including ADHD and autism) and familiarity with medications for common disorders such as ADHD. Requested resources included: mixed media portable teaching modules, on line self-study resources, problem-based or team-based learning cases, small group activities and lectures. Requested curricula areas included human development, psychopathology, mental status exam, child and adolescent assessment, neuroscience and defense mechanisms.

A strategic plan was developed to address identified areas of need. The ADMSEP CAPME Task Force was organized into five sections, each comprised of ADMSEP members and CAP educators. Section leaders without CAP training were partnered with CAP educators as co-leaders.[i] Educators from multiple organizations (ADMSEP, AACAP, AADPRT, AAP, PsychSIGN and APA) volunteered to contribute as section members. Primary administrative support is provided by ADMSEP, with administrative consultation from AACAP.

A national task force requiring full collaboration between educators who may never meet each other poses unique logistical challenges (and many conference calls). The primary CAPME Task Force meeting occurs at the ADMSEP meeting. The CAPME Task Force action plan is a standing agenda item at the AACAP Training and Education Committee, as well as the Program Directors' Luncheon at the AACAP Annual Meeting. Seven section leaders are AADPRT members. At the AADPRT CAP Caucus, a major agenda item is to actively involve CAP educators in the CAPME action plan. In addition, CAPME Task Force members who are attending AAP, PsychSIGN, and APA meetings may arrange to meet there as well.

The five CAPME Task Force sections' objectives and action plan are detailed below:

<u>Section 1</u>: Benchmark CAP learning objectives

Section 1 members reviewed NBME and USMLE content areas, the AAMC clinical skills curricula (10), existing ADMSEP end-of-clerkship competencies, and competencies for medical students from other disciplines. A consensus list of benchmark competencies, with potential assessment measures, was outlined for all students to achieve by the end of medical school. This was endorsed by the CAPME Task

Force, the AACAP Training and Education Committee, ADMSEP Council, and was sent to the Alliance for Clinical Education for review.

Section 2: Regional CAP curricular consultants

This section will offer individualized CAP curricular consultation and mentoring to the nation's 135 medical schools. A coordinator has been designated for each of the four AAMC regions. A regional CAP consultant will connect with the ADMSEP member at each school to offer individualized support, connecting educators with resources compiled by the CAPME Task Force. The consultant will be available to help problem-solve local challenges to implementing CAP benchmarks in the undergraduate curriculum. This will be an iterative process, with concerns brought back for discussion by the Task Force.

Section 3: CAP portable multimedia modules

This section is integrated with ADMSEP's Clinical Simulation Initiative (CSI) Task Force. CSI is designing portable web modules to illustrate core psychiatric disorders across all diagnostic categories. The first CAP web module prototype, "Adolescent Depression," can be viewed at http://www.unmc.edu/bhecn/221.htm. This module was designed by the Section 3 leader with an inter-professional team embedding video clips, voice-over narration, teaching animations, and self-learning quizzes into an interactive webinar. Currently, CSI is gathering data from psychiatry clerkships across several medical schools to analyze the module's effectiveness.

Future goals will be to develop at least one module in each of the following CAP diagnostic categories: eating disorders, attention deficit/hyperactivity disorder, pervasive developmental disorders, and pediatric anxiety disorders. The CSI Task Force is recruiting programmers, and forming an editorial board to develop a peer review process for modules.

Section 4: On-line CAP resources for educators

Medical student educators in psychiatry expressed concern that available resources for CAP education on the web were scattered and not easily accessed. However, many disparate groups within AACAP, AADPRT, and AAP have educational products that may be of interest to medical student educators. Section 4 leadership is coordinating with the AADPRT Model Curricula Project, various AACAP Committees, and others to organize current resources and determine the most effective means of dissemination to medical student educators in psychiatry. Organization web masters will collaborate to ensure that available CAP resources are easily located through links on the ADMSEP, AACAP, and AADPRT websites.

Section 5: CAP opportunities for medical students

Fundamentally, medical students learn best through personal experiences with an involved mentor. This section's objective is to increase medical students' exposure to CAP through direct interactions and connections at the ground level. Active collaboration with PsychSIGN will publicize suggestions for CAP speakers or activities, and information about CAP opportunities (i.e. AACAP medical student fellowships,

and mentoring programs). This section also plans to raise awareness of CAP for students interested in other fields, by working with medical student organizations such as AMSA, AAMC, and SAMSA.

Conclusions

Since psychiatric services for children are often delivered via primary care providers, CAP education must be an essential part of the medical school curriculum. Furthermore, basic skills, such as interviewing an adolescent, are endorsed by the AAMC Clinical Skills curricula. Therefore, all components of the CAPME Task Force share the goal of medical students learning core CAP competencies as part of basic medical education.

Given the limited interaction between CAP educators and medical student educators in psychiatry, the ADMSEP CAPME Task Force may provide the strategic key to bridging the gap and forging new alliances to create productive educational outcomes.

The process of recruiting volunteers for the Task Force sections has recently put medical student education on the agenda for discussion in multiple forums. An additional benefit of this increased visibility may be that CAP educators, regardless of whether or not they volunteer for the Task Force, now have medical student education on their radar, and may make it a higher priority at their home institutions. Similarly, medical student educators now have CAP on their radar as well.

The authors are optimistic that full interorganizational collaboration will lead to significant improvements in CAP education for all medical students. Outcome studies are needed to assess the long-term effect of this endeavor on future physicians' knowledge, attitudes and interest in CAP.

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[i] CAPME Task Force leadership (May 2012)
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