Title
Enhancing Family Oriented Care in Residency and Fellowship Training

Educational Objective
1. Disseminate ideas for incorporating family-oriented care into daily clinical activities.
2. Discuss and share challenges/barriers for teaching about family work.
3. Demonstrate through role-play and video vignettes some examples of teaching about families.

Practice Gap
Family therapy is a critical clinical area that has been underemphasized in psychiatry training over the past several decades. Family therapy training in psychiatry has many advantages: a holistic framework for conceptual formulation, engagement strategy for patients and families, adherence to treatment, and a unifying framework to address underlying interpersonal conflicts driving behavior (1). However, the shift towards psychopharmacology as the primary treatment modality, limited resources, and lack of established core competency model for family therapy has led to progressive decline in family therapy training in psychiatry residency and fellowships. (2, 3.). "Family work" or "family-oriented care" are viewed as a more accurate and useful terms to use with training psychiatry residents who may feel that family therapy is for a different professional discipline to do (4). Family work is seen as an "essential set of skills' ' needed to work with patients in a comprehensive and wholistic way in both inpatient and outpatient psychiatric settings utilizing family assessment, skills in managing family interactions and basic family interventions.

Psychiatric symptoms evolve and progress in a social context. As psychiatry embraces the neuroscience model, it is imperative to pay equal attention to the unifying framework of family therapy to broaden the assessment and management strategies. Psychiatry trainees must learn to use family-oriented care in routine clinical practice to assess, develop a biopsychosocial conceptual model, engage and treat patients. Training programs need to modify their educational offerings to accommodate clinical and didactic opportunities for training in systems thinking and family-oriented care as there is sound evidence that trainees value training in systems thinking to address clinical dilemmas (3). Psychiatric disorders often present with complex underpinnings which warrant a multidimensional assessment and management approach. The success of family-centered healthcare models for patients with general medical illnesses and in certain psychiatric illnesses provides strong support to utilize a family-centered approach in behavioral health.

Scientific Citations
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Abstract

The place of family therapy in general and child psychiatry training programs to this day remains controversial and only a handful of residency and fellowship programs formally teach family therapy. There is also a difference between a full course of family therapy, family assessment, psychoeducation, and family systems intervention. Trainees need critical skills to effectively work with families both in outpatient and inpatient settings. These skills include circular questioning, setting boundaries with the family as a unit, de-escalation skills, hierarchy boundaries, subsystems (marital, parenting, siblings) as well as family meetings. It is true that psychiatrists rarely end up doing family therapy. It is also true that there is strong evidence that family factors are responsible for the initiation and maintenance of many of the psychiatric disorders and psychiatrists need to be able to identify them and ideally manage them. One example is family psychoeducation that is known to be crucial to medication adherence. Another example in the age of shorter hospital stays, we have become more reliant on family support in bringing their loved ones to outpatient appointments as well as creating a supportive environment. Families are crucial parts of biopsychosocial units and psychiatrists should know how to collaborate with them. In the era of COVID-19, political divisiveness and structural racism, the functional outcomes hinge upon the family system.

This workshop will offer some guidance for programs on how to set up family systems training. Changing the focus from strictly "family therapy" training to "family-oriented care" is outlined. It will provide information on how to discuss the initial steps with their program leadership and how to navigate challenges around limited faculty, full didactic schedule and many more. We will propose a curriculum that will work in a program with very limited resources. We will discuss ways to engage residents and fellows and how to practice newly learned skills with them on inpatient and outpatient units. We believe that for almost any psychiatric disorder thinking systemically and including families provides an enriching experience for both the trainees and the faculty. We will also address some ways of teaching about cultural considerations in family systems. Best strategies on how to set up systemically oriented didactics will be discussed.

Agenda

This workshop is aimed at psychiatry program directors, psychiatry clerkship directors, and other medical educators interested in building Family Systems Concepts and Skills into their resident curriculum. The workshop will proceed as follows:

1. Introductory Survey of Family Intervention Program Development and Obstacles - 5 min
2. Overview of Curriculum Elements, Family Systems Concepts, and Training Tools - Total 50 min.
    a. Overview of Curriculum, family Systems Concepts (12 min)
    b. Assessment of Family Systems (12 min)
    c. Running Family Meetings in Different Settings (12 min)
    d. Social Determinants and Cultural Considerations (12 min)
3. Breakouts to Facilitate Discussion of Program Development - 10-15 min

4. Summary, Action Step, and Training Tool Dissemination - 5-10 min

Title
Struggling with faculty recruitment and retention? Let us help you!

Educational Objective
By the end of the session participants should be able to:
1. Identify key differences between major academic and community-based faculty compensation structures
2. Name several key elements in a successful faculty compensation structure.
3. Identify 2 ways in which you can demonstrate GME value to hospital and other decision makers.
4. Describe three methods of creating an attractive initial faculty recruitment package.
5. Describe two successful models that help with long term faculty retention: faculty development and mentoring.
6. Name one structural and one financial change that departments can make to enhance BIPOC faculty recruitment and retention.

Practice Gap
Results from the 2019 American Association of Directors of Psychiatric Residency Training (AADPRT) Workforce Task Force survey indicate that faculty recruitment and retention is a major issue for residency and fellowship training programs. Both residency PDs (76.2%) and fellowship PDs (68.9%) cited difficulty with recruitment and retention of faculty. Most comments discussed difficulty in recruiting faculty, with a prominent theme of noncompetitive academic salaries compared to the private sector. Some also commented that this was a barrier in retaining faculty, especially with junior faculty moving into better paid jobs. Additional themes in faculty recruitment and retention included workload, non-compensated teaching time, location, and chronic short staffing.

AADPRT 2017 Faculty Development Task Force results align with the findings from the 2019 Workforce Task Force. Survey respondents reported that lack of funding, time and excessive clinical demands were the main barriers to seeking a career in graduate medical education.

Recruitment and retention of a diverse and inclusive faculty workforce is required by the ACGME. A diverse faculty group supports recruitment and retention of a diverse resident and staff workforce, enhances productivity. and promotes a more inclusive workforce culture. However, few psychiatry programs or departments have well operationalized guidelines for success.

Best practices for faculty recruitment and retention that apply across academic and community program settings have not been previously been described. This workshop aims to draw from existing data, harness expertise from members of the current AADPRT workshop Taskforce who include two psychiatry department chairs, and from audience members, to address that gap.

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Abstract

The 2019 American Association of Directors of Psychiatric Residency Training (AADPRT) Workforce Task Force survey indicated that faculty recruitment and retention is a major issue for residency and fellowship training programs. Never fear, this workshop will come to your rescue!

We will address known barriers to faculty recruitment and retention, and demonstrate and discuss innovative solutions. Audience members will learn about core principles for academic compensation. Several faculty compensation structures in use at academic and community programs will be presented and compared. Strategies to demonstrate GME value to funding partners and decision makers will be discussed.

Psychiatry department chairs will discuss how to bridge the remaining additional barriers reported in the 2019 ADPRT Workforce Taskforce survey, which include workload, non-compensated teaching time, location, and chronic short staffing.

Participants will engage in large group discussion and report out of salary structures successful in their own settings.

In the second half of this workshop, we will pivot to addressing the top 3 faculty development needs (more protected time, teaching skills workshops and mentorship opportunities)

identified in the 2017 AADPRT Faculty development Taskforce as strategies that can enhance recruitment and retention. Several effective solutions that can be applied to both community and academic settings will be presented.

Finally, one area notably absent in both surveys, but required by the ACGME, is development of strategies and structures that support recruitment and retention of a diverse faculty workforce. Large group discussion to enhance input from audience members will be used to create guidelines for success that will be shared with the group after workshop completion.

Agenda

Before the workshop, audience participants will receive an overview of the data from the 2019 AADPRT workforce and 2017 Faculty Development Taskforce surveys regarding faculty recruitment and retention barriers.

5 mins
Introductions, outline objectives, describe agenda for meeting 2019 AADPRT workforce development task force survey results

25 mins
Compensation principles
Several compensation structures contrasted and compared.
Additional strategies to address remaining recruitment and retention challenges
Large group discussion and report out about other strategies that have been successful

30 mins
2017 Faculty development task force survey results
Different approaches to address faculty workload, development, mentoring, teaching skills workshops

15 mins
Recruitment and retention of a diverse and inclusive faculty – barriers and solutions.
Large group brainstorming and report out

Title

The invaluable lessons of a structured mentorship program: Creating a culture of inquiry and mentorship within Psychiatry Residency Programs

Educational Objective

1. Attendees will learn how to structure focus groups to elicit honest, open feedback from trainees and faculty to generate a program with shared interests and to align needs of trainees and faculty for a mentorship program
2. Attendees will identify the elements and value of a structured mentor program
3. Attendees will apply the needs of their program to a mentor toolkit for using with their home institution
4. Attendees will identify practical strategies for faculty to grow their mentorship skills through coaching communication to build a culture of resourcefulness and support

Practice Gap

Many physicians struggle to establish personal connections with colleagues, and the COVID-19 pandemic has created new challenges to interprofessional communication that are exacerbating the difficulties of relationship building in the clinic. Also, creating sustained, effective formal medical training mentorship programs at the institutional level is difficult. These problems became evident to us after we reviewed qualitative feedback from program directors about mentorship within our institution and after having received multiple requests from faculty for creation of improved mentorship programs. Survey data from within our institution indicated that the traditional informal approach to mentoring had led to a wide disparity between faculty and trainee perceptions about mentorship. Importantly, research has shown that interns and underrepresented minorities are significantly less likely than their peers to establish mentoring relationships on their own (Ramanan, Taylor, Davis, and Phillips, 2006), and that resident satisfaction with the mentorship process is often very low (Thomason et all, 2016). In an era characterized by a focus on resiliency, mentorship programs are a proven tool for helping medical trainees build enduring relationships. A sense of connection with one's professional colleagues is integral to a successful medical career, and mentorship programs can help create a culture of connectivity. Our mentorship development program aims to provide a safe space for trainees to discuss individual aspirations, challenges, and successes within their professional community. By mandating a structured mentorship program, our institution aims to foster equity and inclusion of voice and space for trainee participation, where no one individual or group is targeted or eliminated from the process. To develop our targeted mentorship program, we conducted focus groups with faculty and with trainees to provide an opportunity for all voices and issues to be heard. Focus group findings were incorporated into the mentorship program on a specialty-specific basis. Our program includes critical topics to be addressed in a mentorship relationship and an easy-to-follow structure, allowing for an effective and meaningful mentorship experience for both mentor and trainee. A structured mentorship program designed to address the needs and goals of both faculty and trainees may lead to a stronger and more developed program culture.

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Abstract

Mentorship programs are an educational staple within healthcare organizations, but are they effective? Research indicates that productive mentoring of physician trainees can lead to many positive benefits, including higher career satisfaction, increased research productivity, and improved personal development. Specifically, a mentor is an individual with expertise who can help develop the career of a mentee. The mentor has two primary functions for the mentee.

First, the career-related function establishes the mentor as a coach who provides advice to enhance the mentee's professional performance and development. Second, the psychosocial function establishes the mentor as a role model and support system for the mentee. Both functions provide explicit and implicit lessons related to professional development as well as general work-life balance. (APA, 2017) Our highly interactive session will address how to build a robust clinical training mentorship framework to support the development of physician resiliency through meaningful relationships. Our Mentorship Toolkit was designed by first investigating faculty (mentor) and physician trainee (mentee) views and perspectives on mentorship. We discovered that the two groups had several differing views on the definition and goals of mentorship, and a strength of our approach is that it is based on reconciling these unique perspectives. We will cover the characteristics of successful mentors, outline the key features of our Mentorship Toolkit, discuss a realistic timeline for establishing a mentorship program, and work with participants in developing customized sample mentorship curricula. Participants will leave with a detailed template for implementing a mentorship program relevant to their institution's needs. Presenters will include Henry Ford Psychiatry Program Director, PGY3 Resident and GME Instructional Designers.

Agenda

This workshop is aimed at psychiatry program directors, psychiatry clerkship directors, and other medical educators interested in creating sustainable and effective mentorship programs in their professional communities.

Goals for this workshop:

By the end of the workshop, participants will be able to…

- Describe methods for uncovering the mentorship needs of individuals.
- Engage in activities that promote the facilitation of effective mentoring relationships.
- Explain the implementation of a structure to support the development of meaningful relationships between physicians.

Outline of the workshop:

1. Opening Discussion: What are the characteristics of an effective mentor?
2. Overview of Program using Mentorship Toolkit
3. Focus Group Activity
4. Curriculum Development Activity
5. Participant Review

10 minutes

Opening Discussion. Use polling feature to generate discussion around the question, "What are characteristics of an effective mentor?"

For example, participants respond via polling to the question and then discuss: "True or false, research shows that formal mentorship is more effective than informal mentorship?"

15 minutes
Overview of Program. Provide a sequential timeline for establishing a mentorship program. Use the examples from the Mentorship Toolkit to highlight key aspects of the program.

10 minutes
Focus Group Activity. Participants access a ranking activity via a SurveyMonkey QR code to prioritize mentorship topics.

25 minutes
Curriculum Development Activity. In break-out rooms, participants use survey results to create a sample curriculum for a mentorship program. Each break-out room develops discussion questions that may be used for mentorship programs at their institutions.

5 minutes
Summary and closing remarks

10 minutes
Participant Review, Questions and Answers

75 Minutes Total

Title

Strengthening Development of Residents as Psychotherapists: From Basic Competence to Tracks

Educational Objective

After attending this workshop the participant will be able to:

1. Describe common challenges in psychotherapy education and the role of pathways in supplementing these requirements
2. Use a 3-tier model to identify ways to enhance psychotherapy education in psychiatry residencies from current programming
3. Identify next steps to improve psychotherapy education at their home institution and develop a preliminary action plan

Practice Gap

Psychotherapy skills are a core component of psychiatric training, and the Accreditation Council for Graduate Medical Education (ACGME) requires instruction in three evidence-based psychotherapies (supportive, cognitive-behavioral, and psychodynamic). However, psychiatry training programs meet these requirements with varying degrees of success, with a number of programs reporting that they struggle to offer a full complement of supervision and didactics in the psychotherapies required by the ACGME. More attention is needed to developing psychotherapy training, especially since residents are generally eager for more focused psychotherapy education. Psychotherapy pathways are one way programs can enhance the breadth and depth of their psychotherapy training. A recent survey of programs found that roughly three quarters of programs did not have a psychotherapy-focused training track and identified the main barriers to developing one as time, personnel, resident interest, and funding. . Programs with tracks report satisfaction with their tracks and generally report that additional funding and personnel are not needed. There are diverse types of psychotherapy pathways with degrees of rigor, from informal interest groups to rigorous four-year programming with separate requirements. Adding a pathway that fits the level of need for an individual program provides a flexible way to buffer and supplement core psychotherapy education.

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Abstract
Despite the importance of psychotherapy education to the core identity of psychiatrists as psychotherapists, ACGME requirements are met with varying degrees of success in general psychiatry residencies. Psychotherapy interest groups, pathways, and tracks are a flexible way to enhance psychotherapy education to fit the needs of an individual training program. Programs may be able to supplement their training without additional funding or personnel.

This workshop is derived from the work of a subgroup of the AADPRT Psychotherapy Committee, which has developed a three tier model to supplement psychotherapy education based on the current needs of individual programs. The three tiers include programs needing more basic resources for didactics and supervision, programs ready to start an interest group, and programs interested in starting a formal track. This workshop will review examples of successful applications at different institutions within each of the three tiers and provide resources for programs to develop action plans at their home institution. The workshop will be active in nature, with a small group activity that will allow programs to develop an individual action plan with others in their identified tier.

Agenda
- Welcome and Introductions – 5 min
- Overview of challenges in psychotherapy training & role of tracks – 10 min
- Presentation of three tier model & current examples within each tier – 5 min
- Presentation of examples within each tier at multiple different institutions – 25 min
- Small group discussion and goal-setting, grouped by tier – 15 min
- Large Group Discussion and questions - 10 min
- Evaluations – 5 min

Title
Geriatric Psychiatry Education: Best Practices and Resources

Educational Objective
By the end of this workshop, participants will be able to:
1. Describe competency-based geriatric psychiatry learning objectives for residents in general psychiatry programs
2. Describe inequities that result from limited resources for mental health care in older adults
3. Create a map of learning resources and gaps for geriatric psychiatry education at their home institution
4. List at least 3 additional resources that are widely and freely available to enhance geriatric psychiatry education
5. Implement at least one curricular enhancement related to geriatric psychiatry at their home institution.

Practice Gap
Older adults in 2021 represent an increasingly diverse and growing segment of the national and global population, with complex healthcare needs that often go unmet due to shortages of providers. Nearly 10 years ago, The Institute of Medicine released "The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?", a report revealing a dire shortage of geriatric mental health providers (Eden et al, 2012). Other studies indicate that around 85% of adults with Alzheimer's Disease were diagnosed by a "non-specialist" (usually their primary care physician), and only 36% had seen a specialist five years later (Drabo 2019). If our present systems cannot train enough care providers for current care needs, they will certainly not prepare us for future needs. Some have suggested an "all hands on deck" approach to the geriatric mental health care shortage, whereby general psychiatrists will be increasingly called upon to provide geriatric mental health care.

However, many programs report a lack of resources to implement a high-quality geriatric psychiatry curriculum that can meet the needs of a diverse older adult population and address resulting inequities. In a recent national survey of program directors of psychiatry residency (under revision for publication), Camp et al found that only 12.5% of respondents were "very satisfied" with clinical rotations and 13.8% were "very satisfied" with didactics used to teach neurocognitive disorders. The most commonly cited needs were time, expert faculty, and clinical sites.

A growing trend in geriatric psychiatry education aims to meet unmet educational needs by developing and disseminating readily available resources. However, general psychiatry educators may not be aware of these resources, or they may benefit from additional training in how to integrate them into current curricula.

In this workshop, we aim to equip adult psychiatrists with knowledge and tools to enhance geriatric psychiatry at their institution, so that graduates may be prepared to meet the critical mental health care needs of older adults.

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Abstract

In this workshop, members of the American Association of Geriatric Psychiatry (AAGP) Teaching and Training Committee, Resident Education Subcommittee, will lead participants through exercises designed to help them identify learning gaps and expand available resources for geriatric psychiatry education. The presenters represent five different programs with different landscapes in geriatric psychiatry education. We will draw on both the published literature,

online and readily available resources, experiences of participants, and our own experiences to help learners identify needs and brainstorm solutions that they can take back to their institutions.

We will start by reviewing the literature about general needs assessments for geriatric psychiatry education in general psychiatry residency programs. We will then lead learners through a small group exercise to help them identify specific needs for their institution. They will be invited to map out currently available resources (including time, clinical sites, faculty expertise, and community collaborations). In the process, they will identify gaps and resource needs, and they will have the opportunity to brainstorm potential solutions in their small group and the large group.

To supplement this discussion, presenters will demonstrate the use of several readily available (and free) online resources that can be used to bolster geriatric psychiatry education.

To help learners apply this knowledge, we will then have another small group activity in which participants will work in small groups to respond a clinical education vignette. In this vignettes, a general psychiatrist will supervise a resident seeing an older patient and (1) consider learning objectives for the resident in that encounter and (2) consider how they can draw on resources already discussed to improve this teaching experience and address inequities encountered by the patient.

We will then finish with question and answer large group discussion.

Agenda

-Introduction and background (10 minutes) – We will have a brief presentation of (1) competencies related to geriatric psychiatry and (2) the literature demonstrating where general needs have been demonstrated on national surveys.

-Small Group Activity: Map your geri psych resources and gaps (15 minutes) – Participants will have 5 minutes to map out all of the places where geriatric psychiatry education currently happens in their programs. They will then have 10 minutes to share their maps, collectively identify gaps, and brainstorm ideas about how to potentially meet some of their unmet needs.

-Large Group Activity (5 minutes): Groups will be invited to share their findings with the larger group. In the process, we will create a list of commonly cited gaps that were identified, along with unique solutions.

-Demonstration of Resources (10 minutes): In the large group, we will demonstrate use of several online resources developed by AAGP, the Alzheimer's Association, and National Neuroscience Curriculum Institute that can be used to supplement existing curricula.

Small Group Activity (15 minutes): Participants will be given an educational case in which a general psychiatrist is supervising a resident who is seeing an older adult in the resident

outpatient clinic. The groups will identify potential learning objectives for the resident in that particular patient encounter, and they will draw on resources already discussed to consider ways that the teaching attending could provide enhanced supervision and teaching of the resident.

-Large Group Activity (5 minutes): Groups will debrief about the small group activity with the large group.

Q&A – 15 minutes

Title

Is it really time for Semi-Annual evaluations again? How to develop a robust, efficient, and meaningful process

Educational Objective

By the end of this workshop, participants will be able to:

1) Identify the steps a training program should take to ensure it is meeting ACGME requirements for semi-annual evaluations, Individualized Learning Plans (ILP), and wellness plans
2) Describe how your current process differs from those of other training programs
3) Describe how incorporating a systematic process for self-reflection can guide trainees in the development of learning and wellness goals
4) Develop a plan for how to ensure a more robust, efficient, and meaningful semi-annual review process

Practice Gap

To meet ACGME common program requirements, programs need to aid residents in the development of plans to address their individualized learning needs and personal and professional well-being. Programs can benefit from a process to ensure these requirements are being met and to assist residents in developing the necessary skill set.

Scientific Citations

Li, Su-Ting T. MD, MPH; Paterniti, Debora A. PhD; Co, John Patrick T. MD, MPH; West, Daniel C. MD Successful Self-Directed Lifelong Learning in Medicine: A Conceptual Model Derived From Qualitative Analysis of a National Survey of Pediatric Residents, Academic Medicine: July 2010 - Volume 85 - Issue 7 - p 1229-1236

Li, Su-Ting T,M.D., M.P.H., & Burke, A. E., M.D. (2010). Individualized learning plans: Basics and beyond. Academic Pediatrics, 10(5), 289-92.

Reed S, Lockspeiser TM, Burke A, et al. Practical Suggestions for the Creation and Use of Meaningful Learning Goals in Graduate Medical Education. Academic Pediatrics. 2016 Jan-Feb;16(1):20-24.

ACGME Common Program Requirements https://www.acgme.org/what-we-do/accreditation/common-program-requirements/

Abstract

In this workshop, we will assist program directors in optimizing the process by which they are meeting ACGME requirements for semi-annual evaluations, ILPs, and wellness plans. Through an interactive format, participants will learn about the ways in which the process at their institution differs from others and consider various changes they may wish to implement. OHSU faculty will share how they developed a semi-annual process involving a systematic self-

reflection exercise which facilitates the resident in drafting of an individualized learning and wellness plan. During the semi-annual meeting, faculty then guide any refinement to these plans. Best practices from other disciplines and institutions will be shared, such as I-SMART strategies for goal generation and plans to track progress on goal achievement. With the establishment of the appropriate structure and preparatory work, the semi-annual meetings can shift from that of administrative burden to a more valuable exercise for both the resident and faculty. This learner-centered approach is more collaborative and provides significant educational benefit to the resident as they develop skills in life-long learning.

Agenda

10 min Overview of ACGME requirements for semi-annual evaluations and individualized learning plans, including basic elements of an ILP.

20 min Small group facilitated discussion with other participants regarding semi-annual process at their institutions; Review the following: Structure, Data reviewed, ILP creation, Wellness elements, Involvement of CCC, Role of Mentors or Coaches

15 min Sharing of OHSU psychiatry residency training program semi-annual/ILP process as well as best practices from other institutions and specialties.

10 min Develop action plan including at least 2 changes to make to your current process and share with larger group

15 min Q&A

5 min Completion of program evaluation

Title

Efficiency or accuracy? Can we really have both? -- Evaluating trainees with competency-specific evaluations that drive meaningful CCC assessment and accurate ACGME milestone assignment.

Educational Objective

At the conclusion of this workshop, participants will be able to:

- Successfully use competency-based data for the assessment of trainee progress and the assignment of milestones at Clinical Competence Committee meetings
- Optimize trainee evaluations that promote accurate and competency-specific milestone assignment
- Discuss the pros and cons of several milestone evaluation methods
- Create an action plan for implementation at home institutions

Practice Gap

Across psychiatry training programs there is significant variation in the methodology that Clinical Competency Committees (CCCs) use to evaluate resident performance and to assign Accreditation Council for Graduate Medical Education (ACGME) Milestones for trainees in general and fellowship programs. Assessments can be vulnerable to unconscious bias, recent supervisor-learner interactions, or other factors. Further, while milestone assignments are meant to be reflective of objective measures of trainee progress, evaluation forms vary widely in their ability to contribute meaningful information to the milestone assignment process. Additionally, the administrative burden and time needed for trainee-specific and detailed assessment for each milestone sub-competency is often prohibitive enough that accuracy suffers. CCCs are left with the question: “Should we be efficient? Or should we be accurate?” When left with this dichotomous choice, milestone assignment and CCC assessment are often less meaningful than they could be, and CCC meetings can be tedious and arduous.

Scientific Citations

- Guerrero APS, Aggarwal R, Balon R, et al. The Competency Movement in Psychiatric Education: 2020 View. Acad Psychiatry. 2020;44(6):651-653. doi:10.1007/s40596-020-01358-y.
- Kinzie JM, DeJong SM, Edgar L, et al. Psychiatry Milestones 2.0: Using the Supplemental Guide to Create a Shared Model of the Development of Professional Identity and Expertise. Acad Psychiatry. 2021;45(4):500-505. doi:10.1007/s40596-021-01455-6.
- Lloyd RB, Park YS, Tekian A, Marvin R. Understanding Assessment Systems for Clinical Competency Committee Decisions: Evidence from a Multisite Study of Psychiatry Residency Training Programs. Acad Psychiatry. 2020;44(6):734-740. doi:10.1007/s40596-019-01168-x.
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- Swing SR, Cowley DS, Bentman A. Assessing resident performance on the psychiatry milestones. Acad Psychiatry. 2014;38(3):294-302. doi:10.1007/s40596-014-0114-y.

- Thomas CR. Introduction and commentary on the psychiatry milestones. Acad Psychiatry. 2014;38(3):253-254. doi:10.1007/s40596-014-0096-9.

Abstract
What if there were evaluation tools that accurately and efficiently assess psychiatry trainee performance on the ACGME milestone sub-competencies? What if these evaluations also provide direct information that can be used for ACGME milestone assignment? What if these assignments could be made in minutes, allowing additional time for the CCC to provide additional formative and trainee-specific feedback? Too good to be true? We don't think so!

Accreditation Council for Graduate Medical Education (ACGME) Milestone assignment and Clinical Competency Committee (CCC) evaluation is required bi-yearly by all psychiatry training programs. This can be a daunting and cumbersome task, as trainee evaluations from clinical rotations do not always provide the information needed to make such assignments in an individualized way, nor do they account for discrepant progress across varying core competencies. Further, evaluations using milestones in their entirety are subject to user error, as faculty are not always familiar with the assessment scale and are prone to inadvertent assessment inflation. Additionally, the CCC is often faced with substituting accuracy for efficiency or vice versa. This workshop will introduce tools that have been useful in both residency and fellowship programs to obtain accurate information to guide efficient and individualized milestone assignment and trainee assessment.

This workshop will demonstrate a unique methodology for the creation of evaluation templates and assessment forms that directly inform the CCC regarding trainee competency on each milestone sub-competency. Participants will review different evaluation tools that can allow CCCs and training programs to be more granular with semi-annual milestone assignment. In particular, the use of "yes/no" type questions for individual sub-competencies that are rotation- and year of training-specific will be reviewed, and participants will be able to identify how this information is used by a CCC to assess residents' program towards milestone targets. Participants will be able to work in groups during the workshops to identify ways to improve assessment and CCC practices at their home institutions using these techniques and to create an action plan and next steps.

Agenda
0-5 minutes – Introduction and Learning Objectives
5-15 minutes – Presentation of data about CCC models, process for milestone assignments and trainee performance evaluation in Psychiatry and Child Psychiatry
15 -25 – Breakout groups related to CCC at home institutions: ask participants to reflect on how they conduct and incorporate evaluation tools into their CCC meetings and to discuss relative pros, cons, and pitfalls of these methods.
25-30 – Breakout group reporting about above discussion.
30-45 – Presentation and discussion of a milestone-specific, individualized assessment plan for trainees and how this allows for more accurate milestone reporting.

45-60 – Think-pair-share, worksheet completion and Action plan
60-75 – Question, answer and wrap-up session

Title

The Impact of Patient Suicide on Trainees and Early Career Psychiatrists: Responding to suicides after inpatient hospitalizations

Educational Objective

- Participants will understand the impact of patient suicide on trainees in psychiatry, with a focus on appreciating the expected emotional and psychological responses.
- Participants will explore how medical settings respond to patient suicide after/during inpatient psychiatric hospitalization.
- Participants will be better prepared to respond to the needs of trainees as supervisors, in the event the trainee's patient dies by suicide.
- Participants will appreciate the challenges of transition into independent practice in the context of completed suicides during the early years out of training.

Practice Gap

Suicide is now the second leading cause of death in adolescents and young adults. Center for Disease control and National Institute for Mental Health have reported continued rise of 24 % in the suicide rates over the last fifteen years. Many of our trainees will experience this during their General Psychiatry residency years or during their Child and Adolescent Fellowship training. However, the supervision and guidance around managing the emotional burden is highly variable. The impact of patient loss is often unrecognized and many training institutions do not have formal programmatic supports in place for such an occurrence. Timely oversight and support from supervisors can provide a safe place to explore and process the difficult experience of patient loss due to suicide. The improved comfort and knowledge of supervisors around providing this type of supervision in particular can have a positive impact on trainee experience and learning.

Scientific Citations

1-Qayyum Z, Luff D, Van Schalkwyk GI, AhnAllen CG. Recommendations for effectively supporting psychiatry trainees following a patient suicide. Academic psychiatry. 2021 Jun;45(3):301-5.

2-Qayyum Z, AhnAllen CG, Van Schalkwyk GI, Luff D. “You Really Never Forget It!” Psychiatry Trainee Supervision Needs and Supervisor Experiences Following the Suicide of a Patient. Academic psychiatry. 2021 Jun;45(3):279-87.

3-Balon, R. (2007). Encountering patient suicide: The need for guidelines. Academic Psychiatry. https://doi.org/10.1176/appi.ap.31.5.336

Abstract

Suicide is the second leading cause of death in children, adolescents, and young adults ages 10–34 and the rates continue to rise in the USA. An estimated 30–60% of Psychiatry Residents experience patient suicide during their training. This workshop is aimed to facilitate understanding the trainee and supervisor experiences after the suicide of a patient in order to better inform the supervision and response to such an event.

Method
Twenty-seven participants were identified by criterion sampling and recruited from General Psychiatry residency, Consultation Liaison fellowship, and Child and Adolescent Psychiatry fellowship training programs in the New England region of the USA. Semi-structured interviews of trainees and supervisors were conducted and analyzed using inductive thematic analysis.

Results
The death of a patient by suicide was described as a notable event with a significant impact on the professional lives of the participants. The event was typically characterized as having an immediate emotional impact, led to changes in self-efficacy, and a sense of responsibility for the patient's death. Responses to suicide were influenced by modifiable factors such as (1) unpreparedness of individuals, program, and institution and (2) mediating/complicating factors, including the credibility of the supervisor, societal expectations, and specific patient characteristics.

Conclusions
The death of a patient is a personal and emotional experience for the psychiatrist, for which they do not consistently feel well prepared. The institutional response may be misaligned, more analytical in character and prioritize assessment of risk. There is significant room to improve supervision and preparedness for the death of a patient by suicide.

Agenda
Workshop proposal:
1. Introduction
2. Trainee experiences of patient suicide
3. Supervisor experience of patient suicide
4. Presentation of pertinent research and available data
5. Discussion regarding the impact of patient suicide on trainees and early career psychiatrists, especially as it relates to inpatient hospitalizations.
6. Small group discussions of strategies for improving supports for trainees (20-25 min discussion + 3 min for set up). Depending on the number of attendees, we will divide the audience into small groups or do a large-group discussion if needed.
   - 3-5 small groups (or a large group) facilitated by faculty + trainee presenters
   - ask the groups to discuss the following question: What would be helpful to you when dealing with patient suicide?
   - in the last 5 min, ask each group to share their answer with the large audience
7. Proposed recommendations & Concluding remarks

Title
Brain-ival! Using Interactive Games to Teach Neuroscience

Educational Objective
As a direct result of this educational intervention, participants will be able to:
1. Describe the principles of adult learning that can be implemented using a game-based approach to teaching (neuroscience)
2. Describe benefits of a game-based approach to learning based on their own participation in representative activities
3. Brainstorm specific ways in which game-based models could be used for teaching (neuroscience) at their home program

Practice Gap
The modern neuroscience revolution is redefining the essence of how we conceptualize psychiatric illness. Despite its expanding role and importance, neuroscience education continues to lag. In many settings, psychiatric neuroscience is not taught at all. When it is taught, instruction is often lecture-based, despite an extensive literature suggesting that such approaches may not be the most effective. For our field to advance, it is critical that we find ways to present core material in a way that is engaging, accessible, and relevant to patient care. To address this gap, we have developed and implemented a game-based neuroscience active learning session that can be used with trainees and faculty at multiple learner levels.

Scientific Citations
LK Fung, M Akil, A Widge, LW Roberts, A Etkin. Attitudes Towards Neuroscience Education in Psychiatry: A National Multi-Stakeholder Survey. Academic Psychiatry 2015; 39: 139-146.

DA Ross, MJ Travis, MR Arbuckle. The Future of Psychiatry as Clinical Neuroscience: Why Not Now? JAMA Psychiatry 2015; 72(5):4130414.

MR Arbuckle, MJ Travis, J Eisen, A Wang, AE Walker, JJ Cooper, L Neeley, S Zisook, DS Cowley, and DA Ross. Transforming Psychiatry from the Classroom to the Clinic: Lessons from the National Neuroscience Curriculum Initiative. Academic Psychiatry 2020; 44: 29-36.

Cooper JJ, Walker AE. Neuroscience Education: Making It Relevant to Psychiatric Training. Psychiatr Clin North Am. 2021 Jun;44(2):295-307.

Cooper JJ, Korb AS, Akil M. Bringing neuroscience to the bedside. FOCUS, A Journal of the American Psychiatric Association. 2019 Jan 7;17(1):2-7.

https://www.nncionline.org/course/brain-ival-toxidrome-apalooza/

Abstract
In this session, we will introduce participants to an educational format we call “Brain-ival.” In a “Brain-ival,” learners work in teams to complete educational games in a friendly, competitive environment and earn points through demonstration of knowledge, team work, and peer teaching. Each task is designed to engage learners using principles of adult learning, including retrieval-based practice and the application of knowledge to novel situations.. The overall experience creates a joyful synergy between learning important content and having fun. This workshop will provide participants the opportunity to experience the Brain-ival format as a learner, using materials relating to drug intoxication and withdrawal as the example. Participants will then have the chance to reflect on how they might apply these learning principles and create similar activities in their home program.

Agenda
0-15: Overview of Brain-ival games
15-55: Play Brain-ival games in small groups
55-70: Small group reflections on activities and discussion of strategies for implementations at home institution
70-75: Large group reporting from small groups, discussions, and questions

Title
Putting Feelings into Facts: A Mission Driven Approach for Quantifying Holistic Review

Educational Objective
Through participating in this workshop, attendees will be able to:
1. Describe principles and benefits of holistic review
2. Identify ways to incorporate holistic into recruitment/selection processes
3. Develop a rubric for holistic review that assesses applicants based on your program's identified values and goals for training

Practice Gap
The term "holistic review" describes the gold-standard approach to resident application screening and ranking in which each applicant is assessed as a "whole" applicant. Core principles of holistic review identified by the Association of American Medical Colleges (AAMC) include linking applicant selection criteria to program mission and consideration of experiences and attributes in addition to academic performance. Holistic review has also been identified as a successful strategy for increasing recruitment of applicants from groups that are underrepresented in medicine (URiM). The goal of holistic review can feel at odds with the hard numbers of the resident application process, particularly the large number of applications to be reviewed and the requirement for program directors to submit a rank order list to the National Resident Matching Program (NRMP). This workshop will address this gap between the principle of holistic review and the numerical demands of the Match by presenting a framework for quantifying holistic review.

Scientific Citations
https://www.aamc.org/services/member-capacity-building/holistic-review

Barceló NE, Shadravan S, Wells CR, Goodsmith N, Tarrant B, Shaddox T, Yang Y, Bath E, DeBonis K. Reimagining Merit and Representation: Promoting Equity and Reducing Bias in GME Through Holistic Review. Acad Psychiatry. 2021 Feb;45(1):34-42.

JR Agapoff IV, C Tonai, DM Eckert, G Gavero, and DA Goebert. Challenges and Perspectives to the Rise in General Psychiatry Residency Applications. Acad Psychiatry 2018; 42:674-676.

J Marbin, G Rosenbluth, R Brim, E Cruz, A Martinez, M McNamara. Improving Diversity in Pediatric Residency Selection: Using an Equity Framework to Implement Holistic Review. Journal of Graduate Medical Education. 2021; 13(2):195-200.

Abstract
This workshop will describe the steps our programs have taken to quantify the process of holistic review. The authors will present key processes for establishing an effective framework for holistic review, including redefining the mission statement, creating recruitment goals, and mapping mission-driven recruitment goals onto the applicant evaluation rubric. As holistic review is mission driven, the detailed implementation of holistic review will vary by program.

This workshop will provide participants the opportunity to consider their program mission and identify methods for evaluating residency applicants to meet institutional goals and needs. We will utilize materials for holistic review created by the AAMC to work from information presented in the Electronic Residency Application Service (ERAS) to a holistic evaluation rubric. Participants will be challenged to identify attributes of successful residents and identify metrics for evaluating these characteristics in applicants. Participants will be encouraged to consider which metrics can be emphasized to promote recruitment of URiM applicants while de-emphasizing attributes that are correlated with race and socioeconomic background (AOA, USMLE scores).

Agenda

0-15: Overview of holistic review and demonstration of our program's implementation of holistic review

15-20: Overview of AAMC materials for implementing holistic review

20-30: Facilitators will introduce program mission statements and describe how mission statement serves as guide for recruitment. Working in small groups, participants will identify key program values, seeking to answer the following questions: how does our program define a successful resident? Who are the residents who have best served our patients?

30-40: Facilitators will provide examples of ERAS elements that indicate applicant alignment with program goals. Working in small groups, participants will work with the AAMC holistic review materials to identify elements captured ERAS that serve as indicators for resident alignment with program values and mission

40-60: Working in small groups, participants will develop a rubric for holistic review aligned with the identified program values that utilizes information contained in the ERAS application

60-75: Conclusions, Questions, Feedback

Title
Equitable, Valuable, & Readable – How to Write An 'Outstanding' Letter of Recommendation

Educational Objective
1) Examine the data demonstrating the weight given to letters of recommendation
2) Generate approaches in writing letters with appropriate content and minimizing of inequity
3) Assess elements of an effective letter of recommendation

Practice Gap
The ACGME requires program directors to recruit and select appropriate applicants for general psychiatry residency and subspecialty fellowships. A typical program may receive hundreds of applications for each available residency position, and program directors are often tasked with reviewing hundreds of applications during each recruitment cycle. With multiple ACGME-accredited and non-accredited fellowships available to trainees, fellowship directors must also review substantial numbers of fellowship applications. The ability to accurately and efficiently decipher an applicant's letters of recommendation (LOR) becomes critical. Of equal importance, program directors and faculty in general are often asked to write LORs for prospective applicants. Given that LORs can serve as such important sources of information to round out an individual's application portfolio, writing LORs that are meaningful, accurate, and free from bias is imperative. Careful and deliberate reading and writing of LORs is not typically a skill taught to new (and sometimes more seasoned) faculty including program directors. This workshop is a first step in closing the gap in this necessary skill.

Scientific Citations
American Psychiatric Association. A Roadmap to Psychiatric Residency; 2019. https://www.psychiatry.org/File%20Library/Residents-MedicalStudents/MedicalStudents/Roadmap-to-Psychiatric-Residency.pdf. Accessed 12 Nov 2019.

Chang, A. K., Morreale, M., & Balon, R. (2017). Factors Influencing Psychiatry Residency Applicant Selection for Interview. Academic Psychiatry, 41(3), 438–439.

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MacLean, L. M., Alexander, G., & Oja-Tebbe, N. (2011). Letters of Recommendation in Residency Training: What Do They Really Mean? Academic Psychiatry, 35(5), 342–343.

Maruca-Sullivan, P. E., Lane, C. E., Moore, E. Z., & Ross, D. A. (2018). Plagiarised letters of recommendation submitted for the National Resident Matching Program. Medical Education, 52(6), 632–640.

Saudek, K., Treat, R., Goldblatt, M., Saudek, D., Toth, H., & Weisgerber, M. (2019). Pediatric, Surgery, and Internal Medicine Program Director Interpretations of Letters of Recommendation. Academic Medicine, 94, S64–S68.

Shapiro, S. B., Kallies, K. J., Borgert, A. J., O'Heron, C. T., & Jarman, B. T. (2018). Evolution of Characteristics From Letters of Recommendation in General Surgery Residency Applications. Journal of Surgical Education, 75(6), e23–e30.

Abstract

Letters of recommendation (LOR) serve an essential role throughout the academic physician's career, from residency applications to faculty promotion. Many faculty writing these letters, particularly junior-level academicians, may have little information on what a letter should include or how they can best portray the individual's performance. Biased phrases may generate inequities in a high-stakes career moment. Letter writer generational and gender status may influence the narrative used to describe the individual's characteristics. Similarly, the gender status of the individual may similarly trigger gender bias in reference writing. Thus, it becomes critical that letter writers acquire skills to communicate qualities of an individual accurately and without unintentionally undervaluing the individual. This 75-minute workshop utilizes hands-on learning with active learning techniques (Think-Pair-Share, Small group), and time to work on letters in a highly interactive session. Participants will be asked to bring in two de-identified LORs they have previously written. Participants will rate their own LORs. Then LORs will be evaluated within small groups to generate immediate feedback on the quality and perceptions by the reader for each LOR. Feedback will be focused on identifying possible gender bias in the participants' letters. Ultimately, the large group will come back together to compare and consolidate findings in order to identify overall significant letter features, applicant abilities, commonly used phrases, and potential biases.

Agenda

Introduction to presenters and workshop format, audience polling for background and experience, rating own LORs (10 minutes).

Brief didactic portion reviewing LOR data, literature and social media sources (10 minutes).

Small group work reviewing LORs provided by participants (40 minutes).

Large group discussion (15 minutes)

Title

Results of the 2020 APA Resident/Fellow Census: What is the future of the psychiatric workforce and how might it impact our patients?

Educational Objective

At the end of this session participants should be able to:

1. Summarize findings from the 2020 APA Census, including 5-year trends pertaining to the Match, demographic characteristics and geographic distribution of residents and fellows.
2. Discuss the implications of the Census on recruitment and retention of psychiatry residents in the US, including a need to diversify the workforce.
3. Describe how COVID-related changes to resident recruitment in 2020 may have impacted Match results.

Practice Gap

Recruitment trends in psychiatric training programs have changed in important ways over the last several decades. An increasing percentage of psychiatry residency positions are being filled as more medical students are choosing to pursue careers in psychiatry and a higher percentage of these positions are being filled by US medical graduates as opposed to International Medical Graduates. At the same time, a smaller percentage of fellowship positions are being filled, especially in certain subspecialties. Despite significant changes in these recruitment trends, the racial/ethnic diversity of psychiatry residents continues to remain nearly unchanged over the last decade. It is important to understand the potential implications of these workforce trends on key metrics relevant to the practice of psychiatry, including access to care and treatment of minority communities. This workshop will use recent results from the 2020 APA Resident/Fellow Census to foster discussion of these important considerations.

Scientific Citations

1. Pierre JM, Mahr F, Carter A, Madaan V. Underrepresented in medicine recruitment: rationale, challenges, and strategies for increasing diversity in psychiatry residency programs. Academic Psychiatry. 2017 Apr; 41(2): 226-232.
2. Hammoud M, Standiford T, Carmody B. Potential Implications of COVID-19 for the 2020-2021 Residency Application Cycle. JAMA. 2020; 324 (1): 29-30.
3. Virani S, Mitra S, Grullón AG, Khan A, Kovach J, Cotes R. International Medical Graduate Resident Physicians in Psychiatry: Decreasing Numbers, Geographic Variation, Community Correlations, and Implications. Academic Psychiatry. 2021 Feb; 45 (1): 7-12.
4. Thomas KC, Ellis AR, Konrad TR, Holzer CE, Morrissey JP. County-level estimates of mental health professional shortage in the United States. Psychiatric Services. 2009; 60:1323–8.
5. Brenner AM, Balon R, Coverdale JH, Beresin EV, Guerrero A, Louie AK, Roberts LW. Psychiatry Workforce and Psychiatry Recruitment: Two Intertwined Challenges. Academic Psychiatry. 2017; 41:202–206.

Abstract
Since 1999, the APA Resident/Fellow Census has provided a yearly demographic picture of psychiatry residents and fellows in the United States. The census summarizes selected data from publicly available resources produced by AAMC, ACGME, and NRMP and can be used to assess the psychiatric workforce and track its progress on important metrics relevant to the practice of psychiatry.

This session will provide a brief history of the Resident/Fellow Census and present results from the recently released 2020 Census, which tracks demographic changes in residents and fellows from 2015 to 2020. Key findings that will be highlighted include changes in the number of available and filled psychiatry residency and fellowship positions, demographic factors including the racial and ethnic diversity of residents and fellows, educational debt of residents, and geographic differences across states in the ratio of trainees per capita. Notably, this year's census will also include findings from the 2020-2021 Match, which will be used to highlight the potential impact of COVID-19 on the resident recruitment process.

The session will close with a discussion of the implications of these findings on recruitment and retention efforts of training programs, workforce planning, and access to care. Input from the audience will be solicited through small group exercises to brainstorm potential solutions to some of the key challenges presented, including keeping the principles of diversity, equity, and inclusion at the forefront.

Agenda
0:00-0:05 Topic and panel introduction (Dr. Virani)
0:05-0:10 Brief history of the APA Resident-Fellow Census (Dr. Bommersbach)
0:10-0:30 Presentation of the results of the 2020 APA Resident Census (Dr. Bommersbach and Dr. Virani)
0:30-0:40 Small group activity: Brainstorm potential implications of the results on resident recruitment, efforts to increase racial and ethnic diversity, and access to care (Dr. Cotes)
0:40-0:45 Read out of group ideas (Dr. Madaan)
0:45-0:55: Future directions to advance diversity, equity, and inclusivity in the psychiatric trainee workforce (Dr. Sudak)
0:55-1:00: Trends of IMGs trainees' inclusion in the workforce (Dr. Madaan)
1:00- 1:15 Q&A (all)

Title
Traversing Time and Space: Using Asynchronous Online Dialogue to Engage and Inspire Trainees in Neuroscience

Educational Objective
As a direct result of this educational intervention, participants will be able to:

1. Engage in a novel asynchronous platform for learning psychiatric neuroscience
2. Empower faculty with or without a neuroscience background to feel confident that they can teach neuroscience effectively
3. Brainstorm specific ways to integrate asynchronous learning to engage and inspire trainees

Practice Gap
The modern neuroscience revolution is redefining the essence of how we conceptualize psychiatric illness. Yet despite its expanding role and importance, neuroscience education continues to lag. In many settings, psychiatric neuroscience is not taught at all. When it is taught, instruction is often lecture-based, despite an extensive literature suggesting that such approaches may not be the most effective. For our field to advance, it is critical that we find ways to present core material in a way that is engaging, accessible, and relevant to patient care. To address this gap, we have developed and implemented an interactive, asynchronous learning platform which has been piloted as a 2 week, full time elective for senior medical students. The methods of engagement are applicable across the UME/GME/CME continuum.

Scientific Citations
DA Ross, MJ Travis, MR Arbuckle. The Future of Psychiatry as Clinical Neuroscience: Why Not Now? JAMA Psychiatry 2015; 72(5):4130414.

MR Arbuckle, MJ Travis, J Eisen, A Wang, AE Walker, JJ Cooper, L Neeley, S Zisook, DS Cowley, and DA Ross. Transforming Psychiatry from the Classroom to the Clinic: Lessons from the National Neuroscience Curriculum Initiative. Academic Psychiatry 2020; 44: 29-36.

Cooper JJ, Walker AE. Neuroscience Education: Making It Relevant to Psychiatric Training. Psychiatr Clin North Am. 2021 Jun;44(2):295-307.

Cooper JJ, Korb AS, Akil M. Bringing neuroscience to the bedside. FOCUS, A Journal of the American Psychiatric Association. 2019 Jan 7;17(1):2-7.

Abstract
In this session, we will introduce participants to an interactive educational format which mixes asynchronous engagement in an online forum with synchronous “learning pod” small group activities to create a rich and vibrant discussion around cutting edge psychiatric neuroscience. The course is based on materials from the National Neuroscience Curriculum Initiative and has been approved for credit at the University of Illinois College of Medicine. Pilot versions of the

course have engaged local and visiting medical students as well as non-credit seeking learners from around the world, including international medical students and practicing mental health professionals. In this workshop, participants will first engage in a synchronous small group "learning pod" activity and then in an online Slack workspace to simulate the asynchronous online learning platform. Slack workspace to discuss with other pods. Participants will then have the chance to reflect on how they might create and apply similar activities in their home program, either for neuroscience or more broadly.

Agenda

0-15: Overview of Neuroscience Perspectives in Psychiatry Course and Structure
15-45: Small Group "Learning Pod" activity
45-60: Engage in the Slack workspace with other learning pods
60-65: Reflect within your learning pod on the activities and discuss strategies for implementations at home institution
65-75: Large group reporting from small groups, discussions, and questions

Title
Back to the Basics: A Primer on Competency-Based Assessment

Educational Objective
1. Participants will define competency-based assessment, why it is important, and how to implement it.

2. Participants will evaluate their own programs, identify one area for improvement in their own program and will plan next steps for improvement and implementation.

3. Participants will describe how to minimize bias in assessment and begin to evaluate their own program of assessment with an equity-based lens

Practice Gap
In the past two decades, numerous reports from foundations, professional associations, and government agencies have raised the alarm that medical education is failing to meet the needs of the public. Graduates of our medical education system do not possess the competencies necessary to deliver value in contemporary care delivery models. In addition, there are considerable lags in the adoption of new evidence or de-adoption of practices no longer supported by evidence; in other words, our graduates are not self-regulated learners. Competency-based medical education (CBME) has been adopted to address these and other concerns. CBME requires a programmatic approach to assessment that simultaneously promotes self-regulated learners and competency as judged by a trustworthy process. Yet, variability persists in the widespread adoption of competency-based assessment in residency and fellowship programs and various barriers to effective implementation have been cited. Challenges include inconsistencies in how competencies are defined, developed, implemented, and assessed as well as logistical challenges of time, faculty development, faculty buy-in, valid and reliable assessment tools, and integration of competency-based assessment activities into an overall program of assessment. In addition, when assessment occurs within medical education, the potential for bias, both implicit and explicit, exists and can skew assessment decisions.

Scientific Citations
Young JQ, Holmboe ES, Frank JR. Competency-Based Assessment in Psychiatric Education: A Systems Approach. Psychiatr Clin North Am. 2021 Jun;44(2):217-235. doi: 10.1016/j.psc.2020.12.005. Epub 2021 Apr 29. PMID: 34049645.

Hawkins RE, Welcher CM, Holmboe ES, Kirk LM, Norcini JJ, Simons KB, Skochelak SE. Implementation of competency-based medical education: are we addressing the concerns and challenges? Med Educ. 2015 Nov;49(11):1086-102. doi: 10.1111/medu.12831. PMID: 26494062.

Abstract
In this workshop, participants will learn what constitutes competency-based assessment, why it is important both for medical education and for patient care, how to optimize competency-

based assessment within their own programs and ways in which they can minimize bias when employing competency-based assessment. Presenters will provide vignettes and practical tips to illustrate essential CBME concepts, including workplace-based assessment, CCCs and trustworthy promotion and remediation, learning analytics and dashboards, longitudinal coaching, and continuous faculty development. Using vignettes in these CBME topic areas, we will demonstrate how participants can apply best practices to their own programs. Lastly, participants will be able to evaluate their own programs using a worksheet with prompts. Participants will identify areas of improvement and create a plan for optimizing competency-based assessment within their own programs and will learn from other participants how they have approached competency-based assessment within their own programs.

Agenda

Intended audience:

Anyone involved in medical education and in the assessment of learners will benefit from this workshop, at any level of previous experience with the topic.

Agenda:

20 Minutes: Overview of competency-based assessment, presentation of framework of program of assessment and of ways to minimize bias and promote equity in assessment

30 Minutes: Break up into small groups- Participants evaluate their own programs using the framework of assessment worksheet and provided prompts, identify areas of strength and areas of weakness, dilemmas, pitfalls and create a plan for improvement in their own programs

15 minutes: Return to large group; debrief, answer questions

10 minutes: Q & A

Title

DEI Curriculum Development: The AADPRT Curriculum and Diversity & Inclusion Committees Have Got You Covered!

Educational Objective

By the end of the workshop, the participant will be able to:

1. Describe the six steps in the Kern model for curriculum development.
2. Demonstrate the ability to apply the Kern model in either developing a sample curriculum focused on diversity, equity, and inclusion (DEI) or assessing/revising an existing DEI curriculum.
3. Describe ways to incorporate DEI resources into a comprehensive curriculum.
4. Demonstrate the ability to reflect on potential enablers and barriers in the implementation of a DEI curriculum at their home institution.

Practice Gap

The field of Psychiatry's realization of the importance of diversity and the need for further work in addressing disparities is not new [1-2]. However, there has been a relatively recent and dramatic shift from focusing predominantly on the racial/ethnic characteristics of patients to a broader perspective, which also considers the influence of social forces that perpetuate disparities, not only in healthcare but also in academic medicine [3-7].

In July 2019, the concepts of diversity, equity, and inclusion (DEI) transitioned from lofty ideals to become requirements within academia with the introduction of the Accreditation Council for Graduate Medical Education's (ACGME) DEI-specific common program requirements [8]. The ACGME common program requirements include both recommendations and strict requirements for accreditation. Although some psychiatry residencies and fellowships lead the charge in creating robust DEI-specific learning and recruitment programs, many others continue to struggle with the development, adoption, implementation, and/or maintenance of consistent DEI curricula which has resulted in continued interest in DEI focused workshops.

Anecdotally, while program accreditation is widely valued by departments of psychiatry, some program directors have reported feeling unsupported or under-resourced to be able to adequately address these new DEI-specific requirements. Some challenges are specific to individual institutions, while others are common to many programs. Collaboration among programs can serve to address common barriers facing many programs. Faculty development in DEI-focused education and creating and sharing curricula, are primary missions of the AADPRT Diversity & Inclusion and Curriculum Committees, seeking to empower psychiatry program directors.

Unfortunately, there are currently only two model curricula focused on DEI topics contained within the AADPRT virtual training office [10-11], both of which are 11 years old. While MedEdPortal (https://www.mededportal.org) does contain additional DEI-focused curricula, no repository will ever sufficiently meet the myriad needs of the diverse individual training

programs due to the broad scope of DEI-specific and related topics, and the different contextual factors within which each program exists.

This workshop seeks to address this current need, by engaging participants in collaborative efforts to co-design DEI-specific curricula, while considering common, as well as their own institution's, implementation enablers and barriers. The broader goal of this workshop is to instill in participants a sense that they, and their teams, are capable of overcoming current barriers to the development and maintenance of DEI-specific curricula.

Scientific Citations

Numerous published journal articles have called for action to increase DEI in the clinical learning environment, academic psychiatric departments, and psychiatric workforce:

1. Yager J, Chang C, Karno M. Teaching transcultural psychiatry. Academic Psychiatry. 1989 Sep;13(3):164-71. https://pubmed-ncbi-nlm-nih-gov.treadwell.idm.oclc.org/24431092/
2. Lu FG, Primm A. Mental health disparities, diversity, and cultural competence in medical student education: how psychiatry can play a role. Academic Psychiatry. 2006 Jan;30(1):9-15. https://pubmed-ncbi-nlm-nih-gov.treadwell.idm.oclc.org/16473988/
3. Sudak DM, Stewart AJ. Can We Talk? The Role of Organized Psychiatry in Addressing Structural Racism to Achieve Diversity and Inclusion in Psychiatric Workforce Development. Academic Psychiatry. 2021 Feb;45(1):89-92. https://pubmed-ncbi-nlm-nih-gov.treadwell.idm.oclc.org/33438157/
4. Jordan A, Shim RS, Rodriguez CI, Bath E, Alves-Bradford JM, Eyler L, Trinh NH, Hansen H, Mangurian C. Psychiatry diversity leadership in academic medicine: guidelines for success. American Journal of Psychiatry. 2021 Mar 1;178(3):224-8. https://pubmed-ncbi-nlm-nih-gov.treadwell.idm.oclc.org/33641375/
5. Williams JC, Anderson N, Boatright D. Beyond Diversity and Inclusion: Reparative Justice in Medical Education. Academic Psychiatry. 2021 Feb;45(1):84-8. https://pubmed-ncbi-nlm-nih-gov.treadwell.idm.oclc.org/33409943/
6. Stewart AJ. Dismantling Structural Racism in Academic Psychiatry to Achieve Workforce Diversity. Am J Psychiatry. 2021 Mar 1;178(3):210-212. https://pubmed-ncbi-nlm-nih-gov.treadwell.idm.oclc.org/33641376/
7. Simonsen KA, Shim RS. Embracing Diversity and Inclusion in Psychiatry Leadership. Psychiatr Clin North Am. 2019 Sep;42(3):463-471. https://pubmed-ncbi-nlm-nih-gov.treadwell.idm.oclc.org/31358125/
8. Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements (Residency). 2019 Jul. https://www.acgme.org/globalassets/PFAssets/ProgramRequirements/CPRResidency2019.pdf
9. Accreditation Council for Graduate Medical Education. CLER National Report of Findings 2021. 2021. https://www.acgme.org/globalassets/pdfs/cler/2021clernationalreportoffindings.pdf

Relatively few DEI curricula are available for psychiatry training programs to implement. The AADPRT Virtual Training Office only contains two DEI-focused model curricula, both of which are 11 years old:

10. Lim RF, Koike AK, Gellerman DM, Seritan AL, Servis ME, Lu FG. A Four-Year Model Curriculum on Culture, Gender, LGBT, Religion, and Spirituality for General Psychiatry Residency Training Programs in the United States. https://portal.aadprt.org/public/vto/categories/Virtual%20Classroom/Model%20Curricula%20--%20AADPRT%20Peer-Reviewed/Cultural%20Psychiatry/57fd99b404593_Cultural_Competence_Curriculum.pdf
11. Hansen H, Trujillo M, Hopper K. NYU Medical Center Psychiatry Residency Training Program Cultural Psychiatry Model Curriculum Nomination. https://portal.aadprt.org/public/vto/categories/Virtual%20Classroom/Model%20Curricula%20--%20AADPRT%20Peer-Reviewed/Cultural%20Psychiatry/57fd996816bcf_cultural_psych_nyu_10.pdf

While MedEdPortal [12] does contain additional DEI-focused curricula, no repository will ever sufficiently meet the myriad needs of individual training programs due to the broad scope of DEI-specific and related topics, and the different contextual factors within which each program exists.

12. Association of American Medical Colleges. MedEdPORTAL. 2021. https://www.mededportal.org

Other References:

13. Thomas PA, Kern DE, Hughes MT, Chen BY, editors. Curriculum development for medical education: a six-step approach. JHU Press; 2016 Jan 29.
14. Acosta D, Ackerman-Barger K. Breaking the Silence: Time to Talk About Race and Racism. Acad Med. 2017 Mar;92(3):285-288. https://pubmed.ncbi.nlm.nih.gov/27655050/
15. Sue DW. Race talk: the psychology of racial dialogues. Am Psychol. 2013 Nov;68(8):663-72. https://pubmed.ncbi.nlm.nih.gov/24320648/

Abstract

The last several years have shined a spotlight on structural racism and discriminatory practices which has prompted introspection within professional organizations, institutions, and academia. This process has sparked a realization in many that “business as usual” is no longer acceptable and that in order to progress we must embrace the values of diversity, equity, and inclusion (DEI) in all aspects of our work and lives. The Accreditation Council for Graduate Medical Education has also recognized the importance of addressing health disparities, in particular with the introduction of the 2019 DEI-specific common program requirements and as part of the Clinical Learning Environment Review Program [8-9]. In keeping with this, residency

and fellowship programs have had to develop new, or significantly redesign existing, DEI curricula.

Curriculum development is challenging no matter what the topic, but DEI can be particularly difficult given its broad scope and complexities. These include issues of structural racism, health disparities, and implicit bias, just to name a few. Many different groups are affected encompassing race, ethnicity, gender, sexual orientation, age, body weight, ability, religion, and so many more. How does a program director or faculty member, whether new or seasoned, even know where to start?

Whenever such dilemmas arise in training, advice from, and collaboration with, colleagues can have powerful benefits. The purpose of this workshop is to bring together like-minded individuals who wish to systematically consider (or re-consider) their DEI curricular efforts using Kern's six-step approach to curriculum development [13] as a framework. Representatives from the AADPRT Curriculum Committee will provide a review of this widely-used model for curriculum development, which will aid in structuring programs' thinking and efforts as they are applied to DEI curricula. AADPRT Diversity & Inclusion (DI) Committee representatives will provide content expertise on issues to consider throughout the curriculum development process, from problem identification to assessment. Participants are encouraged to bring ideas on DEI curricular efforts from their own institutions to share at this workshop. Participants will also be collaborating with others in designing (or redesigning) DEI-focused curricula during small group breakout sessions. Additionally, participants will be able to seek real-time consultations from representatives of the AADPRT DI and Curriculum Committees during the small group breakout sessions and during the final large group discussion portion of the workshop.

Agenda

- 5 min: Welcome and introductions
- 10 min: 1st Large group presentation - DEI problem identification, needs assessment, goal setting
- 10 min: 1st Breakout group - Review current DEI curricula brought in by members and discuss current problems/needs/future goals, or discuss problems/needs common to all members and propose goals/objectives to be addressed by a shared curriculum
- 5 min: 2nd Large group presentation - Educational strategies, assessment methods
- 10 min: 2nd Breakout group - Propose revisions to current DEI educational strategies/assessment methods, or propose new DEI educational strategies/assessment methods for shared curriculum
- 10 min: 3rd Large group presentation - Implementation issues, experiential and immersive experiences (dialogue based, implicit bias assessment) – benefits and challenges.
- 5 min: 3rd Breakout group - Small groups will discuss enablers and barriers to implementation of current curricula, or propose strategies to leverage enablers and address barriers to optimize chances of successful implementation of shared curriculum
- 15 min: Large group report back and questions/answers
- 5 min: Session evaluation

Title
Changing self and systems: Effective use of the disciplinary process

Educational Objective
1) Identify the timeline of the disciplinary process
2) Recognize the key elements of a remediation plan and disciplinary letter emphasizing resident dignity and a fair process
3) Develop tools to address common challenges and missteps in the disciplinary process
4) Identify means to limit collateral damage among residents

Practice Gap
Feedback on prior disciplinary workshops suggests that new program directors and even those with some experience are challenged by the complexities of the disciplinary process and need basic, step-by-step instructions in order to make the process work effectively. This workshop is designed to meet that need while containing the impact of the process on fellow residents.

Scientific Citations
Paglia MJ, Frishman. The trainee in difficulty: a viewpoint from the USA. The Obstetrician and Gynecologist 2011: 13:247-251.

Ratan RB, Pica AG, Berkowitz RL. A model for instituting a comprehensive program of remediation for at-risk residents. Obstetrics and Gynecology 2008; 112:1155-1159.

Schwartz AC, Kotwicki RJ, McDonald WM. Developing a modern standard to define and assess professionalism in trainees. Academic Psychiatry 2009: 33:442-450.

Abstract
For all program directors, the disciplinary process is challenging. Initial faculty assertions of problematic behavior or incompetence may evaporate, arrive after submission of a passing evaluation, or become lost in the shuffle among rotations and sites. When confronted, the resident may be scared, misrepresent the issues, or be entirely unaware of the concerns. In spite of guidelines that seem clear, implementing the disciplinary process can leave the program director in a “grey zone” of confusion, surprises and difficult choices which can challenge even the most seasoned among us.

Following a brief overview and outline of the disciplinary process, we will discuss the process of writing letters of deficiency and developing remediation plans. Samples of both will be shared and discussed. The workshop will also address common challenges in the disciplinary process including:

1) Addressing concerns with resident performance including poor insight, difficulty receiving feedback, executive dysfunction, poor boundaries, underlying psychiatric or substance use disorders to name a few.
2) The case of poor performance but limited written documentation (though lots of verbal feedback from faculty in the hallway)

3) Challenges in implementing a plan to address deficiencies (which requires intensive resources, faculty time, mentoring)
4) Difficulties in ensuring a fair process, preserving resident dignity, and supporting the advanced residents and faculty involved in remediation
5) Problematic structural issues in the Department (low faculty morale, complex institutional requirements)

We will discuss solutions to these problems and share techniques and experiences that have worked! The role of mentorship and coaching will be emphasized as there is something to be gained in the process, often by everyone involved.

In a discussion about pitfalls and collateral damage, we will address the effects of disciplinary actions on other residents in the program and discuss how to manage the challenging and complicated feelings of vulnerability and fear that may arise in the context of remediation or dismissal of a fellow resident.

Agenda
10 min, Introduction and the basics of the disciplinary process (discovery to resolution) (DeGolia)
15 min, Remediation plan and the contents of a disciplinary letter (Spitz)
15 min, Challenges and missteps in the Disciplinary Process (Schwartz)
15 min, Pitfalls and Collateral Damage (Bentman)
20 min, Discussion, QA and wrap-up (all)

Title

Teaching risk management skills for patients who threaten mass killing

Educational Objective

1. Outline the educational importance of learning how to perform a threat assessment within a non-forensic psychiatrist's scope of practice.
2. Review available resources for psychiatrists, including clinical, non-clinical, and legal literature.
3. Describe a structured framework for threat assessment within the role of a psychiatrist: collecting clinical data and collateral information, threat assessment, decision-making, and documentation.
4. Consider how these skills can be incorporated into a curriculum for trainees and faculty across different subspecialty programs.

Practice Gap

Psychiatric residents and fellows in various training programs are increasingly likely to care for adult and pediatric patients who make threats to kill multiple people (ESSN, 2019; FBI, 2021). Both trainees and their supervisors would benefit if training programs could teach cognitive frameworks by which to approach these highly emotive, anxiogenic patient encounters. This preparation would equip supervisees and their faculty to feel confident in gathering data adequately and in a timely fashion, access appropriate support and assistance, and conduct risk assessments within their scope of practice as psychiatrists. Currently, little structured educational support exists to teach non-forensic psychiatrists how to conduct mass killing threat assessments.

Scientific Citations

1. ESSN (Educator's School Safety Network) (2019). Violent Threats and Incidents in Schools: An Analysis of the 2018-2019 School Year. Electronic publication available at: https://eschoolsafety.org/violence/ (Accessed 10/25/21).
2. FBI (Federal Bureau of Investigation) (2021). FBI Reports and Publications. Available at: https://www.fbi.gov/resources/library (Accessed 10/25/21).
3. Mossman, D. (2008). Violence risk: is clinical judgment enough? Current Psychiatry, 7, 66–72.
4. Large, M.M. (2018). The role of prediction in suicide prevention. Dialogues in Clinical Neuroscience, 20(3): 197–205. https://doi.org/10.31887/DCNS.2018.20.3/mlarge
5. Westreich, L. (1991). Assessing an adult patient's suicide risk. What primary care physicians need to know. Postgraduate Medicine. 90(4), 59-62. https://doi.org/10.1080/00325481.1991.11701059
6. Douglas T, Pugh J, Singh I, et al. (2017). Risk assessment tools in criminal justice and forensic psychiatry: the need for better data. European Psychiatry, 42, 134–137. https://doi.org/10.1016/j.eurpsy.2016.12.009
7. Resnick, P., Saxton, A. (2019). Malpractice Liability Due to Patient Violence. Focus, 17(4), 343-348. https://doi.org/10.1176/appi.focus.20190022

8. Weisbrot, D.M. (2020). "The Need to See and Respond": The Role of the Child and Adolescent Psychiatrist in School Threat Assessment. Journal of the American Academy of Child & Adolescent Psychiatry, 59:1, 20-26. https://doi.org/10.1016/j.jaac.2019.09.001
9. Flannery, D.J., Modzeleski, W., Kretschmar J.M. (2013). Violence and School Shootings. Child and Adolescent Disorders, 15, 331. https://doi.org/10.1007/s11920-012-0331-6
10. Twemlow, S.W., Fonagy, P., Sacco, F.C., O'Toole, M.E., Vernberg, E. (2002). Premeditated Mass Shootings in Schools: Threat Assessment. Journal of the American Academy of Child & Adolescent Psychiatry, 41:4, 475-477. https://doi.org/10.1097/00004583-200204000-00021

Abstract

Weighing risks is a part of psychiatrists' daily clinical duties, whether it is assessing the possibility of suicide, self-harm, homicide, or behavioral dyscontrol. Programs teach trainees to perform clinical assessments that balance the risk of harm to the patient/others against the patient's autonomy and clinical needs. Programs also teach trainees to understand the limitations of such predictions (Mossman, 2008; Large, 2018). All psychiatric training programs are comfortable with teaching suicide risk assessment (Westreich, 1991). However, most programs and their faculty are probably less familiar or comfortable with managing situations where a pediatric or adult patient threatens mass killings, such as a school/college shooting, a hospital bombing, etc. While actual mass homicide events are extremely rare, both threats and events are becoming more common (ESSN, 2019; FBI, 2021). These types of threats can be intensely worrying for community and academic psychiatrists, partly because they typically lack experience in forensically assessing violence risk in patients (Douglas, 2017).

It is not possible for any psychiatrist to predict risks with absolute certainty (Resnick, 2019) but it is possible to teach trainees how to make thoughtful threat assessments, engage appropriate supervision, and utilize clinical, legal, county, school, and family resources (Weisbrot, 2020). This workshop helps program directors and other academic faculty consider how they prepare their trainees to assess a child or adult patient who has made a mass killing threat, while staying within their scope of practice. We will review the role of the typical non-forensically trained psychiatrist, different sources of collateral information, various community resources, basic legal considerations, and documentation techniques (Flannery 2013; Twemlow 2002). We will share how a child & adolescent and a forensic psychiatry training program collaborated together to create a curriculum to teach threat assessment, and a fellow-run consultative service for threat assessment. We will use fictitious scenarios based on real-world situations to allow participants to practice implementing the information we provide and consider how they could share it with their own trainees. We will share the teaching documents we created for our own program.

Agenda

The intended audience is psychiatry program directors and any other medical educators who might have to assist trainees with a threat assessment and/or create a training module for risk management and mitigation. Residents and fellows may also find it very helpful to directly learn

the threat assessment information that we review. We will start with an anonymized description of a time-urgent mass killing threat. We will describe how this situation unveiled a lack of threat assessment skills amongst trainees and faculty. We will then hold a facilitated small-group breakout to allow participants to experience how they might handle a similar scenario. We will join back together for an overview of risk assessment strategies, showing how to use forensic specialty knowledge to learn how to manage risk in general psychiatry settings. The second facilitated small-group breakout will allow participants to apply their new skills in a different threat assessment scenario. We will finish with reviewing the sample curriculum we created, which can be adapted to various types of training programs.

1. Introductions, goals & objectives (5 minutes)
2. Presentation: the situation that precipitated the creation of our curriculum (10 minutes)
3. Break-out: how would you handle scenario number 1? (10 minutes)
4. Risk management strategies (20 minutes)
5. Break-out: using the risk management strategies, how would you handle scenario number 2? (10 minutes)
6. Reviewing the joint curriculum (5 minutes)
7. Questions and discussion (15 minutes)

Title
Balancing Act: Navigating Parental Leaves

Educational Objective
By the end of the session, participants will be able to
1) Describe the ACGME's position on parental leave as reflected in the forthcoming revisions of the institutional requirements and determine how it applies practically in planning parental leaves for trainees.
2) Summarize the factors important to psychiatry trainees in creating a parental leave agreement.
3) Discuss the tension between supporting trainee wellbeing and parenthood with preparing trainees with adequate training for independent clinical practice.
4) Develop a guide for developing parental leave agreements for psychiatry training programs at your institution.

Practice Gap
Since the ACGME statement on the new ABMS policy requiring a minimum of six weeks for parental leave, training programs have been struggling with how to create parental leave agreements that comply with the new policy, comply with state and federal parental leave laws, and satisfy training requirements and their own standards for their training program. Tensions of wanting to support trainee parenthood and wellbeing while also ensuring that their trainees graduate with a robust clinical competency that prepares them for independent practice seem inevitable. This workshop brings together training policy leaders, program directors, and psychiatry trainees to discuss the factors involved in creating meaningful parental leave agreements.

Scientific Citations
American Board of Medical Specialities. July 1, 2021. American Board of Medical Specialities Policy on Parental, Caregiver and Medical Leave During Training. https://www.abms.org/wp-content/uploads/2020/11/parental-caregiver-and-medical-leave-during-training-policy.pdf.

Stentz NC, Griffith KA, Perkins E, Jones RD, Jagsi R. Fertility and childbearing among American female physicians. J Womens Health 2016;25:1059–1065.

Homans, J. C., DeJong, S., Ruble, A., Wichser, L. M. H. "Parenting in Residency: How parent-learners strengthen programs and how programs can best support them", American Association of Directors of Psychiatry Residency Training Workshop,, Dallas, Texas. (March 4, 2020). Presentation/Talk.

Abstract
Starting in July 2021, the American Board of Medical Specialties (ABMS) implemented a leave policy that requires all training programs of two or more years of education to allow for a minimum of paid six weeks of parental, caregiver, and medical leave for all residents and

fellows in addition to other paid off time requirements. ACGME has revised the institutional requirements to reflect this new policy; these revisions are awaiting final approval. This change in policy has coincided with a national conversation and effort to improve parental leave laws and a growing number of states and cities passing local parental leave laws. How these laws intersect with the new ABMS policy and forthcoming ACGME revisions remains unclear. AADPRT listserv discussions recently have reflected confusion about the new requirements and how to create parental leave agreements with trainees. At the same time, recent literature suggests that parenthood during training is a high priority for medical trainees, and that postponing parenthood can pose health risks (Stentz et al., 2016). The confluence of these factors raises a tension between supporting the wellbeing of psychiatry trainees and optimizing psychiatric training and trainees' residence to practice. This workshop will provide participants with an opportunity to learn from the Psychiatry RRC Chair about the new institutional requirements, to describe the perspectives on parental leave negotiations from the trainee and program directors' perspectives, and to apply this information to how training programs can create parental leave plans at their own institutions.

Agenda

1. Welcome (10 minutes): Presenters and participants introduce themselves. Participants share their goals for the workshop via a jam board.

2. Dr. Sampang provides an overview of the forthcoming ACGME revised institutional requirements on parental leave which will align with the new ABMS policy (10 minutes). Time is provided for participants to ask questions.

3. Residents from the University of Minnesota present qualitative data on views of parental leaves during training from medical trainees (10 minutes) Drs. Odebunmi and Cahill

4. Small Group discussion of case vignette of a training director working with a resident to create a parental leave agreement. Groups will be asked to discuss the factors important to the resident and to the training director (30 minutes) Dr. Damodaran

5. Large Group discussion of case vignette. Small groups will be asked to summarize their discussions and we will generate a list of themes and factors important in a parental leave agreement (10 minutes) Dr. DeJong

6. Wrap-up Discussion and Questions (10 minutes)

Title

Re-thinking Core Values: How Medical "Professionalism" Perpetuates Discrimination against Black, Indigenous, and People of Color (BIPOC)

Educational Objective

At the conclusion of this session, each participant will be able to:

1. Describe medical professionalism as a fluid, contextual, subjective notion informed by current conceptions of professionalism have been largely based on adhering to white-dominant culture and norms
2. Recognize that professionalism concerns and citations are disproportionately deployed to assimilate and "correct" BIPOC individuals, while privileging traditionally white cis/heteronormative western cultural values and norms
3. Demonstrate, through a series of case vignettes, ways in which medical "professionalism" can perpetuate intersectional discrimination
4. Begin to construct a re-conceptualization of medical professionalism that allows for diverse and inclusive manners of speech, affect, dress, and unwritten codes of conduct.

Practice Gap

Professionalism has become an entrenched, assumed core value in academic medicine, and stands as an integral method by which training institutions evaluate trainees and students. However, the concept lacks definitional consensus, and existing data show that diverse identity groups may have different understandings of what professionalism is and looks like. Despite widespread desire to explore the impact of structural racism on trainee experiences, to date there are no broad instutional efforts that specifically examine institutional norms of professionalism through an anti-racist, anti-sexist lens. While people from groups under-represented in medicine tend to place greater emphasis on the importance of professionalism in the workplace, they report greater scrutiny over their professional actions and greater infringements on their professional boundaries (Alexis et al., 2020). This may have important implications for the disproportionate rates of attrition from academic medicine observed within these groups (Cropsey et al., 2008). Program directors and teaching faculty need to have historically-informed perspectives – an awareness of how professionalism is historically (and currently) deployed to encode and reinforce white cis/heteronormative cultural norms and values that marginalize Black, Indigenous, People of Color (BIPOC). Further, program directors need to employ a critical perspective when evaluating a trainee's professionalism that takes into account the trainee's identity, culture, and lived experience.

Scientific Citations

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Abstract

“Professionalism” has been considered a foundational pillar of American medicine since its inception. As one of the six core competencies set forth by both the LCME and ACGME, medical professionalism is used as a central component of evaluations at all levels of training. Yet despite its pervasive use – and the gravity with which deviations are treated – “professionalism” is an abstract, vague notion that currently has no consensus definition (Birden et al, 2014; Lee, 2017). Furthermore, conceptions of professionalism are differentially operationalized across contexts (e.g., clinical, pedagogical, workplace culture, etc.), and used to encompass a broad set of behaviors, language, affect, styles of dress, and unwritten codes of conduct. Scholars have described – especially in historically white-dominated institutions such as hospitals and universities – how standards of professionalism often encode and reinforce white-dominant culture and marginalize BIPOC (Black, Indigenous, People of Color) (Gray, 2019; Marom, 2019). Recent literature suggests that professionalism concerns and citations are disproportionately used as “corrective feedback” towards women and BIPOC trainees, which may be contributing to the increased attrition among these groups. One large survey study demonstrated that women and BIPOC, compared to their white male colleagues, tend to experience more infringements on their professional boundaries and have more often considered changing jobs because of others’ unprofessional behaviors (Alexis et al, 2020). The overarching goal of this workshop is for participants to reflect on how current conceptions and subjective evaluations of medical professionalism often perpetuate intersectional discrimination, which disproportionately has a deleterious impact on women and BIPOC physicians. We will present a brief historical overview and literature review on the fluid and contextual nature of professionalism. Participants will engage in active learning and skills-building via small and large group discussions of case vignettes. They will work in small groups to unpack and recognize intersectional discrimination embedded in the current conceptualization of medical professionalism. Participants will leave the workshop with an appreciation for the imperative to re-imagine the concept of professionalism in ways that allow for more diverse and inclusive identities in medicine.

Agenda

5’ - Introduction
10’ - Small group breakout
5’ - Large group share out
10’ - Brief historical overview

5’ - Brief literature review
30’ - Small group breakout discussions of case vignettes
10’ - Large group share out and Q&A

Title

Teaching Relationship-Centered Communication to Psychiatry Trainees

Educational Objective

At the end of the workshop, participants will be able to:

1. Recognize communication as a fundamental skill that can be explicitly taught and deliberately practiced
2. Appreciate the relevance of communication training in psychiatry residency, including its role in improving the effectiveness of communication across sociocultural differences, decreasing health disparities, and promoting health equity
3. Identify relationship-centered communication as one model of communication training
4. Communicate more effectively diagnosis and treatment recommendations to patients using a relationship-centered communication skill—one that also has been proposed as a tool that can mitigate interpersonal bias
5. Consider strategies for implementing communication training in psychiatry residency

Practice Gap

Communication is a fundamental skill and is one of the six Core Competencies identified by the Accreditation Council of Graduate Medical Education (The Milestone Project, 2014). Effective communication improves patient outcomes and enhances patient, family, and caregiver satisfaction (Chou et al, 2014). Patient-clinician communication also has been identified as fundamental in contributing to and reducing healthcare disparities (Smedley et al, 2003). Historically, limited attention has been given during residency to explicit training in effective communication (Ericsson, 2004). While psychiatry training frequently focuses explicitly on psychotherapeutic techniques, competence in the more fundamental and universal patient-physician communication skills is often assumed.

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Abstract

Communication is a fundamental skill and is one of the Accreditation Council of Graduate Medical Education's six Core Competencies (The Milestone Project, 2014). It is a procedure in which the average clinician engages approximately 200,000 times during an average practice lifetime. Effective communication has been associated with improved outcomes, including greater patient and provider satisfaction, increased likelihood of adherence to a treatment plan, and reduced malpractice risk (Chou et al, 2014; Levinson et al, 1997; Levinson et al 2010). Patient-clinician communication has also been identified as fundamental in contributing to and reducing healthcare disparities (Smedley et al, 2003). However, other than addressing some circumscribed domains such as "delivering bad news" or "managing the angry patient," few graduate medical education programs' curricula incorporate formal communication skills training. In 2013, leadership at NewYork-Presbyterian (NYP) collaborated with the Academy of Communication in Healthcare to develop a relationship-centered communication (RCC) workshop to enhance providers' skills and improve patient experience. Relationship-centered communication (in contrast to patient- or provider-centered communication) recognizes explicitly the importance of the patient-provider relationship to the delivery of care, and emphasizes the providers' abilities to partner with patients, empathize with patients, and understand their perspectives. To date, over 1,000 NYP healthcare providers have completed the NYP RCC workshop. Feedback collected through 2016 indicated that, immediately following the workshop, participants regarded the training positively and, six weeks later, endorsed significant improvements in their self-efficacy, attitudes, and behaviors related to communication with patients (Saslaw et al, 2017). Since 2016 and as part of their first-year summer orientation, over 80 residents in the NYP Child and Adolescent Psychiatry (CAP) Residency Training Program have completed the RCC workshop. Almost 88% of those CAP residents who completed a follow-up survey agreed or strongly agreed that the RCC workshop was useful to their education. The aims of this AADPRT workshop are to increase recognition that communication is a fundamental skill that can be taught and practiced, and that communication training is relevant to psychiatry residency education—including its role in improving the effectiveness of communication across sociocultural differences, decreasing health disparities, and promoting health equity. This workshop will utilize (1) a brief overview of the RCC workshop's three modules, (2) live demonstration of targeted communication skills, and (3) opportunities for participants to practice one RCC skill (one that has been proposed as a tool that can mitigate interpersonal bias (Cordero & Davis, 2020)) through observed role-play with real-time feedback. A debrief will allow participants to share their experiences and address potential barriers to the use of the skill. As a result of this workshop, participants will learn about and experience first-hand through active learning one model by which to teach

psychiatric residents communications skills and to consider how to potentially bring communication skills training to their home institutions.

Agenda

1. Welcome and introductions – 5 minutes
2. Presentation of evidence in support of communication skills training – 5 minutes
3. Overview of relationship-centered communication (RCC) workshop at NewYork-Presbyterian (NYP) – 10 minutes
4. Interactive skill-building exercise (demonstration by workshop leaders and role play by participants) – 45 minutes
5. Debrief/discussion – 5 minutes
6. Wrap-up – 5 minutes

Title

Healing Racism at the Bedside: Equipping residents with practical clinical tools

Educational Objective

At the conclusion of this session, each participant will be able to:

1. Recognize current and historical pathways through which psychiatry perpetuates racism and stigmatization
2. Understand clinical interventions to mitigate structural and interpersonal racism in the clinical encounter, while history-taking, reviewing collateral, documenting, and diagnosing
3. Utilize proactive clinical tools to reduce medical racism, after practicing in session with vignettes and role-playing

Practice Gap

Current health equity training often focuses on teaching reactive frameworks such as recognizing ongoing biases and historical inequities. However, literature indicates that current psychiatric clinical practice actively perpetuates racial inequities. In order to most effectively combat medical racism, we must shift our focus from reactive to proactive interventions. This workshop will provide participants with tools to actively combat racial trauma in clinical settings.

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Abstract

The integration of social justice and health equity into psychiatric training and practice is necessary and long overdue.(1) This integration is essential to prepare trainees to combat structural racism.(2) Oftentimes, training in health equity is centered around identifying implicit bias and reflecting on the impacts of inequity. While helpful for clinicians to challenge their own personal biases, we must also critically assess how our practices perpetuate stigma. For example, diagnostic labels can have significant deleterious consequences: people diagnosed with schizophrenia often fail to receive necessary non-psychiatric medical care, (3) and children

labelled with oppositional defiant disorder may have that diagnoses weaponized against them in the court of law through criminalization.(4) As structural and cultural racism perpetuates racial disparities in psychiatric diagnosis, our practices may actively harm vulnerable patients.(5) Health equity training must go further to neutralize this ethical threat. We must develop the requisite skill sets to combat racist practices in real time and thereby mitigate and eventually eliminate the racial harm practitioners might inflict upon patients.

This workshop was adapted from a lecture series organized by Drs. Rupi Legha, Michael Mensah, Ann Crawford-Roberts, Kaosoluchi Enendu, and student doctor Angelica Johnsen. We will provide participants the requisite skills to progress from reacting to racially-mediated harms to proactively protecting their patients through clinical practices that challenge racial trauma. We will begin with an evidence-based review of racism in psychiatry, then highlight current ways that psychiatric practices are perpetuating racism. Participants will engage in active learning and skills-building via small group case vignettes, role playing, and larger group discussion and reflection. Participants will work in small groups to develop an anti-racist "toolbox" to both identify racism in clinical practice as well as combat it in tangible ways. These tools will include challenging racialized diagnoses, conducting a trauma history, documenting adequately, critically assessing collateral information, and making referrals to community partners. Participants will leave with a patient-centered framework that they can implement into their clinical practice immediately.

Agenda

Intended Audience

Though originally developed for Child and Adolescent Psychiatry, the skills taught in this workshop are relevant to all areas of psychiatric clinical practice. The intended audience includes all psychiatric providers with an interest in increasing the equity of their clinical practice. This group includes medical students, psychiatric and psychological trainees in all specialties, and social workers, psychologists and psychiatrists with an interest in equity.

Activity Schedule

0:00-5:00 Introduction
5:00-15:00 Presentation of literature
15:00-25:00 Practice - Case Vignettes and Role Playing- in small group breakouts
25:00-35:00 Large group reflection
35:00-45:00 Presentation of literature
45:00-55:00 Practice - Case Vignettes and Role Playing- in small group breakouts
55:00-65:00 Large group reflection
65:00-70:00 Q&As
70:00-75:00 Conclusion

Title
Recruitment vs. Selection: Minimizing the Impact of Racism and Other Biases in the Match

Educational Objective
1. Understand the systematic biases inherent to the tools we use to evaluate applicants to our residency programs.
2. Experience their own susceptibility to these biases.
3. Learn about the presenters' experiences implementing a less-biased recruitment process at NYU
4. Consider and discuss strategies to minimize the bias in their own recruitment processes

Practice Gap
We are all making great efforts to meet the treatment needs of the diverse populations we serve and the educational needs of our residents. Many departments are rightly focused on recruiting applicants who are members of groups historically underrepresented in psychiatry as a part of their strategy to mitigate barriers to care and race-based structural problems with access and quality. However, many of the tools available to us to evaluate candidates for residency training have been developed in systems that are, themselves, biased against underrepresented groups. Additionally, there is more and more cause to question whether the tools we use to predict applicants' success as residents are reliable even without the concerns around bias. This results in a recruitment and selection process that may work in opposition to our ability to build the diverse residency programs and workforce that we know are needed.

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Abstract

Out of concern for difficulty faced in recruiting a diverse class of residents three years ago and an ever growing literature showing the systematic biases embedded in the residency selection process, the New York University Psychiatry Residency training office developed and implemented a system for recruitment designed to minimize the impact of bias on our final rank list. We were first convinced through group discussions and independent reflection of our own biases and the risks related to these biases influencing our selection process. We then reviewed the literature and developed a plan to minimize program leadership reliance on highly biased measures when considering applicants for interview and to blind our interviewers to all but the personal statement and CV of the applicants they would meet. We oriented a large group of interviewers to the data supporting the new procedure and requested that each interviewer perform their own Implicit Assumption Testing to prepare themselves for the interview. In this workshop, we will share what we have learned in this process and its impact on the representation of underrepresented students on our rank and match lists. There have been interesting dynamics to observe, technical issues to navigate, and some pitfalls that we hope will be useful to others. We will also offer the opportunity for attendees to participate in a mock applicant rating exercise that will help them examine their own biases and their impact on how participants assess candidates. Finally, we will ask participants to consider how they might implement similar strategies in their home departments and help anticipate how to address challenges they may face.

Agenda

Introduction and Background - 10 minutes
Breakout Session #1 - Exercise in rating composite applicants - 15 minutes
Post-breakout Debrief #1- 10 minutes
Presentation of workshop leaders' recruitment approach - 10 minutes
Details of implementation, pitfalls and lessons learned - 10 minutes
Breakout Session #2 - Exercise rating applicants with bias-minimized materials - 15 minutes

Post-breakout Debrief #2 - 10 minutes
Sharing results of presenters match in years since implementing bias-minimizing processes and unblinding of ratings given by workshop participants in the session - 10 minutes

Title

Rural Residency Training as a Strategy to Address Rural Health Disparities: A Roadmap for Rural Psychiatry Program Development

Educational Objective

1. Understand the importance of bolstering rural health workforce capacity by expanding r ural residency training in underserved communities.
2. Describe the framework and key milestones for planning and developing rural residencies.
3. Identify barriers and opportunities for developing psychiatry programs to meet rural physician workforce needs
4. Describe resources and tools available to the public and obtain recommendations about gaps in knowledge and resources to guide future work of the TAC

Practice Gap

Health disparities between rural and urban America have been well-documented. Although drivers of these disparities are multifaceted, a key determinant of poorer health in rural populations is lower access to timely, quality healthcare. One proven strategy for addressing the rural-urban outcome gap is increasing physician supply in rural communities. Evidence for a residency program-based strategy to boost rural healthcare workforce supply is strong. Despite this evidence, graduate medical education (GME) in rural areas remains very limited, and the Government Accountability Office estimates that only 1% of residents across all specialties train in rural areas. This is due in part to the unique challenges that face rural health organizations in the Unites States, which often operate on thin financial margins with limited providers and staff. Rural hospitals and federally qualified health centers (FQHCs) often lack the capacity and resources to design, develop, start-up, and maintain rural residency training programs in their communities. The small size and remoteness of rural programs make them susceptible to unique challenges such as inadequate patient volumes, lack of sustained funding after startup grants, frequent leadership turnover, limited educational resources, difficulty recruiting residents, and insufficient support for faculty development and protected teaching time.

As a result, both HRSA and ACGME have adopted strategic policies and resources to support development of rurally-located GME programs. The HRSA Rural Residency Planning and Development (RRPD) program has completed two years across three grant cycles, now with 46 grantees in family medicine (n=35), psychiatry (n=6), internal medicine (n=4), and general surgery (n=1). The Technical Assistance Center (TAC), found at www.ruralgme.org, developed a model to propel grantees through the stages of development, and to help inform effective initiatives and address barriers for development. The RRPD-TAC is working with the awarded programs to develop individualized action plans towards financial sustainability and ACGME accreditation, ensure adequate resources for support, and establish and grow learning collaboratives. Portions of a toolbox created in support of these programs will be available to non-grantees. In addition, the RRPD-TAC aims to evaluate and continuously improve services, track the outcomes of the RRPD programs and disseminate findings to influence policy.

Scientific Citations

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Abstract

Health disparities between rural and urban America have been well-documented. Although drivers of these disparities are multifaceted, a key determinant of poorer health in rural populations is lower access to timely, quality healthcare. One proven strategy for addressing the rural-urban outcome gap is increasing physician supply in rural communities. Evidence for a residency program-based strategy to boost rural healthcare workforce supply is strong. Despite this evidence, graduate medical education (GME) in rural areas remains very limited. As a result, both HRSA and ACGME have adopted strategic policies and resources to support development of rurally-located GME programs. The HRSA Rural Residency Planning and Development (RRPD) program has completed two years across three grant cycles, now with 46

grantees in family medicine (n=35), psychiatry (n=6), internal medicine (n=4), and general surgery (n=1).

To address the unique barriers facing these and other rural communities interested in starting residency programs, HRSA also funded a Technical Assistance Center (RRPD-TAC) comprised of content experts who have helped launch over 100 rural residencies. The RRPD-TAC's mission is to help rural communities overcome the significant challenges involved in designing rural training programs, securing sustainable funding, achieving Accreditation Council for Graduate Medical Education (ACGME) accreditation, and developing governance structures for GME training. The Technical Assistance Center (TAC) developed a model to propel grantees through the stages of development, and to help inform effective initiatives and address barriers for development. The RRPD-TAC developed a framework that describes the steps needed in each of 5 key stages of program development—exploration, design, development, start-up, and maintenance. The Roadmap model details the progressive stages of the process, from early interest and recognized need for a GME program to meet local health care needs, to the implementation of a functional, accredited, and financially sustainable program.

The objectives of the workshop are to 1) Understand the importance of bolstering rural health workforce capacity by expanding rural residency training in underserved communities, 2) Describe the framework and key milestones for planning and developing rural residencies, 3) Identify barriers and opportunities for developing psychiatry programs to meet rural physician workforce needs, 4) Describe resources and tools available to the public and obtain recommendations about gaps in knowledge and resources to guide future work of the TAC. Grantee progress, including key barriers and milestones, has been tracked quarterly. Common challenges such as financial planning, faculty recruitment, curricular design, faculty development, student recruitment, and accreditation were identified through the RRPD-TAC tracking system and were improved with webinars, targeted consultations, and peer support. In two years, twenty programs have obtained ACGME (283 residency positions at full complement), and 12 rural programs have lunched and successful recruiting residencies (94 filled positions). Of note, three psychiatry programs have become accredited (32 resident positions at full complement) and one program successfully recruited residents in the match. Demonstrating successful pathways for development of these programs is essential. This work seeks to strengthen the rural residency-to-workforce pipeline for rural communities in the United States.

Agenda
AADPRT Workshop Outline (75 min)

5 min
Intro to workshop/Introduce speakers and their programs.

15 min
Background on rural training needs- identify challenges with rural populations/resident recruitment/faculty recruitment and development etc.

Outline UNIQUE rural training opportunities.
Examples of rural training program development and implementation.
Role of HRSA and RRPD in supporting rural psychiatry training.
Role of and relationship with Sponsoring Institutions
Discuss recent ACGME changes (July 2021) to rural program designation.

10 min
Real time polling with audience- Specific poll questions to address:
Audience- identify familiarity with rural training needs/background
Clinical and Educational Needs
Areas for Growth/Opportunities/Needs assessment
Rural Training Limitations
Funding Opportunities
Local Community/Investment
Sponsoring Institution/Working with Core Program

30 min
Split into facilitated working groups to review real-time survey results and discuss above content- Identify main areas for development/attention. Participants share experiences, resources challenges etc. Group leader facilitates conversations and flow of smaller working groups.

15 min
Wrap up/Discussion/Questions
Feedback from each group. Each group leader will summarize their discussion in approximately 5 minutes.

Title
It's not you, it's us: Structural Humility and Professionalism in Residency Training

Educational Objective
To prepare residency program leaders to apply structural humility approaches in the implementation of professionalism standards, development of professionalism curricula, and in guiding resident remediation when there are professionalism concerns at their home institutions.

Practice Gap
Professionalism is a core ACGME competency across all residency programs. Additionally, Milestones 2.0 has expanded domains of professionalism to include (1) professional behavior and ethical principles, (2) accountability/conscientiousness and (3) management of individual wellbeing. Residency programs have the difficult responsibility of teaching and assessing professionalism as well as remediating unprofessional behavior. At the same time, professionalism policies and standards that comprise part of the structural component of residency programs vary widely and can be subjective, ill-defined and inconsistently implemented. This has significant implications in light of the increasing diversity of psychiatric residency trainees. Implicit bias and other factors can influence the interpretation and implementation of professionalism standards and remediation processes. Cultural and structural humility frameworks offer a consistent, applicable approach to integrating concepts of culture, structure, and equity within the context of residency training of residents from diverse backgrounds.

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Abstract
Residency programs have the difficult responsibility of teaching and assessing professionalism as well as remediating unprofessional behavior. At the same time, professionalism policies and standards that comprise part of the structural component of residency programs vary widely and can be subjective and ill-defined. This has significant implications in light of the recruitment of psychiatric trainees from increasingly diverse and historically marginalized backgrounds, as implicit bias and other factors can influence the interpretation and implementation of professionalism standards and remediation processes. If these biases are left unaddressed, these processes can ultimately perpetuate harm against trainees. Structural humility builds on the cultural humility concepts of (1) life-long self/institutional reflection, (2) identifying and decreasing the power imbalance between structures and their constituents (e.g. training programs and their trainees), and (3) developing partnerships at a systems level that mutually serve each constituent. It has been defined as "the orientation emphasizing collaboration with patients and populations in developing responses to structural vulnerability, rather than assuming that health professionals alone have all the answers. This includes awareness of interpersonal privilege and power hierarchies in healthcare" [1]. Applied to residency programs, cultural and structural humility offer a framework that encourages residency leaders to collaborate with trainees from historically marginalized backgrounds to understand their particular burden and experience in the power hierarchies and to observe the ways these hierarchies may discriminate when applied to professionalism concerns. This workshop will focus on the application of structural humility to professionalism training, assessment, and remediation with a goal of increasing equity in these residency processes, identifying and eliminating bias against residents who are from backgrounds that have been historically excluded in medicine and mitigating potential harm caused by unjust remediation processes.

Agenda
5 min ice breaker activity
20 min Introduction to Structural Humility as related to professionalism
15 min pair/small group learner-centered activity "The Professionalism Award"
15 min large group discussion around the above exercise
15 minute large group case demonstration around structural humility and professionalism
15 minutes pair/small group case review
15 min large group discussion of cases (all)

Title

Seize The Movement, Not The Moment – The Benefit Of Diversity, Equity and Inclusion Long-Term Strategies on Instagram and Twitter for Residency Recruitment

Educational Objective

1. Understand the necessity for the use of a long-term social media strategy to support DEI movements and residency recruitment.
2. Inventory a residency program's current approaches to support DEI movements and as part of the recruitment process.
3. Employ an initial plan to design a DEI long-term strategy on social media.

Practice Gap

Social media is ubiquitous and becoming more commonly used by particular social groups and professions to raise awareness about critical public issues including challenges related to Diversity, Equity, and Inclusion (DEI). There is increasing social media utilization in healthcare by academic health centers, provider organizations, medical journals, research centers, and individual physicians and educators (Liu et al. 2019, Logghe et al. 2018). Residency training programs use social media to help shape a program's image and publicize activities of the program. Applicants have been considering different aspects of diversity more and more when applying to and ranking residency programs (Dinh and Salas, 2019). Therefore, posting aspects of DEI and efforts made by programs to tackle challenges associated with DEI on social media can help programs recruit from a broader range of interested applicants who can amplify the DEI voice. Intentional use of social media can be a powerful means of reaching diverse applicants and developing professional networks of like-minded programs, organizations, and social movements. Residency programs often create DEI social media campaigns for special occasions, such as diversity month, Black History Month, Women's History Month, or Pride at this point. Programs also may post about holidays recognizing marginalized groups of individuals. While these posts are certainly a great start and suggest awareness of DEI issues, training programs' efforts would be even more compelling if they did not just celebrate moments in time but went beyond this to post content that genuinely supports the purpose of the DEI movements. As such, programs need to move from one-time posts and statements to content posted in the context of a long-term DEI social media strategy. A long-term social media strategy can showcase the program's steadfast commitment to DEI, attracting a more diverse pool of applicants.

Scientific Citations

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Abstract

Diversity, equity, and inclusion have existed for decades, newer social movements such as Me Too or Black Lives Matter have emerged in recent years. Pre-existing racial disparities in institutions and society have been exacerbated by the recent COVID-19 pandemic, negatively impacting patients, learners, staff members, and faculty. At the same time, individuals and institutions seem more willing than ever before to make significant changes and positive contributions to the DEI field. While internal changes related to DEI are essential, continuous external communication and role-modeling can be equally important. Residency training programs, program directors, program coordinators, and interested residents are uniquely positioned to utilize social media to promote departmental and program specific DEI-related efforts. Beyond benefits such as widening and diversifying the applicant pool, programs can also connect with like-minded organizations and social movements online, enhancing and amplifying DEI activities. This workshop will help programs understand the benefits of moving from sporadic DEI social media posts to developing a long-term DEI social media strategy in the context of residency recruitment. We will explore this topic by looking at two commonly used social media platforms (Instagram and Twitter) and focusing on strategies from two institutions (Duke University and University of Nebraska Medical Center). The workshop aims to motivate programs to draft a long-term DEI social media strategy. The material will be customized for sporadic DEI content posting programs; programs with more experience (and even with a long-term strategy in place) are welcome and encouraged to participate.

Agenda

1. Introduction (20 mins): a discussion of DEI-related matters, terminology, and principles; a review of existing approaches to DEI on social media (focusing on Instagram and Twitter). General principles will be highlighted, the need for a long-term DEI social media strategy will be discussed. A handout with terms and resources will be provided. For the last 5-10 mins, participants are invited to share personal experiences about DEI and social media focusing on the residency program/recruitment context.
2. Small Groups (30 mins): facilitators will divide the audience into equal groups (at least 5 participants/group). For the first 5 mins, attendees are encouraged to reflect on their program's DEI efforts and understand if and how these efforts are represented on their social media platforms. For the next 5 mins, participants will then highlight some of their thoughts. Differences and commonalities will be highlighted. For the remaining 20 mins, participants will start to brainstorm essential elements of a long-term DEI social media strategy based on the previous discussions. They will also explore how to make the strategy specific to their programs and how it can aid programs' efforts to diversify the residency application pool. Facilitators will also highlight common pitfalls to avoid. Facilitators act as note-takers.

3. Teach/report back (10 mins): Facilitators will summarize the discussions from the small groups. Facilitators will also encourage participants to consolidate their learning through a post-workshop challenge.
4. Protected time for Q&A and evaluation (15 mins)

Title

Enhancing Competency and Equity in Addictions Education: Resources and Best Practices for a "Post"-Covid World

Educational Objective

1. Discuss educational needs for training general psychiatry residents to care for patients with substance use disorders and other psychiatric disorders
2. Describe existing resources for teaching addiction psychiatry that are already available in the public domain
3. List examples of current disparities in the recognition and treatment of substance use disorders for traditionally underserved patient populations, including communities of color
4. Identify 1-2 concrete, actionable ways to enhance addictions training in one's home training program

Practice Gap

Substance use disorders occur at high rates in almost all fields of medicine, and in psychiatry, up to half of patients with another mental health diagnosis also meet criteria for a substance use disorder. Despite this, addiction psychiatry is under-represented in both undergraduate and graduate medical education programs, and many program directors have reported they have insufficient resources to teach addiction psychiatry within their general psychiatry training programs. The impact of the Covid pandemic, and associated increases in substance use and overdose, has brought a renewed focus on the importance of broad training in addictions for all future psychiatrists, as well as the importance of recognizing and addressing health disparities within addiction psychiatry. This workshop will assist training leaders in recognizing and identifying ways they can address these unmet needs within their home training programs.

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Abstract

In 2019, 7.4 percent of the US population (20.4 million people) met criteria for a substance use disorder (SUD) in the past year. It is also estimated that half of patients with another mental health diagnosis also meet criteria for a substance use disorder (SUD). In spite of this, addiction psychiatry is drastically under-represented in undergraduate, graduate and continuing medical education programs. The opioid epidemic and the COVID19 pandemic have brought an even greater urgency to ensuring all psychiatrists are competent and prepared to treat addictions, as the disruption of the pandemic has been associated with an increase in alcohol and drug use and a record number of opioid overdoses. The burden of increased SUD and SUD-related mortality during the pandemic has also disproportionately impacted minority communities that often have even more limited access to substance use treatment and recovery services for SUD; despite this, the intersection between addiction psychiatry education and health equity has received little attention in existing curricula and learning requirements.

This workshop will demonstrate innovative teaching methods and resources to improve knowledge and performance in the teaching and clinical practice of addiction psychiatry. These will include an overview of public domain resources, including practice guidelines, professional organizations with online content to enhance addictions knowledge and practice, existing addictions curricula, and multimedia content. The workshop will also review strategies to incorporate education about health equity and disparities in SUD education, as well as ways to broaden clinical venues for learning about addictions beyond inpatient settings for medically managed withdrawal (formerly known as “detox units”). In small groups, participants will explore available resources, brainstorm together about both clinical and didactic learning opportunities, and actively consult with other participants and session leaders to match these resources and opportunities with their educational needs. Participants will have the opportunity to reflect on their individual training program’s areas for growth and should leave this workshop with one to two concrete strategies for improving their addictions curriculum in their home program.

Agenda

- Welcome and Introductions (5 min)
- Overview of existing gaps in Addiction Psychiatry training in general psychiatry training programs (5 min)
- Small group discussion: Vignettes highlighting existing resources for education in Addiction Psychiatry for general training programs, as well as teaching opportunities outside of a traditional “detox” unit (15 min)
- Large Group discussion: review of key points from the vignettes, summary of available resources (10 minutes)
- Small group discussion: Vignette highlighting intersection of healthcare disparities, addiction psychiatry education, and diversity, equity, and inclusion (15 min)
- Large group discussion: Review of key points from the second vignette and associated resources (10 min)
- Program Action Planning: With a partner, participants reflect on and commit to 1-2 specific changes they would like to make to their programs’ addiction psychiatry curriculum (10 min)
- Wrap up and Questions (5 min)

Title

Motivational Interviewing: Curriculum and Assessment in a Time Requiring Epic Behavior Change.

Educational Objective

By the end of the workshop, participants will be able to:

1. Describe several models for teaching Motivational Interviewing in psychiatry residency and fellowship programs
2. Describe strategies to engage learners and faculty to support Motivational Interviewing skill acquisition
3. Identify strategies to provide formative and summative Motivational Interviewing skill acquisition feedback.

Practice Gap

Psychiatry educators have an opportunity to train residents and fellows in techniques with evidence to help people make changes. All of us: educators, residents, fellows and patients alike, are faced with many opportunities to change our behavior and systems to advance diversity, equity and inclusivity. Motivational Interviewing (MI) gives us tools to work through ambivalence and build our motivation to become advocates for those with less power.

MI is a client-centered, collaborative, directive counseling style that guides individuals towards resolving their ambivalence about making important changes in their behavior (Miller & Rollnick, 2002). More traditionally, MI has demonstrated efficacy for treating alcohol and substance use disorders. MI also has evidence for promoting other health behaviors and as a prelude to psychotherapies (Hsieh, 2005).

Despite support for the use of MI, its incorporation into curriculums is still emerging. MI training in medical school is variable, thus residents coming to psychiatry residency come with a spectrum of MI knowledge and skills. Learners report that learning the skill without support/structure was difficult and often fell short. The AADPRT Addiction Taskforce recommended the use of MI (Moran, 2021). Currently, the ACGME requires cognitive behavioral therapy, psychodynamic and supportive therapy training during residency (ACGME 2020). Several authors have called for the ACGME to require MI competency to ensure universal training is provided (Abele, 2016; Arnaout, 2019). Without requirements, 90.9% of general, 80,5% of child/adolescent, and 100% of addiction psychiatry training programs provided MI education according to a 2014 national survey of psychiatry training directors (Abele, 2016) indicating the perceived high importance of MI in clinical practice.

Little is known about how programs are incorporating MI into their curriculum. The national survey of psychiatry program directors suggested wide variability ranging from observing other staff doing MI to videotaped supervision and objective assessment of skills with motivational interviewing treatment integrity (MITI) scale (Abele, 2016). MI learners' self-assessment of MI skills can be inaccurate (Wain, 2015), thus collateral objective feedback is instrumental. Evidence for effective strategies to support high fidelity skill acquisition and competency have

been demonstrated (Miller, 2001; Miller, 2004; Smith 2012). Psychiatric educators have an opportunity to adapt effective strategies into training curriculum. This workshop is an opportunity for various programs to support each other in developing training and assessment processes that have the potential to help us all change.

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Abstract

MI training in psychiatric programs take a variety of forms. The workshop will start with a brief overview of several different approaches to implementing curriculum. Intensity of curriculums could be considered on a continuum. There is something for every program, from the program beginning to aspirational models to strive towards. Several modalities that have evidence for developing a competent MI therapist will be presented. Possible implementations of MI in clinical care and leadership/administration will be discussed.

Exercise #1 will ask participants to self-select into two tracts:

a. MI 101: What is MI? Brief overview of MI, then launch into a persuasion exercise and then shift to a MI exercise, then compare and contrast the 2 methods.

b. MI 201: Operationalizing MI curriculum into curriculum. The facilitators will allow ask participants to form dyads. Each pair will use MI techniques (Change Plan Worksheet) on each other to brainstorm how they could make first steps towards enhancing their training programs development.

Formative and summative competency assessment tools will be discussed. Pros and cons of tools will be presented.

Exercise #2

Participants will have an opportunity to trial one tool by coding a pre-prepared audio recording of someone practicing MI.

Agenda

75 min total

0-55 min: Workshop

1. Didactic 15 min
2. Exercise #1 20 min
3. Didactic 5 min
4. Exercise #2 15 min

56-70 min: Question and Answer

71-75 min: Evaluation of Workshop

Title

Edutainment: Using TV Clips to Set the Stage for Difficult Conversations around Race Bias in Medicine

Educational Objective

1. Gain increased awareness of scenarios and sensitivity as to how race bias and discrimination occurs in our workspace
2. Identify at least two specific strategies to communicate effectively with other health professionals about race bias and discrimination in medicine
3. Determine at least one individual-level and one community-level change that could be made to promote racial equity in our medical community

Practice Gap

Many medical systems and training programs have methods in place for the recruitment and retention of a racially and ethnically diverse workforce. Research suggests, however, there is inadequate focus on improving the work experience and training experience of individuals from racial and ethnic groups underrepresented in medicine (URiM). In fact, there is evidence that URiM trainees continue to face daily disadvantage and hardship – from discrimination, to social isolation, to different professional expectations. While accreditation agencies and institutions have called for the development and incorporation of curricular content to address these issues, educational programs that are effective, scalable, and able to be implemented nationally are lacking. One promising educational technique—often referred to as "edutainment"—utilizes entertainment, such as television or video games, as an instructive strategy. Each year, the average American watches 2,000 hours of primetime television and 104 hours of medical television, but only speaks to a health care provider for about 1 hour. Physicians need to understand the perspectives of our patient populations not only from real-life experiences, but also perceptions of our patients from popular entertainment media. Furthermore, research suggests that integrating "edutainment" in the form of clips from popular television programs into medical curricula is feasible, efficacious, and more engaging for students than traditional lecture-type formats. Utilizing television clips to improve trainee communication skills and address bias towards medical conditions suggests such clips may be a powerful tool with which to develop curricular content specific to racial discrimination and bias.

Scientific Citations

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Abstract

The session will open with a brief description of objectives and utilization of interactive polling with participants about their familiarity of targeted media and related topics. Participants will then view and discuss three television clips that depict interactions among providers related to race bias and discrimination in medicine. Prior to viewing each media clip, participants will be oriented to background information (e.g. character background, plot, etc.) via a brief PowerPoint. Three clips include: (1) This Is Us (i.e., in the aftermath of George Floyd's murder, Randall, a Black man who was adopted as an infant by a white family, tells his therapist that he needs to see a Black therapist); (2) Grey's Anatomy (i.e., after missing a diagnosis in an Asian-American patient, Dr. Hunt talks with Dr. Bailey about how race biases impact medical decision-making. The crucial difference between equity and equality are also discussed); and (3) New Amsterdam (i.e., the medical director of the hospital is on a quest to end systemic racism. His Black female colleague points out his misguided attempts to be an ally and the importance of listening and not relying on quick fixes.) After viewing the clips, participants will break into small groups. The facilitators will guide the small group participants in a reflective exercise that will allow room for difficult conversations to happen. Small groups will also be given three sets of prompt questions that will help participants engage meaningfully and interactively (e.g., re-write the script, roleplay the supervision, etc.). After each small group, participants will debrief in the larger group. At the end of the session, the workshop leaders from two institutions, University of Pittsburgh and University of Cincinnati, will present briefly on lessons-learned on implementing edutainment and answer any questions that the audience might have about how to implement this innovative educational methodology at the participants' home institutions.

Agenda

1. Welcome and Introduction to Edutainment
2. Clip #1 - This Is Us
    a. Small Groups
    b. Large Group Report out
3. Clip #2 - Grey's Anatomy

a. Small Groups
b. Large Group Report out
4. Clip #3 - New Amsterdam
a. Small Groups
b. Large Group Report out
5. Wrap-up

Title
Residents with Difficulties: When Accommodation and Performance Collide

Educational Objective
1. Explore strategies in the assessment and management of residents with problems.
2. Review American Disabilities Act and its implications for residency training.
3. Discuss documentation requirements during and after training.
4. Recognize the impact of a resident adverse action, including dismissal, on the program.
5. Appreciate the emotional impact working with a resident who is having difficulties can take on the resident, program director, other faculty members, staff and resident peers.

Practice Gap
Training directors spend significant time assessing residents with a variety of difficulties that interfere with residents' training. This workshop is designed to increase the knowledge and skill of participants by reviewing residency programs' options when a difficult resident situation arises. Knowledge of resources to support the training director, faculty, and residents is essential in minimizing negative impact and outcomes.

Scientific Citations
Chou, C. Guidelines: The dos, don'ts and don't knows of remediation in medical education.

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Murano, T. Mandated State Medical Licensing Board Disclosures Regarding Resident Performance. Journal of Graduate Medical Education Volume: 11 Issue 3 (2019) ISSN: 1949-8349 Online ISSN: 1949-835

Schenarts. The Fundamentals of Resident Dismissal. The American Surgeon Volume: 83 Issue 2 (2017) ISSN: 0003-1348 Online ISSN: 1555-9823

Abstract
The workshop is a reconfiguration of prior workshops on strategies and ethical obligations of the residency director with problem residents and residents with problems. The workshop will highlight a differential approach to addressing resident problems, guidelines for documentation, and challenges that occur even after resident departure. A resident case presentation will highlight sequential steps to addressing concerns while also supporting the resident. The roles of GME, HR, legal, Ombuds and state physician health programs will be reviewed, and a guide for ADA accommodation will be discussed. Essential elements of documentation will be discussed, including written communication requests after the resident's

departure. Impact on the program, faculty, resident peers, and staff will be reviewed. The enduring emotional impact on the training director will also be explored. After the general presentation, the audience will be divided into four small groups, each led by workshop presenters. In each group, participants will have the opportunity to share their own experiences, and the workshop presenters will lead the group consultation. The large group will reconvene at the end to share key lessons learned.

Agenda

- Introduction of workshop. (5 min)
- Overview of guidelines in assessment and management of resident problems. (15 min)
- Case presentation involving trainee with concerns, including varying perspectives of different institutions. (20 min)
- Review guidelines for ADA accommodations. (5 min)
- Small group consultation: Audience will be split into smaller groups for group consultation. Workshop presenters will facilitate small group discussion. (20 minutes)
- Wrap up as each small group shares recurring themes and experiences among different programs. (10 minutes)

Title

Wellness for whom? Addressing structural inequality and increasing BIPOC/LGBTQ+ Well-being in Psychiatry Residency training

Educational Objective

Educational Objectives:
-Review the relevant literature on BIPOC/LGBTQ+ well-being in Psychiatry residency training
-Discuss individual and structural interventions to increase well-being for diverse provider populations
-Provide opportunities to explore best practices and areas for growth

Practice Gap

Practice Gap:
In recent years, there have been increasing focus on physician well-being and pathways to support trainees in reducing professional burnout. Little focus, however, has been given to the particular strain residents of color and members of the LGBTQ+ community face in navigating psychiatric training. BIPOC physicians remain significantly underrepresented in medicine with marked deficits in residency and Psychiatric faculty representation (Wyse et al., 2020).

Scientific Citations

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Roberts, L. W. (2020). Belonging, respectful inclusion, and diversity in medical education. Academic Medicine, 95(5), 661-664.

Abstract

Abstract:

While increasingly programs have embraced including cultural psychiatry in their curricula, which provides education on structural competency, cultural humility as well as the impact that racism or discrimination has on patient mental health, there continues to be limited

resources provided to trainees navigating systemic oppression while fulfilling the demanding requirements of a Psychiatric residency training program.

The “minority tax” is a well established burden URiM physicians carry to not only thrive within academic institutions but also to improve systems not designed to support them. So often, individuals of color or members of LGBTQ+ community are not only confronted with the onslaught of racism or bigotry while providing care but also face lack of awareness and accountability from the institutions where they serve. Beyond this, the obligation to improve or educate other providers/patients falls to these individuals, providing further psychological and professional strain. Isolation, lack of mentorship, and tokenization compound these effects causing a collective “tax ” felt by residents of racial, gender, or sexual minorities in training. How do we as educators and training directors begin to undo this overburdening and provide concrete support to URiM trainees learning Psychiatry? During our interactive session, we will summarize recent scholarship on this topic and provide a rationale for its critical importance in Psychiatric practice and education. We will provide concrete examples from our own department, demonstrating successes and failures in creating greater wellness for our URiM residents. Finally, we will offer future directions for expanding support for trainees as we collectively work to change institutions for a more equitable future in Academic Psychiatry.

Agenda

Agenda:
0:00 Introduction
0:05 Didactic Presentation: BIPOC and LGBTQ well-being
0:20 Discussion/Breakout: Institutional need for greater DEI wellness
0:35 Didactic: Structural and individual opportunities for increasing well-being
0:50 Discussion/Breakout: Near misses and learning in DEI/wellness
1:00 Question and Answer Session
1:15 End of Session

Title

Psychological Safety: An Important Ingredient for Creating a Culture of Inclusion

Educational Objective

1. Define the primary tenants of psychological safety
2. Describe several ways to assess the psychological safety of trainees and faculty
3. Practice implementing strategies that improve psychological safety
4. Explore obstacles and solutions to enhancing psychological safety in each participant's setting

Practice Gap

While recruiting practices must be altered in order to increase the diversity within programs and institutions, creating an environment of inclusion is essential for retention, growth and altering historically racist systems. Psychological safety is an often overlooked, but critical component of creating an institutional culture of inclusion. [1] As part of its approach to increasing Diversity, Equity and Inclusion, the ACGME requires programs to "cultivate an environment in which residents and fellows can raise concerns and provide feedback without fear of intimidation or retaliation." [2] The environment they describe is one where psychological safety exists. For growth and change to occur, trainees and faculty must feel safe to be themselves, speak up, take risks and make mistakes. If they feel that they will be punished, humiliated or unfairly remediated for speaking up or making mistakes, this can lead to burnout, lack of empathy, and stagnation [3]. Medicine and medical training must prioritize diversity and inclusion in order to better serve our patients and to create a healthcare system that embraces antiracist policies. While the what and why is clear, the best practices of "how" is still largely unknown. [4] Psychological safety is fundamental for innovating and implementing strategies that will address the how. Program directors need a systematic way to assess the psychological safety of their departments. They also need strategies for addressing any deficits in psychological safety with faculty and trainees.

Scientific Citations

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3. Risky Business: Psychological Safety and the Risks of Learning Medicine: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5180540/
4. Keeping Our Promise –Supporting Trainees from Groups That Are Underrepresented in Medicine https://www.nejm.org/doi/full/10.1056/NEJMp2105270
5. Managing diversity at work: Does psychological safety hold the key to racial differences in employee performance? https://bpspsychub.onlinelibrary.wiley.com/doi/10.1111/joop.12015
6. Does Psychological Safety Impact the Clinical Learning Environment for Resident Physicians? Results from the VA's Learners' Perceptions Survey: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5180524/

7. Psychological Safety Among Learners: When Connection is More than Just Communication: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5559258/

Abstract

This workshop builds upon a workshop that was presented at AADPRT in 2019 entitled, "Psychological Safety: It's not Just for Snowflakes." The goal of this workshop is to help attendees address the importance of psychological safety in supporting DEI initiatives within their home departments in a systematic way. The workshop will start with an ice breaker designed to engage the participants and start building psychological safety within the group. We will have the group define the important factors that contribute to psychological safety and create our own ground rules for the workshop. Next, using an interactive and anonymous tool (Poll Everywhere), we will have the participants take a Psychological Safety Survey that was created to examine the importance of psychological safety in creating a diverse and inclusive work environment [5]. We will also identify common obstacles to psychological safety using the interactive tool and discuss other assessments for psychological safety that participants can utilize to assess their own programs. We will then have interactive breakout sessions where we will use DEI themed scenarios experienced by residents and faculty where there was there was not psychological safety. The small groups will reconsider the scenarios using the tenants of psychological safety and process the differences. Large group discussion will focus on the experiences of the participants. There will be a brief presentation of practical strategies to strengthen psychological safety in a department and in work environments for both residents and faculty. We will have the participants make a commitment to themselves to trial one of the strategies. Then we will conclude with a review of the importance of psychological safety, obstacles to it and commitments to assess it and intervene when necessary. Participants will receive handouts that include strategies for creating psychological safety and the scenarios to spark conversation and change within their own institutions.

Agenda

1. Introduction: Interactive ice breaker (5 min)
2. Group definition of psychological safety and setting norms (5 min)
3. Interactive assessment of psychological safety and obstacles (10 min)
4. Small Groups role play scenarios (20 min)
5. Large Group Report Back (10 min)
6. Presentation of practical ways to actively create psychological safety (10 min)
7. Conclusion: Discussions, Questions and Evaluation forms (15 min)

Title

Harnessing Self and Systems in Supervisory Relationships to Advance Diversity, Equity, and Inclusivity

Educational Objective

1. Appreciate the dominant cultural values and assumptions within medicine that may impact supervision, and the role of talking explicitly about cultural difference and experiences in supervisory relationships.
2. Develop a practice of self-reflection to prepare for conversations about culture and identity in supervision.
3. Demonstrate approaches to discussing culture and identity within supervision.
4. Identify strategies to manage ruptures in discussing culture and identity within supervision.

Practice Gap

The supervision of residents and medical students is an expectation of psychiatrists who work in academic and teaching clinical settings. Learning supervision, however, is rarely a major focus of psychiatry training programs or of faculty development. As the cultural diversity of trainees outpaces the diversity of faculty (AAMC), attending to issues of culture and identity within the supervisory dyad is of critical importance – whether in clinical or nonclinical supervision.

Many traits of the dominant culture that remains elevated or prioritized in medicine, whether through biases and archetypes or through valuing certain traits like perfectionism, individualism, and stances of so-called objectivity, contribute to adversely evaluating or misperceiving trainees from minoritized groups as not meeting desired standards or expectations of proficiency, unintended paternalistic approaches to supervision, power hoarding, fear of conflict and other problematic features in a supervisory relationship.

Scientific Citations

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- Schen CR and Greenlee A (2018). Race in Supervision: Let's Talk About It. Psychodynamic Psychiatry 46(1):1-21, 2018
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· Watkins CE Jr: Psychotherapy Supervision Research in Supervision in Psychiatric Practice: Practical Approaches Across Venues and Providers. Edited by DeGolia S, Corcoran K. American Psychiatric Association Publishing, WDC. April 2019

Abstract
Research has suggested that willingness to consider multicultural differences and their potential impact have been increasingly recognized as critical to good supervision practice (Watkins 2019). Neglecting to talk about race and culture in supervision negatively impacts supervisees of color in psychodynamic psychotherapy settings (Tummala-Narra 2004). Yet, how this happens requires mutual trust, self-reflection and certain skills (Schen & Greenlee 2018). A strong supervisory alliance is necessary to enable a productive discussion around insensitivities, misunderstandings, microaggressions, and rupturing events surrounding multicultural variables that may occur within supervision (e.g., Inman et al. 2014; Soheilian, Inman, Klinger, Isenberg and Kulp 2014). Supervisors are in an important position to guide multicultural discussions and research shows that supervisees desire such discussions in supervision (cf. Soheilian, Inman, Klinger, Isenberg and Kulp 2014, Tohidian and Quek 2017).

This workshop will explore personal and systemic challenges to attending to such issues and ways to advance productive discussions of multicultural issues within the supervisory dyad. Didactic and experiential examples will be provided.

Agenda
8 min - Introduction and purpose of workshop and resident perspective
10 min - Didactic: Step 0: Understand the culture of medicine and cultivate cultural humility
10 min - Didactic: Step 1: Assess - Recognizing our cultural biases and assumptions about supervision
6 min - Individual reflection exercise
10 min - Didactic: Step 2: Ask - Talking about culture in supervision
8 min - Breakout discussion group
10 min - Didactic: Step 3: Adjust - Addressing the need for repair in talking about culture
8 min - Role play activity
5 min - Q&A

Title

Revealed: Secret and Arcane Strategies to Teach CAP Fellows How to Assess and Treat Youth Substance Use Disorders

Educational Objective

1. Describe the importance of and national need for further training of child and adolescent psychiatry (CAP) fellows in addictions
2. Evaluate how the Kaminer text "Youth Addictive Disorders" can be used to develop an addiction curriculum in a CAP fellowship.
3. Develop developmentally- and culturally-informed strategies to educate CAP fellows about assessment, prevention, and treatment of SUD in programs of varied resources and within systems of care traditionally underserved (e.g., juvenile justice)
4. Name a variety of sources for consultation and guidance available to help program directors in developing addiction training in their program.

Practice Gap

According to the 2019 NSDUH, marijuana use is increasing in teens and young adults, with the largest increase in 12-17 year-olds. In the past 15 years, adolescents and young adult use of prescription opioids, heroin, and fentanyl has increased, paralleled by increasing rates of Opioid Use Disorder and opioid-related overdoses and deaths, the latter of which reached almost 5,000 in 2017. (1) Alcohol and other drug use, while continuing to fall, still affects too many teens. (2) A survey published in 2018 showed that most programs do not make use of Addiction Psychiatry Fellows, faculty, and resources. They admit to a limited number of faculty/staff with expertise. (3) Although the limiting factor may be that most faculty and staff are not trained to treat adolescent substance use, training child and adolescent faculty in diagnosing and treating substance use disorders can be achieved. A model curriculum based on a "gold standard" textbook can be developed with the help of national experts in this specialty.

Scientific Citations

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2. NSDUH, 2019 https://www.samhsa.gov/data/release/2019-national-survey-drug-use-and-health-nsduh-releases
3. Welsh JW, Schwartz AC, DeJong SM. Addictions Training in Child and Adolescent Psychiatry Fellowships. Acad Psychiatry. 2019 Feb;43(1):13-17. doi: 10.1007/s40596-018-0959-6. Epub 2018 Jul 31. PMID: 30066242.
4. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm
5. https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002922
6. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.htm#cooccur2
7. Kaminer Y, Winters KC (2020) Clinical Manual of Youth Addictive Disorders. American Psychiatric Association Publishing, Washington, D.C., U.S.A.

8. ACGME Program Requirements for Graduate Medical Education in Child and Adolescent Psychiatry, 2021 (https://www.acgme.org/globalassets/pfassets/programrequirements/405_childadolescentpsychiatry_2021.pdf)

Abstract

Adolescents are not immune to the challenges of Substances Use Disorder (SUD), with 12% of overdose deaths in 2017 among 15–24 year-olds. (4) Adolescents with SUDs are also likely to have a mental health diagnosis. In 2017, the percentage of adolescents aged 12 to 17 past-year illicit drug use was higher among those with major depressive disorder than those without(5). Given local, regional, and national needs, the likelihood of a child and adolescent psychiatrists treating and/or consulting on adolescents with SUDs is high. The ACGME requires that child and adolescent psychiatry fellows receive education in substance use disorders, requiring demonstration of competence in evaluating and treating patients representing the full spectrum of psychiatric illnesses, including developmental and substance use disorders (8) (ACGME 2021). However, there is a dearth of experts to provide this education for fellows. A recent survey of child and adolescent psychiatry program directors conducted by the AACAP Addictions committee revealed that program directors were hampered by limited number of faculty/staff, limited number of faculty/staff with expertise, and insufficient clinical teaching sites (Welsh et al 2019). While most programs (78.72%) had formal didactics, many were dissatisfied with their ability to address important content. A lack of services in adolescent addictions may be a limiting factor; however, developing expertise through faculty development activities and nationally disseminated model curricula with educational resources can improve national adolescent addictions training. This workshop will provide program directors with an approach to teaching SUD using the Youth Addictive Disorders Kaminer text (7), considered the current gold standard for this field . We will provide a brief overview of the text and how it can be used in curriculum development. Participants will use the breakout groups to develop plans for implementing or enhancing SUD curricula within their programs. Participants will have the option to join one of two breakout groups: each group will choose one of four youth addictive disorders (Opioid Use Disorder; Alcohol Use Disorder; Tobacco Use Disorder; or Internet Gaming Disorder) and participate in use of the Kaminer text to outline a model curriculum. The small group discussion will allow diverse programs with varied resources to address their cap training practice gaps. Participants will leave with implementation plans for next steps to enhance SUD education at their programs.

Agenda

The intended audience is child and adolescent fellowship faculty and more broadly faculty of general psychiatry residencies. Child and adolescent fellows are included as well.

0:00 – 00:10 – Intro/Discuss knowledge of current gaps in training - Cathryn
00:10 – 00:25 – present information about the textbook, Youth Addictive Disorders by Kaminer, et al.
00:25 – 00:50 – breakout groups –The participants will receive coaching on the use of Kaminer's text within the context of their own resources. They will develop an outlive to

enhance SUD training at their own program. Participants will leave next steps to enhance SUD education at their programs.
00:50 – 01:00 – re-group to discuss individual ideas for further developing SUD curricula at their programs.
01:00 – 00:15 - questions and discussion, including 5 minutes for members to complete the evaluation form