Educational Workshops for the 2022 AADPRT Annual Meeting

Title
Enhancing Family Oriented Care in Residency and Fellowship Training

Presenters
Ayame Takahashi, MD
Richelle Moen, PhD
Andrew Hunt, MD
Magdalena Romanowicz, MD
Fauzia Mahr, MD

Educational Objective(s)
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

1. Rait D, Glick I: Reintegrating family therapy training in psychiatric residency programs: making the case. Acad Psychiatry 2008A; 32:76–80
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3. Rait D, Glick I: Whatever Happened to Couples and Family Therapy in Psychiatry? The American Journal of Psychotherapy 2019; 72:4 :85-87
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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
Professionalism: New Standards For A New Day?

Presenters
Randon Welton, MD
Suzie Nelson, MD
Kelly Blankenship, DO
Holly Van Den Beldt, MD
Erin Crocker, MD

Educational Objective(s)
By the end of this training attendees will be able to:
1. Critique competing models of professionalism
2. Discuss occupational, social, racial, and cultural factors that impact the concept of professionalism
3. Define professionalism when faced with conflicting value systems
4. Develop professionalism training experiences for residents using tools that will be provided

Practice Gap
This modified and updated workshop considers changing conceptualizations and standards for professionalism and how they can be taught and addressed in residency training. Professionalism is an increasingly challenging aspect of psychiatric training, and residencies have been obligated to develop methods for promoting and assessing professionalism among their residents. Unfortunately this ACGME-driven approach has led to overly reductionistic and simplistic views of professionalism. Often professionalism in residency is boiled down to avoiding a series of forbidden behaviors. Residents are often led to consider professionalism as an all-or-nothing trait intrinsic to all physicians. A broader view of professionalism must include occupational, racial, social, and cultural attitudes and realities that impact what is and is not considered professional. It would involve discussions of the many separate, and sometimes competing, facets of professionalism and would describe professionalism more as a spectrum than a dichotomy. A more complex understanding of professionalism would consider the possibility that standards of professionalism may change over time and vary by location and job description and may be impacted by the individual's and organization's social/cultural milieu. Residency programs have a limited array of educational strategies and techniques to promote professionalism. The simplest strategies involve hectoring residents to accept lists of unchanging and unchangeable values or to discuss egregious examples of misconduct. Few of the strategies address complex and competing systems of professionalism.

Scientific Citations
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- Irby, D.M., Hamstra, S.J. Parting the Clouds: Three Professionalism Frameworks in Medical Education. Academic Medicine, 2016; 91: 1606-1611
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Abstract

This updated workshop challenges the notion that “Being a Professional” is a one-size-fits-all concept. Since professionalism is partly defined by the standards of conduct within the local community, professional standards vary over time and may be partly dependent on where the psychiatrist works and their racial, social, and cultural background. We will discuss what residencies can do to understand this broader concept of professionalism and promote professional attitudes and styles of thinking.

We will start by describing a developmental view of professionalism, which asserts that individuals become more professional as they observe, interpret and mimic the standards of care in the community. This leads naturally to conclusions that professionalism is a malleable quantity and defies simple descriptions. As a large group we discuss various theoretical systems of professionalism that vary depending on practice. As a group we will brainstorm how racial, social, and cultural variables might impact applicable standards of professionalism.

Attendees will be asked to review the Professional Commitments found in the Medical Professionalism In The New Millennium: A Physicians’ Charter which has been promulgated by the American Board of Internal Medicine and other prominent organizations. In small groups they will discuss the relative value of these commitments and be asked to generate a prioritized list of these commitments. Within their groups they will be asked to report and defend their rankings. The small groups will also be asked to discuss which, if any, of these priorities are socially, culturally, or racially based/biased.

When some consensus has been reached within the small groups they will be given a series of scenarios describing residents’ conduct and attitudes. They will be asked to evaluate the residents in light of their list of professional commitments. Lessons learned in the small group

will be shared with the large group. Finally we will discuss how these exercises could be adapted for their institutions.

This process mimics a professionalism-training seminar used at some of our institutions. This interactive seminar will provide opportunities for small group discussion, large group discussion, and peer based discussion and learning.

Agenda

- Introduction of Speakers (5 minutes)
- Models of Professionalism (Didactic) (5 minutes)
- Competing Systems of Professionalism (Didactic) (5 minutes)
- Impact of racial, social, and cultural factors on definitions of professionalism – (Large Group Discussion) (10 minutes)
- Reviewing Professional Commitments from Medical Professionalism In The New Millennium: A Physicians' Charter (Didactic) (10 minutes)
- Small Group Discussion of Professional Commitments (10 minutes)
- Small Group Discussion of the Potential for Racial/Cultural Bias in Commitments (5 minutes)
- Small Group Discussion of Professionalism scenarios (15 minutes)
- Large Group Discussion - Reporting from Small Groups – (5 minutes)
- Applying this workshop to your residency (Large Group Discussion) (5 minutes)

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

Presenters
Tanya Keeble, MD
Deborah Cowley, MD
Jed Magen, DO,MS
Kari Wolf, MD
Rashi Aggarwal, MD

Educational Objective(s)
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.

Scientific Citations

1. Mara Pheister, Deborah Cowley, William Sanders , Tanya Keeble , Francis Lu , Lindsey Pershern , Kari Wolf , Art Walaszek , Rashi Aggarwal. Growing the Psychiatry Workforce Through Expansion or Creation of Residencies and Fellowships: The Results of a Survey by the AADPRT Workforce Task Force. Acad Psychiatry. 2021 Jul 22;1-7.
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3. Psychiatry Diversity Leadership in Academic Medicine: Guidelines for Success. Ayana Jordan, M.D., Ph.D., Ruth S. Shim, M.D., M.P.H., Carolyn I. Rodriguez, M.D., Ph.D., Eraka Bath, M.D., Jean-Marie Alves-Bradford, M.D., Lisa Eyler, Ph.D., Nhi-Ha Trinh, M.D., Helena Hansen, M.D., Ph.D., Christina Mangurian, M.D., M.A.S. American J of Psychiatry. 2021; Mar 1; 224-228.
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4. ACGME Common Program Requirements (CPR) (Residency) https://acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2020.pdf
5. ACGME Common Program Requirements (CPR) (Fellowship) https://acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRFellowship2020.pdf
6. Lord JA, Mourtzanos E, McLaren K, Murray SB, Kimmel RJ, Cowley DS. A peer mentoring group for junior clinician educators: four years' experience. Med 2012
7. Shanafelt et al. Career fit and burnout among academic faculty. Arch Intern Med. 2009: 169 (10): 990-995

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
Starting a new program - a practical toolkit

Presenters
Tanya Keeble, MD
Elizabeth Ann Cunningham, DO
Areef Kassam, MD
Rebecca Lundquist, MD
Lindsey Pershern, MD

Educational Objective(s)
By the end of the session participants should be able to:
1. Name 3 funding opportunities available for new program development, track development or program expansion.
2. Give a one sentence rationale for right sizing a program from the beginning – including fellowship
3. Understand several effective approaches to developing scholarly culture in a new program – including faculty development.
4. Outline one faculty and one resident recruitment strategy to enhance diversity that is achievable in your specific residency training setting

Practice Gap
Workforce development is a critical issue in the United States, with many parts of the country without any mental health provider, let alone psychiatrists. By 2030, the supply of psychiatrists is expected to decrease by approximately 27% given the number of psychiatrists entering, leaving, and changing work hours. Demand for psychiatrists is expected to increase by 6% over that timeframe, resulting in an estimated shortage of 21,150 FTE psychiatrists by 2030. In 2019, AADPRT convened a specific taskforce to focus on this issue.

Growth in psychiatry residency development reflects the trend in numbers of medical students applying into psychiatry residency. Nearly three times the number of programs were newly accredited in psychiatry in the last 5 academic years 16-17 through 20-21, than the prior 5-year period.

It is clear from three previous workshops on this subject that AADPRT attendees include those who are in the planning stages of psychiatry residency or fellowship development, initial stages of accreditation, have not yet graduated their first class or are programs considering expansion, track or fellowship development. There are currently few practical resources to help guide new program developers though the novel challenges they face. Errors made during initial program or fellowship development have a lasting impact. Those errors include under-sizing the program, failing to consider desired expansion, fellowship development, or other novel funding sources. Spending inadequate time considering alignment with the sponsoring institution can undermine program strategy and negatively impact faculty and resident recruitment. Exploring community partnerships is critical in diversifying funding and rotation opportunities. New

community programs face challenges in developing of scholarly culture that includes faculty development and teaching, as well as, formal scholarly activity work.

Facilitators in this workshop have successfully steered their programs through these early developmental stages and aim to provide attendees with a community on which they can lean, as they navigate the choppy waters, and exciting times that those early years bring.

Scientific Citations

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6. Growing the Psychiatry Workforce Through Expansion or Creation of Residencies and Fellowships: the Results of a Survey by the AADPRT Workforce Task Force
Mara Pheister, Deborah Cowley, William Sanders, Tanya Keeble, Francis Lu, Lindsey Pershern, Kari Wolf, Art Walaszek, Rashi Aggarwal
PMID: 34292538 PMCID: PMC8296832 DOI: 10.1007/s40596-021-01509-9
Acad Psychiatry. 2021 Jul 22;1-7. doi: 10.1007/s40596-021-01509-9. Online ahead of print.

Abstract

New program development has been on the rise over the past 5 years. This workshop will provide a set of practical tips and resources aimed at helping those in the early planning stages of psychiatry residency and/or fellowship development as well as those programs with initial accreditation or in the early stages of an existing program, and those who are considering track development. The workshop focuses on the stage of development past the needs assessment. It tackles funding models, to include typical CMS funding, grants, VAMC, state and other more recent funding mechanisms, including FQHC and teaching health clinic opportunities. Lastly, it emphasizes direct revenue generating opportunities.

We will discuss ways in which to right size your program from the beginning, sharing some examples of programs that under sized their programs or did not consider fellowship development, as well as an example of a program that anticipated growth, right from the earliest stages of development.

Inadequate focus on development of a scholarly academic culture in a new program is one of the errors many programs make and can impact initial accreditation or result in new program

citations. Faculty development in a new program is often a significant challenge. We will walk you through several ways to approach this and allow for group brainstorming.

Successful initial marketing and a recruitment strategy is a must. Attending to the increased reach of your program given virtual recruitment fairs and social media is essential. Collaborating with the institutional recruitment department is an underutilized way to enhance your success. Being mindful of recruitment strategies to enhance diversity of your program is imperative as it is known that a diverse physician workforce promotes health equity. We will provide a handout to all participants, and facilitate large group discussion.

At the end of the workshop, we will provide details about how to access each of the facilitators for small group discussion on your choice of the following topics: Writing the application and preparing for the site visit (Ann Cunningham). Creating an academic environment in a community program (Tanya Keeble). Tips for navigating the challenges of being a new PD in a new program (Rebecca Lundquist). New Track Development (Lindsey Pershern). Successful resident recruitment and post residency faculty life in a new program (Areef Kassam)

Agenda

5min. Overview of ACGME psychiatry residency program accreditation in the past 5 years: Tanya Keeble. Didactic

10 min. Let's get to know a little about you, your programs, your main challenges what you hope to get out of attending this workshop. Areef Kassam. Poll

15 min. Sponsorship and funding. Tanya/Ann/Lindsey/Rebecca. Didactic and Large group discussion

10min. How to right size your program including fellowship and track development. Ann/Tanya/Lindsey. Didactic and Large group discussion

20min. Creating a scholarly culture. Tanya/Ann/ Rebecca. Didactic and Large group discussion

10 min. Initial marketing and recruitment. Lindsey/Areef. Didactic and Large group brainstorming session

5 mins. Wrap up – Where to meet for small group topic sessions - topics. Areef. Didactic

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

Presenters
Esther Akinyemi, MD
Mara Hoffert, PhD
Anastasia Mortimore
Jennifer Newman
Shivali Patel, MD

Educational Objective(s)
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.

Scientific Citations

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2. Bauchner H. 2021. On Mentoring. JAMA 325:1393.
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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
Recruitment, Teaching, Clinical Care - a Trivalent approach to addressing Diversity, Equity, and Inclusion

Presenters
Shambhavi Chandraiah, FRCP (C), MD, DFAPA
Lillian Houston, FAPA, MD
Irena Bukelis, MD
Taylor Preston, MD

Educational Objective(s)
Learning Objective 1:
Develop or optimize (at their own institution) diversity recruitment and retention strategies for faculty and trainees
Learning Objective 2:
Describe activities that build cultural competency and sensitivity within their department and institution
Learning Objective 3:
Devise proposal(s) to involve institutional, governmental, and community leadership to provide resources (money, time, staff, space) to support and retain diverse clinicians, teachers, and trainees as well as to develop cultural competency curricula and clinics addressing the unique needs of diverse and minority clinical populations such as Appalachian, Hispanic, LGBTQ, transgender, rural, veteran, and others.

Practice Gap
It is recognized and has been reported that simply asking URiM (Under-Represented in Medicine) candidates to apply does not result in success whether at faculty or resident levels. However, institutions with consistently strong, successful recruitment accomplish this at multiple levels that first start at the highest administrative level and utilize aggressive personal recruitment, mentoring, 'grow your own' strategies, and maintenance of a pipeline. URiM residency fairs have also been reported to successfully help advertise URiM presence in residency programs.
Beyond recruitment, training residents to provide culturally competent care requires a structurally and culturally competent curriculum and the knowledgeable faculty to teach it. Clinical exposure to URiM faculty and diverse underserved populations illustrating the impact of allostatic load and social determinants of mental health on development of psychiatric illness and resulting difficulties experienced is important, as is receiving equitable care. The black and brown tax on URiM faculty supervising and mentoring trainees negatively impacts academic progress and often results in a flight from academia.
Lastly, development and maintenance of specialty clinics that address various diverse patient groups requires support at all levels from administrators, faculty, trainees, and staff as well as resources for the unique care needs of a population. The success of such clinics can be compromised by social determinants of mental health of the patients or turnover of the treating clinicians.

This workshop will address the challenges, and strategies that can be used, at the different levels of recruitment and retention of faculty and trainees, along with the curriculum needed to establish and maintain diverse, equitable clinics.

Scientific Citations

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Abstract

Addressing DEI (Diversity, Equity, Inclusion) at the individual and systems level requires both the recognition of the multilevel presence, as well as the concordant opportunities, this provides for interventions for change. Within the academic environment, it is important to emphasize recruitment, retention, education, and direct care which can help ensure a pipeline of future educators, clinicians, and trainees who can provide ongoing minority, diverse, and equitable patient care. Despite the 2009 LCME (Liaison Committee on Medical Education)

standards to increase institutional diversity, AAMC (American Association of Medical Colleges) data show that recruitment of URiM (Under-Represented in Medicine) medical students, while increasing over the past 2 decades (notably for women) still lags significantly, especially for African American males and American Indians/Alaska Natives. A majority of the 2044 US population will belong to a minority group necessitating a greater need for culturally competent, consonant care. A recent study of representation of women and URiM groups in academic medicine over the past 30 years showed a similar improvement for women; but URiM representation, while still lagging far behind, improved more for some specialties than in psychiatry. The ACGME (Accreditation Council for Graduate Medical Education) recently implemented Common Program Requirements for institutions and programs to increase minority recruitment at all levels of graduate medical education including leadership, faculty, and graduate medical trainees.

Addressing DEI in Residency training requires firstly a commitment from the institution to recruitment of individuals (senior administrators, faculty, staff, and residents) who can be part of the modelling, teaching, and learning that can pay forward to addressing these issues in patient care as well. In this workshop, academic leaders (Vice Chairs and Psychiatry and Psychology Program Directors) from psychiatry programs that have won diversity awards will share their formulas for building a culturally competent culture including successful faculty/trainee diversity recruitment/retention, development of a culturally competent didactic and clinical curriculum, and the establishment of specialized clinics targeting the mental health of diverse, minority patients that further builds academic interest, attracts future recruits, and decreases mental health disparities. Brief didactic presentations will be followed by small group discussions where participants can share their different experiences and develop individualized plans to implement at their own institutions to address local inequities in psychiatric recruitment, education, and care.

Agenda

Introduction and Objectives, & Poll 5 min.
Didactic presentation 10 min - AAMC and APA data illustrating current status and trends in diversity of recruitment of medical students, residents/fellows, and faculty. Examples of initiatives from presenters' institutions to improve diversity recruitment and retention will be shared.
Small group discussion 15min -Using the presented data develop at least 1 intervention to increase diversity recruitment at your own institution or program.
Large group debrief 5 min.
Didactic presentation 10 min a) development of a cultural competency curriculum involving faculty and trainees to establish a foundation for cultural sensitivity and competence to care for patients from diverse cultural backgrounds b) establishment of specialty clinics with trainee involvement to further increase cultural competency learning, apply skills learned in didactics, and provide direct care to address mental health inequities c) examples of successes and challenges in the development of collaborations to decrease inequities through shared resources, educational opportunities, multidisciplinary clinics, and other support.

Small group work 20 min - Describe a) 2 opportunities to improve your cultural curriculum from a didactic and clinical rotation perspective b) create a proposal for a new collaboration or clinic to improve mental health care disparities at your local institution or community. Participants will also find a partner to contact in 6 months to discuss roadblocks or successful attainment in implementing their proposal.
Large group debrief - 5 min.
Summary and 3 take home points 5 min.

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

Presenters
Laurel Pellegrino, MD
Aimee Murray, PsyD
Elizabeth Lazaroff, MD
Marla Wald, MD
David Topor, PhD

Educational Objective(s)
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.

Scientific Citations
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2. Sudak DM, Goldberg DA. Trends in psychotherapy training: a national survey of psychiatry residency training. Acad Psychiatry J Am Assoc Dir Psychiatr Resid Train Assoc Acad Psychiatry. 2012 Sep 1;36(5):369–73.
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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
Making Our Residents Better Supportive Therapists

Presenters
Randon Welton, MD
Erin Crocker, MD
Holly Van Den Beldt, MD
Allison Cowan, MD
Jacob Groen, DO

Educational Objective(s)
After attending this workshop the participant will be able to:
1. Promote the use of Supportive Therapy in a wide variety of clinical settings
2. Evaluate residents' provision of Supportive Therapy using standardized assessment tools
3. Provide formative feedback to residents using standardized Supportive Therapy assessment tools
4. Employ these assessment tools in improving Supportive Therapy training

Practice Gap
Supportive Therapy, famously called the "Cinderella of Psychotherapies", can be adapted to a vast array of clinical settings. Clinicians on inpatient psychiatric units, Emergency Departments, Consultations / Liaison Services, and medication management clinics often find it to be the psychotherapy of choice. Despite its ubiquitous nature, little time is spent teaching or formally supervising Supportive Therapy in residency programs. Rather than a powerful, flexible tool for addressing the psychosocial needs of a broad variety of patients, residents frequently consider it be the therapy of last resort. Instead of a set of interventions intended to meet specific treatment goals, it is reduced to simply "being supportive of the patient".

To promote the effective use of Supportive Therapy, residency programs and therapy supervisors need a systematic approach to teaching and supervising Supportive Therapy. The basic underlying principles of Supportive Therapy can be found in a number of recently published texts. Very little guidance exists, however, on supervising Supportive Therapy in clinical practice. Impactful formative feedback relies on repeated, structured assessments comparing the resident's performance to acknowledged standards. The AADPRT Psychotherapy Committee created a series of assessment tools to help supervisors assess resident's performance and provide meaningful feedback. Ultimately these same tools could also be used to supplement training in Supportive Therapy.

Scientific Citations
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- Welton RS, Crocker EM. Supportive therapy in the medically ill: Using psychiatric skills to enhance primary care. Primary Care Companion For CNS Disorders 2021; 23 (1): PMID: 34000137; DOI: 10.4088/PCC.20nr02758

Abstract

This updated workshop will briefly reacquaint attendees with the evidence supporting the effectiveness of Supportive Therapy in the treatment of various medical conditions and mental illnesses. The workshop will focus on tools developed by the AADPRT Psychotherapy Committee to assess resident's provision of Supportive Therapy and using those tools to provide formative feedback to residents. The presenters will explain the forms and attendees will use them to evaluate video examples of resident-supervisor and resident-patient interactions.

The AADPRT Supportive Therapy Rating Scales (ASTRS) assesses the attitudes and interventions used by clinicians who are providing Supportive Therapy. Supervisors can use the ASTRS while watching videos of the residents at work or when observing actual patient encounters. The ASTRS-A provides specific anchor points for evaluating Attitudes and Interactions commonly found in Supportive Therapy including: "Therapeutic Alliance", "Empathy", "Non-judgmental Acceptance", "Active Listening", and "Respect". The ASTRS-S describes 16 different Skills and Interventions that are frequently used in Supportive Therapy. Supervisors can use the ASTRS-S to note if the resident used an appropriate intervention, used it especially skillfully, or missed an opportunity to use an intervention. These assessments then form the basis for specific, actionable feedback for the trainee. Attendees in small groups will discuss their evaluation of observed resident-patient interactions and the formative feedback they would give to the resident.

New for this seminar will be an increased focus on how these forms can be used to assess and enhance Supportive Therapy provided in medical settings. We will also discuss how these assessment tools can be 'reverse engineered' to develop approaches for training residents to provide Supportive Therapy. The ASTRS forms can help focus attention on the attitudes, approaches, and interventions of Supportive Therapy.

Agenda

- Welcome and Introduction – Didactic - 5 minutes
- Provide evidence supporting the use of Supportive Therapy in various psychiatric condition – Didactic - 5 minutes
- Introduce "AADPRT Supportive Therapy Rating Scales" – Didactic - 10 minutes

- “AADPRT Supportive Therapy Rating Scales” Interactive Exercise 1 – Small Group Discussion - 20 minutes
- Using the ASTRS in medical settings – Large Group Discussion – 5 minutes
- “AADPRT Supportive Therapy Rating Scales” Interactive Exercise 2 – 15 minutes
- Using these forms to supplement training in Supportive Therapy – Large Group Discussion - 5 minutes
- Questions and Comments – Large Group Discussion - 10 minutes

Title
Geriatric Psychiatry Education: Best Practices and Resources

Presenters
Mary Camp, MD
Erica Garcia-Pittman, FAPA, MD
Badr Ratnakaran, MBBS
Uma Suryadevara, MD
Esther Akinyemi, MD

Educational Objective(s)
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.

Scientific Citations

1. Institute of Medicine (U.S.), Committee on Mental Health Workforce for Geriatric Populations. In: Eden J, editor. The mental health and substance use workforce for older adults : in whose hands? vol. xxiii. Washington, D.C: National Academies Press; 2012. p. 372.
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11. Bartels SJ, Naslund JA. The underside of the silver tsunami--older adults and mental health care. N Engl J Med. 2013;368:493–496. doi: 10.1056/NEJMp1211456

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
Equity for All: Bringing an Interactive Course on Equity Mindsets to a Diverse Group of Learners and Educators

Presenters
Debra Forrest, MD
Ashley Walker, MD
Christin Drake, MD
Michael Mei, BA, BS, MD

Educational Objective(s)
At the end of this session, participants will be able to:
1. Recognize the value of teaching and taking a course on equity mindsets.
2. Utilize freely available tools to facilitate a course on equity mindsets.
3. Adapt a course on equity mindsets to the specific learning needs and potential challenges of their department, division, or program.

Practice Gap
Many leaders in medicine do not have a regimented or recurring way to facilitate learning and discussion amongst their departments on the topics of Equity and Diversity. This course provides a simple framework for leading such a course, and adapting it for audiences at various stages of training and professional backgrounds within healthcare.

Scientific Citations
Equity in Progress: Development of Health Equity Curricula in Three Psychiatry Residency Programs. Isom, J., Jordan, A., Goodsmith, N. et al. Acad Psychiatry 45, 54–60 (2021). https://doi.org/10.1007/s40596-020-01390-y

Reich, Justin and Milner, H. Richard IV. "Becoming a More Equitable Educator: Mindsets and Practices," by MIT Teaching Systems Lab, offered through edX ®, and licensed under CC BY 4.0. https://www.edx.org/course/becoming-a-more-equitable-educator-mindsets-and-practices

"Embracing Diversity and Inclusion in Psychiatry Leadership" Kari Simonsen, MD; Ruth Shim, MD, MPH. Psychiatr Clin N Am. 42: 463-471. 2019. ScienceDirect. https://www.sciencedirect.com/science/article/pii/S0193953X19300474?via%3Dihub

Abstract
Each day medical professionals must make numerous decisions: whom to recruit, how to handle clinical situations, and how to engage colleagues and learners with different strengths and needs across a range of settings and platforms. These day-to-day choices take place amidst a variable milieu of identities -- those of faculty, staff, trainees, as well as patients -- and a contextual backdrop of seemingly never-ending societal crises. Building awareness of the presence and potential impact of these moments (and skills to navigate them!) takes courage and practice. Although equity training exists for businesspeople and educators at large, less

programming is designed specifically for the needs of medical practitioners, and there is even less that is geared to the specific situations faced by resident trainees. The online course "Becoming a More Equitable Educator: Mindsets and Practices," was designed by the MIT Teaching Systems Lab to help kindergarten through 12th grade educators develop equity mindsets, and it has previously been adapted to include content relevant to psychiatric training directors. In this workshop we share the experiences of those at different institutions who have further adapted the content for a variety of clinicians and learners, to meaningfully bring this material to an array of audiences with unique needs. Workshop attendees will experience some of this new content and discuss challenges and potential solutions to the process of adapting it to new audiences, including residents and non-physician clinicians. Participants will then begin envisioning how they can make their own adaptations to bring equity mindsets back to their own settings, and facilitate discussions in pursuit of equity for all.

Agenda

This workshop is designed for anyone who wishes to facilitate mindsets, discussions, and practices around equity and inclusion in their own settings. Participants will engage via a variety of active learning techniques, including case vignettes, small and large group discussions, and multimedia.

- Introduction (10 min)
- Equity Mindset Course Experience Using Video, Vignette and Discussion (25 min)
- Large Group Discussion on Adapting the Course (15 min)
- Individual and Paired time to Plan Implementation (15 min)
- Large Group Debrief and Q&A (10 min)

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

Presenters
Melissa Buboltz, MD
Michael Sean Stanley, MD

Educational Objective(s)
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.

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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
The Grief Toolkit: A Program Director's Guide to Fostering Resident Wellness During Challenging Life Events

Presenters
Daniel Knoepflmacher, MD
Ariella Dagi, MD
June Elgudin, MD
Shoshana Weiner, MD

Educational Objective(s)
1. Define grief events and review current data, including from the COVID-19 pandemic, about the need for a standardized approach to supporting residents during a crisis.

2. Review the Grief Events Toolkit ("Toolkit") and explore approaches to implementing the Toolkit that fit with a training program's existing resources and needs.

3. Identify ways in which the Toolkit can empower program directors to support individual residents while also functioning as a broader wellness initiative within training programs.

Practice Gap
Grief events are an unfortunate but ubiquitous element of graduate medical education given the length and intensity of training programs and the realities of life. Grief-inducing events may include many different kinds of circumstances, such as the death of a loved one, an experience of illness, a divorce, or even a significant loss in a clinical setting. In the context of increasing trainee burnout and elevated rates of depression and suicide in medical professionals relative to the general population, grief events go largely unrecognized as potentially key, modifiable risk factors for these negative outcomes.

Program directors are in a unique position to help support residents experiencing grief events. Yet no formal guidance exists for training institutions to respond to such events. A systematic and thoughtful response from program directors has the potential not only to protect individual trainee's mental health but also to prevent burnout and improve wellness across the training program.

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Watson P. Caring for yourself & others during the COVID-19 pandemic: managing healthcare workers' stress. Schwartz Center for Compassionate Healthcare webinar. March 24, 2020. https://www.theschwartzcenter.org/webinar/caring-for-yourself-others-during-the-covid-19-pandemic-managing-healthcare-workers-stress/

Abstract

Despite the widespread occurrence of grief events during resident training, there is no formal guidance on addressing them. The manner and extent to which residents are supported during a time of acute stress impacts their coping, recovery, and patient care. Data from the COVID-19 pandemic suggests that proactive institutional support initiated before and delivered throughout a crisis increases the odds that an individual will recover and thrive rather than develop burnout, or even depression, anxiety, post-traumatic stress, or other psychiatric morbidities.

The goal of this workshop is to equip participants with a structured but flexible guide to addressing resident grief events within their institutions. To start, we will define grief events and review relevant existing literature. Utilizing the polling functionality of our platform, workshop participants will engage in a survey to describe and consider their current institution’s manner of handling resident grief events. We will then present our proposed Toolkit, including a practical framework for interactions with the affected resident with customizable components to fit individual program needs. With tools in hand, we will utilize break out rooms to stimulate small group discussions about participant experiences in dealing with such events, current practices, and ways in which the Toolkit could be implemented and adapted to fit their institution. We will conclude with a large group debrief to focus on take-home points for the successful implementation of grief event response initiative as well as answer any remaining participant questions.

Residency programs can help prevent burnout and improve the mental health and wellbeing of their trainees by establishing a proactive and systematic approach to responding to grief events. This interactive workshop lays a foundation and provides practical, customizable guidance for program directors to do so.

Agenda

0:00-0:05 - Introductions, background, and poll of participants

0:05-0:25 - Presentation of the Toolkit (document will be available through AADPRT website)

0:25-0:55 - Break out room discussions led by presenters on current practices across programs, use of the Toolkit, current gaps, and adaptation of the toolkit to fit individual programs

0:55-0:65 - Large group review and discussion

0:65-0:75 - Question and answer session

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.

Presenters

Neha Hudepohl, MD
Megan Zappitelli, MD
Raphaela Fontana, DO

Educational Objective(s)

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

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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
Meaning and Medication: Teaching the Psychosocial Dimension of Psychopharmacology

Presenters
David Mintz, MD,DFAPA
Laura Warren, MD
Kristofer Joondeph-Breidbart, MD

Educational Objective(s)
At the conclusion of this workshop, participants should be able to:

1) Teach students to consider the impact of psychosocial variables on pharmacologic treatment outcomes.
2) Support the development of effective and patient-centered pharmacotherapeutic alliances.
3) Teach basic psychotherapeutic interventions to enhance patients' capacities to make healthy use of pharmacotherapy.
4) Describe how a focus on the psychosocial dimension of pharmacotherapy can affect resident development and identity.

Practice Gap
While a focus on teaching evidence-based pharmacotherapy has enhanced the training of psychiatrists, in practice this evidence-based focus is often restricted to matching symptoms or diagnoses with proven medications. There is another, oft-neglected evidence base that provides guidance about psychosocial aspects of the prescribing process that contribute meaningfully to treatment outcomes. Learning how to prescribe may contribute as much or more to positive outcomes as learning what to prescribe.

Further, the evidence base for many (or most) medications is established with patients who are often not representative of the patients that make up the caseloads of psychiatrists. Our patients are frequently more complex and carry more co-morbidities than patients who meet criteria for inclusion in clinical trials. A narrow focus on matching diagnoses with medications often does not prepare residents to address complex and comorbid patients whose psychology represents major barriers to the healthy use of psychiatric treatment.

In this workshop, we will address the implications of including a module on the psychosocial dimension of pharmacotherapy within the core psychopharmacology curriculum, including reflecting on the goals of pharmacotherapy and the relation of those goals to patient-centeredness. We will consider the evidence base that provides guidance about how to prescribe to optimize pharmacotherapy outcomes. Lastly, we will consider how to identify and address psychological factors in the patient that interfere with optimal use of pharmacotherapy.

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Abstract
While advancements in the field of psychopharmacology have offered more options for prescribing and the promise of precision medicine, this can also give rise to the psychiatry resident's "grandiose professional self" (Brightman, 1984). Focusing singularly on what to prescribe can lead to a "delusion of precision"(Gutheil, 1982), where medications are treated as if their actions are simply precise, concrete, straightforward and specific. This can leave residents unprepared for the complex relationships that arise between them and their patients with regard to prescribed medications, including nonadherence to medication, lack of treatment response, and negative transferences to caregiving. Instruction in the psychosocial aspects of pharmacotherapy can thus lead both to improved medication outcomes and decreased resident distress.

Traditionally psychiatry residency program curricula have taught the fundamentals of what to prescribe well, especially where there are specific society guidelines. In contrast to this, there are often deficits when it comes to topics where there is more nuance and guidelines are less clear (Georgiopoulos, & Huffman, 2005). These gaps are perhaps most meaningful when prescribing for complex, comorbid patients who are typically excluded from those studies on which the evidence base is built. Residents have specifically requested increased teaching on the "dynamic issues arising in the course of short psychopharmacology visits." (Georgiopoulos, & Huffman, 2005).

Recent articles have focused on encouraging diverse methods of teaching psychopharmacology including problem based learning , games, patient centered learning, journal clubs, and web based learning (Zisook et al, 2005), but they have still emphasized the learning of symptoms and side effects over the psychodynamics of prescribing. Recommendations for improving the pedagogy of psychopharmacology have noted the "art" of prescribing psychotropics is also insufficiently emphasized in psychopharmacology training and requires teaching residents about the broader context of a patient's symptoms and disorders rather than focusing only on a DSM-driven symptom checklist (Glick et al, 2007).

In this workshop, we will describe the approach developed at Cambridge Health Alliance's adult psychiatry residency to address these needs. After briefly describing some of the evidence base establishing the importance of psychosocial factors for positive pharmacotherapy outcomes, we will describe the process and reasoning for developing a curricular unit on "the psychosocial dimension of psychopharmacology." We will then discuss the curriculum that was developed from the perspective of the teacher and the course director, and explore other possible approaches for teaching an evidence-based prescribing process. Lastly, we will explore a resident's perspective on the experience of learning in this unit, including implications for skill acquisition, professional identity, and burnout prevention.

The structure of the workshop will leverage the expertise and experience of the group, and allow ample time for discussion.

Agenda

0-10 minutes
Exercise – Clinical vignette: What skills would you want your residents to have to optimize treatment outcomes?

10-20 minutes
Meaning & Medication: A brief introduction to the evidence base

20-25 minutes
Discussion: How have you tried to integrate teaching the psychosocial dimension of pharmacotherapy in your residency program?

25-35 minutes
Course Director perspective: Rationale for beginning PGY-3 Psychopharmacology Seminar with this approach

35-45 minutes
Discussion: Barriers to implementation (Large group discussion if in person, small group if virtual)

45-55 minutes
Designing a course: Where, When, & What (Large group discussion).

55-65 minutes
The Learners' Experience

65-75 minutes
Discussion and workshop evaluation

Title

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

Presenters

Zheala Qayyum, MD
Marguerite Schneider, MD, PhD
Hun Millard, MD
Jeffrey Hunt, MD

Educational Objective(s)

- 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

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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
Graduate Medical Education Financing Made Less Complex

Presenters
Jed Magen, DO,MS
Krystle Graham, DO
Emily Schnurr, DO
Sarah Mohiuddin, MD

Educational Objective(s)
Objective:
Training Directors and program coordinatorswill understand:
1. Graduate Medical Education Funding mechanisms
2. consequences of current funding structures for rural health care, consequences of funding structures for minority health care
3. how hospitals and programs may respond to regulatory changes and to changes in funding levels.
4. various program strategies given decreases in funding levels

Practice Gap
1. Program directors and program coordinators have a poor understanding of how residency programs are funded and are not equipped to respond to program funding cuts with creative solutions.
2. community based programs, especially those in rural areas have fewer to no individuals with expertise in funding issues.

Scientific Citations
The Basics of GME Finance for Program Directors https://www.cothweb.org/wp-content/uploads/Basics-of-GME-Finance-for-Program-Directors.pdf
The Graduate Medical Education Compliance Project https://gmecomplianceproject.org/

Abstract
Graduate Medical Education programs rely heavily on Medicare funding mechanisms. Caps on hospital residency numbers decrease flexibility to change numbers and other regulations increasingly constrain programs. Funding cuts in a COVID environment are common. Congressional action on GME has also increased some funds for some kinds of programs, principally teaching health center and rural programs. This seminar will help training directors understand current basic mechanisms of program funding, review recent GME regulatory changes and discuss how GME funding has historically adversely impacted rural programs, and poor and minority communities.

The following topics will be discussed:
1. The Basics of Graduate Medical Education Funding
    a. direct GME costs/reimbursement

b. indirect GME costs/reimbursement
c. caps on housestaff numbers and years of training
d. workforce issues
e. contrasts between academic medical center and community based programs. Contrasts between rural and urban programs.

2. Other Sources of Funding
   a. faculty generated revenues when supervising residents
   b. other funding sources (state, local)
   c. "outsourcing", consortiums, other novel responses
   e. Federally Qualified Health Centers and Teaching Health Center grants.

3. Health Care Reform and GME.

Agenda

We will first discuss basics of GME then answer questions. We will break out groups based on cartegories that may include rural/urban/teaching health center/academic medical center/community based by informally polling the group to ascertain which groups are of interest. Breakout groups will have stimulus scenarios to discuss.

Title
Brain-ival! Using Interactive Games to Teach Neuroscience

Presenters
Adriane dela Cruz, PhD, MD
Lindsey Pershern, MD
Bernice Yau, MD
Joseph Cooper, MD
David Ross, PhD, MD

Educational Objective(s)
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
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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
Direct Observation/Structured Feedback in Competency-Based Education

Presenters
Michael Jibson, MD, PhD
Erick Hung, MD
Moataz Ragheb, MD, PhD
Julie Sadhu, MD
John Q Young, MD, PhD, MPH

Educational Objective(s)
- Participants will appreciate the critical role that direct observation and structured feedback plays in competency-based instruction and assessment.
- Participants will understand the key, evidence-based features of an effective direct observation and structured feedback program.
- Participants will identify one goal for improvement in their own programs and outline a plan to address it.

Practice Gap
In the past two decades, the importance of competency-based medical education and outcomes has been emphasized by professional associations, regulatory bodies, and credentialing organizations, including the AAMC, ACGME, and ABPN, to ensure that graduates of our medical education system both possess and utilize the knowledge, skills, and attitudes necessary to function optimally in contemporary care delivery systems. Despite widespread agreement among educators on the desirability of these goals, programs use relatively few competency-based teaching and assessment tools, most faculty have little, if any, formal training in their use, standardization is limited, and the potential for both implicit and explicit bias exists, all of which can skew both formative feedback and summative assessment decisions. Direct observation and structured feedback are two components of workplace-based assessments that allow trainees to demonstrate “how” and “what” they do in clinical encounters, not merely what they “know” and “know how” to do in theory. Yet, even direct observation and feedback have been criticized not only for their infrequency in clinical training programs, but also for a lack of consistency in their purpose and implementation. Thus, residency programs face the challenges of building a set of valid observation and feedback tools, as well as training and motivating faculty to use them optimally.

Scientific Citations
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Young JQ, Sugarman R, Schwartz J, O’Sullivan PSl. Overcoming the Challenges of Direct Observation and Feedback Programs: A Qualitative Exploration of Resident and Faculty

Experiences. Teach Learn Med 2020; 32:541-51.
https://doi.org/10.1080/10401334.2020.1767107.

Norcini J, Anderson MB, Bollela V, et al. 2018 Consensus framework for good assessment. Med Teacher 2018; 40:1102-09. DOI: 10.1080/0142159X.2018.1500016.

Abstract

In this workshop, participants will examine the role of direct observation/structured feedback as a tool for competency-based assessment, identify threats and best practices regarding its implementation and validity, conduct a systematic assessment of their own programs, and outline 1 goal and implementation plan for their programs. Presenters will provide data, vignettes, and expert guidelines on the use of direct observation/structured feedback tools. Presenters will facilitate participants' evaluation of and goals for their own programs with specific prompts for reflection and group discussion.

Agenda

30 Minutes: Overview of the role of direct observation/structured feedback as a tool for competency-based assessment, and threats and best practices regarding its implementation and validity.

30 Minutes: Small groups (3-5 participants) will evaluate and discuss their own programs with specific prompts for reflection and discussion.

15 minutes: Large-group debriefing, Q&A.

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

Presenters
Adriane dela Cruz, MD, PhD
Paul Carlson, MD
Lindsey Pershern, MD
Lia Thomas, MD

Educational Objective(s)
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
Racism: A Mental Health Crisis An Approach to Teaching Antiracism & Cultural Intersectionality as it pertains to Race in The UTSW Psychiatry Clerkship

Presenters
Kathlene Trello-Rishel, MD
Danielle Morelli, MD
Evelyn Ashiofu, MD,MPH
Sarah Baker, MD
Lia Thomas, MD

Educational Objective(s)
At the end of this workshop, participants will be able to:

Learning Objective 1: Feel more prepared and confident exploring and implementing a framework for teaching antiracism at the participants' own institutions as well as reflecting on barriers to implementation.

Learning Objective 2: Reflect on one's own identity and personal biases surrounding people of color and other vulnerable populations and how they influence patient care.

Learning Objective 3: Recognize historical health disparities and events and their contributions to racism as a social determinant of mental health.

Learning Objective 4: Define and identify specific types of microaggressions and understand the additive impact of microaggressions on mental health outcomes and impact at respective institutions.

Learning Objective 5: Identify Cultural/Minority Stress from development to adulthood and recognize how it contributes to adverse mental health outcomes.

Practice Gap
Amidst the national civil rights movement galvanized by the killings of Breonna Taylor, George Floyd, and Ahmaud Arbery, there is growing awareness of the need for enhanced teaching on racism, antiracism, and cultural intersectionality and humility within medical education. Educators at UTSW developed an approach for teaching antiracism and cultural intersectionality, with the goal of creating a culture shift that prepared trainees, faculty, and staff to advocate for those facing healthcare disparities and discrimination. By recognizing racism's influence on the personhood of others, we aimed to instill an approach to medical education and lifelong learning that is more inclusive and oriented toward moral action and advocacy.

Incorporation of antiracism initiatives at institutions is often met with fear, intimidation, lack of support, and often implemented in the way of special seminars and one-time-a-year events.

However, this approach has long run its course and is no longer sufficient. In an Academic Medicine article, they discuss how an important component to creating antiracism curricula is moving away from checklists and "competency" and moving towards frameworks that emphasize lifelong learning and "continuous growth." One goal of this workshop is to provide a working space to discuss the history and rationale behind these challenges. Another goal is to provide a successful model of incorporating antiracism work in an interactive, digestible, and sustainable way that participants can bring back to their own institutions. Lastly, we hope to empower colleagues to dig deep and create a brave space for this work.

Scientific Citations

1. Hays, Pamela A. Addressing Cultural Complexities in Practice, Second Edition: Assessment, Diagnosis, and Therapy. American Psychological Association Overview (2008)

2. Sue DW, Capodilupo CM, Torino, GC, Bucceri JM, Holder AMB, Nadal, KL, Esquilin, M. Racial Microaggression in Everyday Life. American Psychologist (2007)

3. Kendi, Ibram X. Stamped from The Beginning (2016)

4. Metzl, Jonathan. The Protest Psychosis (2009)

5. The New York Times Magazine. 1619 Project and Podcast (2019) (https://www.nytimes.com/2020/01/23/podcasts/1619-podcast.html)

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8. Proctor SK, Williams B, Scherr T, Li K. Intersectionality & School Psychology: Implications for Practice. National Association of School Psychologist (2017) (https://www.nasponline.org/resources-and-publications/resources-and-podcasts/diversity-and-social-justice/social-justice/intersectionality-and-school-psychology-implications-for-practice)

9. Owen, J, Rinane JM, Tao KW, Adelson, J. An Experimental Test of Microaggression Detection in Psychotherapy: Therapist Multicultural Orientation. American Psychological Association. (2018)

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11. Argueza BR, Saenz SR, McBride D. From Diversity and Inclusion to Antiracism in Medical Training Institutions. Acad Med. 2021 Jun 1;96(6):798-801. doi: 10.1097/ACM.0000000000004017

Abstract

Background

At our institution, we have a recurring 2.5-hour educational activity where students, residents, and faculty discuss mental health disparities, racism and its impact on Black Americans. The activity includes pre-preparation with identity exercises, brave space guidelines, media pieces, and information on retraumatization. During the activity, participants first listen to didactics on racism in America and the types of racism and microaggressions as they relate to social determinants of health. Then, there is an interactive portion, which highlights vulnerable populations through life stories, where participants are asked to identify microaggressions and cultivate empathy for minority stress. The activity ends with the provision of community resources to participants.

During our proposed AADPRT workshop, we will take participants through an abbreviated version of the UTSW workshop while also exploring barriers to implementation of antiracism efforts.

Methods

First, there will be an introduction reflection on antiracism curricula and its challenges using Poll Everywhere to engage attendees. Then, there will be a didactics presentation on UTSW's antiracism workshop to provide a specific example of a fully developed and implemented model. Next, attendees will participate in a group activity of an abridged version of the UTSW antiracism workshop, which will include didactic information in a large group setting and critical thinking-empathy exercises in a small group breakout setting. Facilitators will work closely with each small group to reflect on real life stories that focus on intersectionality, racism, social determinants of health, and minority stress. Finally, participants will return to the large group to brainstorm solutions and consider how to bring back/adapt the activity to their respective programs/departments

Agenda

Session Format

- Large Group Introductory Reflection Exercise on Antiracism: 15 mins

Participants will be prompted to use Poll Everywhere to create two different word clouds on how institutions have incorporated antiracism and cultural humility/intersectionality into their curricula and then another on challenges. Presenters will guide a reflective discussion on the proposed challenges to incorporation.

- Didactics: 10 mins

Presenters will review the UTSW Antiracism Workshop including outlines, goals, objectives, manual description, case examples, and preliminary data. Presenters will also discuss mechanisms of implementation as well as challenges/barriers.

- Group Activity: 50 mins

Participants will participate in an abridged version of the UTSW workshop, including individual and small group critical thinking and reflective empathy exercises:

- Part I (10 mins): In a large group setting, provide didactic information on Racism in America & Types of Racism & Microaggressions in order to provide participants with a basic overview and understanding of these concepts to prepare them for the small group activity.

- Part II (25 mins): Vulnerable Population Small Group Activity on social determinants of health and minority stress (each small group would focus on a different vulnerable population, i.e. LGBTQIA+, Childhood, Trauma & Development, Poverty & Food Insecurity). Participants will be tasked with reading through a real life experience of an individual from the above vulnerable populations and identify the micro and macroaggressions present in the scenario. Participants will then reflect on the scenario through consideration of reflection questions.

- Part III (15 mins): Return to the large group setting for discussion and recap of the vulnerable populations small group discussions. Participants will then reflect on the session, provide feedback, and consider how to bring back/adapt the activity to their respective psychiatry programs/departments, using the group to brainstorm solutions to possible barriers to implementation.

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

Presenters
Paula Wadell, MD
Anne McBride, BA, MD
Alan Koike, MD, MS
Daniel Gih, DFAPA, MD, DFAACAP
Brianne Newman, MD

Educational Objective(s)
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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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
How to meet ACGME scholarly requirements if your program is not affiliated with a research organization

Presenters
Kathleen Crapanzano, MD
Sandra Batsel-Thomas, MD
Krystle Graham, DO
Natalie Hunsinger, MD
Mareen Dennis, MA

Educational Objective(s)
By the end of the presentation, attendees will be
1. Motivated to turn their current work into a scholarly project
2. Able to operationalize several pathways to meet ACGME scholarly requirements despite a pack of research infrastructure
3. Capable of mentoring other faculty members and residents in developing an array of scholarly products
4. Willing to set scholarly goals for self and assist other core faculty in doing the same

Practice Gap
Some institutions have well developed research programs that provide natural pathways for faculty to meet ACGME scholarly activity goals. But many new programs are not associated with a developed research or academic program, do not have faculty with a track record of research, and struggle to meet the ACGME scholarly activity goals. Clinical demands and a lack of faculty protected time can make things even more complicated. Other potential obstacles such as lack of "scholarly faculty" to mentor junior faculty and residents and a lack of funding for research projects are other complications

Scientific Citations
Balon R. Observations: will the ACGME faculty scholarly activity requirements promote dishonesty among program directors? J Grad Med Educ. 2015;7(2):299

Seehussen DA, Asplund CA, Friedman M. A point system for resident scholarly activity. Fam Med. 2009;41(7):467-9
Waheed A, Nasir M, Azhar E. Development of a Culture of Scholarship: The Impact of a Structured Roadmap for Scholarly Activity in Family Medicine Residency Program. Cureus.202;12(3):e7153

Abstract
Many community programs struggle to meet the scholarly activity requirements for the ACGME, but there are methods and resources that programs can utilize to meet and exceed them. Programs can parlay educational innovations into posters for meetings, educational outcomes research and the materials can be published through meded portal or medical

education journals. Presentations within and without the institution can be developed. Connections with universities in the community can result in unexpected collaborations. Pubmed ID's can be obtained from letters to the editor or sometimes book reviews.

Getting faculty to share the vision of meeting the goals is critical. Not all faculty need to publish-- but each can contribute something to the academic mission and it can be easier than one thinks!

Agenda

0-10 Introductions and setting the stage
10-25 What is scholarly activity? (Didactic presentation)
25-35 Obstacles to Scholarly Activity in non-research institution (Brainstorming)
35-55 Innovative ways to meet requirements (Small groups discussions with each group leader demonstrating a different approach to scholarly activity. Attendees will move between groups to get exposure to all approaches)
55-60 Resources (Handouts with ideas in each of the scholarly domains and ways to get them done)
60-75 Questions, evaluation

Title

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

Presenters

Sanya Virani, MD
Tanner Bommersbach, MD
Robert Cotes, MD
Donna Sudak, MD
Vishal Madaan, DFAACAP, MD, DFAPA

Educational Objective(s)

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
Coaching Psychiatry Trainees on Their First Job Hunt

Presenters
Daniel Gih, DFAPA, DFAACAP, MD
Jeana Benton, MD
Sara Zachman, MD
Laura LaPlante, MD
Sandra Batsel-Thomas, MD

Educational Objective(s)
Appraise various transition to practice activities that are used within training programs.
Build a longitudinal curriculum that can be adapted to different training programs.
Anticipate individual needs for both trainees and faculty regarding professional development and career placement.

Practice Gap
In exploring a myriad of employment opportunities, many trainees encounter difficulties preparing, screening, and eventually selecting their primary place of employment after graduation. Faculty members are often ill-equipped due to a lack of knowledge or limited experience regarding employment trends and current pressures trainees face in their first professional job search. Limited literature exists for guidance in psychiatry. Studies in other areas of medicine, including Cardiothoracic Surgery and Radiation Oncology, indicate that senior residents and recent graduates wanted more support and resources for the various transition to practice topics, including the identification and comparison of job opportunities, contract negotiation, practice management, and financial planning. Finally, the current pandemic has changed recruitment for both prospective residents and job seekers. Recent reflections and experiences on an all-virtual job search will be discussed.

Scientific Citations
Gih, D. E. (2016). Guiding Psychiatry Trainees on Their First Job Search. Academic Psychiatry, 41(3), 423–426. doi:10.1007/s40596-016-0618-8.
Best LR, Sengupta A, Murphy RJL, de Metz C, Trotter T, Loewen SK, Ingledew PA, Sargeant J. Transition to practice in radiation oncology: Mind the gap. Radiother Oncol. 2019 Sep;138:126-131. doi: 10.1016/j.radonc.2019.06.012. Epub 2019 Jun 25. PubMed PMID: 31252294.
Sterbling HM, Molena D, Rao SR, Stein SL, Litle VR. Initial report on young cardiothoracic surgeons' first job: from searching to securing and the gaps in between. J Thorac Cardiovasc Surg. 2019;158:632-41.
Association of American Medical Colleges. Medical Student Education: Debt, Costs and Loan Repayment Fact Card for the Class of 2020. https://store.aamc.org/downloadable/download/sample/sample_id/374/. Accessed 27 Oct 2021.

Abstract
Psychiatry residents and fellows spend almost a decade after college in medical education and postgraduate training while incurring significant debt. Training culminates with a transition to independent practice. The trainee's first job out of training should optimally match the trainee's needs and demands. However, trainees are often unprepared to navigate the vast array of employment opportunities, and faculty members may be equally ill-equipped to guide them. The workshop will offer several practical examples and meaningful activities designed to assist programs to support trainees as they embark on their careers.

The first half of the workshop will consider the job seeker's needs and generate ideas for potential didactics and activities for a transition to practice series that span the course of training. Consideration and timing of topics such as professionalism, financial pressures, and licensing will be explored. The audience will divide into groups, and members will assemble a potential model curriculum using team feedback. Results will be compared to existing didactics from member institutions.

The second half will reflect more on the individualized needs of faculty and program staff, which help improve the transition and confidence in the job search process for trainees. Case examples will be used to draw out common scenarios. Finally, training program characteristics, such as setting and size, may inform what professional development opportunities are possible and how to coach a program's trainees better.

Agenda

- Facilitated Group Discussion 1: Introduction of workshop facilitators, presentation of common issues in training, as it pertains to first job search (10 minutes)
- Small group activity 1: brainstorming ideas and construction of a sample curriculum (20 minutes).
    - Attendees will individually build a list of topics for didactics.
    - They will then join with a small group of other attendees to debate, prioritize, and order a sample curriculum of 10 classes that could be delivered over a four-year period. (Some ideas will be eliminated or absorbed by other ideas.)
- Facilitated Group Discussion 2: coaching/individualizing the experience for the upcoming graduate (10 minutes)
- Small group activity 2: example cases (20 minutes). Each case will be designed to feature common dilemmas such as imposter syndrome, biases, and decision-making.
- Facilitated Group Discussion 3: questions and discussion, completion of the evaluation form (15 minutes)

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

Presenters
Joseph Cooper, MD
David Ross, MD,PhD
Bernice Yau, MD

Educational Objective(s)
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
Maps, Games, and Formulations: Educating Trainees and Faculty to Address Social Determinants of Mental Health

Presenters
Ana Ozdoba, MD
Brigitte Bailey, BS,MD
Sarah Mohiuddin, MD
Francis Lu, MD
Paul Rosenfield, MD

Educational Objective(s)
Define social determinants of mental health and demonstrate how they contribute to mental illness severity and health disparities

Understand the importance of teaching psychiatry trainees how to assess and address social determinants of mental health

Explore different interactive teaching strategies utilized by residency training programs nationally to teach trainees how to assess social determinants of health and consider their impact on case formulation and treatment options

Discuss some of the opportunities and challenges addressing social determinants of health in the clinical setting

Discuss the importance of implementing training on the social determinants of mental health training for all mental health providers.

Practice Gap
It has become more evident in recent years that social determinants of health impact the experiences of our patients with mental health disorders, the systems in place for them to seek care, and the outcomes they achieve. Trainees and clinicians in academic institutions often feel ill-equipped to assess and address social determinants of health in a meaningful way. Some academic and training programs around the country have developed engaging teaching strategies to educate residents and staff on social determinants of health. In addition, these programs have developed strategies to help clinicians incorporate this discussion into the patient encounter. However, many training programs do not provide significant or adequate teaching on social determinants of health and trainees do not feel prepared to address them. Our goal is to share a framework and specific strategies for how psychiatrists and other mental health clinicians can be taught to assess and incorporate social determinants of health into patient care, which we anticipate could improve quality of care and patient outcomes.

Scientific Citations

1) Compton, M.T. and Shim, RS (2015). The Social Determinants of Mental Health. Arlington, VA: American Psychiatric Publishing.
2) Hansen, H., Braslow, J., & Rohrbaugh, R. M. (2018). From Cultural to Structural Competency—Training Psychiatry Residents to Act on Social Determinants of Health and Institutional Racism. JAMA Psychiatry, 75(2), 117. doi: 10.1001/jamapsychiatry.2017.3894
3) O'Brien, M. J., Garland, J. M., Murphy, K. M., Shuman, S. J., Whitaker, R. C., & Larson, S. C. (2014). Training medical students in the social determinants of health: the Health Scholars Program at Puentes de Salud. Advances in medical education and practice, 5, 307–314. doi:10.2147/AMEP.S67480
4) APA Resource Document on Social Determinants of Health (https://www.psychiatry.org/File%20Library/Psychiatrists/Directories/Library-and-Archive/resource_documents/Resource-Document-2020-Social-Determinants-of-Health.pdf)

Abstract

As mental health providers, it is essential to understand how social determinants of mental health play an important role in the lives of those struggling with mental illness. Social determinants of health and structural racism have affected the lives of our patients and introduce disproportionate medical and mental health risks. This makes it essential for us, as psychiatrists, to assess and address social determinants of mental health in clinical practice. Residency training programs have increased their efforts to address social determinants of health and how these impact daily life and mental health treatment. This general session aims to share how residency training programs across the country are tackling the task of including social determinants of health as part of the discussion in assessing and treating patients with mental illness. We will review the creative approaches used in residency training programs across the country, including our four programs: Adult Psychiatry Programs at Mount Sinai Morningside/West and Montefiore Medical Center, and Child and Adolescent Programs at the University of Texas Health, San Antonio, and University of Michigan Health System. We will share how community mapping can be used as a way to explore social determinants of health and understand how these impact the patients and their psychiatric treatment. We will discuss the role of racism, bias, and social structures, which together with social determinants of health, impact the outcomes for our patients. We will also provide techniques of how to use community mapping in the therapeutic space with the patients. We will discuss how to incorporate the social determinants of health as part of your biopsychosocial formulation and part of your treatment planning. We will share creative approaches to discussing social determinants of health, using a game created at one of our residency training programs and incorporating community tours to understand the strength of our surrounding communities. Finally, we will discuss challenges our programs have encountered when teaching about social determinants of health. These concepts and strategies will be shared to help introduce mental health providers in the clinical setting on how to incorporate social determinants of mental health into clinical assessments and management of our psychiatric patients for both trainees and faculty.

Agenda

Introduction to importance of Social Determinants of Mental Health in Psychiatry (10 min)
Discuss Initiatives to teach and implement Social Determinants of Mental Health across the country (10 min)
Discuss Specific Teaching Strategies (10 min)
Break into groups to use some of the teaching strategies (30 min)
Discuss challenges of Teaching (15 min)
Discussion/Q&A (15 min)

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

Presenters
Julie Sadhu, MD
Erick Hung, MD
Moataz Ragheb, MD, PhD
John Q Young, MD, MPH, PhD

Educational Objective(s)
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
Getting Started With Global Mental Health and Health Equity

Presenters
Arya Soman, DFAACAP, MD
Theddeus Iheanacho, MD
Gabriela Ruchelli, MD
Sirikanya Sellers, MD
Paul Eigenberger, MD

Educational Objective(s)
Participants will:
Name at least 2 key steps to building a successful global mental health elective
Learn how to incorporate telehealth into clinical global mental health electives
Leave with a toolset for incorporating Global Mental Health initiatives in their curriculums
Identify at least one step they can take towards beginning global health experiences in their training programs

Practice Gap
Longstanding socioeconomic inequities have led to profound disparities in psychiatric health and healthcare delivery. Whether considering race, ethnicity, income or other sociodemographic factors, the psychiatric workforce does not reflect the patients and communities it serves1. Furthermore, trainees and attendings who are underrepresented in medicine often find medical institutions to be unwelcoming2. Finally, many graduates choose to practice in settings that do not take insurance, public or private. For this and many more reasons, it is imperative that psychiatry residency training programs develop and embed more robust diversity, equity and inclusion (DEI) curricula into psychiatry training. Doing so will benefit the recruitment of an increasingly diverse workforce. Additionally, incorporating more DEI curricula will successfully equip residents with DEI-related competencies, including practicing cultural humility and sensitivity, addressing social determinants of health/mental health3, recognizing and managing unconscious bias, incorporating cost awareness, and reducing disparities.

International health experiences (IHEs), which are relatively under-developed in psychiatry residency training programs 4,5, have emerged as an important mechanism to acquire these competencies and to deepen commitment to locally underserved communities. IHEs have been shown to work best when embedded within a longer-term partnership between the academic health center and a local organization6. Furthermore, the rapid expansion of telepsychiatry has facilitated such longitudinal collaborations with international partners.

Scientific Citations
1. Shim RS and Vinson SY. Social (In)Justice and Mental Health. Washington DC: American Psychiatric Publishing, 2021.

2. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace. JAMA Netw Open. 2018;1(5):e182723. doi:10.1001/jamanetworkopen.2018.2723
3. Compton MT and Shim R. The Social Determinants of Mental Health. Arlington, VA: American Psychiatric Publishing, 2015.
4. Tsai AC et al. "Global health training in US graduate psychiatric education." Acad Psychiatry. 2014; 38 (4):426-32.
5. Belkin GS, Yusim A, Anbarasan D, Bernstein CA. "Teaching 'global mental health': psychiatry residency directors' attitudes and practices regarding international opportunities for psychiatry residents." Acad Psychiatry. 2011;35(6):400-3.
6. Hua DK et al. "Global health training among U.S. residency specialties: a systematic literature review." Med Educ Online. 2017; 22(1): 1270020

Abstract
In this workshop, residents and faculty from the Psychiatry Residency Program at Zucker Hillside Hospital (Zucker School of Medicine at Hofstra/Northwell, or Zucker SOM) and the Yale Global Mental Health Program (Yale School of Medicine, or Yale SOM) will share two unique approaches to incorporating global mental health elective experiences into psychiatry residency training and education.

Zucker SOM presenters will share the process of beginning two global health initiatives in South India and in Ecuador, in collaboration with Northwell's Center for Global Health and local health partners in the two countries. The initiatives include a combination of onsite and telehealth based clinical experiences. Each model is unique, while also built on similar principles. Presenters will highlight the successes and challenges of the current models, as well as preliminary results and feedback. Verbal feedback has been overwhelmingly positive, and the program is developing more formal quantitative and qualitative evaluations to further assess the short and long term impacts of electives. These pilot global health experiences do support residents' development of DEI-related competencies, though longitudinal follow up is needed to determine if they increase residents' long-term commitment to advancing health equity through working with locally or globally underserved communities.

Yale SOM presenters will describe the Yale Global Mental Health (YGMH) Distinction Pathway, in which participating residents attend a monthly seminar series and develop an academic project. In the Seminar Series, residents learn from mental health practitioners primarily based in low middle-income countries (LMIC) regarding their community-based mental health interventions. Additionally, residents are matched with a faculty mentor and develop an academic project to address global mental health inequities. Current resident projects focus on Rural Psychiatry and Mental Health Disparity in America, mental health capacity building through the HAPPINESS project in Nigeria, and interdisciplinary collaboration with the addition of mental health to an existing Global Health program in Uganda. In the short term, residents will present findings from their projects in the department-wide grand rounds. Program leadership plans to do a longitudinal follow up to determine if participation in the YGMH

Distinction Pathway increases residents' understanding and commitment to address global mental health inequity.

Together, presenters will compare and contrast approaches by programs while identifying lessons learned. They will invite participants to consider ways in which to adapt or begin their own unique global health experiences within their programs/settings.

Agenda

10 min Introduction: Presenters will introduce the concept of global health experiences and their relevance to the development of DEI-related competencies. After a brief overview of the workshop agenda, presenters will invite participants to share whether they have prior experience (e.g. involved with global health work, in the process of beginning a program) or whether they do not have prior experience but are interested in learning more.
25 min Yale SOM program presentation
25 min ZSOM SOM program presentation
15 Min Q&A

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

Presenters
Paul Lee, MPH, MD, MS
Jacqueline Hobbs, PhD, FAPA, MD
Aaron Reliford, MD
Adrienne Adams, MD, MSc

Educational Objective(s)
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

Stop Repeating History: Breaking the Cycle through Creation and Implementation of a Longitudinal Anti-Racism Curriculum for Psychiatry Residents

Presenters

Arya Soman, DFAACAP, MD
Martina Santarsieri, MD

Educational Objective(s)

1. Identify key elements of antiracism curriculum development as well as potential obstacles/challenges to implementation
2. Review an example of a model curriculum that residency programs nationwide may adapt and customize
3. Engage in experiential training exercises utilized in the example curriculum
4. Receive guidance on how to adapt an anti-racism curriculum at participants' home institutions

Practice Gap

There has been a growing recognition of the "social determinants of health," including race, as a key determinant of health outcomes, yet this language often serves to euphemize and de-emphasize the root cause of inequity -- racism. By not acting to eliminate racism, medical institutions can end up reinforcing the systemic racist structures which perpetuate injustice and inequity. It is therefore our professional and ethical responsibility as clinicians to recognize and dismantle structurally racist systems. While this need to address racism in medical training has been recognized, there are few examples of formal anti-racism curricula in the literature.

Scientific Citations

1. Paradies Y, Ben J, Denson N, Elias A, Priest N, Pieterse A, et al. (2015) Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. PLoS ONE 10(9).
2. Beach MC, Price EG, Gary TL, et al. Cultural competence: a systematic review of health care provider educational interventions. Med Care. 2005;43(4):356-373.
3. Corral I, Johnson TL, Shelton PG, Glass O. Psychiatry resident training in cultural competence: an educator's toolkit. Psychiatr Q 2017;88:295–306.
4. Abrams LS, Moio JA. Critical race theory and the cultural competence dilemma in social work education. J Soc Work Educ. 2009;45(2):245-261.
5. Hansen H, Braslow J, Rohrbaugh RM. From Cultural to Structural Competency—Training Psychiatry Residents to Act on Social Determinants of Health and Institutional Racism. JAMA Psychiatry. 2018; 75(2):117-118.
6. Wear D, Zarconi J, Aultman JM, Chyatte MR, Kumagai AK. Remembering Freddie Gray: medical education for social justice. Acad Med. 2017;92(3):312-317.
7. Metzl JM, Roberts DE. Structural competency meets structural racism: race, politics, and the structure of medical knowledge. AMA J Ethics. 2014; 16(9):674–690.

8. van Ryn M, Hardeman R, Phelan SM, et al. Medical school experiences associated with change in implicit racial bias among 3547 students: a Medical Student CHANGES study report. J Gen Intern Med. 2015;30(12):1748-1756.
9. Shim RS. Dismantling structural racism in psychiatry: a path to mental health equity. Am J Psychiatry. 2021; 178:592–598

Abstract

Of note, this workshop and the curriculum it highlights was developed and implemented by Co-Lead PGY-4 Dr. Martina Santarsieri, in the context of the residency's Pathways to Expertise Program, a 3pyear mentored longitudinal program designed to enable residents to develop a chosen area of expertise. Her co-presenter, Dr. Arya Soman, is her faculty mentor.

Many existing curricula focus on cultural competency, which is training in the behaviors and beliefs of patient groups that experience health inequities (Beach et al, 2005, Corral et al, 2017). It has been suggested, however, that cultural competence may oversimplify culture and thereby perpetuate stereotyping, as well as disregard the provider's role in bias (Abrams, 2009). Further, by ignoring discussion of the institutions and policies that perpetuate health inequity, cultural competency training alone does not provide a complete representation of the true underpinnings and impact of social determinants of health (Hansen, 2018, Wear 2017). It can be likened to treating the symptom rather than the cause. It is not surprising, therefore, that this approach has not been shown to contribute significantly to health equity, as it neglects to address how racism helps create inequities and does not challenge the behaviors that sustain them.

It is increasingly being recognized as essential to highlight how providers and their institutions are complicit in our shared reality of structural racism, because without these conversations, work towards eliminating social injustices is stymied. For these reasons, a new movement emphasizing structural competency is gaining momentum (Metzl 2014). When racism is directly addressed in medical training, positive change in implicit racial attitudes has been shown (van Ryn et al, 2015).

During the 2021-22 academic year, a longitudinal 4-year anti-racism curriculum was developed and integrated into the Zucker Hillside Hospital Psychiatry Residency required didactic curriculum. After extensive literature review and consultation, key themes were identified, and a curriculum was created consisting of two sessions per year, with a particular content focus during each year: (1) RECOGNIZING the historical context of racism in the US, in medicine, and in psychiatry, (2) REFLECTING on providers' own power, privilege and biases, (3) EQUIPPING trainees with tools to talk about race and challenge racism in clinical care, and (4) EMPOWERING clinicians to become advocates of social justice. In departure from traditional SDH curricula that emphasize "awareness," this curriculum challenges providers to examine the role of medicine and psychiatry within the sociocultural landscape that perpetuates health inequity, encourage reflection on providers' own power and privilege, and foster a commitment to advocacy and social justice.

This workshop will introduce an example of this model curriculum designed to address gaps in knowledge and clinical skills regarding the impact of racism and bias on the delivery of psychiatric care that residency programs nationwide may adapt and customize.

Agenda

1. Welcome, introduction – 5 min
2. Assessment of participants' perception of challenges in anti-racism curriculum development - 10 min
3. Overview of curriculum development process – 10 min
4. Experiential exercise # 1 – 20 min
5. Experiential exercise # 2 – 20 min
6. Debrief and questions – 10 min

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

Presenters
Ann Schwartz, MD
Adrienne Bentman, MD
Deborah Spitz, MD
Sallie DeGolia, MPH, MD

Educational Objective(s)
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

Utilization of Lines-of-Effort and Plans of Action with Milestones for Program Improvement: a Novel Strategy for a Program Evaluation Committee

Presenters

David Nissan, FAPA, MD
Lauretta Ziajko, MD
Joanna Galati, MD
Amanda Ries, MD
Danielle Rumsey, DO

Educational Objective(s)

By the end of this workshop, learners will be able to
Define the concept of operational approach
Define and be able to create lines-of-effort
Define and be able to create plans of action with milestones (POAMs)

Practice Gap

The concepts outlined in this talk/interactive exercise are well known in military planning circles, but not widely utilized in education. We believe these terms and concepts will allow programs to more efficiently devote resources towards making programmatic change, and that they offer a strategy to increase the overall engagement of faculty and residents towards making meaningful improvements.

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Abstract

Complex operations require coordination between multiple entities towards a single common goal. Psychiatry residencies are certainly complex operations, requiring coordination amongst

program faculty, trainees, leadership, and multiple hospital entities. Military organizations utilize the concept of lines-of-effort to link multiple tasks and missions towards a single concerted goal. Developing plans of action (defining a problem, setting specific goals towards a clear, well-defined end point) results in a more efficient use of resources towards creating meaningful change. While a psychiatry residency may not bear much resemblance with military organizations, utilizing lines-of-effort and POAMs is a useful strategy for making substantial improvements.

In 2021, the NMCSD Psychiatry program noted a broad decline in the ACGME survey, falling below national average across numerous domains. In the years immediately prior to this survey, we were able to focus on a few specific, sometimes unrelated deficits, and design shorter term projects to implement improvements. These broader deficits required a different approach, one that required greater coordination and involvement that we had utilized in years past. We began by defining four broad areas for change: Teaching, Workload, Communication, and Diversity, Equity and Inclusion (DEI). Our program director outlined the broad strategy, describing the operational approach and broad goals that would be the result of coordinated efforts. The faculty and residents were divided into four working groups, each tasked with developing plans of action with definitive milestones to be aligned to form lines-of-effort towards a common goal. The result was the development of succinct, clear plans of action, each with an identifiable action officer.

In this interactive workshop, we hope to highlight the use of lines-of-effort and POAMs, describing how these concepts borrowed from military strategy and operational planning can be applied to making meaningful programmatic change. We hope this workshop will allow other programs to evaluate if these concepts could be applied to their program improvement efforts.

Agenda
75 minutes
Introduction: 5 minutes
Introduce the panel members, and outline the goals for the presentation.

Didactic portion: 20 minutes
Background, introduction of the relevant terms, description of the learning objectives.

Small group session: 20 minutes
Participants will be broken into groups of 5-7, and together conduct an exercise to develop lines-of-effort and Plans of Action with Milestones

Discussion: 20 minutes
Review each groups work, guided discussion as a larger group.

Conclusion, questions: 10 minutes

Title
Teaching risk management skills for patients who threaten mass killing

Presenters
Jacquetta Blacker, MD
Thomas Briese, MD
Chinmoy Gulrajani, MD

Educational Objective(s)
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
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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
Shifting the Curve for Patient Safety and Quality Improvement Curriculum and Faculty Development: Lessons from AADPRT's Participation in the PDPQ Educators Network

Presenters
Uma Suryadevara, MD
Mariam Rahmani, MD
Michelle Roley-Roberts, PhD
Ray Hsiao, DFAACAP, MD
Jacqueline Hobbs, FAPA, MD, PhD

Educational Objective(s)
By the end of this presentation, participants will be able to:

1. Explain the gap between the Clinical Learning Environment's (CLE) needs for resident participation in PS/QI and GME milestone expectations.
2. Describe the Program Directors Patient Safety and Quality (PDPQ) Educators Network, including AADPRT's participation to date.
3. Review the structured PDPQ PS/QI "buckets" of stakeholder analysis, longitudinal learning, assessment, and faculty development.
4. Demonstrate the PDPQ structured format for PS/QI curriculum and faculty development.
5. Plan how programs can participate in, learn from, and continue to build the future of the PDPQ for Psychiatry and AADPRT.

Practice Gap
ACGME Psychiatry Milestones for patient safety (PS) and quality improvement (QI) are delineated by "levels" 1-5 with level 1 generally expected upon starting the training program and level 4 expected by graduation. Level 5 is generally expected to be attained post-graduation, during practice. The GME "expectations", however, are very different from the "needs" of the clinical learning environment (CLE). The CLE (e.g., hospital or health system) needs trainees who have advanced participation and even basic leadership skills in PS/QI as quickly as possible in order to affect the often rapid changes necessary for quality and safe patient care. In essence, the learning curve must be significantly shifted left with a much steeper upward trajectory.

Many training programs lack immediate resources or trained faculty to implement the necessary curriculum related to PS/QI that will meet the needs of the CLE. The PDPQ Educators Network helps program directors, associate program directors, and interested faculty learn how to develop curricula for their programs in PS/QI. In this workshop, the session leaders will help training programs learn more about the structured PDPQ curriculum and the resources available to assist them in developing PS/QI curricula and developing their faculty to train the next generation of psychiatrists who will provide the safest and best quality patient care.

Scientific Citations

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https://pubmed.ncbi.nlm.nih.gov/33680321/

https://pubmed.ncbi.nlm.nih.gov/31743389/

Abstract

In this workshop, five AADPRT faculty who have participated in the PDPQ Educators Network will review the details of the PDPQ, its mission, and the relevance to AADPRT members. Participants will be led through exercises to identify the challenges in and solutions for creating PS/QI curricula and developing faculty to teach the content. The presenters are from different training programs across the country, which provide a broad scope of the range of local and regional barriers to PS/QI curricula and faculty development.

The current state of program/institution PS/QI curricula and the need for improvement will be the starting point. Via small and large group activities, participants will identify current leadership and GME stakeholder involvement in their PS/QI programs and how to further develop sustainable partnerships with organizational leaders at and external to their institution to both promote and train residents/fellows in patient safety and healthcare quality. The importance of multidisciplinary interprofessional teams will be emphasized and make the whole experience more meaningful. Because QI is a continuous process, and patient safety and quality cannot be improved without evaluations and assessments, evidence-based approaches for learner assessment and program evaluation will be reviewed.

Providing a framework for the development of PS/QI curriculum from PDPQ can alleviate some of the daunting tasks involved in furthering these important GME milestones. Further discussion will occur on how AADPRT members can get involved in the structured aspect of PDPQ as well as new initiatives by AADPRT to continuously train and develop program directors and teaching faculty in PS/QI teaching now and in the future.

Agenda

Introduction and background (10 minutes) – A brief presentation on
1. Literature on existing gaps in GME expectations and health system needs in patient safety/quality improvement (PS/QI).
2. Importance of developing and implementing PS/QI curricula in training programs.

Small Group Activity: Map the existing QI/PS program at participant sites (15 minutes) – Learners will have 5 minutes to map out the opportunities/resources and challenges with implementing such a program at their institution. In the next 10 minutes, they will share these ideas with other team members and collectively come up with ideas to create a curriculum to address the unmet needs.

Large Group Activity (10 minutes): Each small group will designate a spokesperson who will share their findings in the larger group. During this time, a list of commonly encountered challenges will be created; discussion of how PDPQ can help guide further.

Small Group Activity (15 minutes): Learners will map the essential learning experiences in PS and QI for early, middle, and final training periods for residents/fellows. Required resources including stakeholders, faculty, timing, required data/other information to support the experience as well as learner and program assessment will be delineated.

Large Group Activity (10 minutes): The potential resources identified by small groups will be used to curate a list of evidence-based evaluation techniques or resources.

Q&A/Session Evaluation – 15 minutes

Title
Balancing Act: Navigating Parental Leaves

Presenters
Sandra DeJong, MD, MSc
Swathi Damodaran, MD, MPH
Tolu Odebunmi, MPH, MD
Michael Cahill, MPH, MD
Suzanne Sampang, MD

Educational Objective(s)
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.

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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
"Let's Flip it" ; Aligning Psychiatry Residency Didactics with Adult Learning Theory: Toward Self-Directed Didactics

Presenters
Jyotsna Ranga, MD
Mark Mullen, MD
Nargis Sadat, MD
Tony Pesavento, MD, MS
Michelle Roley-Roberts, PhD

Educational Objective(s)
At the end of the poster/workshop presentation, the participants will be able to

1. Describe steps in the construction of a flipped classroom curriculum

2. Creatively use an interactive platform where learning objectives and resources are uploaded

3. List faculty development strategies

4. Anticipate, evaluate challenges, and identify continuous improvement strategies

5. Assess periodically resident engagement and participation via surveys

Practice Gap
ACGME requires protected time for didactics for every residency program, to advance medical knowledge. Didactics are provided in several formats- Grand Rounds, Journal Clubs etc. Often residents report dissatisfaction in didactic education. At Creighton University Psychiatry Residency, during annual surveys, resident feedback has been that didactics could be more engaging, interactive and evidence based. Lectures have been the standard delivery format. Retention rates are about 5%, for passive learners. Residencies are tasked with providing quality and differentiated didactics to graduate medical education learners, who are busy, preoccupied and have a wide variety of learning styles, preferences, and professional and personal goals. Keeping residents engaged, focused, interactive, and teaching each other is a very difficult task in the traditional 1–2-hour lecture format. Programs are responsible for maintaining intellectual curiosity in the learning environment, and the trainee's progression on all milestones is the goal for all. In an attempt to create a learning experience that the residents would actively participate in creating, moderated by faculty, we hope to move closer to alignment in resident and faculty satisfaction with didactics.

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Abstract
Introduction: Adult learning is distinct from the traditional lecture style of learning. Adults learn best when content is self-directed, and when learners have a sense of agency, applicability, and meaning in the exercise. Additionally, practice based learning is an ACGME Milestone and mastery of this skill is important as evidenced by the format in ABPN recertification examinations and the focus on continuous lifelong learning.In an annual survey, CUSOM Psychiatry Residents have indicated a concern that didactics were not engaging or interactive. To reconcile our didactic sessions with these realities, our team worked to develop a “flipped classroom” for our residency’s didactic curriculum.

Materials and methods: An initial needs assessment survey was conducted to inform curricular development and establish a baseline description of resident opinions about current didactic curriculum. Curricula was developed wherein residents would prepare for didactic sessions through assigned reading. Assignments varied by postgraduate year (PGY), but class was conducted with the entire program cohort simultaneously. Class time consisted of problem-based and team-based learning exercises. Continuous feedback was deliberately elicited from learners following each session, and curricula was modified accordingly. Following six newly redesigned didactic sessions, residents again completed the needs assessment.

Results: Our team learned several important lessons through the continuous feedback process. Learners must be given clear, attainable instructions as to exactly what material to cover and what resources

should be used. Time management during didactic sessions was essential for optimal engagement and learning. Faculty must be prepared to engage in critical analysis of resident perspectives and tie discussion points to pre-determined learning objectives. The leader must also ensure comprehensive coverage of the material. Overall, learners indicated that the "flipped classroom" approach was preferred to our traditional lecture-based model for didactic learning. Results (quantitative and qualitative) of surveys are forthcoming (to be included in poster).

Conclusion: Residents preferred "flipped classroom" didactics to the traditional lecture-based model. This process must be continually revised based on deliberately sought, direct feedback from learners. This project will demonstrate the effectiveness of an adult learning model for didactics in a psychiatry residency program. It will establish that a flipped classroom is not only effective but also is a preferred way of learning for psychiatry residents. Lastly, we aim to provide a blueprint for other programs looking at changing their didactics to a more modern style of learning.

Agenda

1.Dr. Ranga will present an Introduction and presentation of the evidence regarding active learning vs passive learning. Discuss the Adult Learning theory and the evidence base in Graduate Medical Education-Duration:10minutes

2. PGY2 Dr. Mullen will present steps we took in our program to move to active engaged learning. Duration:10 minutes

3. Dr. Nargis Sadat and Dr.Tony Pesavento will execute the didactic exactly as we do in the residency; the attendees are divided into small groups.(breakout rooms if virtual) They select a name for their group. They are given a passage to read. They are then asked to answer 10 questions related to the topic individually via Poll everywhere. Each question is given 1 minute after which the answers are locked. After this, they are required to discuss each of the 10 questions with their small group and why they chose their specific answers.

This will be followed by a large group discussion and the faculty moderator going through each question and asking each group for the answer, and to explain rationale. The results of the individual responses are displayed as each question is discussed, and there is a lively discussion on why the other options may be incorrect. Duration:30 minutes

Wrap up: Dr. Mullen will discuss lessons learned in our program and we will request reflections and feedback to be shared by the participants.

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

Presenters
Ashley Walker, MD
J. Corey Williams, MA,MD
Kaosoluchi Enendu, MBA,MD
Jaya Aysola, MD,MPH
David Ross, MD,PhD

Educational Objective(s)
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.

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Birden, H., Glass, N., Wilson, I., Harrison, M., Usherwood, T., & Nass, D. (2014). Defining professionalism in medical education: a systematic review. Medical teacher, 36(1), 47-61.
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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
Psychiatry Residency Recruitment Trends: COVID-19 2.0, "fit" and DEI efforts

Presenters
Moataz Ragheb, MD, PhD
Anna Kerlek, MD
Lia Thomas, MD
Sandra Batsel-Thomas, MD

Educational Objective(s)
1. Review of the 2021 residency recruitment season data and 5 year trends
2. Describe programs' experience during virtual interview season and its impact on efforts promoting diversity, equity and inclusion
3. Generate or modify strategies for future equitable recruitment

Practice Gap
It has been an eventful two years for Graduate Medical Education (GME) community and while the COVID-19 pandemic has abated some, perhaps an endemic is on the horizon. Those programs that implemented changes in their recruitment strategies and methods based on experience from the prior year may now have a better idea of what worked and what did not. Now is a good time to evaluate the outcome of these efforts. A review of this year's National Residency Matching Program (NRMP) trends shows that interest in psychiatry among applicants continues to be strong; more US seniors (MDs and DOs) are pursuing psychiatry residency this year than ever before. At the same time, the number of IMG applicants continues decline, in psychiatry and the Match as a whole. The average number of allopathic applications per applicant did not show the feared spike we feared in the Match 2021 cycle. It is our goal to summarize trends in order to attempt to plan for future recruitment cycles.
In addition, there has been little if any research into the effect this might have had on diversity, equity and inclusion (DEI) efforts to improve recruitment of underrepresented minorities in medicine (URiM) in residency training in general, let alone psychiatry. The never-ending pursuit of the "perfect fit" might have been affected as well. More widespread use of Situational Judgment Tests (SJT) in recruitment may have an impact as well. This workshop will review this year's Match data and start a wider discussion on whether DEI efforts were negatively affected.

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Abstract
Stating that the whole world witnessed major changes, transformations and existential questions during the past year is an understatement. GME is no exception. The recruitment platform has become totally 'virtualized', and in this process innovations were introduced by program directors to market their institutions while still providing a solid interview experience for all involved.

Beyond numerical data trends, little is known on whether the changes brought about by COVID-19 have helped or hindered DEI efforts in GME. Under "normal" circumstances, many diversity programs fail. A number of factors can create barriers to achieving a culture of inclusive excellence. Structured evaluation of these barriers is not as advanced as one would hope. The new virtual platform introduces an additional layer of complexity that we do not fully understand.

Several questions beg for answers; how will current conditions impact the approach to the not-very-well-defined concept of "fit" between applicants and residency programs?
That "fit" has been pursued from different angles; geographical, program focus), familiarity with institution "culture," ethnicity and other individual factors, communication style, and even personal hobbies. This "fit" has also been criticized as being riddled with bias leading to "like chooses like" phenomenon. Will absence of direct interaction render faculty interviewers more susceptible to implicit bias? Will the practice of tokenism decrease? How can that be prevented or remedied? What else are program directors saying to themselves that might just be coded for implicit bias? Does that levy an additional burden and responsibility on the residency program to provide more advanced training and faculty development? Are there additional safeguards against bias that can be used?

With gradually expanding use of situational judgment tests (SJTs), concerns have been raised about their assessment of "Values Fit" between applicants and programs. Preliminary data

pointed to possible bias against URiM and IMGs, while other results report absence of such bias.

This workshop will provide the audience an opportunity to brainstorm and reflect on one's unique experience in recruitment and DEI strategies, and discuss possible answers/testable hypotheses to these questions with a broader group.

We will start with an overview of trends and changes in the 2021-2022 recruitment cycle and known program DEI efforts. We will utilize poll questions to stimulate discussion. The breakout rooms will focus on recurring "hot topics" such as program culture and values fit. Small groups will present their discussion about new strategies and techniques they adopted or could adopt in the future.

Agenda

10 minutes: Overview of the 2021-22 psychiatry recruitment season data trends as compared to prior years
10 minutes: Review of DEI efforts in GME and how "fit" may be cloaked in bias
5 minutes: Polling questions that will inform small group discussion
30 min small groups: each group will have an assigned moderator and will guide the brainstorming activity.
15 minutes of larger audience discussion; best ways to approach recruitment with a true DEI lens and work towards possible new strategies for Match 2023
Final 5 minutes: designated time for evaluation and feedback

Title
Teaching Relationship-Centered Communication to Psychiatry Trainees

Presenters
Oliver Stroeh, DFAACAP, DFAPA, MD
Swana De Gijsel, MD
Helen Ding, MD
Nana Asabere, MD
Rebecca Rendleman, MD

Educational Objective(s)
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
No Resident Left Behind: Navigating Resident Mental Health Crisis Within Post-Graduate Training Programs

Presenters
Rebecca Leval, MD
Kellen Andersen, MD
Jyotsna Ranga, MD
Zheala Qayyum, MD
Shambhavi Chandraiah, FRCP (C),DFAPA, MD

Educational Objective(s)
At the end of the workshop, participants will be able to:

1.Understand the prevalence of resident mental health crises.
2.Identify potential consequences of resident mental health crises on residents and their patients.
3.Identify potential barriers to the identification and treatment of resident mental health crises.
4.Identify potential actions plans for various resident mental health crisis scenarios.
5.Consider means of strengthening program resources and policies at their own institution.

Practice Gap
Despite the challenges of training - role transitioning, relocation, work hours, feelings of isolation – and the documented high rates of depression and suicide in medical residents, no national guidelines exist to address resident mental health crises (1). Between 2000 and 2014, within ACGME-approved programs, suicide was found to be the second leading cause of death in medical residents, the majority of occurring within the first and second years of training, during the first and third quarters of the academic year (2).

Unfortunately, residents are not always willing or able to receive the mental health treatment they require. In the DEPRESS-Ohio Study, 70% of residents expressing some degree of suicidal ideations were not receiving mental health care (3). Barriers to treatment include: access, perception, confidentiality, risk, cost, time, stigma, and autonomy. These barriers place both residents and their patients at risk, as rates of medical errors are higher in residents struggling with depression (4).

Additionally, medical students often elect not to disclose preexisting mental illness on residency applications out of concern of discrimination and stigma. Even psychiatry residency Program Directors have demonstrated having stigmatizing attitudes towards applicants with mental illnesses (5)(6). A lack of disclosure of mental illness is linked to a lack of receiving treatment (5). Program Directors are in a unique position to address this issue. Although the majority of residents indicated that they would be unlikely to seek mental health help on their own, they did want their Program Director to inquire as to the state of their mental health. Residents also reported an increased likelihood of seeking help, if facilitated by the Program Director (7).

Screening measures include web-based Interactive Screening Programs (8) used in conjunction with a means of referral for those found to be at moderate to high risk for depression and suicide (9).

Residents and faculty should be made aware of how to identify and confidentially report issues of impairment. Physicians are mandated to report physician impairment, which The Federation of State Medical Boards (FSMB) and The American Medical Association similarly define as a physician's inability, as a consequence of a mental, physical, or substance-related disorder, to safely practice medicine. Curriculum reform has served as a means of educating residents as to how to identify signs of stress and potential impairment (11).

Comprehensive models of educational outreach (wellness workshops, suicide prevention screenings, support groups/luncheons) and direct care (individual counseling, psychiatric evaluation, consultations with GME, referrals to community providers for specialized care) have received positive ratings from residents (12). Stress inoculation, such as the brief web-based cognitive behavioral therapy (wCBT) has, in a randomized clinical trial, been shown to reduce the likelihood of suicidal ideations among residents (13)(14).

Finally, studies have demonstrated the importance of removing barriers to psychiatric treatment such as ensuring resident health insurance/disability coverage includes provisions for mental health treatments, identifying mental health professionals within the community willing to treat residents (15), and providing designated time off for mental health screening appointments with campus mental health providers (16).

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Abstract

Background: Despite the challenges of training - role transitioning, relocation, work hours, feelings of isolation – and the documented high rates of depression and suicide in medical residents, no national guidelines exist to address resident mental health crises (1). In a study of ACGME-approved programs between 2000 and 2014, suicide was found to be the second leading cause of death in medical residents, the majority of which occurred during the first and second years of training, during the first and third quarters of the academic year (2).

Unfortunately, residents are not always willing or able to receive the mental health treatment they require. In the DEPRESS-Ohio Study, 70% of residents expressing some degree of suicidal ideations were not receiving mental health care (3). Barriers to treatment include: access, perception, confidentiality, risk, cost, time, stigma, and autonomy. These barriers place both residents and their patients at risk, as rates of medical errors are higher in residents struggling with depression (4).

Methods: A pre-intervention, cross-sectional, anonymous, online survey will be sent to Creighton University resident physicians to evaluate the current understanding of program mental health crisis resources and policies. Surveys will include questions regarding

respondents' definition of a mental health crisis and how he/she might recognize signs of a crisis in his/herself, as well as in peers, and how he/she might respond. Questions regarding barriers to care, as well as any pre-existing support a resident has in place or believes the program ought to have in place will also be included.

Our team is currently consolidating all university policies and resources relating to resident mental health crises. These policies and resources will be provided to all residents, as a guide, to provide greater clarity into the process.

A post-intervention, cross-sectional, anonymous, online survey will then be sent to all Creighton University resident physicians, to ascertain if there is an improved understanding amongst residents and additional means of further enhancing the process.
Results & Conclusions: Conclusions will be drawn based on results of the pre- and post-intervention surveys. We anticipate, based on similar studies conducted within this area, that there will be generally low levels of awareness of mental health crisis resources, and hopefully, an improved level of understanding post-intervention. We also anticipate, based on the literature review that has been conducted, that there will be a relatively large percentage of residents who have experienced personal mental health crises and that there were notable barriers to seeking and obtaining mental health care.

Agenda
1. Brief opening on the significance of resident mental health and wellbeing and the epidemiological data on resident mental health crises. (10 minutes)
2. We would open the workshop with three case presentations. Each case focuses on a resident in crisis - three different crises, with three different outcomes (15 minutes)
Presenters from each of the three different residency programs will each share a case of a resident experiencing a mental health crisis and how their case left a lasting impact.
3. Participant reflection (5 minutes)
They may reflect on how they might have utilized resources available at the time and what resources might be needed to create positive outcomes if a similar case were to occur in the future.
4. Literature review (10 minutes)
5. Participants would be divided into small groups for role playing scenarios (15 minutes)
6. We would discuss how cases resulted in programmatic changes (15 minutes)

Groups will share obstacles they faced while working towards an action plan, as well as their final action plans. Presenters will provide feedback on the group solutions to foster a meaningful discussion. Presenters will also discuss options available at each of their programs and additional steps they have taken towards further strengthening program resources.

7. Closing remarks and final comments (5 minutes)

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

Presenters
Kaosoluchi Enendu, MBA, MD
Ann Crawford-Roberts, MPH, MD
Michael Mensah, MPH, MD
Enrico Castillo, MD, MS

Educational Objective(s)
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
Using your voice to affect change: advocacy by and for our profession

Presenters
Kari Wolf, MD
Art Walaszek, MD
Jed Magen, DO, MS
Rashi Aggarwal, MD

Educational Objective(s)
By the end of this session, participants will be able to:
- Describe venues where we have the opportunity to influence policy
- Apply stories and statistics to create an "elevator speech" on your chosen topic
- Practice delivering an elevator speech on an advocacy topic
- Identify potential audiences for your policy topic/speech

Practice Gap
The Institute on Medicine as a Profession has stated: "Physician advocacy extends beyond the provision of good clinical care and advocacy on behalf of individual patients to include collaborations with people and organizations that combat interpersonal, structural, and systematic inequities and abuses in our society. Advocacy is the bridge that links patient care with efforts to address social determinants of health, institutionalized prejudices, and structural dislocations that patients and communities face. Physicians are especially qualified to advocate upon behalf of social change. The prestige and credibility that they command may serve as valuable resources in advocacy efforts." (http://imapny.org/physician-advocacy/physician-advocacy-program-overview/) In fact, there are professional societies whose primary purpose is dedicated to advocacy, such as Doctors for America.

Some medical schools have implemented advocacy training as a key element of medical school. However, these are often optional programs. Megan Sandel, an associate professor of Pediatrics at Boston University helped create such a program for their medical students. She describes the practice gap as: "A fitting analogy is that everyone takes cardiology in medical school with the understanding that not everyone is going to be a cardiologist, but we think learning how the heart works is inherent to being a good physician. Every physician should at least be aware of advocacy skills and competencies, while a certain subset is going to go on to be that advocacy specialist, which will be a career-defining part of their profession. We want our curriculum offerings to be able to toggle between both."

Finally, the 2010 article from Academic Medicine (listed below) argues "Because of the current paucity of formal physician advocacy training, successful physician advocacy tends to be exceptional… If the profession of medicine considers advocacy a professional imperative, then advocacy must cease to be exceptional. For this to occur, physicians and medical educators must become thoughtful and deliberate about training advocates. If left to chance, the charge to serve as public advocates rings hollow and will not be met."

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Abstract

In these challenging times, psychiatrists (and other medical professionals) often feel ill-equipped to influence policy and advocacy that affects their patients and their professional lives. While professional societies play a profound role in advocating for our profession, we are often left feeling like we want to do something, but don't know how to begin.

Advocacy efforts are often directed toward politicians. In this workshop we will briefly address advocacy with politicians but will also explore other people and groups (such as institutions, payers, hospital leadership) to target to expand our impact. According to the Association for Progressive Communication's approach to advocacy, "It is widely recognised, for example, that change comes rarely from force of logical argument alone or from the presentation of irrefutable evidence in support of the changes required.... Much depends on the character, approach and credibility of those seeking change and the receptiveness of those they are seeking to persuade. Advocacy is inherently political and an understanding of political dynamics is at the heart of effective advocacy."1

In this experiential workshop, we will brainstorm ways that we can affect policy through individual or small group actions by exploring ways to augment our credibility, determine who our audience is, enhance the receptiveness of that audience, combine storytelling with data to underscore our message, practice delivering a short pitch to our audience, and review opportunities to use social media as an advocacy platform.

The skills developed in the workshop will allow participants to successfully advocate across a broad array of topics such as: increased resources to support one's training program; policy/funding changes that impact our patients, our learners, and our profession; and laws and regulations governing the practice of psychiatry. We will also address how to build advocacy skills into residency program curricula.

Agenda

I. Introduction – 5 minutes
II. Liberating Structure: Small group exercise on how to make complex information understandable and persuasive – 15 minutes
III. Liberating Structure: Small group exercise to explore what makes effective advocacy – 15 minutes
IV. Role Play exercise to develop and practice your elevator speech (we will provide a fact sheet that can be used as the basis of these speeches) – 30 minutes
V. Wrap up with Q&A – 10 minutes

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

Presenters
Christin Drake, MD
Deepti Anbarasan, MD
Ajay Nair, MD

Educational Objective(s)
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

The Nontraditional Trainee: Beyond race, ethnicity, gender and sexual orientation – Taking the next step towards diversity, equity, and inclusivity

Presenters

Kim Lan Czelusta, MD
Sana Younus, MD
Fiona Fonseca, MD, MS

Educational Objective(s)

1. Review the current literature on challenges faced by minority trainees and those from diverse cultural backgrounds.
2. Identify commonalities and differences between minoritized trainees
3. Discuss additional factors, beyond race, ethnicity, gender and sexual orientation, which make a trainee's experience during residency different from their peers.
4. Explore strategies to identify 'nontraditional' variables which can result in a marginalized experience for trainees.
5. Examine strategies to address marginalization of trainees during residency.

Practice Gap

Psychiatry residency programs across the country have their own distinct culture. Such culture can offer an enriching experience to trainees as they navigate their own professional development, but it also presents challenges as individuals and institutions make space for trainees from diverse cultural backgrounds. In recent years, there has been much discussion about the importance of understanding the prevalence, etiology, and manifestation of discrimination against individuals from diverse cultural backgrounds and in some cases, efforts are being made to address this endemic (1). However, this work predominantly focuses on struggles and needs of trainees based on their race, ethnicity, gender, and sexual orientation. Literature is significantly limited for trainees who are different from their peers in terms of age, religion, nationality, immigration status, medical school (American versus International), and prior career experiences. While some personal narrative blogs and news articles are available online addressing some of these variables, scientific literature about the experiences of 'nontraditional' trainees who may not be different from their peers based on race, ethnicity, gender, and sexual orientation but are different in other ways is limited (2)(3). These differences pose a unique set of challenges to trainees. Scarcity of literature about these significant variables has led to their omission within discussions of diversity, equity, and inclusiveness. Inevitably, leaders within training programs may have limited understanding of these nuances which leads to challenges in addressing the needs of their 'nontraditional' trainees and support them.

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Abstract

In the early 1900's, the word "melting pot" was used to describe the cultural integration in the United States. More than 100 years later, we are still learning about the implications of such integration for individuals living in the United States, including healthcare providers. Cultural diversity observed in psychiatry training programs at both faculty and trainee levels has led to discussion and training to improve clinical experiences for individuals with diverse cultural backgrounds. Research has confirmed various forms of discrimination against minoritized individuals in healthcare which includes medical students, trainees, and faculty members (4)(5). However, the majority of this research highlights minorities and individuals with diverse cultural backgrounds based on gender, sexual orientation, race, and ethnicity. These are important variables to consider while advancing diversity, equity, and inclusivity, but are not the only ones. This workshop will explore these variables which are not routinely considered in research and diversity training. Psychiatry trainees differ from each other based on their age, religion, nationality, immigration status, medical school (American versus International), and prior career experiences. This workshop will help training directors identify 'nontraditional trainees' and consider ways that such trainees can enhance their training program. We will also explore the needs of nontraditional trainees to promote a positive learning and training experience as well as to nurture resilience. We will invite the audience to share experiences of working with such minoritized trainees and collaboratively discuss ways to improve the experience from both the trainee and program perspective. During the next part of the workshop, the presenters will share their personal "nontraditional" narratives with the group and discuss ways to identify and address the needs of nontraditional trainees during psychiatry residency. This workshop aims to help training directors scrutinize their programs from new perspectives to further augment inclusivity in learning spaces for their nontraditional trainees.

Agenda

This workshop is aimed at psychiatry program directors, faculty, and administrators interested in a discussion about diversity, equity, and inclusiveness as it applies to trainees, including factors beyond race, ethnicity, gender, and sexual orientation. A literature review will be followed by an interactive discussion with audience response system to identify the common

diversity variables routinely considered by participants. The less common variables which could result in a trainee feeling “different” from the general residency cohort will be reviewed, followed by a discussion of specific efforts to support trainees’ unique challenges and needs.

0:00-0:05 Introduction
0:05-0:15 Brief literature review related to diversity and related challenges in training programs and breadth of trainees’ variables identified and included in research
0:15-0:20 Audience Response System.
0:20-0:35 Personal narratives shared by presenters about their differences when compared to their peers
0:35-0:40 Audience Response System .
0:40-0:55 Small group discussion about strategies that can be used to identify the nontraditional trainee in training programs and address their needs
0:55-1:10 Presentation of strategies to the large group. (or delete this section if we decide to not divide up into small groups)
1:10-1:15 Popcorn survey the audience about something they will take with them that will change the way they work with their trainees prior to wrap-up/ Q&A.

Title

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

Presenters

Daniel Elswick, MD
Brandon Riley, MD
Lisa Rudolph-Watson, FAPA,MD
Dena Whitesell, MD
James Dalkiewicz, MBA

Educational Objective(s)

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

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.

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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
We're In This Together: Strategies for Faculty & Trainees to Make Feedback Cooperative and Useful

Presenters
Erica Shoemaker, MD, MPH
Jeffrey Hunt, MD
Ayame Takahashi, MD
Isheeta Zalpuri, MD

Educational Objective(s)
1) Describe obstacles both faculty members and trainees can face that interfere with their ability to listen to feedback from one another
2) Identify the ADAPT model and the Educational Alliance as two methods for overcoming these obstacles.
3) Identify in which clinical rotation/supervisory structures the ADAPT or Educational Alliance models may be most useful in psychiatry training programs.

Practice Gap
For both faculty and trainees, receiving feedback and reflecting on it to improve their performance are essential pieces of growing into more skillful and effective psychiatrists. The ACGME Milestones for Psychiatry state that "openness to performance data (feedback and other input)" and "consistently seeking such input with openness and humility" are Level 2 & 4 Milestones (respectively) for residents. Furthermore, the Psychiatry Program Requirements state, "Faculty members should provide feedback frequently throughout the course of each rotation. Residents require feedback from faculty members to reinforce well-performed duties and tasks, as well as to correct deficiencies." However, in practice, both faculty and trainees struggle with skillfully giving and thoughtfully receiving feedback from one another. Trainees often perceive feedback as untrue or unfair, and faculty often feel that trainees are dismissing their input on how the trainee could improve.

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Abstract
This workshop was adapted from a departmental Grand Rounds on giving/receiving feedback. The Grand Rounds was well-received by faculty and trainees alike. This workshop was built on a two precepts:

1) While many departments currently train faculty in skillfully giving feedback, few departments train faculty or trainees on how to be receptive to feedback
2) Feedback is built on a two-way relationship, where both supervisor and trainee are invested in and open to learning from one another

This workshop will introduce participants to three primary frameworks for understanding the feedback process. The first is borrowed from Stone & Heen's book "Thanks for the Feedback," and it describes how learners often reject feedback that threatens Truth (ie the feedback is not accurate), Identity (ie identity as a competent doctor), or Relationship (ie relationship with a role model). Workshop leaders will role play a scenario whereby a well-intentioned faculty member gives a high-achieving resident feedback that triggers all 3 of these obstacles; viewers will observe how the resident is unable to accept that feedback and learn from this faculty member. After the role play, participants will break into small groups for discussion. As everyone reconvenes into the large group, leaders will facilitate a large-group discussion about how the supervisor's feedback in the role play was running up against these obstacles of truth, identity, and relationship. We will likewise discuss how the faculty member was unable to correct course in this discussion because of how the interaction threatened the faculty member's own Truth, Identity, and Relationships.

The second part of the workshop will introduce two methods for overcoming the obstacles of Truth, Relationship, and Identity. Both methods are designed to engage the trainee's self-reflective capacity and their intrinsic motivation to improve. The first framework, especially useful in short-term supervisory relationships, is the ADAPT Framework. In the ADAPT framework, both the supervisor and the trainee come to feedback exchanges with responsibilities to reflect on their practice and to set goals for future improvement. The Educational Alliance, suitable for longer-term supervisor-trainee relationships, is based on the concept of the therapeutic alliance. For an educational alliance, the supervisor and trainee work together over time to build a bond, to agree on performance goals for the trainee over the time they work together, and to agree on the tasks of supervision (which sometimes includes giving/receiving painful feedback). The reciprocal (ie having the trainee provide the supervisor with feedback) will also be addressed. Workshop participants will move to a pair-and-share format. Each pair will be assigned either the ADAPT model or the Educational Alliance, and they will repeat the role play themselves, with the faculty member in the vignette using one of these frameworks for feedback. The pairs will report back to the how the faculty

member and resident in the original vignette could have used either ADAPT or an Educational Alliance to help them both grow as psychiatrists.

Agenda

- Welcome & Introduction (5min)
- Part 1 (30min): Obstacles to Individual Faculty and Trainees Giving & Receiving Feedback: TRUTH, RELATIONSHIP, IDENTITY.
  - Introductory slides
  - role play by presenters of well-intentioned feedback gone bad
  - division into small groups for discussion
  - report back to large groups using polleverywhere
- Part 2 (30min): Strategies for giving/receiving feedback in long-term and short-term supervisory relationships. ADAPT (a good way to approach feedback in supervisor-trainee short-term relationships) and Educational Alliance (suited to long-term relationships).
- Introductory Slides
- Pair and Share—each dyad assigned to determine how Educational Alliance or ADAPT would have changed the scenario in part 1's role play
- Report back to large groups using polleverywhere
- Closing remarks, Q&A (10min)

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

Presenters
Poh Choo How, MD, PhD
Raziya Wang, MD
Takesha Cooper, MD, MS
Ryan Harris, MD

Educational Objective(s)
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.

Scientific Citations
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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
How to Utilize the Model Curricula in the Virtual Training Office to Improve your DEI Curriculum and More: the Nuts & Bolts to develop engaging, specific, high-quality curricula from peer-reviewed resources

Presenters
Rochelle Woods, MA, MD
Melissa Buboltz, MD
Robert Lloyd, PhD, MD
Anuja Mehta, MD

Educational Objective(s)
By the end of the session, participants will be able to:
1) Describe the resources within the Virtual Training Office (VTO), including those related to Diversity, Equity, and Inclusion
2) Adapt VTO resources to the specific needs of one's institution
3) Identify resources within and beyond the VTO to utilize in the development of DEI curriculum
4) Develop action plan for DEI curriculum implementation

Practice Gap
The Accreditation Council for Graduate Medical Education (ACGME) program requirements for training residents and fellows state that program directors (PD) must provide trainees with core didactic activities, which broadly include conferences, didactic teaching, appraisal of the literature, simulations, and grand rounds. PDs must identify faculty in their program that may be able to deliver education on a wide range of topics and assist faculty to prepare didactics. The requirements now include formal educational activities around patient safety, quality improvement, and understanding of health care disparities beyond traditional topics in psychiatry. In part, the training programs will need to consider how to incorporate didactics on a wide range of topics across competencies to inform health care disparities, systems' failures, and community needs within the curriculum. For many new programs or smaller programs, this may pose a challenge if new material needs to be developed or if the program lacks experts in a content area. This workshop will provide attendees the opportunity to identify curricular resources within our organization and mechanisms to utilize available curricula and to adapt them to their training program.

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Abstract
The ACGME asserts that clinical learning environments should be safe and supportive and that programs should ensure that residents and fellows learn to care for diverse populations. There has been rapid growth in the number of General Psychiatry Residency and Psychiatry Fellowship programs across the U.S. fueled by largely Community-hospital based programs. Core Faculty at smaller and community-based programs tend to have more clinical demands and therefore less protected time to prepare didactics for trainees. These programs may also lack faculty in subspecialty areas that are not required for ACGME accreditation. A recent report published in Academic Psychiatry surveyed General Psychiatry Residency PDs about the amount of time dedicated to LGBT-specific education during training. Authors found that over half of the programs who responded spent less than 5 hours providing LGBT training to their residents despite the high prevalence of mental health burden in this population. This study concluded that there is an urgent need to develop and implement LGBT-specific curricula that can be used by PDs for their programs. AADPRT provides peer-reviewed model curricula on various topics to all its members that can be accessed through Virtual Training Office (VTO) on the website. Model curricula covers wide-ranging topics as well as facilitator guide in many cases which can help PDs with implementation at their programs.

In this workshop, the participants will be shown how to navigate through the VTO on AADPRT's website. Participants will be provided a framework for how to approach the model curricula in the VTO and adapt them to their institution's needs. Participants will discuss the current state of DEI curriculum implementation at their institution and then

Agenda

Workshop Agenda (75 min)
Introduction: Overview of Virtual Training office (5 min)
Brief Presentation: Utilization of various resources to implement a general psychiatry residency curriculum (5 min)
Small group discussion: Current state of DEI curriculum implementation at one's institution (15 min)
Self-reflection exercise: Development of DEI curriculum goals (5 min)
Brief presentation: DEI curricula in VTO and beyond (15 min)
Think-pair-share exercise: Development of action plans (15 min)
General questions/discussion (10 min)

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

Presenters
Rick Peter Fritz Wolthusen, MD
Jordan Broadway, MD
Heather Vestal, MD
Riley Machal, BS, MD
Jeana Benton, MD

Educational Objective(s)
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.

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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
Rethinking Evaluations: Increasing Evaluation Compliance and Feedback Quality

Presenters
Jenna Triana, BS, MD
Jacquetta Blacker, MD
M. Philip Luber, MD

Educational Objective(s)
1. Examine the barriers training programs face in completion of evaluation forms, including ease of access, form length, and question types.
2. Consider the goals of evaluation forms, and how clear goals can help refine and shorten forms for higher quality feedback.
3. Present strategies for improvement in evaluation forms to increase compliance and quality of feedback.

Practice Gap
Evaluations are at the core of medical training programs [Meier, 2016]. Program leadership relies on evaluations to track the progress of learners, ensure rotations are meeting educational goals, and to monitor the performance of teaching faculty [Gale, 1997; Tomisato, 2014]. Our graduate medical education program was struggling with evaluation compliance from both learners and faculty. This results in little data about the performance of learners, making it difficult to track progress on ACGME milestones and various competencies and limits the availability of actionable feedback. This can also limit the ability of programs to monitor educational quality of rotations and didactics. Without completed evaluations, faculty development is hindered, and faculty pursuing promotion are missing a key piece of their academic portfolios [Ghahrani, 2015].

Scientific Citations
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Abstract
In our program, we previously had long, detailed evaluation forms that were infrequently completed. Therefore, we had little data each year about the performance of our learners and teaching faculty, or the quality of our rotations and didactics. In this workshop, we will share our approach to the rethinking of evaluations of all kinds in our CAP fellowship program. We will describe our approach to this process, the reasoning behind the changes made, and present the outcomes to date. Further, we will provide worksheets outlining a framework for participants to rethink evaluations in their home programs, which will be completed together as we walk through our process. Participants may bring examples of evaluation forms from their home programs to rethink as they actively work through the framework provided.

In rethinking our evaluation forms, we reconsidered what data we truly needed and what could be excluded [Gale, 1997; Tomisato, 2014]. The focus shifted from obtaining overly detailed feedback to increasing user accessibility and efficiency. We hoped this would increase user participation, which would in turn improve data collection, representative sampling, and timeliness of feedback.

Changes included:
1. Fewer questions per form;
2. Increased specific narrative comment versus multiple choice prompts;
3. Moving from the MedHub software platform to Qualtrics which allows QR code access by phone and thus removes logging-in as a barrier;
4. Linking didactic feedback forms to attendance tracking as incentivization;
5. Providing brief protected time during our didactics blocks for fellows to complete forms.

We also created a “day-to-day bidirectional feedback tool” to facilitate feedback conversations between fellows and teaching faculty, and to track progress in various learner and educator competencies over time, outside of our formal evaluations.

After rolling out the changes to our evaluations and feedback forms for the 2021-22 academic year, we have seen a substantial increase in compliance for completion of evaluations of all kinds. The shift towards fewer questions with a higher proportion of narrative comment prompts has resulted in more specific, higher quality feedback than previous forms provided, even when comment boxes were available. Data from our new evaluations will be provided to the Clinical Competency Committee, which should allow for improved milestone assessments and higher quality mid- and end-of-year evaluations of our fellows. Further, we are now able to provide much more detailed and timely feedback to our teaching faculty so they can continue to grow as educators and add these evaluations to their academic portfolios.

Agenda
5 Min: Introduction of topic and presenters
5 Min: Discuss practice gap and share struggles with evaluations in our program

10-15 Min: Participants engage in TRIZ exercise to brainstorm the “worst” evaluation system, then use ideas to evaluate current evaluation systems in their programs. First work in small groups then share in large group discussion.
10-15 Min: Share our approach in making changes, introduce the framework developed, and brief presentation of outcomes to support our process.
25-30 Min: Walk through our process step-by-step while guiding participants through worksheet

- Share process step and our thinking about the decision point for this step
- A few minutes for participants to work through question on their sheet
- Brief large group share of 1-2 examples or questions
- Repeat for next step

15 Min: Final discussion, questions, evaluation completion

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

Presenters
Julia Frew, MD
Anne Ruble, MD
Tauheed Zaman, MD
Ann Schwartz, MD
Amber Frank, MD

Educational Objective(s)
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
Be a part of the consensus rating process! A New Online Training Module to Prepare Clinical Skills Evaluation (CSE) Examiners in Psychiatry

Presenters
Tolulope Odebunmi, MBBS, MPH
Kaz Nelson, MD
Michael Jibson, MD, PhD

Educational Objective(s)
1) Describe the American Board of Psychiatry and Neurology's (ABPN) vision for the standardization of clinical skill evaluations (CSEs)
2) Provide an overview of recent developments related to the project to develop an online training module to standardize the training of faculty conducting CSEs
3) Observe newly produced videos of resident-patient interactions and participate in developing consensus scores using the American Board of Psychiatry and Neurology CSE rubric for use in the new module.

Practice Gap
While educational materials have been developed by the American Association of Directors of Psychiatric Training (AADPRT) to train evaluators and improve inter-rater reliability in rating resident's performance on the CSE, there were significant barriers to access and participation. To make this training more accessible to training program faculty, an online training module was developed, which incorporated the original AADPRT training materials. This training module is currently housed on the AADPRT website. So far, this online training has demonstrated interrater reliability. Unfortunately, the videos in this module have privacy limitations because real patients were used who signed limited consent for use of their images for educational purposes. This substantially limits the capacity to share this module publicly. Therefore, we are producing new videos without such privacy limitations. Once consensus ratings are developed, we will be able to incorporate the new videos into the online module, which will increase the capacity to widely disseminate the module for open access.

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This project has been determined by the University of Minnesota Institutional Review Board as not human subjects research: STUDY00011847.

This project is supported by an Educational Research Grant awarded by the American Board of Psychiatry and Neurology.

Statistical analyses will be conducted by University of Minnesota (UMN) Clinical and Translational Science Institute (CTSI) biostatisticians. The UMN CTSI is supported by the National Center for Advancing Translational Sciences of the National Institutes of Health Award Number UL1-TR002494

Abstract

The American Board of Psychiatry and Neurology (ABPN) instated the clinical skills evaluation (CSE) for psychiatry trainees who started training in July 2005. The CSE component of certification aims to "identify qualified specialists through rigorous credential and training requirements and successful completion of board examinations for psychiatry". In order to achieve the central mission of the ABPN, we must work to ensure public trust and confidence in the ABPN certification of psychiatrists. A primary strategy to achieve this is by standardizing the CSE evaluation process nationally. We have produced three new video vignettes using actors who provide full consent to the right to use their images. Each vignette will emphasize the three major competencies of the CSE: 1) Physician-patient relationship 2) Interview conduct & mental status examination and 3) Case presentation. During this workshop, participants will contribute to this important process by viewing the videos and providing feedback in order to establish consensus ratings for the performance of the resident in the newly produced videos. These new videos will replace original videos in the existing online training module.

Agenda

This workshop is aimed at board certified psychiatrists, all attendees are welcome.

Welcome (5 minutes): Presenters and participants introduce themselves.

Learner needs assessment: Individual reflection followed by breakout sessions related to program needs and experience with CSE faculty evaluator training. (10 minutes)

Overview of the work to standardize the CSE process (5 minutes)

Participants will view 3 brief videos and evaluate the resident performance in each video using an ABPN approved CSE rubric. Participants will be polled on the outcome of their individual application of the CSE rubric and participants will actively negotiate consensus ratings for each of the 3 videos. (15 minutes for each video)

Respond to comments, questions, and wrap-up (10 minutes)

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

Presenters
Amy Burns, MD
Zsuzsa Szombathyne Meszaros, MD,PhD
Allie Thomas-Fannin, MD
Anne McBride, BA,MD
Erik Loraas, MD

Educational Objective(s)
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
Teaching and Learning Clinically Relevant Neuroscience: What to Say When Patients Ask

Presenters
Ashley Walker, MD
Mayada Akil, MD
Belinda Bandstra, MA,MD
Asher Simon, MD
Maja Skikic, MD

Educational Objective(s)
At the conclusion of this session, each participant will be able to:
1. Describe a method for learning clinically relevant neuroscience.
2. Utilize a novel educational tool that incorporates adult learning principles to teach clinical neuroscience.
3. Adapt this teaching methodology for use in their own didactic settings.

Practice Gap
Despite the rapid advances in medical literature related to psychiatric neuroscience over the last decade, most psychiatrists still have relatively minimal knowledge of neuroscience as it relates to their day-to-day clinical and didactic activities. Many factors may contribute to this gap, including difficulty keeping pace with the expanding literature, and uncertainty in translating complex research findings into patient care scenarios. Many clinical faculty did not receive significant exposure to neuroscience during their own training, and may not feel comfortable discussing these topics with trainees. Additionally, neuroscience education often remains lecture-based, without utilizing principles of adult learning, which may make effective teaching and learning even more challenging in virtual classroom settings. New studies suggest that innovative educational interventions, including use of brief videos and role play, can effectively bridge these gaps for both faculty and trainee learners.

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Abstract

Neuroscientific knowledge about mental illness is exploding. While many psychiatrists recognize the importance of neuroscience to the field of mental health, they may not have an effective way to approach learning about neuroscience and may not readily see its relevance to their clinical practice. As a result, they may not feel comfortable discussing neuroscientific concepts with patients or incorporating them into their teaching of trainees. Additionally, despite new evidence demonstrating the effectiveness of using brief videos, role play, and other active educational methodologies, many faculty have difficulty adapting their didactic instruction from traditional slide-based lecture formats, especially (and despite) recent shifts to virtual learning settings. All of these factors contribute to an ongoing disparity between the central role that neuroscience plays in psychiatry, and the ability to integrate these perspectives into teaching and clinical activities. To bridge this divide, we present a novel teaching tool called What to Say When Patients Ask (WTS), which is interactive, based on principles of adult learning, and uses multimedia instruction. It is organized around answering an imagined patient's questions about their illness, symptoms, treatment, or expected outcome/response from a neuroscientific perspective. This workshop will provide participants the opportunity to practice using this learning tool and reflect on how this format can be modified for self-directed lifelong learning as well as education of medical trainees.

Agenda

10' - Introduction
10' - Paired case discussion and role play
10' - Multimedia learning activity
10' - Large group discussion
10' - Paired role play
10' - Small group debrief
15' - Large group discussion and Q&A

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

Presenters
Sansea Jacobson, MD
Meredith Spada, MD
Piper Carroll, MD
Gabrielle Paul, MD
Brian Kurtz, MD

Educational Objective(s)
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.

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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
An Inconvenient Education: Finding Room for Climate Mental Health in Residency Curricula

Presenters
Sandra DeJong, MD, MSc
Elizabeth Haase, MD
Joshua Wortzel, MD

Educational Objective(s)
At the end of this session, participants will be able to:

1) Outline key elements of the impact of climate change on mental health and how they disproportionately affect BIPOC.
2) Access didactic materials available to teach climate mental health impacts
3) Identify shared obstacles to and motivations for teaching about the impacts of climate change on psychiatric and psychological well-being in their programs
4) Describe potential ways to incorporate climate mental health into existing areas of psychiatric training curricula

Practice Gap
Climate health and mental health impacts are a new but important area of undergraduate and graduate medical education. Within the next decade and increasing thereafter, all practicing physicians will be regularly confronted with the impacts of climate instability on all aspects of the social determinants of health and mental health, as well as the unique impacts of the existential stress of our deteriorating environment. Educators need assistance digesting the vast body of literature on climate mental health and incorporating it into an already crowded curriculum in a way that is practical and impactful, in proportion to the importance of climate change as the greatest health threat of the 21st century.

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Wu J, Snell G, Samji H, (2020) Climate anxiety in young people: A call to action, Lancet planetary health, 1-2

Abstract

Climate change is advancing rapidly, accompanied by a host of problems that include the effects of unstable weather, natural disasters, air pollution, fires, floods, and heat and environmental losses that affect both our essential resources and our psychological well-being. Higher rates of suicide, violence, neuropsychiatric disease, dementia, anxiety, depression, existential distress and domestic and civic destabilization are direct and indirect effects of advancing climate instability that impact psychiatric symptoms residents must identify and treat in their patients. These problems affect disadvantaged groups in gross disproportion, including non-white and under-resourced populations as well as those with mental illness. To rectify the unjust health impacts of climate change on these populations is an ethical imperative for all physicians.

How should training directors integrate this global problem into residency education? On the one hand, this is a problem that directly produces severe psychiatric symptoms and exacerbates underlying disorders. It is considered the greatest threat to health of our century, and has disproportionate effects on the mentally ill. On the other, it is a diffuse and complex influence on mental well-being that can become marginalized as we consider the essentials of training.

This session will consider this question through the introduction of teaching materials that cover core scientific and clinical knowledge and provide case studies for teaching climate psychiatric impacts. The bulk of the session will be spent workshopping the integration and use of these materials in the psychiatric curriculum and discussing the problems associated with including and teaching this material.

Agenda

Welcome – 10 minutes
Presenters and participants introduce themselves; participants indicate the benefits and obstacles they perceive in including climate mental health in their curricula and what they hope to gain from attending the workshop

Presentation of curriculum materials – 10 minutes.

Participants will be provided a two-page handout of the core scientific and clinical points regarding climate mental health that residents should be aware of and a 4-page handout and slide deck (provided electronically) of case studies that explore the intersection of climate change, psychiatric and psychological symptoms, and climate equity and justice issues for those with mental illness.

Small breakout group work – 25 minutes
Participants will discuss the materials provided and how and where they might incorporate them into existing curriculum structures. Discussion will be organized by panelists and breakout group leaders who have experience teaching in this area and will be facilitated by a series of questions such as, “How will climate impacts be most visible in cases encountered in common psychiatric settings?” and “What knowledge in these documents would be essential to prevent negative outcomes because of the way climate changes affect common psychiatric interventions?”

Large Group discussion - 15 minutes
Participants will share and collate the most common responses to and ideas about the use of the vignettes and clinical resources.

Wrap-up, action plan development, questions, and evaluations – 15 minutes

Title
Residents with Difficulties: When Accommodation and Performance Collide

Presenters
Kim Lan Czelusta, MD
Vishal Madaan, DFAACAP, DFAPA, MD
Elizabeth Ann Cunningham, DO
Tanya Keeble, MD
Rick Carlson, MD

Educational Objective(s)
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.

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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
Are We Prepared? Programmatic and Institutional Strategies to Address Discrimination Towards Minority Trainees

Presenters
Sarah Mohiuddin, MD
Adrienne Adams, MD, MSc
Neha Sharma, DO

Educational Objective(s)
1) Attendees will learn about the rate and prevalence of discrimination and microaggression that minority trainees face during training
2) Attendees will identify their current state of how they address discrimination and mistreatment as a program and as a larger system/institution
3) Attendees will identify practical strategies faculty can use as a program to intervene and support trainees who experience discrimination.
4) Attendees will identify institutional strategies to address structural discrimination at their institutions.

Practice Gap
Minority trainees often describe experiences with discrimination during the course of their medical training as well as during residency and fellowship. These include a range of experiences including refusal of care, decreased perception of clinical skill or acumen, inappropriate verbal comments on physical appearance, receiving less trust from staff or patients, and being mistaken for non-physicians (1). In addition to this, minority physicians are more likely to experience formal complaints (8) and are more likely to be dismissed from training programs (6). Despite the widespread occurrence of negative outcomes for minority trainees and physicians, few studies address how training programs and training directors can address this as a program. Even fewer studies address system and institutionally-based solutions. It is imperative that program directors and institutions work to not only recruit minority trainees, but also learn and implement strategies to address structural inequities impacting minority trainees, improve organizational climate, and help minority trainees thrive.

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Abstract

There has been increased focus on recruitment and retention of minority trainees. However, increased efforts are needed to improve programmatic experiences and organizational climate for minority trainees. This is of particular importance as we know that minority trainees experience discrimination and mistreatment at greater rates than non-minority trainees. In addition, minority trainees are more likely to experience disciplinary action during the course of training. They are also twice as likely to experience formal complaints that result in "fitness to practice" evaluations. Previous studies suggest that these experiences with discrimination during training impact trainee decisions related to program continuation and an overall sense of well-being. Despite increasing emphasis on diversity, equity and inclusion, many training directors and academic institutions are under-prepared to adequately address the needs of the minority trainees. Specifically, they struggle with addressing local and systemic issues that underlie these experiences with discrimination. This workshop serves to help training directors recognize experiences with discrimination within their home programs, intervene to support their trainees and build a culture that supports minority trainees throughout the course of training. In addition, this workshop serves to provide a framework for institutional changes to improve the organizational climate for minority trainees, including strategies for leadership and infrastructure, faculty development and bias-reporting mechanisms.

Agenda

0:00-0:05 Introduction
0:05-0:10 Brief presentation on types of discrimination trainees face in programs
0:10-0:25: Breakout #1: identify current state of how individuals address discrimination and mistreatment as a program and as a larger system/institution as well as barriers
0:25-0:30 Polling and report from Breakout groups on common themes and barriers
0:30-0:50 Presentation of specific strategies implemented at three different institutions to address discrimination
0:50-0:65 Breakout #2: Identify and develop action plans to address programmatic and systems-based solutions to discrimination in their home institutions.
0:65-0:70 Report from Breakout groups

0:70-0:75 Q&A and time for evaluation

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

Presenters
Mary Elizabeth Yaden, MD
Angel Augustin, MD
E Cabrina Campbell, BA, MD
Kristin Leight, MD

Educational Objective(s)
-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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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
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
Protecting your Trainees and your Program: How to deal with Trainee Unprofessionalism.

Presenters
Ahmad Hameed, MD, DFAPA
Randon Welton, MD

Educational Objective(s)
Educational objectives:

By the end of this seminar the attendees will be able to:

1. Describe steps for evaluating (and documenting) the conduct of trainee unprofessionalism

2. Identify strategies for managing unprofessional trainees

3. List resources that might be available in dealing with issues of professionalism

4. Discuss the emotional, psychological, and administrative impact that unprofessional trainees have on their colleagues and the program

Practice Gap
Despite the best efforts of training directors and recruiting committees to select flawless trainees, some trainees will display unprofessional and troubling behavior during their training. These behaviors may initially fall short of gross unprofessional conduct but do raise concerns among faculty members and trainees. Residency programs are often ill-prepared to define the line between acceptable, if unusual, behavior and frank misconduct which warrants administrative action or even termination. This 'grey zone' may include misuse of resources or time, sexualized comments and behavior, or extreme displays of emotion. Training programs can be guided by therapeutic impulses to ignore the behavior or treat the trainees rather than to confront or punish the trainee. This can have an unintended, adverse impact on trainees or faculty members who are witnessing the same behavior and having a different personal response. Trainees and faculty can divide into pro-trainee and anti-trainee camps in a similar fashion as splitting occurs on inpatient psychiatric units. Few resources exist to help training directors consider and discuss these situations.

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Abstract
This workshop will describe several cases of trainees who manifested, unexpected unprofessional and troubling behavior during their residency programs. Initially this behavior might not be egregious enough to warrant immediate administrative action. Often the reports of troubling behavior were second or third hand, undocumented, and minimized or denied by the trainee. Among the cases to be discussed included trainees who:

- Taking extreme advantage of vacation and CME policies

- Taking extreme advantage of generous cafeteria policies

- Behavior detrimental to the profession, institution and the program outside working hours

- Sexual innuendos in the presence of other trainees and medical students

- Hearing and reading what they wanted to hear and read to justify their behavior and actions

We will discuss some of the aspects that make these cases so difficult. There are often delays in reporting concerns but once the first concern is voiced there is a “piling on” of complaints. Other trainees may be reluctant to “tattle” on a peer. Some faculty members may be prone to pathologize or explain away bad behavior and give the trainee third and fourth chances. Those

same faculty members may exhibit a desire to be seen as “nice” and protective of the trainees. Decision makers like the Program Director may resist seeing the big picture and base their actions only on what they have personally experienced. Program Directors may also see identifying a failing trainee as a narcissistic injury to them which they resist.

Because of these factors, programs are often slow to react. Responding to these complaints requires the training director to either take on a potentially uncomfortable investigator role or to ignore unsubstantiated but concerning accusations from the staff and trainees. Programs often fail to appreciate the long-term impact that delaying action causes on trainees, their colleagues and the program. These behaviors can result in significant splits among trainees and faculty; between those who are ready to punish and those who deny that there is a problem or want to handle it therapeutically. The importance of thorough documentation will be stressed. Documentation should include signed statements from eyewitnesses as well as all documentation of the discussions and decisions concerning the trainee. We will review the options available to the training directors and review how they can select the most appropriate option.

Attendees will be invited to describe similar cases in their programs and how they resolved them.

Agenda

- Introduction – 5 minutes
- Description of case 1 – 5 minutes
- Poll and large group discussion about appropriate behaviors – 10 minutes
- Description of case 2 – 5 minutes
- Poll and small group discussion about appropriate behaviors – 10 minutes
- Description of case 3 – 5 minutes
- Poll and large group discussion about appropriate behaviors – 10 minutes
- General principles and resources for managing these troubling residents (Didactic) – 10 minutes
- Cases from attendees – (Large Group Discussion and Q&A)- Evaluation Survey and Conclusion - 15 minutes

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

Presenters
Kristen Durbin, MD
Kristi Kleinschmit, MD
Jordan Koncinsky, MD
Jennifer O'Donohoe, MD
Timothy Spiegel, MD

Educational Objective(s)
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.

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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
Rewriting the narrative: Managing groupthink in a psychiatry training program

Presenters
Megan Zappitelli, MD
Neha Hudepohl, MD
Anusuiya Nagar, MD
Raphaela Fontana, DO
Jane Ripperger-Suhler, MA, MD

Educational Objective(s)
At the conclusion of this workshop, participants will be able to:
- Define groupthink and its role in psychiatry training programs
- Identify the factors that contribute to challenging group dynamics among psychiatry residency and fellowship trainees
- Discuss strategies that can successfully manage group conflict when it is adversely influencing training programs and contributing to trainee and faculty burnout
- Generate solutions for group conflict in their home institution

Practice Gap
Trainee group dynamics are a powerful force in shaping the culture and "feel" of a psychiatry residency or fellowship training program. The groupthink construct occurs when a desire for a shared group opinion on a concept surpasses individually held beliefs or opinions. Groupthink can promote the culture and well-being of a training program; however, when groupthink turns negative, the culture of a training program can feel impossibly challenging for all involved. Program directors and leadership may not always be prepared to navigate the negative narratives that can be created by the group. The power of groupthink can impact trainee and faculty morale, recruitment practices, and even impact ACGME site survey results. Groupthink can also divide trainees from their program leadership. Program directors may feel that their responses are reactive instead of proactive, which may contribute to reinforcement of negative groupthink mentality.

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Abstract

Managing interpersonal conflict and trainee burnout is one of the most challenging aspects of a program director's responsibilities. This is particularly difficult when there is a divide between the trainees and the faculty —the "us" and the "them." In many cases groupthink among trainees and faculty promote this division to support group cohesion. Unfortunately, this division also contributes to unwarranted conflict between groups, to burnout, to decreased job satisfaction, and even to attrition. Psychiatry training program leaders can learn how to manage the power of groupthink in effort to unify the group while still promoting the needs of the individual group members and to promote diversity of opinion.

During this workshop, participants will learn about the groupthink construct and its role in psychiatry training programs. Participants will be asked to identify scenarios in their home institutions that contribute to the groupthink construct, and ways in which this impacts resident and faculty morale and program dynamics. Participants will be given the opportunity to discuss openly the difficulties of navigating negative trainee group dynamics and creating collaborative solutions to resident concerns. Case scenarios of groupthink will be discussed, and participants will problem-solve approaches and solutions using traditional methods and interventions based on the groupthink model. Participants will discuss in both breakout groups and with the larger workshop the ways in which these interventions can create unique solutions to destructive group dynamics. At the conclusion of this workshop, participants will be able to incorporate these tools to navigate group conflict in their home training programs.

Agenda

0-5 minutes – Introduction and Learning Objectives
5-15 minutes – Presentation of the groupthink construct and psychiatry trainee group dynamics.
15-30 – Breakout groups: case-based discussion of several real-life scenarios that involve groupthink in psychiatry training programs. Each group will have a unique case that they will collaboratively problem-solve and will share back to the large group.
30-40 minutes – Presentation of methods used to constructively manage groupthink.
40-55 – Breakout groups reconvene to collaboratively problem-solve their scenario using the skills learned to manage groupthink and will share back to the large group.

55-65 – Larger group discussion about ways to implement strategies for managing groupthink in home institutions.
65-75 – Question, answer and wrap-up session

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

Presenters
Belinda Bandstra, MA, MD
Lucy Ogbu-Nwobodo, MD, MS
Sallie DeGolia, MD, MPH

Educational Objective(s)
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.

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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
Reducing the Power Distance Between Trainees and Faculty: Mentorship Initiative for Diversity and Inclusion

Presenters
Sam Saenz, MD, MPH
Catherine Shir, MD
Kyle McKinley, MPH
Belinda Bandstra, MA, MD

Educational Objective(s)
1. Participants will learn about the needs of mentees with diverse backgrounds and intersecting identities, including race, gender, and sexual orientation.
2. Participants will increase their knowledge base about cultural humility working with diverse trainees.
3. Participants will identify how microaggressions and the educational profiling of trainees from diverse backgrounds negatively impact them, and how to address this in mentoring relationships.
4. Participants will promote and develop productive and inclusive mentor-mentee relationships.

Practice Gap
Research has identified inequity of access to mentorship as an important factor in perpetuating disparities in representation in academic medicine. One study of underrepresented in medicine (URM) medical students showed that >30% of students perceived having difficulty finding a mentor or role model of the same background as a significant barrier, and that >25% of students perceived lack of a robust support network as a significant barrier. Lack of diverse faculty members may contribute to URM residents reporting decreased satisfaction and benefit from mentorship relationships, and URM residents are less likely to perceive mentorship initiatives as inclusive of URM individuals. This may be due to the distinct career barriers URM individuals face, including bias, isolation, difficulty with cross-cultural relationships, and devaluation of work.

In our own program, resident mentee pre-programmatic feedback provided further impetus for space to discuss larger themes related to diversity, equity, and inclusion in academic medicine. For example, 37.5% (3/8) of resident respondents were either “somewhat dissatisfied” or “very dissatisfied” with the workplace culture of diversity and inclusion; 25% (2/8) of resident respondents similarly felt dissatisfied with a feeling of relatedness in academic medicine. One resident mentee asked program leadership to “make space for mentees to use this as a platform to educate the mentors in the room about our experiences.”

Scientific Citations
The need for this activity was brought to our attention after examining the needs of our own department, which specifically lacked a collaborative space for residents and faculty to explore

and apply important skills in allyship, anti-racism, and cultural humility to foster a more inclusive learning environment throughout the department.

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Abstract

Recognizing the importance of culturally attuned, inclusive mentorship in reducing the disparities in academic medicine, researchers have begun to explore evidence-based approaches to mentorship that are culturally informed. There has been growing interest in developing more interactive mentorship models that explicitly explore the cultural differences between mentors and mentees. Such models acknowledge that encouraging open and honest discussions about topics such as race, discrimination, and unconscious bias can build more authentic mentorship relationships. They also improve the capacity of mentors to actively address racial and ethnic dynamics in their mentoring relationships. Mentorship interventions

guided by the above ideas may help increase the representation of minority physicians and defuse the discomfort that often surrounds conversations on culture and race.
To explicitly address the unique mentorship challenges that trainees from diverse backgrounds face, we established a specialized mentorship program, the Mentorship Initiative for Diversity and Inclusion (MIDI). The program, which was resident-initiated and resident-led, recruited and paired twelve residents with twelve mentors for a year-long, guided mentorship experience. This workshop aims to replicate the collaborative learning model of this mentorship program to promote meaningful conversations about identity and culture. Specific topics covered will include power distance in mentorship, sponsorship, and rupture/repair in mentorship relationships. This workshop teaches participants key frameworks for recognizing and addressing common pitfalls when mentoring across cultures and identities, such as responding to microaggressions. Participants will work together in small groups to apply these frameworks to cases inspired by real-world mentorship scenarios. Lessons will be shared from our first year in running this program.
This workshop has been produced by trainees with a faculty mentor/AADPRT member.

Agenda
5 min: Introduction
5 min: Background and intersectional challenges in supporting diverse trainees
10 min: Power and culture in the mentorship relationship
10 min: Common pitfalls in working across differences in culture
10 min: 1st case example followed by small group breakout discussion
10 min: Strategies to improve mentorship relationships: sponsorship, cultural humility, addressing ruptures
10 min: 2nd case example followed by small groups breakouts
10 min: Large group discussion and reflection
5 min: Q&A

Title

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

Presenters

Gerald Busch, FAPA, MD, MPH
Cathryn Galanter, MD
Kenneth Zoucha, MD
Ray Hsiao, DFAACAP, MD
Kevin Simon, MD

Educational Objective(s)

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.

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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

Title
Teaching child and adolescent psychiatry fellows to develop an ethical framework and health systems approach for practice with multicultural communities along the U.S./Mexico border

Presenters
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Adrian Mejia, MD

Educational Objective(s)
By the end of this session, the participant will be able to:

1. List the 5 considerations for a framework for ethical practice in multicultural communities to teach to fellows.

2. Discuss and apply these 5 considerations in case studies provided through the workshop.

3. Determine what other considerations should be made in addition to the 5 discussed for ethical practice in multicultural communities to teach to fellows.

Practice Gap
Fellows rely on supervisors' guidance on how to navigate ethical dilemmas during the training. The cultural and linguistic needs of multicultural communities often add to the complexity of teaching psychiatry fellows to develop an ethical framework. While the process for approaching dilemmas may be situational, supporting fellows to develop an ethical framework beyond training is essential to the field of psychiatry in multicultural communities. The challenge of developing an ethical framework requires further attention when working with multicultural communities where psychiatric practices do not always align with the beliefs of the family or the community. The health-systems approach holds promise for understanding the person in the environment, health perceptions, mental illness, and medication beliefs, illness presentations, and interactions between the family system and psychiatrists. Supporting fellows to develop an ethical framework that integrates a health systems approach is ideal for building the psychiatric workforce that can meet the needs of a multicultural population. Clinical psychiatry training directors along the rural southern U.S./Mexico border aspire to develop trainees that are prepared to provide ethical practice in multicultural communities. Child psychiatry fellows working with diverse communities face ethical dilemmas where decisions can be medically appropriate, but not congruent with the core beliefs of the cultural group. The disconnection between practice and beliefs can potentially jeopardize university-community relationships and the therapeutic alliance with the family. Another disconnection occurs when psychiatry fellows take the "physician knows best" approach that contributes to racial and ethnic disparities. Disconnection is likely to occur when psychiatry trainees are unable to account for language differences, recognize and respect alternative healing practices,

and examine beliefs, judgments, and practices during clinical encounters. Clinical training directors are posed with the challenge of training fellows to develop an ethical framework for practice that respects the inherent dignity of the community.

Scientific Citations

1. Corneau, S., & Stergiopoulos, V. (2012). More than being against it: Anti-racism and anti-oppression in mental health services. Transcultural psychiatry, 49(2), 261-282.
2. Dolgoff, R., Harrington, D., & Loewenberg, F. M. (2012). Brooks/Cole empowerment series: Ethical decisions for social work practice. Cengage Learning.
3. Judd, F., Davis, J., Hodgins, G., Scopelliti, J., Agin, B., & Hulbert, C. (2004). Rural Integrated Primary Care Psychiatry Programme: a systems approach to education, training and service integration. Australasian Psychiatry, 12(1), 42-47.
4. Mosalanejad, L., Razeghi, B., & Ifard, S. A. (2018). Educational Game: A Fun and team based learning in psychiatric course and its effects on Learning Indicators. Bangladesh Journal of Medical Science, 17(4), 631-637.
5. Prince, M., Livingston, G., & Katona, C. (2007). Mental health care for the elderly in low-income countries: a health systems approach. World Psychiatry, 6(1), 5.

Abstract

Fellows rely on supervisors' guidance on how to navigate ethical dilemmas during the training. The cultural and linguistic needs of multicultural communities often add to the complexity of teaching psychiatry fellows to develop an ethical framework. While the process for approaching dilemmas may be situational, supporting fellows to develop an ethical framework beyond training is essential to the field of psychiatry in multicultural communities. The challenge of developing an ethical framework requires further attention when working with multicultural communities where psychiatric practices do not always align with the beliefs of the family or the community. The health-systems approach holds promise for understanding the person in the environment, health perceptions, mental illness, and medication beliefs, illness presentations, and interactions between the family system and psychiatrists. Supporting fellows to develop an ethical framework that integrates a health systems approach is ideal for building the psychiatric workforce that can meet the needs of a multicultural population. Clinical psychiatry training directors along the rural southern U.S./Mexico border aspire to develop trainees that are prepared to provide ethical practice in multicultural communities. Child psychiatry fellows working with diverse communities face ethical dilemmas where decisions can be medically appropriate, but not congruent with the core beliefs of the cultural group. The disconnection between practice and beliefs can potentially jeopardize university-community relationships and the therapeutic alliance with the family. Clinical training directors are posed with the challenge of training fellows to develop an ethical framework for practice that respects the inherent dignity of the community. Our aim is to present a case discussion of a psychiatry training program working with multicultural communities along the U.S./Mexico border and lessons learned in supporting fellows to develop an ethical framework for navigating dilemmas. We focus primarily on training experiences with child and adolescent psychiatry fellows, although our experiences may apply more broadly to trainees working with multicultural communities. Our ethical framework adapts from the ethical screening framework

(Dolgoff, Loewenberg, & Harrington, 2005) and the anti-racism and anti-oppression framework (Cornea & Stergiopoulus, 2012). We include a) identifying and valuing community values; b) fostering reflexivity of personal and professional values; c) developing strategies for minimizing conflicts between competing values; d) co-constructing knowledge of mental health with the community; and e) selecting effective decisions that will most likely benefit the community while also attending to professional obligations. We draw upon patient cases from the child and adolescent psychiatry training program to illustrate the framework to conference participants. We will implement the Jigsaw method to aid conference participants in active discussion and develop other suggestions for developing a teachable ethical framework. Training directors support fellows in developing an ethical framework and health systems approach for working with multicultural communities. By developing a teachable framework, training directors may support fellows to maintain the inherent respect and dignity of the community, where they learn from and about the community, make ethical decisions that work within the system not against it. Change in medications could be considered if indicated after collaborative discussions with the family.

Agenda

Presenter introductions - 5 minutes
Review educational objectives - 5 minutes
PowerPoint content - 10 minutes
Small-group breakouts - 20 minutes
Large group discussion - 15 minutes
Wrap-up - 5 minutes