

# Snapshots from the Cutting Edge: Innovations in Child and Adolescent Psychiatry Training to Address Workforce Shortages

Anthony P. S. Guerrero<sup>1</sup>  • Laura Weiss Roberts<sup>2</sup>

Received: 28 June 2017 / Accepted: 9 July 2017 / Published online: 21 July 2017  
© Academic Psychiatry 2017

Child and adolescent psychiatry continues to be an important and unique sub-specialty. While it is commonplace for general psychiatrists to see elderly patients, patients with addictions, forensic patients, and patients with co-existing medical illnesses, it is uncommon in many places for psychiatrists to see children and adolescents, a group which currently represents nearly one-quarter of the entire US population, without fellowship or other equivalent training (via a triple-board or post-pediatric portal program). Current Accreditation Council for Graduate Medical Education (ACGME) psychiatry residency training program requirements call for no less than 2 months of child and adolescent psychiatry, supervised by child and adolescent psychiatrists who have been certified by the American Board of Psychiatry and Neurology. This training prepares psychiatrists with general adult training to provide care, for example, to transitional age youth (16–24 years) under many circumstances. This 2-month requirement stands in contrast to other sub-specialty requirements, which are either of shorter duration (1 month for geriatric and addiction psychiatry, not specified exactly for forensic psychiatry) or do not necessarily require the supervision of board-certified subspecialists (geriatric, addiction, forensic, and consultation-liaison psychiatry) [1].

Updated workforce statistics have confirmed a continued shortage of child and adolescent psychiatrists in the USA. The current workforce of approximately 8300 child psychiatrists remains inadequate, as nearly 20% of all children and

adolescents experience psychiatric disturbances [2]. Child and adolescent psychiatry training programs, therefore, have the important challenge of building a workforce that is adequate in number, fully competent in the basic skills of the sub-specialty (currently defined by ACGME milestones), and additionally qualified and prepared to practice in a short supply/high demand context.

In this issue of *Academic Psychiatry*, we are pleased to feature articles on child and adolescent psychiatric training initiatives that are innovative responses to these contemporary challenges. Specifically, we touch upon modernizing training towards improving access, ensuring basic competency and compliance with milestones and new accreditation requirements, and, finally, improving recruitment.

Two of the most prominent strategies for improving accessibility to child and adolescent psychiatric services are telepsychiatry and primary care integration [3]. While the former can mitigate geographic barriers to access and reduce inefficiencies related to travel time, the latter further leverages child and adolescent psychiatrists' time and expertise through collaboration with primary care providers. Parmar et al. [4] describe child and adolescent telepsychiatry training for general psychiatry residents and Biel et al. [5] describe child and adolescent mental health training for pediatric primary care providers. While neither telepsychiatry nor primary care integration are mandated training experiences for psychiatry or its sub-specialties, these new models will likely play a greater role in the careers of future psychiatrists, and the need for psychiatric curricula in these areas, as introduced in these two articles, will increase.

Several of the articles in this issue describe strategies for improving recruitment into child and adolescent mental healthcare careers. Diamond et al. [6] deserve special commendation for their focus on undergraduate college students, who are at an earlier stage of career development than the

---

✉ Anthony P. S. Guerrero  
GuerreroA@dop.hawaii.edu

<sup>1</sup> John A. Burns School of Medicine, University of Hawaii, Honolulu, HI, USA

<sup>2</sup> Stanford University, Stanford, CA, USA

medical students and residents who are more common targets of recruitment initiatives. The programs described in the other articles in this issue may also benefit child and adolescent psychiatric recruitment. Parmar et al.'s program [4] may benefit recruitment of general psychiatry residents with a positive child and adolescent telepsychiatry experience, and Biel et al.'s program [5] may benefit recruitment of medical students and residents who are able to experience an effective primary care collaboration model.

The articles in this series provide very practical and concrete examples of how certain programs have managed their curricula in the era of milestones, facing an ever-growing need to ensure basic competency amid pressures to provide more services for more people in a shortage specialty field. Sadhu et al. [7] provide a very useful and accessible discussion of the “nuts and bolts” of curricular restructuring, in the interests of “hardwiring” compliance with new ACGME accreditation requirements, which essentially defer to programs on how exactly requirements should be met. Peeples et al. [8] compare the use of problem-based learning (PBL) among child and adolescent psychiatry programs and raise the provocative question of whether PBL may, in fact, be an ideal and potentially standardized way to teach and assess medical knowledge milestones, which often call for the active application of knowledge. Finally, Drell [9] discusses, from a very practical standpoint, how to teach the core topic of psychodynamic psychotherapy, a competency which risks being diluted in the context of the following: the necessity of increased curricular coverage in contemporary service delivery models, the overwhelming need to see as many people as possible in certain practice settings, and the fact that simultaneous attention must be paid to the multitude of other competencies that need to be demonstrated within 2 years of fellowship training.

Ongoing innovation in training is needed, along with ongoing dialog about this innovation, in order for child and adolescent psychiatry, as a sub-specialty, to achieve its training goals, to be accessible *and relevant* in an evolving healthcare system, and to resiliently face the challenges inherent in being in short supply. The articles in this issue of *Academic Psychiatry* provide a useful snapshot of the types of innovation on the cutting edge of child and adolescent psychiatric training. The articles also provide an important stimulus for further critical questions that the specialty will need to face. For example, if we deem telepsychiatry and primary care integration training as potentially valuable, even if not currently required, how could we make such training more available in programs across the country?

Integration with primary care, greater engagement of telehealth modalities, and collaborative care models are increasingly recognized for their value in strengthening quality and access to mental health services in the USA and elsewhere throughout the world [10]. Such approaches are critically important for rural communities, which represent 75% of the US

landmass and have far too few psychiatrists and child psychiatrists to meet the tremendous needs of residents. Primary care integration and expanded telehealth could enable economically established countries to build capacity by providing resources to geographic regions with even more significant system challenges and workforce shortages. It is clear that the training programs of academic psychiatry departments in the USA could help to amplify the positive impact of early career physician expertise. It is important to understand, however, that this may be an important global responsibility in the future.

Recruitment has remained a challenge for the specialty, notwithstanding important efforts to diversify portals of entry, to advocate for enhanced funding and incentives for training, and to promote mentorship [11]. In light of the current workforce challenge and considering the potential importance of child and adolescent psychiatry experiences for general psychiatry residents, perhaps the discipline should revisit the question of whether child and adolescent psychiatry training needs to be strengthened during the 4 years of “general” psychiatry training. We strongly endorse this approach, as it prepares general psychiatrists to provide care for individuals and families across the age spectrum. We believe that strengthened exposure to child psychiatry during general residency upholds the original intent of general training, rather than “everything but child” as is currently more often implied. Moreover, the state of translational neurosciences in psychiatry is such that each medical student, resident, and fellow should acquire basic knowledge of neurodevelopmental processes and how they influence the prevention, emergence, and amelioration of all mental disorders.

Now that the field is targeting earlier stages of career development for recruitment, is child and adolescent mental health knowledge available enough in pre-medical school curricula? Is it possible to make health and mental health literacy a curricular focus even earlier, starting in elementary, middle, and high school, thereby producing not only potentially increased recruitment, but also a mentally healthier population with a lower demand for services in the future? Three years ago, one of us, along with faculty colleagues at Stanford, created a novel program for high school students called the Clinical Neurosciences Immersion Experience, or CNI-X [12]. Over time it will be possible to determine whether such efforts lead to stronger recruitment into the mental health professions, including child and adolescent psychiatry, and lead to improved health outcomes.

Finally, it is important to remain mindful that, in the USA, child and adolescent psychiatry is a discrete, recognized subspecialty with a standardized training track; other countries are not so fortunate and have an even more dramatic shortage of child and adolescent psychiatric services [13]. Any innovations in the educational experiences of our fellows could improve child and adolescent mental health not only in the USA,

but also in other countries that strive to grow and train an adequate workforce. Clearly, the cutting edge of child and adolescent psychiatric training needs to continue to advance. *Academic Psychiatry* embraces its role as a catalyst for this advancement.

#### Compliance with Ethical Standards

**Disclosures** On behalf of all authors, the corresponding author states that there is no conflict of interest.

#### References

1. Accreditation Council for Graduate Medical Education (ACGME). ACGME Program Requirements for Graduate Medical Education in Psychiatry. Revised Common Program Requirements effective: July 1, 2016. Available from: [https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400\\_psychiatry\\_2016.pdf](https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2016.pdf) Accessed 6/18/2017.
2. American Academy of Child and Adolescent Psychiatry (AACAP). Workforce Issues. Last Updated February 2016. Available from: [http://www.aacap.org/aacap/Resources\\_for\\_Primary\\_Care/Workforce\\_Issues.aspx](http://www.aacap.org/aacap/Resources_for_Primary_Care/Workforce_Issues.aspx) Accessed 6/20/2017.
3. Fortney JC, Pyne JM, Turner EE, et al. Telepsychiatry integration of mental health services into rural primary care settings. *Int Rev Psychiatry*. 2015;27(6):525–39. doi:10.3109/09540261.2015.1085838.
4. Parmar A, Sharma P, Vats D, Aligeti M. Rural community child and adolescent psychiatry experience in an urban psychiatry residency program via telepsychiatry: residents' perspectives. *Acad Psychiatry*.
5. Biel MG, Anthony BJ, Mlynarski L, Godoy L, Beers LS. Collaborative training efforts with pediatric providers in addressing mental health problems in primary care. *Acad Psychiatry*. 2017; doi:10.1007/s40596-017-0709-1.
6. Diamond U, Di Bartolo CA, Badin E, Shatkin JP. Almost psychiatry: the impact of teaching child and adolescent mental health studies to undergraduate college students. *Acad Psychiatry*. 2017; doi:10.1007/s40596-017-0680-x.
7. Sadhu JM, Lee PC, Stewart C, et al. Lessons from the launch: program directors reflect on implementing the CAP milestones. *Acad Psychiatry*.
8. Peebles D, Guerrero A, Bernstein B, et al. Comparing and contrasting the use of problem based learning in child and adolescent psychiatry programs. *Acad Psychiatry*. 2017; doi:10.1007/s40596-017-0719-z.
9. Drell MJ. Teaching psychodynamic therapy during difficult times: one child training director's experience. *Acad Psychiatry*. 2017; doi:10.1007/s40596-016-0652-6.
10. Huffman JC, Niazi SK, Rundell JR, Sharpe M, Katon WJ. Essential articles on collaborative care models for the treatment of psychiatric disorders in medical settings: a publication by the academy of psychosomatic medicine research and evidence-based practice committee. *Psychosomatics*. 2014;55:109–22.
11. Kim W. Recruitment. *Child Adolesc Psychiatr Clin N Am*. 2007;16(1):45–54. viii
12. Stanford Medicine Department of Psychiatry and Behavioral Sciences. Clinical Neuroscience Immersion Experience (CNI-X). 2017. Available from: <https://med.stanford.edu/psychiatry/special-initiatives/CNIX.html> Accessed 6/28/2017.
13. Mian AI, Milavić G, Skokauskas N. Child and adolescent psychiatry training: a global perspective. *Child Adolesc Psychiatr Clin N Am*. 2015;24(4):699–714. doi:10.1016/j.chc.2015.06.011.