Advocacy Training in Residency and Addressing Needs in Child and Adolescent Psychiatry: A Review

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The American Medical Association (AMA), in its *Declaration of Professional Responsibility*, states that all physicians must "advocate for the social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being."[1] Increasingly, medical schools and graduate medical education (GME) programs are "adopting advocacy and service-learning curricula that include community resource identification and referral, screening for social determinants of health, [and] effective use of medical-legal partnerships and political engagement," aimed to improve outcomes of physician-driven advocacy efforts.[2]

Given the rapidly evolving political climate and health care reforms, trainings focused on medical-legal partnerships, health policy and political engagement serve to better enable the production of much needed and more well-informed and skilled physician advocates for children and adolescents. Moreover, child and adolescent patient populations have readily identifiable needs for effective physician-driven advocacy, as youth have "little political voice of their own and rely on the proxy voice of others" to affect change.[3] This author defines the role of the physician advocate as one encompassing purposeful action to affect change through the use of both information and skill. This is accomplished by identifying social determinants of health that adversely impact individuals and/or communities, using expertise to inform those that can enact change or initiating change oneself by addressing community and system-level issues through legislation/policy.

With the notable exception of pediatric training requirements, currently there is little specific and directed mention of "advocacy" despite some recent changes in language in the common or specialty training program requirements by the Accreditation Council of Graduate Medical Education (ACGME).[4,5,6] These requirements do not fully capture all that is expected of training programs. Additionally, each specialty has a Milestone Project through joint initiatives between the respective associated specialty board certifying organization and the ACGME. The projects provide frameworks for the assessment of the developing trainee for use in evaluations of key dimensions of physician competency in their field. These expectations and assessment criteria are specific to each required milestone. Similar to the ACGME training program requirements, pediatrics is again the sole exception containing both language for modular learning, a rotational experience, in "child advocacy" in their requirements and milestone specific to advocacy.[5,7] Despite serving the same population, child and adolescent psychiatry (CAP) fellowship ACGME requirements have yet to as fully incorporate specific and more directed language for advocacy training as pediatric programs do respectively. Requirements for CAP fellowship have made some effort to include language inferring advocacy training without actually using the term "advocacy." Instead, the language that is used describes only the level of competency in a specific learning domain in the evaluation metrics for milestone achievements including understanding of systems as a criteria for higher marks in the grading rubric.[6,8] This alone is insufficient as the trainee can still achieve the higher level marks without necessary meeting this specific criterion.

To provide an informed and evidence-based representation of current practices and methodologies used to train residents around advocacy, this author performed a systematic literature review. This review included literature from across all medical specialties, with a particular focus on CAP programs, that addresses the training of residents in health policy and legislative advocacy. This

author posed the following specific questions: (1) What are the current requirements for advocacy training in resident programs with additional focus on CAP fellowship programs? (2) What are the current learning objectives, practices and competency assessments for effective advocacy training with specific attention to health policy and legislative advocacy?

Method

A fixed-length systematic review of academic literature on advocacy training during residency and a subsequent review of academic literature specific to advocacy training during psychiatry and child and adolescent psychiatry training programs was obtained through PubMed. Table 1 summarizes the inclusion criteria, and Figure 1 on the following page, summaries the search strategy and keywords used. Manual search of resulted publications, referenced articles, ACGME Training Program Requirements/Milestones Projects and "related" publications recommended by PubMed and/or GoogleScholar was performed. All relevant publications published from January 1992 to December 2017 were included in this review.

Table 1. Criteria Used to Assess Academic Literature and Related Articles for Inclusion

1.	Clear focus on specific domains of advocacy training; policy education, policy change, contacting legislators, understanding health inequalities, and understanding the role of the health advocate.
2.	Clear focus on training house-staff/resident physicians in advocacy efforts, and/or competency, and/or interest in health care advocacy.
3.	Format was limited to letters to editors, editorials, opinion/commentaries, cohort studies, systematic reviews, prospective and retrospective appraisals of advocacy training efforts, and meta-analyses.
4.	Articles were required to be published/presented in finalized draft.
5.	Excluded articles were those with clear focus only in advocating for resident physicians, on patient advocacy regarding health care choices without inclusion of above noted issues pertaining to advocacy, or solely promoting citizens' access to existing services or benefits, etc.
6.	Due to the rapidity of change in the policy landscape and residency training requirements, a 25year scope was applied to search results limiting all results to those published from January 1, 1992 to December 31, 2017.

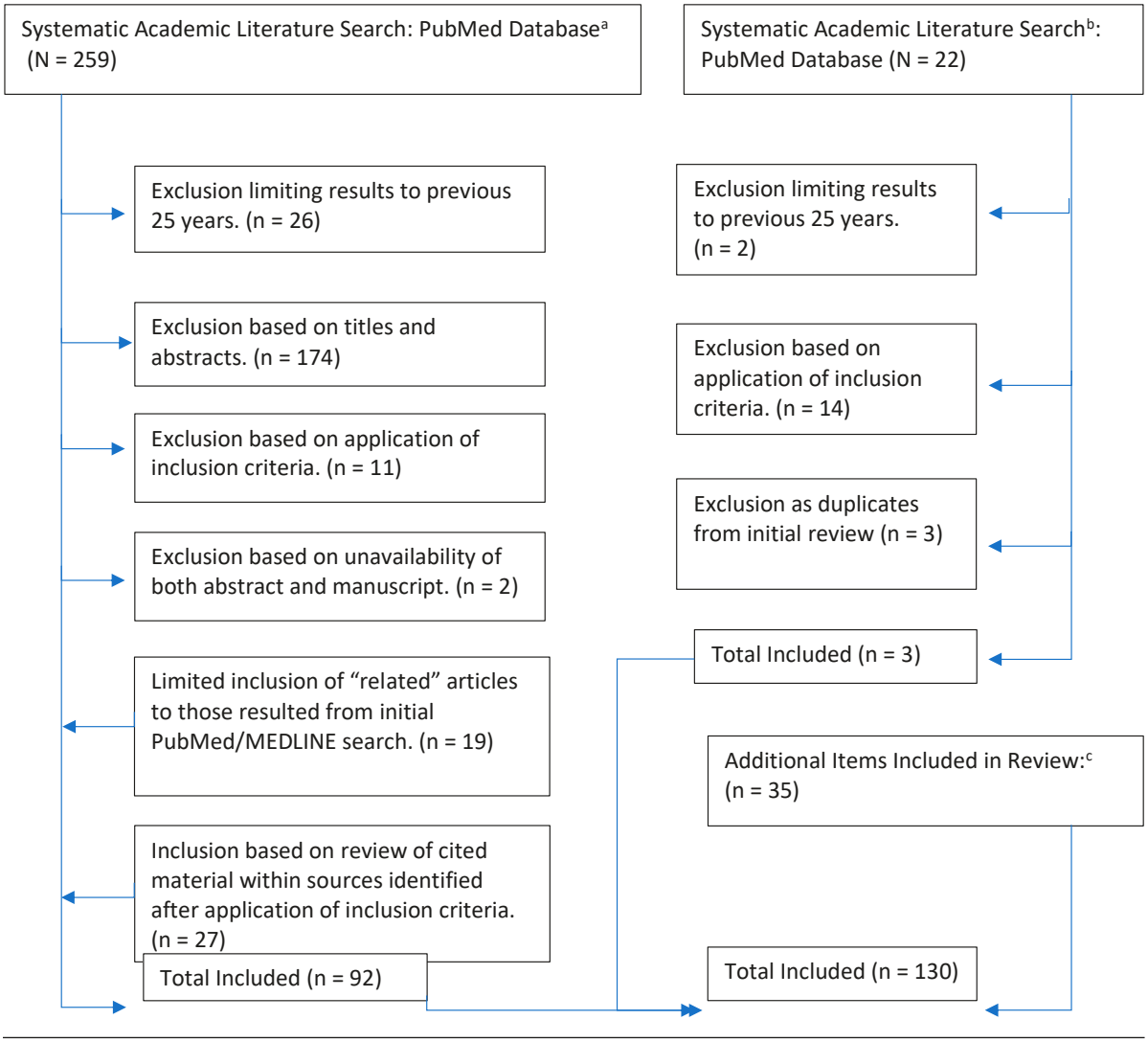
Results

The literature search produced 281 publications, of which 49 met the inclusion criteria and were reviewed. An additional 46 publications were identified from materials referenced or related, as noted above, and reviewed. Additional items reviewed included ACGME Program Training Requirements (n = 18) and Milestone projects (n = 17). A total of 130 sources were selected and reviewed; these sources included literature reviews, meta-analyses, letters to editors, opinion editorials, cross-sectional surveys, retrospective/prospective analyses, published program requirements/milestones and textbook excerpts.

What are the current requirements for advocacy training in resident programs with additional focus on cap fellowship programs? From among the reviewed publications, ACGME program requirements and Milestone projects, only Pediatric training programs had language requiring modular learning in advocacy including the requirement that "a minimum of five educational units of ambulatory experiences, including: (Core) ambulatory experiences to include elements of community pediatrics and child advocacy."[4,5,6,7] The common program requirements and other specialty specific requirements include advocacy language that is limited and does not require a specific experience in advocacy during training. It requires programs to train residents and fellows to "advocate for the promotion of health and the prevention of disease and injury in populations."[4] Psychiatry program requirements include the addition of "advocate for the promotion of mental health and the prevention of mental disorders" and "advocate for quality care and optimal care systems," and child and adolescent fellowships include the additional statement requiring trainees to "advocate for quality patient care and assist patients in dealing with system complexities. Including disparities in mental health for child and adolescents," but neither require a training experience in advocacy.[6,9]

The child and adolescent psychiatry fellowship milestones project mention advocacy as part of understanding systems which include schools, courts, community based organizations, and governmental

Figure 1. Literature Search Result Analysis Pathway



Note: *[a]Terms: Advocacy AND Residency AND Training*
[b]Terms: Psychiatric AND/OR Psychiatry AND Residency AND Advocacy AND Training
[c]Additional Items include Specific ACGME Program Training Requirements and Milestone Projects

agencies; looking further, advocacy is again mentioned in the grading criteria recommended to evaluate a trainees level of expertise.[7] The pediatric training programs have a milestone regarding systems-based practice specifically in advocacy with more advanced criteria ranging from the novice recognizing an issue in a patient evaluation relevant to public action to working on a new piece of legislation at the expert level.[4]

What are the current learning objectives, practices, and competency assessments for effective advocacy training with specific attention to health policy and legislative advocacy? As program requirements and milestone projects provide framework and recommendations, there has not been consistent standardization of how, when or where to implement an advocacy experience. Looking specifically at the

training requirements and opportunities, of the 83 pediatric residency training programs surveyed (response rate = 43%) 30% offered a separate training track and or 6 block individualized curriculum in community pediatrics or advocacy."[12] Schwartz *et al.* looked retrospectively at a 2-week elective experience where as Delago *et al.* compared 4-week and 2-week electives. They concluded that trainees preferred advocacy training interwoven throughout other rotations and that there is no statistically significant difference in outcome between 2- and 4-week elective experiences.[2,13] Goldshore *et al.* looked at trainees' experiences and concluded that >8 days of involvement in community settings (66.6%, n = 683) showed that the more involved the trainee had been during training the higher the likelihood of anticipated involvement in advocacy.[14]

Specific activities during the advocacy rotations or learning experiences required by pediatric training programs included legislative activities, clinic-based group projects, classroom based didactic and formal poster presentations as the most frequent teaching methodology.[12] Evaluation tools used to gage trainee performance and recommendations for training opportunities were also studied, of which, grading by observational evaluation, portfolio review and written reflection was most frequent.[12] One study reported that faculty and residents in one survey (n=79) described participation in either short-term or longitudinal projects was "the best way to teach and learn advocacy skills."[15]

Discussion

ACGME training requirements provide a framework and a set of requirements to maintain a standard outcome for trainees. Taking a step further, Milestone Initiative Projects provide rubric-styled guidance and set of evaluation criteria to determine proficiency and competence attained during that training to more clearly define what an acceptable standard outcome should be in achieving specialty competency. Training programs may be providing opportunities in advocacy, but there is no requirement to do so. Pediatric programs have requirements for modular learning that have proven to be helpful in increasing trainees willingness to participate in advocacy related events as well as anticipation of involvement.[14] As the health care landscape evolves and system frustrations with managed care continue, understanding the principles of effective advocacy with the expectation of involvement instilled during training will be a critical step to address the gap that has already been identified and addressed in pediatric training programs. As subspecialists who provide care to children and adolescents as well, child and adolescent psychiatrists should be provided training to be more effective advocates similar to our colleagues in pediatric training programs.

Few studies were identified that evaluated general psychiatry resident or child and adolescent psychiatry fellows' interest in advocacy education or experiential learning opportunities. It is time to consider new strategies to broaden the scope of training to include advocacy more definitively. Legislative committees of local and national organizations need to expand their role from engagement in public policy to include training.[8] Whether through pilot initiatives in individual programs or through outside experiences, such as the American Academy of Child and Adolescent Psychiatry (AACAP) Resident Scholar Fellowship, opportunities for training need to be expanded. Changes to training program requirements is the most effective strategy to standardize a framework for training strong child and adolescent psychiatry advocates.

Take Home Summary

Children rely on the voice of others to affect political change. Pediatric residencies have required training in advocacy since the early 2000s to address this need for children, and child and adolescent psychiatry training programs need to catch up.

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