Training, Education, and Curriculum Development for the Pediatric Psychiatry Emergency Service

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KEYWORDS

• Curriculum • Training and education • Emergency pediatric psychiatry
• Child psychiatry

KEY POINTS

- There is no standard care delivery model for pediatric psychiatric emergencies.
- With minimal directives, training programs lack guidance on developing optimal curricula for this setting.
- A model curriculum for child and adolescent psychiatry trainees must assess baseline knowledge, teach core subject content, encourage development of essential skills, and supervise learners.
- Future directions include further study in current pediatric emergency psychiatry education as well as expanding the scope and reach of curricula to different learners and delivery models.

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BACKGROUND AND RELEVANCE

Emergency child psychiatry is growing in importance and relevance. There is increased use of the emergency department (ED), both as a site for child and adolescent crisis evaluation and also as a front door to mental health services.[1,2] Training in this area is relevant for all mental health professionals who may treat children. Child and adolescent psychiatrists will especially benefit from this education, as even those who do not work primarily in the ED will use learned crisis skills while taking calls, working within a group, or practicing individually.

There are multiple models for service delivery of emergency psychiatric care. These models include mobile crisis services in the community, freestanding crisis centers, psychiatric consultation to the emergency department, separate locked psychiatric areas within the ED, and specialized comprehensive psychiatric emergency programs.[3] Additionally, children and adolescents receive evaluations in different ways. Some programs use social workers to triage and assess patients and determine appropriate disposition, whereas others consult psychiatry for each patient with a behavioral health chief complaint. Within each of these settings, there may be various types of front-line care providers at distinct levels of training, including but not limited to: social workers, licensed mental health workers, advanced practice nurses (APRNs), psychology trainees, medical students, adult psychiatry residents, residents from alternate disciplines, child psychiatry fellows, and attending child and/or adult psychiatrists. These front-line providers may report to various people in different specialties, such as ED physicians, senior-level child and adolescent psychiatry trainees, and attending psychiatrists.

INTRODUCTION TO CURRICULUM DEVELOPMENT IN EMERGENCY PSYCHIATRY

Given there is no one standard delivery model for psychiatric emergencies, many different education and curriculum models have been developed to address the individual system needs of each training program. Several emergency psychiatry services have created boot camp curricula targeting first-year child psychiatry fellows in the first few months of training. This curriculum typically contains information about the highest yield topics, such as managing agitation, assessing suicide and homicide risk, and identifying legal and other issues within the specific system of care. Alternatively, other services have created educational opportunities within the rotation itself. These opportunities typically include a detailed approach to pertinent topics, such as communication and triage, risk assessment, workup for first-break psychosis, legal issues specific to the ED, and child protective laws. Many programs use both models.

Educators are responsible for producing core learning outcomes for their medical curricula.[4] The Accreditation Council for Graduate Medical Education (ACGME) has published vague guidelines on the necessary elements of education in emergency child psychiatry: “Fellows must have an organized educational clinical experience in…initial management of psychiatric emergencies in children and adolescents.”[5] ACGME expects trainees to demonstrate proficiency in 6 core competency areas of medical knowledge, patient care, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Beyond this, there are no formal curricular objectives for emergency child psychiatric care.

With minimal directives, programs lack guidance on developing optimal curricula for this setting. There is some guidance by way of general emergency psychiatry training curricula.[6–9] However, nothing to date has specifically addressed pediatric emergency psychiatry. Therefore, this group designed an informal survey distributed to American