

CONCLUSIONS

We are at a crossroad in determining where we are going with medical education in this country. We have a choice to seek the high ground and approach the ACGME competencies with an invigorating, innovative approach. We can curse at the darkness and look at the glass half-empty (i.e., these competencies were thrust upon us and to some faculty represent yet another hoop to jump through). On the other hand, for those of us immersed in medical education during difficult financial times, we see the competencies representing a glass half-full (i.e., they are an opportunity to reexamine our educational system and create change). The competencies will provide avenues for scholarship for clinician-educators. The ultimate benefactors will be everyone who is a stakeholder, from our medical schools and training programs all the way to our parents and patients. I'm taking the high road and hope to see you with me.

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REFERENCES

1. Accreditation Council for Graduate Medical Education Outcomes Project. Available at: www.acgme.org/outcome. Accessed January 2, 2003
2. Knowles MS, Horton EF, Swanson, RA. *The Adult Learner*. 5th Ed. Woburn, MA: Butterworth-Heinemann; 1998
3. Covey SR. *Seven Habits of Highly Effective People*. New York, NY: Simon and Schuster; 1989
4. Boyer EL. *Scholarship Reconsidered Priorities of the Professoriate*. San Francisco, CA: Carnegie Foundation for the Advancement of Teaching, Jossey-Bass; 1990
5. Glassick CE, Huber MT, Maeroff GI. *Scholarship Assessed: Evaluation of the Professoriate*. San Francisco, CA: Carnegie Foundation for the Advancement of Teaching, Jossey-Bass; 1997
6. Council of Academic Societies Task Force on Scholarship, ed. *Acad Med*. 2000;75(theme issue):871-943
7. Smilansky J, Foley R, Runkle N, Solomon L. Instructor plays patient: an alternative to the case presentation. *J Fam Pract*. 1978;6:1037-1040

Are We Ready and Willing to Address the Mental Health Needs of Children? Implications From September 11th

The survey of pediatric practitioners by Laraque et al in this issue demonstrates the enormous emotional impact of the events of September 11, 2001: 23% estimated that >10% of their patients were presenting with mental health complaints re-

lated to September 11th,¹ likely a conservative estimate, because adults tend to underestimate the impact of disasters on children.² In a study using parental report also in this issue, Fairbrother et al³ illustrate the striking disparity between mental health needs of children in New York City post-September 11th and their receipt of counseling services: only 27% of children with severe or very severe posttraumatic stress reactions received any counseling. Together, these studies provide sobering insights into the psychosocial impact of crisis and should serve as a wake-up call to plan for the mental health needs of children in the setting of disaster or terrorism.

Fairbrother et al suggest a more active role for pediatricians in screening for mental health needs after a crisis and in providing services for less severe cases.¹ However, the survey of Laraque et al demonstrates that most pediatric practitioners feel inadequately trained to identify, let alone treat, these mental health concerns.³ In the setting of a crisis, pediatricians need to be able to detect somatization, screen for adjustment problems, perform timely and effective triage, provide brief supportive interventions, and make appropriate referrals for mental health support and counseling as indicated.²

It is not surprising that children's mental health needs after September 11th were not met fully, given the longstanding inadequacy of resources for quality mental health care for children throughout the United States and the formidable barriers to access and reimbursement constructed by the managed care environment. The primary medical care system has become the de facto mental health care system in the United States. Children are most likely to receive treatment, including psychotropic drugs, from primary care physicians for symptoms associated with mental disorders. Improving the skills of pediatricians to address the mental health needs of children and providing adequate reimbursement for these services therefore is critical not only to disaster preparedness, but because crisis is not uncommon in the lives of children, it is also vital to ensuring quality pediatric care even in the absence of a national crisis.

The events of September 11th hopefully will remain an unequaled tragedy in US history. This crisis, however, is not an isolated event but part of a growing concern related to terrorism; natural disasters continue to occur throughout the world as well. As such, the country is investing the resources to develop an unparalleled security system and initiate a much-needed rebuilding of its public health infrastructure. The events of September 11th are a tragic wake-up call regarding the chronically unmet mental health needs of our nation's children and our lack of preparedness to meet the increased demands in times of crisis. It forces us to ask: What more will it take before we are ready to make the commitment to create the infrastructure needed to support the mental health of children, our most vulnerable citizens and our country's future?

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REFERENCES

1. Laraque D, Boscarino J, Battista A, et al. Reactions and needs of tri-state area pediatricians following the events of September 11th: implications for children's mental health services. *Pediatrics*. 2004;113:1357-1366
2. Schonfeld D. Supporting children after terrorist events: potential roles for pediatricians. *Pediatr Ann*. 2003;32:182-187
3. Fairbrother G, Stuber J, Galea S, Pfefferbaum B, Fleischman A. Unmet need for counseling services by children in New York City following the September 11th attacks on the World Trade Center: implications for pediatricians. *Pediatrics*. 2004;113:1367-1374

Should We Test 4-Year-Olds?

Last fall, ~450 000 4-year-olds from every state and nearly every locale in the nation were administered a new standardized test called the Head Start National Reporting System (NRS). This may have been the single largest test administration in US history, and it is scheduled to be repeated again this spring and twice a year thereafter, each year at a cost in excess of \$16 million.

Many in the field urged that, if the test had to be given (and in most cases it is administered by the children's teachers), only a sample of children in Head Start be tested as is done in such other national assessments as the National Assessment for Educational Progress.¹ However, there is no sampling design for the NRS. All children who are the right age and speak the right languages (ie, English or Spanish) are tested.

The test items are extremely problematic (see ref. 2 for a critique). Although administered individually rather than group-administered, the NRS is fundamentally a high-stakes test that relies heavily on multiple-choice items. It consists of subtests that measure English-language competence, vocabulary knowledge, letter names, and mathematics.

Several key issues stand out as psychometric problems with the NRS. They include:

1. External validity of the subtests: There is no evidence to demonstrate that these particular subtests measure what they purport to measure.
2. Construct underrepresentation: Both the math and literacy items fail to capture important aspects of the construct that the test is intended to measure.
3. Construct-irrelevant variance: The test scores are very likely influenced by factors that are irrelevant to the constructs the test is intended to measure, such as choice of vocabulary, selection of

- illustrations, language burden of math items, or how the items appear on the page.
4. Lack of sampling strategies: There is no justification for testing every child in every program (except for non-English-, non-Spanish-speaking children) when a sampling strategy could save time and money and lessen or prevent teaching to the test.

Two additional issues at least as serious as these are noteworthy. The first is the model of pedagogy implicit in this test. It is a model of passive reception, of pouring into a vessel knowledge and skills that are needed for competence rather than recognizing learning as active and teaching as a joint process of interaction between child and adult. This is important because, in a workforce that contains <30% Bachelor's degree-prepared teachers and nearly 50% of teachers who do not even hold an Associate's degree, too many teachers in Head Start will alter their teaching to conform to the pedagogical model implicit in this test (this is also known as "measurement-driven instruction"). Research tells us that when a teacher knows that the results of a test will be used to make decisions that may affect the program's continuation (and this is one of the explicit purposes of the NRS), teachers are sorely tempted to begin teaching to the test.³

The second problem revolves around the overall rationale for the NRS. Policy makers in Washington, DC, have long recognized that poor children, and in particular children enrolled in Head Start, do not start school with skills equivalent to children from more affluent backgrounds. If Head Start were doing its job, this argument goes, this discrepancy or incipient achievement gap should be eliminated. This argument, of course, is very familiar. When Head Start was proposed originally by President Johnson, it was intended to reverse the cycle of poverty and bring equity to school achievement despite children's inequitable life circumstances. At first many believed that this could happen in just a 6-week summer program. We've learned a lot since 1965.

One thing we have learned is that children come to us dramatically different one from the other. Just because nearly all the children in Head Start are poor does not mean that they are all the same. Moreover, development is not linear. Research has shown repeatedly that, in the first 5 to 8 years of life, change is more the rule than the exception. That is one of the reasons that so little of the variance in outcomes at first or second grade is accounted for by preschool tests. The variance is ~25% for cognition and only 10% for socioemotional predictions.⁴ To believe that a test of this kind can tell us enough to improve programs and enhance children's learning is to assume a homogeneity of children and programs that is entirely unjustified.

All of this is not to reject the importance of measuring outcomes. It is possible to construct assessments that provide fair and equitable information about what young children have learned, how they have been taught, and what those working with them can do next in order to advance growth and