

BMJ Open Pilot qualitative exploration of the impact of community asset mapping within the undergraduate psychiatry curriculum at an Irish medical school

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ABSTRACT

Introduction Providing an effective response to global health disparities requires that future doctors are better prepared to embrace a public health ethos. Asset-based approaches see people and communities as coproducers of health and well-being and have begun to influence healthcare policy and the training of health professionals. However, to date, there is scant research in this area within undergraduate medical education.

Objectives To explore: (1) whether an asset-mapping assignment enhances medical students' experience and understanding of psychiatry. (2) The extent to which asset mapping promotes engagement of students with the clinical teams and communities in which they are placed, as perceived by students, clinical tutors and other team members.

Design Using a qualitative case study approach, semistructured interviews were completed with 16 students, 8 psychiatry tutors and 3 multidisciplinary team members (MDTMs) to explore their experiences of the initiative. Interview transcripts were thematically analysed, based on the study aims.

Setting This research was carried out at Ireland's largest medical school, among undergraduate medical students following a 6-week psychiatry clerkship.

Intervention Students completed a team-based assignment to elicit information on community assets from patients and presented an asset map to their host clinical team at the end of the clerkship.

Results We identified three over-arching themes within the data: (a) connecting the individual patient with the community; (b) relationship building; and (c) pedagogical challenges and rewards. Students found the asset-mapping assignment not only challenging but also rewarding and supported its retention within the curriculum. Tutors were predominantly positive, but some felt that the social focus diluted students' professional identity. MDTMs welcomed the initiative and wished to be more involved.

Conclusion Our findings suggest that community asset mapping offers added value within the undergraduate medical curriculum, sensitising students to the importance of exploring patient-perceived community assets.

INTRODUCTION

There is increasing awareness of the importance of the social determinants of health, and of the profoundly negative impacts on health

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ The study explored the perspectives of three key populations: students, clinical tutors and multidisciplinary team members across urban and rural clinical sites.
- ⇒ The study methodology did not address the patient experience of asset mapping.
- ⇒ The number of multidisciplinary team members participating in the study was low.

and mortality rates that result from avoidable structural inequities that disadvantage society's most vulnerable individuals and communities.¹ In addressing inequities between and within countries, the need to include the individual and the community as active partners in a whole-system approach to health and social care is recognised.^{2 3} Such concepts as salutogenesis, self-management, personalised medicine and social prescribing reflect this awareness and have gained considerable traction as reflected in the academic literature.⁴⁻⁷ In mental healthcare, the recovery model, prioritising the patient experience and quality of life over symptomatic improvement, has begun to shape policy and influence practice.⁸

In a parallel development, Kretzmann and McKnight, in the 1990s, criticised traditional societal responses to deprived communities as overly focused on problems and needs as opposed to strengths and capacities.⁹ They proposed asset-based community development (ABCD), as a model that aims to guide communities to discover untapped assets, so that their residents become agents of change rather than passive service recipients and as an alternative to the traditional need-based approach to service delivery.¹⁰ Assets, in this context, refer to those social, physical, environmental or human resources that, in the eyes of the beholder, protect against negative health outcomes and improve life chances.

Building on Kretzmann and Knight's original work, subsequent literature has described a range of initiatives and adaptations under the broad heading of asset-based approaches, and this has influenced recent developments in health and social policy in several jurisdictions.^{11–13} Quantitative studies within this paradigm suggest that mobilising community assets can improve the health of participants, while qualitative research points towards benefits including increased sense of involvement and enhanced well-being.^{11–13} Findings from a recent longitudinal study of participation in community assets among older people with long-term conditions also found an association with improved quality of life and reduced costs of care.¹⁴

Within the asset-based paradigm, community asset mapping has been frequently employed as a tool for an individual or group to generate an inventory of the resources and capacities available within a given community.^{15–16} Studies in this area, conducted primarily among deprived or marginalised groups, suggest that if it is to lead to better health, the asset-mapping process must be driven by and interwoven with relationships at every level.^{17–19}

More recently, asset-based approaches have transferred into health professions education settings. An evaluation of an asset-based component within a paediatric residency programme, reported changed trainee perceptions of the role of the paediatrician, with increased awareness of the importance of forging community partnerships.²⁰ Similarly, Calderon-Larranaga *et al* have developed a research protocol to evaluate the impact of an asset-mapping initiative in the context of a GP training programme in Spain, whereby trainees familiarise themselves with community resources during their clinical placements and then map the assets for subsequent presentation to their host primary care team.²¹ The process involves 8 hours of classroom-based training initially, with sessions on the social determinants of health and community diagnosis, the theoretical foundations of ABCD and the methodology of health assets mapping. This is followed by a practical exercise over a 1-month period, where GP trainees, with support from the primary care team, identify a prevalent health condition and then walk around the local area, introducing themselves to community organisations and identifying community health assets relevant to the selected health condition. The final step in the intervention is where the individual GP trainee collates and presents the identified health assets in a poster that is shared with the primary care team and community organisations.

Providing an effective response to global health needs requires that future doctors are better prepared to embrace a public health ethos and to work in community settings with relatively deprived and vulnerable populations.²² There is evidence that positive clinical learning experiences within underserved, rural and community settings during the undergraduate medical years increase the likelihood of medical graduates being better prepared for and choosing to practice in these

settings in the future,^{21–23–25} thereby helping to redress inequities in the medical manpower within and between countries. This, in turn, demands a shift from a medical professional identity that has been traditionally paternalistic and individualistic, towards one that is community-oriented, patient-centred and collaborative. This trend is consistent with the increasing emphasis on competencies in community-based medical education and with calls for medical schools to demonstrate greater social accountability.^{22–26}

Various initiatives have been reported in undergraduate medical education that aim to nurture awareness of psychosocial factors in healthcare, while promoting values of equity, teamwork and community orientation. These include situated learning experiences in primary care, identifying psychosocial cues in case-based learning, distributive clinical placements in rural areas, student-run clinics in resource-deprived communities and student selected components involving volunteer placements within community-based non-government organisations.^{26–30} To date, however, there is, to the authors' knowledge, no published research into the application of the asset-based approach in an undergraduate medical education context and the present study sought to address this important gap in the literature.

This study took place at the Royal College of Surgeons in Ireland (RCSI), University of Medicine and Health Sciences, a culturally diverse, international institution that offers a range of undergraduate and postgraduate medical programmes. The Department of Psychiatry at RCSI has developed an asset-mapping component in the undergraduate curriculum. We focused on fourth-year undergraduate medical students who were engaged in a 6-week clinical clerkship within geographically dispersed RCSI affiliated mental health services across Ireland.

The primary motivation for introducing the initiative arose out of feedback, from students themselves and their clinical educators, suggesting that during clinical clerkships in regional settings outside their normal RCSI Dublin base, students were often unfamiliar with local community supports and resources outside their immediate clinical teaching setting. This is despite that the university sourced local student accommodation in privately operated guest houses. Almost 80% of RCSI undergraduates are international students, who will progress on graduation to clinical practice in a range of service environments across the globe. It is important, in a context of medical manpower maldistribution, to provide early learning opportunities that promote potential career choices and pathways outside well-resourced and technologically advanced hospitals within large urban settings. Asset mapping as an undergraduate clinical training intervention, adapted from the approach described by Calderon *et al*,³¹ appeared to offer the basis for a pragmatic organisational response to this identified concern. Theoretical principles underlying the asset-based approach that especially appealed, from a pedagogical perspective, were that the model is both

community-oriented and person-centred, requiring that students engage as participatory learners with patients whose opinions matter and are listened to.

Here, we describe a pilot qualitative exploration of the asset-mapping initiative from the perspective of students, their clinical tutors and members of the host clinical teams in which the students are placed. The study objectives were to explore (a) whether an asset-mapping assignment enhances medical students' experience and understanding of psychiatry and (b) the extent to which asset mapping promotes engagement of students with the clinical teams and communities in which they are placed, as perceived by students, clinical tutors and other team members.

METHODS

Methodology

This study adopted a qualitative case study approach. Case studies are used to develop rich insights of bounded systems, for example, a programme, activity, group, etc, within a specific context.^{32–34} In the current study, the asset-mapping activity represents the bounded system, and the clinical clerkship in psychiatry represents the context. A distinctive feature of the case study methodology is the use of triangulation—using two or more theoretical perspectives, methodological approaches, sources of data, study investigators or methods of data analysis, to gain a richer understanding of the phenomenon under investigation.^{32–35} This study used *person triangulation*, a form of data source triangulation, whereby the perspectives and experiences of multiple populations (students, clinical tutors and multidisciplinary team members (MDTMs)) are explored to provide a more complete account of the investigated phenomenon (the asset-mapping activity).³⁶

Context

In year 4 of the RCSI undergraduate medical programme, students rotate through general practice, paediatrics, obstetrics and gynaecology and psychiatry placements. The psychiatry clerkship involves groups of 4–10 students being allocated to host community mental health services across 12 urban and rural settings across Ireland. These community mental health services, the majority of which are publicly funded, deliver a range of in-patient, outpatient, day and home-treatment interventions through consultant-led multidisciplinary teams serving geographic catchment areas. During the 6-week clerkship, students spend 4 days each week within their assigned clinical placements, taking histories, examining patients' mental state and joining mental health professionals in case-based discussions and multidisciplinary care planning meetings. Students return to the RCSI Dublin campus 1 day each week for workshops and seminars facilitated by academic faculty. Their learning outcomes are evaluated through formative and summative assessment at the end of each 6-week rotation and through an end-of-year written examination.

Intervention

The department of psychiatry faculty designed an asset-based assignment, informed by previous literature and largely modelled on and adapted from the approach proposed by Calderon-Larranaga *et al* among Spanish GP trainees.³¹ We piloted the initiative, as a compulsory but non-graded curricular activity, across all 12 clinical teaching sites during the 2021–2022 academic year. Initially, all 12 clinical tutors, all of whom were psychiatry trainees appointed for 1-year periods, attended a dedicated workshop with senior faculty in the department of psychiatry, as part of their induction to the tutor role and their expected tasks in supporting the asset-mapping assignment were outlined. Information on the delivery and assessment of the project were also included in the tutors' handbook (see online supplemental material 1). Faculty leading the project (VR and LM) offered tutors ongoing support by telephone and through an informal WhatsApp group for any outstanding questions or ongoing concerns they might have. Then, at the beginning of each of five 6-week clinical placement throughout the academic year, students themselves participated in a standalone small-group workshop, lasting approximately 90 min, also delivered by senior faculty, to introduce the topic and the assignment. The workshop was reinforced by slides, background reading and literature references, uploaded to the students online learning portal that they could access through the course of the subsequent clinical placement (see online supplemental material 2).

Students were tasked to create an asset map of resources in the local community as perceived by the patients they met during their placement. The asset-mapping exercise was carried out under the guidance of the local clinical tutor, whom students could approach individually or during their weekly group teaching sessions. In addition, tutors were asked to identify a designated permanent member of the local multidisciplinary team, who was familiar with the range of local community resources, as an additional source of support. However, it was emphasised that students were required to elicit information on assets directly from patients, as opportunities arose during their individual routine clinical contacts, rather than merely compiling an inventory of available community supports from information provided by staff. Students were asked to then engage collaboratively with their peers in each clinical site in preparing the asset map as a joint team activity, based on pooled data from their individual patient contacts. In the final week of their rotation, the students, in consultation with their tutor, arranged to make a formal presentation of the asset map to the host community mental health team and provided a PowerPoint digital poster of the map as a physical legacy of their activity during the clerkship. Permission to publish student asset maps was not sought, however, an illustrative example of an asset map, replicating the general style and content of those produced by the students has been developed by one of the authors (LM). This is shown in figure 1.

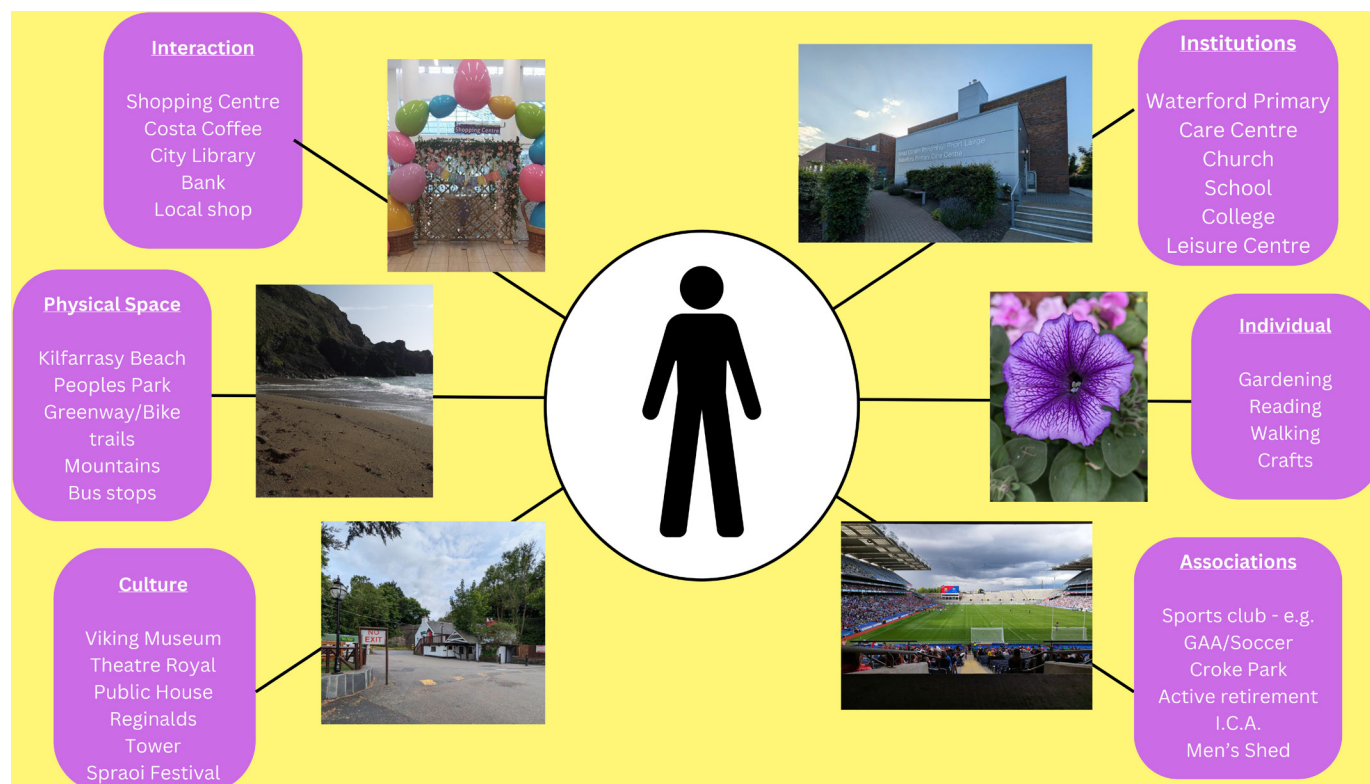


Figure 1 An illustrative asset map showcasing the diversity of resources included in students' posters.

While the asset map was not formally graded, each clinical team across the 12 sites, was asked to select the group of students that engaged best with the project over the course of the academic year, and students in the selected group were awarded an individual certificate of achievement by the RCSI department of psychiatry, which they could add to their learning portfolio and curriculum vitae.

Learning theory background

The intervention was informed by current perspectives in educational theory, which emphasise that learning is to a large extent a social activity, powerfully influenced by context and by the tools available in a specific setting.³⁷ As applied to undergraduate medical training, this points towards the importance of providing a holistic appreciation of the patient experience and situated learning opportunities in settings typical of those in which the future physician will ultimately practice.³⁸ Developments in experiential learning suggest that the meaning students derive is dependent on the quality of relationships between the learner, other agents and the environment.³⁹ It is also recognised that professional identity is intrinsically shaped by the context in which future doctors learn. An important element in optimising experience-based learning and preparing them for future practice is that students are not merely observers but that they make an actual contribution to patient care, however small, through authentic clinical experience with real patients.⁴⁰

More specifically, the experiential learning model developed by Kolb provided a useful conceptual framework for

asset mapping as an educational innovation, which is structured to broadly conform to Kolb's four learning cycles.⁴¹ The initial task of eliciting patient-perceived assets by students, representing a novel 'concrete experience' as described by Kolb, is followed by opportunities for reflective observation, abstract conceptualisation of the experience and active experimentation. In completing the asset mapping assignment, students engage in an iterative process of interpreting the information elicited from patients individually, preparing the asset map as an interactive team-based activity and then presenting it to the host clinical team. The authors anticipated that the asset mapping assignment would support and complement the students other learning, anchoring their pre-existing and largely theoretical knowledge of psychiatry's biopsychosocial model in an authentic and engaging clinical experience of the model's social element.

In approaching the asset mapping task, students would have acquired some limited advance knowledge, skills and practice in the area of reflective learning in the early years of their course. In year 4, all students also complete an integrated reflective writing (RW) assignment, which is a graded activity delivered as a collaboration between the departments of psychiatry, general practice and paediatrics. The RW assignment, which is formally graded by faculty, involves students submitting a 700-word RW report based on an actual clinical experience that had resonance during the course of the respective clinical clerkship.⁴² In preparation for the RW assignment, and separate from the asset mapping innovation, students

had participated in reflective learning workshops, using Gibbs reflective cycle and the Reflection Evaluation For Learner's Enhanced Competencies (REFLECT) rubric, at the commencement of their rotations through psychiatry, obstetrics and gynaecology, and general practice and had support from tutors in completing the RW task^{43 44}

Overall, however, the RCSI undergraduate psychiatry curriculum is more highly structured than those of the other clinical disciplines in year 4. Large and small group teaching in psychiatry is closely supervised by clinical tutors in each teaching site and supported by weekly campus-based lectures and a comprehensive course book and online material that provide very clear goals and explicit learning outcomes. The authors anticipated, therefore, that because of the relatively self-directed nature of the asset mapping assignment, placing greater demands for independent learning and ownership of the learning process, students might be particularly challenged.

Study sample

Participants comprised fourth-year undergraduate medical students who had completed a 6-week clinical clerkship in psychiatry, clinical tutors responsible for the supervision of students while on placement, and members of the host clinical teams (social workers, occupational therapists, consultants, etc) who had interacted with students as part of the multidisciplinary team in their placement sites. There was significant variation in the make-up of local clinical teams, and in the students' interaction with MDTMs across the 12 placement sites. Interaction with MDTMs was frequently either as a chance encounter, or following a formal introduction by the clinical tutor. This was further complicated by COVID-19 restrictions, which meant that many multidisciplinary team meetings were being held online during the time of this cohort's clinical placements.

Study recruitment

Students were informed of the study at the beginning of their clinical clerkships and were contacted by GE once they had completed these placements. The psychiatry administrative team provided lists of potential participants to invite to interview ensuring maximum variation of backgrounds throughout the groups following completion of each rotation. Students were randomly selected according to gender, placement location, and whether the student was direct or graduate entry.

There was a high rate of non-response among students, a situation which is increasingly noted in studies with student populations⁴⁵ and attributable to a range of issues, including: timing, interest in the research topic and fatigue brought on by being an over-researched population.^{45 46} Having initially attempted to purposively select students according to the defined criteria within each rotation, a collective decision was made by the authors to adopt a pragmatic approach to sampling, and an invitation to participate was extended to all students from the 2021/2022 cohort during the final rotation, so

Table 1 Interview participants and participant characteristics

	Number of participants
Total student participation numbers	16
Student characteristics	
Male	7
Female	9
Urban	8
Rural	8
Graduate entry medicine	8
Direct entry medicine	8
Total clinical tutor participation numbers	8
Clinical tutor characteristics	
Male	5
Female	3
Urban	5
Rural	3
Total multidisciplinary team member participation numbers	3
Multidisciplinary team member characteristics	
Male	1
Female	2
Urban	1
Rural	2

as to increase the sample size. We were, however, still able to recruit an equal number of students who were graduate/non-graduate entry and those who completed their clerkships in urban/non-urban areas. We achieved an almost equal split of female/male students (table 1).

Clinical tutors were approached by VR, as clinical lead for the study, and contact details were shared with GE where consent was provided. Clinical tutors provided details of MDTMs working within their services, who had exposure to the project, again where consent was provided. Participants were provided with a Participant Information Leaflet (PIL), given an opportunity to consider involvement, and to ask any questions in advance of meeting with the interviewer. All participants provided explicit, written, informed consent.

384 students, 11 clinical tutors and 3 MDTMs were invited to participate in the study. Ultimately 16 students, 8 tutors and 3 MDTMs were interviewed (table 1). One additional tutor dropped out prior to interview—no explanation was provided, nor required as set out in the study PIL and ethics application.

Patient and public involvement

No patient or public involvement.

Data collection

Qualitative semistructured interviews were considered an appropriate method of data collection due to the exploratory nature of the study within a novel context. Interviews with students were conducted throughout the 2021/2022 academic year and took place following completion of their 6-week psychiatry clerkships. A conscious decision was made to interview clinical tutors and MDTMs in the summer months following the completion of all student rotations, so that they could reflect on the academic year as a whole. All students interviewed completed separate asset-mapping exercises. Some students were in the same clinical site as others, but at different time points.

Interviews were conducted according to the participants' availability, and typically within 2–3 weeks of completing the clerkship (students), or of overseeing the annual cohort of students (clinical tutors/MDTMs). Students who were invited to participate outside of their initial recruitment cycle were interviewed, no more than 6 months following completion of their clerkship. Some clinical tutors were interviewed up to 2 months following completion of the clerkship due to heavy workloads or personal circumstances.

Interviews were conducted online using MS teams and were scheduled and conducted by GE, a male research officer working in the university's education and faculty development unit, who is unaffiliated with the psychiatry department. GE has experience of qualitative research, had no responsibility for teaching this cohort of students and, prior to recruitment, was unknown to all study participants. This minimised the potential for power differentials to arise during data collection.^{47 48}

Interviews were recorded and auto-transcribed before being checked for accuracy and pseudonymised by GE. Identifiers were removed and recordings were irrevocably deleted following the cleaning of the collected data. Pseudonymised transcripts were shared with VR and LM for analysis. Interviews lasted between 20 min and 50 min and separate interview guides were developed and used for the three different participant groups (see online supplemental material 3). The development of interview guides was based on the ABCD literature, and its anticipated impact on the participants in an undergraduate education context. The interview guides differed based on the need to reflect the unique perspectives and challenges of each of the three populations, that is, questions were posed to the tutors about supervising the project, whereas students were asked about the demands of completing and undertaking the asset-mapping exercise as part of their clinical clerkship. Fieldnotes were not taken during interviews, however, non-verbal responses and emphasis on particularly salient points were noted as the transcripts were cleaned and checked for accuracy vis-à-vis the video recordings.

Data analysis

An inductive thematic analysis using Braun and Clarke's six-step approach⁴⁹ was used for the purposes of data

analysis. This followed the processes of data familiarisation, developing initial codes, identifying, reviewing and defining themes and writing the report.

All authors independently familiarised themselves with three transcripts from each population in the first instance, coding line-by-line, before meeting to discuss preliminary observations and to begin identifying initial codes. The remaining transcripts were coded iteratively with authors meeting every second week to discuss progress and to review and refine any additional codes that might have emerged. Frequent meetings and sustained communication ensured that any disagreements were discussed and consensus was achieved. The authors hand-coded all transcripts in shared documents on a cloud-based version of Microsoft Word.

Once all transcripts were coded, the authors grouped codes so as to develop initial themes (see online supplemental material 4). Following a rereading of the transcripts and a review of the initial themes, the authors defined and agreed three themes based on the study aims and objectives. The data were then summarised as per the agreed themes.

The study strived for data sufficiency, which the research team identified as a point whereby further data collection was deemed unnecessary based on existing insights from the current sample.^{50 51} The data gathered from both students and clinical tutors were considered comprehensive based on initial familiarisation and analysis of the data.

RESULTS

We identified three overarching themes, through inductive reasoning, from the qualitative analysis of interviewees' reported experience of the asset-mapping initiative:

1. Connecting the individual patient with the community.
2. Relationship building.
3. Pedagogical challenges and rewards.

Illustrative quotations for each theme can be seen in [table 2](#) (see online supplemental material 4 for additional quotations). Participants consented for pseudonymised quotations to be used verbatim in the reporting of results.

Connecting the individual patient with the community

Student interviewees' responses to questions in the topic guide suggested that they grasped the theoretical principles and identified with the values underlying the asset-based approach. They also recognised the key element of the model, namely the patient's frame of reference. There were frequent references to how the asset-mapping exercise provided actual evidence of the social component within the biopsychosocial model of care, which had been covered extensively in lectures and tutorials from a theoretical perspective, but which was not always evident in students' clinical learning experiences. Some students reported that despite having previously undertaken a clinical placement in the same geographic location, they only

Table 2 Illustrative quotations

Theme	Quotations
Connecting the individual with the community	Student: <i>'I had like my knowledge from the asset mapping of the, of some of the stuff that the GP was recommend to the patients, stuff like clubhouses and that sort of thing like I wouldn't have had any idea what that was if it wasn't for the asset mapping project.'</i>—Student 14 Clinical Tutor: <i>'So these kind of things like well like there are so many things in the local area which honestly I wasn't aware the patient can go to for free and the students found that.'</i>—Clinical Tutor 6 MDTM: <i>'That's really important for medical students to know...we need to know what's going on in our community because that's how the recovery framework is best utilised.'</i>—MDTM 1
Relationship building	Student: <i>'It was really helpful to be able to connect individually with patients, to discuss with them what personally makes you happy, "are you doing that as much anymore and how can we get you back on track?" So I think it was a more tailored conversation when we were both aware of the services that they, they were kind of participating in and they could explain them a bit more to me as well.'</i>—Student 7 Clinical Tutor: <i>'I think it did help them integrate more into the team because you know, part of it was you know, linking in with someone, like a named person from the MDT...so yeah, it integrated them in that respect and then presenting it back to the MDT at the end I guess that kind of gave them a chance to, you know I guess like, yeah, interact more with the team'</i>—Clinical Tutor 1 MDTM: <i>'If you have a list of resources or an asset map like this, and you're thinking right, there's all these things that are around you in the community where you live, you're more likely to open up a conversation with the patient or the service user about what their interests are'</i>—MDTM 1
Pedagogical rewards and challenges	Student: <i>'It should be like in there because the RCSI have a course book, you know it should be in that week 1 material like 'Hey, you can't manage a psychiatric patient without the ABCD approach'...it just makes sense for it to be another backbone, the backbones of psychiatry.'</i>—Student 15 Clinical Tutor: <i>'In a way, I worry that it kind of de-medicalises maybe the doctor's role, because these things are all important but medical students are training to be doctors.'</i>—Clinical Tutor 1 MDTM: <i>'I was very impressed actually at every single presentation at how confident they were at speaking publicly... presenting to a group of, uh, as a medical student to junior doctors and consultants would be an intimidating experience, I would have thought, but they were all seemed to be well able.'</i>—MDTM 2

became aware of local assets after they had participated in the asset mapping project during their psychiatry rotation. Conversely, students who had already completed asset mapping during their psychiatry rotation, before placements in other disciplines, reported that their learning experience was enhanced by greater factual knowledge of local community resources.

When asked about how patients described the types of assets they valued, it was the category of individual assets that was most frequently mentioned activities such as meeting family or walks in the immediate area. The students recognised that many activities were significantly impacted by the COVID-19 pandemic restrictions on travel and in-person attendance at social activities and events, a particular issue in rural areas. They realised that the information elicited from patients was often new to the treating teams, and that the digital poster produced was of benefit to patient care. Comparable comments emerged in interviews with the tutors, with some stating that their knowledge of local resources had increased, while others pointed to the benefit to individual patient care that derived from patient-perceived assets identified by students. Among MDTM interviewees, there was strong enthusiasm for the asset-mapping project in terms of the values it represented. They recognised the similarities with the recovery approach utilised in mental health and they could identify the benefits of asset mapping for themselves in their professional role.

Relationship building

While students were encouraged to seek support in completing the asset-mapping assignment from clinical staff, they were required to elicit the information from patients themselves during history-taking activity. Several students spoke about appreciating the person behind the diagnosis and that this lessened the power imbalance in their interaction with patients. They also acknowledged the value of the patients' input in identifying resources they found beneficial and, as a result, the students reported more willingness to involve the patient in their treatment plan. Beyond the student-patient interaction, it was apparent from the interviews that the structure of the assignment facilitated teamwork between students from different cultural backgrounds, and a greater appreciation of the role and contribution of MDTMs. The asset-mapping exercise provided students with the opportunity to give new information to the treating team, thereby making a unique contribution to patient care, and creating a shift in the traditional student-teacher relationship, from that of passive learner towards one of greater agency on the students' part. Student interviewees reported strong sense of validation from the response received from sharing the asset map with senior members of the clinical team.

Pedagogical rewards and challenges

All student interviewees felt that the asset-mapping assignment was a valid learning activity, complementing

their other experiences during the placement, and that it should be retained within the undergraduate psychiatry curriculum. They embraced the value of holistic care with enthusiasm, with some expressing that it may be more beneficial introduced in the earlier years. Most tutors also expressed positive opinions of the educational value of the asset-mapping exercise. Several felt it promoted teamwork among the students and served to increase integration with non-medical members of the clinical team. However, tutors' responses to questions exploring the educational value of the assignment tended to be nuanced. Some expressed anxiety that the time spent by students on this non-graded activity could distract from what tutors regarded as core learning needs. In marked contrast to views expressed by the students, a small number of tutors cautioned that asset mapping could threaten students' professional identity and cause them to have what one tutor described as a 'wishy-washy' impression of psychiatry.

Students reported little difficulty incorporating questions on assets into their history-taking, often reporting having experimented with different wording, in order to discover which questions worked best. Importantly, several students reported that asset-based questions were non-threatening and helped to establish rapport and trust. They described how eliciting information on perceived assets from patients helped to normalise the interaction and acted as helpful counter-balance to the detailed and intrusive approach required in establishing the presence or otherwise of symptoms of psychopathology, such as hallucinations and delusions.

In exploring perceived challenges and how the asset-mapping activity could be better delivered, student interviewees provided a rich and diverse set of responses. The most frequent challenge described was that asset mapping called on the students' ability to demonstrate resourcefulness and self-directedness as adult learners, and some felt the demands in this regard were excessive. It was also apparent that some teaching sites provided better opportunities for the asset-mapping assignment than others, because of varying opportunities for direct patient contact, local impacts of the COVID-19 pandemic, or other contextual factors affecting the students' overall experience. Some students expressed concern that the project was not sufficiently integrated with other learning resources.

When asked whether they felt the asset-mapping assignment should be formally graded, the great majority of both students and tutors favoured it remaining as a non-graded activity. The current arrangement whereby the department of psychiatry offered a certificate award for the best poster during the academic year from each teaching site found general favour. MDTM interviewees felt they could have better supported students had they been better informed on the project in advance, with some fully grasping the initiative only when the students presented the poster at the end of the placement. Some tutors questioned the appropriateness of asset-mapping

as part of the medical undergraduate learning experience, although even the most sceptical acknowledged that it was not excessively burdensome and that it proved to be a feasible addition to the clinical clerkship.

DISCUSSION

To our knowledge, this is the first published study exploring the impact of community asset mapping as a component of the undergraduate medical curriculum. In summary, our major findings were that medical students embraced the concept of ABCD, felt that asset mapping offered a unique understanding of the social within the biopsychosocial model and that it complemented their other learning experiences. Overseeing the asset-mapping assignment during the clinical clerkship was seen as a manageable task by tutors and the innovation was welcomed by multidisciplinary members of the host clinical teams. Student interviewees demonstrated sensitivity to the individual patient's frame of reference in identifying meaningful community assets across a range of categories, while also describing a greater appreciation of the contribution of non-medical members of the multidisciplinary team. Both students and tutors recognised the importance of factual community knowledge as essential to holistic patient care and the potential applicability of the asset-based approach within clinical specialties other than psychiatry.

Other important findings were, first, that students found that questions exploring perceived assets helped to build rapport with patients and could be easily interwoven into the standard process of psychiatric history-taking. Second, the task of team-based preparation and presentation of the asset map in the form of a PowerPoint poster, as perceived both by students and their local tutors, was transferable across multiple clinical teaching sites and provided a unique opportunity for students' active role in patient care to be validated.

Our first theme, *Connecting the Individual with the Community*, resonates with findings from a qualitative study by Garouette and McCarthy-Gilmore within a third-level sociology programme, suggesting that the asset-mapping experience increased students' understanding of the relationship between individuals and the broader community.⁵² This theme is also consistent with other findings in a postgraduate medical educational context, where there was evidence of a change in paediatric residents' attitudes to their role as paediatricians in the community.³⁰ Our student interviewees' spontaneous references to the benefits of the information on community resources obtained through asset mapping in other specialty rotations, especially general practice, support Calderon *et al*'s contention that primary care medical training is especially well placed to integrate the asset-based approach.³¹

In keeping with previous literature suggesting that relationships, interactions and dialogue are central features of asset-based approaches, our second overarching theme, *Relationship Building*, reflects the shift in

the pattern of relatedness between the various actors involved in the project.⁵³ Students attributed a range of benefits to the asset-mapping experience, including: enhanced person-centredness in their engagement with patients; increased agency in their interactions with their clinical supervisors and more rewarding interactions with non-medical members of the clinical team. Similar findings were reported in a qualitative study among paediatric residents of community placement, which also found a shift in the understanding of their role as physicians.²⁰

Our final overarching theme, *Pedagogical Rewards and Challenges*, reflects findings that are particularly salient for medical educators and curriculum planners. Some students were discomposed initially by the relatively less structured nature of the task in comparison to their other assignments, yet all favoured retaining it within the curriculum. One possible explanation for their receptivity is that, as future healthcare practitioners, the students were instinctively attracted by an approach that builds on the tradition of relationship-based practice and were then reinforced in this regard by the positive emotional response they received from the patients they interviewed.⁵⁴

In this regard, our findings also suggest that in responding to the challenge of a relatively less structured and directed learning task, within a real-world clinical service environment, students were able to adapt and draw creatively on their own resources as adult learners, individually and as a group. The student interviews revealed that the asset-mapping assignment generated anxiety, in keeping with previous literature, much of which frames the transition to clinical learning conceptually as a struggle.⁵⁵ Equally, however, our findings support arguments for positively reframing these transitions as potential and transformative experiences, in which students are offered tools for ownership of their learning and an opportunity to develop coping skills that will be essential as they progress to clinical situations of increasing complexity and uncertainty.⁵⁶

It was interesting that, in contrast to the students' opinions, some tutor interviewees were more cautious and acknowledged fears that asset mapping could contribute to a dilution of students' medical identity. In interpreting this finding, it seems plausible to suggest that tutors, as trainees in psychiatry still in their early career, may be relatively more sensitive to the risk that a socially focused learning experience could risk undermining the students' perception of psychiatry as a fundamentally medical specialty. It is also possible that the reaction of some tutors reflected an understandable fear that students might underperform in their summative assessments and that this, in turn, could reflect negatively on the tutor. Consequently, in introducing asset mapping as an addition to the traditional undergraduate curriculum, our findings suggest that even among younger clinical teachers, the novelty of the approach is such that that enthusiasm for the initiative cannot be assumed and that comprehensive

induction and ongoing support from senior faculty must be provided.

In terms of other challenges, some students critiqued the fact that the ABCD model was not well integrated into their other clinical learning and course materials and felt it should have been introduced during the earlier years of their course. This observation points towards one of the pitfalls identified in the literature in a broader service context, namely that attempts to superimpose a new approach on top of the existing system may encounter what has been described as an inhibitive organisational culture, that leaves the old system intact beneath.⁵⁷ Similarly, it has been argued that if asset-based approaches are to be moved from the margins to the mainstream, organisations must be 'in it for the long game'.⁵⁸ An important consideration, therefore, in ensuring that asset mapping is not merely tokenistic would appear to be that its underlying principles are introduced early, and that related learning opportunities are provided across the full range of clinical specialties.

In comparing our findings to those of other published descriptions and evaluations of the range interventions aimed at introducing students to psychosocial factors in mental health, a common theme emerges that students value direct patient engagement above all.^{59 60} Asset mapping would appear to have the particular advantage over other interventions in the area in that the requirement to elicit the lived experience of the patient is built into the design. A further potential advantage is the intervention's relatively uncomplicated structure, such that major curricular adjustments are not required for its implementation. The asset-mapping component, therefore, could be offered within clinical specialty placements in addition to psychiatry while also providing a rich source of material for an integrated reflective learning experience that cuts across several other disciplines.⁴²

Our study findings are strengthened by the fact that we explored the perspectives of a range of key groups: students, clinical tutors and MDTMs across urban and rural clinical teaching sites. However, as a pilot study, using a qualitative methodology alone, there are several limitations. The sample may have under-represented the views of those who had a less positive experience, while the numbers of non-medical participants was low. In further evaluating the initiative, a quantitative method such as a broader survey of the opinions would be useful. Similarly, the students' factual knowledge of community resources before and after the clerkship could be assessed. While the pilot study yielded a rich qualitative dataset, we were unable to directly explore the patient experience. The benefits of the learning experience may have been reinforced had the project involved direct contacts between students and the community assets identified by the patients. One of our stated objectives was that the asset mapping assignment would enhance students' experience and understanding of psychiatry. It is difficult to draw firm conclusions from our findings regarding the extent to which this objective was met. While the initiative

was received positively by our interviewees, and increased their appreciation of psychiatry's psychosocial aspects, their overall experience and understanding of psychiatry would be influenced by a range of other factors. Introduction of the asset-mapping initiative also coincided with a period during which COVID-19 restrictions may have impacted significantly on the students' overall learning experience.⁶¹

A proposal has been submitted to introduce the asset mapping project within the earlier years of the medical school curriculum. This aligns with recent changes in the RCSI undergraduate medical school programme, which has introduced a spiral curriculum, that is, key topics, subjects and themes are revisited throughout the course.⁶²

CONCLUSION

This pilot qualitative study found that an asset-mapping assignment, while challenging, was experienced positively by students, their tutors and MDTMs, in both urban and rural community placements. Asset mapping promoted greater student awareness of patients as active partners in mental healthcare, who can identify community assets that enhance their well-being and quality of life. The innovation as described, was implemented within a traditional 6week clinical clerkship and as such, could be considered by other specialties and within other undergraduate medical school curricula. Our qualitative findings could inform the design of a larger study to include quantitative methods and an exploration of asset mapping from the patient perspective.

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