GUIDELINES FOR COMBINED PEDIATRICS-PSYCHIATRY-CHILD AND ADOLESCENT PSYCHIATRY RESIDENCY TRAINING

Pediatricians and psychiatrists (adult and child and adolescent) have traditionally been trained in the physical and emotional aspects of patient care. Psychiatrists have been expected to be familiar with organic illnesses presented as psychiatric disorders, while pediatricians have been trained to recognize physical manifestations of psychiatric disease. Acknowledging the large overlap in the domains of these specialties and the increasing need for specialists trained to treat the broad spectrum of illness shared by pediatrics and psychiatry, the specialties have agreed to offer combined training in preparation for certification in pediatrics, psychiatry, and child and adolescent psychiatry.

OBJECTIVES

The objectives of a combined residency in pediatrics-psychiatry-child and adolescent psychiatry include the training of general physicians for practice/academic careers that address the spectrum of mental and emotional illnesses in the newborn, children, adolescents, and adults. Graduates of a combined residency may function in clinical practice and academic environments or enter into further subspecialty training. This clinical training can also prepare graduates to undertake research training in areas shared by psychiatry and pediatrics.

The strengths of the residencies in psychiatry, child and adolescent psychiatry, and pediatrics should complement each other to provide the optimal educational experience.

Combined training residencies include residency training programs in psychiatry, child and adolescent psychiatry, and pediatrics that are accredited respectively by the Review Committee (RC) for Psychiatry and by the RC for Pediatrics, both of which function under the auspices of the Accreditation Council for Graduate Medical Education (ACGME). The training in each combined residency must be approved by the American Board of Pediatrics and the American Board of Psychiatry and Neurology. The Boards will not accept training in a newly established combined residency if the accreditation status of the residencies in any of the three disciplines is provisional or probationary. If any of the residency training programs is accredited on a probationary basis, residents must not be appointed to a combined residency.

GENERAL REQUIREMENTS

A combined residency in psychiatry, child and adolescent psychiatry, and pediatrics must include at least five years of coherent training integral to all three residencies that meet the Program Requirements for accreditation by the RC Psychiatry and RC Pediatrics.

It is strongly recommended that the participating residencies be in the same academic health center. Documentation of hospital and faculty commitment to the combined residency must be available in signed agreements. Such agreements must include institutional goals for the combined residency. Affiliated institutions must be located close enough to facilitate cohesion among the residencies' housestaff, attendance at weekly continuity clinics and integrated conferences, and joint faculty interaction in regard to curriculum, evaluation, administration, and related matters.

Ideally, at least two residents should be enrolled in the combined program each year. If no trainees are in a combined program for a period of three (3) years, the program will not be listed as approved.

At the conclusion of sixty (60) months of training in pediatrics, psychiatry, and child and adolescent psychiatry, residents should have had experience and instruction in the prevention, detection, and treatment of acute and chronic medical and psychiatric illnesses presented in both inpatient and ambulatory settings. Trainees should be exposed to patients with psychiatric and/or medical problems representing all age groups. Trainees should receive training in the socioeconomics of illness, the ethical care of patients, and the team approach to providing patient care.

The training of residents while on pediatric rotations is the responsibility of the pediatric faculty, while on psychiatry rotations the responsibility of the psychiatry faculty, and while on child and adolescent psychiatry the responsibility of the child and adolescent psychiatry faculty. Vacations leave, and meeting time will be shared proportionally by all three training programs (40% pediatrics, 30% general psychiatry, and 30% child and adolescent psychiatry). Departments should proportionately support the vacations, leave, and meeting time and contribute equally to educational/book money and other supports.

Any absence of more than 2 months of the 2 years of the pediatric training should be made up by the same amount and type of training missed.

Any absence in excess of the institutionally approved vacation, meeting, or leave time should be made up by the same amount and type of training missed.

Except for the following provisions, combined residencies must conform to the Program Requirements for accreditation of residencies in pediatrics, psychiatry, and child and adolescent psychiatry.

The Resident

Residents should enter a combined residency at the R-1 level. A resident may enter a combined residency at the R-2 level only if the first residency year was served in a categorical residency in pediatrics. Residents may not enter a combined residency from a pediatric residency or transfer between combined residencies without prospective approval by both Boards.

Training in each discipline must incorporate progressive responsibility for patient care, as well as supervision and teaching of medical students and junior residents throughout the training period.

The Program Director(s)

The combined residency must be coordinated by a full-time designated director or by co-directors who devote sufficient time and effort to the educational program. An overall residency director may be appointed from any of the three specialties. The directors must embrace similar values and goals for their residency. If a single residency director is appointed, an associate director from the other specialties must be named to ensure both integration of the residency and supervision in each discipline. These associate directors may be the training directors for the specialties not represented by the single residency director. An exception to this requirement would be a single director who is certified in all three specialties and has an academic appointment in each of the three departments.

Duration of Training

Training requirements for credentialing related to the certifying examination of each Board will be fulfilled by sixty (60) months of training in an approved combined program. A reduction of twenty four (24) months of training compared to that required for three separate residencies is possible due to overlap of curricular and training requirements. The requirement of thirty-six (36) months pediatric training is met by twenty four (24) months pediatric training with twelve (12) months credit for training appropriate to pediatrics obtained during the thirty-six (36) months of psychiatry and child and adolescent psychiatry training. Likewise, the sixty (60) months psychiatry and child and adolescent psychiatry training requirement is met by thirty-six (36) months psychiatry and child and adolescent psychiatry training with twenty-four (24) months credit for training appropriate to psychiatry obtained during the twenty-four (24) months of pediatric training.

Core Curricular Requirements

A clearly described written curriculum must be made available for residents, faculty, both Review Committees, and both Boards prior to the initiation of the combined residency. There must be 24 months of training in pediatrics, 18 months of training in general psychiatry, and 18 months of training in child and adolescent psychiatry. The curriculum must assure a cohesive, planned educational experience and not simply comprise a series of rotations among the specialties. Residents must be accorded graded responsibility for patient care and teaching. Annual review of the residency curriculum must be performed by the chairs of both departments with consultation with residents and faculty from both departments.

Care must be exercised to avoid unnecessary duplication of educational experiences in order to provide as many opportunities as possible in both breadth and depth.

The training director(s) should hold regular meetings, ideally monthly, that include all residents for program updates and educational activities such as jointly sponsored journal clubs, feedback on performance, counseling, visiting professors, clinic conferences, occasional combined grand rounds, medical ethics conferences, or research projects.

REQUIREMENTS FOR PEDIATRICS

The training should be the same as described in the ACGME Program Requirements for Graduate Medical Education for Pediatrics as outlined in this document with the exceptions that follow.

The curriculum should be organized in educational units. An educational unit should be a block (4 weeks or 1 month) or a longitudinal experience. An outpatient educational unit should be a minimum of 32 half-day sessions. An inpatient educational unit should be a minimum of 200 hours.

The specific curriculum elements are detailed in the following chart.

Program Requirements in General Pediatrics For Combined Training in Pediatrics, Psychiatry, Child and Adolescent Psychiatry

Component	Educational Unit*
Emergency Medicine and Acute Illness	3 (with at least 2 in ED)
Developmental-Behavioral Pediatrics	1
Adolescent Medicine	1
Term Newborn	1
Inpatient Pediatrics (non-ICU)	5 (no maximum)
Ambulatory Experiences (to include community pediatrics and child advocacy)	2
NICU	2
PICU	2
**Additional Subspecialty	4 (minimum)

**Educational Unit = 4 weeks or 1 month block OR outpatient longitudinal experience of 32 half-day sessions OR inpatient longitudinal experience of 200 hours*

**Additional Subspecialty includes 3 units from 3 different subspecialties from the following list:

- child abuse
- medical genetics
- pediatric allergy and immunology
- pediatric cardiology
- pediatric dermatology
- pediatric endocrinology
- pediatric gastroenterology
- pediatric hematology-oncology
- pediatric infectious diseases
- pediatric nephrology
- pediatric neurology
- pediatric pulmonology
- pediatric rheumatology

An additional 1 unit of single or combined subspecialties is required from the list above or below:

- hospice and palliative medicine
- neurodevelopmental disabilities
- pediatric anesthesiology
- pediatric dentistry
- pediatric ophthalmology
- pediatric orthopaedic surgery
- pediatric otolaryngology
- pediatric rehabilitation medicine
- pediatric radiology
- pediatric surgery
- sleep medicine
- sports medicine

Subspecialty Experience

Educational experiences in the subspecialties must emphasize the competencies and skills needed to practice high-quality general pediatrics in the community. They should be a blend of inpatient and outpatient experiences and prepare residents to participate as team members in the care of patients with chronic and complex disorders.

Child and adolescent psychiatry should not be utilized to fulfill the subspecialty requirements during the 24 months of general pediatrics training.

Supervisory Responsibility

At least 5 months of supervisory responsibility must be provided for each resident during the 60 months of training. At least 3 of these months must occur during training in pediatrics and must include experience leading an inpatient team. Two months may occur during the psychiatry training. The supervisory responsibilities must involve both inpatient and outpatient experience.

Continuity Clinic

There must be a minimum of 36 half-day sessions per year of a longitudinal outpatient experience in a continuity clinic throughout the 60 months of training. The sessions must not be scheduled in a time period fewer than 26 weeks per year. The patients should include those previously cared for in the hospital, well children of various ages and children of various ages with special health-care needs and chronic conditions. PGY-1, PGY-2 and PGY-3 residents must have a longitudinal general pediatrics outpatient experience in a setting that provides a medical home for the spectrum of pediatric patients and must care for a panel of patients who identify the resident as their primary care provider. PG-4 and PG-5 residents should continue this experience in a either a pediatric clinic, child psychiatry clinic or a combined continuity clinic for patients with pediatric and psychiatry problems. Allowing residents to serve as primary care providers for children with psychiatry disorders throughout their training is encouraged.

The medical home model of care must focus on wellness and prevention, coordination of care, longitudinal management of children with special health care needs and provide a patient- and family-centered approach to care.

REQUIREMENTS FOR GENERAL PSYCHIATRY

A. The curriculum must include adequate and systematic instruction in basic biological (e.g., neuroscience) and clinical sciences relevant to psychiatry, in the theoretical foundations of psychotherapy, and in appropriate material from the social and behavioral sciences (e.g., psychology, sociology, anthropology).

B. Each resident must have major responsibility for the diagnosis and treatment of a reasonable number and adequate variety of adult patients suffering from all the major categories of mental illness. Two FTE months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions is required. One month of neurology training may be completed in child neurology.

C. Inpatient Psychiatry: not less than 4 months but not more than 9 months (or its FTE) must be spent with significant responsibility in the treatment of adult psychiatric patients who are admitted to traditional psychiatry units, day hospital programs, research units, residential treatment programs, and other settings where the patient population is acutely ill and represents a diverse clinical spectrum of diagnoses, ages, and gender, and patient services are comprehensive, continuous, and allied medical and ancillary staff members are available for back-up support at all times.

D. No fewer than 6 months (or its full-time equivalent) is required in an organized, continuous, and well-supervised outpatient program that includes assessment, diagnosis, and treatment of outpatient adults with a wide variety of disorders and patients. The outpatient experience should include both brief and long-term interventions, utilizing both psychological and biological approaches to outpatient treatment. Each resident must have significant experience treating outpatients longitudinally for at least 9 months when clinically indicated. The outpatient experience should include

1. Evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly under supervision.

2. Exposure to multiple treatment modalities that emphasize developmental, biological, psychological and social approaches to outpatient treatment.

3. Opportunities to evaluate and treat differing disorders in a chronically-ill patient population.

E. One month FTE of organized experience focused on the evaluation and clinical management of patients with substance abuse/dependency problems, including dual diagnosis; Treatment modalities should include detoxification, management of overdose, maintenance pharmacotherapy, the use of psychological and social consequences of addiction in confronting and intervening in chronic addiction rehabilitation used in recovery stages from pre-contemplation to maintenance, and the use of self-help groups. This requirement may be met in psychiatry or in child and adolescent psychiatry. (This month is not required until 7/1/2016.)

F. The following requirements can be completed in psychiatry, in child and adolescent psychiatry, or preferably a combination of both.

1. Supervised clinical experience in the diagnosis and treatment of neurological patients with at least 1 month FTE in pediatric neurology.

2. Consultation experience, during which residents use their specialized knowledge and skills to assist others to function better in their roles, must be in consultation to medical professionals and at least one additional area:

i. Consultation experience with an adequate number of pediatric patients in outpatient and/or inpatient non-psychiatric medical facilities (at least 2 months FTE)

ii. Formal observation and/or consultation experiences in schools

iii. Legal issues relevant to general psychiatry or child and adolescent psychiatry, which may include forensic consultation, court testimony, and/or interaction with a juvenile justice system

iv. Experience consulting to community systems of care

3. Supervised, organized educational experience and responsibility on a 24-hour psychiatry emergency service, at least some of which is the care of children and adolescents, as an integral part of the residency, and experience and learning in crisis intervention techniques, including the evaluation and management of suicidal patients.

4. Supervised responsibility consulting to or providing treatment in community mental health care.

5. Supervised, active collaboration with other professional mental health personnel (psychologists, nurses, social workers, and mental health paraprofessionals) pediatricians, teachers, and other school personnel, legal professionals in the evaluation and treatment of patients.

6. Organized educational clinical experience focused on the treatment in the care of patients with intellectual disabilities and neurodevelopmental disorders, patients with substance abuse disorders, and geriatric patients.

7. Exposure to the more common psychological test procedures to ensure the resident has an understanding of the clinical usefulness of these procedures and of the correlation of psychological testing findings with clinical data in general psychiatry or in child psychiatry.

G. The Committee will take into consideration the information provided by the ABPN regarding resident performance on the certifying examinations during the most recent five years. The expectation is that 70% of those who complete the program will take the certifying examination; and the rate of those passing the psychiatry examination on their first attempt is 50%.

REQUIREMENTS FOR CHILD AND ADOLESCENT PSYCHIATRY

A. There must be systematic teaching of the biological, familial, psychological, and cultural influences on normal development and psychopathology in children from prenatal life through adolescence.

B. All clinical experiences must be well supervised and include the treatment of preschool, primary school-age, and adolescent patients of varied economic and sociocultural backgrounds with the total spectrum of mild to severe psychopathology.

C. Clinical experiences should provide adequate supervised activities in which residents can demonstrate performance and documentation of an adequate individual and family

history, mental status, physical and neurological examinations when appropriate, supplementary medical and psychological data, and integration of these data into a formulation, differential diagnosis, and comprehensive treatment plan.

D. As above, there must be at least 1 month FTE supervised clinical experience in pediatric neurology, if not obtained previously in pediatrics.

E. Outpatient treatment: There must be opportunities for residents to be involved in providing continuous care for at least a year for a variety of patients from different age groups, seen regularly and frequently for an extended time, in a variety of treatment modalities. The training must include treatment of children and adolescents for the development of conceptual understanding and beginning clinical skills in major treatment modalities, which include brief and long-term individual therapy, family therapy, group therapy, crisis intervention, supportive therapy, psychodynamic psychotherapy, cognitive-behavioral therapy, and pharmacotherapy.

Care for outpatients must include work with some child and adolescent patients from each developmental age group, continuously over time, and when clinically appropriate, for one year's duration or more.

F. There must be experience for more than 4 months but no more than 6 months (or its full-time equivalent) caring for acutely- and severely-disturbed children and adolescents, with the residents actively involved with diagnostic assessment and treatment planning. This experience must occur in settings with an organized treatment program, such as inpatient units, residential treatment facilities, partial hospitalization programs and/or day treatment programs.

G. Although the majority of teaching must be from child and adolescent psychiatrists, there must also be clinical experience with professionals from other medical specialties, such as nursing, neuro-psychology, and social work.

H. The expectation is that, over a period of years, for graduated fellows eligible to sit for the child and adolescent psychiatry exam (i.e. having obtained ABPN certification in general psychiatry), at least 70% should take the Child and Adolescent Psychiatry (CAP) certifying examination; and 50% of those should pass the CAP certifying examination on their first attempt.

EVALUATION

Both Boards require the annual tracking evaluations to be completed at the end of each training year.

Periodic evaluation with feedback of the educational progress of the residents is required as outlined in the program requirements for the categorical residencies. These evaluations must be written and regularly discussed with the residents and must be kept on file and available for review. All residents should also take the ABP In-training Examination (ITE) and the Psychiatry Resident In-training Examination (PRITE) each year. The residents should also take the Child and Adolescent Psychiatry In-training Examination beginning in the year they first begin child and adolescent psychiatry experiences.

The program must formally conduct clinical skills evaluations that conform to the requirements

set forth in the current version of the documents, "Requirements for Clinical Skills Evaluation in Psychiatry," and Requirements for Clinical Skills Evaluation of Residents in Child and Adolescent Psychiatry." Residents must successfully complete a minimum of two evaluations in the general psychiatry portion of training and three evaluations in the child and adolescent psychiatry portion of the training. General psychiatry evaluations must be conducted by physicians currently certified in general psychiatry; child and adolescent psychiatry evaluations must be conducted by physicians currently certified in child and adolescent psychiatry. At least three different evaluators must conduct the five evaluations. Satisfactory demonstration of the competencies during the five evaluations is required prior to completing the program. The program director(s) must report the dates and full names of the evaluators to the ABPN in the manner specified.

Annual review of the residency curriculum must be performed by the chairs of the department of pediatrics and the department of psychiatry with consultation with residents and faculty from all three areas.

CERTIFICATION

To meet eligibility requirements for triple certification, the resident must satisfactorily complete 60 months of combined training and his/her clinical competence must be verified by the directors of each program. Lacking verification of acceptable clinical competence in the combined residency or if the resident leaves combined training, the resident must satisfactorily complete the standard length of residency training and all other requirements of each or either certifying board. A candidate may apply for the certifying examination in general pediatrics in his/her fourth year of combined residency and take the examination in the fall of their fifth year if they have successfully completed all pediatric training requirements except for continuity clinic by that time.

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12/96 Approved by American Board of Psychiatry/Neurology
4/97
7/98
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