

The Pediatric Resident Mental Health Rotation: Implementing the ACGME Requirement

ALISON MANNING, MD; KATIE LAMERE, MD; STEPHANIE WAGNER, MD, MPH; ASHLEY MARTINEZ, MD; KAATHYA KASHYAP, BS; SUZANNE MCLAUGHLIN, MD; DIANE DERMARDEROSIAN, MD

ABSTRACT

The need for improved mental and behavioral health training for pediatric residents has been recognized for over 40 years. During this time, the prevalence of child behavioral health issues has steadily increased, culminating in the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declaring a national emergency in children's mental health in 2021. In response, the Accreditation Council for Graduate Medical Education (ACGME) implemented new mental health training requirements for pediatric residents beginning in July 2025. A core group of Brown University Health faculty designed and launched a structured rotation with milestone-informed goals and objectives, clinical experiences, and didactic components. These efforts align with Brown's longstanding commitment to address child and family mental health within a pediatric context. Pre- and post-surveys, qualitative data, and participant feedback were collected. Over 40 residents have participated in the rotation, appreciating the opportunity to tailor experiences to their individualized learning goals. A survey evaluating knowledge and comfort in assessing, diagnosing and treating common mental health conditions was administered before and after the didactic curriculum. Paired t-tests were conducted to evaluate changes in self-efficacy before and after the curriculum. Residents across all years of training reported improved knowledge and comfort in assessing, diagnosing and treating depression, suicide, and attention-deficit/hyperactivity disorder (ADHD) after delivery of the didactic mental health curriculum (all $p \leq 0.05$, $n = 15$), and many of these improvements were sustained at six months. Areas for improvement include increasing first-year exposure to mental health training, creating longitudinal experiences, including direct clinical involvement within the Med-Psych service line, and expanding supported faculty time and resources for development.

KEYWORDS: pediatrics; resident; mental health; education

INTRODUCTION

Mental and behavioral health (MBH) disorders have now surpassed physical illness as the leading cause of childhood disability.¹ Despite an estimated 20% of children experiencing an MBH disorder, the majority do not access appropriate support services, largely due to a significant shortage of mental health providers, particularly child and adolescent psychiatrists.^{2,3} More than half of pediatric primary care visits involve an MBH concern, underscoring the growing demand for competent behavioral health care within pediatrics.⁴

In 2009, the American Academy of Pediatrics (AAP) issued a policy statement which was updated in 2019, outlining core mental health competencies for pediatric primary care providers, yet training programs have not kept pace with these expectations.⁵ In a national survey of pediatric trainees applying for initial board certification in general pediatrics, only one-third reported high competence in MBH assessment skills, and only 20% felt highly competent in MBH treatment skills, even though there was a strong consensus that pediatricians should be proficient in managing these conditions.⁶ Over the past several decades, both the American Academy of Child and Adolescent Psychiatry (AACAP) and the AAP have developed several toolkits, instructional videos, podcasts, curricula and trainings aimed at strengthening pediatricians' skills in addressing mental health and behavioral concerns. These diverse initiatives have led to only modest gains in pediatricians' comfort and confidence in managing patients with MBH presentations. In an effort to more effectively address this gap, the Accreditation Council for Graduate Medical Education (ACGME) mandated that all pediatric residency programs include a formal, structured four-week rotation in mental and behavioral health starting in July 2025 to better prepare pediatricians to practice effectively in the current landscape of child and adolescent health.

Hasbro Children's, the pediatric division of Rhode Island Hospital and the Alpert Medical School of Brown University, have a longstanding history of addressing child and family mental health within a pediatric context. The institutional partnership with Bradley Hospital, the nation's first psychiatric hospital exclusively for children, further strengthens this tradition of integrated care. Another cornerstone is the Brown Triple Board program, a combined residency in Pediatrics, General Psychiatry, and Child and Adolescent

Psychiatry established in 1986 as one of six national pilot programs intended to bridge the gap between pediatrics and child psychiatry, optimizing the health and well-being of children and families. Today, the Brown Triple Board Program is integral to Hasbro Children's identity, shaping the culture of care throughout the children's hospital and positively impacting trainees, faculty, and affiliated programs.

Despite these resources, significant gaps remain in our ability to deliver comprehensive care to children with mental health needs and their families. Without exception, every provider in the hospital system routinely encounters these presentations, yet many continue to feel uncomfortable and underprepared in providing psychiatric care. The demand for mental health services far exceeds the capacity of available specialists, making it imperative that pediatric providers become better equipped to manage common behavioral and mental health concerns across all levels of care. As pediatricians responsible for the full spectrum of child health and wellness, including mental and behavioral health, we have an obligation to ensure that training cultivates competence, confidence, and clinical readiness required to meet these demands.

Prior to the ACGME Mental Health Rotation mandate, the Brown Department of Pediatrics launched the Meeting the Moment for Pediatric Health Care initiative to empower pediatric providers to deliver expert, inclusive, and comprehensive care to children, young adults, and families facing mental health challenges. This department-wide effort incorporated a range of educational strategies, including a yearly lecture series sponsored by Pediatric Grand Rounds, safety care training, and quarterly Med/Psych case conferences. These efforts collectively established the groundwork for developing a formal, structured mental health rotation aligned with the new ACGME requirement.

A four-week mental health rotation was developed and offered to Brown Pediatric residents in academic year 2024–2025, one year prior to the ACGME deadline. The rotation emphasizes direct clinical exposure to common mental health conditions such as anxiety, depression, and attention-deficit/hyperactivity disorder (ADHD), interprofessional collaboration, and a didactic curriculum covering assessment, management, and pathways for specialty referral. This experience is designed to integrate developmental and family context, cultural humility, equity considerations, and longitudinal integration across residency. By graduation, pediatric residents are expected to competently identify, manage, co-manage, and refer children and adolescents with behavioral and mental health concerns across diverse clinical settings.

Hasbro Children's and the Brown Pediatric Residency Program are uniquely positioned to serve as national leaders in this work, given the longstanding history of integrating pediatrics and child psychiatry. The establishment of the division of Pediatric Medicine and Psychiatry in 2021 as the

only division of its kind nationally underscores the institution's commitment to interdisciplinary pediatric mental and behavioral health. In addition, Brown's Triple Board program, the oldest combined Pediatric, Psychiatry and Child Psychiatry residency in the country, continues to play a vital role in resident education with Triple Board fellows making valuable contributions to the development and delivery of the mental health curriculum.

METHODS

Key faculty from the Departments of Pediatrics and Child Psychiatry met regularly in the months leading up to July 2024 to plan the logistics of implementing the new mental health rotation. During this period, goals and objectives were established, teaching faculty were recruited, learning experiences were designed, and didactic topics were selected. Goals, objectives, and educational topics were informed by the pediatric mental health competencies⁶ and common factors' skills.⁷

Goals and objectives

Based on ACGME requirements and the resources available within the Brown University Health organization, the faculty committee developed a comprehensive set of goals and objectives to guide the structure of the new rotation. These goals and objectives span the domains of knowledge, professionalism, practice-based learning and improvement, and patient care and communication skills. Together, they informed the design of the curriculum and highlighted specific needs for aligned didactic sessions [Table 1].

Supplemental funding from an ACGME grant on addressing physician burnout supported the development of the didactic curriculum, which included five hours of instruction occurring over two academic half days with residents across all years of training, and a one-hour process group with interns during their advocacy rotation. This portion of the curriculum was approved by the Brown University Health Institutional Review Board. The didactic curriculum occurred asynchronously with the two-week blocks of the mental health rotation [Table 2].

Rotation components

Rotation components [Table 2] were chosen to blend different mental health experiences within two-week blocks in both the PGY-2 and PGY-3 training years. Didactic components were integrated throughout the pediatric academic half-day curriculum, the advocacy rotation and curriculum (PGY-1 year), and didactic sessions throughout the structured clinical rotation.

The two-week block during PGY-2 year is focused on integrated hospital settings, such as the Hasbro Partial Hospital Program and the Selya 6 integrated medicine-psychiatry inpatient unit. During these experiences, residents observe

Table 1. Goals and Objectives of Brown Mental Health Rotation

Knowledge
Gain exposure to and improve understanding of mental health care across all clinical settings that is sensitive to the developmental stage of the patient and the cultural context of the patient and family
Develop a basic understanding of assessment and management of common mental health presentations in children and adolescents, including Med/Psych conditions, while gaining a greater understanding of how to manage, co-manage, and appropriately refer patients to special resources when indicated
Highlight important psychological considerations in patients with medical conditions
Gain exposure to the successful negotiation of difficult conversations
Professionalism
Demonstrate an understanding of the importance of: <ul style="list-style-type: none"> • Ensuring continuity of care with planful care transitions and handoffs • Responding to communications from patients, families, and collateral providers promptly and respectfully • Communicating clearly and comprehensively with collateral providers
Demonstrate respectful and ethical behavior towards patients, families, and colleagues regardless of age, culture, abilities, ethnicity, gender, and sexual orientation
Practice-Based Learning and Improvement/Systems-Based Practice
Articulate the basic concepts of family-based, integrated treatment, and their application in various settings
Demonstrate an understanding of the range of systems touching patients with psych and med/psych conditions
Demonstrate an understanding of how to access systems to create a comprehensive care plan
Understand the value of collaboration with MDT teams across disciplines and settings
Patient Care/Interpersonal and Communication Skills
Effectively partner with patients and families, fostering therapeutic alliances considering family beliefs, narratives and relationships and their impact on the presentation's development, function, and targets of treatment
Collaborate effectively with the interdisciplinary team, including providers from all levels of care
Gain exposure to diagnostic decision making and maintain awareness of potential cognitive bias
Consider the range of potential treatment components including psychotherapies, medical management, medication options, and other therapeutic modalities

Table 2. Rotation Components

Clinical Components
2 weeks in PGY-2 Year in The Hasbro Partial Hospital Program: <ul style="list-style-type: none"> • Observation and participation in individual, group and family therapy sessions • Collaboration with rehabilitation services and other ancillary therapy providers such as art or music therapy
2 weeks in PGY-3 Year in Integrated, Outpatient, and Community Settings: <ul style="list-style-type: none"> • Ambulatory settings: integrated psychiatry within the resident primary care clinic, outpatient psychiatry clinics • Interaction and collaboration with other disciplines, including psychology and social work in integrated care settings
Didactic Components
Pediatric Academic Half-Day components: <ul style="list-style-type: none"> • 3 hours of Behavioral Health in Pediatric Residency Training (Be ExPeRT) Curriculum⁸ • 2 hours of Brief Psychotherapy Interventions in Primary Care
Advocacy rotation with PGY-1 residents: <ul style="list-style-type: none"> • 1-hour introduction to levels of care and community resources in RI • 1-hour process group on doing mental health work
Mental Health case discussion sessions integrated into primary care curriculum
Additional short didactic sessions with faculty during structured clinical rotation

and participate in individual, group, and family therapy sessions while working alongside pediatricians, psychiatric/psychology providers, rehabilitation providers, and other professionals through a wide range of experiences, including art and music therapies. The two weeks during PGY-3 year focus on integrated ambulatory and community settings. Ambulatory experiences include integrated psychiatry within the resident primary care clinic and outpatient psychiatry clinics at Hasbro and Bradley. Residents also collaborate with psychology and social work in integrated care settings.

To evaluate the didactic curriculum's impact, pre- and post-surveys were administered to assess perceived knowledge about and comfort with assessment, diagnosis and treatment of common mental health conditions, including ADHD, anxiety, depression, and suicidality, using Likert scales (each domain rated from 1–4 = not at all [knowledgeable/comfortable], 4 = a great deal [knowledgeable, comfortable]). Surveys were completed before and after the didactic curriculum and again at six months post-completion. The survey instrument was modified from a previously published, but not validated, version originally developed by the Resource for Advancing Children's Health (REACH) and amended with permission for use only with residents.⁸ Paired t-tests were conducted to evaluate changes in knowledge and comfort scores after the three-hour mental health

curriculum and six months following completion of all didactic training sessions, with some participants having experienced a two-week mental health rotation block during that time. Triple Board fellows implemented the curriculum under the supervision of a Triple-Boarded attending psychiatrist. Senior Triple Board fellows additionally designed and facilitated the psychotherapy skills training and process groups. Written self-reflections collected during these process groups were analyzed using an inductive thematic approach. Two reviewers independently coded responses, reconciled differences, and iteratively grouped codes into broader themes through constant comparison. Residents also developed individualized learning goals at the start of the rotation, and feedback was gathered through the pediatric residency evaluation process and end-of-rotation meetings with the rotation director.

RESULTS

A total of 40 residents completed the rotation, with approximately one-quarter submitting rotation feedback. Residents consistently described the experience as broadly valuable. Key quotes included, "I think this rotation is helpful no matter what specialty you enter." They also noted increased confidence with challenging clinical environments feeling "much more comfortable going to [the inpatient psych unit] when called overnight now having rotated there." Many residents also submitted individualized learning goals (37 residents out of 40), most commonly seeking to: 1) strengthen their understanding of referral resources, 2) improve comfort with navigating difficult and sensitive conversations, and 3) gain more experience screening and interviewing youth presenting with mental health concerns.

Qualitative data

Nineteen residents provided written self-reflections during scheduled process groups. The most prominent themes reflected early feelings of uncertainty, overwhelm, and inadequacy when caring for children with behavioral health needs, especially in ambulatory settings. Residents identified several key challenges contributing to this discomfort, including: 1) Family or caregiver stigma surrounding mental health, which complicated engagement and treatment planning, 2) Limited time during clinical encounters to adequately address behavioral health needs, and 3) Gaps in knowledge, particularly around diagnostic decision-making and management. Collectively, these reflections underscore the need for ongoing longitudinal training, more structured exposure across care settings, and protected time for residents to build confidence in assessing and managing pediatric mental and behavioral health concerns.

Quantitative data

Fifteen residents completed both the pre- and post-curriculum surveys following the three-hour mental health curriculum, and 10 of those residents completed surveys again at six months. Immediately after the curriculum, residents demonstrated significant improvements in knowledge and comfort related to assessing and diagnosing depression, suicide, anxiety, and ADHD, as well as treating depression, suicide, and ADHD ($p \leq 0.05$, $n = 15$). Comfort in treating anxiety also improved significantly ($p \leq 0.05$), although the corresponding increase in knowledge did not reach statistical significance ($p = 0.11$). At six months, residents continued to show sustained improvement in knowledge related to assessing and diagnosing ADHD, and in comfort related to assessing and diagnosing suicide, as well as in both knowledge and comfort in treating depression, suicide, and ADHD (all $p \leq 0.05$, $n = 10$). Improvements in knowledge related to assessing and diagnosing depression, suicide, and anxiety; comfort in assessing and diagnosing depression, anxiety, and ADHD, and knowledge in treating anxiety were not statistically significant at six-month follow-up.

DISCUSSION

MBH conditions in youth have continued to rise, yet pediatric residents across the country remain insufficiently prepared to address these concerns in clinical practice. The new ACGME requirement for a structured mental health rotation for pediatric residents represents a long-awaited and necessary step towards equipping pediatricians with the skills and confidence to assess and manage the most common issues encountered in primary care and specialty practice.

Hasbro Children's and the Brown Pediatric Residency Program are uniquely positioned to develop a model clinical rotation due to the institution's longstanding history of integrated medicine-psychiatry training and patient care, including the Triple Board training program and the Division of Pediatric Med-Psych. Engaging faculty and trainees who are accustomed to navigating both medical and psychiatric frameworks supported the design of a curriculum that is realistic, feasible, and aligned with the day-to-day clinical responsibilities of pediatricians. This collaboration also helped to ensure that didactic materials addressed when pediatric management is appropriate, and when additional resources or specialized care are warranted. Additionally, developing the curriculum with a blend of interdisciplinary faculty members and Triple Board residents supported the creation of educational materials tailored to skills that are both practical and lasting across inpatient and ambulatory settings. Residents highlighted increased comfort with routine expectations, such as inpatient night coverage, and valued opportunities to practice navigating difficult conversations with patients and families.

Data from the first year of implementation suggests that the required rotation was well received. Residents who completed evaluations found the experiences meaningful and applicable to their practice. Pre- and post-curriculum surveys indicated notable improvements in knowledge and comfort related to assessing, diagnosing and treating common mental health conditions, including anxiety, depression, suicide, and ADHD. Importantly, many of these gains persisted at six months, though interpretation is limited by the small response sample.

Limitations and future directions

Implementing the rotation presented several logistical challenges. Clinical learning environments frequently host multiple trainees from a range of disciplines, including psychology, child and adult psychiatry, and medical students, making placement difficult at times. Securing sufficient pediatric psychiatry faculty preceptors was also challenging, and prior work suggests that pediatric trainees prefer to learn from their own pediatric supervisors.⁹ As resident exposure to mental health content continues to expand, parallel investment in faculty development will be critical to ensure that continuity clinic preceptors feel confident and comfortable when supervising MBH care. An additional limitation to this study is the small sample size which limits generalizability of the data. Future directions include enhancing training in mental health competencies, strengthening resident evaluation and feedback processes, including survey responses, as well as increasing opportunities for direct patient care across settings.

While our results indicated improved self-efficacy in mental health competencies in a small sample of residents, this does not necessarily translate to improved patient outcomes. Future research should examine patient level outcomes such as improved mental health screening scale scores over time, or qualitative data related to patient and family perception of mental health care delivery in the resident primary care clinic.

CONCLUSION

In summary, building on a longstanding tradition of integrated med-psych training and patient care, Brown University Health and Hasbro Children's successfully implemented the new required mental health rotation for pediatric trainees starting in July 2024. The rotation was well-received by trainees and led to modest improvements in residents' mental and behavioral health skills across common pediatric conditions. Looking ahead, key areas for growth include expanding opportunities for direct patient care throughout training, strengthening faculty development, and establishing standard evaluation processes to more effectively assess competency progression.

References

- Houtrow AJ, Larson K, Olson LM, Newacheck PW, Halfon N. Changing Trends of Childhood Disability, 2001–2011. *Pediatrics*. 2014;134(3):530-538. doi:10.1542/peds.2014-0594
- Merikangas KR, Jian-ping H, Burstein ME, et al. Service Utilization for Lifetime Mental Disorders in U.S. Adolescents: Results of the National Comorbidity Survey Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry*. 2011;50(1):32-45. doi:10.1016/j.jaac.2010.10.006
- Owens PL, Hoagwood K, Horwitz SM, et al. Barriers to children's mental health services. *J Am Acad Child Adolesc Psychiatry*. 2002;41(6):731-738. doi:10.1097/00004583-200206000-00013
- Merikangas KR, He JP, Brody D, Fisher PW, Bourdon K, Koretz DS. Prevalence and Treatment of Mental Disorders Among US Children in the 2001–2004 NHANES. *Pediatrics*. 2010;125(1):75-81. doi:10.1542/peds.2008-2598
- Green CM, Foy JM, Earls MF. Achieving the Pediatric Mental Health Competencies. *Pediatrics*. 2019;144(5):e20192758. doi:10.1542/peds.2019-2758
- Green C, Leyenaar JK, Turner AL, Leslie LK. Competency of Future Pediatricians Caring for Children With Behavioral and Mental Health Problems. *Pediatrics*. 2020;146(1):e20192884. doi:10.1542/peds.2019-2884
- Wissow L, Anthony B, Brown J, et al. A common factors approach to improving the mental health capacity of pediatric primary care. *Adm Policy Ment Health*. 2008;35(4):305-318. doi:10.1007/s10488-008-0178-7
- Manning A, Weingard M, Fabricius J, French A, Sendak M, Davis N. Be ExPeRT (Behavioral Health Expansion in Pediatric Residency Training): A Case-Based Seminar. *MedEdPORTAL J Teach Learn Resour*. 2023;19:11326. doi:10.15766/mep_2374-8265.11326
- Hampton E, Richardson JE, Bostwick S, Ward MJ, Green C. The current and ideal state of mental health training: pediatric resident perspectives. *Teach Learn Med*. 2015;27(2):147-154. doi:10.1080/10401334.2015.1011653

Authors

- Alison Manning, MD, Assistant Professor, Department of Psychiatry and Behavioral Health, Warren Alpert Medical School of Brown University, Providence, RI.
- Katie Lamere, MD, Triple Board Chief Resident, Warren Alpert Medical School of Brown University, Providence, RI.
- Stephanie Wagner, MD, MPH, Child and Adolescent Psychiatrist, Family Service of Rhode Island, Providence, RI.
- Ashley Martinez, MD, Assistant Professor, Department of Pediatrics, Baylor College of Medicine, Houston, TX.
- Kaathya Kashyap, BS, Warren Alpert Medical School of Brown University, Providence, RI.
- Suzanne McLaughlin, MD, Associate Professor of Medicine, Associate Professor of Pediatrics, Warren Alpert Medical School of Brown University, Providence, RI.
- Diane DerMarderosian, MD, Professor of Pediatrics, Professor of Psychiatry and Human Behavior, Warren Alpert Medical School of Brown University, Providence, RI.

Disclosures

None.

Correspondence

Alison Manning, MD
401-444-4515
Fax 401-444-7018
Amanning1@brownhealth.org