Combined Family Medicine-Psychiatry Curricular Requirements

This document enumerates the **minimum** curricular requirements for combined ACGME-accredited programs in family medicine and psychiatry, as approved by the American Board of Family Medicine (ABFM), American Board of Psychiatry and Neurology (ABPN), American Osteopathic Board of Family Physicians (AOBFP), and American Osteopathic Board of Neurology and Psychiatry (AOBNP). This information was collated from the certifying boards on August 10, 2026 and will be updated as needed.

1. Total duration:
    a) 60 months.
    b) Additional time outside of the minimum requirements must be customized per the mission of the program and the individual needs of each resident.
    c) This time must be equitably allocated between the participating specialties such that the resident acquires the knowledge, skills, and behaviors necessary to enter autonomous practice in each of the participating specialties.

Psychiatry curricular components must be 30 months, including the following:

2. Inpatient psychiatry:
    a) Six months, and no more than 16 months.
    b) Residents must have significant responsibility for the assessment, diagnosis, and treatment of general 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. Patient services must be comprehensive and continuous, and allied medical and ancillary staff must be available for backup support at all times.

3. Outpatient psychiatry:
    a) Twelve months of organized, continuous, and supervised clinical experience in the assessment, diagnosis, and treatment of outpatients with a wide variety of disorders and treatment modalities, with experience in both brief and long-term care of patients.
    b) This longitudinal experience should include evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly under supervision, with significant experience longitudinally following patients for at least one year as clinically indicated; exposure to multiple treatment modalities that emphasize developmental, biological, psychological, and social approaches to outpatient treatment; and opportunities to apply psychosocial rehabilitation techniques, and to evaluate and treat differing disorders in a chronically ill patient population.
    c) No more than 20 percent of outpatients may be child and adolescent patients; this portion of education may be used to fulfill the child and adolescent psychiatry requirements, so long as this component meets the requirements for child and adolescent psychiatry below.

4. Child and adolescent psychiatry:
    a) Two months of organized clinical experiences.
    b) Residents must be supervised by child and adolescent psychiatrists who are certified by the ABPN/AOBNP or who are judged by the Review Committee to have acceptable qualifications.
    c) Residents must be provided opportunities to assess development and to evaluate and treat a variety of diagnoses in male and female children and adolescents, with their families, using a variety of interventional modalities.

5. Consultation/liaison psychiatry:
    a) Two months in which residents consult (under supervision) on other medical and surgical services.

6. Emergency psychiatry:
    a) The emergency psychiatry experience must be conducted in an organized 24-hour psychiatric emergency service, a portion of which may occur in ambulatory urgent-care settings but not as part of the 12-month outpatient requirement.
    b) Residents must be provided with experiences in evaluation, crisis evaluation and management, and triage of psychiatric patients.
    c) On-call experiences may be part of this experience, but no more than 50 percent.

7. The following curricular components may be additional rotations or incorporated into the inpatient or outpatient requirements above (must describe in block diagram notes):
    a) Geriatric psychiatry:
        i. One month of organized experience focused on the specific competencies in areas that are unique to the care of the older adult.
        ii. These include the diagnosis and management of mental disorders in patients with multiple comorbid medical disorders, familiarity with the differential diagnosis and management (including management of the cognitive component) of the degenerative disorders, and understanding of neuropsychological testing as it relates to cognitive functioning in the older adult and the unique pharmacokinetic and pharmacodynamic considerations encountered in the older adult, including drug interactions.
    b) Addiction psychiatry:
        i. One month of organized experience focused on the evaluation and clinical management of patients with substance use disorders, including dual diagnosis.
        ii. 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.
    c) Forensic psychiatry:
        i. This experience must expose residents to the evaluation of forensic issues such as patients facing criminal charges, establishing competence to stand trial, criminal responsibility, commitment, and an assessment of a patient’s potential to harm themselves or others.
        ii. This experience should include writing a forensic report.
        iii. Where feasible, giving testimony in court is highly desirable.

d) Community psychiatry:
    i. This experience must expose residents to persistently and chronically ill patients in the public sector (e.g., community mental health centers, public hospitals and agencies, and other community-based settings).
    ii. The program should provide residents with the opportunity to consult with, learn about, and use community resources and services in planning patient care, as well as to consult and work collaboratively with case managers, crisis teams, and other mental health professionals.

8. Neurology:
    a) Two months of supervised clinical experience in the diagnosis and treatment of patients with neurological disorders/conditions.
    b) At least one month should occur in the first or second year of the program.

Family medicine curricular components must be 30 months, including the following:

9. Family medicine:
    a) At least 30 months of rotations, with rotations identical to the participating family medicine program and associated structured didactic sessions as defined in the Program Requirements for Graduate Medical Education in Family Medicine.
    b) Each year of the combined residency must have at least three months of family medicine curriculum.
    c) A family medicine practice (FMP) compliant with the Program Requirements for Graduate Medical Education in Family Medicine:
        i. Residents must have a minimum of 1,000 hours of scheduled patient time with continuity patients and at least 40 weeks over two consecutive years of the program, with no more than eight weeks away from continuity patients each of these years and no more than one month away from continuity practice at a time. This clinical continuity experience should meet the requirements for patient age distribution, scope of practice, procedures, empanelment, continuity, review of referrals, and review of quality and other dimensions of care.
    d) Family medicine behavioral health experiences must not be replaced by inpatient psychiatry rotations.

Additional Considerations

- In order for graduates of the program to be eligible for ABFM certification, the program director must attest to competence for each of the 15 core outcomes specified by the ABFM. ABFM expects these judgements to be supported by the program's Clinical Competency Committee (CCC) and based on evidence of competence reviewed by the CCC.
- In order for graduates of the program to be eligible for AOBFP certification, the program director must attest to completion of the family medicine curriculum and verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice. AOBFP expects these judgements to be supported by the CCC and based on evidence of competence reviewed by the CCC.