

1                                   **Program Requirements for Residency Education**  
2                                   **in Child and Adolescent Psychiatry**  
3                                   **ACGME Common Program Requirements in BOLD**  
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5 I. Introduction  
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7           A. Definition  
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9                                   Child and adolescent psychiatry is a specialty of medical practice  
10                                  within psychiatry. The goal of residency training in child and  
11                                  adolescent psychiatry is to produce specialists in the delivery of  
12                                  skilled and comprehensive medical care of children and  
13                                  adolescents suffering from psychiatric disorders. The child and  
14                                  adolescent psychiatrist must have a thorough understanding of the  
15                                  development, assessment, treatment, and prevention of  
16                                  psychopathology as it appears from infancy through adulthood. He  
17                                  or she also should have the skills to serve as an effective  
18                                  consultant to primary care physicians, nonpsychiatrist mental health  
19                                  providers, schools, community agencies, and other programs  
20                                  serving children and adolescents.  
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22                                  Approved residencies in child and adolescent psychiatry must offer  
23                                  well-supervised and well-balanced clinical experiences with a  
24                                  continuum of care, which may include inpatients, day hospital  
25                                  patients, outpatients, and consultees, ~~and must also provide a~~  
26                                  ~~formal educational experience.~~ The residency must provide a  
27                                  combination of didactic and clinical work that is both broad enough  
28                                  to ensure knowledge of the full spectrum of disorders of childhood  
29                                  and adolescence, and intensive enough to ensure thorough  
30                                  diagnostic, treatment, and consultative skills. Diagnostic and  
31                                  therapeutic experiences must be provided in sufficient number and  
32                                  depth with preschool, grade school, and adolescent patients of both  
33                                  sexes and their families for the resident to understand the breadth  
34                                  of clinical problems that ~~the~~ he or she will study and treat.  
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36 B. Duration and Scope of Training  
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- 38                                  1.       In addition to the postgraduate first-year and a minimum of  
39                                  2 years of accredited training in general psychiatry, 2 years  
40                                  of training in a child and adolescent psychiatry program  
41                                  accredited by the Accreditation Council for Graduate Medical  
42                                  Education (ACGME) is required.  
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44                                  2.       To achieve greater flexibility in the sequence of residency  
45                                  training and to assist in recruitment, the 2-year FTE child  
46                                  and adolescent psychiatry training experience may be

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initiated ~~immediately following, or at any point beyond,~~ at the PGY-1 level or at any point in the psychiatry residency sequence. This training may be integrated over five years if integrated with the general psychiatry training or may be focused during two years. Child Psychiatry training that is focused into two years is best done full time, and it must be done in no more than two blocks. If done in two blocks, the blocks must not be more than 5 years apart, and the shorter block must not be less than 6 months long. At the discretion of the program director, training credit for part-time status may be given, as long as the training is half-time or more, and is completed in 4 years or less.

3. In general, training in child and adolescent psychiatry obtained as part of the curriculum for general psychiatry training may not count toward residency training in child and adolescent psychiatry. However, certain clinical experiences with children, adolescents, and families taken during the period when the person is designated as a as part of the child and adolescent psychiatry training program, resident may be counted toward at 4<sup>th</sup> year in general psychiatry as well as toward the child and adolescent psychiatry training program requirements thereby fulfilling Program Requirements in general psychiatry and child and adolescent psychiatry at the same time. The following requirements must be met for these experiences:
  - a. limited to child and adolescent psychiatry patients
  - b. up to a maximum of 12 months that can be double counted
  - c. documentation by PD of all areas for which credit is given in both programs
  - d. No reduction in total length of time devoted to training in child and adolescent psychiatry, which must remain at 2 years FTE.
  - e. Only the following experiences can be used to meet requirements in both general and child and adolescent psychiatry training:
    - i. 1 month FTE of child neurology

- 93                                    ii. 1 month FTE of pediatric consultation/liaison
- 94                                    iii. 1 month FTE of addiction psychiatry
- 95                                    iv. Forensic psychiatry experience
- 96                                    v. Community psychiatry experience
- 97                                    vi. Up to 20% of outpatient experience as described in
- 98                                    Section V.B.3 c of the Program Requirements for
- 99                                    Psychiatry

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101                                    ~~limited to 1 month of child neurology, 1 month of pediatric~~  
102                                    ~~consultation/liaison, 3 months of child and adolescent~~  
103                                    ~~inpatient experience, 1 month of addiction psychiatry, up to~~  
104                                    ~~20% of outpatient experience as described in Section V B 1~~  
105                                    ~~c) of the Program Requirements for Psychiatry, and forensic~~  
106                                    ~~psychiatry and community psychiatry experience may be~~  
107                                    ~~designed to fulfill the Program Requirements in general~~  
108                                    ~~psychiatry and child and adolescent psychiatry, if these~~  
109                                    ~~experiences are limited to child and adolescent psychiatry~~  
110                                    ~~patients, up to a maximum of 12 months. The program~~  
111                                    ~~director must document areas for which credit is given in~~  
112                                    ~~both programs. These experiences may not be used to~~  
113                                    ~~reduce the total length of time devoted to training in child~~  
114                                    ~~and adolescent psychiatry, which must remain at 2 years.~~

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117                                    4.     Prior to entry into the program, each resident must be  
118                                    notified in writing of the required length of training for which  
119                                    the program is accredited. The required length of training for  
120                                    a particular resident may not be changed during his or her  
121                                    program without mutual agreement, unless there is an  
122                                    interruption in his or her training or the resident requires  
123                                    remedial training.

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125     **II. Institutions**

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127     **A. Sponsoring Institution**

128                                    **One sponsoring institution must assume ultimate**  
129                                    **responsibility for the program, as described in the Institutional**  
130                                    **Requirements, and this responsibility extends to resident**  
131                                    **assignments at all participating institutions.** The administration  
132                                    of the sponsoring institution(s) should understand the educational  
133                                    goals, and should evidence its willingness and ability to support  
134                                    these goals financially as well as philosophically.

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137     **B. Participating Institutions**

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1. **Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.**
  
2. **Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:**
  - a) **identify the faculty who will assume both educational and supervisory responsibilities for residents;**
  
  - b) **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
  
  - c) **specify the duration and content of the educational experience; and**
  
  - d) **state the policies and procedures that will govern resident education during the assignment.**
  
3. It is important that each affiliated institution offer significant educational opportunities to the overall program. The number and distribution of participating training sites must not preclude satisfactory participation by residents in teaching and training exercises. Geographic proximity will be one factor in evaluating program cohesion, continuity, and peer interaction. ~~"critical mass."~~ Affiliated training sites will be evaluated on the basis of whether they contribute to a well-integrated educational program with respect to both didactic and clinical experiences.
  
- C. In addition, each training program accredited for child and adolescent psychiatry must have a formal educational affiliation agreement with a general psychiatry residency program that is accredited for at least 3 years of training. The written agreement of such affiliation must be signed by the residency directors of both programs, and copies must be submitted for review by the Review Committee (RC). ~~Residency Review Committee (RRC).~~

### **III. Program Personnel and Resources**

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## **A. Program Director**

- 1. There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the RRC through the Web Accreditation Data System of the ACGME.**
  
- 2. The program director, together with the faculty, is responsible for the general administration of the program, including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation and resident progress and performance, and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership. In general the minimum term of appointment must be at least the duration of the program plus one year.**
  
- 3. Qualifications of the program director are as follows:**
  - a) The program director must possess the requisite specialty expertise as well as documented educational, clinical, and administrative abilities.**
  
  - b) The program director must be certified in Child and Adolescent Psychiatry by the American Board of Psychiatry and Neurology, or possess qualifications judged to be acceptable by the Residency Review Committee.**
  
  - c) The program director must be appointed in good standing and based at the primary teaching site, and must be licensed to practice medicine in the state where the institution that sponsors the program is located (certain federal programs are exempted).**
  
- 4. Responsibilities of the program director are as follows:**

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**a) The program director must oversee and organize the activities of the educational program in all institutions that participate in the program. This includes selecting and supervising the faculty and other program personnel at each participating institution, in consultation with the chair of or division chief, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.**

**b) The program director is responsible for selecting residents, planning the curriculum, evaluating individual resident progress, and maintaining records of these endeavors. The program director shall provide residents with the goals of training, their responsibilities, and the evaluation procedures.**

b)

**c) The program director is responsible for preparing an accurate statistical and narrative description of the program as requested by the RRC, as well as updating annually both program and resident records through the ACGME's Accreditation Data System.**

c)

**d) The program director must ensure the implementation of fair policies, grievance procedures, and due process, as established by the sponsoring institution and in compliance with the Institutional Requirements.**

d)

**e) The program director must seek the prior approval of the RRC for any changes in the program that may significantly alter the educational experience of the residents, in order to determine if an adequate educational environment exists to support these changes and if the program's clinical and academic resources are adequate to support these changes. Such changes, for example, include:**

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- (1) **the addition or deletion of a participating institution,** to which residents are assigned half-time or more for 6 months or longer for the full-time equivalent of at least 4 months;
- (2) **a change in the format of the educational program;**
- (3) **a change in the approved resident complement for those specialties that approve resident complement.**
- (4) a request for experimentation or innovative project that may deviate from the program requirements (see ACGME Manual of Policy and Procedures).

**On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.**

e)

f) The program director must ~~devote~~ devote of at least half-time to the training program, including teaching activities. Programs with large patient populations, multiple institutions, and large resident complements may require more than half time effort or appointment of an associate training director.

f)

g) The program director must select residents for appointment to the program ~~in~~ according to established selection procedures.

g)

h) The program director must supervise residents through explicit written descriptions of supervisory lines of responsibility for the care of patients. Such guidelines must be communicated to all members of the program staff.

~~h) The program director must implement fair procedures, as established by the sponsoring institution, regarding~~

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~~academic discipline and resident complaints or grievances.~~

- i) The program director must monitor resident stress, including mental or emotional conditions inhibiting performance or learning and drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Training situations that consistently produce undesirable stress on residents must be evaluated and modified.
- ~~j) The program director must provide an annual written evaluation of the quality of teaching and supervision of each of the teaching faculty.~~
- ~~k)~~
- j) The program director must provide written information regarding financial compensation, liability coverage, and the policies regarding vacations, sick leave, and family leave, as well as other special leaves to residents and applicants who are interviewed.
- ~~l)~~
- k) The program director must notify the executive director of the RRC in writing within 30 days of any major change in the program that may significantly alter the educational experience for the residents, including:
  - (1) changes in leadership of the department of the program;
  - (2) changes in administrative structure, such as an alteration in the status of the program/department within the institution;
  - (3) a reduction in any year of the critical mass of residents below four in the training program; and

- 367 (4) a reduction in the number of faculty below 3  
368 full-time equivalent positions for more than 1  
369 year.  
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371 **B. Faculty**

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- 373 **1. At each participating institution, there must be a**  
374 **sufficient number of faculty** and other mental health  
375 professionals with sufficient breadth and depth of  
376 **documented qualifications to instruct and supervise**  
377 **adequately all residents in the program.** The faculty must  
378 include a total of at least 3 full-time-equivalent, fully-trained  
379 child and adolescent psychiatrists who devote substantial  
380 time to the residency program, 2 of whom must be certified  
381 in child and adolescent psychiatry by the American Board of  
382 Psychiatry and Neurology or judged by the RRC to possess  
383 appropriate educational qualifications. Programs with large  
384 patient populations, multiple institutions, and larger resident  
385 complements will be expected to have the number of  
386 physician faculty appropriate to the program's size and  
387 structure.  
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  - 389 **2. The faculty, furthermore, must devote sufficient time to**  
390 **the educational program to fulfill their supervisory and**  
391 **teaching responsibilities. They must demonstrate a**  
392 **strong interest in the education of residents, and must**  
393 **support the goals and objectives of the educational**  
394 **program of which they are a member.**  
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  - 396 **3. Qualifications of the physician faculty are as follows:**  
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    - 398 **a) The physician faculty must possess the requisite**  
399 **specialty expertise and competence in clinical**  
400 **care and teaching abilities, as well as documented**  
401 **educational and administrative abilities and**  
402 **experience in their field.**
    - 403 **b) The physician faculty must be certified in the**  
404 **specialty by the American Board of Psychiatry**  
405 **and Neurology, or possess appropriate**  
406 **educational qualifications judged to be acceptable**  
407 **by the RRC.**
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    - 409 **c) The physician faculty must be appointed in good**  
410 **standing to the staff of an institution participating**  
411 **in the program.**  
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- 4. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and an active research component must be included in each program. Scholarship is defined as the following:**
- a) the scholarship of discovery, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**
  - b) the scholarship of dissemination, as evidenced by review articles or chapters in textbooks;**
  - c) the scholarship of application, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.**

**Complementary to the above scholarship is the regular participation of the teaching staff in clinical discussions, rounds, journal clubs, and research conferences in a manner that promotes a spirit of inquiry and scholarship (e.g., the offering of guidance and technical support for residents involved in research such as research design and statistical analysis); and the provision of support for residents' participation, as appropriate, in scholarly activities.**

- 5. Qualifications of the nonphysician faculty are as follows:**
- a) Nonphysician faculty must be appropriately qualified in their field.**
  - b) Nonphysician faculty must possess appropriate institutional appointments.**
- ~~6. The faculty must include a total of at least 3 full-time-equivalent, fully-trained child and adolescent psychiatrists who devote substantial time to the residency program, 2 of whom must be certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology or judged by the RRC to possess appropriate educational qualifications.~~

459 7. ~~Psychiatric faculty must participate regularly and~~  
460 ~~systematically in the training program. All members of the~~  
461 ~~teaching staff must demonstrate a strong interest in the~~  
462 ~~education of residents, sound clinical and teaching abilities,~~  
463 ~~support of the goals and objectives of the program, a~~  
464 ~~commitment to their own continuing medical education, and~~  
465 ~~participation in scholarly activities.~~

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469 6. A member of the teaching staff of each participating  
470 institution must be designated to assume responsibility for  
471 the day-to-day activities of the program at that institution,  
472 with overall coordination by the program director.

### 473 474 475 **C. Other Program Personnel**

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477 **Additional necessary professional, technical, and clerical**  
478 **personnel must be provided to support the program. Per cent**  
479 **dedicated time for a residency coordinator should be adequate**  
480 **for the size and complexity of the training program.**

### 481 482 **D. Resources**

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484 **The program must ensure that adequate resources (e.g.,**  
485 **sufficient laboratory space and equipment, computer and**  
486 **statistical consultation services) are available.**

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488 1. Training programs must have adequate facilities and  
489 affiliations to meet the educational objectives of the program.  
490 Ample office space with readily accessible play materials  
491 must be available for each resident to see patients.

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493 2. Space for physical and neurological examinations and  
494 appropriate medical equipment must be readily available.  
495 Access to laboratory testing also must be readily available.

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497 3. There must be adequate space and equipment specifically  
498 designated for seminars, lectures, and other educational  
499 activities. The program must have available such basic  
500 teaching aids such as videotaping equipment or one-way  
501 mirrors.

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503 4. The sponsoring institution must provide residents with ready  
504 access to specialty specific and other appropriate reference

505 materials in print or electronic format and to computerized  
506 literature search capabilities and electronic medical  
507 databases in each participating institution at all times. a  
508 library that contains a substantial number of current basic  
509 textbooks and major journals in psychiatry, child and  
510 adolescent psychiatry, neurology, pediatrics, and general  
511 medicine, sufficient for an excellent educational program.  
512 The library must be capable of obtaining textbooks and  
513 journals on loan from major medical libraries and of carrying  
514 out MEDLINE and other medical information searches (or  
515 accessing a library that has this capacity), and it must be  
516 reasonably available to residents on weekends and during  
517 evening hours.

#### 519 E. Head of Child and Adolescent Psychiatry

- 521 1. The head of the department, division, or section of child and  
522 adolescent psychiatry ~~should~~ must be a fully-trained child  
523 and adolescent psychiatrist with documented clinical,  
524 educational, and administrative abilities and experience, ~~and~~  
525 ~~should~~ The head must be certified in child and adolescent  
526 psychiatry by the American Board of Psychiatry and  
527 Neurology or judged by the RRC to possess appropriate  
528 educational qualifications.
- 529 2. The head of child and adolescent psychiatry must be  
530 appointed to and in good standing with the medical staff of  
531 an institution participating in the program.  
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### 533 IV. Resident Appointments

#### 534 A. Eligibility Criteria

535 **The program director must comply with the criteria for**  
536 **resident eligibility as specified in the Institutional**  
537 **Requirements. In selecting from among qualified applicants,**  
538 **programs should participate in an organized matching program,**  
539 **such as the National Resident Matching Program for Child and**  
540 **Adolescent Psychiatry.**

541 The residency program director must accept only those applicants  
542 whose qualifications of residency include sufficient command of  
543 English to permit accurate and unimpeded communication.  
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#### 545 B. Number of Residents

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551 **The RRC will approve the number of residents based upon**  
552 **established written criteria that include the adequacy of**  
553 **resources for resident education (e.g., the quality and volume**  
554 **of patients and related clinical material available for**  
555 **education), faculty-resident ratio, institutional funding, and the**  
556 **quality of faculty teaching.**

557  
558 A program must have at least 4 residents in the 2-year FTE training  
559 program. (This may not include those residents who participate in a  
560 triple board training format.) Peer interaction and the need for group  
561 discussion in seminars and conferences are crucial. In programs  
562 that are integrated over 5 years, opportunities for peer interaction  
563 and group discussion must be demonstrated.

564 ~~The number of residents from other graduate medical education~~  
565 ~~programs and mental health disciplines who participate in the child~~  
566 ~~and adolescent psychiatry educational curriculum should not be so~~  
567 ~~great as to compromise the educational resources of the child and~~  
568 ~~adolescent psychiatry residency.~~

### 569 570 **C. Resident Transfers**

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572 **To determine the appropriate level of education for residents**  
573 **who are transferring from another residency program, the**  
574 **program director must receive written verification of previous**  
575 **educational experiences and a statement regarding the**  
576 **performance evaluation of the transferring resident prior to**  
577 **their acceptance into the program. A program director is**  
578 **required to provide verification of residency education for**  
579 **residents who may leave the program prior to completion of**  
580 **their education. A documented procedure must be in place for**  
581 **checking the credentials, the clinical training experiences, and the**  
582 **past performance and professional integrity of residents transferring**  
583 **from one program to another, including from a general psychiatry**  
584 **program to a child and adolescent psychiatry program.**

### 585 586 587 **D. Selection of Residents**

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589 The program must document the procedures used to select  
590 residents in accordance with institutional and departmental policies  
591 and procedures. Application records must document information  
592 from graduate medical education programs. ~~A documented~~  
593 ~~procedure must be in place for checking the credentials, the clinical~~  
594 ~~training experiences, and the past performance and professional~~  
595 ~~integrity of residents transferring from one program to another,~~  
596 ~~including from a general psychiatry program to a child and~~

597 adolescent psychiatry program. This procedure must include  
598 solicitation and documentation of relevant information from the  
599 training directors of the previous programs participated in by the  
600 transferring resident.

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602 D.

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#### 604 **E. Appointment of Fellows and Other Students**

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606 **The appointment of fellows and other specialty residents or**

607 **students must not dilute or detract from the educational**

608 **opportunities available to regularly appointed residents.**

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### 610 **V. Program Curriculum**

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#### 612 **A. Program Design**

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##### 614 **1. Format**

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616 **The program design and sequencing of educational**

617 **experiences will be approved by the RRC as part of the review**

618 **process.**

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##### 620 **2. Goals and Objectives**

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622 **The program must possess a written statement that outlines**

623 **its educational goals with respect to the knowledge, skills, and**

624 **other attributes of residents for each major assignment and for**

625 **each level of the program. This statement must be distributed**

626 **to residents and faculty, and applicants who are interviewed,**

627 **and must be reviewed with residents prior to their**

628 **assignments.**

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630 All educational components of a residency program should be

631 related to program goals. There must be sufficient and stable

632 leadership, faculty, clinical facilities, and affiliations to provide a

633 consistent educational experience.

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#### 635 **B. Specialty Curriculum**

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637 **The program must possess a well-organized and effective**

638 **curriculum, both didactic and clinical. The curriculum must**

639 **also provide residents with direct experience in progressive**

640 **responsibility for patient management. In the diagnosis and**

641 **treatment of preschool and grade school children, adolescents, and**

642 **their families over. ~~The program must have an explicitly described~~**

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~~educational curriculum composed of formal didactic instruction and a program of graduated learning and supervised clinical experience through the 2 years, that is distributed to residents and faculty. The latter is to be marked by progressive responsibility for the diagnosis and treatment of preschool and grade school children, adolescents, and their families.—Educational quality must have the highest priority in the allotment of the residents' time and energy. The clinical responsibilities of residents must not infringe unduly on didactic activities.~~

~~The curriculum must also provide residents with direct experience in progressive responsibility for patient management.~~

### 1. Clinical Experience Program Design

- a) Clinical instruction must be well organized, thoughtfully integrated, based on sound educational principles, and carried out on a regularly scheduled basis.
- b) ~~Goals that include knowledge, skill, and attitude objectives must be~~ The program must develop and distribute to all residents and faculty an organized educational plan with competency based goals and objectives that identify educational outcomes for both the didactic and clinical components for the overall program, each year of training, and for each major rotation specified for each clinical rotation.

### 2. General Competencies

The following ACGME competencies must be integrated into the Educational Plan

#### Patient Care

- ↻
- a) Each resident must have responsibility for the evaluation and treatment of a sufficient number and adequate variety of patients representing the full spectrum of psychiatric illnesses in children and adolescents, including developmental and substance use disorders. The number of patients for whom residents have primary responsibility at any one time must permit them to provide each patient with

689 appropriate treatment, as well as to have sufficient  
690 time for other aspects of their educational program.  
691 The depth and variety of clinical experiences must be  
692 adequate.

693  
694 d)  
695

696 b) Clinical records, recorded by the child and adolescent  
697 psychiatry residents, should document an adequate  
698 individual and family history, mental status, physical  
699 and neurological examinations when appropriate,  
700 supplementary medical and psychological data, and  
701 integration of these data into a formulation, differential  
702 diagnosis, and comprehensive treatment plan.

703  
704 e)  
705

706 c) Opportunities for the development of both conceptual  
707 understanding of and beginning clinical skills in the  
708 major treatment modalities with children and  
709 adolescents, which include brief and long-term  
710 individual therapy, family therapy, group therapy,  
711 crisis intervention, supportive therapy, psychodynamic  
712 psychotherapy, cognitive-behavioral therapy, and  
713 pharmacotherapy must be provided. There must be  
714 opportunities for residents to be involved in providing  
715 continuous care for a variety of patients from different  
716 age groups, seen regularly and frequently for an  
717 extended time, in a variety of treatment modalities.  
718 Residents should have some experience with  
719 continuity of patient care across clinical programs  
720 providing different levels of care. Care for outpatients  
721 must include work with some child and adolescent  
722 patients from each developmental group for at least  
723 one year's duration.

724  
725  
726 f)  
727

728 d) Residents must have an opportunity to evaluate and  
729 treat patients from diverse cultural backgrounds and  
730 varied socioeconomic levels.

731  
732 g)  
733

- 734 e) Training must include supervised, active collaboration  
735 with other professional mental health personnel,  
736 pediatricians, teachers, and other school personnel in  
737 the evaluation and treatment of patients.  
738
- 739 h)  
740
- 741 f) There must be teaching about the appropriate uses  
742 and limitations of psychological tests. Residents  
743 should have the opportunity to observe some of their  
744 patients being tested.  
745
- 746 i)  
747
- 748 g) There must be an organized ~~teaching and~~ clinical  
749 experience in each of the following:  
750
- 751 i. pediatric neurology;  
752
- 753 ii. mental retardation, and other developmental  
754 disorders.  
755
- 756 iii. Initial management of psychiatric emergencies in  
757 children and adolescents  
758
- 759 iv. Experience with acutely- and severely-disturbed  
760 children and adolescents during which the resident is  
761 actively involved with the diagnostic assessment and  
762 treatment planning with these patients. This  
763 experience must occur in settings with an organized  
764 treatment program, i.e. inpatient units, residential  
765 treatment facilities, partial hospitalization programs  
766 and/or day treatment programs and must be the FTE  
767 of no fewer than 4 months and no more than 10  
768 months.  
769
- 770 v. Consultation experiences during which they do not  
771 primarily engage in treatment, but use their  
772 specialized knowledge and skills to assist others to  
773 function better in their roles. Training and experience  
774 in consultation to facilities serving children,  
775 adolescents and their families must include  
776 supervised:  
777
- 778 1. consultation experience with an adequate  
779 number of pediatric patients in outpatient

- 780 and/or inpatient non-psychiatric medical  
781 facilities
- 782 2. formal observation and/or consultation  
783 experiences in schools;
- 784
- 785 3. Training in legal issues relevant to child and  
786 adolescent psychiatry, which may include  
787 forensic consultation, court testimony and/or  
788 interaction with a juvenile justice system; and
- 789
- 790 4. Experience consulting to community systems  
791 of care.
- 792
- 793 ~~j) Residents must have experiences in the initial~~  
794 ~~management of psychiatric emergencies in children~~  
795 ~~and adolescents. This experience may occur in a~~  
796 ~~variety of settings.~~
- 797
- 798 ~~k) Experience with acutely and severely disturbed~~  
799 ~~children or young adolescents is an essential part of~~  
800 ~~training. This experience must occur in settings with~~  
801 ~~an organized treatment program, such as inpatient~~  
802 ~~units, residential treatment facilities, partial~~  
803 ~~hospitalization programs, and/or day treatment~~  
804 ~~programs. This experience must be the full-time~~  
805 ~~equivalent of not fewer than 4 or more than 10~~  
806 ~~months. The resident must be actively involved with~~  
807 ~~the diagnostic assessment, treatment planning, and~~  
808 ~~treatment provision for these acutely and severely~~  
809 ~~disturbed patients.~~
- 810
- 811 ~~l) Residents must have experience as consultants in~~  
812 ~~situations in which they do not primarily engage in~~  
813 ~~treatment, but use their specialized knowledge and~~  
814 ~~skills to assist others to function better in their roles.~~  
815 ~~Training and experience in consultation to facilities~~  
816 ~~servicing children, adolescents, and their families must~~  
817 ~~include:~~
- 818
- 819 ~~(1) supervised consultation experience with an~~  
820 ~~adequate number of pediatric patients in~~  
821 ~~outpatient and/or inpatient medical facilities;~~
- 822
- 823 ~~(2) supervised formal observation and/or~~  
824 ~~consultation experiences in schools;~~
- 825

- 826 (3) ~~supervised training and experience in legal~~  
827 ~~issues relevant to child and adolescent~~  
828 ~~psychiatry, which may include forensic~~  
829 ~~consultation, court testimony, and/or interaction~~  
830 ~~with a juvenile justice system; and~~  
831  
832 (4) ~~training and experience in supervised~~  
833 ~~consultation to community systems of care and~~  
834 ~~their treatment components.~~  
835  
836 m) ~~Residents must have experience in administrative~~  
837 ~~decision-making processes and practice management~~  
838 ~~involving health care delivery and interactions with~~  
839 ~~health care systems.~~  
840  
841 h) There must be a record maintained that demonstrates  
842 each resident has met the educational requirements  
843 of the program with regard to variety of patients,  
844 diagnoses, and treatment modalities. In the case of  
845 transferring residents, the records should include the  
846 experiences in the prior as well as the current  
847 program. This record must be reviewed periodically  
848 with the program director or a designee, and must be  
849 available for review by the site visitor  
850  
851 i) Clinical records, recorded by the child and adolescent  
852 psychiatry residents, should document an adequate  
853 individual and family history, mental status, physical  
854 and neurological examinations when appropriate,  
855 supplementary medical and psychological data, and  
856 integration of these data into a formulation, differential  
857 diagnosis, and comprehensive treatment plan.  
858

859 ~~2. Didactic Curriculum~~

860 3. Medical Knowledge

861  
862 Residents must demonstrate knowledge of established and  
863 evolving biomedical, clinical, epidemiological, and social-  
864 behavioral sciences, as well as the application of this  
865 knowledge to patient care.  
866

- 867 a) Didactic instruction must be well organized,  
868 thoughtfully integrated, based on sound educational  
869 principles, and carried out on a regularly scheduled  
870 basis. Goals that include knowledge and attitude  
871 objectives must be specified for each course or

872 seminar. Systematically- organized formal instruction  
873 (prepared lectures, seminars, assigned reading, etc.)  
874 must be integral to the residency. Staff meetings,  
875 clinical case conferences, journal clubs, and grand  
876 rounds are important adjuncts, but they must not be  
877 used as substitutes for an organized didactic  
878 curriculum.

879

880 b) Emphasis on development is an essential part of  
881 training in child and adolescent psychiatry. The  
882 teaching of developmental knowledge and the  
883 integration of neurobiological, phenomenological,  
884 psychological, and sociocultural issues into a  
885 comprehensive formulation of clinical problems are  
886 essential. Teaching about normal development should  
887 include observation of and interaction with normal  
888 children of preschoolers, school aged children and  
889 adolescents. ~~various ages.~~  
890

891 c) The didactic and clinical curriculum must be of  
892 sufficient breadth and depth to provide residents with  
893 a thorough, well-balanced presentation of the  
894 generally-accepted observations and theories, as well  
895 as the major diagnostic, therapeutic, and preventive  
896 procedures in the field of child and adolescent  
897 psychiatry.  
898

899 d) The curriculum must include adequate and systematic  
900 instruction in the following topics:

901

902 i. basic neurobiological, psychological, and  
903 clinical sciences relevant to psychiatry and  
904 in the application of developmental  
905 psychological and sociocultural theories  
906 relevant to the understanding of  
907 psychopathology. It must provide teaching  
908 about the full range of psychopathology in  
909 children and adolescents, including the  
910 etiology, epidemiology, diagnosis,  
911 treatment, and prevention of the major  
912 psychiatric conditions that affect children  
913 and adolescents.

914

915 ii. the full range of psychopathology in  
916 children and adolescents, including the  
917 etiology, epidemiology, diagnosis,

918 treatment, and prevention of the major  
919 psychiatric conditions that affect children  
920 and adolescents.

921  
922 iii. Instruction in the recognition and  
923 management of domestic and community  
924 violence as it affects children and  
925 adolescents. This includes physical and  
926 sexual abuse as well as neglect.

927  
928 ~~e) — The curriculum must also include teaching in the~~  
929 ~~ethical practice of child and adolescent psychiatry.~~  
930 ~~There must as well be instruction in diversity and~~  
931 ~~cultural issues pertinent to children and adolescents.~~

932  
933 ~~f) — Residents must receive instruction in the recognition~~  
934 ~~and management of domestic and community~~  
935 ~~violence as it affects children and adolescents. This~~  
936 ~~includes physical and sexual abuse as well as~~  
937 ~~neglect.~~

938  
939 ~~g) — The opportunity for residents to be involved in~~  
940 ~~research or scholarly activity must be available.~~

941  
942 ~~h)~~

943  
944 ~~e) The curriculum must include an adequate number of~~  
945 ~~interdisciplinary clinical conferences and didactic~~  
946 ~~seminars for residents, where faculty psychiatrists~~  
947 ~~collaborate in teaching with colleagues from other~~  
948 ~~medical specialties and mental health disciplines.~~

949  
950 ~~i) — There should be instruction in the principles and~~  
951 ~~practice of utilization review, quality assurance, and~~  
952 ~~performance improvement.~~

953  
954  
955 4. Practice-based Learning and Improvement

956  
957 Residents must demonstrate the ability to investigate and evaluate  
958 their care of patients, to appraise and assimilate scientific evidence,  
959 and to continuously improve patient care based on constant self-  
960 evaluation and life-long learning. Specific knowledge, skills, and  
961 attitudes in Practice-based Learning and Improvement should  
962 include:

963

- 964 a) taking primary responsibility for lifelong learning to  
965 improve knowledge, skills, and practice performance  
966 through familiarity with general and rotation specific  
967 goals and objectives and attendance at conferences;
- 968  
969 b) analyzing practice experience to recognize one's  
970 strengths, deficiencies, and limits in knowledge and  
971 expertise through participation in a quality  
972 improvement activity;
- 973  
974 c) using evaluations of performance provided by peers,  
975 patients, superiors, and junior colleagues to improve  
976 practice;
- 977  
978 d) locating, appraising, and assimilating evidence from  
979 scientific studies related to their patient's health  
980 problems;
- 981  
982 e) using information technology to optimize lifelong  
983 learning; and
- 984  
985 f) actively participating in the education of patients,  
986 families, students, residents and other health  
987 professionals, which should be documented by  
988 evaluations of a resident's teaching abilities by faculty  
989 and/or learners.

990  
991 5. Interpersonal and Communication Skills  
992

993 Residents must demonstrate interpersonal and communication  
994 skills that result in the effective exchange of information and  
995 teaming with patients, their families, and professional associates.  
996 Specific knowledge, skills, and attitudes in Interpersonal and  
997 Communication Skills should include:

- 998  
999 a) communicating effectively in a developmentally-  
1000 appropriate manner with patients and families to  
1001 create and sustain a professional and therapeutic  
1002 relationship across a broad range of socioeconomic  
1003 and cultural backgrounds;
- 1004  
1005 b) communicating effectively with physicians, other  
1006 health professionals, and health related agencies;
- 1007  
1008 c) working effectively as a member or leader of a health  
1009 care team or other professional group;

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- d) acting in a consultative role to other physicians and health professionals; and
- e) maintaining comprehensive, timely, and legible medical records.

6. Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diversity. Specific knowledge, skills, and attitudes in Professionalism should include:

- a) demonstrating respect, compassion, integrity, and honesty; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession;
- b) demonstrating high standards of ethical behavior which include respect for patient privacy and autonomy, and maintaining appropriate professional boundaries;
- c) demonstrating sensitivity and responsiveness to a diverse patient population, including but not limited to, diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

7. Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Specific knowledge, skills, and attitudes in Systems-based Practice should include:

- a) knowing how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
- b) practicing cost-effective health care and resource allocation that does not compromise quality of care;

- 1056 c) advocating for quality patient care and assisting  
 1057 patients in dealing with system complexities;  
 1058  
 1059 d) partnering with health care managers and health care  
 1060 providers to assess, coordinate, and improve health  
 1061 care;  
 1062  
 1063 e) knowing how to advocate for the promotion of health  
 1064 and the prevention of disease and injury in  
 1065 populations; and  
 1066  
 1067 f) acknowledging the importance of medical errors and  
 1068 examining systems to prevent them.  
 1069 g) Instruction in the practice of utilization review, quality  
 1070 assurance and performance improvement.

1071  
 1072 **C. Residents Scholarly Activities**

1073 **Each program must provide an opportunity for residents to**  
 1074 **participate in research or other scholarly activities, and**  
 1075 **residents must participate actively in such scholarly activities.**  
 1076

1077 Graduate medical education must take place in an environment of  
 1078 inquiry and scholarship in which residents participate in the  
 1079 development of new knowledge, learn to evaluate research  
 1080 findings, and develop habits of inquiry as a practice of life-long  
 1081 learning. The following components of a scholarly environment  
 1082 must be provided: continuing professional responsibility. The  
 1083 responsibility for establishing and maintaining an environment of  
 1084 inquiry and scholarship rests with the teaching staff. Although not  
 1085 all members of a teaching staff must be investigators, the staff as a  
 1086 whole must demonstrate broad involvement in scholarly activity.  
 1087 This activity should include:

- 1088  
 1089 1. an atmosphere of scholarly inquiry, including the provision of  
 1090 access to ongoing research activity in child and adolescent  
 1091 psychiatry. Residents must be taught the design and  
 1092 interpretation of data. The program must teach expertise in  
 1093 the critical appraisal of new therapies and developments that  
 1094 are described in the literature. Residents must be advised  
 1095 and supervised by faculty members qualified in the conduct  
 1096 of research. Programs must have a plan to foster the  
 1097 development of skills for residents who are interested in  
 1098 conducting psychiatric research.  
 1099

- 1100 4.
- 1101
- 1102 2. Active participation of the teaching staff in clinical
- 1103 discussions, rounds, and conferences in a manner that
- 1104 promotes a spirit of inquiry and scholarship. Scholarship
- 1105 implies an in-depth understanding of basic mechanisms of
- 1106 normal and abnormal states, and the application of
- 1107 evidenced based ~~current knowledge to~~ practice;
- 1108
- 1109 2.
- 1110
- 1111 3. participation in journal clubs and research conferences;
- 1112
- 1113 It is strongly desirable that the following components be provided.
- 1114
- 1115 3.
- 1116
- 1117 1. Active participation of faculty in regional or national
- 1118 professional and scientific societies, particularly through
- 1119 presentations at the organizations' meetings and publication
- 1120 in their journals;
- 1121
- 1122 4.
- 1123
- 1124 2. Faculty participation in research, particularly in projects that
- 1125 are funded following peer review and/or result in publications
- 1126 or presentations at regional and national scientific meetings;
- 1127
- 1128 5.
- 1129
- 1130 3. ~~the~~ Offering of guidance and technical support (e.g.,
- 1131 research design, statistical analysis) for residents involved in
- 1132 research;
- 1133
- 1134 6.
- 1135
- 1136 4. ~~the~~ Provision of support for resident participation in scholarly
- 1137 activities- whenever a resident is interested. This plan
- 1138 should include opportunities for conducting research under
- 1139 the supervision of a mentor and training in the principles and
- 1140 methods of research. Whenever research mentors are not
- 1141 available in a program, arrangements for distance mentoring
- 1142 should be made.
- 1143

**D. ACGME Competencies**

1144

1145

1146 ~~The residency program must require its residents to obtain~~  
1147 ~~competence in the six areas listed below to the level expected~~  
1148 ~~of a new practitioner. Programs must define the specific~~  
1149 ~~knowledge, skills, behaviors, and attitudes required, and~~  
1150 ~~provide educational experiences as needed in order for their~~  
1151 ~~residents to demonstrate the following: (e.g. ABPN Core~~  
1152 ~~Competencies in Child and Adolescent Psychiatry):~~  
1153  
1154 ~~1. Patient care that is compassionate, appropriate, and~~  
1155 ~~effective for the treatment of health programs and the~~  
1156 ~~promotion of health;~~  
1157  
1158 ~~2. Medical Knowledge about established and evolving~~  
1159 ~~biomedical, clinical, and cognate sciences, as well as~~  
1160 ~~the application of this knowledge to patient care;~~  
1161 ~~3. Practice-based learning and improvement that involves~~  
1162 ~~the investigation and evaluation of care for their~~  
1163 ~~patients, the appraisal and assimilation of scientific~~  
1164 ~~evidence, and improvements in patient care;~~  
1165  
1166 ~~4. Interpersonal and communication skills that result in the~~  
1167 ~~effective exchange of information and collaboration with~~  
1168 ~~patients, their families, and other health professionals;~~  
1169  
1170 ~~5. Professionalism, as manifested through a commitment~~  
1171 ~~to carrying out professional responsibilities, adherence~~  
1172 ~~to ethical principles, and sensitivity to patients of~~  
1173 ~~diverse backgrounds;~~  
1174  
1175 ~~6. Systems-based practice, as manifested by actions that~~  
1176 ~~demonstrate an awareness of and responsiveness to the~~  
1177 ~~larger context and system of health care, as well as the~~  
1178 ~~ability to call effectively on other resources in the~~  
1179 ~~system to provide optimal health care.~~

1180  
1181 ~~E. Other Required Components~~

1182  
1183 ~~Teaching Opportunities~~

1184  
1185 ~~Opportunities for residents to teach community groups, medical~~  
1186 ~~students, and/or other residents should be available.~~

## 1187 1188 **VI. Resident Duty Hours and the Working Environment**

1189  
1190 **Providing residents with a sound didactic and clinical education**  
1191 **must be carefully planned and balanced with concerns for patient**

1192 safety and resident well-being. Each program must ensure that the  
1193 learning objectives of the program are not compromised by  
1194 excessive reliance on residents to fulfill service obligations. Didactic  
1195 and clinical education must have priority in the allotment of  
1196 residents' time and energy. Duty hour assignments must recognize  
1197 that faculty and residents collectively have responsibility for the  
1198 safety and welfare of patients.

1199  
1200 **A. Supervision of Residents**

- 1201
- 1202 **1. All patient care must be supervised by qualified faculty.**  
1203 **The program director must ensure, direct, and**  
1204 **document adequate supervision of residents at all**  
1205 **times. Residents must be provided with rapid, reliable**  
1206 **systems for communicating with supervising physician**  
1207 **faculty. Residents must be provided sufficient supervision**  
1208 **from Child and Adolescent Psychiatry faculty to enable each**  
1209 **resident to establish working relationships that foster**  
1210 **identification in the role as a child and adolescent**  
1211 **psychiatrist.**
  - 1212
  - 1213 **2. Faculty schedules must be structured to provide**  
1214 **residents with continuous supervision and consultation.**
  - 1215
  - 1216 **3. Faculty and residents must be educated to recognize**  
1217 **the signs of fatigue, and adopt and apply policies to**  
1218 **prevent and counteract its potential negative effects.**
  - 1219
  - 1220 **4. Each resident must have at least 2 hours of individual**  
1221 **supervision weekly, in addition to teaching conferences and**  
1222 **rounds. ~~Residents must be provided with prompt, reliable~~**  
1223 **~~systems for communication and interaction with supervisory~~**  
1224 **~~physicians.~~**

1225  
1226 **B. Duty Hours**

- 1227
- 1228 **1. Duty hours are defined as all clinical and academic**  
1229 **activities related to the residency program; i.e., patient**  
1230 **care (both inpatient and outpatient), administrative**  
1231 **duties relative to patient care, the provision for transfer**  
1232 **of patient care, time spent in-house during call**  
1233 **activities, and scheduled activities such as conferences.**  
1234 **Duty hours do not include reading and preparation time**  
1235 **spent away from the duty site.**

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2. **Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
3. **Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.**
4. **Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**
5. ~~The program should carefully monitor any professional activity outside the residency, and ensure that it does not interfere with education, performance, or clinical responsibility. The program should carefully monitor all on-call schedules and hours within and outside residency to prevent undue interference with education, performance, or clinical responsibility.~~

**C. On-call Activities**

**The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution.**

1. **In-house call must occur no more frequently than every third night, averaged over a 4-week period.**
2. **Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**
3. **No new patients may be accepted after 24 hours of continuous duty.**
4. **At-home call (or pager call) is defined as a call taken from outside the assigned institution.**

- 1283 a) The frequency of at-home call is not subject to the  
1284 every-third- night limitation. At-home call,  
1285 however, must not be so frequent as to preclude  
1286 rest and reasonable personal time for each  
1287 resident. Residents taking at-home call must be  
1288 provided with 1 day in 7 completely free from all  
1289 educational and clinical responsibilities, averaged  
1290 over a 4-week period.  
1291  
1292 b) When residents are called into the hospital from  
1293 home, the hours residents spend in-house are  
1294 counted toward the 80-hour limit.  
1295  
1296 c) The program director and the faculty must  
1297 monitor the demands of at-home call in their  
1298 programs, and make scheduling adjustments as  
1299 necessary to mitigate excessive service demands  
1300 and/or fatigue.  
1301

#### 1302 D. Moonlighting

- 1303  
1304 1. Because residency education is a full-time endeavor, the program  
1305 director must ensure that moonlighting does not interfere with the  
1306 ability of the resident to achieve the goals and objectives of the  
1307 educational program.  
1308  
1309 2. The program director must comply with the sponsoring  
1310 institution's written policies and procedures regarding  
1311 moonlighting, in compliance with the ACGME Institutional  
1312 Requirements.  
1313  
1314 a. specify that residents must not be required to engage in  
1315 moonlighting  
1316  
1317 b. require a prospective, written statement of permission from the  
1318 program director that is made part of the resident's file  
1319  
1320 c. state that the residents' performance will be monitored for the effect  
1321 of these activities upon performance and that adverse effects may  
1322 lead to withdrawal of permission  
1323  
1324 3. The program should carefully monitor any professional activity outside  
1325 the residency, and ensure that it does not interfere with education,  
1326 performance, or clinical responsibility. The program should carefully  
1327 monitor all on-call schedules and hours within and outside residency to

1328 prevent undue interference with education, performance, or clinical  
1329 responsibility.

1330

1331 3.

1332

1333 **4. Any hours a resident works for compensation at the sponsoring**  
1334 **institution or any of the sponsor's primary clinical sites must be**  
1335 **considered part of the 80-hour weekly limit on duty hours. This**  
1336 **refers to the practice of internal moonlighting.**

1337

1338 **E. Oversight**

1339

1340 **1. Each program must have written policies and**  
1341 **procedures consistent with the Institutional and**  
1342 **Program Requirements for resident duty hours and the**  
1343 **working environment. These policies must be**  
1344 **distributed to the residents and the faculty. Duty hours**  
1345 **must be monitored with a frequency sufficient to ensure**  
1346 **an appropriate balance between education and service.**

1347

1348 **2. Back-up support systems must be provided when**  
1349 **patient care responsibilities are unusually difficult or**  
1350 **prolonged, or if unexpected circumstances create**  
1351 **resident fatigue sufficient to jeopardize patient care.**

1352

1353 **F. Duty Hours Exceptions**

1354

1355 **An RRC may grant exceptions for up to 10% of the 80-hour**  
1356 **limit to individual programs based on a sound educational**  
1357 **rationale. Prior permission of the institution's GMEC, however,**  
1358 **is required.**

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1360 **VII. Evaluation**

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1362 The program will maintain records of all evaluations required in this  
1363 section, and these will be made available on review of the program.

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1365 **A. Resident**

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1367 **1. Formative Evaluation**

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1369 **The faculty must evaluate in a timely manner the**  
1370 **residents whom they supervise. In addition, the**  
1371 **residency program must demonstrate that it has an**  
1372 **effective mechanism for assessing resident**  
1373 **performance throughout the program, and for utilizing**

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**the results to improve resident performance.** The program director, with participation of members of the teaching staff, must regularly evaluate residents' knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician.

- a) **Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.** Techniques may include supervisory reports, videotapes, oral examinations, case reports, patient care observations, 360°, or other methods outlined in the ACGME tool box.
  
- b) **Assessment should include the regular and timely performance feedback to residents that includes at least semiannual written evaluations. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.** More frequent meetings may be necessary to ensure that the residents are continually aware of the quality of their progress toward attainment of program goals. Provision should be made for remediation in cases of unsatisfactory performance.
  
- c) **Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.**
  
- d) Residents must be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional growth. In addition to periodic assessments, an annual evaluation procedure is required, which must include a written examination of the knowledge base as well as a formal documented clinical skills examination.

1419 e) A written set of due -process procedures must be in  
1420 place for resolving problems that occur if a resident's  
1421 performance fails to meet required standards. These  
1422 must include the criteria for any adverse action, such  
1423 as placing a resident on probation, or for terminating a  
1424 resident whose performance is unsatisfactory. The  
1425 procedures should be fair to the resident, patients  
1426 under care, and the training program. A copy should  
1427 be provided to the residents at the beginning of  
1428 training.

## 2. Final Evaluation

1431 **The program director must provide a final evaluation for**  
1432 **each resident who completes the program. This**  
1433 **evaluation must include a review of the resident's**  
1434 **performance during the final period of education, and**  
1435 **should verify that the resident has demonstrated**  
1436 **sufficient professional ability to practice competently**  
1437 **and independently. This evaluation should also include**  
1438 **documented evidence of unethical behavior, unprofessional**  
1439 **behavior, or clinical incompetence. Where there is such**  
1440 **evidence, it must be comprehensively recorded, along with**  
1441 **the responses of the resident. The final evaluation must be**  
1442 **part of the resident's permanent record maintained by**  
1443 **the institution.**

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1445  
1446 3. ~~The program must provide an opportunity for the resident~~  
1447 ~~and the program director or designated faculty members to~~  
1448 ~~meet regularly. These meetings, which must be~~  
1449 ~~documented, should be of sufficient frequency, length, and~~  
1450 ~~depth to ensure that the residents are continually aware of~~  
1451 ~~the quality of their progress toward attainment of program~~  
1452 ~~goals. At least semiannually, the program director must~~  
1453 ~~evaluate the knowledge, skills, and professional growth of~~  
1454 ~~the residents, using appropriate criteria and procedures.~~  
1455 ~~Provision should be made for remediation in cases of~~  
1456 ~~unsatisfactory performance.~~

1457  
1458 4. ~~Residents must be advanced to positions of higher~~  
1459 ~~responsibility only on the basis of evidence of their~~  
1460 ~~satisfactory progressive scholarship and professional~~  
1461 ~~growth.~~

1462  
1463 5. ~~In addition to periodic assessments, an annual evaluation~~  
1464 ~~procedure is required, which must include a written~~

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~~examination of the knowledge base as well as a formal documented clinical skills examination.~~

~~6. Programs must develop at least one written core competency for its residents in each of the following areas:~~

~~\_\_\_\_\_ a) Clinical science~~

~~\_\_\_\_\_ b) Interpersonal skills and communication~~

~~\_\_\_\_\_ c) Patient care~~

~~\_\_\_\_\_ d) Practice-based learning and improvement~~

~~\_\_\_\_\_ e) Professionalism and ethical behavior~~

~~\_\_\_\_\_ f) Systems-based care~~

~~The program must provide documented evidence to demonstrate that the proficiency and competence of each resident is assessed, in the six core competencies, using techniques that may include supervisory reports, videotapes, oral examinations, case reports, patient care observations, or other methods.~~

~~7. Evaluation must include a review of the resident's performance during the final period of training, and should verify that the resident has demonstrated sufficient professional ability to practice competently, ethically, and independently, based on the program's defined core competencies.~~

~~8. At the time of the resident's graduation or departure from the program, the program director will affirm in the training record whether there is documented evidence of unethical behavior, unprofessional behavior, or clinical incompetence. Where there is such evidence, it must be comprehensively recorded, along with the responses of the resident. This final evaluation should be part of the resident's permanent record maintained by the institution.~~

~~9. A written set of due process procedures must be in place for resolving problems that occur if a resident's performance fails to meet required standards. These must include the criteria for any adverse action, such as placing a resident on probation, or for terminating a resident whose performance~~

1511 ~~is unsatisfactory. The procedures should be fair to the~~  
1512 ~~resident, patients under care, and the training program. A~~  
1513 ~~copy should be provided to the residents at the beginning of~~  
1514 ~~training.~~

1515  
1516 B. Faculty

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1518 The performance of the faculty must be evaluated by the program  
1519 no less frequently than at the midpoint of the accreditation cycle,  
1520 and again prior to the next site visit. The evaluations should include  
1521 a review of their teaching abilities, commitment to the educational  
1522 program, clinical knowledge, and scholarly activities. This  
1523 evaluation must include annual written confidential evaluations by  
1524 residents. The PD must provide the faculty with a written  
1525 evaluation at the midpoint of the review cycle and prior to the site  
1526 visit.

1527  
1528 ~~The program director is responsible for the evaluation of faculty~~  
1529 ~~teaching and supervision. This must include an annual confidential~~  
1530 ~~written assessment of faculty members by the residents, a~~  
1531 ~~summary of which must be provided to faculty.~~

1532  
1533 C. Program

1534  
1535 **The educational effectiveness of a program must be evaluated**  
1536 **at least annually in a systematic manner.** In particular, the  
1537 quality of the overall educational program and the extent to which  
1538 the educational goals have been met by residents must be  
1539 assessed. Confidential written evaluations by residents must be  
1540 utilized in this process. The teaching staff must annually evaluate  
1541 the utilization of the resources available to the program, the  
1542 contribution of each institution participating in the program, the  
1543 financial and administrative support of the program, the volume and  
1544 variety of patients available to the program for educational  
1545 purposes, the performance of members of the teaching staff, and  
1546 the quality of supervision of residents.

1547  
1548 **1. Representative program personnel (i.e., at least the**  
1549 **program director, representative faculty, and one**  
1550 **resident) must be organized to review program goals**  
1551 **and objectives, and the effectiveness with which they**  
1552 **are achieved. This group must conduct a formal**  
1553 **documented meeting at least annually for this purpose.**  
1554 **In the evaluation process, the group must take into**  
1555 **consideration written comments from the faculty, the**  
1556 **most recent report of the GMEC of the sponsoring**

1557 institution, and the residents' confidential written  
1558 evaluations. If deficiencies are found, the group should  
1559 prepare an explicit plan of action, which should be  
1560 approved by the faculty and documented in the minutes  
1561 of the meeting.

1562  
1563 2. The program should use resident performance and  
1564 outcome assessment in its evaluation of the educational  
1565 effectiveness of the residency program. Performance of  
1566 program graduates on the certification examination  
1567 should be used as one measure of evaluating program  
1568 effectiveness. In its evaluation of residency programs, the  
1569 RRC will take into consideration the information provided by  
1570 the American Board of Psychiatry and Neurology regarding  
1571 resident performance on the certifying examinations during  
1572 the most recent 5 years. The expectation is that, over a  
1573 period of years, for graduated residents eligible to sit for the  
1574 exam (i.e. having obtained ABPN certification in general  
1575 psychiatry), at least 50% should pass the exam on the first  
1576 attempt and/or 70% should take the certifying examination.  
1577 **The program should maintain a process for using**  
1578 **assessment results together with other program**  
1579 **evaluation results to improve the residency program.**

1580  
1581 **VIII. Experimentation and Innovation**

1582  
1583 **Since responsible innovation and experimentation are essential to**  
1584 **improving professional education, experimental projects along**  
1585 **sound educational principles are encouraged. Requests for**  
1586 **experimentation or innovative projects that may deviate from the**  
1587 **program requirements must be approved in advance by the RRC,**  
1588 **and must include the educational rationale and method of evaluation.**  
1589 **The sponsoring institution and program are jointly responsible for**  
1590 **the quality of education offered to residents for the duration of such**  
1591 **a project.**

1592  
1593 **IX. Inquiries Concerning Accreditation and Certification**

1594  
1595 A. All inquiries concerning the accreditation of child and adolescent  
1596 psychiatry residency programs should be addressed to the  
1597 Executive Director, Residency Review Committee for Psychiatry,  
1598 515 N. State St., Ste 2000, Chicago, IL 60610.

1599  
1600 B. All inquiries as to whether an individual physician is qualified to be  
1601 admitted for examination for certification in psychiatry should be  
1602 addressed to Executive Vice President, American Board of

1603                      Psychiatry and Neurology, 500 Lake Cook Rd., Ste 335, Deerfield,  
1604                      IL 60015.  
1605  
1606                      ACGME: February 2000 Effective: January 2001  
1607                      Minor Revision: ACGME: September 2004 Effective: November 12, 2004  
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