

ACGME Program Requirements for Graduate Medical Education in Addiction Psychiatry

Common Program Requirements are in BOLD

Effective: July, 2003

I. Introduction

I.A. Definition of the Subspecialty

Addiction psychiatry is the psychiatry subspecialty that focuses on the prevention, evaluation, and treatment of Substance-related Disorders as well as related education and research. In addition, the addiction psychiatrist will be fully trained in techniques required in the treatment of the larger group of patients with dual diagnoses of addictive disorders and other psychiatric disorders.

I.B. Duration and Scope of Education

I.B.1. The training period in addiction psychiatry must be 12 months. Any program that extends training beyond these minimum requirements must present a clear educational rationale consonant with the special requirements and objectives for residency training in addiction psychiatry.

I.B.2. Training in addiction psychiatry that occurred during the general residency training will not be credited toward the one-year requirement.

I.B.3. Training is best accomplished on a full-time basis. If it is undertaken on a part-time basis, the 12-month program must be completed within a two-year period.

I.B.4. Prior to entry, each addiction psychiatry resident must be notified in writing of the required length of training for which the program is accredited. The required length of training may not be changed without mutual agreement unless there is a break in training or the resident requires remedial training.

I.C. Educational Goals and Objectives

I.C.1. The program must offer advanced training such that the knowledge, skills, clinical judgment, and attitudes essential to the practice of addiction psychiatry at the consultant level are provided.

I.C.2. Clinical experience must include the opportunity to evaluate and follow a variety of patients of both sexes, including adolescents, adults, and geriatric age groups spanning a broad range of diagnoses as enumerated in Program Requirements V.B.3. Residents must provide both primary and consultative care in both inpatient (including intensive care) and outpatient settings for patients with a wide variety of types of Substance-related Disorders. Where the primary site of training is devoted to the care of patients with only a particular form of Substance-related

Disorders, appropriate affiliations must be arranged to ensure that adequate exposure is provided to a sufficient number and variety of patients with Substance-related Disorders.

- I.C.3. Programs must be based on a structured written curriculum with well-defined goals and objectives. Clinical, basic science, and research conferences as well as seminars and critical literature review activities pertaining to Substance-related Disorders must be conducted regularly and as scheduled. The curriculum must include sufficient didactic content so that the graduates will have a comprehensive understanding of the pharmacology of all commonly abused substances, as well as the actions of pharmacological agents used to treat these conditions. Clinical experience and didactics should be integrated to provide appropriate progressive learning.
- I.C.4. Training must focus on the biopsychosocial and functional concepts of diagnosis and treatment as applied to inpatient, outpatient, and other treatment settings. Iatrogenic aspects of illness, as well as cultural, ethnic, racial, socioeconomic, ethical, and legal considerations that may affect or interact with the psychiatric care of these patients must be included in the program.
- I.C.5. The program should present the epidemiology of Substance-related Disorders, such as cultural, ethnic, racial, gender, sexual orientation, socioeconomic, and familial factors affecting the availability and use of addicting substances.

II. Institutions

II.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating institutions.

- II.A.1. The program must be administratively attached to and sponsored by a core residency program in psychiatry that holds full accreditation from the ACGME. The program must function in close relationship to the general psychiatry residency.
- II.A.2. The program must take place in facilities approved by the appropriate state licensing agencies and, where appropriate, by the Joint Commission on the Accreditation of Healthcare Organizations.

II.B. Participating Institutions

- II.B.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.

II.B.1.a) The number of and distance between participating institutions shall not impair training and participation in conferences and other organized educational aspects of the program.

II.B.2. Assignment to a participating institution requires a letter of agreement with the sponsoring institution. Such a letter of agreement should:

II.B.2.a) **identify the faculty who will assume both educational and supervisory responsibilities for residents**

II.B.2.b) **specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**

II.B.2.c) **specify the duration and content of the educational experience; and**

II.B.2.d) **state the policies and procedures that will govern resident education during the assignment.**

II.B.3. Presence of Other Training Programs

The addiction psychiatry program should provide peer interaction between its residents and those of other medical/surgical specialties. To achieve this goal an ACGME-accredited training program in at least one nonpsychiatric specialty, such as neurology, internal medicine, or family medicine should be present within the participating institutions of the program. Peer interaction among the residents should occur in the course of clinical and/or didactic work, but is most satisfactory when organized around joint patient evaluation and/or care.

III. Program Personnel and Resources

III.A. Program Director

III.A.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 Residency Review Committee (RRC) through the Web Accreditation Data System of the Accreditation Council for Graduate Medical Education (ACGME).**

III.A.2. **The program director, together with the faculty, is responsible for the general administration of the program, 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.

III.A.3. Qualifications of the program director are as follows:

III.A.3.a) The program director must possess the requisite specialty expertise, as well as documented educational and administrative abilities.

III.A.3.a).(1) The program director must be an active clinician.

III.A.3.b) The program director must be certified in the specialty by the American Board of Psychiatry and Neurology (ABPN) in the subspecialty of addiction psychiatry, or possess qualifications judged to be acceptable by the RRC.

III.A.3.c) The program director must be appointed in good standing and based at the primary teaching site.

III.A.3.d) devote sufficient time to the program to ensure implementation and achievement of the educational goals and objectives.

III.A.4. Responsibilities of the program director are as follows:

III.A.4.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, appointing a local site director, and monitoring appropriate resident supervision at all participating institutions.

III.A.4.b) 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.

III.A.4.c) 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.

III.A.4.d) 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. Such changes, for example, include:

III.A.4.d).(1) the addition or deletion of a participating institution;

III.A.4.d).(2) a change in the format of the educational program;

- III.A.4.d).(3) a change in the approved resident complement for those specialties that approve resident complement**
- III.A.4.d).(4) On review of a proposal for any such major change in a program, the RRC may determine that a site visit is necessary.**
- III.A.4.e) Supervising the recruitment, selection, and appointment process for applicants, including compliance with appropriate credentialing policies and procedures in accordance with institutional and departmental policies and procedures. The director must receive documentation from the prior general psychiatry program in order to verify satisfactory completion of all educational and ethical requirements for graduation, before appointment to the program.
- III.A.4.f) Ensuring the provision of written descriptions of departmental policies regarding salary and benefits, due process, sickness and other leaves, on-call responsibilities, and vacation time to all residents upon appointment to the program. All residents must be provided with written descriptions of the malpractice coverage provided for each clinical assignment.
- III.A.4.g) Monitoring the progress of each addiction psychiatry resident, including the maintenance of a training record that documents completion of all required components of the program as well as evaluations of residents' clinical and didactic work by supervisors and teachers. This record shall include a patient log which shall document for each addiction psychiatry resident that he/she has completed all clinical experiences required by the Program Requirements and the educational objectives of the program.
- III.A.4.h) Maintaining all other training records including those related to appointment, departmental processes regarding due process, sickness and other leaves, on-call responsibilities, and vacation time.
- III.A.4.i) Ensuring the opportunity for residents to achieve the cognitive knowledge, interpersonal skills, professional attitudes, and practical experience required of an addiction psychiatrist providing acute and chronic care for the patient with Substance-related Disorders.

III.B. Faculty

III.B.1. At each participating institution, there must be a sufficient number of faculty with documented qualifications to instruct and supervise adequately all residents in the program.

- III.B.1.a) In addition to the program director, there must be at least one other faculty member certified by the American Board of Psychiatry and Neurology (ABPN) in the subspecialty of addiction

psychiatry. Programs with large patient populations, multiple institutions, and large resident complements will be expected to have the number of physician faculty appropriate to the program's size and structure.

- III.B.2.** The faculty, furthermore, must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities. They must demonstrate a strong interest in the education of residents, and must support the goals and objectives of the educational program of which they are a member.
- III.B.3.** Qualifications of the physician faculty are as follows:
- III.B.3.a)** The physician faculty must possess the requisite specialty expertise and competence in clinical care and teaching abilities, as well as documented educational and administrative abilities and experience in their field.
- III.B.3.b)** The physician faculty must be certified in the specialty by the American Board of Psychiatry and Neurology (ABPN) in the subspecialty of addiction psychiatry, or possess qualifications judged to be acceptable by the RRC.
- III.B.3.c)** The physician faculty must be appointed in good standing to the staff of an institution participating in the program.
- III.B.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:
- III.B.4.a)** the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;
- III.B.4.b)** the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;
- III.B.4.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.

III.B.5. Qualifications of the nonphysician faculty are as follows:

III.B.5.a) Nonphysician faculty must be appropriately qualified in their field.

III.B.5.b) Nonphysician faculty must possess appropriate institutional appointments.

III.C. Other Program Personnel

Additional necessary professional, technical, and clerical personnel must be provided to support the program.

III.C.1. Addiction psychiatry residents must be provided with meaningful patient care experiences as part of an interdisciplinary care team. The resident should work in settings that include representatives from clinical disciplines such as social work, psychology, psychiatric nursing, occupational therapy, pharmacy, and nutrition, as well as clinicians in anesthesia (including pain management), emergency medicine, family medicine, geriatrics, internal medicine, neurology, obstetrics-gynecology, surgical specialties, and pediatrics/adolescent medicine as appropriate for the care of the patient. In addition, residents should work with other staff such as substance abuse counselors and, where appropriate, with teachers.

III.D. Resources

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

III.D.1. All elements of the program must be located in designated facilities based on written affiliation agreements between the participating institutions and the administration of the program.

III.D.2. Inpatient Care Facility: The sponsor of the program must be a part of, or affiliated with, at least one acute care general hospital with a full range of services, including medical and surgical services, intensive care units, emergency services, diagnostic laboratory, and imaging services. If the acute care hospital is specialized and does not itself have the full spectrum of services described above, the program must document that it has access for training purposes to other affiliated acute care facilities that have the services not present at the specialized facility.

III.D.3. Partial Hospitalization and Day Treatment: Programs must have access to a partial hospitalization and/or day treatment program (such as an intensive outpatient program). Such programs may be located in community-based institutions or within the sponsoring department of psychiatry in its acute care hospital. Exposure to self-help and other community programs (such as 12-step programs widely used by patients with Substance-related Disorders) must be provided.

- III.D.4. Ambulatory Care Service: The program must provide experience in a multidisciplinary ambulatory care facility such as a methadone maintenance clinic, an alcohol treatment clinic, or other specialized outpatient program.
- III.D.5. Library: Residents must have ready access to a major medical library either at the institution where the residents are located or through arrangement with convenient nearby institutions.
- III.D.5.a) Library services should include computer support for electronic retrieval of information from medical databases.
- III.D.5.b) There must be access to an on-site library or to a collection of appropriate texts and journals in each institution participating in the training program. On-site libraries and/or collections of texts and journals must be readily available during nights and weekends.
- III.D.6. Ancillary Support Services: At all participating facilities, there must be appropriate support services to ensure an adequate educational experience. This includes support personnel in all categories including clerical and laboratory and physical resources to ensure that residents have sufficient time and space to carry out their clinical and educational functions.

IV. Resident Appointments

IV.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

- IV.A.1. The addiction psychiatry resident must have satisfactorily completed an ACGME accredited general psychiatry residency prior to entering the program.

IV.B. Number of Residents

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

- IV.B.1. Any permanent changes in resident complement will require prior approval by the RRC.

IV.C. Resident Transfers

To determine the appropriate level of education for residents who are transferring from another residency program, the program director must receive written verification of previous educational experiences and a statement regarding the performance evaluation of the transferring resident prior to their acceptance into the program. A program director is required to provide verification of residency education for residents who may leave the program prior to completion of their education.

IV.D. Appointment of Fellows and Other Students

The appointment of fellows and other specialty residents or students must not dilute or detract from the educational opportunities available to regularly appointed residents.

IV.D.1. At the same time, the presence of residents in addiction psychiatry must not dilute or otherwise detract from the didactic or clinical experience available to general psychiatry residents.

V. Program Curriculum

V.A. Program Design

V.A.1. Format

The program design and sequencing of educational experiences will be approved by the RRC as part of the review process.

V.A.2. Goals and Objectives

The program must possess a written statement that outlines its educational goals with respect to the knowledge, skills, and other attributes of residents for each major assignment and for each level of the program. This statement must be distributed to residents and faculty, and must be reviewed with residents prior to their assignments.

V.B. Specialty Curriculum

The program must possess a well-organized and effective curriculum, both didactic and clinical. The curriculum must also provide residents with direct experience in progressive responsibility for patient management.

V.B.1. Curriculum Content

The field of addiction psychiatry requires knowledge of pharmacology, psychiatry, general medicine, as well as an understanding of the interaction of these disciplines. Programs must include both direct experiences in clinical care as well as formal didactic conferences. Instruction and experience must include the performance of the mental

status examination, a neuropsychiatric evaluation instrument such as the Mini-Mental Status Examination, community and environmental assessments, family and care giver assessments, medical assessments, and physical and psychological functional assessments. These skills comprise the basis for the formal assessment of the addicted patient using a synthesis of clinical findings, historical and current information, as well as data from laboratory and other special studies.

- V.B.1.a) Residents must acquire knowledge and skills in the following areas:
- V.B.1.a).(1) Knowledge of the signs and symptoms of the use and abuse of all of the major categories of substances enumerated in V.B.3.b, as well as knowledge of the types of treatment required for each.
 - V.B.1.a).(2) Knowledge of the signs of withdrawal from these major categories of substances, knowledge and experience with the range of options for treatment of the withdrawal syndromes, and the complications commonly associated with such withdrawal.
 - V.B.1.a).(3) Knowledge of the signs and symptoms of overdose; the medical and psychiatric sequelae of overdose, and experience in providing proper treatment of overdose.
 - V.B.1.a).(4) Management of detoxification: Inpatient management of Substance-related Disorders. Experience in working collaboratively with specialists in the emergency department and intensive care units in the diagnosis and management of acute overdose symptoms.
 - V.B.1.a).(5) Knowledge of the signs and symptoms of the social and psychological problems as well as the medical and psychiatric disorders which often accompany the chronic use and abuse of the major categories of substances.
 - V.B.1.a).(6) Experience in the use of psychoactive medications in the treatment of psychiatric disorders often accompanying the major categories of Substance-related Disorders.
 - V.B.1.a).(7) Experience in the use of techniques required for confrontation of and intervention with a chronic substance abuser, and in dealing with the defense mechanisms that cause the patient to resist entry into treatment.
 - V.B.1.a).(8) Experience in the use of the various psychotherapeutic modalities involved in the ongoing management of the chronic substance abusing patient, including individual psychotherapies (e.g., cognitive-behavioral therapy), couples therapy, family therapy, group therapy,

motivational enhancement therapy, and relapse prevention therapy.

- V.B.1.a).(9) Experience in working collaboratively with other mental health providers and allied health professionals, including nurses, social workers, psychologists, nurse practitioners, counselors, pharmacists, and others who participate in the care of patients with Substance-related Disorders.
- V.B.1.a).(10) Knowledge and understanding of the special problems of the pregnant woman with Substance-related Disorders and of the babies born to these women.
- V.B.1.a).(11) Knowledge of family systems and dynamics relevant to the etiology, diagnosis, and treatment of Substance-related Disorders.
- V.B.1.a).(12) Knowledge of the genetic vulnerabilities, risk and protective factors, epidemiology, and prevention of Substance-related Disorders.
- V.B.1.a).(13) Familiarity with the major medical journals and professional-scientific organizations dealing with research on the understanding and treatment of Substance-related Disorders.
- V.B.1.a).(14) Critical analysis of research reports, as presented in journal clubs and seminars.
- V.B.1.a).(15) Experience in teaching and supervising clinical trainees in the care of patients with Substance-related Disorders.
- V.B.1.a).(16) Understanding of the current economic aspects of providing psychiatric and other healthcare services to the addicted patient.
- V.B.1.a).(17) Knowledge of quality assurance measures and cost effectiveness of various treatment modalities for Substance-related Disorders.

V.B.2. Conferences

Conferences in addiction psychiatry, such as grand rounds, case conferences, reading seminars, and journal clubs, should be specifically designed to complement the clinical experiences. Regular attendance by residents and faculty should be documented.

V.B.3. Clinical Experiences

The number and variety of new and follow-up patients spanning the life cycle from adolescence to old age must be sufficient to ensure an

adequate outpatient and inpatient experience as specified in I.C.2. The spectrum of patients should include diverse socioeconomic, educational, and cultural backgrounds.

The training program must include the following clinical components:

- V.B.3.a) Evaluation, consultation, and treatment of:
 - V.B.3.a).(1) Patients with primary Substance-related Disorders and their families.
 - V.B.3.a).(2) Medical and surgical patients in the emergency department, intensive care units, and general wards of the hospital with acute and chronic Substance-related Disorders, including acute intoxication and overdose.
 - V.B.3.a).(3) Psychiatric inpatients and outpatients with chemical dependencies and co-morbid psychopathology to include a broad range of psychiatric diagnoses, such as affective disorders, psychotic disorders, organic disorders, personality disorders, and anxiety disorders as well as patients suffering from medical conditions commonly associated with Substance-related Disorders such as hepatitis and HIV/AIDS.
 - V.B.3.a).(4) Medication dependent patients with chronic medical disorders/conditions (such as patients with chronic pain).
- V.B.3.b) Exposure to patients with Substance-related Disorders related to the following substances:
 - V.B.3.b).(1) alcohol
 - V.B.3.b).(2) opioids
 - V.B.3.b).(3) cocaine and other stimulants
 - V.B.3.b).(4) cannabis and hallucinogens
 - V.B.3.b).(5) benzodiazepines
 - V.B.3.b).(6) other substances of abuse, including sedatives, hypnotics or anxiolytics
 - V.B.3.b).(7) miscellaneous/unusual, e.g., nutmeg, designer drugs, organic solvents/inhalants
- V.B.3.c) Treatment by the resident of a minimum of 5 addicted outpatients with a variety of diagnoses requiring individual treatment for at least 6 months.

- V.B.3.d) Rotations should provide residents with experience in evaluating acute and chronic patients in inpatient and outpatient settings. There should be an identifiable structured educational experience in neuropsychiatry relevant to the practice of addiction psychiatry that includes both didactic and clinical training methods. The curriculum should emphasize functional assessment, signs and symptoms of neuropsychiatric impairment associated with Substance-related Disorders, and the identification of physical illnesses and iatrogenic factors that can alter mental status, and behavior.
- V.B.3.e) The program must provide specific experiences in consultation to acute and chronic medically ill patients with substance related disorders who are being treated on emergency, intensive care, medical and/or surgical services of a general hospital. Supervision of addiction psychiatry residents in their clinical evaluation of such patients, as well as in their consultative role, is essential. The program should provide residents with the opportunity to function at the level of a specialist consultant to primary care physicians and to intensive care specialists.
- V.B.3.f) Experience in working with multidisciplinary teams as a consultant and as a team leader, including the integration of recommendations and decisions from consulting medical specialists and other professionals in related health disciplines.
- V.B.3.g) Experience in working with patients who are participating in self-help programs.
- V.B.3.h) Experience with opiate replacement therapy.

V.C. Residents Scholarly Activities

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

V.D. ACGME Competencies

The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:

- V.D.1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;**
- V.D.2. *Medical Knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;**

- V.D.3. ***Practice-based learning and improvement*** that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;
- V.D.4. ***Interpersonal and communication skills*** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;
- V.D.5. ***Professionalism***, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;
- V.D.6. ***Systems-based practice***, as manifested by actions that 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.

VI. Resident Duty Hours and the Working Environment

Providing residents with a sound didactic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

VI.A. Supervision of Residents

- VI.A.1. **All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.**
 - VI.A.1.a) Supervision must include observation, assessment, and demonstration of the residents' knowledge and skills in clinical evaluation, technical proficiency, and professional attitudes.
- VI.A.2. **Faculty schedules must be structured to provide residents with continuous supervision and consultation.**
- VI.A.3. **Faculty and residents must be educated to recognize the signs of fatigue, and adopt and apply policies to prevent and counteract its potential negative effects.**
- VI.A.4. Each resident must have a minimum of two hours of individual supervision weekly, of which one hour may be group supervision.

VI.B. Duty Hours

- VI.B.1.** Duty hours are defined as all clinical and academic activities related to the residency program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site.
- VI.B.2.** Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- VI.B.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.
- VI.B.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.

VI.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.

- VI.C.1.** In-house call must occur no more frequently than every third night, averaged over a 4-week period.
- VI.C.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.
- VI.C.3.** No new patients may be accepted after 24 hours of continuous duty.
- VI.C.4.** *At-home call (or pager call)* is defined as a call taken from outside the assigned institution.
- VI.C.4.a)** The frequency of at-home call is not subject to the every-third-night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

- VI.C.4.b)** When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
- VI.C.4.c)** The program director and the faculty must monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
- VI.C.5.** **Moonlighting**
- VI.C.5.a)** Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- VI.C.5.b)** The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.
- VI.C.5.c)** Any hours a resident works for compensation at the sponsoring institution or any of the sponsor's primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of *internal moonlighting*.
- VI.C.6.** **Oversight**
- VI.C.6.a)** Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Duty hours must be monitored with a frequency sufficient to ensure an appropriate balance between education and service.
- VI.C.6.b)** Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.
- VI.C.7.** **Duty Hours Exceptions**
- An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. Prior permission of the institution's GMEC, however, is required.

VI.C.8. Presence of Other Training Programs

The addiction psychiatry program should provide peer interaction between its residents and those of other medical/surgical specialties. To achieve this goal an ACGME-accredited training program in at least one nonpsychiatric specialty, such as neurology, internal medicine, or family medicine should be present within the participating institutions of the program. Peer interaction among the residents should occur in the course of clinical and/or didactic work, but is most satisfactory when organized around joint patient evaluation and/or care.

VI.C.9. Resident Teaching Experiences

The program should provide appropriate experiences designed to develop administrative and teaching skills for the addiction psychiatry residents. As the residents progress through the program, they should have the opportunity to teach personnel such as other residents, medical students, and other allied health professionals.

VII. Evaluation

VII.A. Resident

VII.A.1. Formative Evaluation

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

VII.A.1.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.

VII.A.1.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.

VII.A.1.b).(1) Assessment should include the regularly and timely performance feedback to residents that includes written quarterly evaluations of the residents by all supervisors and the directors of clinical components of training.

VII.A.1.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.

VII.A.2. Final Evaluation

The program director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.

VII.B. Faculty

The performance of the faculty must be evaluated by the program no less frequently than at the midpoint of the accreditation cycle, and again prior to the next site visit. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. This evaluation must include annual written confidential evaluations by residents.

VII.C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

VII.C.1. Representative program personnel (i.e., at least the program director, representative faculty, and one resident) must be organized to review program goals and objectives, and the effectiveness with which they are achieved. This group must conduct a formal documented meeting at least annually for this purpose. In the evaluation process, the group must take into consideration written comments from the faculty, the most recent report of the GMCC of the sponsoring institution, and the residents' confidential written evaluations. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented in the minutes of the meeting.

VII.C.2. The program should use resident performance and outcome assessment in its evaluation of the educational effectiveness of the residency program. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness. The program should maintain a process for using assessment results together with other program evaluation results to improve the residency program.

VIII. Experimentation and Innovation

Since responsible innovation and experimentation are essential to improving professional education, experimental projects along sound educational principles are encouraged. Requests for experimentation or innovative projects that may

deviate from the program requirements must be approved in advance by the RRC, and must include the educational rationale and method of evaluation. The sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

IX. Certification

Residents who plan to seek certification by the American Board of Psychiatry and Neurology in the subspecialty of addiction psychiatry should communicate with the office of the Executive Vice President/Secretary of the Board regarding the full requirements for certification, to ascertain the current requirements for acceptance as a candidate for certification.

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