

# ACGME Program Requirements for Graduate Medical Education in Child and Adolescent Psychiatry

*Common Program Requirements are in BOLD*

*Effective: July 1, 2007*

## Introduction

### Int.A. Definition

Child and adolescent psychiatry is a medical specialty focused on the prevention, diagnosis, and treatment of disorders of thinking, feeling and behavior affecting children, adolescents and their families. The goal of residency education in child and adolescent psychiatry is to produce specialists in the delivery of skilled and comprehensive medical care of children and adolescents suffering from psychiatric disorders. The child and adolescent psychiatrist must have a thorough understanding of the development, assessment, treatment, and prevention of psychopathology as it appears from infancy through adulthood. He or she also should have the skills to serve as an effective consultant to primary care physicians, nonpsychiatrist mental health providers, schools, community agencies, and other programs serving children and adolescents.

### Int.B. Duration and Scope of Education

Int.B.1. In addition to the postgraduate first-year and a minimum of two years of accredited education in general psychiatry, two years of accredited education in a child and adolescent psychiatry program is required. Programs providing this education must be accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Int.B.2. To achieve greater flexibility in the sequence of residency education and to assist in recruitment, the two-year full time equivalent (FTE) child and adolescent psychiatry education experience may be initiated at any point in the psychiatry residency sequence, including the PGY-1 level. This education may be integrated over five years with the general psychiatry program or it may be focused during two years. Child psychiatry education 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 five years apart, and the shorter block must not be less than six months long. At the discretion of the program director, credit for part-time status may be given, as long as the participation is half-time or more.

Int.B.3. In general, residency education in child and adolescent psychiatry obtained as part of the curriculum for general psychiatry may not count toward residency education in child and adolescent psychiatry. However, certain clinical experiences with children, adolescents, and families taken during the period when he/she is designated as a child and adolescent psychiatry resident may be counted toward a fourth year in general psychiatry as well as toward the child and adolescent psychiatry program requirements, thereby fulfilling program requirements in general psychiatry and child and adolescent psychiatry at the same time. For these experiences to be given credit for both child and

adolescent psychiatry and general psychiatry, the experiences must:

- Int.B.3.a) be limited to child and adolescent psychiatry patients;
- Int.B.3.b) be limited to a maximum of 12 months that can be double counted;
- Int.B.3.c) be documented by the program director in all areas for which credit is given in both programs;
- Int.B.3.d) result in no reduction in total length of time devoted to education in child and adolescent psychiatry, which must remain at two years FTE; and,
- Int.B.3.e) be limited to the following experiences:
  - Int.B.3.e).(1) one month FTE of child neurology;
  - Int.B.3.e).(2) one month FTE of pediatric consultation/liaison;
  - Int.B.3.e).(3) one month FTE of addiction psychiatry;
  - Int.B.3.e).(4) forensic psychiatry experience;
  - Int.B.3.e).(5) community psychiatry experience; and,
  - Int.B.3.e).(6) no more than 20% of outpatient experience as described in Section IV.A.5.a.5.c.iv of the Program Requirements for Psychiatry.
- Int.B.4. Electives should enrich the educational experience of residents in accordance with their needs, interest, and/or future professional plans. Electives must have written goals and objectives and must be well constructed, purposeful, and lead to effective learning experiences. The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor.
  - Int.B.4.a) The residency Review Committee encourages programs to identify residents who may be interested in academic child and adolescent psychiatry by introducing research electives early in the residency program.
  - Int.B.4.b) All such electives must demonstrate compliance with the requirements in child and adolescent psychiatry, and be submitted to the committee prior to implementation for review and approval.
- Int.B.5. Prior to entry into the program, each resident must be notified, in writing of the required length of the program. The required length of training for a particular resident may not be changed during his or her program without mutual agreement, unless there is an interruption in his or her education or the resident requires remedial education.

## **I. Institutions**

**I.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 sites.**

**The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.**

**I.B. Participating Sites**

**I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.**

**The PLA should:**

**I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;**

**I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**

**I.B.1.c) specify the duration and content of the educational experience; and,**

**I.B.1.d) state the policies and procedures that will govern resident education during the assignment.**

**I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**

**I.B.3. It is important that each participating site offer significant educational opportunities to the overall program. The number and distribution of participating educational sites must not preclude satisfactory participation by residents in teaching and education exercises. Geographic proximity of participating sites will be one factor in evaluating program cohesion, continuity, and peer interaction.**

**I.B.4. Each 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 three years of education. 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.**

## **II. Program Personnel and Resources**

### **II.A. Program Director**

- II.A.1.** There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.
- II.A.2.** The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.
- II.A.2.a)** In general, the minimum term of appointment must be at least the duration of the program plus one year.
- II.A.3.** Qualifications of the program director must include:
- II.A.3.a)** requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;
- II.A.3.b)** current certification in the specialty by the American Board of Psychiatry and Neurology, or specialty qualifications that are acceptable to the Review Committee; and,
- II.A.3.c)** current medical licensure and appropriate medical staff appointment.
- II.A.4.** The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:
- II.A.4.a)** oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;
- II.A.4.b)** approve a local director at each participating site who is accountable for resident education;
- II.A.4.c)** approve the selection of program faculty as appropriate;
- II.A.4.d)** evaluate program faculty and approve the continued participation of program faculty based on evaluation;
- II.A.4.e)** monitor resident supervision at all participating sites;
- II.A.4.f)** prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is

- accurate and complete;
- II.A.4.g)** provide each resident with documented semiannual evaluation of performance with feedback;
- II.A.4.h)** ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;
- II.A.4.i)** provide verification of residency education for all residents, including those who leave the program prior to completion;
- II.A.4.j)** implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:
- II.A.4.j).(1)** distribute these policies and procedures to the residents and faculty;
- II.A.4.j).(2)** monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
- II.A.4.j).(3)** adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
- II.A.4.j).(4)** if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
- II.A.4.k)** monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
- II.A.4.l)** comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
- II.A.4.m)** be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;
- II.A.4.n)** obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:
- II.A.4.n).(1)** all applications for ACGME accreditation of new programs;

- II.A.4.n).(2) **changes in resident complement;**
- II.A.4.n).(3) **major changes in program structure or length of training;**
- II.A.4.n).(4) **progress reports requested by the Review Committee;**
- II.A.4.n).(5) **responses to all proposed adverse actions;**
- II.A.4.n).(6) **requests for increases or any change to resident duty hours;**
- II.A.4.n).(7) **voluntary withdrawals of ACGME-accredited programs;**
- II.A.4.n).(8) **requests for appeal of an adverse action;**
- II.A.4.n).(9) **appeal presentations to a Board of Appeal or the ACGME; and,**
- II.A.4.n).(10) **proposals to ACGME for approval of innovative educational approaches.**
  
- II.A.4.o) **obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
  - II.A.4.o).(1) **program citations, and/or**
  - II.A.4.o).(2) **request for changes in the program that would have significant impact, including financial, on the program or institution.**
  - II.A.4.o).(3) The sponsoring institution's designated institutional official must approve all major program changes prior to submission to the ACGME through ADS.
  
- II.A.4.p) maintain a process 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 education, their responsibilities, and the evaluation procedures;
  
- II.A.4.q) make resident appointments and assignments in accordance with institutional and departmental policies and procedures;
  
- II.A.4.r) 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;

- II.A.4.s) regularly evaluate residents' knowledge, skills, and overall performance, including the development of professional attitudes consistent with being a physician;
- II.A.4.t) dedicate no less than 50% (at least 20 hours per week) of his or her professional effort to the child and adolescent psychiatry educational program and receive institutional support for this time. This effort must be devoted to administrative and educational activities of the child and adolescent psychiatry educational program. Programs with large patient populations, multiple sites, and large resident complements may require more than half time effort and/or the appointment of an associate program director;
- II.A.4.u) 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. Educational situations that consistently produce undesirable stress on residents must be evaluated and modified; and,
- II.A.4.v) ensure that an organized educational plan with competency-based goals and objectives be developed and distributed to all residents and faculty. These goals and objectives must identify educational outcomes for the didactic and clinical components for the overall program, for each year of residency, and for each major rotation.

**II.B. Faculty**

**II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.**

**The faculty must:**

**II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and**

**II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**

**II.B.2. The physician faculty must have current certification in the specialty by the American Board of Psychiatry and Neurology, or possess qualifications acceptable to the Review Committee.**

II.B.2.a) Overall, the total program faculty must include a minimum of three FTE, fully-trained child and adolescent psychiatrists who devote substantial time to the residency program. Programs with larger

patient populations, multiple sites, and larger resident complements will be expected to have the number of faculty appropriate to the program's size and structure.

- II.B.2.b) A physician faculty member may be appointed to the School of Medicine as a voluntary faculty member.
- II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
- II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
  - II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
  - II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:**
    - II.B.5.b).(1) peer-reviewed funding;**
    - II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
    - II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**
    - II.B.5.b).(4) participation in national committees or educational organizations.**
  - II.B.5.c) Faculty should encourage and support residents in scholarly activities.**
- II.C. Other Program Personnel**

**The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.**

  - II.C.1. A member of the teaching staff in each participating site must be designated to assume responsibility for the day-to-day activities of the program at that site, with overall coordination by the program director.
  - II.C.2. There must be a residency coordinator who has adequate time, based on program size and complexity, to support the residency program.

II.C.3. Head of Child and Adolescent Psychiatry

The head of the department, division or section of child and adolescent psychiatry must be:

- II.C.3.a) a physician who is appointed to and in good standing with the medical staff of a participating site in the program;
- II.C.3.b) a member of the program's core teaching faculty;
- II.C.3.c) qualified and have at least three years' experience as a clinician, administrator, and educator in child and adolescent psychiatry;
- II.C.3.d) certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology or possess qualifications acceptable to the Review Committee;
- II.C.3.e) actively involved in psychiatry through continuing medical education, professional societies, and scholarly activities; and,
- II.C.3.f) capable of mentoring medical faculty, residents, administrators and other health care professionals, and possess medical leadership qualifications consistent with other physician chairs within the sponsoring institution.

II.C.4. Education Policy Committee

The director of the residency program should have an educational policy committee composed of members of the child and adolescent psychiatry program teaching staff. This committee should include representation from the residents as well as a member of the teaching staff from each ACGME-approved subspecialty residency that may be affiliated with the psychiatry residency. There should be a written description of the committee, including its responsibility to the sponsoring department or institution and to the program director. This committee should participate actively in:

- II.C.4.a) planning, developing, implementing, and evaluating all significant features of the residency program, including the selection of residents (unless there is a separate residency selection committee);
- II.C.4.b) determining curriculum goals and objectives; and,
- II.C.4.c) evaluating both the teaching staff and the residents.

**II.D. Resources**

**The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.**

For a child and adolescent psychiatry program these resources include:

- II.D.1. ample office space, containing readily accessible play materials, must be available for each resident to see patients;
- II.D.2. space for physical and neurological examinations with appropriate medical equipment, as well as access to laboratory testing; and,
- II.D.3. adequate space and equipment, including audiovisual equipment with the capability to record and playback sessions, specifically designated for seminars, lectures, and other educational activities.

#### **II.E. Medical Information Access**

**Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.**

### **III. Resident Appointments**

#### **III.A. Eligibility Criteria**

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

- III.A.1. The program director must accept only those applicants whose qualifications of residency include sufficient command of English to permit accurate and unimpeded communication.

#### **III.B. Number of Residents**

**The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.**

- III.B.1. A program must have at least four residents in the two-year FTE residency. (This may not include those residents who participate in a triple board residency format.) Peer interaction and the need for group discussion in seminars and conferences are crucial. In programs that are integrated over five years, opportunities for peer interaction and group discussion must be demonstrated.

#### **III.C. Resident Transfers**

- III.C.1. **Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.**

**III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.**

III.C.3. Verification must include evaluation of professional integrity of residents transferring from one program to another, including from a general psychiatry to a child and adolescent psychiatry program.

III.C.4. A transferring resident's educational program must be sufficiently individualized so that he/she will have met all the educational and clinical experiences of the program, as accredited, prior to graduation.

**III.D. Appointment of Fellows and Other Learners**

**The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.**

**IV. Educational Program**

**IV.A. The curriculum must contain the following educational components:**

**IV.A.1. Overall educational goals for the program, which the program must distribute to residents and faculty annually;**

**IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;**

**IV.A.3. Regularly scheduled didactic sessions;**

**IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,**

**IV.A.5. ACGME Competencies**

**The program must integrate the following ACGME competencies into the curriculum:**

**IV.A.5.a) Patient Care**

**Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:**

- IV.A.5.a).(1) 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 appropriate treatment, as well as to have sufficient time for other aspects of their educational program. The depth and variety of clinical experiences must be adequate;
- IV.A.5.a).(2) must have clinical experiences with children and adolescents for the development of conceptual understanding and beginning clinical skills in major treatment modalities, which include brief and long-term individual therapy, family therapy, group therapy, crisis intervention, supportive therapy, psychodynamic psychotherapy, cognitive-behavioral therapy, and pharmacotherapy. There must be opportunities for residents to be involved in providing continuous care for a variety of patients from different age groups, seen regularly and frequently for an extended time, in a variety of treatment modalities. Residents should have some experience with continuity of patient care across clinical programs providing different levels of care. Care for outpatients must include work with some child and adolescent patients from each developmental age group, continuously over time, and whenever possible, for one year's duration or more;
- IV.A.5.a).(3) must have an opportunity to evaluate and treat patients from diverse cultural backgrounds and varied socioeconomic levels;
- IV.A.5.a).(4) must have education which includes supervised, active collaboration with other professional mental health personnel, pediatricians, teachers, and other school personnel in the evaluation and treatment of patients;
- IV.A.5.a).(5) must have education on the appropriate uses and limitations of psychological tests. Residents should have the opportunity to observe some of their patients being tested;
- IV.A.5.a).(6) must have an organized educational clinical experience in each of the following:
- IV.A.5.a).(6).(a) pediatric neurology;

- IV.A.5.a).(6).(b) mental retardation, and other developmental disorders;
- IV.A.5.a).(6).(c) initial management of psychiatric emergencies in children and adolescents;
- IV.A.5.a).(6).(d) experience with acutely- and severely-disturbed children and adolescents during which the resident is actively involved with diagnostic assessment and treatment planning with these patients. This experience must occur in settings with an organized treatment program, i.e. inpatient units, residential treatment facilities, partial hospitalization programs and/or day treatment programs. This experience must be the FTE of no fewer than four months and no more than 10 months;
- IV.A.5.a).(6).(e) consultation experiences during which residents do not primarily engage in treatment, but use their specialized knowledge and skills to assist others to function better in their roles. Exposure and experience in consultation to facilities serving children, adolescents and their families must include supervised:
- IV.A.5.a).(6).(e).(i) consultation experience with an adequate number of pediatric patients in outpatient and/or inpatient non-psychiatric medical facilities;
- IV.A.5.a).(6).(e).(ii) formal observation and/or consultation experiences in schools;
- IV.A.5.a).(6).(e).(iii) experience in legal issues relevant to child and adolescent psychiatry, which may include forensic consultation, court testimony and/or interaction with a juvenile justice system; and,
- IV.A.5.a).(6).(e).(iv) experience consulting to community systems of care.
- IV.A.5.a).(7) should document in clinical records an adequate individual and family history, mental status, physical and neurological examinations when appropriate, supplementary medical and psychological data, and integration of these data into a formulation, differential diagnosis, and comprehensive treatment plan.

**IV.A.5.b)**

**Medical Knowledge**

**Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:**

IV.A.5.b).(1)

must have didactic instruction that is well organized, thoughtfully integrated, based on sound educational principles, and carried out on a regularly scheduled basis. Goals that include knowledge and attitude objectives must be specified for each course or seminar. Systematically-organized formal instruction (prepared lectures, seminars, assigned reading, etc.) must be integral to the residency. Staff meetings, clinical case conferences, journal clubs, and grand rounds are important adjuncts, but they must not be used as substitutes for an organized didactic curriculum.

The curriculum:

IV.A.5.b).(2)

will emphasize that development is an essential part of education in child and adolescent psychiatry. The teaching of developmental knowledge and the integration of neurobiological, phenomenological, psychological, and sociocultural issues into a comprehensive formulation of clinical problems are essential. Teaching about normal development should include observation of and interaction with normal preschoolers, school-aged children and adolescents;

IV.A.5.b).(3)

both didactic and clinical, must be of sufficient breadth and depth to provide residents with a thorough, well-balanced presentation of the generally-accepted observations and theories, as well as the major diagnostic, therapeutic, and preventive procedures in the field of child and adolescent psychiatry;

IV.A.5.b).(4)

will have didactic sessions that must be scheduled to ensure a minimum of 70% of resident attendance while adhering to program duty hour policy;

IV.A.5.b).(5)

must include adequate and systematic instruction in the following topics:

IV.A.5.b).(5).(a)

basic neurobiological, psychological, and clinical sciences relevant to psychiatry and the application of developmental, psychological, and sociocultural theories relevant to the understanding of psychopathology;

- IV.A.5.b).(5).(b) the full range of psychopathology in children and adolescents, including the etiology, epidemiology, diagnosis, treatment, and prevention of the major psychiatric conditions that affect children and adolescents;
- IV.A.5.b).(5).(c) the recognition and management of domestic and community violence (including physical and sexual abuse, as well as neglect) as it affects children and adolescents; and
- IV.A.5.b).(5).(d) diversity and cultural issues pertinent to children, adolescents, and their families.
- IV.A.5.b).(6) must include an adequate number of interdisciplinary clinical conferences and didactic seminars for residents, where faculty psychiatrists collaborate in teaching with colleagues from other medical specialties and mental health disciplines.

**IV.A.5.c) Practice-based Learning and Improvement**

**Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:**

- IV.A.5.c).(1) **identify strengths, deficiencies, and limits in one’s knowledge and expertise;**
- IV.A.5.c).(2) **set learning and improvement goals;**
- IV.A.5.c).(3) **identify and perform appropriate learning activities;**
- IV.A.5.c).(4) **systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**
- IV.A.5.c).(5) **incorporate formative evaluation feedback into daily practice;**
- IV.A.5.c).(6) **locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;**
- IV.A.5.c).(7) **use information technology to optimize learning; and,**
- IV.A.5.c).(8) **participate in the education of patients, families, students, residents and other health professionals.**

IV.A.5.c).(9) take primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and rotation-specific goals and objectives, as well as attendance at conferences;

IV.A.5.c).(9).(a) Resident's teaching abilities should be documented by evaluations from faculty and/or learners.

**IV.A.5.d) Interpersonal and Communication Skills**

**Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:**

**IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;**

**IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies;**

**IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group;**

**IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and,**

**IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable.**

**IV.A.5.e) Professionalism**

**Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:**

**IV.A.5.e).(1) compassion, integrity, and respect for others;**

**IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest;**

**IV.A.5.e).(3) respect for patient privacy and autonomy;**

**IV.A.5.e).(4) accountability to patients, society and the profession; and,**

**IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and**

**sexual orientation.**

IV.A.5.e).(6) high standards of ethical behavior which include respect for patient privacy and autonomy, maintaining appropriate professional boundaries, and understanding the nuances specific to psychiatric practice. Programs are expected to distribute to residents and operate in accordance with the AMA Principles of Ethics, with “Special Annotations for Psychiatry,” as developed by the American Psychiatric Association and the AACAP code of ethics to ensure that the application and teaching of these principles are an integral part of the educational process.

**IV.A.5.f) 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. Residents are expected to:**

**IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;**

**IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty;**

**IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;**

**IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems;**

**IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,**

**IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions.**

IV.A.5.f).(7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;

IV.A.5.f).(8) practice cost-effective health care and resource allocation that does not compromise quality of mental health care for children and adolescents;

- IV.A.5.f).(9) advocate for quality patient care and assisting patients in dealing with system complexities, including disparities in mental health care for children and adolescents;
- IV.A.5.f).(10) work with health care managers and health care providers to assess, coordinate, and improve health care;
- IV.A.5.f).(11) know how to advocate for the promotion of health and the prevention of disease and injury in populations; and,
- IV.A.5.f).(12) instruct in the practice of utilization review, quality assurance and performance improvement.

#### **IV.B. Residents' Scholarly Activities**

**IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.**

**IV.B.2. Residents should participate in scholarly activity.**

IV.B.2.a) Graduate medical education must take place in an environment of inquiry and scholarship in which residents learn to evaluate research findings, develop habits of inquiry as a practice of life-long learning, and whenever interested, participate in the development of new knowledge. The following components of a scholarly environment must be provided.

IV.B.2.a).(1) All residents should be educated in research literacy. Research literacy is the ability to critically appraise and understand the relevant research literature and to apply research findings appropriately to clinical practice. The concepts and process of Evidence Based Clinical Practice include skill development in question formulation, information searching, critical appraisal, and medical decision-making, thus providing the structure for teaching research literacy to psychiatry residents. The program must promote an atmosphere of scholarly inquiry, including access to ongoing research activity in psychiatry. Residents must be taught the design and interpretation of data.

IV.B.2.a).(2) The program must provide residents with research opportunities and the opportunity for development of research skills for residents interested in conducting research in psychiatry or related fields. The program must provide interested residents access to and the opportunity to participate actively in ongoing research under a mentor. When unavailable in the local program, efforts to establish distant mentoring programs are encouraged.

IV.B.2.a).(3) Teaching staff must participate in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship. Scholarship implies an in-depth understanding of basic mechanisms of normal and abnormal states, and the application of evidenced based practice.

IV.B.2.a).(4) The program must ensure the participation of residents and faculty in journal clubs, research conferences, didactics, and/or other activities that address critical appraisal of the literature and understanding of the research process.

**IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**

## **V. Evaluation**

### **V.A. Resident Evaluation**

#### **V.A.1. Formative Evaluation**

**V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**

**V.A.1.b) The program must:**

**V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**

**V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**

**V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,**

**V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.**

**V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**

**V.A.1.d) The program will maintain records of all evaluations required in this section, and these will be made available on review of the**

program.

- V.A.1.e) 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.
- V.A.1.f) Techniques may include supervisory reports, videotapes, oral examinations, case reports, patient care observations, 360° evaluations, or other methods outlined in the ACGME tool box.
- V.A.1.g) 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.
- V.A.1.h) 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.

#### **V.A.2. Summative Evaluation**

**The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:**

- V.A.2.a) **document the resident's performance during the final period of education, and**
- V.A.2.b) **verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.**
- V.A.2.b).(1) This evaluation should also include documented evidence of any unethical behavior, unprofessional behavior, or clinical incompetence. Where there is such evidence, it must be comprehensively recorded, along with the response(s) of the resident.

#### **V.B. Faculty Evaluation**

- V.B.1. **At least annually, the program must evaluate faculty performance as it relates to the educational program.**
- V.B.2. **These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.**

**V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.**

**V.C. Program Evaluation and Improvement**

**V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:**

**V.C.1.a) resident performance;**

**V.C.1.b) faculty development;**

**V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,**

**V.C.1.d) program quality. Specifically:**

**V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and**

**V.C.1.d).(2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.**

**V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.**

**V.C.3. In particular, the quality of the overall educational program and the extent to which the educational goals have been met by residents must be assessed.**

**V.C.4. In its evaluation of residency programs, the Review Committee will take into consideration the information provided by the American Board of Psychiatry and Neurology regarding resident performance on the certifying examinations during the most recent five years. The expectation is that, over a period of years, for graduated residents eligible to sit for the exam (i.e. having obtained ABPN certification in general psychiatry), at least 50% should pass the exam on the first attempt and 70% should take the certifying examination.**

**VI. Resident Duty Hours in the Learning and Working Environment**

**VI.A. Principles**

**VI.A.1. The program must be committed to and be responsible for**

**promoting patient safety and resident well-being and to providing a supportive educational environment.**

- VI.A.2. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.**
- VI.A.3. Didactic and clinical education must have priority in the allotment of residents' time and energy.**
- VI.A.4. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.**

**VI.B. Supervision of Residents**

**The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.**

- VI.B.1. While supervision by nonphysician faculty is valuable, residents must be provided sufficient supervision from child and adolescent psychiatrists to enable each resident to establish working relationships that foster identification in the role of a child and adolescent psychiatrist.**
- VI.B.2. Each resident must have at least two hours of individual supervision weekly, in addition to teaching conferences and rounds.**

**VI.C. Fatigue**

**Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.**

**VI.D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)**

**Duty hours are defined as all clinical and academic activities related to the 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.D.1. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
- VI.D.2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**
- VI.D.3. 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.E. On-call Activities**

**VI.E.1. In-house call must occur no more frequently than every third night, averaged over a four-week period.**

**VI.E.2. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**

**VI.E.3. No new patients may be accepted after 24 hours of continuous duty.**

**VI.E.4. At-home call (or pager call)**

**VI.E.4.a) The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.**

**VI.E.4.b) Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.**

**VI.E.4.c) When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**

**VI.F. Moonlighting**

**VI.F.1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**

**VI.F.2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.**

**VI.F.2.a) Moonlighting policies must:**

**VI.F.2.b) specify that residents must not be required to engage in moonlighting;**

**VI.F.2.c) require a prospective, written statement of permission from the program director that is made part of the resident's file; and,**

**VI.F.2.d) state that the residents' performance will be monitored for the effect of these activities upon performance and that adverse effects may lead to withdrawal of permission.**

**VI.F.3. 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.

**VI.G. Duty Hours Exceptions**

**A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.**

**VI.G.1. In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.**

**VI.G.2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**

**VII. Experimentation and Innovation**

**Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.**

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