

# ACGME Program Requirements for Graduate Medical Education in Forensic Psychiatry

*Common Program Requirements are in BOLD*

*Effective: June, 2003*

## I. Introduction

### I.A. Definition of the Subspecialty

Forensic psychiatry is the psychiatry subspecialty that focuses on interrelationships between psychiatry and the law (civil, criminal, and administrative law), that include

- I.A.1. the psychiatric evaluation of individuals involved with the legal system, or consultations on behalf of the third parties such as employers or insurance companies;
- I.A.2. the specialized psychiatric treatment required by those who have been incarcerated in jails, prisons, or special forensic psychiatric hospitals;
- I.A.3. active involvement in the area of legal regulation of general psychiatric practice; and
- I.A.4. related education and research efforts.

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

- I.B.1. The training period in forensic psychiatry must be 12 months.
- I.B.2. Training in forensic psychiatry that occurs 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 2-year period.
- I.B.4. Prior to entry, each forensic psychiatry resident must be notified in writing of the required length of training for which the program is accredited and the requirements for satisfactory completion of the program. Neither the required length of training for a particular individual nor the graduation requirements may be changed without mutual agreement during his or her program unless there is a break in his or her training or the individual requires remedial training.

### I.C. Educational Goals and Objectives

- I.C.1. The program must offer advanced training that affords sufficient opportunities for the resident to develop the knowledge, skills, clinical judgment, and attitudes essential to the practice of forensic psychiatry.

- I.C.2. Clinical experience must include experiences in the following three areas:
- I.C.2.a) forensic evaluation of a variety of subjects of both genders, including adolescent, adult, and geriatric age groups, who represent a broad range of mental disorders and circumstances, in both civil and criminal contexts;
  - I.C.2.b) consultation to general psychiatric services on issues related to the legal regulation of psychiatric practice, such as civil commitment, confidentiality, refusal of treatment, decision-making competence, guardianship, etc;
  - I.C.2.c) treatment of persons involved in the criminal justice system. Appropriate affiliations must be arranged to ensure that adequate exposure to a sufficient number and variety of experiences is provided.
- I.C.3. Programs must be based on a structured written curriculum with well-defined goals and objectives. Clinical case conferences and seminars dealing with topics such as law, ethics, the relevant basic and social sciences, and research must be conducted regularly and as scheduled. The curriculum must include sufficient didactic content so that graduates will be knowledgeable about the content outlined in V.B.1.a-e.
- I.C.4. Training must focus on the social and legal context for forensic work, both civil and criminal. Instruction should take into account the sociocultural, ethnic, economic, and ethical considerations that affect mentally ill persons who come into contact with the legal system.

## **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.
- II.A.2. The program must take place in facilities approved by state licensing agencies and, where appropriate, 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 should not be so great as to interfere with 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.**

### **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.1.a) Frequent changes in leadership or long periods of temporary leadership are undesirable and may adversely affect the accreditation status of the program.

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.b) **The program director must be certified in the specialty by the American Board of Psychiatry and Neurology (ABPN) in the subspecialty of forensic 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) be an active clinician and must devote sufficient time to the program to ensure implementation of the educational goals and objectives.
- III.A.3.e) participate in scholarly activities appropriate to the subspecialty such as local, regional, and national specialty societies; research; presentations; and publication.
- 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) Selecting residents for appointment to the program in accordance with institutional and departmental policies and procedures. The director must receive documentation from the general psychiatry program completed by an applicant to verify satisfactory completion of all educational and ethical requirements for graduation before the applicant is appointed to the program. Agreements with applicants made prior to the completion of the general residency must be contingent on this requirement.
- III.A.4.f) Monitoring the progress of each forensic 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 that shall document that each resident has completed all clinical experiences required by the Program Requirements and the educational objectives of the program.
- III.A.4.g) 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 on their appointment to the program. All residents must be provided with written descriptions of the malpractice coverage provided for each clinical assignment.

**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.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 forensic 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.3.d) be additionally qualified by experience in forensic psychiatry to provide the expertise needed to fulfill the didactic, clinical, and research goals of the program.
- III.B.3.e) include at least one certified child and adolescent psychiatrist.
- 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.B.6. Programs with large patient populations, multiple institutions, and large resident complements will be expected to have additional faculty appropriate to their program's size and structure.

- III.B.7. A member of the teaching staff of each participating institution must be designated to assume responsibility for the day-to-day activities of the program at that institution, with overall coordination by the program director. The director of forensic psychiatry training at each participating institution shall be appointed by or with the concurrence of the forensic psychiatry program director.
- III.B.8. The teaching staff must be organized and have regular documented meetings to review program goals and objectives as well as program effectiveness in achieving them. At least one resident representative should participate in these reviews.
- III.B.9. The teaching staff should periodically evaluate the utilization of the resources available to the program, the contribution of each institution participating in the program, the financial and administrative support of the program, the volume and variety of patients available to the program for educational purposes, the performance of members of the teaching staff, and the quality of supervision of residents.

### **III.C. Other Program Personnel**

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

- III.C.1. In addition to the faculty psychiatrists, the faculty must include a lawyer and a forensic psychologist.

### **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 and must include experiences in the following three venues:
- III.D.1.a) Facilities in which forensic psychiatric evaluations are performed on subjects with a broad variety of psychiatric disorders, where residents can learn evaluation techniques. These may include court clinics, inpatient forensic units, outpatient forensic clinics, and private practices.
- III.D.1.b) Facilities that provide general psychiatric services to patients with a broad variety of psychiatric disorders, where residents can learn consultation regarding legal issues in psychiatric practice. These may include inpatient and outpatient facilities or may be specialized facilities that provide psychiatric care to correctional populations.

III.D.1.c) Facilities that treat persons in the correctional system, where residents can learn about the specialized treatment issues raised by these populations and settings. These may include prisons, jails, hospital-based correctional units, halfway facilities, rehabilitation programs, community probation programs, forensic - clinics, juvenile detention facilities, and maximum security forensic hospital facilities. Appropriate support services to ensure an adequate educational experience at all participating institutions must be available, including support personnel and a physically safe environment in which residents may carry out their clinical and educational functions.

III.D.2. Library

III.D.2.a) Residents must have ready access to a major medical library or on-line access to relevant medical and legal materials at the institution where the residents are located or through arrangement with convenient nearby institutions.

III.D.2.b) Library services should include the electronic retrieval of information from medical databases.

#### **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 forensic psychiatry resident must have satisfactorily completed an ACGME accredited general psychiatry residency prior to entering the program.

IV.A.2. An excessively high rate of resident attrition from a program will be a cause of concern to the RRC.

##### **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 require prior approval by the RRC.

##### **IV.C. Resident Transfer**

**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 forensic 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. Didactic Curriculum**

The didactic curriculum must include the following components:

V.B.1.a) A psychiatric curriculum that includes the

V.B.1.a).(1) history of forensic psychiatry;

V.B.1.a).(2) roles and responsibilities of forensic psychiatrists;

- V.B.1.a).(3) assessment of competency to stand trial, criminal responsibility, amnesia, testamentary capacity, and civil competency;
- V.B.1.a).(4) issues involved in the assessment of dangerousness;
- V.B.1.a).(5) assessment of the accused sexual offender;
- V.B.1.a).(6) evaluation and treatment of incarcerated individuals;
- V.B.1.a).(7) ethical, administrative, and legal issues in forensic psychiatry;
- V.B.1.a).(8) legal regulation of psychiatric practice;
- V.B.1.a).(9) writing of a forensic report; and
- V.B.1.a).(10) eyewitness testimony.
- V.B.1.b) A law curriculum that covers issues in the legal system related to forensic psychiatry, such as
  - V.B.1.b).(1) fundamentals of law, statutes, and administrative regulations;
  - V.B.1.b).(2) the structure of federal and state court systems;
  - V.B.1.b).(3) use of a law library or on-line legal reference services;
  - V.B.1.b).(4) theory and practice of sentencing of the convicted offender;
  - V.B.1.b).(5) basic civil procedure;
  - V.B.1.b).(6) basic criminal procedure;
  - V.B.1.b).(7) jurisdiction;
  - V.B.1.b).(8) responsibility;
  - V.B.1.b).(9) tort law:
  - V.B.1.b).(10) children's rights;
  - V.B.1.b).(11) family law;
  - V.B.1.b).(12) confessions;
  - V.B.1.b).(13) structure and function of juvenile systems; and,
  - V.B.1.b).(14) structure and function of correctional systems.

- V.B.1.c) A civil law curriculum that includes issues such as
- V.B.1.c).(1) conservators and guardianships;
  - V.B.1.c).(2) child custody determinations;
  - V.B.1.c).(3) parental competence and termination of parental rights;
  - V.B.1.c).(4) child abuse/neglect
  - V.B.1.c).(5) psychiatric disability determinations;
  - V.B.1.c).(6) testamentary capacity;
  - V.B.1.c).(7) psychiatric malpractice;
  - V.B.1.c).(8) personal injury litigation; and
  - V.B.1.c).(9) developmental disability law, i.e., individualized educational needs and the right to the least restrictive environment for education.

- V.B.1.d) A criminal law curriculum that includes issues such as
- V.B.1.d).(1) competence to stand trial;
  - V.B.1.d).(2) competence to enter a plea;
  - V.B.1.d).(3) testimonial capacity;
  - V.B.1.d).(4) voluntariness of confessions;
  - V.B.1.d).(5) insanity defense(s);
  - V.B.1.d).(6) diminished capacity;
  - V.B.1.d).(7) evaluations in aid of sentencing;
  - V.B.1.d).(8) safe release of persons acquitted by reason of insanity; and,
  - V.B.1.d).(9) competence to be executed.

V.B.1.e) Conferences in forensic psychiatry, such as grand rounds, case conferences, readings seminars, and journal clubs, should be specifically designed to augment the clinical experiences. Regular attendance by the residents and the faculty should be documented.

- V.B.2. Forensic experiences
- V.B.2.a) Forensic experiences must provide residents with sufficient opportunity for the psychiatric evaluation of individuals involving
- V.B.2.a).(1) criminal behavior
- V.B.2.a).(2) criminal responsibility and competency to stand trial,
- V.B.2.a).(3) sexual misconduct,
- V.B.2.a).(4) dangerousness, and
- V.B.2.a).(5) civil law and regulation of psychiatry issues.
- V.B.2.b) Residents also must have experience in the review of written records, including clinical and legal documents, and in the preparation of written reports and/or testimony in a diversity of cases, for example:
- V.B.2.b).(1) aiding the court in the sentencing of criminal offenders,
- V.B.2.b).(2) domestic relations cases,
- V.B.2.b).(3) personal injury cases,
- V.B.2.b).(4) allegations of sexual abuse, and
- V.B.2.b).(5) other cases involving ethical issues and legal regulation, such as involuntary hospitalization, confidentiality, right to treatment, right to refuse treatment, informed consent, and professional liability.
- V.B.2.c) Residents must have supervised experience in testifying in court or in mock trial simulations.
- V.B.2.d) Residents must have supervised training in the relevance of legal documents, such as police reports, court testimony, polygraphs, hypnosis, narcoanalysis, psychological and neuropsychological testing, brain-imaging techniques, and other procedures relevant to assessments and treatment in forensic psychiatry.
- V.B.2.e) Consultative experiences must provide residents with an opportunity to interact with clinicians regarding legal issues that arise in psychiatric practice. This can occur in inpatient or outpatient settings and should include patients from diverse socioeconomic, educational, ethnic, and cultural backgrounds, with a variety of diagnoses. Residents should have the opportunity to consult with clinicians regarding civil commitment and dangerousness, confidentiality, decision-making competence, guardianship, and refusal of treatment.

V.B.2.f) Clinical placement must provide residents with experience in the evaluation and management of acutely and chronically ill patients in correctional systems such as prisons, jails, community programs, and secure forensic facilities. There also must be experience in working with other professionals and personnel in both forensic and community settings. A sufficient number and variety of patients, ranging from adolescence to old age and of diverse backgrounds, should be provided to ensure an adequate experience. Residents must have at least 6 months' experience in the management of patients in correctional systems.

V.B.2.g) Direct clinical work with children under the age of 14 years should be limited to residents who have previously completed ACGME-approved training in child and adolescent psychiatry or to residents who are under the supervision of a board certified child and adolescent psychiatrist or an individual who possesses qualifications judged to be acceptable by the RRC.

#### 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.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 must be individual and 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.D. Moonlighting

VI.D.1. 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.D.2. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the ACGME Institutional Requirements.**

**VI.D.3. 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.E. Oversight**

**VI.E.1. 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.E.2. 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.F. 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.G. Presence of Other Training Programs**

The forensic psychiatry program should provide peer interaction between its residents and those of other specialties. To achieve this goal, an accredited training program in at least one nonpsychiatric medical specialty should be present within the program's participating institutions. Peer interaction among the residents should occur in the course of clinical and/or didactic work, but it is most satisfactory when organized around joint patient evaluation and/or care. In addition, peer interaction with students in related fields, such as law, psychology, and social work, is highly desirable.

**VI.H. Resident Administrative and Teaching Experiences**

The program should provide appropriate experience designed to develop the administrative and teaching skills of forensic psychiatry residents. As residents progress through the program, they should have the opportunity to teach personnel such as other residents, mental health professionals, and students.

## **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) These should be quarterly written 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 GMEC 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. Board Certification

Residents who plan to seek certification by the American Board of Psychiatry and Neurology in the subspecialty of forensic psychiatry should communicate with the office of the Executive Vice President 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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