Program Requirements for Residency Education in Child and Adolescent Psychiatry
ACGME Common Program Requirements in BOLD

I. Introduction

A. Definition

Child and adolescent psychiatry is a specialty of medical practice within psychiatry. The goal of residency training 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.

Approved residencies in child and adolescent psychiatry must offer well-supervised and well-balanced clinical experiences with a continuum of care, which may include inpatients, day hospital patients, outpatients, and consultees, and must also provide a formal educational experience. The residency must provide a combination of didactic and clinical work that is both broad enough to ensure knowledge of the full spectrum of disorders of childhood and adolescence, and intensive enough to ensure thorough diagnostic, treatment, and consultative skills. Diagnostic and therapeutic experiences must be provided in sufficient number and depth with preschool, grade school, and adolescent patients of both sexes and their families for the resident to understand the breadth of clinical problems the he or she will study and treat.

B. Duration and Scope of Training

1. In addition to the postgraduate first-year and a minimum of 2 years of accredited training in general psychiatry, 2 years of training in a child and adolescent psychiatry program accredited by the Accreditation Council for Graduate Medical Education (ACGME) is required.

2. To achieve greater flexibility in the sequence of residency training and to assist in recruitment, the 2-year child and

adolescent psychiatry training experience may be initiated immediately following, or at any point beyond, the PGY-1 level in the psychiatry residency sequence. Training is best done full time, and it must be done in no more than two blocks. If done in two blocks, the blocks must not be more than 5 years apart, and the shorter block must not be less than 6 months long. At the discretion of the program director, training credit for part-time status may be given, as long as the training is half-time or more and is completed in 4 years or less.

3. In general, training in child and adolescent psychiatry obtained as part of the curriculum for general psychiatry training may not count toward residency training in child and adolescent psychiatry. However, certain clinical experiences with children, adolescents, and families taken as part of the child and adolescent psychiatry training program, limited to 1 month of child neurology, 1 month of pediatric consultation/liaison, 3 months of child and adolescent inpatient experience, 1 month of addiction psychiatry, up to 20% of outpatient experience as described in Section V B 1 c) of the Program Requirements for Psychiatry, and forensic psychiatry and community psychiatry experience may be designed to fulfill the Program Requirements in general psychiatry and child and adolescent psychiatry, if these experiences are limited to child and adolescent psychiatry patients, up to a maximum of 12 months. The program director must document areas for which credit is given in both programs. These experiences may not be used to reduce the total length of time devoted to training in child and adolescent psychiatry, which must remain at 2 years.

   Prior to entry into the program, each resident must be notified in writing of the required length of training for which the program is accredited. 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 training or the resident requires remedial training.

II. Institutions

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. The administration of the sponsoring institution(s) should understand the educational goals, and should evidence its willingness and ability to support these goals financially as well as philosophically.

B. Participating Institutions

1. Assignment to an institution must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives. When multiple participating institutions are used, there should be assurance of the continuity of the educational experience.

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

a) identify the faculty who will assume both educational and supervisory responsibilities for residents;

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

c) specify the duration and content of the educational experience; and

d) state the policies and procedures that will govern resident education during the assignment.

3. It is important that each affiliated institution offer significant educational opportunities to the overall program. The number and distribution of participating training sites must not preclude satisfactory participation by residents in teaching and training exercises. Geographic proximity will be one factor in evaluating program cohesion, continuity, and "critical mass." Affiliated training sites will be evaluated on the basis of whether they contribute to a well-integrated educational program with respect to both didactic and clinical experiences.

C. In addition, each training program accredited for child and adolescent psychiatry must have a formal educational affiliation

agreement with a general psychiatry residency program that is accredited for at least 3 years of training. The written agreement of such affiliation must be signed by the residency directors of both programs, and copies must be submitted for review by the Residency Review Committee (RRC).

III. Program Personnel and Resources

A. Program Director

1. **There must be a single program director responsible for the program. The person designated with this authority is accountable for the operation of the program. In the event of a change of either program director or department chair, the program director should promptly notify the executive director of the RRC through the Web Accreditation Data System of the ACGME.**

. 2. **The program director, together with the faculty, is responsible for the general administration of the program,** including those activities related to the recruitment, selection, instruction, supervision, counseling, evaluation, and advancement of residents and the maintenance of records related to program accreditation and resident progress and performance, **and for the establishment and maintenance of a stable educational environment. Adequate lengths of appointment for both the program director and faculty are essential to maintaining such an appropriate continuity of leadership.**

3. **Qualifications of the program director are as follows:**

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

   b) **The program director must be certified in** child and adolescent psychiatry **by the American Board of** Psychiatry and Neurology, **or possess qualifications judged to be acceptable by the Residency Review Committee.**

   c) **The program director must be appointed in good standing and based at the primary teaching site**, and must be licensed to practice medicine in the state

where the institution that sponsors the program is located (certain federal programs are exempted).

4. Responsibilities of the program director are as follows:

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

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

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

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

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

(1) **the addition or deletion of a participating institution,** to which residents are assigned half-time or more for 6 months or longer for the full-time equivalent of at least 4 months;

(2) **a change in the format of the educational program;**

(3) **a change in the approved resident complement for those specialties that approve resident complement.**

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

e) The program director must devotion of at least half-time to the training program, including teaching activities.

f) The program director must select residents for appointment to the program in procedures.

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

h) The program director must implement fair procedures, as established by the sponsoring institution, regarding academic discipline and resident complaints or grievances.

i) The program director must monitor resident stress, including mental or emotional conditions inhibiting performance or learning and drug- or alcohol-related dysfunction. Program directors and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support services to residents. Training situations that consistently produce undesirable stress on residents must be evaluated and modified.

j) The program director must provide an annual written evaluation of the quality of teaching and supervision

of each of the teaching faculty.

k) The program director must provide written information regarding financial compensation, liability coverage, and the policies regarding vacations, sick leave, and family leave, as well as other special leaves to residents and applicants who are interviewed.

l) The program director must notify the executive director of the RRC in writing within 30 days of any major change in the program that may significantly alter the educational experience for the residents, including:

(1) changes in leadership of the department of the program;

(2) changes in administrative structure, such as an alteration in the status of the program/department within the institution;

(3) a reduction in any year of the critical mass of residents below four in the training program; and

(4) a reduction in the number of faculty below 3 full-time equivalent positions for more than 1 year.

B. Faculty

1. At each participating institution, there must be a sufficient number of faculty and other mental health professionals **with** sufficient breadth and depth of **documented qualifications to instruct and supervise adequately all residents in the program.**

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.

3. Qualifications of the physician faculty are as follows:

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.**

b) **The physician faculty must be certified in the specialty by the American Board of** Psychiatry and Neurology, **or possess appropriate educational qualifications judged to be acceptable by the RRC.**

c) **The physician faculty must be appointed in good standing to the staff of an institution participating in the program.**

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:

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a) **the scholarship of *discovery*, as evidenced by peer-reviewed funding or by publication of original research in a peer-reviewed journal;**

b) **the scholarship of *dissemination*, as evidenced by review articles or chapters in textbooks;**

c) **the scholarship of *application*, as evidenced by the publication or presentation of, for example, case reports or clinical series at local, regional, or national professional and scientific society meetings.**

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

5. Qualifications of the nonphysician faculty are as follows:

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

b) Nonphysician faculty must possess appropriate institutional appointments.

6. The faculty must include a total of at least 3 full-time-equivalent, fully-trained child and adolescent psychiatrists who devote substantial time to the residency program, 2 of whom must be certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology or judged by the RRC to possess appropriate educational qualifications.

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

8. 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.

C. Other Program Personnel

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

D. Resources

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

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

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

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

4. The sponsoring institution must provide residents with ready access to a library that contains a substantial number of current basic textbooks and major journals in psychiatry, child and adolescent psychiatry, neurology, pediatrics, and general medicine, sufficient for an excellent educational program. The library must be capable of obtaining textbooks and journals on loan from major medical libraries and of carrying out MEDLINE and other medical information searches (or accessing a library that has this capacity), and it must be reasonably available to residents on weekends and during evening hours.

E. Head of Child and Adolescent Psychiatry

1. The head of the department, division, or section of child and adolescent psychiatry should be a fully-trained child and adolescent psychiatrist with documented clinical, educational, and administrative abilities and experience, and should be certified in child and adolescent psychiatry by the American Board of Psychiatry and Neurology or judged by the RRC to possess appropriate educational qualifications.

2. The head of child and adolescent psychiatry must be appointed to and in good standing with the medical staff of an institution participating in the program.

IV. Resident Appointments

A. Eligibility Criteria

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

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

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.

A program must have at least 4 residents in the 2-year training program. (This may not include those residents who participate in a triple board training format.) Peer interaction and the need for group discussion in seminars and conferences are crucial.

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

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.

The program must document the procedures used to select residents in accordance with institutional and departmental policies and procedures. Application records must document information from graduate medical education programs. A documented procedure must be in place for checking the credentials, the clinical training experiences, and the past performance and professional integrity of residents transferring from one program to another, including from a general psychiatry program to a child and adolescent psychiatry program. This procedure must include solicitation and documentation of relevant information from the

training directors of the previous programs participated in by the transferring resident.

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.

V. Program Curriculum

A. Program Design

1. Format

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

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 applicants who are interviewed, **and must be reviewed with residents prior to their assignments.**

All educational components of a residency program should be related to program goals. There must be sufficient stable leadership, faculty, clinical facilities, and affiliations to provide a consistent educational experience.

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. The program must have an explicitly-described educational curriculum composed of formal didactic instruction and a program of graduated learning and supervised clinical experience through the 2 years that is distributed to residents and faculty. The latter is to be marked by progressive responsibility for the diagnosis and treatment of

preschool and grade school children, adolescents, and their families.
Educational quality must have the highest priority in the allotment of the residents' time and energy. The clinical responsibilities of residents must not infringe unduly on didactic activities.

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

1. Clinical Experience

   a) Clinical instruction must be well organized, thoughtfully integrated, based on sound educational principles, and carried out on a regularly scheduled basis.

   b) Goals that include knowledge, skill, and attitude objectives must be specified for each clinical rotation.

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

   d) Clinical records, recorded by the child and adolescent psychiatry residents, should document 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.

   e) Opportunities for the development of both conceptual understanding of and clinical skills in the major treatment modalities with children and adolescents, which include brief and long-term individual therapy, family therapy, group therapy, crisis intervention, supportive therapy, psychodynamic psychotherapy,

cognitive-behavioral therapy, and pharmacotherapy must be provided. 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 for at least one year's duration.

f) Residents must have an opportunity to evaluate and treat patients from diverse cultural backgrounds and varied socioeconomic levels.

g) Training must include supervised, active collaboration with other professional mental health personnel, pediatricians, teachers, and other school personnel in the evaluation and treatment of patients.

h) There must be teaching about the appropriate uses and limitations of psychological tests. Residents should have the opportunity to observe some of their patients being tested.

i) There must be an organized teaching and clinical experience in pediatric neurology, mental retardation, and other developmental disorders.

j) Residents must have experiences in the initial management of psychiatric emergencies in children and adolescents. This experience may occur in a variety of settings.

k) Experience with acutely- and severely-disturbed children or young adolescents is an essential part of training. This experience must occur in settings with an organized treatment program, such as inpatient units, residential treatment facilities, partial hospitalization programs, and/or day treatment programs. This experience must be the full-time equivalent of not fewer than 4 or more than 10 months. The resident must be actively involved with the diagnostic assessment, treatment planning, and treatment provision for these acutely and severely

disturbed patients.

l) Residents must have experience as consultants in situations in which they do not primarily engage in treatment, but use their specialized knowledge and skills to assist others to function better in their roles. Training and experience in consultation to facilities serving children, adolescents, and their families must include:

(1) supervised consultation experience with an adequate number of pediatric patients in outpatient and/or inpatient medical facilities;

(2) supervised formal observation and/or consultation experiences in schools;

(3) supervised training and 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

(4) training and experience in supervised consultation to community systems of care and their treatment components.

m) Residents must have experience in administrative decision-making processes and practice management involving health care delivery and interactions with health care systems.

2. Didactic Curriculum

a) Didactic instruction must be 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.

b) Emphasis on development is an essential part of training 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 children of various ages.

c) The didactic and clinical curriculum 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.

d) The curriculum must include adequate and systematic instruction in basic neurobiological, psychological, and clinical sciences relevant to psychiatry and in the application of developmental psychological and sociocultural theories relevant to the understanding of psychopathology. It must provide teaching about 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.

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

f) Residents must receive instruction in the recognition and management of domestic and community violence as it affects children and adolescents. This includes physical and sexual abuse as well as neglect.

g) The opportunity for residents to be involved in research or scholarly activity must be available.

h) The curriculum 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.

i) There should be instruction in the principles and practice of utilization review, quality assurance, and performance improvement.

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. Graduate medical education must take place in an environment of inquiry and scholarship in which residents participate in the development of new knowledge, learn to evaluate research findings, and develop habits of inquiry as a continuing professional responsibility. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the teaching staff. Although not all members of a teaching staff must be investigators, the staff as a whole must demonstrate broad involvement in scholarly activity. This activity should include:

1. active participation of the teaching staff 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 current knowledge to practice;

2. participation in journal clubs and research conferences;

3. active participation in regional or national professional and scientific societies, particularly through presentations at the organizations' meetings and publication in their journals;

4. participation in research, particularly in projects that are funded following peer review and/or result in publications or presentations at regional and national scientific meetings;

5. the offering of guidance and technical support (e.g., research design, statistical analysis) for residents involved in research;

6. the provision of support for resident participation in scholarly activities.

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:

1. *Patient care* that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health;

2. *Medical Knowledge* about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patience care;

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;

4. *Interpersonal and communication skills* that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;

5. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;

***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.**

E. Other Required Components

Teaching Opportunities

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

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.

A. Supervision of Residents

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.**

2. **Faculty schedules must be structured to provide residents with continuous supervision and consultation.**

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.**

Each resident must have at least 2 hours of individual supervision weekly, in addition to teaching conferences and rounds. Residents must be provided with prompt, reliable systems for communication and interaction with supervisory physicians.

B. Duty Hours

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.**

2. **Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**

3. **Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as 1 continuous 24-hour period free from all clinical, educational, and administrative duties.**

4. **Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**

5. The program should carefully monitor any professional activity outside the residency, and ensure that it does not interfere with education, performance, or clinical responsibility. The program should carefully monitor all on-call schedules and hours within and outside residency to prevent undue interference with education, performance, or clinical responsibility.

C. On-call Activities

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

1. **In-house call must occur no more frequently than every third night, averaged over a 4-week period.**

2. **Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**

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

4. ***At-home call* (or *pager call*) is defined as a call taken from outside the assigned institution.**

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.**

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

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.**

D. Moonlighting

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.**

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

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*.**

E. Oversight

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.

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.

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.

VII. Evaluation

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

A. Resident

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

a) Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

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.

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.

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.

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

4. Residents must be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive scholarship and professional growth.

5. 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.

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

   a) Clinical science

   b) Interpersonal skills and communication

   c) Patient care

   d) Practice-based learning and improvement

   e) Professionalism and ethical behavior

   f) Systems-based care

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

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

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

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

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.

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

C. Program

The educational effectiveness of a program must be evaluated at least annually in a systematic manner. 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. Confidential written evaluations by residents must be utilized in this process. The teaching staff must annually 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.

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.**

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. Inquiries Concerning Accreditation and Certification

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

B. All inquiries as to whether an individual physician is qualified to be admitted for examination for certification in psychiatry should be addressed to Executive Vice President, American Board of Psychiatry and Neurology, 500 Lake Cook Rd., Ste 335, Deerfield, IL 60015.

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