



University at Buffalo Department of Psychiatry  
Division of Child and Adolescent Psychiatry

Residency Training Program  
**Child and Adolescent Psychiatry**

2009-10

**Women and Children's Hospital of Buffalo**

## Welcome

Do not train a child to learn by force or harshness; but direct them to it by what amuses their minds, so that you may be better able to discover with accuracy the peculiar bent of the genius of each.

Plato

As we embark on our 18<sup>th</sup> academic year we welcome you to the Residency Training Program in Child and Adolescent Psychiatry at SUNY at Buffalo. The Department of Psychiatry, Chaired by Steven Dubovsky, M.D., and the Division of Child and Adolescent Psychiatry, led by Bruce Miller, M.D. have never been stronger. We look forward to providing an outstanding learning environment for residents' professional growth and development. While our clinical teaching base has filled out and remains our core strength, research capacities have also expanded substantially. Psychodynamic and relationship-based psychotherapies remain a central value of the program and are taught comprehensively. At the same time residents learn other evidence-supported treatments and enjoy increasing opportunities to participate in the development of the field's knowledge base through research and writing. We place a premium on resident's active participation in their own education and welcome your input not only in formal committee work but also informally.

While the world in general, and health care in particular continue to swirl around us we still feel that child and adolescent psychiatry affords unique possibilities for deep and positive impact on the lives of children and families. While it is an awesome responsibility, it is equally a noble opportunity. No other medical specialty brings together the whole of a child's mind and body, along with their need for meaningful relatedness. We now know more about children's inner lives, their brains, and effective treatments than ever before. We hope that these next two years will leave you with the tools for a lifetime of professional accomplishment and fulfillment. As we sign off we will leave you with a few quotes, poems, and passages on the next few pages.

David L. Kaye, M.D.  
Director of Training in Child/Adol. Psychiatry

July 1, 2009

As they leave this stage, adolescent boys and girls are beginning to feel real, to have a sense of *self* and of *being*. This is health. From being comes doing, but there can be no *do* before *be*, and this is their message to us.

D.W.Winnicott, M.D.

“The only thing sadder than seeing children who are abnormally old--who at the ripe age of four are talking and behaving and carrying the responsibility of adults--is to see adults who are emotionally child-like yet intellectually struggling to play the game of being adults. Watching this painful process has led me to an increasing conviction that there is a way to make life more livable. If the parents can be childish (read *child-like*) with their children then the children can be themselves. Not only do they have the fun of being children when they *are* children, not only do they have the fun of playing with their parents who are also playing, but they discover the inside of themselves--and if the parents who are also playing, but they discover the inside of themselves--and if the parents get courage from this, the parents also may discover the inside of themselves.”

Carl Whitaker, M.D.

There is a widespread refusal to let children know that the source of much that goes wrong in life is due to our very own natures--the propensity of all men for acting aggressively, asocially, selfishly, out of anger and anxiety. Instead, we want our children to believe that, inherently, all men are good. But children know that they are not always good; and often, even when they are, they would prefer not to be. This contradicts what they are told by their parents, and therefore makes the child a monster in his own eyes.

Bruno Bettelheim, Ph.D.

Setting an example is not the main means of influencing another, it is the only means.  
Albert Einstein

“A more practical definition of love has been given by the great American psychiatrist Harry Stack Sullivan: “When the satisfaction or the security of another person becomes as significant to one as is one’s own satisfaction or security, then the state of love exists.” The state of love described by Sullivan is possible in marriage--but few spouses are prepared for it, or capable of experiencing it, right after the wedding. Its coming, if it comes at all, is the result of luck of years of hard work and patience.....”

William Lederer and Don Jackson, M.D.

“To establish a new framework, we need to begin with a frank acknowledgment of the basic humanness and Americanness of each of us. And we must acknowledge that as a people--E Pluribus Unum--we are on a slippery slope toward economic strife, social turmoil, and cultural chaos. If we go down, we go down together. The Los Angeles upheaval forced us to see not only that we are not connected in ways we would like to be but also, in a more profound sense, that this failure to connect binds us ever more tightly together. The paradox of race in America is that our common destiny is more pronounced and imperiled precisely when our divisions are deeper. The Civil War and its legacy speak loudly here. And our divisions are growing deeper. Today, 86 percent of white suburban Americans live in neighborhoods that are less than 1 percent black, meaning that the prospects for the country depend largely on how its cities fare in the hands of a suburban electorate. There is no escape from our interracial interdependence, yet enforced racial hierarchy dooms us as a nation to collective paranoia and hysteria--the unmaking of any democratic order.”

Cornel West, Ph.D

Grief has a life of its own and its own work to do. It is born howling, it labors, it grows old. For five years my days were dominated by her absence. Somewhere around the sixth year my life began to take on independence, to find or assume a life of its own.

Donald Hall

#### Doctors

Man dies too soon, beside his works half-planned.

His days are counted and reprieve is vain:  
Who shall entreat with Death to stay his hand;  
Or cloke the shameful nakedness of pain?

Send here the bold, the seekers of the way—  
The passionless, the unshakeable of soul,  
Who serve the inmost mysteries of man's clay,  
And ask no more than leave to make them whole.

Rudyard Kipling

## **Statement of Mission**

The Division of Child and Adolescent Psychiatry offers a fully ACGME-accredited 2 year Residency Training Program in Child and Adolescent Psychiatry. The program is sponsored at institutional and departmental levels by the University at Buffalo's Graduate Medical-Dental Education Consortium of Buffalo (GMDECB) and Department of Psychiatry respectively.

The goal of the Residency Training Program in Child and Adolescent Psychiatry is to provide for an outstanding environment in which residents can learn to become highly competent, ethical, broad based clinical child and adolescent psychiatrists. Academic rigor, technical skill, and research are highly valued and are well-integrated into our efforts to foster the development of residents' empathy, capacity for leadership and interpersonal relatedness. The program pursues a systemic biopsychosocial approach recognizing that psychotherapeutic skill with children and families, the heart and soul of clinical practice, must be integrated with a strong foundation in psychopharmacology and the neurosciences. While acknowledging the fiscal realities of medical practice today, the impact of managed care, and the need for efficiency and technical expertise, the program holds the doctor-patient relationship as central to all healing. With the completion of training, our goal is for residents to respect their own knowledge base while maintaining a desire to continue their professional and personal development. Residents provide evaluation and treatment to a wide variety of patients and families with differing configurations, cultural/ethnic backgrounds, socioeconomic class, as well as diagnoses. We hope that our residents leave with an appreciation for the richness of cultural experience and for the uniqueness of each family's interactive process. Through this appreciation, one can better understand and intervene in the worlds of children and adolescents.

## CLINICAL ROTATIONS

Below (Figure 1) is a grid diagram of the clinical rotations which you will experience over the two years. The first year is divided into three major clinical rotations, each 4 months in length (WNYCPC, ECMC, C/L). You may be assigned to any of these three blocks initially and then rotate through the others in turn. Throughout Year I there is some time (about 0.5 day per week) for outpatient treatment, allowing for longitudinal experience during your training. The second year is primarily an outpatient year, interspersed with assignments to multiple, time-limited subspecialty experiences (typically 0.5 days per week for 2-4 months). There is greater flexibility in Year II so that elective time (2-4 weeks full time equivalent) can be scheduled at any point in that year. Specific plans should be discussed with the Director of Training at least 2 months in advance.

On the pages that follow the grid diagram you will find more specific descriptions of each rotation. Because the clinical rotations are the most critical components of the educational experience we are continuously reviewing these rotations and looking for ways to improve them or add new ones.

**FIGURE I**

Year I

Inpatient-WNYCPC ITU  General CAP Outpt. Clinic Intake Evaluation Clinic	Inpatient-ECMC Adol. Unit  General CAP Outpt. Clinic Intake Evaluation Clinic	Pediatric Consult-Liaison  General CAP Outpt. Clinic Intake Evaluation Clinic
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Year II

General CAP Outpatient Clinic  ADHD Summer Rx Program Day Treatment Substance Abuse Williams syndrome Dual Dx/Developmental disabilities	General CAP Outpt. Clinic  Pediatric Neurology  School Consultation Dual Dx/Developmental disabilities  Research	General CAP Outpt. Clinic Preschool Eval. And Treatment Program  Forensic/Detention Ctr. Dual Dx/Developmental disabilities  Elective
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**SUNY at Buffalo**  
**Residency Training Program in Child/Adolescent Psychiatry**

**Lines of Responsibility for Patient Care**

Although residents often have first line responsibility for patient care as part of their training experiences, there is an identified faculty attending who is medico-legally and clinically responsible for the care of the patient in all cases.

The table below delineates the lines of responsibility on each clinical service.

<b>Clinical Rotation</b>	<b>Faculty Attending</b>
<b>Year I</b>	
WCHOB Consult-Liaison Service	Mondays, Wednesdays, Fridays-B. Smith, M.D. Tuesdays, Thursdays-B. Miller, M.D.
WNY Children's Psych. Center Intensive Treatment Unit	D. Sanderson, M.D. P. Bohnert, M.D. P. Stein, M.D. A. Morganstein, M.D.
Erie Co. Med. Center Acute Adol. Unit	M. Cummings, M.D. D. Marshall, M.D.
Childrens' Psychiatry Outpt. Clinic	D. Kaye, M.D. J. Waxmonsky, M.D. B. Smith, M.D.
Intake Clinic	D. Kaye, M.D.
<b>Year II</b>	
ADHD Summer Treatment Program	J. Waxmonsky, M.D.
Childrens' Psychiatry Outpt. Clinic	J. Haak, M.D. D. Kaye, M.D. B. Smith, M.D. J. Waxmonsky, M.D.
Community Services/Day Treatment	H. Aronoff, M.D. K. Dobson, M.D.
Developmental Disabilities Dual Diagnosis	B. Smith, M.D.
Forensic Consultation	K. Dobson, M.D.
Pediatric Neurology	S. Finnegan, M.D.
Preschool Eval. and Treatment	D. Crawford, Ph.D.
School Consultation	D. Kaye, M.D. A. Freeman, M.S.W.
Substance Abuse	D. Kaye, M.D.
William syndrome	D. Kaye, M.D.

6/07

ROTATION Inpatient-WNYCPC Intensive Treatment Unit

LOCATION Western New York Children's Psychiatric Center  
1010 East and West Road, West Seneca, New York 14224

PHONE# 677-7000

ROTATION SUPERVISOR D. Sanderson MD, P. Stein M.D., P. Bohnert M.D., A. Morganstein M.D.

DURATION OF ROTATION

Approximately 0.75 FTE for four months

DESCRIPTION

The resident will assume primary responsibility for overseeing the evaluation and treatment of a limited number of children or adolescents hospitalized on the Intensive Treatment Unit, Adolescent Treatment Unit, or Children's Treatment Unit of the Western New York Children's Psychiatric Center. This hospital is a state facility with an intermediate length of stay of 3-6 months. The goal is to thoroughly familiarize the resident with the strengths and limitations of inpatient treatment; to thoroughly understand the role of the milieu; to appreciate the different components and multi-disciplinary nature of such treatment; to develop skills in evaluation, play, group, and family therapy, and psychopharmacology; to learn how to assume a leadership role in the inpatient hierarchy. The ITU receives numerous referrals from court jurisdictions affording the resident an opportunity for forensic evaluation experience as well.

CASELOAD

3-4 patients at any one time; a minimum of two forensic evaluations

SUPERVISION

Contemporaneous as well as weekly scheduled supervision with Drs. Sanderson, Morganstein, or Bohnert.

ROTATION Inpatient-Erie County Medical Center

LOCATION Erie County Medical Center, 4<sup>th</sup> floor, zone 4

PHONE 898-5420

ROTATION SUPERVISOR M. Cummings, M.D., D. Marshall M.D., M. Guppenberger M.D.

DURATION OF ROTATION  
0.75 FTE for 4 months in first year

#### DESCRIPTION

Residents learn to evaluate, manage, and provide treatment for selected adolescents admitted to this acute inpatient unit in a busy county hospital with short lengths of stay.

#### CASELOAD

6-8 patients at any one time that the resident holds primary responsibility for.

#### SUPERVISION

On site with Drs. Cummings, Marshall, and Guppenberger (direct and indirect). The resident has opportunities to sit in with all attendings while they evaluate patients and their families.

ROTATION General Child and Adolescent Psychiatry Outpatient Clinic

LOCATION Millard Fillmore Hospital Gates Cir. 8<sup>th</sup> fl.  
The Childrens' Psychiatry Clinic

PHONE# 887-5800

ROTATION SUPERVISOR Various

#### DURATION OF ROTATION

Varying time commitment for the full two years.

#### DESCRIPTION

The resident will have the primary responsibility for the evaluation and treatment of children, adolescents, and their families seen through the Childrens' Psychiatry Outpatient Clinic. Co-therapy with peers, general residents, or other faculty/staff is encouraged. The goal is to develop the residents' skill in evaluation and treatment planning, the various treatment modalities, all within a multidisciplinary team framework.

#### CASELOAD

Varies from 3 - 10 hours per week.

#### SUPERVISION

2 hours scheduled individual supervision per week in Year I, 3 hours in Year II. Group supervision also meets weekly to address play therapy, cognitive-behavior therapy, and family therapy modalities (see Case focused Conferences and Seminars section). Additional scheduled supervision arranged through Dr. Kaye at the request of the resident.

ROTATION Pediatric Consultation – Liaison

LOCATION Children’s Hospital of Buffalo

PHONE# 878-7645

ROTATION SUPERVISOR B. Smith, M.D., B. Miller M.D.

DURATION OF ROTATION

Approximately 0.6 FTE for 4 months

DESCRIPTION

The resident will be an active member of a busy consultation-liaison service at Children’s Hospital of Buffalo. The resident can anticipate a wide variety of child, adolescent, and maternity cases. The goal is to develop the resident’s skill in understanding the role of the consultant; assessing difficulties at the psyche - somatic interface; working with pediatricians in a hospital setting; and carrying out brief, time-limited treatment interventions.

CASELOAD

3 to 5 new consultations per week in addition to follow up care of those patients requiring ongoing involvement of the service.

SUPERVISION

Contemporaneous as well as scheduled supervision with Drs. Miller and Smith

ROTATION Preschool Evaluation and Treatment Program

LOCATION 1657 Kensington Ave, Buffalo, N.Y. 14215

PHONE# 831-4175

ROTATION SUPERVISOR D. Crawford, Ph.D.

DURATION OF ROTATION

4 hours/week for 3-4 months

DESCRIPTION

The resident will become thoroughly acquainted with a comprehensive treatment approach to emotionally disturbed preschoolers and their families. The goal is to develop the resident's skill in evaluating preschoolers; to learn to recognize signs of disturbance in this population; to understand the necessity for comprehensive approach to such problems and to appreciate the need for a multi disciplinary team; to respect the knowledge of other members of the team while assuming a position appropriate for a child psychiatric consultant.

CASELOAD

8-10 evaluations.

SUPERVISION

On site by Dr. Crawford

ROTATION Intake Clinic

LOCATION Children's Psychiatry Clinic

Millard Fillmore Gates Hospital, 8<sup>th</sup> fl

PHONE# 887-5800

ROTATION SUPERVISION David L. Kaye, MD

DURATION OF ROTATION

Every Wednesday afternoon (1<sup>st</sup> years only), 2:15-3:45

DESCRIPTION

First year residents will evaluate new patients referred to the CAP Outpatient Clinic in collaboration with Dr. Kaye, who will observe the case through a closed circuit TV monitor. Residents will take turns interviewing and observing the cases. The goal is to develop the resident's capacity to interview children, adolescents, and their caregivers effectively; perform comprehensive evaluations and assessments; generate cohesive biopsychosocial assessments and complex treatment plans; complete written evaluations; and effectively communicate their findings to the family.

CASELOAD

One new case per week will be scheduled for first year residents, with each resident rotating responsibility each week for bringing in a new case.

SUPERVISION

Dr. Kaye is present for "real time" supervision for both intake and followup visits.

ROTATION Substance Abuse

LOCATION Renaissance House, Promise House, Stepping Stones  
920 Harlem Road, West Seneca, NY 14224

PHONE # 821-0391

ROTATION SUPERVISOR D.Kaye, MD

DURATION OF ROTATION

6 hours/week for 4 months

#### DESCRIPTION

Renaissance House, Promise House and Stepping Stones provides extended residential and transitional services for male and female adolescents with substance abuse or dependence. All facilities are located on the same grounds. The resident will evaluate and provide medication management for referred adolescents, work with the multidisciplinary team, participate in team meetings, and provide staff consultation and education.

#### CASELOAD

Resident will be involved with individual patients upon referral of Clinical Director at each site (Jody Altman, MSW, Kathy Damon MSW). Typically will provide consultation to staff, evaluate new patients, prescribe medications where appropriate, and provide follow up for these patients. Residents occasionally give lectures to the staff regarding various psychiatric topics.

#### SUPERVISION

On site by Dr. Kaye.

ROTATION Pediatric Neurology

LOCATION Children's Hospital of Buffalo-Amherst site  
Neurology Outpatient Clinic

PHONE# 878-7840

ROTATION SUPERVISORS S.Kerr MD, S. Finnegan MD, N. Diegelman PhD  
(Tourette's syndrome)

#### DURATION OF ROTATION

3-4 hours/week for 4 months

#### DESCRIPTION

In the course of this rotation, the resident will become proficient in the pediatric neurological exam; develop solid knowledge about common pediatric neurological problems with particular attention to epilepsy, headaches, Tourette's syndrome, brain tumors, CNS trauma, and developmental disabilities; become well versed in neuroimaging and other diagnostic techniques; and develop competence in the clinical use and management of anticonvulsants in the pediatric population.

#### CASELOAD

Residents are assigned to the Neurology Outpatient Teaching Clinic for 4 months and will see Tourette's patients with N. Diegelman PhD at the WCHOB Children's Psychiatry Clinic for up to 6 weeks. During this time they will perform neurological exams on assigned patients in each of these Clinics.

#### SUPERVISION

On site by Neurology faculty; Tourettes by N. Diegelman.

ROTATION Intensive Day Treatment/Day Treatment

LOCATION WNYCPC Day Treatment Program  
575 Alberta Dr., Amherst, N.Y. 14226

PHONE# 832-0726

ROTATION SUPERVISOR H. Aronoff, M.D., K. Dobson, MD

#### DURATION OF ROTATION

3-4 hours per month for 10-12 weeks

#### DESCRIPTION

The resident will develop a working understanding of the organization of a day treatment program, the patients appropriate for this treatment modality, and the limitations of this model. The resident will observe the on-site classrooms of the program and consult to the teachers regarding the behavior management of selected children. The resident will also participate in any CSE meetings for these children. When ready for discharge the resident will aid in the transition of these children back into the public school setting.

#### CASELOAD

No direct patient care responsibility. The resident will provide consultation and support services to selected children (see above).

#### SUPERVISION

On-site with Drs. Aronoff, Ramirez.

ROTATION ADHD Summer Treatment Program

LOCATION UB South Campus, Center for Children and Families

PHONE 829-2244

ROTATION SUPERVISOR J. Waxmonsky M.D.; Bill Pelham, PhD; Lisa Burrows-McLean, PhD

#### DURATION OF ROTATION

4-6 hours per week for summer of Year II

#### DESCRIPTION

The resident will have the opportunity to intensively learn about the multimodal treatment of ADHD in this model treatment program for 5-13 year olds. Residents will receive intensive training in behavior management as well as Parent Training in large group and individual family settings. Residents will also observe the social skills and sports skill building groups, as well as the classrooms run by this program. Double blind, placebo controlled medication evaluations are also conducted by the program.

#### CASELOAD

There is no clinical responsibility during this rotation. Residents observe all aspects of the program including the sports and school portions, as well as the parent management psychoeducation groups.

#### SUPERVISION

On site with Drs Waxmonsky, Burrows-McLean, and Pelham.

ROTATION Williams Syndrome

LOCATION WNY Pediatric Cardiology Center

PHONE 878-7595

ROTATION SUPERVISOR D. Kaye, MD

#### DURATION OF ROTATION

Second year residents rotate in attending this clinic, which operates on the second Monday morning of each month (8-9 months of the year).

#### DESCRIPTION

Run under the auspices of the Division of Pediatric Genetics, this is the only clinic of its type in the upstate New York region. The clinic follows virtually all diagnosed cases of William Syndrome in this multidisciplinary clinic that includes genetics, dysmorphology, cardiology, rehabilitation, and psychiatry specialists.

#### CASELOAD

Each clinic sees approximately 4 patients from 2 years to adult.

#### SUPERVISION

On site by Dr. Kaye. Typically cases are seen jointly or reviewed immediately with Dr. Kaye.

ROTATION Forensic-Juvenile Detention Center

LOCATION Erie County Detention Center  
810 East Ferry St., Buffalo, N.Y.

PHONE 923-4000

SUPERVISOR K. Dobson, M.D.

DURATION OF ROTATION

4 hours per week for 4 months

DESCRIPTION

The E.C. Detention Center is the holding center for youths adjudicated as juvenile delinquents who are awaiting a final disposition. The facility houses all such youth in the county. Residents learn about the court system, juvenile delinquency, and the juvenile justice system by evaluating the inmates held, participating in court hearings, and multidisciplinary meetings at the center.

CASELOAD

As assigned by Dr. Dobson. Residents will evaluate juveniles for management and treatment at the facility as well as for the Family court. Observation of court proceedings is also arranged.

SUPERVISION

On site by Dr. Dobson.

ROTATION School consultation

LOCATION Bennett High School

SUPERVISOR D. Kaye, M.D., A. Freeman MSW.

DURATION OF ROTATION

Monday ams for 2-3 months

DESCRIPTION

School based health clinics are increasingly utilized to provide services to hard-to-reach populations. Mental health services are often, although not always, part of the services offered to these vulnerable youth. Residents rotating through will have an opportunity to observe students in their “natural” surroundings. They will observe classes, CSE meetings, and other administrative meetings at the school, and provide consultation to school based health clinic staff.

CASELOAD

Residents have no clinical responsibilities on this rotation.

SUPERVISORS

Ms. Freeman provides on site supervision.

## SEMINARS, SUPERVISION, AND OTHER TEACHING ACTIVITIES

The **Seminar/Core Lecture Series** and other academic conferences has been designed for the resident in Child & Adolescent Psychiatry to provide exposure to a wide variety of topics in the field. While it is by no means exhaustive we feel it is comprehensive and will stand you in good stead when you complete your training. We all must be life-long learners and this seminar series is intended to provide a solid foundation.

Although lectures are at times given, for the most part we want you to be an active participant in these discussions. We like the idea that they are indeed seminars, which Webster's defines as: "a group of advanced students studying under a professor with each doing original research and all exchanging results through reports and discussion." In short, please come prepared to discuss your ideas and questions.

The Seminar Series has 4 sequences: Child Development; Developmental Psychopathology and its Treatment; Psychological and Educational Testing; and Topics in Child and Adolescent Psychiatry. Residents from both years participate in the series together. The Developmental Psychopathology sequence is given one year and the other three sequences are given the next so that each year the schedule alternates in focus. This allows for residents in both years to participate together in the series, although there is variation in which year any given resident will have each sequence. We will distribute readings prior to each seminar and will make every effort to keep them under 25 pages per seminar so that you will be able to complete the readings *beforehand*. If you have not received a specific reading then assume that the relevant chapter out of the Lewis's Textbook of Child and Adolescent Psychiatry, Rutter's textbook, or the Weiner and Dulcan text should be read. Seminars take place on **Wednesdays from 10:00-12:00** at the Children's Psychiatry Clinic, Millard Fillmore Hospital. An **Orientation series** will be given for beginning residents.

**Individual Supervision** is, for many trainees, the most important and powerful component of their residency. It is individualized, personal, immediate and clinically based. Optimally it is a forum to discuss all clinically relevant material with someone who has been around the block a few times. Policy guidelines follow on pages \_\_\_\_\_. Residents will have regularly scheduled supervision, which is divided as follows:

- 1 hour/week individually with Rotation Supervisor
- 2 hours/week (1 hour caseload and 1 hour psychotherapy) individual outpatient supervision for Year I
- 3 hours/week (1 hour group caseload; 1 hour psychodynamic psychotherapy; 1 hour CBT) outpatient supervision in Year II
- 1 ½ hours/week Group Supervision in Psychotherapies (see below)

Caseload Supervisors are assigned for 6 months; psychotherapy supervisors are assigned for 12 months. If you have specific requests contact Dr. Kaye. Written evaluations are provided every 4-6 months (by Caseload and Psychotherapy Supervisors) and at the end of a given rotation (by Rotation Supervisors). Midway evaluations (i.e. 3 months) are provided for Year I rotations.

**Regular Teaching conferences** (see next page). Another major teaching conference takes place on Wednesdays from 12-1:00 or 1:00-2:00PM.

**Group Supervision in the Psychotherapies** takes place Wednesdays from 8:30-9:45 AM (child-focused family assessment and intervention). The goal of this series is to provide an opportunity for practical, clinically focused supervision in four of the major psychotherapy modalities used with children and adolescents: psychodynamic play therapy with younger children; psychodynamic psychotherapy with adolescents; cognitive-behavior therapy; and child-focused family assessment and intervention. The play therapy sequence (July-September) is led by Sue Bundy-Myrow, Ph.D. and David Myrow, Ph.D.; family intervention series (September-Dec) by David Kaye MD; the cognitive behavior therapy sequence (January-February) by Jennifer Batterman-Faunce, Ph.D.; and the psychodynamic psychotherapy (Mar-June) by Emily Ets-Hokin, Ph.D.. Use of videotaped sessions and live supervision is encouraged. Readings are distributed to supplement the clinical material.

**Academic Rounds** are scheduled for Thursdays (September-June) from 12-1:00 PM. 2<sup>nd</sup> year residents are expected to attend this conference regularly. First year residents rotating on the consult liaison service may be able to attend many although are not expected to attend while rotating at ECMC or CPC. There is a smorgasbord of presentations relevant to the entire staff of the Division. Some presentations are research presentations, other are case conferences, review of a topic, or description of other community-based programs. The **second week** of each month we have our **Administrative** meeting. It is extremely important that you attend this as we frequently discuss clinic policies, procedures, and issues that directly involve the residents. Every effort must be made to attend these meetings.

**Book and Movie Club** meets two-three times per year, generally at faculty homes. Books are selected jointly by faculty and residents for their relevance, timeliness, and interest. We have read a wide variety of books from the classics to current literature, from psychiatry to neuroscience in focus.

**University Grand Rounds** is sponsored by the Department of Psychiatry and generally takes place at Buffalo Psychiatric Center on Fridays at 8:00 am from September through June. Nationally and internationally known speakers are invited for a formal presentation followed by informal discussion over lunch. This is an excellent opportunity to meet and hear from some of the most well known individuals in the field. While most of the presentations are oriented to General Psychiatry, each semester there are a number oriented specifically to Child and Adolescent Psychiatry.

## Regular Teaching Conference Schedule 2009-2010 Academic Year

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This following is the schedule for our Wednesday regular teaching conferences:

**1st week** of each month **Difficult Case Conference**. Dr. Smith will meet with the Child and Adolescent psychiatry residents and other assigned trainees to review and discuss a specific difficult case in depth. Dr. Steven Dubovsky will attend at this conference 3-4 times per year. Individual residents will be assigned a date each month (see attached for schedule). It is expected that these cases will typically involve other mental health professionals (i.e. psychologists, social workers, etc.) and these individuals should also be invited to the case conference. The resident should prepare a one page written summary of the case and then will present the case to residents, faculty, and staff. The resident should select 1-3 issues (e.g. psychopharmacologic management, behavioral issues, diagnosis, etc.) to focus on in the discussion.

**2<sup>nd</sup> week** of each month 12:00-1:00 **Pedi Psychopharmacology Journal Review**. Dr. Waxmonsky will lead this conference as each resident will be responsible for selecting a current, relevant journal article regarding pediatric psychopharmacology. Each resident will be expected to give a 5 minute thumbnail review of the article for the benefit of their resident colleagues with Dr. Waxmonsky supplementing the discussion with his own editorial comments. *Please forward the article to Dr. Waxmonsky by Monday of the week of the conference so that he can be of most help!* The goal of this seminar is for the residents to remain current in their psychopharmacology knowledge base.

**2<sup>nd</sup> week** of each month 1:00-2:15 **Brief Assessment and Intervention Conference**. In this conference for **2<sup>nd</sup> year residents** Dr. Miller demonstrates and discusses psychodynamic approaches to assessing and making brief interventions with children and adolescents. Videotaped interviews are reviewed with a microanalytic technique that allows for a depth of discussion of important issues in the doctor-pediatric patient relationship. Relevant readings will also be distributed.

**2<sup>nd</sup> week of each month 1:00-2:00 for 1<sup>st</sup> year residents Practical Pediatric Psychopharmacology**. In this conference Dr. Wax will review practical aspects of treating children and adolescents with psychopharmacologic approaches. Each month a different topic (i.e. dr-patient relationship, depression, anxiety disorders, etc.) will be reviewed. Readings will supplement the presentation.

**3rd week** of each month 1:00-2:00 **EBM Journal Club**. This seminar is led by Alex Cogswell PhD and David Kaye MD. The Journal Club begins with a question from a case vignette that all participants will search the literature for the best supported answer. We will then get together and discuss our search strategies and which article(s) we identified. The best article will be selected for critical analysis at the following month's EMB Journal Club. This 2 step, clinically focused approach will be repeated through the year. The emphasis will be on lifelong learning, developing skills for searching the literature, honing skills in critically appraising the scientific literature and understanding the strengths and limitations of evidence-based approaches.

**4<sup>th</sup> week** from 12:00-1:00 **Emergency Child and Adolescent Psychiatry Seminar** takes place once each month. This seminar is run by B. Miller, M.D. and covers a range of pertinent topics, typically arising from the cases residents are seeing on call. Readings may be distributed to supplement the case discussions.

**4<sup>th</sup> week from 1:00-2:00 Ethics Case Conference and Seminar**. This seminar sequence, led by Kim Dobson M.D. and Anne Lockwood PhD, focuses on ethical issues faced by the residents. Residents are encouraged to present cases that generate discussion of relevant ethical issues. Dr. Dobson will also assist in the generation of an agenda as well as provide readings for the course.

### Teaching Conference Schedule 2009-10

	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>
<b>Wed 12-1</b>	Difficult Case (Smith)	Pedi Psychopharm JI Club (Wax)	Fac-Fellow lunch	Emergency Psych (Miller)	TBA
<b>Wed 1-2</b>	Fac-fellow lunch	Brief Assess/Intervention (Miller)** Practical Ped Psychopharm (J. Wax) *	EBM JI Club (Cogswell/Kaye)	Ethics (Dobson/Lockwood)	TBA
<b>Wed 2:15-3:45</b>	Intake Clinic	Intake Clinic	Intake Clinic	Intake Clinic	Intake Clinic
<b>Th 12-1**</b>	Acad Rnds	Acad Rnds	Acad Rnds	Acad Rnds	Acad Rnds
*1 <sup>st</sup> yr ONLY					
**2 <sup>nd</sup> year ONLY					

## Resident Supervisee Responsibilities

**Note:** Individual supervision is a critical ingredient in resident education. Residents must take ownership (along with the supervisor) for the success of this process. While the focus is on the resident's professional development, supervision invariably borders on or enters the realm of personal development. While this ambiguity is inevitable the program recognizes that supervision is *not* psychotherapy, and **strongly supports residents entry into their own personal psychotherapy as a component of ideal residency training.** As psychiatrists we are frequently the instrument of change. Hence personal growth and development and, in particular, the development of self-awareness and acceptance are critical elements in professional effectiveness. The program holds that personal psychotherapy is the most powerful and efficient method of fostering this type of development and sees a resident's decision to enter psychotherapy as a sign of strength and maturity. Any concerns/questions should be taken up with the Training Director.

### To make the most of your supervision experiences:

1. **Contact your assigned supervisor(s) and schedule a weekly time to meet.**  
Clarify where and when you will meet. The time should be mutually convenient and the same each week (i.e. Tuesdays at 3:30)
2. Attend all scheduled supervision appointments, regardless of patient cancellations. If you are not able to attend for any reason, notify your supervisor by phone or in person. If you know in advance you will be away, let the supervisor know the week before or more if able.
3. On inpatient units, all written notes (i.e. evaluations, progress notes, correspondence, etc.) must be co-signed by the attending supervisor.
4. In the outpatient clinic, please follow the following guidelines:
  - a. **All progress notes for office visits must be co-signed by the caseload supervisor.** The chart should not leave the clinic, although the progress note may be brought to the supervisor for co-signing.
  - b. **Initial evaluations (one-page summary sheet) should be typed and must be co-signed by the caseload supervisor.** These may be brought to the supervisor for signing. The resident should then assure that the evaluation is returned to the chart.
  - c. **All supervision MUST be documented in the progress note (i.e. "case discussed with.....") at a minimum of every 6 weeks.**
  - d. **Letters to outside professionals or agencies (schools, social services, juvenile justice, etc) MUST be co-signed by the supervisor.**
  - e. Every 4-6 months charts will be monitored for concordance with this policy. The Chief Resident will set the meeting dates but may delegate the responsibility for organizing these meetings. Each resident will have a minimum of 5 cases reviewed every 4 months.

## Caseload Supervisor Responsibilities

1. Caseload supervisors are assigned for 6-12 months.
2. **The caseload supervisor is the physician of record for all resident cases seen in the clinic.** It is the caseload supervisor's responsibility to sign off on all of the assigned resident's cases, including psychotherapy cases. In addition it is the caseload supervisor's job to review all medication management cases.
3. Establish frame: where, when, WEEKLY. If resident is not attending supervision, notify Training Director.
4. Review the resident's patient log and assure that all outpatient cases being seen by the resident have been supervised. This can be done by reviewing the case log once every month.
5. Resident must document EACH time case discussed with supervising attending in progress note for that date (i.e. "case discussed with....")
6. **Co-sign ALL progress notes** (except for missed sessions, phone calls). Name and degree is sufficient.
7. **Co-sign the initial evaluation** (a one-page summary that should be completed on ALL new cases opened in clinic) **and all official correspondence** (i.e. letters to court, DSS, schools, etc.) Supervisors should sign off as "Supervisor, Staff Child/Adol. Psychiatrist"
8. Treatment plans do not require the supervisor's co-signature.
9. Evaluations should be completed for each resident minimally every 6 months. Forms will be distributed 4-6 weeks before the end of the assignment period, and should be filled out and discussed with the resident prior to the end of the 6 month assignment.

## Psychotherapy Supervisor Responsibilities

1. Psychotherapy supervisors are assigned for one year at a time.
2. Establish frame: where, when, WEEKLY. If resident is not attending supervision, notify Training Director.
3. Residents should attend supervision every week they are available, regardless of whether the patient(s) attended that week.
4. Notify the resident in advance of any anticipated absences. The resident is instructed to do the same.
5. Select a small number of cases that can be followed in-depth and consistently over a period of time. The focus of this should be on the technique and process of the psychotherapy.
6. Supervisors are responsible for completing a written evaluation of their supervisee once every 6 months, generally done in December and June. Fill out the forms with enough time to review them with the resident prior to the last scheduled supervision time.
7. Psychotherapy supervisors are **not expected to co-sign resident progress notes or initial evaluations.**

5/09

**Resident U.R. Chart Review**

Resident \_\_\_\_\_

Reviewer \_\_\_\_\_

Date \_\_\_\_\_

- |  | Yes | No  |
|--|-----|-----|
| 1. Is there a legible initial evaluation in the chart?   | ___ | ___ |
| 2. Is the initial evaluation co-signed by the supervisor?  | ___ | ___ |
| 3. Are ALL progress notes co-signed by the supervisor?   | ___ | ___ |
| 4. Is there documentation that the case was discussed with the supervisor at least once every 6 weeks? | ___ | ___ |
| 5. Is other relevant correspondence co-signed?   | ___ | ___ |
| 6. Are hand written notes legible?   | ___ | ___ |

6/04

## RESIDENCY PROGRAM ORGANIZATION AND GOVERNANCE

The Chair of the Department of Psychiatry (Steve Dubovsky, M.D.) and the Chief of the Division of Child and Adolescent Psychiatry (Bruce Miller, M.D.), along with their appointed Director of Training, have ultimate responsibility for the residency training program. However, nothing good can be accomplished without the help of many individuals including faculty, residents, and support staff. First on the list is our Program Coordinator, Gloria Mayo. Gloria is knowledgeable about virtually every administrative aspect of the program and welcomes your questions. She is the hub of communications for the residency program and will generally communicate with residents via email. So check your email regularly!! She is also responsible for tracking all the important administrative needs of the Department, University, Medical School, and national accrediting bodies (i.e. Accreditation Council of Graduate Medical Education or ACGME). Please respond punctually to her requests for information or input.

**Faculty-Resident lunches take place on the first and third Wednesdays of each month.** During these lunches residents and faculty have an opportunity to raise administrative issues related to the program. The Director of Training is present for these meetings and the focus is on maintaining communication between residents and faculty, as well as to trouble shoot “real time” administrative or clinical issues. Residents are encouraged to bring concerns to the Training Director directly as well. Additionally, a major function of the Chief Resident(s) is to bolster communication between the residents and the Training Director. Any concerns can be brought up with the Chief Resident who can raise the issue with the Training Director. Twice per year the Training Director meets for **Resident Feedback Sessions**. Verbal feedback is solicited from the residents and all aspects of the program are reviewed. In addition, residents provide written feedback/evaluations of all rotations, lectures, teaching conferences, and faculty.

**Chief Resident** fills a critical need for linking the residents with the faculty and program. The Chief’s position runs from June 1 of the first year to June 30 of the 2<sup>nd</sup> year. This allows for the smooth transitioning of patient care and administrative responsibilities. The Chief must be a 2<sup>nd</sup> year resident who has spent at least 10 months in the program by June 30; must have passed USMLE Step III by the time of selection; must have passed Mock Boards in General Psychiatry by the time of selection; and should have performed better than 50<sup>th</sup>ile on the PRITE and Child PRITE exams in the year preceding selection. The process for selection will be as follows: in early March the residents will nominate their selection(s) by an anonymous survey sent to all residents in the program and returned to Gloria Mayo; Gloria Mayo will collate results and forward to the faculty who will make the final selection at the Spring Evaluation Committee meeting.

Much of the “work” of developing and sustaining the program is done by its **committees**. On the next page is a description of the residency training program committees. As a resident you will participate in these committees and are looked to as critical members in these committees. We see residents as providing necessary input, and value the fresh perspective residents bring to the program.

## **C O M M I T T E E S**

### **Child & Adolescent Psychiatry Education Policy Committee**

The Education Policy Committee (EPC) is responsible for overseeing the entire Residency Training Program, as well as teaching of medical students, pediatric and other medical residents, and general psychiatry residents. This Committee reviews and retains final say over the work of all of its subcommittees. The EPC is responsible for all aspects of the residency training program in CAP, including recruitment and the admissions policy; determining and updating the goals and objectives of the Training Program; the clinical rotations; seminars and other teaching conferences; supervision; evaluation procedures; and criteria for promotion and graduation. The committee's membership includes the Director of the Division, the Training Director, core faculty, the Chief Resident, and 2 residents (one Year I and one Year II resident). The EPC meets 4 times per year (September, December, March, and June).

### **Resident Selection Subcommittee**

The Resident Selection Subcommittee is responsible for the selection of residents. The Committee is responsible for interviewing candidates, and making recommendations to the Training Director regarding admission to the program. All faculty and residents are asked to participate in interviews, depending on scheduling. All candidates will interview with at least 2 residents. Following interviews input will be solicited from all program constituents (faculty and residents) before final determinations are made. The Selection Subcommittee is composed of the Training Director, Director of the Division, core faculty, the Chief Resident, and two residents (one first year resident, one second year resident).

### **Evaluation Subcommittee**

The Evaluation Subcommittee is responsible for reviewing each resident's overall performance. This Committee meets 4 times each year and reviews and integrates performance evaluations of each resident. The Evaluation Committee participates in the determination of promotions, graduation, probation and termination in accordance with the criteria set by the TEC. All core faculty members participate in this subcommittee.

### **Scholarly Project Subcommittee**

The Scholarly Project Subcommittee's (SPS) functions to encourage and oversee research/scholarship activities of the residents. The SPS is responsible for developing policy and procedures for the resident's Research/Scholarly Project requirement. The committee also signs off on residents' projects once completed. The SPS is comprised of Betsy Wood, Ph.D. (Chair), Bruce Miller, M.D., David Kaye, M.D., James Waxmonsky, M.D. Beth Smith M.D., and one resident

# CHILD PSYCHIATRY FELLOWSHIP SCHOLARLY PROJECT

Beatrice L. Wood, Ph.D., Chair Scholarly Project Committee (SPC)  
Revised September, 2007

## Scholarly Project Committee (2007-2008)

Beatrice L. Wood, Ph.D., Chair; Bruce Miller, M.D., Jim Waxmonsky, M.D. Beth Smith, M.D., and David Kaye, M.D., Residency Training Director.

Categories of Scholarly Projects:

- 1) Supervised empirical research experience (independent project or apprenticeship in a faculty member's lab);
- 2) Single-case research designs or case studies;
- 3) Critical, synthetic, literature reviews;
- 4) Quality Improvement Project;
- 5) Training or teaching projects which analyze and present knowledge in new and effective ways. Examples: software or video tape media for education.

The goal is to complete a project that reflects high quality scholarly inquiry in the realm of discovery (research), dissemination of knowledge (reviews, case studies, training or teaching projects), or application of knowledge in innovative and improved ways (quality improvement).

Grades will be: Unsatisfactory, Satisfactory, Honors

Grades are determined by meeting interim deadlines and by completion of project.

"Satisfactory" completion is required for graduation.

**TIME TABLE:** (Fellows who are off-cycle, See addendum #1)

## YEAR 1 DEADLINES (SUBMISSIONS ARE REQUIRED TO BE ELECTRONIC)

**JULY 1:** trainee assigned to preceptor

**DEC 15:**

- 1) **Letter** to Chair of SPC. Brief summary of proposed topic, mentor (1 paragraph) and category of project.
- 2) **Copy email to Mentor, Mentor send confirmation of mentorship and plan to SPC chair (bwood@buffalo.edu).**
- 3) **Certificate of completion of the CITI** on-line training in research ethics (both Biomedical and Social and Behavioral course which highly overlap) for human subjects must be attached. Required even if the project does not involve human subjects.

**MARCH 1: Scholarly Project Proposal** to Chair of SPC for review by committee.

Include determination of whether IRB review is required. **(See attached Outline)**

**APRIL 1: Revised** (if necessary) **Proposal due.**

**JULY 1: Progress report** (Brief outline) to Chair SPC. **Submit copy of IRB approval or explanation of exemption at this time.** Document what has been accomplished to date, and present a time line for completion of phases of the project.

## YEAR 2 DEADLINES

**SEPT 1: Progress report** (Brief outline) to Chair SPC. Document progress. **Mentor to confirm that current time line is feasible. If not, propose alternatives.**

**DEC 1: Draft of Introduction (with full literature review), Methods** to Chair SPC.

**MARCH 1: Final report** to Chair SPC. **Use AMA format (see attached “Format for Scholarly Project Report)**

If revisions are necessary, revised report due April 1.

**PRESENTATION OF PROJECT TO ACADEMIC ROUNDS IN APRIL AND FIRST TWO WEEKS IN MAY.** The presentation at Academic Rounds should be formal, including appropriate A/V or handouts, and lasting 40 minutes (leaving 20 minutes for questioning).

It is a goal (but not a requirement) for the resident to submit an abstract of their project for presentation at a meeting of an appropriate professional organization (e.g., American Academy of Child & Adolescent Psychiatry) or submit a manuscript to a scholarly journal. **Submission of the project for presentation or publication is required to earn “Honors” in the Scholarly Project.**

### **Expected Time Commitments**

It is expected that the residents will spend **2hrs/week during the first year** of their residency on activities related to completion of their scholarly project requirement. In the second year, this time will be expanded to the equivalent of **6 weeks, full-time**, spread throughout the second year.

### **Responsibilities of the Training Director, Preceptor, Mentor, and Committee**

#### **1. The training director**

a. is responsible for assigning each newly incoming resident to a preceptor. The assignment should be based upon a rotating system; the preceptor should be a member of the SPC;

b. will schedule resident presentations in academic rounds in April and first two weeks in May;

c. will collect evaluations for residents from the mentors and research committee, and from the residents for their preceptor and mentor.

**2. Preceptors** and residents will meet on at least a monthly basis. **The first meeting should occur prior to September. It is the responsibility of the resident to schedule this appointment.** The goal of interactions between the resident and preceptor is to review the procedures and deadlines for the scholarly project, generate a scholarly topic and to identify an appropriate mentor. If the topic, project type and mentor are approved, the mentor assumes the responsibility of guiding the trainee in writing the full proposal and the preceptor withdraws. The preceptor may become the mentor depending upon the scholarly topic chosen and mutual agreement between the

resident and preceptor. If difficulties arise in an external mentorship (e.g., problems over the scheduling of meetings or deadlines), the resident should seek advice from their preceptor. The preceptor may suggest that he or she meet with both the trainee and mentor to resolve the problem.

**3. Mentor:** The mentor is responsible for supervising all aspects of the scholarly project. In the case of studies involving human subjects, this includes supervision of the submission of the research proposal to the IRB, data collection and data analysis, and write-up of the final report (in APA style format, according to the Publication Manual of the American Psychological Association, 5th Edition). The mentor need not be a faculty member in the Department of Psychiatry, but must have sufficient research/scholarly experience to direct a trainee to successful completion of a project within the defined time limits. **It is the responsibility of the resident, and not the mentor, to meet all deadlines.** Members of the SPC remain available to the resident, preceptor, and mentor as a source of additional information and support if required.

### **Evaluation of Scholarly Project**

**Faculty:** The CAP Training Director will have the mentor, as well as all members of the SPC complete a form evaluating the resident's performance on their scholarly project. (See attached Scholarly Project Committee Evaluation Form)

#### **Domains of Evaluation:**

1. Timely observance of deadlines
2. Written Report
3. Oral Presentation
4. Submission for presentation or publication (for honors).

**The CAP Training Director will also have the resident complete a Faculty Evaluation for the mentor.** (See attached Resident Feedback for Research Mentor)

### **Addendum #1:**

To accommodate those residents **entering the program in Year 1 at some point other than July**, the following dates should be used for fulfillment of the project requirements:

(Compute months and fill in blanks as per below.)

\_\_\_\_\_ **(5 MONTHS AFTER ENTRY): Letter** to Chair of SPC. Brief summary of topic (1 paragraph) and category of project. **Confirmation from mentor. Certificate of completion of the CITI** on-line training in research ethics (psychosocial, NOT medical) for human subjects must be attached.

\_\_\_\_\_ **(8 MONTHS AFTER ENTRY): Scholarly Project Proposal** to Chair of SPC for review by committee. Include determination of whether IRB review is required. If revisions are necessary, **revised proposal is due by the First of the next month.**

\_\_\_\_\_(12 MONTHS AFTER ENTRY): **Progress report** (Outline) to Chair SPC.  
**Submit copy of IRB approval or explanation of exemption at this time.** Document what has been accomplished to date, and present a time line for completion of phases of the project

\_\_\_\_\_(14 MONTHS AFTER ENTRY): **Progress report** (Outline) to Chair SPC.  
Document progress. **Mentor to confirm that current time line is feasible. If not, propose alternatives.**

\_\_\_\_\_(17 MONTHS AFTER ENTRY): **Draft of Introduction (full literature review, Methods,** to Chair SPC.

\_\_\_\_\_(20 MONTHS AFTER ENTRY): **Final report** to Chair SPC.  
If revisions are necessary, revised report due the First of the next month.

**PRESENTATION OF PROJECT TO ACADEMIC ROUNDS IN THE NEXT MONTH**

\_\_\_\_\_

## OUTLINE FOR SCHOLARLY PROJECT PROPOSAL

Due February 1 of first fellowship year

**Beatrice L. Wood, PH.D., Chair, Scholarly Project Committee  
September 18, 2007**

This outline is designed for an empirical research project, however all other project proposals should follow a logically analogous outline and format. Double space the proposal. The length noted for each section is approximate and for double spacing. Be sure to convey what is essential in as concise a manner as possible.

**I. Project Title Page**

Project title  
Project type  
Resident name  
Mentor  
Date Submitted

**II. Specific Aims** (what you plan to accomplish, e.g. question(s) addressed or hypotheses to be tested, and how you plan to accomplish your aims.)  
**(1-2 paragraphs)**

**III. Scientific/Clinical significance of project** (justify the importance of the specific aims) **(1 paragraph)**

**IV. Background** (brief literature review and rationale for specific aims)**(1 page)**

**V. Methods** (subjects, design of project, methods, including procedure and measures) **(1 page)**

**VI. Data reduction and analysis procedures** (if necessary) **(1 paragraph)**

**VII. Determination of whether IRB approval is necessary or not.** If not, explain reason why the project is exempt. This determination should be based on the CITI description of requirements, and on the CYIRB (biomedical) or the Social and Behavioral IRB, if appropriate).

**If IRB approval is necessary, note when the submission to IRB is due.  
(The proposal is to be submitted by the resident to the IRB after  
approval of the proposal by the Scholarly Project Committee.)**

**SCHOLARLY PROJECT REPORT  
FORMAT  
Due March 1 of Second Fellowship Year**

**Beatrice L. Wood, PH.D., Chair, Scholarly Project Committee**  
September 18, 2007

**Reports are to be written double-spaced in accordance with AMA American Medical Association) format.** Here's the link to a website describing the style:  
<http://edmgr.ovid.com/jaacap/accounts/ifaauth-after-April1.htm>

The following format is designed for a research report. However other project types may use a logically analogous format.

**VIII. Title page format**

Scholarly Project Title  
Project Category  
Date Submitted  
Resident's Name  
Resident in Child and Adolescent Psychiatry  
Preceptor:  
Mentor(s):  
Submitted in partial fulfillment of the  
Scholarly Project requirement of the Residency Training Program,  
Division of Child & Adolescent Psychiatry,  
School of Medicine and Biomedical Sciences,  
University at Buffalo

**IX. Background** (literature review and rationale leading to the specific aims)  
Include specific aims and scientific/clinical significance **(1-2 pages)**

**X. Methods** (subjects, design of project, methods, including procedure and measures) Indicate IRB approval (or exempt status) and informed consent obtained, if appropriate. **(1 page).**

**XI. Data reduction and analysis procedures** (if appropriate) **(1 paragraph)**

**XII. Results** (if appropriate) **(1 page)**

**Discussion (1 page)**

(If the project is a literature review there will be no data analysis or results section, the bulk of the report will be the review. However background justifying the reason for and value of the review, and method by which the literature was searched and evaluated, is appropriate.)

**Reports should be 6-10 pages, double-spaced.**

**University at Buffalo**  
**Child and Adolescent Psychiatry**  
**Resident Evaluation of Scholarly Project Mentor**

**Mentor:**

**Date:**

Circle your responses:

	Poor			Excellent
<b>1. Availability</b>	1	2	3	4
<b>2. Collegiality</b>	1	2	3	4
<b>3. Support and Encouragement</b>	1	2	3	4
<b>4. Usefulness of Feedback</b>	1	2	3	4
<b>5. Quality of guidance about Research Methods and Process</b>	1	2	3	4
<b>6. Quality of guidance about Critical Reading of Scientific Literature</b>	1	2	3	4
<b>7. Quality of guidance about Scientific Writing</b>	1	2	3	4
<b>9. Overall Rating</b>	1	2	3	4

**Comments on above or suggestions for improvement**

Resident Signature: \_\_\_\_\_ Date \_\_\_\_\_

Faculty Signature \_\_\_\_\_ Date \_\_\_\_\_

University at Buffalo  
Division of Child and Adolescent Psychiatry

**Scholarly Project Committee  
Evaluation Form**

Resident:  
Title of Project  
Category of Project

Rate the following on a scale of 1-3 (1=Fail, 2=Pass, 3=Honors level)

- 1. Timeliness of meeting deadlines \_\_\_\_\_
- 2. Scholarly Rigor of literature review \_\_\_\_\_
- 3. Significance of specific aims \_\_\_\_\_
- 4. Scholarly Rigor of Methods \_\_\_\_\_
- 5. Scholarly Rigor of Discussion \_\_\_\_\_
- 6. Quality of writing \_\_\_\_\_
- 7. Quality of Oral presentation \_\_\_\_\_
- 8. OVERALL \_\_\_\_\_

Comments:

\_\_\_\_\_  
Beatrice Wood, Ph.D.  
Chair, Scholarly Project Committee

\_\_\_\_\_  
Date

I have read the above evaluation.

\_\_\_\_\_  
Resident

\_\_\_\_\_  
Date

## NUTS AND BOLTS

Note: the UB CAP program follows all the policies and procedures of the UB GME office. Please see their website <http://www.smbs.buffalo.edu/GME/index.php> for details of all relevant policies. Salary and benefits are described at: [http://www.smbs.buffalo.edu/GME/documents/Employee Benefits and Leave Policy 002.pdf](http://www.smbs.buffalo.edu/GME/documents/Employee_Benefits_and_Leave_Policy_002.pdf) What follows is a summary and should be consistent with the UB GME policies. If you have questions, check with the website for the most current policy or contact Kathleen Harrison (829-6130) in the GME office. Gloria Mayo can assist you with identifying the best person in the GME office to contact for specific issues. For questions about your state of New York salary or benefits ask Gloria Mayo who to contact at the Buffalo Psychiatric Center (where all the human resources personnel have offices).

### 1. Salary

Residents in the CAP program are paid from two different sources. In the first year residents are paid through the University system (University Medical Resident Services or UMRS) which is administered through the GME office. In the second year the salary is divided between UMRS and the State of New York through our contract with the Western New York Children's Psychiatric Center. The state portion is considerably higher than the UMRS schedule, and hence your second year salary is significantly higher than the first year, when you will be paid solely on a UMRS pay line. In the second year your benefits will be administered through the State of New York. Do not assume that your benefits will be the same in each year because they will be different!! **Note in particular that when you begin on the State payline, as with all state employees, health insurance does not begin for the first 2 months of your employment.** You must make other arrangements for health insurance to cover these 2 months (i.e. COBRA your previous insurance for the 2 months). Depending on your start date you will receive up to 12 months of pay from the State/UMRS combination. If you have started off cycle (i.e. any time other than July 1) you may receive this higher pay for a shorter period of time. If you have questions about this confusing situation ask Dr. Kaye or Gloria Mayo.

### 2. Vacation:

1<sup>st</sup> year\*: 20 days  
2<sup>nd</sup> year: 20 days

Please note the following:

1. Vacation days require the prior written approval of the Training Director at least 2 weeks in advance of planned vacations.
2. Vacations during major holidays must be discussed with your fellow residents before making final plans.
3. First year residents may not take off **more than 10 consecutive working (i.e. non-holiday Monday-Fridays) days or more than 2 weeks in total during one major clinical rotation (note: a resident may take longer vacations if the time overlaps 2 major rotations)**. Note that on the C-L service the maximum time off is 7 working days.
4. All **vacations greater than one week** duration must be discussed with fellow residents **before finalizing plans**. All call or other clinical responsibilities must be covered and discussed with your co-residents and faculty *before plans are final*.
5. Vacation should **not** be scheduled to conflict with major teaching activities (i.e. Mock Boards, PRITE, etc.). It is the resident's responsibility to see that this does not happen!

### 3. Holidays:

Residents are entitled to 6 Holidays (New Years Day, Memorial Day, 4<sup>th</sup> of July, Labor Day, Thanksgiving, and Christmas) in addition to Vacation days. All other days are considered non-holidays by the program, even if they are holidays by the hospital schedule (e.g. Columbus Day, etc). If you work or are on call for any of the above 6 Holidays then you are entitled to an additional "vacation" day.

### 4. Sick Leave:

1<sup>st</sup> year (UMRS contract): 18 days, accrued at 1 ½ day per month beginning July 1 (or the first day of training).

2<sup>nd</sup> year (State of NY contract): 13 days, accrued at 1 1/12 day per month beginning July 1 (or first day of the second year of training).

**Important: when taking a sick day (or other unexpected absence) please follow this procedure:**

1. **Call the outpatient front office staff** to tell them of your absence. If you let them know your patient schedule they will call your patients to notify them and reschedule.
2. **Call Gloria Mayo** to notify her that you will be away for the day. If you tell her your supervision appointments she will notify them.
3. **Call the Chief Resident who can help with notifying others and coverage.**
4. **First years: notify your clinical supervisor on an inpatient rotation or consult service.**

### 5. Educational Leave:

Up to 5 days per year. Must have prior approval by Training Director. Specific examples of eligible activities include:

- a. up to 2 days for study/preparing for National Exams
- b. taking of National Exams (e.g. USMLE, ABPN Boards)
- c. Attending educational conferences or meetings.

### 6. Bereavement Time:

House staff are entitled to time off with pay in the event of the death of a member of the immediate family. Up to three weeks may be excused by the Director of Training. Bereavement time off is considered part of "sick time" so must be taken from accrued sick leave time. "Immediate family" is defined as: parent or guardian (including in-laws in each case), brother or sister, son or daughter, spouse, grandparents, grandchildren, ward of the resident, or any other relative of the resident who was a permanent resident of the resident's household at the time of death.

### 7. Maternity, Child Care Leave, Disability:

**As soon as you are aware of a potential child care leave be sure to work out details of the leave with Gloria Mayo, Kathleen Harrison in the GME office, and the Director of Training.** The provisions for these leaves are complicated and vary depending on which year in the program this occurs. Note again that any time off taken beyond allotted vacation, holiday, sick days, and education leave (**8 weeks maximum total days off**) will need to be made up prior to graduation from the program. During time off all scheduled on call assignments must be made up so that all graduating

residents have the same total number of on call dates.

#### 8. Leave of Absence:

Residents may be eligible for leave under the Family Medical Leave Act. Be aware that FMLA leaves only provide for continuance of health insurance. An unpaid leave of absence for up to 3 months may also be considered at the discretion of the Director of Training. A Leave of Absence may be granted for personal reasons such as education, dependent care or community service. A Leave may not be granted for the primary purpose of enabling a resident to maintain employment elsewhere. **Continuation of benefits should not be assumed** and should be discussed a priori with the Director of Training.

Note: There is no "official policy" by the American Board of Psychiatry and Neurology as to how much time a trainee can be absent from a residency program due to illness, leave of absence, personal leave. The ABPN considers this to be at the discretion of the Director of Training. This program's policy is that **any amount of Leave time totaling beyond 8 weeks (i.e. including vacation, holiday, sick leave, education, child care and any other leave) must be made up to receive 12 months academic credit.** However, to receive credit all training must be done at least on a half-time basis.

#### 10. Medical Insurance

**1<sup>st</sup> year residents (benefits by UMRS):** Medical insurance coverage is offered through BlueCross BlueShield of Western New York effective on the first day of employment. The plan provides hospital, surgical, medical and prescription coverage. **Premiums for single and family coverage are paid in full by the employer.** Additional options are available for residents with eligible dependents who reside outside the Western New York area.

Residents who decline coverage because they are covered by another insurance plan may be eligible for an annual salary increase of \$500. Proof of other insurance is required.

##### **DENTAL INSURANCE:**

Dental insurance coverage is available through BlueCross BlueShield of Western New York effective

**2<sup>nd</sup> year residents (benefits from state of NY):** note that health insurance benefits do not begin until two months after employment begins. This means that you will have to find COBRA coverage for those two months after you finish the first year and before the state of NY makes you eligible for health insurance. Following this two month period health insurance benefits are paid for residents. For details talk with Gloria Mayo.

#### 11. Malpractice Insurance

Each of the affiliated teaching hospitals, at its expense, maintains professional liability insurance coverage on behalf of the residents for the professional resident services rendered at that institution. This coverage is specific to the hospital in which the resident is rotating. Coverage in non-hospital settings is provided for GMEC approved rotations only at the expense of the hospital supporting the resident pay line. **No coverage is provided for moonlighting or other activities that are not part of the approved residency curriculum.**

#### 12. On-call:

Residents take on-call to cover the Emergency Room and wards of the Women and Children's Hospital of Buffalo ONLY. This call is done 1 day at a time and will be arranged through the Chief Resident. On-call is taken from your home and a beeper will be provided to you while on call. **Once the call schedule for the month has been**

**agreed on and sent out, further changes to the schedule should only occur for genuine emergencies (i.e. illness, injury, etc.) Call should not be switched for ANY OTHER reason!! For further details see the Bush Pilot's Guide to On Call.**

### **13. Moonlighting:**

Moonlighting may not be required of residents but is permitted for PGY-4 and PGY-5 residents in good standing in the program and provided that moonlighting activities do not interfere with the resident's learning process, administrative and clinical responsibilities including on-call. Moonlighting is allowed up to 8 hours per week AFTER the resident's usual working hours, and MUST be in compliance with NYS regulation 405, the ACGME, and the UB Graduate Medical Education office. The resident must possess the following prior to engaging in moonlighting activities:

1. A New York State license unless a temporary license is granted by the institution which employs them.
2. Own liability insurance unless liability insurance is provided by the hiring agency.
3. Prior approval by the Director of the Residency Training Program. To receive approval, the resident must submit in writing (see letter template next page) to the Director the name of the institution or agency hiring them; the nature of the work; the hours; and the identity of the person responsible. The letter must state that the resident understands that they must possess a NYS medical license and their own malpractice. The Training Director will provide written permission to the resident, a copy of which will be placed in the resident's file. A copy of this letter will be sent to the GME office.
4. Residents who moonlight will be monitored for continued satisfactory progress in the program and for evidence of interference with educational activities and responsibilities.

**SUNY at Buffalo  
Residency Training Program in Child and Adolescent Psychiatry**

**RESIDENT REQUEST FOR TIME OFF**

Name: \_\_\_\_\_ Date of request: \_\_\_\_\_

Dates away:

From: \_\_\_\_\_ to: \_\_\_\_\_ Return to work: \_\_\_\_\_

Total number of days off: \_\_\_\_\_

**Days to be charged to:**

Vacation: \_\_\_\_\_ Education Leave: \_\_\_\_\_ Sick Leave: \_\_\_\_\_ Holiday: \_\_\_\_\_ Other: \_\_\_\_\_

Vacation days remaining for Academic Year: \_\_\_\_\_

Clinical Coverage Provided By: \_\_\_\_\_

Notes:

1. Requests must be submitted at least 14 days in advance to Program Director and Rotation Supervisor (*1<sup>st</sup> year only*).
2. Vacation time off must not be for more than 2 weeks in a row without written permission from the Program Director.
3. During the 1<sup>st</sup> year, no more than 1 week consecutively and/or 2 weeks in should be taken off during the course of a major clinical rotation; if more than 1 week off is requested, it should overlap 2 rotations (i.e. the last week of one rotation, and the first week of the next).
4. All vacations greater than one week duration must be discussed with fellow residents before finalizing plans. All call or other clinical responsibilities must be covered and discussed with your co-residents and faculty before final plans are made.
5. Vacation should not be scheduled to conflict with major teaching activities (i.e. Mock Boards, PRITE, etc.) or major professional meetings (APA, AACAP) without prior written permission from the Program Director.

Approved: \_\_\_\_\_

Not approved: \_\_\_\_\_

Rotation Supervisor \_\_\_\_\_ Program Director \_\_\_\_\_  
(1<sup>st</sup> year only)

Date: \_\_\_\_\_

(University letterhead stationary)

MOONLIGHTING LETTER TEMPLATE

Date

David Kaye, M.D.  
Director of Training in Child/Adol. Psychiatry  
University at Buffalo  
Buffalo, N.Y.

Dear Dr. Kaye,

This letter is to request permission for moonlighting activities beginning \_\_\_\_\_ . I understand that in order to do moonlighting activities I must:

1. Be a PGY-V in good standing in the residency training program.
2. Possess a New York State license unless a temporary license is granted by the institution which employs them.
3. Possess own liability insurance unless liability insurance is provided by the hiring agency (note: the malpractice insurance provided under my resident contract does not cover these activities.)

I further understand that these activities must not interfere with my primary clinical, educational, and administrative responsibilities in the residency training program; they may not exceed 32 hours per month on average and must be in compliance with the ACGME and NYS regulations regarding duty work hours (copy attached).

Name of hiring institution/agency \_\_\_\_\_

Name/phone of responsible contact person \_\_\_\_\_

Hours proposed/anticipated \_\_\_\_\_

Nature of work \_\_\_\_\_

This agreement is for one year unless otherwise stated.

Sincerely,

Suzy Creamcheese, MD/DO  
Resident in Child/Adolescent Psychiatry

## Resident Evaluation, Promotion, and Graduation Policy

The goal of the residency training program is to have residents reach a level of competence in all core areas and to graduate **all** residents accepted into the program. The Evaluation Committee is responsible for reviewing the progress of each resident. In conjunction with the Training Director, the Evaluation Committee makes recommendations regarding remediation, promotion, and graduation to the Training Director, who brings them to the Division Chief and Chair of the Department for final approval. In the process of their review the Evaluation Committee considers the following areas (in order of importance) in making their decisions:

1. Professional and personal conduct. This includes availability for and attendance at required activities; appropriate professional conduct with patients, faculty, and staff; and personal ethics.
2. Written evaluations from service chiefs, outpatient supervisors, clinic staff, support staff, seminar leaders and lecturers, other preceptors/mentors.
3. Participation in seminars and educational conferences.
4. Fulfillment of scholarly project requirement.
5. Performance on Mock Board Exams, PRITE, and Child PRITE exams.

**Written feedback and evaluations** of residents are obtained from the following:

1. Clinical rotation supervisors (every 2-4 months depending on the rotation)
2. Caseload and psychotherapy supervisors (every 4-6 months)
3. Group psychotherapies faculty leaders (at conclusion of each sequence)
4. Research/Scholarly Project
5. Ethics and Emergency CAP seminar faculty
6. Journal Club faculty
7. Chart reviews
8. Mock Boards (General Psychiatry exam twice per year; CAP once per year)
9. PRITE and Child PRITE exams (each yearly; note: **if passed ABPN Part I then exempted from PRITE exam**)
10. Support staff at WCHOB Outpatient Clinic (every 6 months)
11. Patients (every 6 months selected patients are asked for feedback)

**Residents are also asked to provide written feedback about faculty** for seminars (on going), and rotations and supervision (every 6 months). Despite what residents might think, It is critical for faculty advancement that these evaluation forms be filled out! Teaching evaluations of faculty are an important part of their dossier that must be presented for advancement.

### **A word about USMLE Step III and NYS Medical Licensure**

**All residents are expected to pass Step III, preferably by the time of beginning the program, but in any event by the end of their first year of child training. Residents who have not passed Step III are not eligible to be selected as Chief Resident. Residents who have passed Step III are expected to obtain NYS licensure as soon as possible.**

1. All residents who have not passed Step III by the beginning of the program must take the exam within 6 months of starting.
2. Residents who have not passed the exam by the end of the first year

- must submit a plan of remediation and may be placed on Enhancement status in the program.**
- 3. Residents who have not passed by 18 months into the program may be asked to take an Educational Leave and/or may be subject to disciplinary action, including Warning or Probation.**
  - 4. Residents who have not passed by the end of training may not receive their certificate of completion until they have passed the exam.**

The Evaluation Subcommittee meets twice per year (Fall and Spring). At a minimum, the Evaluation subcommittee will be composed of the Training Director, the Division Chief, and two other faculty members at least one of whom has had direct involvement with the resident's training. Following these meetings the Training Director will individually review the committee's consensus and recommendations with each resident. When a resident is seen as progressing satisfactorily in all areas then a designation as **Continued Good Standing** will be applied. When a resident's performance is seen as unsatisfactory in one or more areas the Committee may take any of the following actions:

**Enhancement** is offered when overall progress is satisfactory (i.e. the resident is considered "in good standing" but is at risk, and that particular areas require additional, focused attention. This is considered an *informal status* in the program. One example would be for the initial recognition of issues in the area of professionalism or interpersonal relations. Depending on the severity of the issues (i.e. severe issues might require Warning status) issues in these areas may be specifically delineated and addressed with Enhancement. Difficulties in spoken or written English may also be addressed with Enhancement. Two other specific examples are Mock Board Examinations and PRITE/Child PRITE scores. If a resident **performs unsatisfactorily a Mock Board Examination** (in Adult defined as a score of <4 on the first Mock Exam and <5 on Exams thereafter; or the Child Exam with an average score of <4 in the 1<sup>st</sup> year and <5 in the 2<sup>nd</sup>) the Director of Training will review the exam result with the resident and will arrange for a repeat Mock Exam within one month. For a second unsatisfactory the resident will be required to generate a written plan of remediation in collaboration with the Director of Training and may be placed on Warning status.

**Residents must pass a Mock Oral Exam in both Adult (twice) and Child/Adolescent in order to graduate from the program.** In the case of percentile rank of **25% or less** in either the **PRITE** (on a major subtest i.e. global psychiatry or neurology) or **Child PRITE** the resident within 1 month will review the exam independently and then re-reference 75 questions from the exam using an alternative standard textbook (e.g. MGH Board Review Book). As noted above, failure to pass Step III may also be seen as reason for receiving professional enhancement.

**Warning.** This is a formal status that indicates that performance is seen as well below expected standards in one or more areas. Generally a Warning will be given when the resident is at significant risk for being placed on probation. Notification to the GME office is required in this situation. Residents may be on Warning status for up to three months. Decisions for Warning are recommended by the Evaluation Committee to the Director of Training. The Director of Training along with the Division Chief and Chair make the recommendation final.

**Probation.** A resident is formally placed on Probation when serious deficiencies in one or more areas exist. Decisions for Probation are recommended by the

Evaluation Committee to the Director of Training. The Director of Training, along with the Division Chief and Chair, give final approval for the recommendation. While the program will do everything it can to see residents through to completion of the program, failure to address problem areas may result in further disciplinary action (i.e. Termination). A resident may be placed on Probation for any of the following reasons:

1. Clinical skills are seen as substantially below that expected for a resident at their level of training.
2. Work habits (e.g. attendance, timeliness, paper work, reading) do not meet acceptable professional standards.
3. Serious or multiple complaints about interpersonal relationships with patients, families, staff, faculty.
4. Unethical behavior.

When a resident is placed on Warning or Probation they will be notified by the Training Director (Level I discussion). At this time the reasons for the Warning or Probation and proposed corrective actions will be discussed and summarized in a written letter. The letter will include the specific areas of difficulty, the length of the probation, and a corrective plan of remediation. By rules of the Consortium a copy of this letter must be forwarded to the Office of Graduate Medical Education and Housestaff Affairs and the Chair of the Department of Psychiatry. Unless explicitly stated a resident placed on probation retains all privileges and responsibilities they had prior to probation. The length of the Probation is 3 months which, at the discretion of the Director of Training may be extended an additional 3 months. The Evaluation Committee will review the resident's progress each month and provide written feedback. Probation may be terminated at any time by consensus of the Evaluation Committee. The Evaluation Committee will utilize the same evaluative information as noted above. The Division Chief and Chair of the Department gives final approval of any decisions made.

**Termination.** When a resident is unable to satisfactorily remediate a Probationary period the resident may be Terminated. The effective date of Termination will be at the discretion of the Director of Training. A resident may be terminated from the program for the following:

1. Failure to satisfactorily address identified deficiencies during the probationary period.
2. Flagrantly immoral or unethical behavior (including lying, cheating, misrepresentation, and exploitation).

Termination is recommended by the Evaluation Committee and given final approval by the Division Chief and Chair. The resident will be notified in writing of his/her termination and the effective date of such.

**Automatic Dismissal.** Automatic dismissal from the program results from any of the following:

1. Misrepresentation of facts or falsification of employment documents.
2. Conviction of a felony while enrolled in the residency program.
3. Failure to comply with Consortium policies (e.g. impaired physician policy).

4. Failure to comply with the bylaws and applicable rules, regulations, and procedures at Consortium hospitals.

Recommendations of automatic dismissal are made by the Evaluation Committee with the Division Chief and Chair providing final approval. The resident will be notified in writing of the reasons for and effective date of dismissal.

**Nonrenewal** of a resident's contract must be communicated in writing at least 30 days prior to the end of the current contract.

**Appeals.** When an adverse decision is made a resident has the right to due process. Residents may appeal any adverse decision with the Director of the Division and/or the Chair of the Department of Psychiatry. Further appeals follow the guidelines set by the Graduate Medical-Dental Educational Consortium of Buffalo (see Appendix "Grievance Procedure").

**Procedure for Evaluation Committee:**

1. Evaluation Committee meetings will take place in September and March.
2. Obtain current supervisors' written evaluation or feedback forms prior to meeting
3. Obtain feedback from support staff; clinicians; patients; and chart reviews prior to meeting.
4. Obtain results of recent Mock Boards, PRITE exam scores
5. Solicit feedback from core faculty unable to attend meeting
6. Review each resident, allotting 15 minutes for each
  - a. First 5-10 minutes open general discussion
  - b. Second 5 minutes review ratings for each of the 6 core competencies
  - c. Additional time as needed to determine any academic enhancement, warning; probation status
  - d. Additional time as needed to develop plan of remediation
7. Following meeting, a written narrative will be produced for each resident to be reviewed with each individual resident and placed in their permanent resident file.
8. A Summative Evaluation Form will be filled out for each resident and placed in their permanent file.
9. A Summative Self-evaluation will be completed by each resident.

0409



SUNY at Buffalo Residency Training Program in Child/Adolescent Psychiatry  
Global Assessment Form

Resident \_\_\_\_\_ Faculty \_\_\_\_\_  
Rotation: \_\_\_\_\_ Dates of Rotation: \_\_\_\_\_

	Unable to evaluate	1	2	3
<b>I. PATIENT CARE</b>				
A. Establishes sensitive and culturally attuned working alliance with children, adolescents, and adult caretakers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Obtains a complete history and mental status exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Observes and assesses family relational process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Constructs a comprehensive formulation and diff. dx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Constructs a comprehensive, biopsychosocial Rx plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Assesses/manages suicidal/homicidal risk and other safety issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>II. MEDICAL KNOWLEDGE</b>				
	U/E	1	2	3
A. Child, Adolescent and Family Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. General medical/pediatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Psychopathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Assessment, including use of laboratory, psych. testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Biological treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Psychosocial treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>III. INTERPERSONAL AND COMMUNICATION SKILLS</b>				
	U/E	1	2	3
A. Works well with patients and families from diverse cultural, ethnic, and socioeconomic backgrounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Effective language skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Educates patient/family regarding the nature of the illness, goals in treatment, methods of treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Effectively maintains written documentation and communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Effectively maintains communication and collaborates with other professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Presents cases in a concise and organized fashion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>IV. SYSTEMS-BASED PRACTICE</b>				
	U/E	1	2	3
A. Demonstrates an understanding of local patient population trends and resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Effectively collaborates with professionals in community agencies and other systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Appropriately participates in treatment/discharge planning including managed care companies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Knowledge and utilization of community resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**V. PRACTICE-BASED LEARNING AND IMPROVEMENT**      **U/E**      **1**      **2**      **3**

---

- |  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| A. Demonstrates a desire to learn; seeks out and applies relevant literature | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Seeks and responds to feedback/supervision                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Demonstrates an ability to observe and learn from practice                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Aware of strengths and limitations  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Utilizes relevant information technology                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Effectively teaches and supervises students                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**VI. PROFESSIONALISM**      **U/E**      **1**      **2**      **3**

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- |  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| A. Demonstrates quality and timeliness in medical record keeping, documentation, and reports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Punctuality and timely response to clinical/educational/administrative responsibilities   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Ability to apply sound legal and ethical standards to decision making                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Displays a sense of responsibility and respect to patients, families, staff and peers     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Maintains a professional appearance   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

<b>VII. OVERALL RATING</b>	
A. Unsatisfactory	<input type="checkbox"/>
B. Needs Improvement	<input type="checkbox"/>
C. Satisfactory	<input type="checkbox"/>
D. With Distinction	<input type="checkbox"/>

<b>VIII. ASSESSMENT METHODS</b> (check all that apply)	
A. Direct Observation	<input type="checkbox"/>
B. Records Review	<input type="checkbox"/>
C. Discussion with Resident	<input type="checkbox"/>
D. Video	<input type="checkbox"/>
E. Other _____	<input type="checkbox"/>

**IX. GENERAL COMMENTS** (feel free to use additional page)

**Faculty****Resident****Date****PERFORMANCE EVALUATION GUIDLEINE****SUNY AT BUFFALO CHILD AND ADOLESCENT PSYCHIATRY****1. CLINICAL SKILLS**

	1 Unsatisfactory	2 Satisfactory	
History, Physical and Mental Status Exam	Superficial, inaccurate, incomplete or illogical. Significant difficulty collecting relevant data consistently. Unable to screen unrelated or unimportant information. Data insufficient to support diagnosis. Major omissions.	Consistently collects relevant data with essential positives and negatives, sufficient to support diagnosis. Occasional gaps.	Efficiently, con from multiple patient. Well-comprehensiv measurement
Interviewing Skills	Inefficient, disorganized, awkward. Lacks focus. Misses important patient cues or findings. Fails to collect all elements of H&P in reasonable time frame. Omits critical portions of exam.	Conducts complete interviews. Solicits data for all elements of H&P, including pertinent positives and negatives. May lack logical, flowing sequence or transitions. Some backtracking.	Conducts well Rarely misses sensitive data efficient, focus subtle or sens effectively.
Diagnosis & Formulation	Misses major problems. Cannot interpret basic data. Unable to correctly identify a working diagnosis without assistance.	Independently identifies major problems, a working diagnosis and key differentials. Constructs an accurate multi-axial diagnosis and rudimentary biopsychosociocultural formulation.	Sophisticated show advance hypotheses. A precipitating, Correctly prior
Treatment Planning	Difficulty understanding or formulating treatment options. Sets unrealistic goals. Regularly overlooks important aspects of comprehensive treatment plan i.e. is too narrow in focus. Unaware of practice parameter, clinical care guidelines, etc.	With assistance, identifies appropriate treatment options and weighs choices to create a realistic multi-modal and/or multi-disciplinary plan. Involves patient and family in planning. Aware of and utilizes practice parameters, clinical care guidelines, etc.	Treatment pla collaborative, each patient, effective and o
Assesses, manages S/H risk and other safety issues	Unsafe, erroneous or neglectful practices. Often underestimates patient dangerousness. May fail to monitor or follow-up patients closely. May cause iatrogenic disease. May be uninvolved in decision-making.	Effectively assumes significant responsibility for patient management. Provides appropriate, high quality care. Shows sound clinical judgment. Uses tests appropriately. Performs procedures safely. Recognizes and handles emergencies competently. Reevaluates patients regularly and modifies plans with assistance, as needed.	Effectively prie Reasons well i high degree o monitoring an interventions

**2. MEDICAL KNOWLEDGE**

	1 Unsatisfactory	2 Satisfactory	
Psychiatric (including biological and psychosocial treatments, psychopathology, assessment, development) and Medical Fund of Knowledge	Major deficiencies in basic concepts and key medical facts. Fails to apply basic science and clinical principles to care of patients. Poor or unjustified use of laboratory.	Consistently demonstrates an adequate fund of knowledge. Applies basic science and clinical principles to patient care. Appropriate use of laboratory.	Comprehensive Demonstrates thinking. Artic or unsolved an with literature laboratory

**3. PRACTICE-BASED LEARNING AND IMPROVEMENT**

	1 Unsatisfactory	2 Satisfactory	
Seeks/responds to f'dback/supervision , observes and learns from practice, effectively teaches	Fails to perform self-evaluation. Consistently has difficulty integrating feedback. Fails to use EBM skills to pursue self-improvement or enhance patient care. Doesn't facilitate learning for others. Passive or negative participant in seminars.	Shows a growing habit of self-assessment and disciplined self-directed learning. Shows at least novice-level information searching and EBM skills. Accepts feedback without defensiveness and uses it for change. Facilitates learning of others.	Committed to of initiative, e evidence-base from supervis resource for o Positive partic
Demonstrates a desire to learn, seeks out and applies relevant literature, uses i.t. well	Does not show evidence of reading. Poor initiative. Fails to acknowledge errors or limits to knowledge. Poorly responsive to constructive criticism. Unable to perform literature search to obtain high quality information	Works at expected level of independence. Completes reading assignments reliably. Recognizes limits to knowledge or skill. Seeks help and supervision when needed. Recognizes errors. Accepts feedback without defensiveness. Performs high quality literature searches that serve patient care well.	Exemplary dri habits of self- way to help o literature sear information.

**4. INTERPERSONAL AND COMMUNICATION SKILLS**

	1 Unsatisfactory	2 Satisfactory	
Works well with diverse patients and families	Unable to establish rapport or an adequate working relationship with patients or families. Unable to retain patients in treatment. Shows insensitivity to patient concerns. Lacks basic listening or communication skills, integrity, respect, or empathy. Repeated patient/family complaints. May demonstrate unethical behaviors.	Creates and sustains a therapeutic and culturally attuned relationship with patients and their families. Communicates effectively. Demonstrates caring, respectful behaviors that supercede self-interest. Listens effectively. Effectively counsels and educates patients and their families. Keeps appropriate boundaries.	Able to create with very chal manages a vo boundary issu well. Shows m recognizes an countertransfe

Works effectively with other professionals	1 Unsatisfactory	2 Satisfactory	
	Irresponsible, unreliable, or uncooperative. May be antagonistic, disruptive, arrogant with support staff, colleagues, faculty. He/she may be the source of complaints by personnel.	Works effectively with associates. Invites mutual respect. Regarded as accountable by support staff, colleagues, faculty.	Shows high leadership. Effective consultation and collaboration with others.
Oral Presentations	Unfocused, disorganized, incomplete. Ill-prepared. Major omissions or requires excessive prompting.	Usually complete, organized presentations include all basic information in standard format.	Consistently thorough presentation. Clear and understandable.

### 5. PROFESSIONALISM

Timely responses to patients, staff, faculty	1 Unsatisfactory	2 Satisfactory	
	Often absent, unavailable, or late. Unfinished patient care tasks. Lacks follow-up. Often fails to plan. Misses changes in patient status. Delegates tasks inappropriately. Fails to respond to pages. Often looks sloppy.	Satisfactory attendance. Generally punctual. Usually available when needed. Usually reliable & timely response to pages. Keeps appearance tidy + professional. Complies with administrative requirements.	Impeccably punctual. Immediately responsive. Reliable. Answers promptly.
Effectively maintains written documentation and communication	1 Unsatisfactory	2 Satisfactory	
	Inaccurate or missing data/notes. Illegible. Overdue. Misleading. Disorganized. Important omissions. Rationale unclear. Change or progress unclear. Poor grammar, typos. Poses legal risk.	Records are generally complete, legible, well-written, and timely. Illustrate progression of care. Records include basic elements to satisfy billing, legal and future patient care needs. Compliant with all electronic medical record requirements.	Exceptionally thorough. May include comprehensive charts, rating systems.
Ethical Decision-Making, Honesty, Cultural Sensitivity	1 Unsatisfactory	2 Satisfactory	
	Lacks integrity, honesty, respect. Unsatisfactory ethical behaviors. May place self-interests above patient interests. May not share credit or accept blame. Insensitive to patient diversity issues.	Applies professional ethical standards to patient care. Honest. Demonstrates sensitivity and responsiveness to patients' culture, age, gender and disabilities.	Impeccable leadership. Dedication to patient care in the most challenging model for other professionals.

### 6. SYSTEMS-BASED PRACTICE

Knowledge of, utilization, and effective collaboration with community resources/systems	1 Unsatisfactory	2 Satisfactory	
	Lacks recognition of community programs/systems available to children, families. Fails to utilize or alienates professionals in other agencies/systems. Frequently mismanages patients due to these deficiencies. Excessive, redundant or inappropriate use of tests or treatments. Doesn't allocate limited resources appropriately.	Appreciates the organization of community programs/systems and plans individual patients' care accordingly. Practices cost-effective medicine. Advocates for quality patient care with teachers, school personnel, social services, juvenile justice, case managers, utilization review personnel, etc. Assists patients and families in dealing with system complexities.	Sophisticated understanding of systems. Develops strategies to maximize service. Advocates in management of service.

## Resident Selection Policy

The UB CAP program is committed to identifying the highest quality applicants with diverse backgrounds to meet the public health need for well-trained child/adolescent psychiatrists. Applications are initially reviewed by the Training Director on a first come, first served basis. It is the policy of the UB residency training program in child/adolescent psychiatry to participate in the NRMP subspecialty match for all applicants. Applicants must submit the following to be considered for admission to the program:

1. UB GME or Common CAP application
2. Two letters of recommendation from faculty from their current residency program.
3. A letter of recommendation from the Training Director of their general psychiatry residency. This letter must include all clinical rotations successfully completed, any rotations expected to be completed by the beginning of their CAP training, and any outstanding rotations that they must complete to fulfill their general psychiatry residency requirements.
4. Medical school diploma or transcript
5. Personal statement
6. USMLE scores from Step I, II, and III
7. Curriculum vitae
8. If applicable, ECFMG certification

Although applicants may apply at any point following medical school graduation, strong preference is given to applicants who have completed at least 2 years of residency in general psychiatry prior to applying. Based on the above qualifications the Training Director will verbally discuss the applicant with the resident's general psychiatry (GP) training director. All applicants must be discussed with their general psychiatry TD prior to being offered an interview. Input from the Selection Committee is sought at this point and applicants who receive positive verbal recommendations, including confirmation of competent written and verbal English skills, from their general psychiatry training director are typically offered interviews. Interviews are conducted on a mutually agreeable date and consist of 6 hours of interviews by faculty and current residents. At the conclusion of the day all faculty and residents who interviewed the applicant fill out evaluation forms and return to the Training Director. The applicant's credentials and interview are discussed by the Selection Committee, who reach a consensus about the acceptability of the candidate. All final decisions are made by the Selection Committee, which consists of the Training Director, Director of the Division, core faculty, the Chief Resident, and two residents (one first year resident, one second year resident). The Selection Committee convenes prior to the NRMP match to construct the final match list which is then submitted by the Training Director. No applicants are ranked without an interview.

## Faculty Roster

### Core Faculty and Staff

Helen Aronoff, M.D., Assoc. Professor of Psychiatry  
Joe Baker, M.S.W., Senior Clinical Social Worker  
Laura Benedict, Ph.D., Clinical Asst. Professor of Psychiatry  
Peggy Bohnert, M.D., Clinical Asst. Professor of Psychiatry  
Alex Cogswell, Ph.D., Asst. Professor of Psychiatry  
Gary N. Cohen, M.D., Assoc. Professor of Psychiatry  
Darci Cramer-Benjamin, Ph.D., Research Asst. Professor of Psychiatry  
Don Crawford, Ph.D., Clinical Asst. Professor of Psychiatry  
Michael Cummings, M.D., Asst. Professor of Psychiatry  
Nathan Diegelman, Ph.D., Clinical Asst. Professor of Psychiatry  
Kim Dobson, M.D., Clinical Asst. Professor of Psychiatry  
Allie Freeman, M.S.W., Instructor  
Jennifer Haak, M.D., Clinical Asst. Professor of Psychiatry  
Dori Marshall, M.D., Asst. Professor of Psychiatry  
David L. Kaye, M.D., Professor of Psychiatry  
Anne Lockwood, Ph.D., Clinical Asst. Professor of Psychiatry  
Bruce Miller, M.D., Division Chief and Professor of Psychiatry and Pediatrics  
Allan Morganstein, M.D. Clinical Asst. Professor of Psychiatry  
Balwant Nagra, M.D., Clinical Asst. Professor of Psychiatry  
Diana Sanderson, M.D., Asst. Professor of Psychiatry  
Beth Smith, M.D., Asst. Professor of Psychiatry  
Patrick Stein, M.D. Clinical Asst. Professor of Psychiatry  
James Waxmonsky, M.D., Asst. Professor of Psychiatry and Pediatrics  
Beatrice Wood, Ph.D., Professor of Psychiatry and Pediatrics

### Visiting Faculty

David Keith, M.D., Professor of Psychiatry, SUNY at Syracuse  
Steve Munson, M.D., Assoc. Professor of Psychiatry, U. of Rochester

### Off-site Faculty

Bruce Bleichfeld, Ph.D., Clinical Asst. Professor of Psychiatry  
Lisa Burrows-MacLean, Ph.D., Asst. Professor of Psychology  
Emily Ets-Hokin, Ph.D., Clinical Asst. Professor of Psychiatry  
Theresa Jaworski, Ph.D.  
Ewen MacPherson, M.D., Clinical Asst. Professor of Psychiatry  
Susan Bundy-Myrow, Ph.D., Clinical Asst. Professor of Psychiatry  
David Myrow, Ph.D., Clinical Asst. Professor of Psychiatry  
Christine Oliver, M.D., Asst. Professor of Clinical Psychiatry  
William Pelham, Ph.D., Professor of Psychology and Psychiatry  
Stefan Perkowski, MSW, Clinical Instructor