CHAPTER 1

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River Park Professional Center ....................................................................................................... Fax (305) 999-0011
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North Miami Beach, FL 33180
**First Year Residents:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ash Bhatt, M.D.</td>
<td>305-727-8475</td>
</tr>
<tr>
<td>Lokararanjit Chalasani, M.D.</td>
<td>305-727-0851</td>
</tr>
<tr>
<td>Ana Maria Muniz-Leen, M.D.</td>
<td>305-727-0871</td>
</tr>
<tr>
<td>Hung Nguyen, M.D.</td>
<td>305-727-9171</td>
</tr>
<tr>
<td>Fernando Pomeraniec, M.D.</td>
<td>305-727-0538</td>
</tr>
</tbody>
</table>

**Second Year Residents:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Castro, Kenia, M.D.</td>
<td>305-727-0847</td>
</tr>
<tr>
<td>Ignatov, Rostislav, M.D.</td>
<td>305-727-0210</td>
</tr>
<tr>
<td>Katyal, Shalini, M.D.</td>
<td>305-727-8011</td>
</tr>
<tr>
<td>Oms, Elssy, M.D.</td>
<td>305-727-8480</td>
</tr>
<tr>
<td>Picuric, Neda, M.D.</td>
<td>305-727-0035</td>
</tr>
</tbody>
</table>
CRISIS ON CALL YELLOW PAGES
JACKSON MEMORIAL HOSPITAL

Mental Health Emergency Service (MHES) ................................................................. 305-355-7777
  Crisis

Child Inpatient Unit .................................................................................................................. 305-355-7343

Juvenile Addiction Receiving Facility (JARF) ................................................................. 305-355-8011

Partial Hospitalization Unit (PHP) ...................................................................................... 305-355-7268

Child and Adolescent Psychiatry ......................................................................................... 305-355-7353
  OASIS

Mental Health Admission Service (Bed Control) ......................................................... 305-355-7158/7159
  Highland Park Pavilion

Medical ER .......................................................................................................................... 305-585-6677

Pediatric ER ......................................................................................................................... 305-585-7600

Administrator in Charge (AIC) ......................................................................................... 305-355-7254

Page Operator ...................................................................................................................... 305-585-7320

UNIVERSITY OF MIAMI
  Faculty Answering Service ................................................................................................. 305-545-5601
CHAPTER 2

Organization Structure
SPONSORSHIP AND OVERALL ADMINISTRATIVE ORGANIZATION

The graduate medical education (residency) programs in this center are accredited under the auspices of the University of Miami-Jackson Memorial Medical Center (UM-JMMC) which is comprised of three institutions: The University of Miami School of Medicine, Jackson Memorial Hospital (JMH), and the Veterans Administration Medical Center -- only the first two of which are participants in this training program in Child and Adolescent Psychiatry. Within the organizational and administrative structure of the medical school, the Division of Child and Adolescent Psychiatry is part of the Department of Psychiatry, and its director reports to the Chairman of the Department who, in turn, reports to the Dean of the School of Medicine. The Dean is also the Vice President for Medical Affairs of the University of Miami and reports directly to the President of the University. This university is a private institution and its president reports to its Board of Trustees.

The faculty of the Division of Child and Adolescent Psychiatry staff, the Child and Adolescent Psychiatry (CAP) Service of JMH, and the Director of the Division acts as Chief of the CAP Service. The Chief of the CAP Service reports to the Chief of the Psychiatric Service of JMH who, in turn, reports to the hospital's chief operating officer. This hospital, although owned and financed primarily by Dade County, is operated independently of the County government under the direction of the Public Health Trust (PHT). The CEO of the hospital is also President of the PHT. Decisions regarding the training programs are made ultimately by the PHT on the advice of the House Staff Committee and the JMH Medical Staff Executive Committee.

The CAP Service participates fully in the affairs of the Psychiatric Service generally. The Training Director for Child Psychiatry sits on the Chief of Services Executive Training Committee consisting of the Director of the (general) Psychiatric Residency Program, the Director of Undergraduate Psychiatric Education, the Coordinator of the Training in the VAMC, the Director of Geriatric Psychiatry Training and Education, and the Director of Continuing Psychiatric Education. The Assistant Training Director for Child Psychiatry sits on the Training Committee for the Psychiatric Service as a whole.

Funding for the CAP programs comes from the following sources:

1. For all psychiatrist (and social scientists and some faculty members of other professions who are not in the CAP Division but who participate actively in the program): From (a) the university budget; (b) the Annual Operating Agreement within which funds are transferred from JMH to the medical school for administration of the clinical services and supervision of the training programs; (c) grants and contracts, and (d) income from private patient fees within the provisions of the faculty's Professional Income Plan;
2. For all psychologists, social workers, nurses, ancillary therapist, paraprofessionals, etc. Directly from the JMH budget;
3. For teachers: From the Dade County School Systems.

INTERNAL ORGANIZATION OF THE JMH CAP SERVICE

The various components of the CAP Service are organized in a manner assuring that the basic functions of each component are carried out in an effective and efficient manner.

The clinical components of the CAP Service, as they currently exist, are as follows:

1. The CAP Outpatient Service (also designated as the CAP Clinic)
2. The Child and Adolescent Behavior Medicine Center, Kendall
3. The CAP Inpatient Service
4. OASIS Adolescent Residential Program
5. Juvenile Addiction Receiving Facility (JARF)
6. The CAP Consultation/Liaison Service
7. The CAP School and Community Consultation Service
8. The Child and Adolescent Crisis Service

Each component is under the overall clinical direction of a child and adolescent psychiatrist designated as Chief, Medical Director, or Director, as appropriate, of that component.

The senior member of each mental health profession or discipline, as a member of the component's clinical team, is accountable to the Chief Director, or Medical Director charged with overall responsibility for that component. At the same time, he/she is accountable to the staff member next senior within his/her own discipline in the administrative structure of the Psychiatric Service as a whole.
TRAINING PROGRAMS IN CHILD AND ADOLESCENT PSYCHIATRY

The residency training programs in psychiatry and child psychiatry are fully integrated. The training responsibilities of the CAP Service include, in addition to the Residency program in child psychiatry, the following: A four month, full-time rotation for all PGY-3 Residents in general psychiatry; a six-week clinical clerkship for third-year medical students throughout the year (16-20 students on the Psychiatric Service at a time, two of whom are assigned to the Child and Adolescent Psychiatry inpatient services as their primary clinical experience and two to the Child and Adolescent Psychiatry Outpatient Clinic); and elective experience for several fourth-year medical students each year.

The Training Director, Lourdes Illa, M.D. is responsible for developing, directing and coordinating under the supervision of the Chief of Child and Adolescent Psychiatry all educational activities in the child and adolescent psychiatry training program. This position provides an overall training curriculum and maintains a training manual delineating all aspects of the training program. The Training Director moderates seminars, conducts clinical case conferences, provides case supervision on an individual basis and coordinates all supervisory and teaching responsibilities of the clinical faculty. This position chairs the child and adolescent psychiatry training committee and is an active participant in research and the medical school's private practice plan.

The role of the Director of Child Psychiatry Education is to assist the Chief of Child and Adolescent Psychiatry in the development, implementation and coordination and training of the Child and Adolescent Psychiatry Fellows and General Psychiatry Residents in accordance with criteria established by "The Essentials of Accredited Residencies in Graduate Medical Education", recommendation of various appropriate clinical and training committees of the American Academy of Child Psychiatry, as well as the medical and sociocultural needs of the community.

The Director of Child Psychiatry Education, is responsible in assisting the Chief of Child and Adolescent Psychiatry Service in:

1. Developing and annually reviewing the basic educational requirements for Child and Adolescent Psychiatry Residents, General Psychiatry Residents, and Medical Students rotating through this Service.

2. Planning and coordinating the implementation of schedules for clinical conferences and didactic seminars.

3. Selection of Child Psychiatry Residents, planning their supervision and maintaining records of their progress in aspects of the program.

4. Providing Residents with an understanding of the goals of training and evaluation procedures, as well as the responsibilities of the Residents for their own learning and clinical work.

5. Provide the Residents with an annually updated Child and Adolescent Psychiatry Bibliography.

6. Assist the faculty members and clinical child psychiatry consultants in their educational activities and assessment of Fellows training development.

Training Logs. Training logs must be kept by each child psychiatry resident. The training logs delineate patient's initial age, sex, diagnosis, length of therapy, type of therapy, etc. and help the trainee and the training office keep an adequate balance of cases. Training logs should be kept for the following rotations:

- Outpatient Evaluations
- Outpatient Individual Psychotherapy
- Consultation/Liaison
- OASIS/JARF
- Partial Hospitalization Program
- Child and Adolescent Inpatients
- Crisis/On call
- School Consultation
- Pedi/Neuro and Developmental Disorders

Residents must log all therapy patient contacts into an established Microsoft Access database. Please refer to Appendix A. This information will be utilized by the Training Director to ensure that residents are exposed to patients diverse in age, gender, diagnosis and treatment modality.

Training Committee. The Training Committee consists of the Division Chief, Training Director, psychiatry, psychology and social work faculty, and the chief resident. The Committee meets on the first Monday of the month and is chaired by the Division Chief. A written record of the meeting includes an attendance record, a review of past minutes, old business, new business, and a continuing updated agenda. The committee is responsible for ongoing review and evaluation of the training curriculum and the clinical training experiences. It also monitors the training progress of child and adolescent residents as well as the
general psychiatry residents. Mid year evaluations include resident critique of clinical rotations, faculty, and seminars, as well as assessments of the residents at six month intervals. The Training Director discusses the results of these evaluations with each individual resident.
QUALITY ASSURANCE PROGRAM

Objectives:

1. To provide ongoing and continuous monitoring of patient care including evaluation, treatment planning, achievement of therapeutic goals, and the documentation of treatment progress.
2. To provide review of any special procedures and/or unusual or experimental drugs.
3. To provide medication usage review, including review of medication records, adverse reactions and errors involving medication.
4. To provide review of unusual incidents involving patient care as well as the general quality and appropriateness of patient care under unusual circumstances.
5. The clinical performance of all individuals with clinical privileges are monitored and evaluated.
6. To provide for the maintenance of the quality and content of medical records.
7. To provide a credentialing record and regular review of all clinically active personnel.
8. To identify opportunities for improving care: Using methods and theories that reflect current knowledge and clinical experience.
10. To interface with other clinical services Department of Psychiatry and coordinate quality assurance concerns.
11. To provide a forum for continuous education and feedback about quality patient care issues within the Child and Adolescent Psychiatry Service.

Organization. The Child and Adolescent Psychiatry Division Quality Assurance Program will be implemented utilizing clinic professional personnel.

Mechanisms. The Child and Adolescent Service Quality Assurance/ Utilization Review Committee will consist of all clinic professional senior staff and the Chief Fellow.

There will be a monthly Quality Assurance/Utilization Review Committee meeting held the first Monday each month as a part of the regular staff meetings. This meeting is chaired by the Division Chief or his delegate. A written record of the meeting includes an attendance record, a review of past minutes, old business, new business, and a continuing updated agenda.

There will be a monthly updated list of active cases in the clinic. This list will be organized by the

Chief, CAP Outpatient clinic. These will be the cases that will be subject to random audit, one case from each therapist on the service and within the Department who is seeing children or families in treatment. All Child and family charts will be kept in Mental Health Medical Records. All resident/fellow/graduate student cases will have an assigned supervisor.

In addition to the random monthly audit, an audit of all active charts will be done yearly during the month of June and additional times as may be determined by the faculty.

The following elements will be audited:

1. All administrative forms are present and appropriately implemented.
2. All clinical forms are present and appropriately implemented.
3. All entries are signed, dated and timed.
4. A complete intake/evaluation that includes: demographic data, a statement of symptoms and problems, their onset, evolution, and duration, a Developmental History, Pertinent Medical History, Family History, an Objective Examination of the patient, a Summary or Formulation, a Diagnostic Impression and a Treatment or Follow-up Plan.
5. Evidence of appropriate effort to carry out the treatment plan and regular review of the plan.
6. Documentation of supervision.
7. History of previous audits, noted deficiencies and the clinician correction or response (Audit Form plus any Audit Committee note reflecting the monitoring of deficiencies).
8. Ongoing Utilization Review issues will be addressed and updated monthly. Annual Summaries of Psychology, consultation-liaison, outpatient, and training parameters that are identified and monitored are required. New appropriate studies can be introduced at anytime and current studies reviewed monthly.
9. Risk Management problems in clinical care or program management will be reviewed on a monthly basis and reported. On-going monitoring of proposed solutions will be documented.
10. All staff and outside consultant supervisors will be credentialed for the specific work they do on the service assisting in the care of patients, residents, fellows, graduate students or staff on the service. These credentials will be reviewed on a yearly basis.
CHAPTER 3

Application Procedures
RESIDENCY APPLICATION AND APPOINTMENT PROCEDURE

Since child and adolescent psychiatry is a sub-specialty of psychiatry with its own certification procedures by the American Board of Psychiatry and Neurology and its separate training program accreditation by the Accreditation Council for Graduate Medical Education, a new, original application must be submitted by all applicants for appointment to a residency position.

Applicants From Other Residency Programs In Psychiatry

All documents listed at the bottom of page 3 of the application form must be submitted as well as the biographical sketch mentioned on page 4 of the application form. At least three letters of reference are required, and one of these must be from the applicant's general psychiatric residency training program director.

Applicants from UM-JMH Residency Program In Psychiatry

Applicants from our own general residency program need not submit a letter of reference from their medical school dean or transcripts of their medical school scholastic records.

Application Procedure

Inquiries and request for application. The CAP training program coordinator will prepare a letter for the CAP Training Director's signature within three working days of receipt of the inquiry. The letter will be mailed with the following enclosures (at the least): Description of the CAP training program; material descriptive of the Medical Center and the community; an application form.

Receipt of Applications. On receipt of an application the training program coordinator will open a file in the applicant's name; all material relevant to the applications (documents, correspondence, etc.) will be maintained in this file under the supervision of the training program secretary.

Application Check-Off form. The training program secretary will maintain a check-off form for each active application and a summary check-off form (q.v.) for all active applications.

Incomplete Applications. On a date specified by the Training Director, the training program coordinator will contact by telephone each applicant whose application lacks any of the required documentation, letters of reference, etc., and explain specifically what is necessary for the application to be considered complete. The content of this call will be recorded and communicated immediately to the Training Director.

If there is any doubt about the validity of the documentation, the candidate's current Training Director will be contacted.

Each interviewer should complete the applicant evaluation form within three working days and forward it to the Training Director in the Confidential envelope already provided.

The Selection Procedure. The Training Director will convene the Training Committee to consider all completed applications.

Each member of the Training Committee will be provided with a complete copy of the documentation in each applicant's file.

The Training Director will designate one of each applicant's interviewers to review the application in detail and to be prepared to summarize it appropriately at the Training Committee meeting.

The Committee will discuss each application on its merits. By secret ballot each Committee member will rank all applicants preferentially, beginning with the numeral 1 for the applicant of top priority, two for the next one, etc.

The numerical ranks of each applicant will be totaled and a composite ranking will be determined, the lowest total score ranking, the next lowest score ranking two, etc.
VACATIONS, EDUCATIONAL LEAVES OF ABSENCE AND SICK LEAVE

Vacations

Your contract with JMH entitles you to four (4) full weeks of (duty-free) vacation per residency year. (Please refer to your Collective Bargaining Contract).

Vacations must be planned with the needs of our own clinical services and those of our affiliated institutions in mind, but every effort will be made, within these constraints, to schedule such requested absences at the times you desire. We will attempt to develop for all Residents a schedule for the entire year of all vacations of four days or longer. The Chief Resident has the responsibility for developing this master schedule, and you should provide him/her with any information you wish considered in this process. During the month of June, vacations will not be allowed. Residents must schedule vacation time in one week or two week blocks and must schedule 2 full weeks prior to December 31 and 2 full weeks between January 1 and May 31. Special requests for variation as well as vacation requests for weeks that contain holidays must go to the Residency Training Committee.

Educational Leave of Absence

Naturally we hope to provide an excellent educational experience for you within our own training program, but no program can provide everything. Occasionally a worthwhile educational opportunity occurs in which you may wish to participate and which would require time away from our own program. In considering requests for educational leave, the advantages of taking part in such an extra-curricular activity will be balanced against the disadvantages of not participating in part of our own program. The needs of the clinical services to which we are obligated will also be considered.

Procedures For Requesting Vacations or Educational Leave of Absence

CAP Residents will always carry assignments in the CAP Clinic and usually on one of the other clinical services as well. The procedure outlined below is required in the following circumstances: (a) a new request for a vacation of 3 days or less, (b) a request for change in an already-scheduled vacation, or (c) a request for educational leave.

Complete the JMH "Leave Request" form (obtainable in the CAP clinic office or in the departmental Office of Psychiatric Education; Obtain approval signatures of the following in the order indicated:

- From the Chief/Director/Medical Director of each clinical service to which you are assigned;
- From the CAP Training Director;
- From the Chief Resident in CAP;
- From the Chief of the CAP Service;

Submit the completed request to the departmental Office of Psychiatric Education for transmission the JMH House Staff Office.

Sick Leave: Your JMH contract specifies that you are permitted fourteen (14) sick days per academic year. Additional time away from work because of illness is considered sick leave and requires written verification by a physician. If you become ill while on the job, you should immediately inform the Chief of the clinical service component on which you are then working and the Training Director for Child and Adolescent Psychiatry, who will take responsibility for notifying other faculty as appropriate. If you become ill at home and are unable to report for your regularly scheduled activities, you should call the Training Director for Child and Adolescent Psychiatry as soon as possible, preferably before the time at which you would ordinarily be expected to appear for duty. If you become ill during an approved vacation period, you should call the Training Director for Child and Adolescent Psychiatry on the first day of illness and request that your vacation be canceled. You must call again each day thereafter on which you continue to be ill. When you return to work you must present written verification from your physician that illness necessitated your absence. Otherwise the days on which you were absent for reasons unverified as illness will be counted as vacation.

HEALTH BENEFITS AND MEDICAL INSURANCE

You are automatically covered under the JMH House Staff Health Benefit Plan as of the date you are placed on the JMH payroll. Detailed descriptions of the following are contained in a brochure prepared by the JMH administration: Eligibility and enrollment; extent of coverage; dependent coverage; benefits (including those for maternity); child health supervisory services; benefits for mental disorders, alcoholism, and drug addiction; expenses not covered; how to file a claim, etc.

You should have been given a copy of all your insurance plans at the general orientation provided by JMH.
SALARY AND BENEFITS

Cash Stipend July, 2006

| Post Graduate Year 1 | $43,471.15 |
| Post Graduate Year 2 | $45,446.69 |
| Post Graduate Year 3 | $47,420.01 |
| Post Graduate Year 4 | $49,717.07 |
| Post Graduate Year 5 | $52,400.00 |
| Post Graduate Year 6 | $53,972.23 |
| Post Graduate Year 7 | $56,423.40 |

Pay Supplement
$50.00 bi-weekly

Please refer to Article 2; Section 1 of the Collective Bargaining Agreement when assigning PGY levels.

Benefits

I. Medical Insurance for the resident and dependents
   Choice of medical plans offered

   (1) Jackson Quality Care
       - 100% coverage
       - no deductibles
       - no copayments or premiums
   (2) Opt Out Insurance
       - Deductibles
       - Single coverage $750.00
       - Family coverage $1,500.00
       - After deductible is met, hospital pays 75%, resident pays 25%

II. Dental Insurance provided by Oral Health Services for the resident and dependents

III. Mental Health Insurance provided by University of Miami Behavioral Health for the resident and dependents

IV. Disability Insurance provided free to the resident while in training

V. $50,000 term Life Insurance provided free to the resident while in training
   - Supplemental Insurance of $50,000 available for $72.00/year

VI. $1,150 Professional Educational Allowance

VII. Discounted parking

VIII. Three new lab coats provided at the beginning of each academic year

IX. Physician Dining Card allocated for On-call Meals ($1,275)

X. Free prescription drugs to be filled at the hospital’s facilities

XI. Vacation - 4 weeks

XII. Sick Leave- 14 days/year
CHAPTER 4

Education and Training
Activities
GENERAL DESCRIPTION
GOALS AND OBJECTIVES

Goals:

1. The overall goal at the end of the 2 year child psychiatry training program is to produce a psychiatric physician with the skill and knowledge base essential for the clinical practice of child psychiatry with child and adolescent patients.

2. The resident should demonstrate familiarity with and understanding of the medical knowledge upon which the practice of this subspecialty is based.

3. The resident should possess a good understanding of research methodology and design so as to be able to evaluate critically the literature in our field, and incorporate that which is valuable into the clinical care of her/his patients.

Objectives:

1. Demonstrate skills interviewing children, adolescents and their families, formulate a differential diagnosis, a biopsychosocial and psychodynamic formulation and to elaborate a treatment plan based on the information obtained.

2. Demonstrate ability to interpret these findings and recommendation to parents in a constructive, therapeutic manner.

3. Demonstrate an adequate knowledge of normal and abnormal development, sociocultural processes, epidemiology and phenomenology of childhood psychiatric disorders.

4. Demonstrate knowledge of the various psychopharmacological and psychosocial interventions to include individual, family, group, milieu, forensic, and behavioral approaches.

5. Demonstrate ability to carry out an evaluative and therapeutic process in a constructive manner.

6. Demonstrate skills in working as a consultant in child and adolescent psychiatry to other medical specialties and health care professionals in clinical settings, teachers, and counselors in the school system, personnel in the juvenile justice system and the staff of other community agencies that provide services to children.

7. Demonstrate ability to record clinical findings, diagnostic opinions, treatment plans, progress notes and discharge summaries systematically, accurately, eligibly and in a manner that can easily be understood by others.

8. Complete a “scholarly paper” which residents are expected to present at end of the second year at the Division’s Research Symposium. This scholarly paper may be clinically or empirically based at the end of the training experience which should reflect a substantial and thoughtful inquiry. Acceptable projects include:

   a. Use of a primary research dataset to test hypotheses which have direct and important impact on psychological theory or address an immediate practical issue or problem in psychiatry or psychology.

   b. Exemplary evaluation of a particular program, treatment or intervention. The evaluation is expected to include a needs assessment, empirical evaluation of clinical services, cost-benefit analyses, etc. and by considering multiple perspectives.

   c. A thorough literature review with a meta-analysis. A meta-analysis is a statistical method of combining the results of a number of studies that address a set of related research hypotheses. Meta-analysts translate results from different studies to a common metric and statistically explore relations between study characteristics and findings.

   d. An intensive study of a clinical syndrome with focus on individual persons, family, group, etc. A case study must be clearly embedded in a thorough literature review. The information must be richly detailed and usually in narrative form.

   e. A scholarly review and analysis of a topic with a focus on development, a clinical syndrome, therapeutic approach, transcultural dimension or possibly psychobiography.
THE DIDACTIC ACTIVITIES

General Description

The didactic activities offered by the CAP training program include lectures, seminars, CAP Clinical Case Conferences, psychopharmacology conferences, monthly CAP Child Rounds, the weekly Departmental Grand Rounds, the CAP Journal Club, and formal clinical demonstrations and supervised evaluations of children, adolescents and their families. Individual supervisory sessions are considered part of the didactic activities (2 per week for psychotherapy cases, one for consultation-liaison, one for school consultation, and at least one per week for residents on the inpatient service).

These activities are considered mandatory and your attendance is expected. Attendance records are maintained for each activity. In the event of an anticipated excused absence (vacation, educational leave, etc.), it is your responsibility to so inform the staff member in charge of each didactic activity you will miss. Given the time constraints of a reasonable work week over a two-year period, it is impossible to schedule a formal didactic exercise for every possible aspect of child and adolescent psychiatry. It is assumed that many, if not most, of the issues important in acquiring an adequate knowledge base for the practice of child and adolescent psychiatry will arise in the context of clinical work with child and adolescent patients during the two-year span of the training period and that they will be discussed with the designated supervisor (and other faculty members if desirable or necessary) in appropriate breadth and depth. For example, five 1-1/2-hour seminars in the first year of training are devoted specifically to transcultural issues in human development and clinical syndromes, but cultural issues are discussed regularly as an integral part of patient-care oriented working as well as being a regular part of the discussion in the Clinical Case Conference and in the seminars.
**BOTH RESIDENCY YEARS**

**Child Rounds**

*The first Monday of each month, September - June, 9-10 sessions, 1½ hours.*

Child Rounds are a formal part of the educational/training program and consist of presentations by both local and visiting "experts" in a variety of areas of special interest to child and adolescent psychiatry.

**Goals:**

1. Residents will become familiar with current areas of special interest to child and adolescent psychiatry.

2. To provide an educational experience for residents in child and adolescent psychiatry, for residents in general psychiatry, pediatrics and other medical specialties, for pre- and post-doctoral interns in clinical psychology, for third- and fourth-year medical students, and members in training of other health disciplines.

3. To provide regular and voluntary psychiatric faculty members with an opportunity for a continuing educational experience in areas relevant to the practice of clinical child and adolescent psychiatry.

4. To provide a continuing educational experience for other mental health professionals.

**Objectives:**

1. Residents will attend 80% of rounds

2. Residents will actively participate in discussions.

**Clinical Case Conference**

*Jon A. Shaw, M.D., second and fourth Monday every month, September – June; 18 sessions, 1½ hours. This conference is planned and presented as a formal learning experience.*

**Goals:**

1. To provide a learning experience for psychology interns, residents, and medical students and a continuing education experience for faculty/staff members of all disciplines;

2. To provide an opportunity for all trainees and staff to become familiar with child and adolescent psychopathology, psychodynamic formulation, and transcultural experiences, and therapeutic issues as represented by patients undergoing evaluation and/or treatment;

3. To provide an opportunity for trainees and staff members to present and discuss a variety of patients and families in a formal manner.

**Objectives:**

1. Residents will attend 80% of rounds

2. Residents will actively participate in discussions.

3. Residents, and psychology interns will demonstrate competence in presenting cases in a formal manner before a professional audience;

4. Trainees, when appropriate, will demonstrate competence in acting formally as the primary discussant of case presentations before a professional audience;

5. Trainees demonstrate familiarity with the range of psychopathology, psychodynamics, and therapies represented in the caseload of the clinical services comprising the training resources of this program.

**General Guidelines.** Each clinical case conference will be 1 hour, 30 minutes in duration and will be started and ended promptly at the time announced; Each participant will be required to complete a form evaluating various aspects of each conference.

**Guidelines for Presenter.** The presenter will be expected to do the following:

1. If in trainee status, discuss in advance with his/her supervisor the content and form of the presentation plan.

2. Discuss in advance with the Chief Resident, the moderator, the interviewer, and the formal discussant the desired focus and format of the conference, including how and by whom live interviews are to be conducted, the time allotted as to the presentation, patient/parent/family interviews or video tape, etc. The trainee is responsible for selecting discussant interviewers and inviting the participation of other treatment team members.

3. Present the case in a formal manner, including all
relevant information (history, mental status examination, special examination, progress in treatment etc.) but not including (except as part of the general discussion) the presumptive diagnosis, the psychodynamic formulation, or the pro's and con's of an actual or contemplated treatment plan. Presentation of diagnostic test results (such as psychological testing should be coordinated with the tester.

4. Act as formal discussant when appropriate.

5. Provide a copy of the presentation material (in narrative or outline form), identified by the patient's hospital or clinic number, for inclusion in the evaluation package. There will be a list of trainees participating in presenting the cores.

**Child and Adolescent Psychiatry Journal Club**

*Jon A. Shaw, M.D., third Monday every month, September - June, 9 sessions, 1 ½ hours.*

The Child Psychiatry Journal Club will be held once a month, usually the third Monday, during the regular case conference time. The child psychiatry resident, in conjunction with their faculty discussant, is to provide a brief series of articles on a single topic, to the faculty and trainees in the division. The support staff will assist in photocopying and distributing these articles. Articles should be distributed at least five days in advance. Questions about the appropriateness of the topic, the number, type and source of the articles should be addressed with Dr. Shaw.

The purpose of the journal club is to expand the knowledge base of the participants and attendees of the journal club, to compare and contrast the differences in professional journals and to critically look at the research and the authors’ conclusions.

As the attendees are expected to have read the article beforehand, the presentation of the article should be a specific summary and not a reading of the article. Emphasis should be placed on the study design, methods employed, findings and conclusions. Ongoing exchange between the presenters and attendees is encouraged during the presentation though the faculty discussant will lead the discussion of the article or articles after the presentation is complete.

All residents and faculty participate in a review, moderated by a faculty member, of current key journals in child and adolescent psychiatry.

**Goals:**

1. Residents will become awareness of published research that is directly relevant to the practice of child and adolescent psychiatry.
2. Residents will demonstrate familiarity with critical reading of published research
3. To foster intellectual exchange among the residents and faculty

**Objectives:**

1. Residents will attend 80% of rounds
2. Residents will actively participate in discussions.
3. Residents will demonstrate the ability to understand scientific reasoning and methodologies
4. Residents will demonstrate knowledge of common statistical procedures

**Departmental Grand Rounds**

*Every Friday, July-May, 1½ hours.*

All residents are expected to attend this part of the general educational activities of the Department of Psychiatry.

**Continuous Child and Adolescent Case Conference and Individual Psychotherapy Seminar**

*Jon A. Shaw, M.D., September - June, 28 sessions, 1 ½ hours.*

The Psychotherapy Seminar provides a review of the current empirically based studies on the efficaciousness of the various psychotherapeutic interventions in children and adolescents. Following this introduction specific topical areas are addressed to include: the frame work of treatment, scheduling and attendance, the therapeutic relationship, the child’s mode of expression, the role of play in child psychotherapy, psychodynamic therapy, interpretation and intervention, collateral treatment with parents,
cognitive behavioral therapy, interpersonal psychotherapy with children and adolescents, integrated therapy, brief and time limited psychotherapy, the effects of medication on the process of psychotherapy, termination.

The Continuous Clinical Case Conference, Monday from 2:00 p.m.-3:30 p.m. consists of a child and adolescent being presented on alternate weeks. The case is usually present by a second year resident and represents ongoing psychotherapeutic process in which the case material is presented either by videotape or transcription of an audiotape. This format presents the opportunity for close monitoring of the therapeutic process, strategies of intervention, a discussion of transference and counter transferences mechanisms, elaboration of technique, intervention tactics, and its allegiance and fidelity to a specific manualized approach. Emphasis is placed on understanding the various intervention paradigms and the importance of defining therapeutic goals and objective and establishing measures with which to evaluate course and outcome.

Goals:

1. Residents will be knowledgeable about the various psychotherapeutic interventions in children and adolescents

2. Residents will become knowledgeable about the therapeutic process, strategies of intervention, transference and counter transference mechanisms, and allegiance and fidelity to a specific manualized approach.

3. Residents will understand the various intervention paradigms and the importance of defining therapeutic goals and objective and establishing measures with which to evaluate course and outcome.

Objectives:

1. Residents will attend 80% of rounds

2. Residents will actively participate in discussions.

3. Residents will present a case which represents an ongoing psychotherapeutic process, in which case material is presented either by videotape or transcription of an audiotape.

4. Residents will discuss areas such as the framework of treatment, scheduling and attendance, the therapeutic relationship, the child’s mode of expression, the role of play in child psychotherapy, interpretation and intervention, collateral treatment with parents, the effects of medication on the process of psychotherapy, and termination.

Family Continuous Case Conference

Carleen Robinson, MSW, LCSW, 8 sessions, 1 ½ hour each

This conference alternates with the Continuous Child and Adolescent Case Conference. It consists of a family therapy case being presented by second year resident. Family therapy sessions are conducted by the resident and the faculty member behind a one way mirror and observed by residents and medical students. Cases are used to illustrate family therapy principles and intervention strategies.

Goals:

1. Residents will demonstrate ability to conceptualize cases from a systems point of view.

2. Residents will demonstrate knowledge about the therapeutic process and strategies of intervention in working with families.

Objectives:

1. residents will attend 80% of seminars

2. residents will actively participate in discussions.

3. a resident and the family therapy supervisor will conduct several sessions with a family behind a one-way mirror.

4. residents will use the case material to illustrate family therapy principles and intervention strategies.

Family Therapy Seminar –

Carleen Robinson, MSW, LCSW, 7 sessions, 1 hour each

Introduction to family systems models – This seminar provides an overview of theoretical models, needs assessments and goals of family therapy. Instructional modalities include lecture, case examples from fellows and from books, case
consultation, videotapes and readings. One of the goals of this seminar is to get you to think systemically, not just about families but also about your relationship with your patients, and your place in other systems in which you live and work. This will help you understand what’s going on and open up avenues of solutions to problems. A system is comprised of parts that are interdependent or interrelated. Human systems, such as the family, have rules that regulate behavior and reciprocal processes such that the behavior of one part of the system influences the behavior of other parts, i.e., persons respond to each other’s behaviors.

**Goals:**

1. Residents will become familiar with family systems theory, the sociocultural role of family, characteristics of the dysfunctional family, and structural family theory.

2. Residents will become familiar with processes of restructuring and elements of family therapeutic intervention.

**Objectives:**

1. Residents will attend 80% of seminars.

2. Residents will actively participate in discussions.

3. Residents will demonstrate an adequate knowledge of family therapy principles and intervention strategies.

4. Residents will demonstrate ability to understand that families have rules that regulate behavior and reciprocal processes such that the behavior of one part of the system influences the behavior of other parts.

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**Ethics in Child and Adolescent Psychiatry.**

*Douglas Feltman, M.D., 2 sessions, 1 hour each*

This seminar will review the concepts of ethics and morality, the major ethical theories and principles, the manners in which moral decisions are justified, and the principles of psychiatric ethics elaborated by the AMA and AACAP.

From this, using the case method, the seminar participants will endeavor to reach decisions on some of the "typical" moral dilemmas which confront the child and adolescent psychiatrist.

**Goals:**

1. Residents will review concepts the major ethical theories and principles, the manners in which moral decisions are justified and the principles of psychiatric ethics elaborated by the AMA and AACAP.

**Objectives:**

1. Residents will actively participate in discussions.

2. Residents will use case material to illustrate ethical principles.
EDUCATIONAL ACTIVITIES
FIRST RESIDENCY YEAR

Summer Lecture Series

July - August
These seminars will highlight the fundamental techniques and background knowledge needed to begin child and adolescent specialty training. 16 sessions, 1 hour each.

Mondays, 1:00 pm-2:00 pm
- Diagnostic Interview of the Child - Part I
- Diagnostic Interview of the Child- Part II
- The Clinical Historical Method
- History of Child Psychiatry
- The Meaning and Uses of Play
- Assessing Children in Crisis
- Core Competencies
- Systems Based Learning: Community Services for Children and Families

Mondays, 2:00 pm-3:00 pm
- Terrorism/Disaster
- Suicide
- Psychology Testing – Part I
- Psychology Testing – Part II
- Psychology Testing – Part III
- Parenting-Part I- III-This special seminar focuses on the practical application of behavior modification theory and research to provide strategies for parents in modifying their children’s behavior. The theoretical framework of this approach centers primarily on operant conditioning methods. Trainees will learn to apply these principles to teach parents how to effectively decrease their child’s problematic behaviors (such as fighting, tantrums, and whining) while simultaneously reinforcing appropriate and desirable behaviors to replace the disruptive behaviors. A booklet for parents that illustrates the primary principles will be provided.

Goals:
1. Residents will attend 80% of seminars
2. Residents will actively participate in discussions.
3. Residents will become knowledgeable about the diagnostic interview of children and adolescents, the assessment of children/adolescents in crisis and suicide.
4. Residents will become familiar with the impact of trauma/terrorism on children and adolescents.
5. Residents will become familiar with parenting techniques and principles of psychological testing.

Child and Adolescent Growth and Development Seminar and Child Psychopharmacology Seminar

The Child Psychopharmacology Seminar alternates with the Child and Adolescent Growth and Development Seminar throughout the year on Thursdays from 1:00 pm to 2:00 pm.

Child and Adolescent Growth and Development Seminar
Jon A. Shaw, M.D., Sept. - June, 20 sessions, 1 hour
The Child and Adolescent Growth and Development Seminar will focus on the child's development with emphasis on the burgeoning research in the area of infant development, temperament, attachment behavior, Piagetian and psychoanalytic concepts of internalization, oedipal conflicts, middle childhood and adolescent experience. Specific attention will be given to the role of the family and the socio-cultural milieu and the biological dimensions as they influence and determine the developmental process within the context of the family.

Goals:
1. Residents will demonstrate knowledge on child development, including temperament, attachment behavior, Piagetian and psychoanalytic concepts, oedipal conflicts, middle childhood and adolescent experience.

Objectives:
1. Residents will attend 80% of seminars.
2. Residents will complete assigned readings and actively participate in seminars.
3. Residents will use case material to illustrate
developmental stages.

**Child Psychopharmacology Seminar**

*Child and Adolescent Psychiatry faculty, Sept. - June, 12 sessions, 1 hour*

The Child Psychopharmacology Seminar’s goal is to provide a clinical logic that incorporates contemporary knowledge about drug therapies into the management of mental disorders and behavioral disturbances in children and adolescents. Topics to be covered include pharmacokinetics, mechanisms of drug action, drug study designs, clinical therapeutic strategies, polypharmacy, medico-legal and ethical issues, safety monitoring, and manage care conundrums. Residents are expected to be active participants by means of presentations and critical analyses of the literature and real life cases.

**Goal:**

1. Residents will demonstrate knowledge on a clinical logic that incorporates contemporary knowledge about drug therapies into the management of mental disorders and behavioral disturbances in children and adolescents.

**Objectives:**

1. Residents will attend 80% of rounds
2. Residents will actively participate by means of presentations and critical analyses of the literature and real life cases.
3. Residents will demonstrate knowledge about pharmacokinetics, mechanisms of drug action, drug study designs, clinical therapeutic strategies, polypharmacy, medico-legal and ethical issues, safety monitoring, and manage care conundrums.

**Substance Abuse Seminar**

Lauren Williams, M.D., Louis B. Antoine, M.D., 49 sessions, 1 hour each, Wednesdays 8:30 – 9:30 am.

This seminar is held in collaboration with the Addiction Psychiatry Residency Program. The fellow rotating on JARF will attend those sessions held during their 10 week JARF rotation. At the completion of this seminar, participants will become familiar with the epidemiology, pathophysiology and clinical presentation of common substances of abuse and dependence. The resident will also become familiar with developmental issues related to substance use disorders in adolescents.

**Goals:**

1. Residents will demonstrate knowledge about the epidemiology, pathophysiology and clinical presentation of common substances of abuse and dependence.
2. The resident will also become familiar with developmental issues related to substance use disorders in adolescents.

**Objectives:**

1. residents will attend 80% of seminars.
2. residents will complete assigned readings and present selected readings to the peer group and supervisor.
3. residents will demonstrate knowledge about the psychiatric disorders of children and adolescents
4. residents will demonstrate knowledge about divorce, child abuse, adoption, acculturation and aggression.
supervisor.

3. Residents will actively participate by means of presentations and critical analyses of the literature and real life cases.

**Cognitive Behavioral Therapy**

*Teresa Carreno, M.D., 5 sessions, 1 hour each*

This seminar will review the development of Cognitive Behavioral Therapy theory, the Cognitive Behavioral case formulation, and the application of Cognitive Behavioral case formulation to a case. It will also review the integration of Cognitive Behavioral formulation and development theory and the application of the cognitive behavioral principles to different developmental stages. Two case examples (preschooler and teenager) are used to contrast formulations and approaches to treatment. In addition, the application of specific Cognitive Behavioral Protocol for OCD and phobias will be reviewed.

**Goals**

1. Residents will become knowledgeable about the principles of Cognitive Behavioral Therapy theory and the application of CBT case formulation to a case.
2. Residents will become knowledgeable about the application of Cognitive Behavioral Therapy to different developmental stages.

**Objectives:**

1. Residents will attend 80% of seminars.
2. Residents will actively participate in discussions.
3. Residents will use two case examples (preschooler and teenager) to contrast formulations and approaches to treatment.
4. Residents will demonstrate the ability to formulate a treatment plan using basic principles and basic terminology of Cognitive Behavioral Therapy.
5. Residents will demonstrate the ability to formulate individualize CBT treatment plan by integrating concepts of developmental theory.
6. Residents will learn a specific protocol for the treatment of Obsessive Compulsive Disorder and Simple Phobia using CBT.

**Research Methodology I.**

*Director of Child Psychology TBA, 2 sessions, 1 hour each*

The purpose of this seminar is to discuss the aspects involved in the preparation of a research study. The following topics will be covered:

1. Selection of the hypothesis to be tested or questions(s) to be answered.
2. Originally of the proposed study.
3. Is the resident aware of what has been done in the field? (Background)
4. Why is the study worth doing? (Significance)
5. Specific objectives of the study.
6. Appropriate methodology.
7. Available resources (subjects, project site, etc.)
8. Time frame for the study.
9. What are the expected results?

**Goals:**

1. Residents will become knowledgeable about study design, research methodology, data analysis, interpretation of results, and protection of human subjects.

**Objectives:**

1. Residents will attend 80% of seminars.
2. Residents will actively participate in discussions.
3. Residents will demonstrate ability to design a study, including methodology, data analysis and interpretation.

Residents will demonstrate knowledge of guidelines for human subject protection.

**Research Timeline – Class of 2008**

August, 2006  Select research idea and mentor

September, 2006  Present research concept to Training Committee

October, 2006  Present final proposal to Training Committee
EDUCATIONAL ACTIVITIES
SECOND RESIDENCY YEAR

Consultation/Liaison Seminar

*Lourdes Illa, M.D. & Evelyn F. Benitez, Ph.D., July - May (alternates with Consultation/Liaison Case Conference), 20 sessions, 1 hour.*

Seminar will focus on topics relevant to a child and adolescent psychiatric consultant in a large pediatrics hospital. Presenters will be from both within and outside of the CAP faculty. Each fellow and psychology intern will present a topic with a faculty and will have an opportunity to choose from several topics. Topics covered will include coping with chronic illness, specific illnesses and relation to psychiatric disorders, family issues, medical disclosure, pain management, etc.

**Goals:**

1. Residents will become knowledgeable about childhood chronic illness and the relation to psychiatric disorders, family issues, medical disclosure, and pain management.

**Objectives:**

1. Residents will attend 80% of seminars
2. Residents will actively participate by means of presentations and critical analyses of the literature and real life cases.
3. Residents will complete assigned readings and actively participate in seminars.
4. Residents will use case material to illustrate relevant C/L issues.

Consultation/Liaison Case Conference

*Lourdes Illa, M.D. & Evelyn F. Benitez, Ph.D., July - May (alternates with Consultation/Liaison Seminar), 20 sessions, 1 hour.*

This conference focuses on case specific issues in consultative mental health. The fellow or psychology intern will present a case relating the patient’s medical history and reasons for consultation. Appropriate interaction with medical staff, approach to the patient, and interventions will be discussed. The presenter is expected to provide pertinent relative literature. The case should be discussed with the C/L supervisor in advance to prepare for the conference.

**Goals:**

1. Residents will demonstrate knowledge of the role of a consultant, proper interaction with medical staff, approach to the patient and family, and treatment of the C/L patient.

**Objectives:**

1. Residents will attend 80% of seminars.
2. Residents will actively participate in discussions.
3. Residents will present a case and pertinent scientific literature.
4. Residents will complete assigned readings and actively participate in seminars.

Special Seminars

There is a year long series of seminars on special topics in Child and Adolescent Psychiatry to include the following:

School Consultation Seminar

*Eugenio Rothe, M.D., June-July, 3 sessions, 1 hour.*

This seminar will provide an introduction to the history and development of school consultation as a therapeutic intervention process, and an overview of the University of Miami/Jackson Memorial Medical Center/Bertha Abbess Children's Center school consultation program.

There will be a discussion of school problems encountered, services rendered, treatment approaches utilized and the perceived efficaciousness of the different intervention strategies.

Administrative policies governing special education program, school placement of emotional disturbed children will be explored.

**Goals:**

1. Residents will become knowledgeable about the school consultation model, school problems, and the perceived efficaciousness of the different intervention strategies.
2. Residents will become familiar with administrative policies governing special
education programs.

Objectives:
1. Residents will attend 80% of seminars.
2. Residents will actively participate in discussions.
3. Residents will become familiar with the University of Miami/Bertha Abbess Children’s Center school consultation program.
4. Residents demonstrate knowledge about school problems encountered as a consultant, services rendered, and various intervention strategies utilized.
5. Residents will become familiar with administrative policies for school placement of emotionally disturbed children.

Forensic Child Psychiatry

Jon A. Shaw, M.D., 7 sessions, 1 hour each

Introduction to the general area of forensic issues in child and adolescent psychiatry to include history of child forensic psychiatry, child forensic evaluation, child custody evaluation, testifying in court and sexual abuse.

Goals:
1. Residents will become knowledgeable about forensic issues in child and adolescent psychiatry.

Objectives:
1. Residents will attend 80% of seminars.
2. Residents will actively participate in discussions.
3. Residents will demonstrate knowledge of the child forensic evaluation and child custody evaluation.
4. Residents will become knowledgeable about testifying in court.

Transcultural Issues in Child and Adolescent Psychiatry

Eugenio Rothe, M.D. Louis B. Antoine, M.D., Jon A. Shaw, M.D., and Carl Eisdorfer, Ph.D., M.D. 5 sessions, 1 hour/week

This seminar will focus on issues related to child psychiatry and child rearing practices from a multicultural perspective, e.g. Hispanic, African American, Haitian cultures. Other issues such as the effect of migration on the developmental process and psychiatric syndromes across different cultures will be discussed.

Goals:
1. Residents will become knowledgeable about the influence of culture on family development across different cultures.

Objectives:
1. Residents will attend 80% of seminars.
2. Residents will actively participate in discussions.
3. Residents will become familiar with the child rearing practices from a multicultural perspective.
4. Residents will become familiar with the effect of migration on the developmental process and psychiatric syndromes across different cultures.

Psychotherapy Seminar

Jon A. Shaw, M.D., 4 sessions, 1 hour each

The first session of this seminar will review the efficacy and effectiveness of the various psychotherapy modalities. Subsequently, two sessions will be spent on interpersonal psychotherapy and one on psychodynamic psychotherapy. This seminar is intended to complement the psychotherapy training conducted in the Continuous Case Conference and in other seminars conducted throughout the two year training experience.

Research Methodology II

Director of Child Psychology - TBA, 4 sessions, 1 hour/week

This seminar for second year fellows will focus on hypothesis testing procedures, alpha/beta errors, and internal/external validity. In addition, descriptive statistics, such as mean, standard deviation, and correlation, as well as inferential statistics, such as ANOVA, Chi Square, and regression will be covered. Also, the basic criteria for evaluating or writing a research paper will be presented.

Goals:
Residents will become familiar with hypothesis testing procedures and various statistical concepts.

Objectives:

1. Residents will attend 80% of seminars.
2. Residents will actively participate in discussions.
3. Residents will demonstrate knowledge about hypothesis testing procedures.
4. Residents will demonstrate knowledge of alpha/beta errors and internal/external validity.
5. Residents will become familiar with various descriptive statistics.

Child Psychological Testing Seminar

Director of Child Psychology - TBA, 4 sessions, 1 hour/week

An introduction to child testing, including intelligence, achievement, projectives, and neuropsychological assessment. The seminar will also focus on interpretation of scores to help the resident understand and interpret test reports once they are received.

Goals:

1. Residents will become knowledgeable about the different types of psychological testing available for children and adolescents.
2. Residents will become knowledgeable on the interpretation of testing scores.
3. Residents will review actual psychological testing material to understand and interpret reports.

Establishing a Private Practice

Various Faculty, 4 sessions, 1 hour/week

Faculty in private practice will present to the residents topics relevant to the practice child psychiatry in the private sector. These include starting a solo practice, joining a group, managed care, insurance and malpractice issues, and establishing a referral network.

Goals:

1. Residents will become familiar with private practice options and learn how to set up a private practice.

Objectives:

1. Residents will become familiar with practice types, including solo practice or joining a group.
2. Residents will become familiar with issues of managed care, malpractice issues and establishing a referral network.
CHAPTER 5

Competencies in Child and Adolescent Psychiatry
Child and Adolescent Psychiatry Residency Program
Core Competency

PATIENT CARE

A. Core Competency in Psychotherapy

1. Knowledge
   a. Theory seminar: covering psychoanalytic, learning, systems and group theory
   b. Technique Seminars: Individual child therapies; family therapy; group therapy sequences with accompanying observational sessions, demonstrating each therapy technique
   c. Supervision: 2-4 hours per week of individual supervision. Observed Senior Faculty interviews

2. Expectations
   a. Resident attends 75% of all offered psychotherapy seminars. Resident reads assigned readings for seminars
   b. Resident actively participates in seminar discussion
   c. Resident attends 75% of supervisory hours and uses written notes to describe patient-doctor interactions

3. Skills
   a. Resident develops skills to conduct individual interview of child or adolescent patient, using techniques of play therapy, direct questioning, and empathic listening as indicated
   b. Resident develops skills to conduct parent/family interview using knowledge of systems theory, psychodynamic theory, family functioning and attributional theory
   c. Resident can formulate case from interview, mental status exam, and historical material in multiple settings: clinic, inpatient unit, forensic
   d. Resident can conduct a psychotherapy over a substantial period of time, formulating and implementing a treatment plan, with the goal of resolving certain identifiable symptoms
   e. Expectations:
      i. Resident is familiar with all theories of psychotherapy and has treated at least one case with each method
      ii. Resident is competent in interviewing all ages of child and adolescent, is comfortable with both genders of patients, and engaging the system within which the patient is embedded.
      iii. Upon graduation, the resident is familiar with all schools of therapy, is competent in referring to subspecialties

4. Attitudes
   a. The resident in Child and Adolescent Psychiatry will attend all seminars and supervisions at greater than a 75% rate.
   b. Resident will meet programmatic immersion criteria for numbers of cases, ages, gender, diagnostic grouping of patients
   c. Resident will share personal reactions to patients with their supervisors, so as to develop increased clinical precision, assure the presence of thoughtful boundaries
   d. Resident will insure the quality of their work in making it visible to designated supervisors/faculty members through use of one-way mirror, videotaped sequences, and our directly witnessed sessions
   e. Medical director on inpatient services provides informal consultation to one’s work

B. Core Competency in Psychopharmacology

1. Knowledge
   a. Seminars in neuroscience, neurochemistry, and clinical psychopharmacology
   b. Seminars on descriptive psychiatry and symptom assessment and diagnosis
   c. Supervision of clinical psychopharmacology

2. Skills
a. The resident will have learned research-based clinical care and safe methods for the empirical dosing of symptoms with singular and multiple drugs
b. The resident will learn methods of evaluating the efficacy of any prescribed rug
c. The resident will learn dosages of medications, their interactions with other psychiatric and medical drugs, and learn the relationship of dose with regard to age, gender, and size of child patient
d. The resident will learn how to formulate a case and anticipate how these issues would influence compliance
e. The resident will learn how to manage drug abuse clients and the prescription of scheduled drugs
f. The resident will learn the skills of a psychopharmacology consultant and how to integrate his/her care with that of a primary therapist or pediatrician
g. The resident will learn the skills of integrating psychopharmacology interventions within the context of an ongoing psychotherapy within one’s independent practice.

3. Expectations
   a. To prescribe medications safely and effectively
   b. To prescribe medications within the context of an ongoing psychotherapy, with another psychotherapist or within one’s own practice

4. Attitudes
   a. The resident will avail themselves of seminar and supervision teaching at a 75% attendance record or better

5. Measurement/Assessment
   a. Supervision Assessment of clinical work
   b. Completion of CHILD PRITE annually and review of individual scores with training director
c. Regular documentation by clinical and teaching faculty of participation in didactic modules, case conferences, etc. to potentially include documentation of attendance as well
d. Supervision
   i. Documentation of resident performance in areas relevant to clinical science by supervision outpatient and on-rotation faculty
e. Clinical Skill Evaluation
   i. Direct observation of the individual resident’s clinical and didactic activities by identified faculty
   ii. Annual clinical exam of the “mock boards type
   iii. Review of the clinical exam performance with the training director
   iv. Observation and evaluation of videotaped patient interactions by supervisors and/or other teaching faculty on a regular basis
f. Independent learning
g. Demonstration of self-initiated as well as directed study through leadership of discussion in both didactic and clinical activities and through presentation to the residency program in various formats (e.g., required paper presentations; grand rounds presentations, etc.)
h. Deficiency remediation
   i. Regular review of the various measures of performance and competence for each individual resident with the training director, identifying specific deficits and developing specific remediation plans based on the particular deficiencies identified
   ii. Documentation of all identified areas where remediation or focus may be needed, remediation plans developed and assessment of outcome based on the assessment method originally used to identify the deficit (e.g., evaluation of area of relative deficits identified on the CHILD PRITE might be reassessed by later performance on CHILD PRITE; identification of deficits through supervisory process to be reassessed by subsequent supervisory reports specifically aimed at assessing identified deficiencies, etc.)
Child and Adolescent Psychiatry Residency Program
Core Competency

MEDICAL KNOWLEDGE

1. Knowledge
   a. Definition: Residents, by the time they graduate, must possess an adequate fund of knowledge in established and evolving biomedical, clinical, epidemiological, and psychosocial science domains to assure the understanding and practice of child and adolescent psychiatry
   b. Expectation
      Residents will master the basic information integral to the basic academic and clinical principles of child and adolescent psychiatry as presented in the didactic and clinical curriculum and augmented by self-directed learning. Suggested broad topics though not inclusive or necessarily required include:
      i. Development
      ii. Biological Sciences related to Child and Adolescent Psychiatry
      iii. Clinical Sciences related to Child and Adolescent Psychiatry
      iv. Psychopathology/ classification/ differential diagnosis
      v. Assessment procedures
      vi. Treatment to include somatic, psychological and residential treatments as well as cultural competency
      vii. Consultation, both pediatric and community agencies
      viii. Issues in practice not specified under other topics
      ix. Prevention

2. Skills
   a. Definition: The resident will acquire knowledge regarding the basic and clinically supportive sciences through participation in didactic and clinical discussions and be able to apply this information to both didactic and clinical situations
   b. Expectations
      i. Attend and participate in didactics, demonstrating the ability to learn and disseminate effectively relevant data and knowledge about child and adolescent psychiatry
      ii. Demonstrate through the provision of care for children, adolescents and families the ability to apply the fund of knowledge in clinical science gained in didactic and clinical situations

3. Attitudes
   a. Definition: Residents must have an analytic and investigatory approach to clinical situations
   b. Expectations:
      i. Participate actively in didactic offerings by being able to discuss assigned readings and effectively present various topics in different forums, making relevant comments during discussions
      ii. Participate actively in clinically based conferences, bringing to these conferences literature and knowledge from the clinical sciences that are relevant to the clinical situation being discussed.
      iii. The resident will immerse themselves in the clinical situation
      iv. The resident will immerse themselves in the training and mentoring opportunities of a residency
      v. The resident will be able to offer informed psychotherapy services to all patients presenting themselves in their independent practices

4. Assessment/Measurement
   a. Supervisor evaluation
   b. An observed “mock board” interview
   c. Presentation of several videotaped excerpts from ongoing clinical cases
   d. Tutorials with regard to theory and the practice of psychotherapy
   e. Expectations:
      i. The resident will actively demonstrate their capacity to provide psychotherapy services.
Child and Adolescent Psychiatry Residency Program
Core Competency

INTERPERSONAL AND COMMUNICATION SKILLS

1. Knowledge
   a. Definition
      Interpersonal and communication skills are defined as the specific techniques and methods which facilitate effective and empathic communication between the psychiatrist, patients, colleagues, and staff. In addition to specific skill acquisition, interpersonal skills require an underlying set of attitudes involving the residents personal beliefs and values, self-understanding, opinions about other people, and understanding of the child and adolescent psychiatrist’s role as a consultant to patients and their contextual system. Development of interpersonal skills is enhanced by acquisition of basic information about interpersonal communication.

   b. Expectations:
      i. At regular intervals during subspecialty training, the child and adolescent psychiatry resident will demonstrate progressive attainment of the knowledge, skills and attitudes required to develop and maintain appropriate interpersonal therapeutic relationships; and communicate effectively with patients, their patients’ families, professional associates, and the public. Competence in interpersonal and communication skills must be demonstrated in order to graduate: Specific expectations for knowledge skills and attitudes are outlined below.
      ii. Residents are expected to develop a knowledge base relating to interpersonal skills appropriate to their level of training. Specifically child and adolescent psychiatry residents should demonstrate knowledge of variety of interviewing techniques that facilitate:
         1. effective understanding of the concerns of children, adolescents, and families
         2. effective communication including education about psychiatric disorders and their treatments
         3. establishment and maintenance of a therapeutic contract and therapeutic alliance
         4. delivery and reception of difficult formation in an empathic manner
      iii. the impact of the patient’s emotional reactions and associations to the therapist (and vice versa) on psychiatric evaluation and treatment
      iv. techniques for communicating effectively with allied professionals
      v. the structure and function of multidisciplinary teams in various settings
      vi. cultural differences and their impact

2. Skills
   The competent resident is able to demonstrate the following:
   a. Interpersonal skills with reliability and efficiency in a wide range of settings, appropriate to their level of training. Specifically, child adolescent psychiatry residents should be able to:
      i. Listen to, understand, and communicate effectively with children, adolescents, adults and families
      ii. create and sustain a therapeutic alliance and ethically sound relationship with patients and caregivers
      iii. elicit and provide information using effective verbal and nonverbal interactions
      iv. use negotiation to develop an agreed upon health care management plan with patients and caregivers
      v. educate children, families, and professionals about medical, psychological and behavioral issues in the life of children and families in a clear effective manner
      vi. self-observe and appropriately manage the physician’s own feelings and behavior in psychiatric interactions
      vii. work effectively within multidisciplinary team structures as member, consultant or leader
      viii. exhibit culturally sensitive, professional, ethnically sound behavior and attitudes in all patient and professional interactions
ix. to be able to write and express clinical thoughts and impressions in a correct manner

3. Attitudes
   a. Residents are expected to identify and develop attitudes
      i. Child and adolescent psychiatry residents should demonstrate
         1. an underlying attitudes of respect for others, even those with differing points of view or from different backgrounds
         2. the desire to gain understanding of another’s position and reasoning
         3. a belief in the intrinsic worth of other human beings
         4. the wish to build collaboration and achieve mutual understanding
         5. the desire to share information in an open rather than dogmatic fashion
         6. the willingness to continuously self-observe and confront one’s own biases and emotional reactions, and
         7. a willingness to act as the patient’s advocate as indicated

4. Assessment/Measurement
   a. Residents should show increasing effectiveness and consistency of interpersonal and communication skills over the course of their training
   b. Continuing formative assessment of the residents’ knowledge, attitude, and skills; with feedback, should occur on an ongoing basis through closely supervised clinical encounters
   c. Methods of evaluation of interpersonal skills include:
      i. Standardized patients
      ii. Oral clinical examinations with evaluation of observed interviews (e.g., objective structured clinical examinations, or Boards format)
      iii. Patient survey questionnaires
      iv. Direct observations in clinical settings, videotape observation, chart review for written skills (i.e., letters of evaluation reports)
      v. Supervisory evaluations from clinical rotations (including global rating evaluations from clinical personnel who work with the resident)
   d. Identified and deficiencies should be followed up by suggestions for improvement and specific objectives and timeline for evaluation of successful remediation
Child and Adolescent Psychiatry Residency Program
Core Competency

PROFESSIONALISM

The residency program must ensure that its residents, by the time they graduate, demonstrate the fundamental qualities of professionalism, “in the best interest of child.”

1. Knowledge
   a. The AACAP Code of ethics
   b. Legal and ethical principles of
      i. Confidentiality
      ii. The minor’s and guardian’s rights to receive and refuse treatment
      iii. Involuntary commitment
   c. Assent and consent principles in research
   d. Cultural competence in the areas of:
      i. Cultural diversity of the US population and cultural differences on children’s development
      ii. Cultural influences on identification of mental health problems and help seeking behavior
      iii. Etno-cultural influences in psychopharmacology and psychosocial interventions

2. Skills
   The resident should demonstrate competencies in the following areas:
   a. To review and discuss the institutional and governmental ethical guidelines
   b. Legal and ethical principles
      i. To obtain and discuss treatment consent forms
      ii. To observe and participate in involuntary commitment procedures
   c. To review and discuss research consent/assent forms
   d. Cultural competencies
      i. To interview children and families from different ethnic groups with openness and sensitivity to cultural differences and communication
      ii. To formulate treatment plans which are culturally sensitive to the child’s and parent’s concept of mental illness
      iii. To provide clinical care with an understanding of possible cultural differences in treatment expectations
      iv. To work with health care system’s professionals of diverse backgrounds

3. Attitudes
   Residents should demonstrate in their behavior and demeanor the following:
   a. Respect, regard and integrity, and a responsiveness to the needs of patients and society that supersedes self-interest; assume responsibility and act responsibly; and a commitment to excellence
   b. Commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
   c. The capacity to know when and how to challenge/provide procedures and practices for the patient’s benefit, consistent with ongoing research and practice development in child and adolescent psychiatry
   d. Sensitivity and responsiveness to cultural differences, including awareness of their own and their patients’ cultural differences, including awareness of their own and their patient’s cultural perspectives

4. Assessment/Measurement
   a. Evaluation by clinical supervisors in relation to confidentiality, informed consent, and patients’ rights to providing assessment and treatment of children and adolescents
   b. Observation of patient interviews, simulated oral boards examination, with regards to ethical principles and cultural competence
   c. A periodic review of case log for diversity in terms of ethnic, racial, gender, age and socioeconomic backgrounds
   d. Evaluation of participation in case conferences, didactic seminars and CHILD PRITE performance in the relation to ethical, forensic areas, and cultural competence
   e. Overall review of professionalism, ethical standards, responsibility, and cultural competence in resident evaluation process in relation to program standards
Child and Adolescent Psychiatry Residency Program
Core Competency

PRACTICE BASED LEARNING AND IMPROVEMENT

A. Identification and Self-Remediation of Gaps in Knowledge, Skills and Attitudes

1. Knowledge
   a. Recognize that knowledge is inherently incomplete
   b. Definition
      Throughout a professional’s career, new knowledge or treatments are developed and
      recognized as efficacious. A professional also often encounters clinical problems with
      which he or she has limited experience. These situations require a willingness to develop
      new knowledge and skills, a recognition of knowledge and skill gaps, and an approach for
      continuously evaluating and improving one’s knowledge and skills.
   c. Expectation
      By the time they graduate, residents should be able to investigate, evaluate and improve
      their patient care practices.

2. Skills
   a. Accurately assess knowledge, clinical abilities, and practice-based improvement activities using a
      systematic methodology. Examples of such an approach may include developing a learning and
      skill development program, as well as critical assessment of new knowledge and techniques and
      their applicability to one’s practice
   b. Locate, appraise and assimilate “best practices”, practice parameters and treatment guidelines that
      are relevant to the care of childhood psychiatric disorders
   c. Acquire and integrate information from a variety of sources, including electronic databases,
      scientific literature, presentations and consultations, to support clinical care, patient education and
      one’s own education

3. Attitudes
   a. Recognize the need for lifelong learning and monitoring of one’s own practice
   b. Willing to pursue continuing education and supervised experience to keep one’s own practice
      commensurate with the community standard of care
   c. Willing to obtain information from databases and scientific literature in child and adolescent
      psychiatry and related fields

4. Assessment/Measurement
   a. Residents are expected to take an area of knowledge and/or clinical practice which in unfamiliar to
      them and develop a systematic methodology to remedy this gap. Examples of an approach may
      include the following:
      i. Review literature
      ii. Attend workshops, seminars or clinical consultations
      iii. Develop a presentation for a seminar or grand rounds. During this process the resident
          should demonstrate to the training director or a supervisor how he or she gained the
          knowledge and how he or she is using those skills
      iv. Supervision records, resident self-assessment, self-directed learning and skill
          development and utilization of methods of gaining new knowledge and skills
      v. Course directors to assign seminar topics by course directors to trainees and evaluate their
          capacity to obtain and use new information
B. Use of Scientific Literature

1. Knowledge
   a. Definition
      To review and critically assess the scientific literature to determine how quality of care can be improved in relation to one’s practice (i.e., reliable and valid assessment techniques, treatment approaches with established effectiveness, practice parameter adherence).
   b. Expectation
      The resident should be able assess the generalizability or applicability of research findings to one’s patients, in relation to their sociodemographic and clinical characteristics.
   c. Be familiar with the scope of recent scientific literature in child and adolescent psychiatry and related fields.
   d. Be familiar with research designs and statistical methods.

2. Skills
   a. Critically read the scientific literature and apply information from scientific literature and apply to current patient/clinical problems. Examples of such a skill include the following:
      i. Identify and utilize appropriate journals and knowledge of what are necessary parts of successful research, clinical and review articles.
      ii. Ability to apply one’s knowledge of study designs and statistical methods to appraise information on diagnostic validity and/or therapeutic effectiveness.
      iii. Evaluate research with apparent differing conclusions and determine how research methodologies may have contributed to such findings.

3. Attitudes
   a. Willing to remain abreast of scientific advances, new clinical approaches and investigation of clinical outcome.
   b. Recognize that the scientific literature is constantly evolving, that no one report or idea is necessarily true for all situations, and that the literature should be critically judged for its methodology and applicability.

4. Assessment/Measurement
   a. Residents are expected to identify a knowledge gap and develop a systematic approach using relevant scientific literature to remedy this gap. Examples of an approach may include the following:
      i. A journal club during which a resident presents a critical review of selected articles and comments upon the applicability to a clinical case.
      ii. A graduation paper or scholarly presentation during which a resident receives an evaluation of their ability to utilize and synthesize the scientific literature.
      iii. An evaluation of a resident’s ability to utilize and synthesize scientific literature in relationship to clinical problems and patient care dilemmas by course directors or supervisors.
Child and Adolescent Psychiatry Residency Program
Core Competency

SYSTEMS-BASED CARE

Definition: Treatment of children and adolescents with psychiatric problems is undertaken in the context of multiple, complex systems. The most important competencies in systems-based care are:

a. works in a mutually respectful, culturally competent manner with systems of care including various family compositions and extended family,
b. demonstrates a working knowledge of the diverse systems involved in treating children and adolescents, integrates multiple systems of care in treatment planning,
c. effectively collaborates in developing a shared treatment plan and,
d. advocates for children and adolescents in various systems of care

1. Knowledge

a. Definition: Understands the concepts of systems theory
   i. Expectations: Articulates basic concepts of systems theory, and how they are used in child and adolescent psychiatry

b. Definition: The resident should demonstrate a working knowledge of the diverse systems involved in treating children and adolescents, and understand how to use the systems as part of a comprehensive system of care in general, and as part of a comprehensive, individualized treatment plan. The resident should also have an understanding of the consultation role with multiple systems and agencies and be able to demonstrate knowledge of consultation principles.
   i. Expectations: There are expectations for several systems, which have variable components among states. These include:
      1. Education System
         a. Demonstrates knowledge of the resources available both publicly and privately, for the treatment of learning disorders, and psychiatric/behavioral problems impacting a child or adolescent’s ability to learn
         b. Understands the concept of school-based mental health care
         c. Exhibits knowledge of the legal aspects of education as they impact children and adolescents with psychiatric problems.
         d. Understands the development of Individual Education Plans (IEP) an the child and adolescent psychiatrist’s role in the process for determining the needs of special populations such as learning disabilities classes, behavioral disorders classes, emotionally handicapped classes, etc.)
         e. Understands school culture and the roles and approach of school personnel.
      2. Social Services
         a. Knows functions of child welfare services and is able to explain the role and function of the following:
            i. Protective services
            ii. Child welfare outreach services
            iii. Adoption and foster care
            iv. Federal and state funding mechanisms
         b. Is familiar with services for physically and developmentally disabled children and adolescents and the federal laws and regulations ensuring availability of services
         c. Understands the role of social services in the treatment system
      3. Medical
         a. Demonstrates knowledge of the public and private medical resources available in the community in clinical settings.
b. Understands the structure and function of primary care and subspecialty pediatrics and related specialties and health care professions frequently involved in the care of children and adolescents.

c. Understands how their patient-care practices and related actions impact component units of the health care delivery system and the total delivery system, and how delivery systems impact provision of health care.

d. Knows systems-based approaches for controlling health care costs and allocating resources; and practice cost-effective health care and resource allocation that does not compromise quality of care.

e. Advocates for quality patient care and assists patients in dealing with system complexities.

f. Knows how to partner with health care managers and health care providers to assess, coordinate, and improve health care and knows how these activities can impact system performance.

4. Mental Health System

a. Has working knowledge of available services in the community, both public and private.

b. Understands the use of home, school, and other community-based treatments such as family preservation, intensive case management.

c. Assesses patients for the level and intensity of care required.

d. Explain the role of community-based treatment and their appropriate use to supervisors.

2. Skills

a. Definition:

i. Able to communicate effectively with multiple systems described above.

ii. Expectations:

1. Elicits information from community systems involved in the care of a child or adolescent and listens to the input. Shows the ability to use elicited data in the development of a treatment plan.

2. Able to communicate a child or adolescent’s mental health problems to other systems, including recommendations for the system’s role in the treatment plan.

3. Communicates in a respectful and culturally sensitive manner.

b. Definition:

i. Provides consultation services to multiple systems.

ii. Expectations: develops the ability to skillfully interact with multiple systems in a consultation model.

c. Definition:

i. Uses community resources effectively and focuses on community-based treatments.

ii. Expectations:

1. Demonstrates the ability to integrate data from multiple systems in a treatment plan.

2. Able to access and use community resources.

3. Collaborates with community based programs in the treatment of specific children or adolescents.

d. Definition:

i. Advocates for the child and family within the multiple systems involved with them.

ii. Expectations:

1. Can explain the roles of various individuals and groups in community systems of care.

2. Demonstrates knowledge of advocacy groups. Examples are the National Alliance for the Mentally Ill and the Tourette’s Disorder Association.

3. Demonstrates an ability to advocate for children and adolescents in various systems of care.

4. Demonstrates an understanding of the “social authority” of the mental health practitioner in advancing advocacy across policy, program and practice sectors.
3. Attitudes
   a. Definition:
      i. The resident should develop attitudes that reflect respect for the patient, family and other caregivers
   ii. Expectations
      1. works in a mutually respectful, culturally competent manner
      2. acts in the best interest of the child and family
      3. utilizes the concept of “least restrictive environment”
      4. provides treatment services as close to home as possible
      5. expects to collaborate with others to enhance a child or adolescent’s situation
CHAPTER 6

Clinical Inpatient Program
CLINICAL INPATIENT PROGRAMS

Juvenile Addictions Receiving Facility (JARF)

Goals:
1. To understand the epidemiology of drug use among teens.
2. To become proficient in the assessment management of dually-diagnosed adolescents (SUD & major psychiatric diagnosis) in a patient setting.
3. To develop leadership skills.

Objectives:
1. Resident will become proficient in obtaining a history from adolescents with substance abuse.
2. Resident will become proficient in determining what level of care is indicated for an adolescent with substance abuse problems in need of further services.
3. Resident will become proficient in dictating a psychiatric summary in an efficient and professional way.
4. Resident will participate effectively in an interdisciplinary treatment team.
5. Resident will provide education in-services to staff.

This inpatient service consists of 20 beds for adolescents between the ages of 13 and 18. It is located on the second floor of the mental health building, next to the Office of the Director of Training of the General Psychiatry Program.

Those adolescents that are in need of substance abuse assessment and acute stabilization are admitted to the unit either from the court system, the crisis emergency room or the community. This adolescent population has a myriad of stressors including psychosocial adversity, psychiatric comorbidity and poor access to primary care services.

Organizational Structure. The unit is organized by the team approach to patient care. The team is comprised by two social workers, a court liaison, substance abuse screeners, an administrative director, a medical director, nurses, school teachers, and mental health staff.

There are two treatment teams that meet individually once a week in order to discuss all cases. Issues such as assessment, disposition and behavioral observations are discussed in a collegial way. Appropriate recommendations are done and agreed upon by all members of the team.

Responsibilities. The first year residents in Child Psychiatry are assigned to the unit for a ten-week rotation. Coverage, while on vacation, is the responsibility of the resident taking leave. This responsibility can be shared with colleagues doing their rotation in the General Psychiatry Unit on the first floor.

Each patient admitted to the unit will need a comprehensive evaluation, physical examination and medical assessment. Depending on the initial assessment, further psychological tests and/or orders should be given by the resident in consultation with the Medical Director.

The Child and Adolescent Psychiatry resident as well as the resident in the General Psychiatry Program on rotation is responsible for a daily progress note, attendance at the weekly treatment team meeting and reviewing the medications or orders on a weekly basis. By the end of their stay each patient needs to have a typed psychiatric summary in their chart. While this can be accomplished within 48 hours or even later, is of utmost importance that these are completed as soon as possible since a delay in dictation might result in the accumulation of many reports.

Three mornings a week (Monday, Wednesday and Friday) there is a morning report from the nursing staff. During this time any new admissions from the day before will be discussed and reviewed with the Medical Director. Joint interviews in the presence of colleagues will be done in order to familiarize the fellow with the skills necessary to conduct an efficient and complete psychiatric interview with this type of patients.

Unit Activities. Unit activities consist of the following:
- Team rounds (twice a week)
- Daily rounds on individual patients
- Community groups in early mornings
- Psychoeducational Groups
- Family Therapy Sessions
- Group Therapy Sessions

Opportunities. Given the variability of interest among fellows, the resident should be able to focus his or her interest with this population. One advantage of working in this inpatient unit, is the assured presence of the patients on a daily basis for at least three weeks. This facilitates the further refinement of therapeutic skills such as interpersonal
psychotherapy, group therapy and/or family therapy among other interventions. Teaching opportunities do exist as well as learning how to assume leadership positions within a team of mental health professionals. For those interested in the forensic aspects of this population, they can go to the Juvenile Court System for one day in order to be better acquainted with the legal process.

Duties and responsibilities:
- Perform psychiatric evaluation on all patients.
- See patient daily and write daily progress notes.
- Attend to medical needs of all assigned patients. (PE, Lab review initiate consults).
- Participate in weekly clinical interdisciplinary team meeting.
- Review case daily with attending.
- Dictate all discharge summaries.
- Process issues with patient and address psychological needs and develop appropriate treatment plan.
- Teach residents about child psychiatry treatment/psychopathology.
- Follow up on orders to ensure timely and adequate implementation by nursing staff.

SIPP/OASIS Residential Program

Goals:
- To develop ability to assess, manage and plan treatment for children and adolescent with severe and chronic psychiatric disorders.
- To learn the impact of the therapeutic milieu on the course of mental disorders in adolescents.
- To develop leadership skills though participation in interdisciplinary clinical team meeting.
- To develop adequate understanding of the different components of the mental health system as they relate to children and adolescent.

Objectives:
1. Resident will become proficient in the implementation of crisis intervention in explosive/violent adolescent.
2. Resident will conduct individual therapy with selected patients.
3. Resident will work collaboratively with other treatment team members.
4. Resident will participate effectively in an interdisciplinary treatment team.

Description of Facility. The OASIS at Jackson Mental Health Hospital Center is a place where the Children and Adolescents under our care can be assured that they will find a group of trained and dedicated professionals who clearly understand that within each person lies a healthy individual awaiting an opportunity to shine, the program is based on the deeply rooted belief that every child can succeed. The interdisciplinary utilizes multiple modalities of treatment to facilitate the restoration of our children shattered lives and prepare them for future challenges.

The 20 bed OASIS Residential Treatment Unit created under Florida SIPP (Statewide inpatient psychiatric program) will be housed within the Jackson Mental Health Hospital Center, but will be separated physically and programmatically from all other inpatient services. Each shift will employ a registered nurse to insure the medical safety of each resident. Counselors, a case manager and recreational therapists will provide group, individual and family treatment. Academic instruction will be provided on site by at least one certified teacher provided by the Metro Dade County Public Schools.

Training Mission: The program because of its location at the University of Miami/JMH must offer training opportunities for interns, residents and other health professionals.

Research Mission: As mentioned earlier, after a long period of abuse, misuse, and lack of accountability of the residential approach to the treatment, policy makers often guided primarily by need for coat containment have adopted a blanket rejection attitude towards residential treatment services. They have described them as costly and ineffective, often without the empirical studies to support their claims one way or another. As the numbers of children in foster care are climbing and the demand for something that works is getting louder, there is an opportunity to take another look at residential treatment modality and address this
nagging question by establishing rigorous methodology leading to valid and meaningful outcome results. Approaching each individual as a subject would offer the advantage of developing a real understanding of this difficult population and allow for better planning for its care.

Referral and Admission Procedures

When children are wards and dependents of the Juvenile Court, the court, through the court officers, must take responsibility for information exchange. This needs to include treatment summaries, psychological testing, and any available past information on medication management. The administration of the residential facility needs to insist on basic information coming with the child prior to admission. This needs to include all available psychiatric hospitalization summaries. A referral packet on a new patient should include treatment summaries, including reports from the previous treating psychiatrist. The name and phone number of the previous treating psychiatrist needs to be included. All psychological and educational testing should also be in a referral packet. A list of current psychotropic medications, dosages, length of time on each medication, and a sufficient supply of medication until the child can be seen is mandatory. This packet is received by the Program Director and then forwarded to the Nursing Director and the Medical Director. After review and discussion, a screening is scheduled with the candidate and a decision is rendered. First Health is then notified and the criteria for admission are presented. After approval from First Health is received, the patient is scheduled for admission.

Treatment Approaches and Therapeutic Modalities

Milieu Therapy

It is well known that the peer group holds significant power in influencing, molding, and shaping the behaviors and values of youth. Utilizing this fact, OASIS utilizes the influences of positive peer culture through the therapeutic community and teams. Positive peer culture's aim is to develop pro-social behaviors through interacting and living in a therapeutic community that fosters a sense of belonging and includes a safe environment. The resident develops a sense that he/she can make a significant positive contribution as well as demonstrate social responsibility to the OASIS community. The OASIS community in turn assists the resident by providing reinforcement for pro-social behavior and censure for maladaptive behavior. In this way, the OASIS community takes on the therapeutic properties that reinforce positive change. This approach must be based on the staff familiarity of the issues that the resident faces at each stage of their development.

Behavioral Management Program

- School Activities
- Individual Therapy
- Group Therapy

Assertiveness Training

One of the characteristics of conduct disordered adolescents is the violation of other people space and the refusal to abide societal rules. These adolescents show very poor problem-solving skills and are easy prey for criminal behavior and drug use. Teaching them social skills and pro-social values should in theory improve their ability to perform in a more appropriate manner. Assertiveness is the social skill that is defined as expressing one's rights and opinions with respect for the rights of others. However, Bandura (1977), the father of social cognitive theory stipulates that the acquisition of symbolic information is not sufficient for behavior change.

- Cognitive Behavioral Training
- Anger Management

Since the work of Novaco (1975) who described anger as a cognitive-behavioral concept, a stress reaction with cognitive, behavioral and physiological responses, attempts have been made to find practical interventions in order to assist troubled adolescents with anger and impulse control problems. (Kellner & Millicent 1995). Highly structured 12-session group therapy have been developed and have often been proposed to desperate judges as a panacea to resolve the staggering problem among adolescents in our community. They focus on: (1) education about the cognitive and behavioral components of anger; (2) teaching cognitive and behavioral techniques to manage anger; and (3) facilitating application of the newly acquired skills. The participants are encouraged to record 1) the specific trigger associated with the anger-provoking incident, (2) the incident itself, (3) how he/she handled the incident, (4) a self-appraisal of the degree of anger experienced, and (5) a self-appraisal of how well he/she managed the incident. Specific skills are taught in each group session, including relaxation, assertion, self-instruction, thinking ahead, self-evaluation, and problem solving. To be successful however, such interventions must take into consideration the actual developmental stage and cognitive skills of the individual patient. Modifications need to be made in the actual length of the sessions and the reading level of the material discussed since the

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reading skills of the emotionally and behaviorally disturbed adolescents might be poor.

- Role Playing
- Psychodrama

Pharmacotherapy

Developing algorithm for special populations
By the time the adolescents are admitted in the program, they will have tried an average of 3-5 different medications ranging from psycho-stimulants, antidepressants, anti-psychotics and mood stabilizers with various degrees of compliance and results. An accurate list of medication is not always forthcoming from hostile adolescents until the clinician start mentioning some names. One cannot assume however that all prior treatments have failed until the history is carefully reviewed with particular attention to duration of treatment, dosage, compliance and monitoring by trained child psychiatrists.

Duties and Responsibilities:

- Take morning report from Nursing staff at 8:30 A.M. daily and communicate any problem to attending.
- Perform psychiatric evaluation and review records on all new admission.
- Attend to daily medical needs of the residents (PE, lab work review, initiate consults)
- Meet with all patients at least twice (2) a week and document encounters in a descriptive problems oriented manner.
- Attend interdisciplinary treatment team review twice a week.
- Participate in screening of all candidates of admission as scheduled.
- Respond to all request for ETO, S&R with telephone order and face to face evaluation within the hour during working hours (8-5 PM).
- Dictate all discharge summaries on the day of discharge.
- Discuss all clinical problems as they present with attending.
- Meet with attending weekly for supervision.

Partial Hospitalization Program (PHP)

Goals:

1. To become familiar with the dynamics of adolescent group interactions with a fairly stable group of patients
2. To participate as co-facilitator for adolescent groups.
3. To become familiar with the admission and discharge criteria for partial hospitalization programs as part of a continuum of outpatient and inpatient treatment facilities.

Objectives:

1. Resident will participate as a co-facilitator for adolescent groups.
2. Resident will participate in the admissions and discharge planning for patients.

Description of Facility. This service has a capacity for ten adolescents, between the ages of 13 and 18, that come to the hospital in order to participate in therapeutic and educational activities. It is located in the first floor of the Mental Health Facility, a hospital which is part of Jackson Memorial Medical Center and the University of Miami.

It is designed for adolescents that need an intermediate program between the intensity of inpatient programs and outpatient treatment for Substance Abuse and other comorbid disorders.

Fellow assignment and responsibilities. A second year resident in Child and Adolescent Psychiatry will rotate through this required service for a period of 8 weeks while he or she participates in the OASIS Residential Treatment Program located at the same hospital.

The resident is expected to spend an average of six to eight hours a week in this program. Two to three hours will be in group sessions with the adolescents, in conjunction with the Medical Director. Individual supervision is provided afterwards, mostly related to the group experience.

The resident is expected to participate in intake interviews as well, and this might occur on a weekly basis. There must be attendance at the weekly treatment team meetings.

The resident is also responsible for doing a comprehensive assessment of the patient at intake. A physical examination should be completed within one week of admission. A weekly note reflecting individual contact with each of the patients should be present, in
addition to a weekly treatment note. This note should reflect the multidisciplinary meeting discussions. The resident will also be responsible for monitoring medications, urine for toxicology tests and any concurrent medical problems that the patient might have.

_Treatment Team._ It currently meets on Friday from 10:30 a.m.-12:00 p.m. The program is organized by the team approach to patient care. The Medical Director, Social Worker, School Teacher, Nurse and Mental Health Technician would be present at the meeting in order to review the patient’s progress during the week and discuss other pertinent issues.

_Opportunities._ This rotation gives the unique opportunity of experiencing the dynamics of adolescent group interactions with a fairly stable group of patients. The resident is encouraged to study on his own related textbooks on group psychotherapy. This experience will complement the insight obtained with the assessment unit with that of a voluntary partial hospitalization program. Given the longer stay in the program the fellow would be able to understand and know the patient better.

**The Child And Adolescents Psychiatry/Psychology Consultation/Liaison Service**

_Goals:_

1. To become familiar with the psychological responses of children and families to acute and chronic medical illness of children
2. To learn about psychiatric manifestations of physical illness
3. To provide consultation to and liaison with medical teams in a professional manner
4. To become proficient in performing comprehensive psychiatric assessments and disposition of patients admitted on a medical floor

_Objectives:_

1. Residents will conduct psychiatric evaluations of children admitted to the hospital for medical illnesses, under the supervision of the attending psychiatrist
2. Residents will develop treatment recommendations and an aftercare plan for each patient
3. Residents will discuss recommendations with consulting medical team

The Child and Adolescent Psychiatry/Psychology Consultation/Liaison Service provide a consultative and collaborative teaching program for many areas of the UM/JMH.

The C/L Service is staffed by two attendings: Dr. Illa and Dr. Benitez. A second year child psychiatry residents as well as two psychology interns are assigned to the service.

Clinical Rounds are scheduled each week. In addition, a multi-disciplinary team conference is held weekly, during which current cases are presented and discussed. Each resident and intern is responsible for formally presenting and discussing a case accompanied by relevant literature during this rotation. Didactic seminars are held throughout the year, beginning with introductory lectures followed by a series of specialty lectures.

**Crisis Service/Acute Inpatient**

Daniel Castellanos, M.D. - Approximately ten weeks for Crisis and four months for Inpatient rotation

_Goals and Objectives for Rotation on Child & Adolescent Psychiatry Acute Inpatient Unit_

_Goals:_

1. Demonstrate ability to work in a multi-disciplinary team setting
2. Demonstrate ability to perform appropriate evaluations of children, adolescents and their families in an acute psychiatric inpatient setting
3. Demonstrate ability to elaborate appropriate treatment plans and interventions for children, adolescents and their families admitted to an acute psychiatric inpatient setting

_Objectives:_

1. Demonstrate knowledge of the use of medications and integrating medications in the overall management of children and adolescents
2. Demonstrate knowledge of the choice and use of specific psychotherapeutic modalities in the overall management of children and adolescents
3. Completion of documentation and medical records in a timely manner

4. Supervision of third and fourth year medical students

**Goals and Objectives for Rotation on Children’s Crisis Service**

**Goals:**

1. Demonstrate ability to perform appropriate evaluations of children, adolescents and their families in an acute psychiatric emergency setting.

2. Demonstrate ability to elaborate and implement appropriate treatment plans and interventions for children, adolescents and their families admitted to an acute psychiatric emergency setting. This shall include, but not be limited to, determining the need for psychiatric hospitalization.

**Objectives:**

1. Demonstrate ability to coordinate the multiple needs of children and adolescents in an acute emergency setting.

2. Demonstrate ability to coordinate the demands of the Crisis Service and other clinical and non-clinical activities.

3. Completion of documentation and medical records in a timely manner.

**Description:** The Child & Adolescent Psychiatry Acute Care Service is comprised of the Children’s Crisis Service and the Acute Inpatient Unit. Our programs are responsible for providing all acute psychiatric services to children and adolescents under age 18 and their families. We provide these services throughout the entire University of Miami/Jackson Memorial Medical Center. Each resident will obtain exposure and experience on both the Children’s Crisis Service and the Acute Inpatient Unit. The rotations will provide the residents with exposure to children with a wide variety of clinical problems. The Children’s Crisis Service is responsible for the evaluation and management of children who present to any of the Medical Center’s emergency areas - Mental Health Emergency Service, Pediatric, Medical, Surgical, Ob-Gyn and Trauma emergency areas. We also provide psychiatric services to the Rape Treatment Center and the Urgent Care Center. The focus is on rapid assessment, appropriate intervention and disposition.

The Acute Inpatient Unit provides for comprehensive treatment in a multi disciplinary setting. Initial evaluations, daily rounds and team meetings are performed together with all members of the team. The treatment team consists of the attending, residents, medical students, staff psychologist, staff social worker(s), nurses, occupational/recreational therapists and teachers. Treatment interventions and plans are focused on the elaboration and improvement of acute problems that can be appropriately managed in an acute inpatient setting. Our programs have as their goals to provide the optimum care available to all children and adolescents who present for psychiatric treatment.

While on the Crisis Service please remember our motto:

“Life does not entail the elimination of all crisis; it involves the management of crisis”.

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**The Bertha Abbess Children's Center (BACC)**

**Goals:**

1. To become proficient at providing psychiatric consultation for children in school programs for emotionally disturbed children and adolescents.

2. To become familiar with the behavior of children and adolescents

**Objectives:**

1. Residents will provide psychiatric consultation of children with emotional and behavioral problems in a school consultation program.

2. Residents will observe the behavior of children and adolescents not identified as patients.

This private, non-profit service operates programs for severely emotionally disturbed children and adolescents in eight elementary and junior high schools by contract with the Dade County School Board. Each senior resident spends one-half day/week in one of
these schools, each resident having experience in both an elementary and a junior high school. The resident sees from four to seven students/day, observes the students in class, cafeteria, and/or playground as necessary and appropriate, and evaluates each student with respect to classroom behavior and academic performance, family relationships, mental and emotional status, and appropriateness of clinical plan (including pharmacotherapy). The resident confers with and advises the BACC clinicians and, when indicated, the child's teacher(s). The resident acts as the child's attending physician with respect to indicated medication. Individual off-site supervision one hour/week and additionally on an as needed basis is provided by the faculty supervisor. Once each quarter the resident participates in a two-hour conference of all BACC clinicians and CAP faculty involved in this program.
CHAPTER 7

Clinical Outpatient Program
CLINICAL OUTPATIENT PROGRAMS: THE CHILD AND ADOLESCENTS PSYCHIATRY OUTPATIENT CLINIC

Goals:

Assignment to the JMH Child and Adolescent Outpatient Clinic (The CAP Clinic) is planned and organized to provide the resident with the opportunity for the following:

1. Evaluate and treat children and adolescents with a wide range of behavioral and emotional problems utilizing a biopsychosociocultural approach;

2. Become proficient in carrying out an informative empathic mental status evaluation of children and adolescents;

3. Develop appropriate diagnostic and treatment plans, including needed family interventions, appropriate laboratory work, necessary consultations, community advocacy, and further psychiatric care;

4. Learn the skills necessary to carry out the formulated treatment plans. These skills include: psychodynamic psychotherapies, parental counseling, and cognitive-behavioral therapies among others.

Objectives:

1. Residents will work, as the team leader, with social worker and psychologists in a multidisciplinary approach to evaluation and treatment.

2. Residents will become proficient at gathering and recording pertinent information for diagnostic and therapeutic purposes.

3. Residents will formulate cases in a developmental framework, synthesizing dynamic and non-dynamic factors and arriving at DSM IV diagnoses;

4. Develop habits of exemplary documentation for the services provided.

Ages of patients range from 3 to 18 years. Disorders seen include conduct disorder, attention deficit hyperactivity disorder, separation anxiety disorder, depression and dysthymic disorders, elimination disorders, eating disorders, oppositional disorder, post-traumatic stress disorder, autistic disorder, learning disorder and organic mental disorders. Patients with disorders less frequently seen and unlikely to be part of every resident's case load are presented in the CAP Clinical Case Conference. This clinic's case load includes a reasonable balance between boys and girls but is now fairly heavily tilted (about 60%) toward youngsters of Hispanic origin. Patients are all seen individually and parent(s) are also always seen, sometimes by the resident in a family approach and sometimes alone in a process parallel to and integrated with the treatment of the child. The usual therapeutic model is psychodynamically-oriented. Brief psychotherapy, and supportive and cognitive behavioral therapies when considered are also utilized appropriately. Each resident also spends four hours each week throughout the year in a specialized clinic for youngsters who require medication and brief supportive visits but who are not candidates for more intensive psychotherapeutic relationships or are receiving additional psychotherapeutic help elsewhere, such as in the school. Each resident receives an hour a week from each of two faculty supervisors for his/her psychotherapy patients, weekly supervision by the group therapist of the group for which the resident is co-therapist, and on-site supervision prn in the medication clinic.

SPECIALTY CLINICS

Child Trauma Clinic

Goals:

1. To reduce the acute and enduring psychological morbidity of children who have been exposed to traumatic stressors in which the individual has experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others.

2. To provide psychological and psychiatric assessment and evaluation of children and adolescents who have been sexually abused or traumatized that we might make an informed decision regarding case management and treatment interventions.
3. To decrease the risk of children who have been sexually abused from becoming sexually reactive perpetrators.

4. To provide research informed measures that we might evaluate and determine risk factors, protective factors and intervention strategies that effect course and outcome.

Objectives:
1. Residents will demonstrate knowledge of the evaluation of children and adolescents who have been sexually abused or traumatized.

2. Residents will become familiar with the spectrum of interventions that have been proven to be efficacious in the treatments of children and their families who are the victims of traumatic experiences.

Mission: To provide psychological and psychiatric services to children who have been the victims of trauma or children who have experienced the death of a loved one. A particular focus of the clinic will address issues of grief and mourning in children.

Inclusion criteria: Children and adolescents who have been exposed to actual trauma such as a sexual abuse, physical assaults, motor vehicular accidents or children who have experienced the sudden and unexpected death of a loved one.

Time and Location: The clinic meets Monday’s from 8:30-10:00am. A reading seminar will alternate weekly with case presentations. A bibliography will be provided. The residents and psychology interns and practicum students will present the readings for discussion. The meeting will take place in room 1513.

Assessment and Evaluative Procedures. The program will focus on the assessment and evaluation of children who have been the victims of actual trauma. The assessment of children who have been sexually victimized will focus on the determination of risk factors which are known to effect course and outcome such as parental and family support systems, degrees of sexual coercion, invasiveness, bodily and life threat, dose and duration of sexual victimization and the use of a weapon. Demographic, developmental and family history and information will be obtained. Standardized psychological instruments will be used to assess psychological distress, post-traumatic stress symptomatology, and adaptive and coping skills. A comprehensive evaluation of children necessarily requires multiple informants as to the child’s everyday functioning and will include parent and teacher’s report, and self report measures. Special instruments, which may be used, include the Child Behavior Check List (CBCL), The Teachers’ Rating Form (TRF), and the Trauma Symptom Checklist for Children (TSCC), the Pynoos Post-traumatic Stress Disorder Reaction Index (PTSDRI) and the Child Psychiatric Inventory (CPI). There will be pre and post treatment measures. The program will be evaluated on an ongoing basis. It is known that the most effective treatment program is those that are research informed.

Treatment Program. Children will be provided opportunities for either individual, family or group therapeutic approaches depending on the presenting symptoms, risk factors and family configuration. Emphasis will be placed on anxiety management techniques, cognitive-behavioral perspectives and information processing theory with its focus on explicating the meaning of the sexual trauma and subsequent adaptive and coping mechanism. Parents will be involved in a modular parent psychoeducational group.

The treatment of victims of sexual crimes will be incorporated into the larger mental health activities of the Division of Child and Adolescent Psychiatry with its focus on child and family mental health. Mental health services will be provided 24 hours a day for emergency evaluation and crisis intervention. Psychiatric, psychological and social work personnel will be involved.

Administration. The Trauma Clinic operates under the direction of Jon A. Shaw, Director of the Division of Child and Adolescent Psychiatry and Evelyn Benitez, Ph.D. Child Psychologist.

Developmental Disorders Clinic.

The Developmental Disorders Clinic will be held Tuesday, 8:00 a.m. to 12:00 noon. The focus of the clinic is the assessment, diagnosis, triage and treatment of children with developmental delays.

Goals:

1. To become familiar with the neuropsychiatric disorders and the autistic spectrum of developmental disorders

2. To become familiar with the importance of a multiple modality and multiple disciplinary
approaches to the diagnosis and treatment of these conditions.

Objectives:

1. Residents will demonstrate knowledge of the autistic spectrum of developmental disorders.

2. Residents will provide evaluation and treatment to children with developmental disorders as part of a multidisciplinary team.

Clinic Procedures

All children/parents seen in DDC will be administered the following research measures which will be discussed with the team to aid in diagnosis and understanding of the child and parent.

Parent Measures: Administered to the primary caregiver:

1. The Scales of Independent Behavior measures the child’s independent functioning in everyday situations, such as communication, motor skills, eating, dressing, time awareness, etc. A total score, the Broad Independence Score, is an average of the four cluster scores: Motor Skills, Social & Communication, Personal Living Skills, and Community Living Skills. The Problem Behavior Scales will also be administered to provide a focus for behavioral modification treatment, if necessary, for each child’s behaviors.

2. The Parenting Stress Inventory measures how much stress the parent currently feels regarding their child’s behaviors.

Child Measures: Administered during the second session with child:

1. IQ Assessment: The strategy for measuring IQ will employ a hierarchy of two tests, depending on the Child’s ability level. The Kaufman Brief Intelligence Test (K-BIT; Kaufman and Kaufman, 1990) is to be used preferentially when possible. The K-BIT is a brief, individually administered measure of verbal and nonverbal intelligence. While it is not intended to substitute for a comprehensive measure of intelligence, it is adequate for our screening purposes. The K-BIT IQ composite score was correlated .80 with the WISC-R full scale IQ. Children for whom the K-BIT is unfeasible will try the Mullen Scale of Early Development (Mullen, 1995). The Mullen consists of five brief scales that yield a good picture of early cognitive and motor development. It is appropriate for children with autistic disorder and developmental delays.

2. Developmental Screening is completed using a variety of tasks at relatively early developmental levels in order to better understand the child’s developmental level, as well as to assess imitation, ability to follow directions, and engagability. Tasks include putting pegs/shapes into form boards, constructing with blocks, naming colors/shapes/numbers/letters, labeling objects, and recalling pictures of objects.

3. The Childhood Autism Rating Scale is completed at the end of the evaluation. This measure utilizes direct observation of the child’s behaviors during the interview, parent report, informal testing, and record review to make judgments on 15 behaviors that are primary or secondary features of autism. Consideration of the peculiarity, frequency, intensity, and duration of the behavior is important.

4. The Aberrant Behavior Checklist (ABC; Aman et al., 1985; Marshburn & Aman, 1992). The ABC is a 58-item rating scale that was developed primarily to measure the effects of pharmacological intervention in people with mental retardation. Several psychometric studies have proven the reliability and validity of the ABC in children with autism. The ABC will be completed during each scheduled visit.

The Children’s Illness Clinic (CHIC)

Description: The Children’s Illness Clinic (CHIC) is a clinic dedicated to providing psychiatric and psychological services for children and families living with HIV/AIDS. It operates under the auspices of the Healing Place, a mental health clinic providing services to HIV infected individuals of all ages and their families.

Currently it is staffed by Lourdes Illa, M.D., and a psychology faculty, who also serves as the liaison between the referral sources and the CHIC Clinic. A second year child psychiatry resident, PGY III’s on their child rotation, and psychology post doctoral fellows are assigned to the clinic.

The focus of the clinic is the assessment, diagnosis, triage and treatment of children and adolescents who are infected with or are affected by a chronic medical illness.

Organization: CHIC is held on Tuesdays from 8:30 am. to 12:00. An initial evaluation is scheduled from 8:30 to 10am and medication appointments are scheduled from 10am to noon. Clinic patients are
followed for medication management either at CAP or at the appropriate outpatient medical clinic. Follow-up appointments are scheduled in coordination with medical appointments to the greatest extent possible.

**Liaison Procedures for Linkage with Referral Sources:**

1. In cases where there is a recommendation for psychotropic medication for HIV+ children, the assigned psychiatrist will discuss the recommendation with the child’s Pediatric Special Immunology attending prior to prescribing any medication to insure proper coordination of the treatment regimen.

**Goals:**

1. To become proficient in the psychiatric evaluation and treatment of children and adolescents who have been infected by HIV or whose illness has progressed to AIDS.
2. To become familiar with an “interactive stressor model” that recognizes the array of family and biopsychosocial stressors that impinge on the child with chronic medical illness.
3. To become familiar with the developmental and neuropsychiatric manifestations of HIV/AIDS in children and adolescents.

**Objectives:**

1. Residents will conduct psychiatric evaluations of children and adolescents living with HIV.
2. Residents will provide psychiatric treatment to children and families living with HIV, in coordination with the primary care team caring for the child.

**Psychopharmacology Clinics**

**Goals:**

1. Residents will demonstrate knowledge of the various psychopharmacologic agents used to treat psychiatric disorders of children and adolescents.
2. Residents will demonstrate knowledge of the side effect profiles, laboratory testing and the ongoing monitoring of various psychopharmacologic agents.

**Objectives:**

1. Residents will discuss treatment options with patients and families, under supervision of attending psychiatrist.
2. Residents will provide psychopharmacologic treatment of children with various psychiatric disorders, under the direct supervision of an attending psychiatrist.
3. Residents will review side effects with patients and families.

Second year residents and PGY-III’s, Eugenio Rothe, M.D. and Linda Messer, RN.

Referrals to medication clinic are initially done at the disposition conference. Patients referred to medication clinic include: a) patients taking medication but not requiring individual psychotherapy (some of these patients also attend group therapy); b) patients with a poor record of attendance to individual appointment, that usually show up only when medication runs out; and; c) patients not amenable to psychotherapy due to lack of interest, compliance or other limitations, who also not in need of supportive interventions but who need occasional medication prescription renewed. In addition residents may transfer cases into their own medication clinic. In order to do so, the resident must provide the name of the child to Hodalys Barrios and submit the chart for review prior to setting an appointment for medication clinic. Therapists may refer patients for evaluation of need for psychotropic medication.

**Structure.** Medication clinic appointments are kept in the HIS System. All problems can be consulted with Dr. Rothe. Cases are assigned to each individual resident by the attending. The resident reviews the chart and consults the case with the medication clinic attending. Disposition is accomplished by giving the patient a follow up appointment and logging the appointment in the HIS system. A copy of the appointment slip should be given to the patient, and the other copy to the clinic secretary. This is the responsibility of the resident. The Medication Clinic has been expanded to two afternoons and will have a strong psychopharmacology research component. All patients and their parents who agree to participate, will be administered research instruments by a research assistant and occasionally, by a resident or fellow. This will provide trainees with a research experience and an opportunity to derive their own senior research projects from these clinics.

**Early Child Development**

First year residents will rotate through early development classes at the Debbie School for Child
Enrichment for one half day per week for a ten week period. This rotation, which allows residents to observe typically developing children ages 0-5, is intended to serve as a companion activity for the Growth and Development Seminar.

ADDITIONAL CLINICAL SERVICES

Parenting Skills Groups

Parents of CAP Clinic patients should be encouraged to attend one of the parenting groups co-led by psychologists, social workers, and trainees. PGY-III’s and residents are welcome to co-lead groups and should contact Director of Child Psychology - TBA if interested. Groups will focus on how to increase positive interactions between parent and child, as well as how to decrease disruptive/annoying behaviors using behavior modification strategies. A parenting booklet will be given to each participant to reinforce techniques learned in the groups. Parents will also be encouraged to support each other and share information to promote group cohesiveness and generalization.

Parents of children in the DDC, ADHD Program or Trauma Clinic, will attend specific groups in those clinics. Other parents are invited to join either the Preschool Parenting Group (children age 1-6, English only), the CAP Parenting Group (children ages 7-12, English only) or the Spanish Speaking Parenting Group (all ages). All groups are on Thursdays at 11:00 a.m. These groups are for parents only; children do not attend. Parents must be able to make a commitment to attend group every week, be able to participate appropriately, and be willing to do some “homework”.

To refer a parent, give the parent an appointment for the next group, and put it in the appropriate group leader’s box in the CAP Clinic. Please refer to Appendix B.

Psychological Testing

Several types of testing are available for English and Spanish speaking children/adolescents in the CAP Clinic, including psychological, psycho-educational, and developmental assessments. The reason for testing should be discussed with the parent before the referral form is completed and the patient will then be put on the waiting list. See Appendix C for complete information and referral forms.
How patients are assigned and what all residents and interns should know about CAP Clinic.

Initial Evaluations:

Step 1. Parents/legal guardian call on the telephone to request psychiatric services. An intake form is filled out over the telephone by the assessment center staff. The phone number is (305) 324-4357.

Step 2. Intake forms are reviewed by Lourdes Illa, M.D., Eugenio Rothe, M.D., Director of Child Psychology - TBA, Leyla Gomez, L.C.S.W., and Linda Messer, R.N. during staffing meeting (Wednesday, 1 p.m.). Urgent cases are reviewed prn. Cases are assigned to one of several CAP clinic evaluation modalities.

Residents Evaluations:

Second year residents will be assigned a maximum of two evaluations per week. First year residents will be assigned a maximum of three evaluations per month throughout the year. In addition, first year residents will have a more in-depth outpatient experience while on the CAP/Early Child Development rotation.

The Resident will be expected to conduct the evaluation, interviewing parents and child, and obtaining information from outside sources, so as to arrive at a differential diagnosis, case formulation, and treatment plan. Second year residents will discuss all new cases with the clinic attending, Dr. Rothe.

Evaluation Teams:

Evaluation teams provide an opportunity to learn interviewing techniques, therapeutic interventions and all the skills that are required during the initial evaluation of children, adolescents and their families in a psychiatric setting.

Each evaluation team is supervised by an attending psychiatrist or psychologist faculty member who will supervise the interview process by the resident, or intern, discuss the case with the group, and decide treatment and disposition. Each supervisor will have a particular style or will provide a comprehensive discussion with the group. Evaluation team cases are selected by their level of complexity and teaching value.

Cases are assigned to the individual resident or intern, to ensure a broad clinical experience.

Therapy Patients

Residents will periodically be assigned patients for individual or family therapy by the Training Director, based on their current therapy caseload and to ensure a broad clinical experience.

Disposition Conference

All disposition conferences will be held on Thursdays at 1:00 P.M. Each Resident will be assigned a date every month.

All Charts assigned to a Resident are to be requested from medical records the day before and bought disposition.

The following should be presented in Disposition Conference:

1. All new evaluations done.
2. All cases that are transferred to another doctor, terminated, closed, transferred to another agency or transferred to another clinic modality, e.g. individual therapy to medical clinic etc.
3. All cases entering the clinic from other services (inpatient, crisis, C/L, etc.).

Why Disposition Conference? The clinic staff needs to know exactly who is treating each case and whether the case is active or not. Thus, the trainee uses disposition conferences to communicate any change in status of patients to the clinic staff.

How it works? Times are assigned by the attending on a monthly basis. Please bring all of your charts with you.

Write a note on the chart afterwards indicating disposition. For example: You saw an 11 years old boy for an initial evaluation, you diagnosed him as ADHD started treatment with psycho-stimulants. He has missed two of the last three appointments. You realize he will not use individual therapy well but the family calls on an emergency basis every time the medication runs out. You want to suggest a different treatment modality. Bring the case to disposition conference and present the case. Disposition: He is transferred to medication clinic (once a month).

PATIENT RECORDS
1. Medical Records:

Everyday Medical Records delivers all of the charts of the patients being seen early in the morning and picks them up by 4:00 p.m. on the same date.

PLEASE NOTE: that it takes three days to obtain the medical records once the appointment has been logged in the HIS system by the CAP staff.

The Child and Adolescent Psychiatry Division will maintain a clinical record of all patients receiving mental health outpatient care.

All charts are filed by medical record number. To assist the clinician in identifying what specialty clinic these charts belong to, the chart is tagged with a colored dot.

<table>
<thead>
<tr>
<th>CHART</th>
<th>DOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy</td>
<td>Blue</td>
</tr>
<tr>
<td>Trauma</td>
<td>Green</td>
</tr>
<tr>
<td>Medication Clinic</td>
<td>Yellow</td>
</tr>
<tr>
<td>Developmental Disorder</td>
<td>Red</td>
</tr>
</tbody>
</table>

All charts must be returned to the CAP office prior to the clinic closing each day. Under no circumstances is a chart to be kept overnight in therapist’s office or removed from the clinic except to be sent to Mental Health Medical Records office.

2. Chart Forms

Forms are kept in the file cabinet in the office. Please ask the office staff if you are unable to find something you need.

Chart Elements. All outpatient child evaluation and therapy charts will have the following elements:

A. Treatment Plan C-477 or C-429
B. Evaluation - Typed
C. Growth Chart
D. Progress Records C-255
E. Mediation Sheets C-442 (left side of chart)
F. Clinic Demographics
G. Medication Release and Treatment Forms
H. General Consent for Treatment C-613
I. Patient Rights Form
J. Authorization for Medications if receiving an injection
K. School Forms
L. Conners Forms

3. Care Plans

All patients must have a care plan initiated at time evaluation is done and goals must be reviewed every 60 days. Care Plan Reviews for medication charts must be documented on C-442 and for therapy chart on the C-255.

4. Progress Notes

All patient encounters are documented on the Progress Record (C-255) and must be keyplated.

1. Document in sequence and legibly.
2. Time and date each entry and sign all entries with your legal name, professional title, and I.D. number.
3. In the content of your note indicate the actual amount of time you saw the patient
4. If an error is made, draw a single line through it and write “error” and your initials. Do not scratch out, obliterate or white out errors.
5. Use black ink only, no felt tip pens and no blue ink.
6. All entries should reflect the goals that have been identified in the patients care plan.
7. All patients who are seen for therapy that receive medication, in addition to a progress note must have a C-442 completed as Meds must be logged in HIS system.

5. Medication Sheets C-442

1. All patients being started on medications must have an authorization for medication form initiated prior to ordering.
   Exception: Children in foster care must have a medical affidavit completed, notarized, and filed with the courts. A court order must be obtained and placed in the chart prior to initiating medications.
2. All patients seen for medication only must have a C-442 completed. (It is imperative that this form is filled out completely each time the patient is seen. No part of the form is to be left blank.)
3. If a patient is seen for therapy and medication a C-442 must also be completed. (It is imperative that this form is filled out completely each time the patient is seen. No part of the form is to be left blank.)
4. You must document on the C-442 that you
informed the patient and/or parent/legal guardian of mediation side effects every time you start or change a medication.

Therapy rooms are available for all to use. Sign up sheets are on the door. Please sign up for times you wish to see your therapy patients.

We ask that all who use the rooms be considerate and clean up after each session. Please remember to keep an eye on younger siblings when seeing an entire family in the office. Under no circumstances should children be left alone in any office.

PLEASE NOTE: Under no circumstances is a CAP outpatient record ever to be taken to mental health child inpatient unit. If a CAP outpatient is admitted to the mental health inpatient unit, the clinician in CAP may xerox a copy of the evaluation to put into the inpatient medical record.

6. Closed Charts

All charts to be closed must first be presented in Disposition Conference. A discharge summary must be completed on all charts after appropriate closing steps have been taken.

- Warning letter
- Closing letter
- If a patient has not been to the clinic for 6 months, the chart is to be closed by the clinician.
- The final diagnosis on the dictated discharge summary is NEVER to be abbreviated.

EVALUATIONS

A. Referrals from Assessment Center:

Once a patient’s intake referral has been staffed by the CAP team, patients are scheduled for an initial evaluation, and follow up evaluation.

1. All evaluations regardless of who does them (Residents, Internals, Social Worker) must follow the format outlined in this training manual, to ensure uniformity across disciplines. Please refer to Appendix D.

2. Prior to beginning an evaluation the clinician must obtain a Consent for treatment (C-613). It must be signed by the patient and/or parent/guardian. It is to be witnessed, dated and timed or it is incomplete.

3. Evaluation packet must be turned in, to have chart opened on day of initial evaluation

4. All evaluations must be reviewed and corrected by your supervisor.

5. First draft of the evaluation must be submitted to the supervisor no later than one week (7 days) following the completion of the evaluation.

6. Check over your evaluation to make sure all items are covered before submitting to your supervisor. Make sure all areas are addressed even through they are WNL (e.g. no hospitalization, N.K.D.A., etc.).

7. The evaluation will be written prior to being typed following the format of the CAP Clinic Evaluation Summary outline and discussed with the clinic director before inclusion in the patient’s record.

8. All CAP evaluations must be typed and final copies placed on JMH letterhead and signed by an Attending.

B. Patients referred from Mental Health Child and Adolescent Inpatient:

The Inpatient Social Worker is to call the CAP Clinic staff to get an appointment date and time, prior to the patient’s discharge. (Set time for the appointment is Tuesdays, 3:00 P.M.)
The inpatient Social worker is responsible for insuring that the CAP referral package is delivered to the CAP Clinic before the appointment. The CAP referral package must include copies of the following:

- Intake note by physician
- Psychosocial report (C217A and C217B)
- Admission note (C220)
- Nursing Admission Assessment (C530Y)
- Physical exam (C225H)
- Psychological testing (if completed)
- All lab results
- EKG (if requested)
- Discharge order from (C290B0)

On the date of the scheduled appointment the resident fellow or psychology intern is to document on a Progress note (C255). **THIS NOTE SHOULD BE TITLED “TRANSFER NOTE” AND SHOULD INCLUDE A BRIEF SUMMARY OF THE CONSULTATION AND FOLLOW-UP.** Any areas not covered in the CAP initial evaluation template must be included in this note. (Immunizations, nutrition, pain assessment, cultural and religious considerations, etc.).

C. **Patients seen in Psychiatric Emergency Services (PES) by a Child Fellow and referred to CAP:**

Fellow must give patient an appointment for evaluation and turn in an appointment slip with the patient’s name, medical record number, date and time.

D. **Patients seen by C&L service referred to CAP:**

The C&L Fellow or Psychology Intern must give the patient a clinic appointment and turn in an appointment slip to CAP with the patient’s name, medical record number, date and time of the appointment. A copy of the consult may be used in lieu of an evaluation. However, on the date of the scheduled appointment the resident fellow or psychology intern is to document on a Progress note (C255). This note should be titled “TRANSFER NOTE” and should include a brief summary of the consultation and follow-up, and any areas not covered in
CHAPTER 8

PGY III Program
CHILD AND ADOLESCENT PSYCHIATRY
PGY-III PROGRAM

GOALS:

1. To be comfortable and competent in carrying out evaluation of children and adolescents who present with parent/child relationship difficulties, behavior disorders, and other common psychiatric problems.

2. To be able to develop and carry out an appropriate treatment plan if necessary or desirable.

3. To be able to refer properly when appropriate.

4. To acquire the knowledge base necessary for achieving the competencies listed above.

OBJECTIVES:

1. Attend 80% of seminars and activities.

2. Demonstrate ability to interview a child and an adolescent and obtain information useful for evaluating his/her mental status.

3. Demonstrate ability to interview the parent(s) of a child and an adolescent and obtain a developmental and social history useful in evaluating his/her psychiatric status.

4. Demonstrate ability to integrate this information into a tenable biopsychosociocultural formulation, consider a reasonable differential diagnosis, and reach a working diagnosis in DSM-III-R terminology.

5. Demonstrate ability to develop a reasonable treatment plan.

6. Demonstrate ability to interpret these findings, opinions and recommendations to parents in a constructive (therapeutic) manner.

7. Demonstrate ability to terminate an evaluative and therapeutic process in a constructive manner.

8. Demonstrate ability to communicate effectively with teachers, pediatricians and community agencies, when appropriate, to enhance the understanding and treatment of the patient.

9. Demonstrate ability to consult and utilize social work and psychology staff constructively in a team approach to child and adolescent evaluations and treatment.

10. Demonstrate ability to perform a comprehensive evaluation of a child or adolescent by considering the total family picture, medical problems, and school related problems and taking the developmental stage of the child into account.

11. Demonstrate ability to record clinical findings, diagnostic opinions, treatment plans, progress notes, and discharge summaries systematically, accurately, legibly, and in a manner that can be easily understood by others.

12. Demonstrate basic knowledge in the following areas sufficient to achieve 75% correct responses in written multiple choice examination:

   a. The biological, psychological, social, ethnic, and family factors that significantly influence physical and psychological development infancy, childhood and adolescence.

   b. Techniques for psychiatric evaluation of children and adolescents.

   c. Therapeutic approaches to the emotional and mental disorders of children and adolescents.

   d. The historical development of child and adolescent psychiatry.

PGY III CASE ASSIGNMENTS

All PGY III’s will be assigned 2-4 psychotherapy cases by Eugenio Rothe, M.D. at the beginning of their rotation. They will also receive new cases through the evaluation teams.
SPECIAL SEMINARS

Child and Adolescent Psychopathology Seminar

_Eugenio Rothe, M.D, August - June, 28 sessions, 1 hour._

The seminar will focus on the psychiatric syndromes of children and adolescents as well as factors, such as divorce and child abuse, which may lead to psychiatric problems. Attention will also be paid to transcultural issues. A course reading list is provided. This course is given to the PGY III residents in the general program to prepare them for entry into the child psychiatry rotation.

Normal Child and Adolescent Development Seminar

_Eugenio Rothe, M.D, January - April, 12 sessions, 1 hour._

The seminar is mandatory for PGY II residents in the general psychiatry program. It prepares them for the Child Psychopathology seminar in the third year of general psychiatry and also for the Adult Psychiatry boards section covering normal human development.
CHAPTER 9

Medical Student Program
CHILD AND ADOLESCENT PSYCHIATRY
MEDICAL STUDENT PROGRAM

Third year medical students rotate through the Division of Child and Adolescent Psychiatry for a three-week period as part of their six-week clinical clerkship (16-20 students on the Psychiatric Service at a time). The rotation offers students exposure to both the Child and Adolescent Acute Inpatient Unit and the Child and Adolescent Psychiatry Outpatient Clinic. Elective experience is also available for fourth-year medical students each year.

GOALS:

1. To be familiar with normal growth and development
2. To be familiar with common psychiatric disorders of childhood and adolescence.
3. To be comfortable interviewing children, adolescents and families
4. To be familiar with the evaluation of children and adolescents who present with parent/child relationship difficulties, behavior disorders, and other common psychiatric problems.
5. To be able to develop reasonable and multidisciplinary treatment plans
6. To be able to refer properly when appropriate
7. To become familiar with community resources for children and adolescents

OBJECTIVES:

1. Attend 80% of seminars and activities.
2. Exhibits culturally sensitive, professional, ethically sound behavior and attitudes in all patient and professional interactions
3. Listens to, understands and communicates effectively with children, adolescents and families
4. Demonstrates the ability to interview a child/adolescent and family in a culturally sensitive manner
5. Demonstrates knowledge of the epidemiology and phenomenology of childhood psychiatric disorders and is familiar with the biological, psychological, social, ethnic, and family factors that significantly influence physical and psychological development infancy, childhood and adolescence
6. Demonstrates knowledge of the various psychopharmacological treatment options
7. Demonstrates knowledge of the various psychosocial interventions, including individual, family, group and behavioral approaches
8. Demonstrate ability to integrate information from a clinical interview and historical information, consider a reasonable differential diagnosis, reach a working diagnosis in DSM-IV terminology, and develop a reasonable treatment plan.
CHAPTER 10

Administrative Policy and Procedures
ON-CALL DUTIES AND RESPONSIBILITIES

The Child Residents are on night call in supportive Capacity for the general psychiatric resident who is asked to evaluate a child or adolescent. After the psychiatric resident on call completes his evaluation of the child he will contact the Child Resident through the on-call beeper to discuss the case and plan an appropriate disposition.

If the case demands it, the Child Resident is obligated to come to the hospital and personally evaluate the child. Then he is to discuss the case with the resident and other staff involved in the Child's care.

Therefore, the Child Fellow should always be available to come in during his on-call week (i.e., therefore no moonlighting).

Each first Child Resident will be on-call approximately every six to eight weeks for a period of seven days. Each Second year Child Resident will be on call approximately 2 to 3 times per year for a period of 7 days. A faculty member will be on call each week along with the Residents as well.

TERMS OF APPOINTMENT

The general (institutional) terms of your residency appointment in this training program are contained in the Letter of Agreement and Collective Bargaining Agreement which you signed on acceptance of your appointment. As you surely already know, this covers such conditions of employment as stipends and benefits, working conditions, general institutional rules and regulations, and the basis for handling disciplinary matters and grievance procedures. If you haven't done so already, you should make yourself familiar with this document. Additional rules and regulations are sometimes adopted by our training program to deal with issues that might be unique to our service. These will, of course, always be consistent with the agreement you have with the institution.

If you are assigned to another institution for part of your training, you would, of course, be expected to adhere to any special rules and regulations it might have. These should, however, be consistent with the terms of your basic agreement with JMH, and any differences or apparent conflicts should be brought to the attention of the Training Director for Child and Adolescent Psychiatry.

RECORDING YOUR CLINICAL EXPERIENCE

The Special Requirements for Psychiatry, as established by the Accreditation Council for Graduate Medical Education (ACGME), contains the following section: “There must be a record maintained of specific cases treated by residents, in a manner which does not identify patients, but which illustrates each resident’s clinical experience in the program. This record must demonstrate that each resident has met the educational requirements of the program with regard to variety of patients, diagnoses, and treatment modalities. This record should be reviewed periodically with the program director or a designee, and be made available to the surveyor of the program.”

The American Board of Psychiatry and Neurology (ABPN) expects that such a record be maintained accurately and in detail and may require that such information be submitted as part of the credentials accompanying an application for admission to examination for certification in psychiatry. If you are in your PGY-IV year, you will recall that the first fellowship year in child and adolescent psychiatry constitutes the fourth year of required training for certification in general psychiatry. As such, it is evaluated when you apply for admission to examination for your certification in general.

It is a good idea, though, for those of you who are at PGY-V level, whether in your first or second residency year, to maintain such a record in the event that you are ever asked to produce it.

Our program regards the maintenance of such a record as the personal responsibility of the individual Residents. You should immediately initiate such a record as a running "log" of your clinical experience. A suggested format is attached. For each activity recorded and each assignment completed, you should obtain the initial or signature, as appropriate, of the responsible faculty supervisor.

SELECTIVE PROCEDURE FOR CHIEF RESIDENT
The Residents will get together and nominate two or three candidates for the position of Chief Resident. Their names will be given by the outgoing Chief Resident to the training committee, who will in turn make the selection of Chief Resident. If the names submitted are not deemed acceptable for such position, the faculty reserves the right to select another person.

**Responsibilities of The Chief Resident**

**Guidelines for the Chief Resident.** The Chief Resident for Child and Adolescent Psychiatry will carry responsibility for the following: The Chief Resident will serve as the primary liaison between faculty and all those who are in training status in our clinical service—child and adolescent psychiatry residents, PGY-3 interns, junior and senior medical students:

1. Responsibility for maintaining the on-call schedules for faculty and trainees;
2. Responsibility for planning, implementing, and chairing the monthly Child and Adolescent Psychiatry Grand Rounds;
3. Assisting the Chief, Child and Adolescent Psychiatry Division and the Training Director in planning, organizing, and implementing the weekly Child and Adolescent Psychiatric Clinical Case Conferences;
4. Serving on the Child and Adolescent Psychiatry Training Committee;
5. Working appropriately with the representative(s) of each of the trainee groups;
6. Chairman, Playroom Committee;
7. Assisting the Chief of the Child and Adolescent Psychiatry Division in various other clinical/administrative matters as designated.

**SUBPOENAS**

From time to time a Resident may be served with a subpoena. The proper procedure to implement immediately is as follows:

1. Make two copies of the subpoena;
2. Take the original to the administrator of the Mental Health Services Hospital Center;
3. Place a copy in the clinic/hospital chart;
4. Take the other copy to the faculty member responsible for supervising your work with the patient to whom the subpoena refers and discuss the issues involved.
5. Do not talk to outside attorneys without prior consultation with supervisor and Risk management representatives.

**YOUR ROLE AS AN EXPERT WITNESS**

At some time during your training you may have opportunity (we hope you do have, but it depends on factors over which we have incomplete control) to act as an expert witness in the process of litigation. Whether or not you will need to participate actively in the litigation process (conferring with legal counsel, preparing a report, giving a deposition or testimony in court, etc.) will depend on the administrative and legal matters at issue.

Areas of our professional work in which this may occur include, but are not necessarily limited to, the following: Involuntary hospitalization of a child or adolescent; custody issues; physical and/or sexual abuse; competency and criminal responsibility issues.

**MEDICAL LICENSURE**

Preparing adequately for such an experience makes the difference between effective or ineffective performance in the role of expert witness. Under no circumstances should you agree to appear in such role without detailed discussion with the staff supervisor with whom you are carrying the case. The Executive Training Committee of the Psychiatric Service has established the following policy regarding Florida Licensure: "Residents will be required to take a state medical licensure examination no later than PGY-II and to have a copy of their license in our office no later than the end of PGY-III. Advancement to the PGY-IV or residency year will be contingent on completion of the above."

To be consistent with this policy, eligibility for appointment to a residency in child and adolescent psychiatry on or after 1 July 1990 will include the possession of a valid and current license to practice medicine and surgery in the State of Florida.

**CHECKOUT PROCEDURE FOR GRADUATING RESIDENTS**
Upon termination of the residency, the residents must checkout with the training office of the Division of Child and Adolescent Psychiatry and the Director of the CAP clinic. Keys must be returned to the Training Office of the General Psychiatry Department. Check out procedures that apply to house staff should be followed. The final signature for clearance will be given by the General Psychiatry Training Office and the Office of Physician Services. Residents without formal clearance, graduation certificates will not be issued.

Keys. A special "T" key is needed to go into the locked inpatient wards and other offices in the Mental Health Building at JMH. These can be obtained by the residents or residents from the office of training in the General Psychiatry Program. New faculty members joining the Division of Child and Adolescent Psychiatry can obtain their keys from Dr. Shaw’s office.

Parking. Residents and residents can get Parking Forms from Physician Services. These parking forms must be taken to the Parking Garage. The Parking Garage office is located on the south end of the Main Parking Garage, first floor.
The Child and Adolescent Psychiatry Residency Training Program’s policy and procedures for resident duty hours, in compliance with the Accreditation Council of Graduate Medical Education (ACGME), are as follows.

A. House Staff Officers must not be scheduled for more than 80 hours averaged over a four-week period.

B. House Staff Officers must have one full day in seven off free of duties, averaged over a four-week period.

C. House Staff Officers must not be assigned in-house call more often that every third night, averaged on a four-week period.

D. House Staff Officers must have a minimum rest period of 10 hours between duty periods.

E. Continuous time on call is limited to 24 hours. House Staff Officers may not assume responsibility for patients after 24 hours. Residents may remain on duty for up to 6 additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical care.

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

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

H. The frequency of at-home call is not subject to the ever-third night limitation. At-home call, however, must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

I. When House Staff take call from home and are called in to the hospital, the time spent in the hospital must be counted toward the weekly duty hour limit.

J. The program director and faculty will monitor the demands of at-home call in their programs, and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

K. Any hours a resident works for compensation at the sponsoring institution or any of the sponsor’s primary clinical sites must be considered part of the 80-hour weekly limit on duty hours. This refers to the practice of internal moonlighting.

L. The program director and faculty will monitor individual resident moonlighting hours each month to assure that moonlighting activities do not contribute to excess fatigue or detrimental educational performance. Permission to moonlight may be withdrawn if the activities adversely affect House Staff performance.

M. Residents found to be in violation of this policy will be subject to disciplinary action as detailed in the Collective Bargaining between the Public Health Trust and the Committee of Interns and Residents (CIR).
MEMORANDUM

TO: Each Resident and Fellow, Psychiatry Service
FROM: Richard M. Steinbook, M.D.
SUBJECT: Attached “Moonlighting” Request

It is the policy of the Psychiatric Service that any resident wishing to engage in moonlighting activities after normal duty hours must receive prior permission for such activities from the Director of Residency Training and the Chief of Service. Moonlighting activities are confined to basic on-call medical management and preclude working as a psychiatrist.

If you intend to moonlight, the attached form must be completed, approved and returned to Dr. Steinbook's office before you begin moonlighting. If you do not intend to moonlight, complete the form indicating that you will not be moonlighting.

Should you, at any time during the year, plan to moonlight or make any changes in your moonlighting activities, a new form must be completed and be approved prior to your engaging in any moonlighting activities.

Failure to comply with this policy will lead to formal disciplinary action.

Thank you for your cooperation in this matter.

RMS/bb
Attachment

cc: Carl Eisdorfer, Ph.D., M.D.
MEMORANDUM

TO: Richard M. Steinbook, M.D.
    Director, Psychiatric Residency Training

SUBJECT: Extracurricular-professional activity (moonlighting)

I propose to engage in the following professional activity outside the regularly scheduled psychiatric residency program. I understand that these moonlighting activities are confined to basic on-call medical management and preclude working as a psychiatrist. I request approval according to the following arrangement:

1. Institution or facility in which this activity will occur.
   Address:  Telephone:

2. Individual to whom I will be directly and legally responsible in this activity.

3. Nature of this activity:
   a. I consider this activity as medical management
      ( ) In a psychiatric facility
      ( ) in a non-psychiatric facility

4. Individual who will provide professional supervision for my work:

5. Exact hour and day I will engage in this activity.

6. Method by which I will be paid:

I understand that professional liability insurance provided by Jackson Memorial Hospital covers only those activities directly associated with the residency training program and in no way will apply to extracurricular activities such as outlined in this letter. I further understand that it is my personal responsibility to obtain individual professional liability insurance or institutional coverage when it is available through the institution at which I might perform extracurricular activities.
Extracurricular-professional activity (moonlighting)

Memorandum
To: Richard Steinbook, M.D.
Page two

I am aware that any extracurricular work I do must not conflict with any aspect of the formally-constituted psychiatric residency program and in no case will ever be considered a valid reason for absences from any of its scheduled activities or for failure to carry out the clinical duties that are part of it.

I am also aware that I must not engage in any psychiatric or other medical activity on a fee-for service basis or in any other way that requires my billing a patient or an agency for my services.

I am also aware that I must not use any academic title other than "Resident in Psychiatry" or "Fellow in Child Psychiatry" during my training period.

I recognize that this arrangement for extracurricular-professional activity, if approved, constitutes an agreement the violation of which could result in the loss of credit for part of my residency training or in separation from the training program.

________________________ I do not intend to engage in any moonlighting activity.

(Signature)

(Name--printed)

Date

Approved as outlined above:

________________________
Training Director

________________________
Chief of Service

CE
CHAPTER 11

Evaluations Activity
EVALUATION ACTIVITIES

General Description

Evaluation of everything we do is a regular part of our activities. Most evaluations are required by the Accreditation Council for Graduate Medical Education (ACGME). Your performance will be evaluated formally by each of your CAP Clinic supervisors twice yearly and by the Chief (and perhaps other supervisory staff) of each clinical rotation as you leave it. We have recently acquired a new online evaluation system, which can be accessed securely through the internet at www.new-innov.com. A copy of the resident evaluation is attached your information. Once an evaluation has been completed by the attending, a copy will be automatically forwarded to the resident for his/her review and acknowledgement. These evaluations will be discussed with you, not only as an assessment of your performance as such but as a basis for planning your on-going training experiences. Login information can be obtained from Sheena Richards.

You, in turn, will be asked to evaluate each of your supervisors, seminars, rotations and the overall program twice yearly. You will also be asked to evaluate each clinical service to which you are assigned as you complete your rotation.

Other aspects of our program are evaluated regularly as well by both faculty and trainees. Each CAP Clinical Case Conference and CAP Grand Rounds is evaluated as it occurs. Each seminar series and the Journal Club are evaluated twice yearly. It is important that you give us your most thoughtful input into this process.

The Special Requirements for Psychiatry, as published in the ACGME's Essentials of Accredited Residencies, contains the following section: “The Program must formally examine the cognitive knowledge of each resident at least annually in the PG-II through PG-IV years, and conduct an organized examination of clinical skills at least twice during the four years of training.”

To comply with this requirement, you will be given a written examination at the end of your CAP rotation. The questions will include material from the lecture series, from the resource materials you have been provided, and from your clinical experience. We will also attempt to assess how well you can utilize your knowledge and clinical experience in responding to questions that deal with issues we may not have specifically or formally covered in your training program.

In the event of less than satisfactory performance in any aspect of your didactic and clinical assignments, your training experience in the CAP Service may be considered as incomplete, and special arrangements may be required for its satisfactory completion.

Training Deficiencies

Occasionally, for one or more reasons, a Resident may be deficient in some aspect of his/her training. Deficiencies may be in the area of the knowledge base expected of a resident at a particular stage of training, or they may be errors of commission or omission in performance of clinical responsibilities. The faculty supervisor is expected to identify such deficiencies early and to discuss them with the Resident promptly, even though a formal overall evaluation is not yet due. The goal of such a discussion would be for both supervisor and resident to reach a clear understanding of the matter(s) at issue and to formulate a mutually acceptable plan, including a time frame, for remedying the deficiencies. Such an action would have no punitive implications whatsoever.

If deficiencies are not remedied according to the plan, however, the procedures adopted by the Psychiatric Service as a whole would be invoked, as abstracted below: If deficiencies are not remedied as planned, a next meeting will be scheduled with the Resident, the cognizant supervisor, the Training Director for Child and Adolescent Psychiatry, and the Chief Resident for Child and Adolescent Psychiatry for the purpose of determining the next step;

If the deficiencies are not remedied as expected in the plan adopted at the previous step, either the Training Director for CAP or the Resident may request a conference of all concerned with the Chief of the Child and Adolescent Psychiatric Service;

If the matter continues unresolved and the deficiency which has not been remedied is regarded as requiring more stringent administrative action, one of two courses may be taken, as follows:

1. The resident's training for the particular assignment in question may be regarded as incomplete and promotion to the next level of training (in the case of a first-year resident) or a certificate of satisfactory completion of residency requirements (in the case of a second-year resident) will be withheld until deficiencies have been remedied, or;

2. In the event that the resident is in the first half of the first residency year, the resident will be notified in writing that he/she will not be reappointed for the next residency level.

As a final step in this sequence, the resident has available the grievance process specified in the JMH House Staff contract (Graduate Medical Educational Agreement).
DUE PROCESS

Guidelines for Dealing with the Resident in Difficulty

1) The evaluation forms attached.

2) Each supervisor working with a resident must complete an evaluation every six months. It is proposed, however, that ongoing evaluation is an absolute necessary and should include both verbal comments to the resident on a daily, moment to moment basis, as well as should there be further difficulty, a written evaluation of specifics, objective data, and a copy of the evaluation form be submitted at any time during the interim period.

3) This written objective evaluation must have the signature of both the faculty supervisor and the resident so that it is formally documented that the resident has been apprized of his particular deficiencies or areas of excellence.

4) The following additional evaluation steps have been recommended for the resident in difficulty.

A. The supervisor and resident have a conference in which counseling occurs. This leads to the evaluation and documentation as noted above. It can include remedial recommendation and an appropriate time for correction.

B. If deficiencies continue, the faculty and resident have a second session which includes the Chief of the particular division that the resident is working on, and the Training Director.

C. The next level of review is the Training Committee is apprized by the Training Director of the difficulties experienced by the resident. The Training Committee consists of the Director, Division of Child and Adolescent Psychiatry; Training Director; all child psychiatry faculty; chief resident; chief, child psychology and chief social work service. The Training Committee recommendations for remedial action are provided by the committee to the Training Director.

D. The Training Director meets individually with the resident concerned and counsels the resident providing recommendations derived from the Training Committee. Follow up meetings with the Training director are provided with recommendations and/or probationary indications. These are required to be specifically documented with copies provided to the resident. A time is established for correcting the deficiencies.

E. If again this is not satisfactory in resolution, the resident is required to meet with the chief of Child and Adolescent Psychiatry, or his designee, in order to be provided with a formal documented letter per the guidelines for Grievance Procedures through the Public Health Trust.

F. A full Grievance Procedure is enacted which includes the Administrators for the Public Health Trust, and a Grievance Committee comprised of various residents and faculty selected by the Public Health Trust. This step-wise evaluation, remedial recommendations, probationary requirements, and grievance process fulfills the requirements of the resident contract, while at the same time prepares the resident for remedial actions in a step-wise and logical fashion. If extraordinary circumstances arise which will endanger the patients or the program the resident can be reassigned immediately at the prerogative of the Chief of Service.