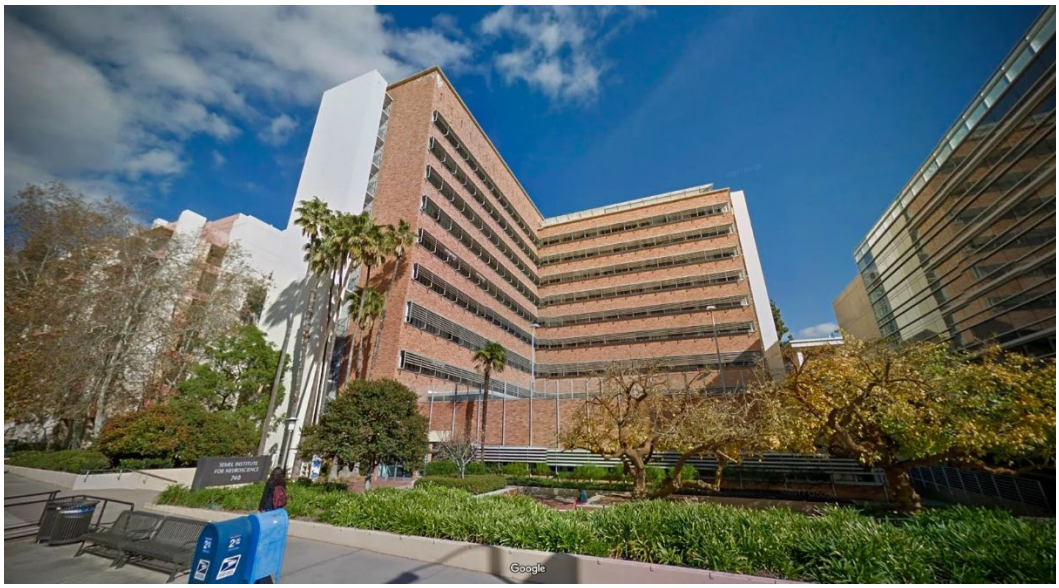
UCLA SEMEL INSTITUTE PSYCHOLOGY DOCTORAL INTERNSHIP TRAINING PROGRAM



Manual 2026-2027

Department of Psychiatry
& Biobehavioral Sciences
-
David Geffen School of Medicine
-
Department of Psychiatry and
Biobehavioral Sciences
-
Semel Institute for Neuroscience &
Human Behavior
and the Resnick Neuropsychiatric
Hospital
-
760 Westwood Plaza
and
300 Medical Plaza

Division of Psychology

Jane & Terry Semel Institute for Neuroscience & Human Behavior
University of California Los Angeles

760 Westwood Plaza, B7-357
Los Angeles, California 90095-1759
voice (310) 794-5715
fax (310) 825-6483
pwalshaw@mednet.ucla.edu

Dear Applicant:

Thank you for your interest in our internship program.

The Department of Psychiatry and Biobehavioral Sciences of the David Geffen School of Medicine, the Semel Institute for Neuroscience & Human Behavior and the Resnick Neuropsychiatric Hospital offer a 12-month clinical psychology internship accredited by the American Psychological Association*. The internship is characterized by a wide variety of clinical activities, supervision by multidisciplinary faculty who frequently are nationally known in their specialty, and a wide array of clinical offerings, seminars, and other educational experiences.

The Semel Institute for Neuroscience & Human Behavior is a facility designated for research and training. Within the Institute there are a wide variety of inpatient, day treatment and outpatient clinics and programs serving children, adolescents, and adults.

APPOINTMENTS: July 1, 2027, to June 30, 2028

STIPENDS: The training stipend is $52,200 plus benefits.

POSITIONS AVAILABLE: We expect to have 21 full-time positions:

Child Tracks:
Adolescent Serious Mental Illness: 1
Autism & Neurodevelopmental Disabilities: Assessment: 1
Autism & Neurodevelopmental Disabilities: Treatment: 1
Child and Adolescent Acute Care: 1
General Child: 3
Pediatric Consultation-Liaison : 1
Pediatric Neuropsychology: 3
Stress, Trauma and Resilience: 2
Training, Intervention, Education and Services (TIES) for Families: 1
Adult Tracks:
Adult Neuropsychology: 3
Geriatric Psychology-Neuropsychology: 1
Health & Behavior: 1
Major Mental Illness: 1
Lifespan Assessment Through Integrated Neuropsychology: 2

HOW TO APPLY: Applications will only be accepted through **AAPI Online**.

Information about the AAPI Online, along with instructions about how to access the service, can be found at www.appic.org, by clicking "AAPI ONLINE".

Applicants may apply for one or multiple tracks. Please be sure to select the program codes for the track/s you are applying to. Choices are not binding and may be changed at any time during the application process. One cover letter is sufficient for multiple tracks. We are requesting a minimum of 3 letters of recommendation. We are requesting two reports of comprehensive neuropsychological evaluations for application to the following tracks: Pediatric Neuropsychology, Adult Neuropsychology, Geriatric Psychology-Neuropsychology, and Lifespan Assessment Through Integrated Neuropsychology.

All materials for this site must be submitted by NOVEMBER 1, 2026

Any questions should be addressed to Psychology Training Coordinator, Jewelle Dela Cruz. Contact information is as follows: SemelCPTP@mednet.ucla.edu phone: 310-206-5110, fax: 310-825-6483. E-mail contact is preferred.

Our Open House and interviews will take place via Zoom.

INTERVIEWS: After an initial round of applicant review, a group of applicants will be selected and invited for virtual interviews/Open House. Applicants will be notified in early December if they are invited and will be able to request their preferred interview date. Please note that whatever tracks you are invited to interview for are the tracks you are being considered for.

LOCATION: UCLA is in a geographically desirable area--warm days, cool nights, just a few miles to the ocean, skiing two hours away in the winter, and an abundance of culturally stimulating activities.

ELIGIBILITY: Students enrolled in APA-approved or PCSAS-approved clinical psychology graduate programs within the United States which grant the doctorate upon completion of the internship are eligible to apply. The exception to this is neuropsychology applicants from programs not described as clinical psychology programs. These applicants should inquire about their eligibility. There is no minimum number of hours required to apply.

PROGRAM: The primary aim of the internship is to provide a year of intensive exposure to a wide variety of clinical experiences with diverse populations and to maximize the personal growth of each intern. Typically, clinical activities are accompanied by an associated seminar or teaching conference, frequently in a setting where research on that population is ongoing. Interns are encouraged to explore research opportunities with faculty members if they wish.

At the beginning of the year each intern is assigned an advisor who functions as both mentor and advocate. Together, the intern and advisor design a program that supplements and complements previous training and that considers future professional direction. The advisor and intern meet weekly throughout the year to assure the intern's professional development.

The program takes advantage of multiple theoretical orientations and a multidisciplinary faculty and relies on a wide variety of clinical services to assure breadth. The individually tailored programs are reviewed and approved by the Training Committee.

TRAINING FOCUS: There are fourteen tracks. Within each track there are many training opportunities. Nearly all electives are open to all interns.

Program codes for each of the tracks are listed below. You may rank as many tracks as you like. Multiple rankings do not reduce your chances of matching into your most preferred program, although it is advisable to only rank tracks in which you were invited for an interview. Please be sure to select the program codes for the track/s you are applying to.

General Child	113412
Geropsychology	113413
Health & Behavior	113414
Major Mental Illness	113415
Child and Adolescent Acute Care Track	113416
Autism & Neurodevelopmental Disabilities: Assessment	113425
Autism & Neurodevelopmental Disabilities: Treatment	113424

Pediatric Consultation-Liaison	113418
Adult Neuropsychology	113419
Adolescent Serious Mental Illness	113421
Pediatric Neuropsychology	113422
Stress, Trauma, and Resilience	113423
Lifespan Assessment Through Integrated Neuropsychology	113417
TIES for Families	113411

Your interest in our program is appreciated!
Best,
Patricia Walshaw, Ph.D.
UCLA Semel Institute
Director, Psychology Doctoral Internship Training Program

Emily Ricketts, Ph.D.
UCLA Semel Institute
Associate Director, Psychology Doctoral Internship Training Program

**Questions related to the program's accredited status should be directed to the Commission on Accreditation:*

Office of Program Consultation and Accreditation
American Psychological Association
750 1st Street, NE, Washington, DC 20002
Phone: (202) 336-5979
Email: apaaccred@apa.org

Table of Contents

History and Organization of UCLA's Semel Institute Psychology Internship Training Program 9
Structural Organizational Chart 11
Aims of Psychology Internship Training 12
Supervision 13
APPIC Taxonomy and Levels of Education 15
Designing Your Program 15
Track and Major Rotation Hours Per Week and Supervisors 18
Program Schedule 20
Evaluations of Interns, Supervisors, Advisors, Seminars, and the Training Program 21
Participation in Departmental Meetings and Committees 21
Child Tracks 22
General Child Track 22
Child and Adolescent Acute Care Track 22
Child and Adolescent Inpatient Service 23
UCLA Child Day Treatment Service – ABC Program 25
Pediatric Psychology Consultation-Liaison Service 29
Autism & Neurodevelopmental Disabilities-Assessment Track and Autism & Neurodevelopmental Disabilities-Treatment Track 33
Pediatric Neuropsychology Track 39
Adolescent Serious Mental Illness Track 41
Stress, Trauma and Resilience Track 45
UCLA TIES for Families 48
Adult Tracks 54
Adult Neuropsychology Track 54
Health and Behavior Track 56
Major Mental Illness Track 59
Geriatric Psychology – Neuropsychology Track 60
Lifespan Assessment Through Integrated Neuropsychology 63
Elective Services and Programs 65
Health Equity Elective 65
Child Elective Clinical Services and Programs 66
4W Child/Adolescent Inpatient Group Elective 66
Adolescent Medicine Outpatient Clinic Elective 67
Adolescent Serious Mental Illness Treatment Elective 68
Child and Adolescent Mood Disorders Program (CHAMP) 69
Child and Adolescent OCD Intensive Outpatient Program (IOP) 70

Child and Adult Neurodevelopmental Clinic (CAN): Multidisciplinary and High Complexity Evaluations and Treatments 72
Child OCD, Anxiety, and Tic Disorders Program 74
Family Development Program (FDP) *Available for the 26-27 training year* 76
UCLA EMPWR Program for LGBTQ Mental Health 78
Family Stress, Trauma and Resilience Clinic (STAR) *Available for the 26-27 training year* 79
Family Therapy Clinic 80
FOCUS for Spanish-speaking Families 81
UCLA Fit for Healthy Weight Clinic 82
MOMS Clinic: Maternal Outpatient Mental Health Services 83
Parent-Child Interaction Therapy (PCIT) 84
Parent Training Program 85
Peds Liver Transplant Clinic 86
PEERS ® Clinic: Evidence-Based, Parent-Assisted Social Skills Program 88
UCLA Tarjan Center 90
Tarjan Center Developmental Disabilities Travel Award 91
thinkSMART Program 92
Youth Stress & Youth Mood Program (YSAM): Evaluation and Treatment of Suicidal & Self-Harm Behavior and Depression 93
Youth Stress & Youth Mood (YSAM) Program: Research Rotation-Treatment and Prevention of Suicidal and Self-Harm Behavior 94
Adult and Geropsychology Elective Clinical Services and Programs 97
Adult OCD Intensive Treatment and Research Program 97
Aftercare Program 98
BrainSPORT Program 99
Insomnia Treatment Group: UCLA Student Mental Health Clinic – Adult Psychiatry (SHIP Clinic) 100
Neurobehavioral Epilepsy Program 103
PEERS ® Clinic: Caregiver Assisted Social Skills Program for Young Adults 104
Psychosis Clinic 105
Spanish Language Caregiver Support 106
Spanish Speaking Psychosocial Clinic (SSPC) Elective Rotation 106
Seminars 109
Psychology Interns' Seminar 109
Fundamentals of Child and Adolescent Psychiatry Seminar 109
Neuropsychology Seminars 109
Additional Elective Seminars 109
Ethical, Legal and Confidentiality Issues 109
Legal and Ethical Consultation 109

Patient Advisement by Psychology Interns 109
Release of Information 110
Abuse Reporting 110
Warning of Dangerous Patients 110
Policies, Procedures, and General Administrative Issues 111
Psychology Trainee Administration Office 111
Record Retention 111
Termination Procedures as outlined by the Graduate Medical Education Office (modified as applicable to psychology internship) 111
Due Process Policies and Procedures 114
Mistreatment and Non-Discrimination Policies 114
SOFI Reporting 116
UCLA Non-Discrimination Policy 117
Affirmative Action Policy 117
Patient Responsibilities 117
Intern Performance Evaluation, Feedback, Advisement, Retention and Minimal Requirements 117
Campus Safety and Transportation 118
Psychotherapy for Interns 118
Time Off Policy 119
Vacation 119
Sick Leave 119
Educational Leave 119
Internal Trainings 119
Tracking time off on MedHub 119
Jury Duty 119
Educational Support Awards for Clinical Psychology Trainees 119
Benefits 119
Professional Liability Insurance 120
UKG – Bi-Weekly Timesheet 120
Overtime 120
Email Policy 120
Technology 120
SPOK Mobile Policy 120
Telephones 121
Contact with Patients 121
Dictation Service 121
Interpretation/Translation Service 121

Medical Psychology Assessment Center (MPAC) 121
Medical References/Libraries 122
Faculty & Supervisor Roster 123
Sample Evaluation Forms 144
Evaluation of Interns by Supervisors 144
Evaluation of Teaching Activities: Supervisor 162
Evaluation of Teaching Activities: Lecture 164
Tri-Annual Evaluation Form 165
Major Rotation Evaluation 168
Clinic Elective Evaluation 171
Internship Alumni Questionnaire 172
Appendix 189

History and Organization of UCLA's Semel Institute Psychology Internship Training Program

The Division of Psychology within the Department of Psychiatry and Biobehavioral Sciences of the David Geffen School Medicine, the Jane and Terry Semel Institute for Neuroscience & Human Behavior and the Stewart and Lynda Resnick Neuropsychiatric Hospital offer a 12-month clinical psychology internship.

The internship was established in 1958 and has been continuously accredited by the American Psychological Association Accreditation Committee since May 1963[1]. Originally known as The UCLA Neuropsychiatric Institute, the Jane and Terry Semel Institute was created by a 1957 California statute and charged with providing a model for "treating patients with organic and functional disorders of the nervous system and to further the respective educational, training, and research programs of both the University and the Department of Mental Hygiene." The Institute was transferred from the Department of Mental Hygiene to the UC Regents on July 1, 1973. Faculty from many other UCLA departments and schools also participate in the Semel Institute and Resnick Neuropsychiatric Hospital activities.

Administratively, there are three overlapping organizations in which faculty and staff participate: The UCLA Semel Institute, with an academic research mission, the Department of Psychiatry and Biobehavioral Sciences of the David Geffen School of Medicine at UCLA, with an academic training mission, and the Resnick Neuropsychiatric Hospital and Clinics with a clinical mission.

The Interim Director of the Semel Institute and Chair of the Department is Helena Hansen, M.D., PhD, and the Medical Director of the Resnick Neuropsychiatric Hospital is Erick Cheung, M.D. April Thames, Ph.D. is

[1] Questions related to the program's accredited status should be directed to the Commission on Accreditation:
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Email: apaaccred@apa.org

the Chief of the Division of Psychology, which oversees the discipline of Psychology within the Institute, Department and Hospital. Patricia Walshaw, Ph.D. is the Director of Psychology Internship Training. Emily Ricketts, Ph.D. is the Associate Director of Psychology Internship Training.

There are three age-oriented clinical Divisions within the Institute, Department and Hospital: Suma Jacob, M.D. is the Director of the Child and Adolescent Psychiatry Division. Michael Gitlin, M.D., is Director of the Adult Psychology Division, and acting director of the Geriatric Psychiatry Division. Within each of the age-oriented divisions there is a Chief Psychologist. The Chief Psychologist for the Child Division is John Piacentini, Ph.D.; for the Adult Division the Chief Psychologist is April Thames, Ph.D.; and for the Geriatric Division the Interim Chief Psychologist is Kathy Tingus, Ph.D. There is also the Division of Population Behavioral Health, under which Blanca Orellana, PhD is the Chief Psychologist.

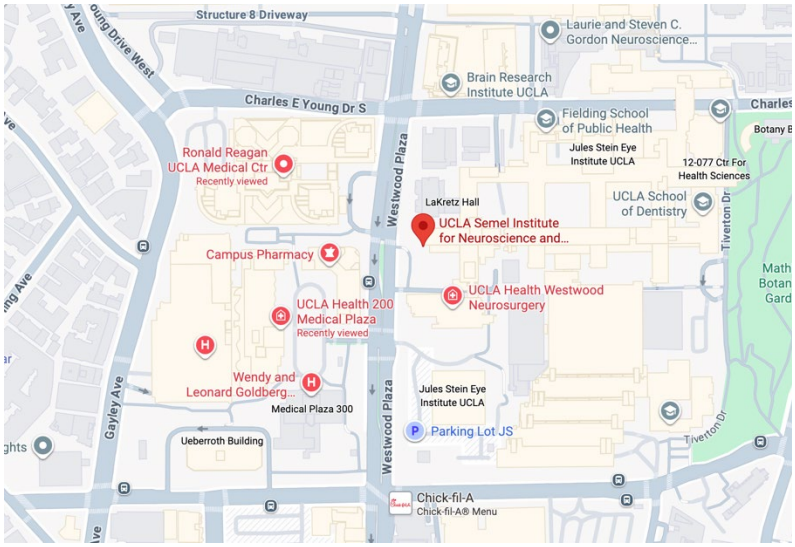
The Adult Division coordinates the adult psychiatry educational programs, including the Psychiatry Residency Program under the directorship of Jonathan Heldt, M.D. The Child Division has a Child Psychiatry Fellowship program, under the directorship of Misty Richards, M.D.

The Division of Psychology and its clinical psychology internship cut across all the divisional lines within the Institute, Department and Hospital. Each psychologist has two primary clinical and training identifications: (1) within the Division of Psychology, which is responsible for the oversight of the psychology training programs and the Medical Psychology Assessment Center (MPAC); and (2) within the specific Adult, Child, Geriatric, and Population Behavioral Health Division clinical services in which they have assignments.

Physical Location

The UCLA Semel Institute Psychology Internship has several physical locations where patients are seen.

- The Semel Institute is located at 760 Westwood Plaza, Los Angeles, CA 90095, on the south end of the main UCLA campus.
- Across Westwood Blvd is the primary medical hospital is Ronald Reagan UCLA Medical Center (RRUMC). This is where all medical inpatients are housed.
- Next door to RRUMC are the medical outpatient buildings (100, 200, and 300 Medical Plaza). There are a number of outpatient psychiatry clinics that are housed in the 300MP building (e.g. . Medical outpatient clinics are generally located in the 200MP building (e.g. Adolescent Medicine).



- Beginning in August 2026, UCLA will be moving the Resnick Neuropsychiatric Hospital and partial hospitalization programs to a new, state-of-the-art freestanding behavioral health hospital located at 5900 West Olympic Blvd, Los Angeles, CA 90036. Free transportation shuttles will be provided between the main UCLA Health campus in Westwood and this Mid-Wilshire location for all trainees, faculty, and staff. Programs at this location will be the psychiatric inpatient units (child/adolescent, adult, and geriatric) and partial hospitalization programs (ABC (child) and adult PHP). https://www.uclahealth.org/hospitals/mid-wilshire

Structural Organizational Chart

DIVISION OF PSYCHOLOGY (2026-2027)

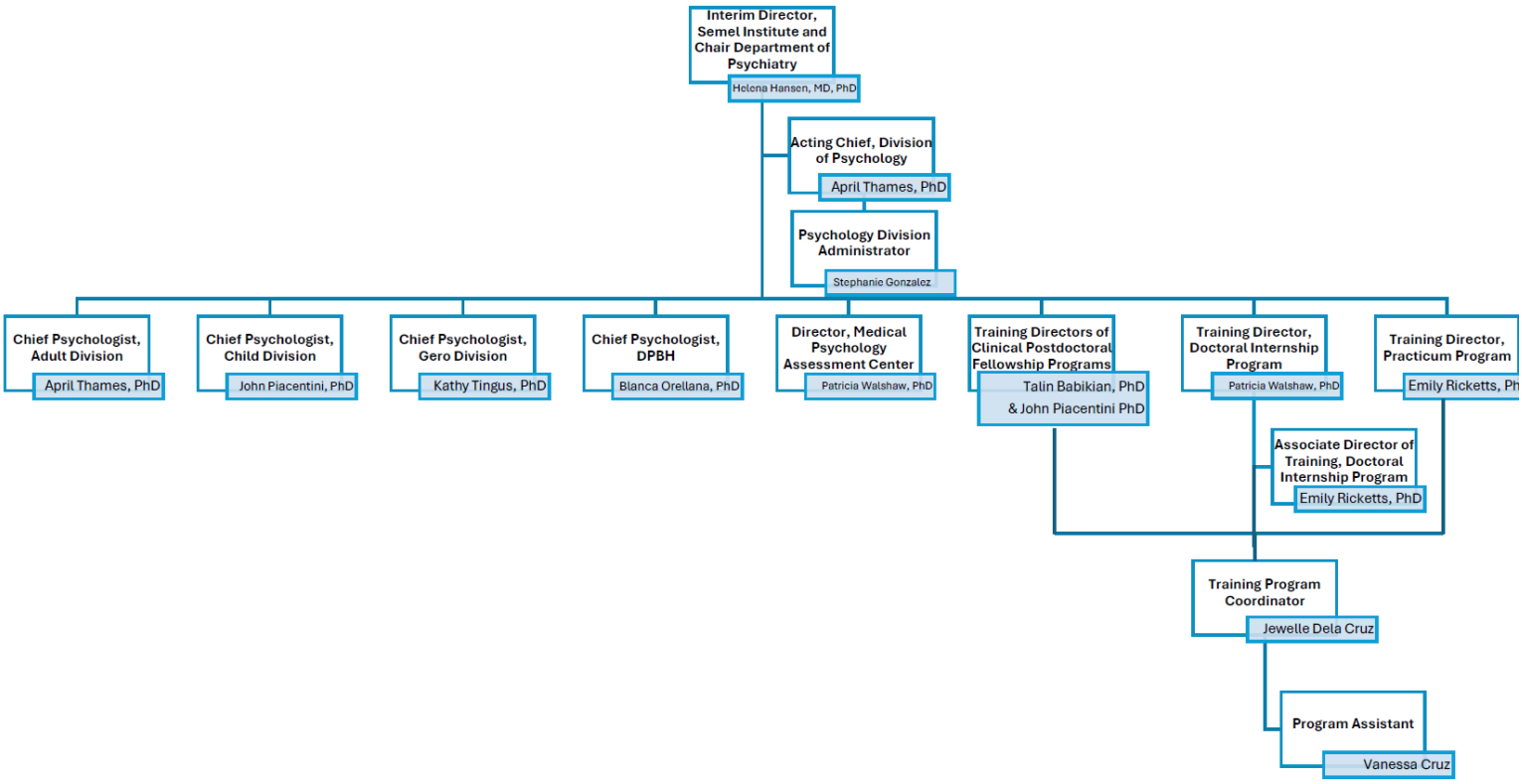
JANE & TERRY SEMEL INSTITUTE FOR NEUROSCIENCE AND HUMAN BEHAVIOR

STEWART & LYNDA RESNICK NEUROPSYCHIATRIC HOSPITAL

DEPARTMENT OF PSYCHIATRY & BIOBEHAVIORAL SCIENCES, DAVID GEFFEN SCHOOL OF MEDICINE

Highlights:

- 169 Psychologists (faculty & staff) in UCLA Health with
- 144 in Psychiatry, 25 in other departments
- 146 Trainees in Clinical Psychology programs


Interim Director, Semel Institute and Chair Department of Psychiatry
Helena Hansen, MD, PhD
Acting Chief, Division of Psychology
April Thames, PhD
Psychology Division Administrator
Stephanie Gonzalez
Chief Psychologist, Adult Division
April Thames, PhD
Chief Psychologist, Child Division
John Piacentini, PhD
Chief Psychologist, Gero Division
Kathy Tingus, PhD
Chief Psychologist, DPBH
Blanca Orellana, PhD
Director, Medical Psychology Assessment Center
Patricia Walshaw, PhD
Training Directors of Clinical Postdoctoral Fellowship Programs
Talin Babikian, PhD
& John Piacentini PhD
Training Director, Doctoral Internship Program
Patricia Walshaw, PhD
Training Director, Practicum Program
Emily Ricketts, Ph
Associate Director of Training, Doctoral Internship Program
Emily Ricketts, PhD
Training Program Coordinator
Jewelle Dela Cruz
Program Assistant
Vanessa Cruz

Aims of Psychology Internship Training

The internship provides a year of intensive experiential learning through exposure to a wide variety of clinical experiences. Interns gain clinical experience through direct delivery of assessment, therapy, and/or consultation services with patients. The training is designed to maximize the personal growth of each intern, and is primarily not directed at specialization, although interns are expected to develop proficiency in the focus of their track. Our aim is to ensure that clinical training provide appropriate breadth of training and build upon skills developed from clinical training activities completed during prior doctoral training. Interns are encouraged to pursue training opportunities outside of their core track domain.

Beyond the core training rotations within each track, elective rotation training activities are selected based on intern interests, with selections reviewed and revised in a collaborative process. In the beginning of the year and in November and March, interns review their proposed schedules with their advisor and the internship training committee.

As a training program, we aim for the principles of health equity and inclusion to guide us in our clinical care, teaching and research. As a faculty, we vow to work with cultural humility and to have self-reflection in our own professional behavior. We vow to better understand the role culture plays in the lives of those we serve so that we may better serve the healthcare needs of all Californians and patients who come to our health system. Faculty and current interns have come together with plans and initiatives to improve our curriculum and our clinical services to reflect our commitment to health equity and inclusion. There are many opportunities for you to join in these efforts during your internship year.

We adapted to the challenges faced by COVID by delivering outpatient clinical services via a combination of in-person and telehealth visits. Trainees work onsite to provide clinical service, although some clinics continue to offer telehealth services which improves access to care for many patients.

Since clinical experience is designated as the top priority, treatment, supervision, consultation, and assessment experiences are given priority in the assignment of the intern's time. Seminars are geared toward clinical service and founded in research. The integration of service and research is an important emphasis of the program and interns may elect to engage in UCLA clinical research as an additional educational experience if they choose.

Supervision

The strength of the internship program is the caliber and accessibility of our supervisors. Psychologists and psychiatrists provide supervision and clinical teaching. Many of our clinical faculty supervisors are researchers and are leaders in their respective areas of interest. All interns receive at least 4 hours of formal supervision per week, with at least 2 of those hours in individual supervision. A minimum of one hour of the total four hours per week of supervision is to be held in person. The remaining hours and any additional hours over four may be held via telesupervision or in person, depending on what format is deemed beneficial for the clinical aspects of the case and the trainee's needs. If telesupervision is not deemed appropriate, in-person supervision will be provided. The minimum one hour of in person supervision can be either individual or group format, depending on the logistics of the clinic and needs of the trainee. Telesupervision is provided via UCLA Health Zoom, a commonly used platform, in order to ensure HIPAA compliance. It must use both audio and visual formats. There must be a stable internet

connection for both intern and supervisor and telesupervision must be conducted on both ends in a quiet and secure location to avoid sharing of PHI.

Initial supervision encounters should be provided to the intern to establish rapport and a supervisory relationship with the supervisor. When telesupervision is provided and a supervisor is off-site, that supervisor maintains full responsibility for the case through direct knowledge of details of the case, direct observation via Zoom for a specified portion of the case, and regular updates from the intern. If a clinical emergency arises, the intern/off-site supervisor should contact an on-site licensed supervisor to provide immediate care to the patient and in-person supervision. There is always a licensed psychologist supervisor on-site when patient care is being provided.

Mentorship

Each intern has an advisor who functions as a guide and advocate within the system. Your advisor will help connect you to other faculty members who can also serve as guides and advocates. You may choose to have more than one advisor, and we encourage interns to seek mentorship from a number of different people. One hour of each week is devoted to this mentorship, either with your advisor or with another faculty member. This is an opportunity to discuss issues surrounding training and professional development. This meeting is separate from clinical supervision. While every effort is made to match advisors and trainees, if the relationship is not an optimal one, the trainee may speak with Drs. Patricia Walshaw and Emily Ricketts and request a reassignment.

The Department of Psychiatry and Biobehavioral Sciences has 150 full-time faculty. An additional 373 psychiatrists and psychologists are on the voluntary clinical faculty. There are 90 psychologists in the Medical Psychology-Neuropsychology Program. Of the 51 clinical psychologists most actively involved in the internship program, all are licensed, and many have diplomate status (i.e., are board certified by the American Board of Professional Psychology or ABPP).

APPIC Taxonomy and Levels of Education

1. Major Area of Study: > 50% **2.** Emphasis: 30-50% **3.** Experience: 20-30% **4.** Exposure: < 20%

ACTIVITY	Adult NP	Gero	H&B	MMI	Peds NP	Gen Ch	Ch/ Adol Acute Care	Peds C-L	AND: A/T	STAR	ASMI	Lifespan Assessment	TIES
Clinical Neuropsychology	1	1	3	3	1				4		4	1	
Clinical Health Psychology	4	2				3	3	1					
Clinical Psychology	4		1						3		2	4	
Clinical Child Psychology		4			3	1	1	1	1	1	2		1
Geropsychology	4	1										4	
Serious Mental Illness Psychology	4			1		2	2	2			1	4	

Designing Your Program

Orientation takes place in the first week of the program. During that week you will meet with your advisor to discuss which aspects of the Semel Institute and Resnick NPH experience will best meet your training needs. You will present your proposed program to the Training Committee for review.

In designing your program, review the training experiences that you have had, take note of the kinds of training experiences that you wish to have, and then discuss with your advisor the various ways in which you might meet those needs. To provide breadth as well as depth, we strongly encourage you to arrange for clinical experiences outside of your track area. There are a wide variety of elective activities available, including clinics and seminars. Nearly all electives are available to all interns. The exception is for neuropsychological assessment electives, which require some familiarity with the measures used. Electives vary in time commitment per week and in duration. The various clinics are described in this manual. The seminars available can be found in this manual.

The internship is 40 hours per week, inclusive of all mandatory clinical activities, supervision, electives, and mandatory didactics. Interns may choose to attend extra seminars as additional educational experience on their own time. Each intern spends approximately 31 hours per week in their major track rotation, 1 hour per week in the Interns' Seminar, and 1 hour per week in an advisement meeting. Each track has additional mandatory seminar(s). The number of hours you will have available for electives varies by track. Please refer to the track descriptions in this manual for detailed information.

You and your advisor will create your program schedule using the following forms:

- Mandatory Seminars and Grand Rounds by Track (page 16)
- Track and Major Rotation Hours Per Week and Supervisors (page 18)

- Program Schedule Form (page 20)

Mandatory Seminars and Grand Rounds by Track

July – October

ACTIVITY	Adult NP	Gero	H&B	MMI	Peds NP	Gen Ch	Ch/ Adol Acute Care	Peds C-L	AND A/T	STAR	ASMI	Lifespan Assessment	TIES
Interns' Seminar (1)	x	x	x	x	x	x	x	x	x	x	x	x	x
Wkly Mtg w/Advisor (1)	x	x	x	x	x	x	x	x	x	x	x	x	x
Fundamentals of Child and Adolescent Psychiatry (1.5)					X*	x	x	x	x				x
STAR Seminar (1)										x			
CL Psychiatry Seminar (1)			x										
Ch Psychiatry Grand Rounds (0.5) (Sept-Oct)						x	x	x	x	x	x		x

*Note: Peds NP attends Brain Cutting and Functional Neuroanatomy instead of Fundamentals of Child and Adolescent Psychiatry from Sept -Dec

November - February

ACTIVITY	Adult NP	Gero	H&B	MMI	Peds NP	Gen Ch	Ch/ Adol Acute Care	Peds C-L	AND A/T	STAR	ASMI	Lifespan Assessment	TIES
Interns' Seminar (1)	x	x	x	x	x	x	x	x	x	x	x	x	x
Wkly Mtg w/Advisor (1)	x	x	x	x	x	x	x	x	x	x	x	x	x
Fundamentals of Child and Adolescent Psychiatry(1.5)					X*	x	x	x	x				x
Ch Psychiatry Grand Rounds (0.5)						x	x	x	x	x	x		x
STAR Seminar (1)										x			

*Note: Peds NP attend Brain Cutting and Functional Neuroanatomy instead of Fundamentals of Child and Adolescent Psychiatry from Sept 23rd-Dec 13th

March – June

ACTIVITY	Adult NP	Gero	H&B	MMI	Peds NP	Gen Ch	Ch/ Adol Acute Care	Peds C-L	AND: A/T	STAR	ASMI	Lifespan Assessment	TIES
Interns' Seminar (1)	x	x	x	x	x	x	x	x	x	x	x	x	x
Wkly Mtg w/Advisor (1)	x	x	x	x	x	x	x	x	x	x	x	x	x
Fundamentals of Child and Adolescent Psychiatry (1.5)			x (2 mo.)		x	x	x	x	x				x
Ch Psych Grand Rounds (0.5)			x			x	x	x	x	x	x		x
STAR Seminar (1)										x			

Track and Major Rotation Hours Per Week and Supervisors

TRACK/MAJOR ROTATION	EST HRS/WK	SUPERVISOR/S
Geropsychology/NP		
Geropsychology Service	31	Tingus
Adult NP		
MPAC for Adult	30	Walshaw, Thames, Bookheimer, and others
Peds NP		
MPAC for Peds-NP	30	Loo, Dillon, Walshaw, and others
Lifespan Assessment Through Integrated Neuropsychology		
Lifespan Assessment Through Integrated Neuropsychology Clinic	30	Suarez, Safi, Cavanagh, Fernandez, Saucedo, Lechuga
Health & Behavior		
Adult C-L Service + MPAC (July-Feb)	28	Thames, Segal and others
Peds C-L + MPAC (March-June)	31	Emerson
Major Mental Illness		
MMI (MPAC + Aftercare)	28	Nuechterlein
General Child		
Child & Adolescent Inpt (4 months)	30	Tabuenca, Murray
ABC (4 months)	30	Peris
Peds-CL (4 months)	31	Emerson
Child and Adolescent Acute Care		
Child & Adolescent Inpt (July-Feb)	30	Tabuenca, Murray

Peds-CL (March-June)	31	Emerson
Peds C-L		
Peds C-L (July-Feb)	31	Emerson
Child & Adolescent Inpt (March-June)	30	Tabuenca, Murray
AND: Assessment/Treatment		
CAN Clinic	31	Renno, Gulsrud, Lord, McDonald, McCracken
PEERS Clinic	31	Laugeson, Veytsman, Moody, Estabillo, Bruce, Sanders
STAR		
Star Clinic	30	Orellana, Hajal, Marlotte
ASMI		
CAPPS Program	29	Bearden, Zinberg, Denenny, Adery

Program Schedule

Name:_____
Advisor:_____
Period: July – October / November – February / March - June

MAJOR ROTATION	EST HRS/WEEK	SUPERVISORS

OTHER MANDATORY ACTIVITIES	EST HRS/WEEK
Interns' Seminar	1
Weekly meeting with advisor	1
TOTAL HOURS:	

ELECTIVES	DAY/TIME	EST HRS/WEEK	SUPERVISOR

ESTIMATED HOURS PER WEEK	
MAJOR ROTATION	
OTHER MANDATORY ACTIVITIES	
ELECTIVES	
TOTAL (no more than 40 hours)	

Evaluations of Interns, Supervisors, Advisors, Seminars, and the Training Program

Interns are evaluated on the 9 areas of Professional Wide Competency (PWC) required by all APA approved Internship programs (please see form at the end of the manual). Evaluations of supervisors, interns and program activities are designed to provide early, timely feedback in case there are problems or issues.

Faculty supervisors submit written evaluations of interns in November, March, and late May via MedHub. The Internship Training Committee meets every four months, October, February and late May with advisors and supervisors to discuss all phases of the interns' progress and their progress on PWCs. These are the only Training Committee meetings in which interns are not able to participate. All other Training Committee meetings may have at least one trainee representative present. Following evaluation meetings, interns then meet with their advisors to discuss feedback on their progress in the internship program and specific PWCs. Interns can see their evaluations directly on MedHub once they complete a reciprocal evaluation for their supervisor.

Interns may submit anonymous written evaluations of clinics and programs in November, March, and June. Following graduation, alumni are sent a follow-up questionnaire to evaluate their experience of the internship and its impact on their career development.

The faculty appreciates feedback on what is positive about the program and what improvements might be beneficial to the program. Feedback may occur in several ways. Interns may decide to discuss issues with faculty directly, the Training Director may give general feedback at a Training Committee meeting, in individual meetings, or via e-mail. Training Committee meetings serve to assure smooth flowing of the program by detecting problem areas early, as well as to give feedback regarding what works well. In addition to these and written evaluations, interns meet twice a year at a retreat with Drs. Walshaw and Ricketts to discuss all aspects of the training program and provide feedback.

Copies of all evaluation forms can be found at the end of the manual.

Interns submit written evaluations of their supervisors in November, March, and June via MedHub (ucla.medhub.com) These evaluations help us improve our training program and are also considered important sources of information when faculty members are reviewed for promotion. A triannual evaluation of the program is also completed by interns via Qualtrics.

Participation in Departmental Meetings and Committees

Interns may participate in various departmental meetings. Psychology internship training committee meetings are held the third Friday of the month from 9-10 am. Child Psychiatry faculty meetings are the first Wednesday of the month from 9-10 am. Interns may attend these meetings as representatives on a rotating basis if they wish as an additional educational opportunity. Child Psychiatry Grand Rounds take place the second and fourth Wednesday of the month from 9-10am. *All general child, acute care, pediatric C/L track interns are required to present their research in these rounds during the year.* There are also a number of committees and activities which focus on health equity in which interns can participate.

Child Tracks

General Child Track

DESCRIPTION:

Interns in the General Child Track receive training in the ABC children's day treatment program, the Child and Adolescent Inpatient Service, the Adolescent Partial Hospitalization program and in Pediatric Psychology Consultation-Liaison service. This offers a breadth and depth of training in the assessment and treatment of children and adolescents with severe psychopathology and severe psychosocial stressors and children and adolescents with a wide variety of psychiatric, behavioral, emotional, and family problems that are complicating their medical care.

ROTATION SCHEDULE

ABC Program	Child and Adolescent Inpatient Service/ Adolescent Partial Hospitalization Program	Pediatric Psychology Consultation-Liaison
4 months	4 months	4 months

Child and Adolescent Acute Care Track

DESCRIPTION:

The intern in the Child and Adolescent Acute Care Track receives 8 months of training in the Child and Adolescent Inpatient Psychiatric Service, offering an intensive experience in severe psychopathology and severe psychosocial stressors in children and adolescents. The intern also receives training on the Pediatric Psychology Consultation-Liaison service working with children and adolescents with a wide variety of psychiatric, behavioral, emotional, and family problems that are complicating their medical care.

ROTATION SCHEDULE

Child and Adolescent Inpatient Service	Pediatric Psychology Consultation-Liaison
8 months	4 months

HOURS PER WEEK IN MAJOR ROTATION:

4W: 30
Pediatric Consultation-Liaison Service: 27

OTHER MANDATORY ACTIVITIES:

- Interns' Seminar, 1 hour per week (Fridays 12-1)
- Fundamentals of Child and Adolescent Psychiatry Seminar: 1.5 hours per week (Thursdays 8:00am-9:20am)

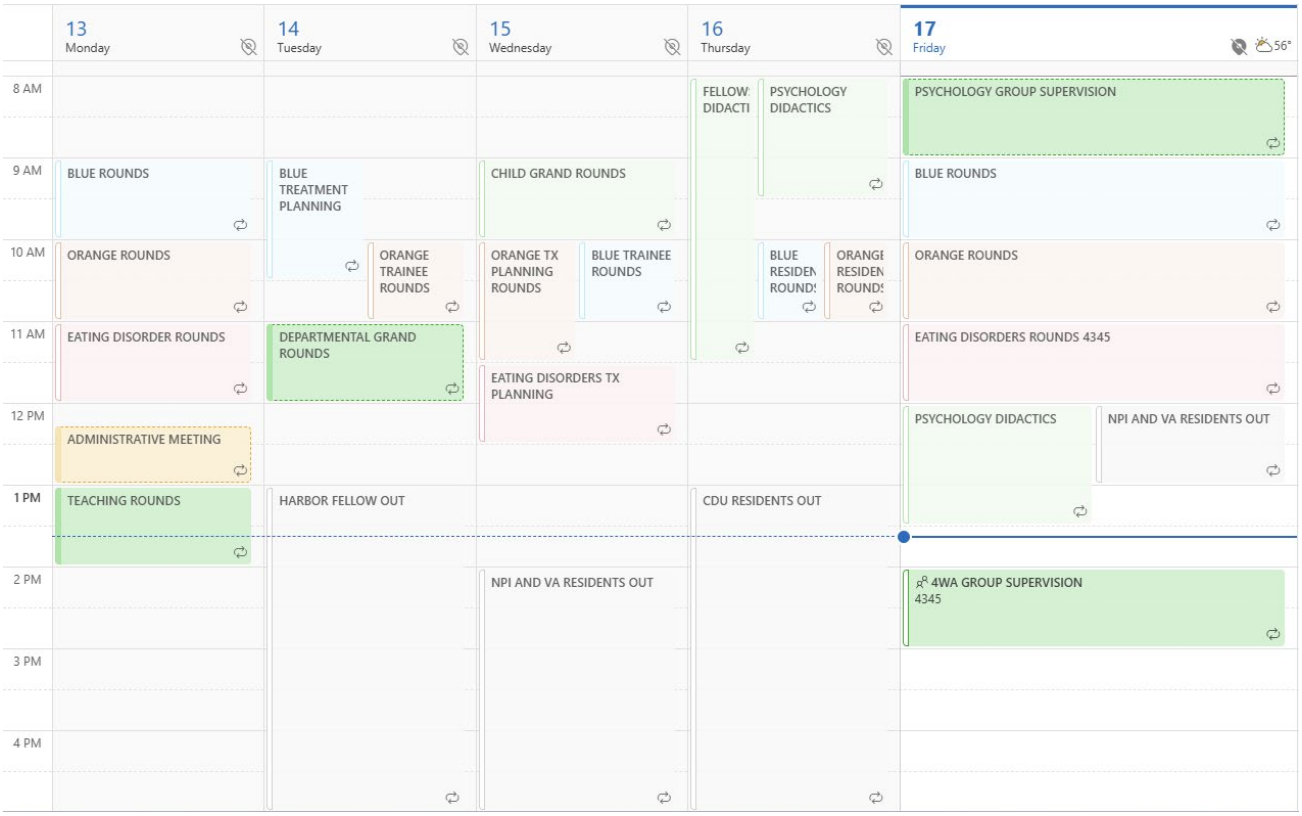
- Child Grand Rounds: 2nd and 4th Wednesday of the month, 0.5 hours per week (Wednesday 9-10am)
- Meeting with Advisor: 1 hour per week

APPROXIMATE NUMBER OF HOURS PER WEEK FOR ELECTIVES DURING ROTATIONS:
Child and Adolescent Inpatient: 6
Pediatric Consultation-Liaison Service: 5

Child and Adolescent Inpatient Service

Unit 4-West of the Resnick Neuropsychiatric Hospital in the Ronald Reagan Hospital is the Inpatient Service of the Child and Adolescent Psychiatry Division. This unit contains 25 beds for youth from 4 to 17 years of age. The unit operates on the multidisciplinary team model, including psychology interns, child psychiatry fellows, psychiatry residents, and medical students are key parts of the service. The staff on each unit includes individuals from: child psychiatry, psychology, social work, nursing, education, nutrition, occupational therapy, recreational therapy, behaviorists, psychometrists, and speech language pathology. Family participation in each patient's program is an important part of the evaluation/diagnostic process as well as treatment.

Treatment is multifaceted, featuring individual, group, and family therapy, pharmacotherapy, occupational & recreational therapy. Therapy is individualized to meet the special needs of each child and family. Patients may be enrolled in the RNPH Carlson School, a Los Angeles Unified special education school.



*Psychotherapy rounds not listed

FACULTY AND STAFF:

Benjamin Schneider, M.D., Interim Medical Director
Natalie Ramos, M.D., Medical Director of Eating Disorders Program, Attending Psychiatrist
Krista Tabuenca, Ph.D., Director of Inpatient Psychology, Attending Psychologist
Stuart Murray, Ph.D., Psy.D., Director of Eating Disorders Program, Attending Psychologist
Manal Khan, M.D., Attending Psychiatrist
Sabrina Reed, M.D., Attending Psychiatrist
Brandon Ito, M.D., Attending Psychiatrist
Michael Enenbach, M.D., Attending Psychiatrist
Robert Suddath, M.D, Attending Psychiatrist
Colleen Mccord, LCSW, Associate Chief of Social Work

TRAINING PROVIDED:

Interns have primary case management responsibilities for three patients at any given time during their 4- or 8-month rotation. The caseload of three includes patients in both the high acuity units and eating disorders unit.. Child Psychiatry fellows and psychiatry residents serve as medical backups for interns.

The training experience entails diagnostic interviewing, individual therapy family treatment, attendance at relevant clinical and teaching conferences, and coordination of all facets of hospital treatment. Interns learn to formulate differential diagnoses, gain familiarity with the developmental, familial, biological, and behavioral features of the major emotional disorders of childhood and adolescence gain experience in the modalities of short-term treatment, psychopharmacology, and understanding of multidisciplinary staff relations within a complex treatment system.

Krista Tabuenca, Ph.D. primarily supervises cases on the Orange and Blue Teams for Units B & C. Stuart Murray, Psy.D., Ph.D., primarily supervises cases on the eating disorders service, Unit A.

DIVERSITY TRAINING:

In the Child and Adolescent Inpatient Service, we work with children and adolescents who are diverse in terms of race, ethnicity, gender identity, socioeconomic status, sexual orientation, and religion. Considerations of diversity issues are central to our work with these children and families.

We believe it is imperative to do our best to understand the cultural practices of each individual patient and their family so that we may integrate this understanding into treatment in a meaningful way.

Guidance is provided in multidisciplinary team treatment planning, rounds and in supervision to frame discussions related to assessment results, diagnoses, and recommendations to children and their families.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation, Case Presentation
Format: Individual and Group
Hours Per Week: 4 (at least 1 hour individual)
Days and Times: Group supervision Fridays at 8-9am (Tabuenca), Fridays at 2-3pm (Murray) Individual Supervision arranged with Supervisors
Names of Supervisor(s): Krista Tabuenca, Ph.D., Stuart Murray, Ph.D., Psy.D.

UCLA Child Day Treatment Service – ABC Program

The **A**chievement, **B**ehavior, **C**ognition (ABC) Programs provide comprehensive mental health services for children between the ages of 6 and 12 years. ABC programs include the Partial Hospitalization Program (PHP), which meets daily from 7:30-2:30, and the Intensive Outpatient Program (IOP), which meets three afternoons a week from 3:00-5:00. Both services are time-limited, multimodal treatment programs dedicated to serving youngsters with the full spectrum of psychopathology using current evidence-based clinical practices. The programs offer state-of-the-art treatment for children with difficulties related to mood, anxiety, impulse control, attention and hyperactivity, fetal alcohol exposure, autism, and other neurodevelopmental challenges, including intellectual disability.

Children in the ABC PHP program receive a combination of individual and group therapies tailored to meet their individual needs. These include group cognitive behavior therapy, social skills training, mindfulness, and groups to promote healthy habits (wellness). They also participate in academic instruction, occupational and recreation therapy, psychological testing and educational consultation as needed. ABC PHP treatment involves a robust parent/family component and includes weekly parent training, family therapy, and parent mindfulness groups along with daily contact and coaching of parents around home practice assignments. Each child is assigned a case coordinator, a primary nurse, and social worker who work directly with the child and the family. The case coordinator may be either a child psychiatry fellow or clinical psychology intern. Parents and guardians have opportunities to observe the child interacting in the program, meet regularly with the case coordinator and the treatment team, and receive assistance with the child's transition back to the school and community.

HOURS PER WEEK:
30 hours per week (ABC + IOP)

MANDATORY MEETINGS:

Day	Time	Meeting
Monday	9:45-11	ABC Master Treatment Planning
	11-12	ABC Teaching Rounds
Tuesday	12:30-1:30	Didactics
	1:30-2:30	IOP Treatment Planning and Rounds
Wednesday	11-12	ABC Rounds
Thursday	3:30-5	Individual Therapy in IOP
Friday	11-12	Group Supervision

Interns are expected to meet with the parents of their patients each morning during the hours of 7:30 to 8:30 am to discuss the child's behavioral plan. These are brief check-ins that occur during drop-off, and they allow follow-up practice that has occurred at home and updates on any key events from the previous

evening. Interns are also encouraged to meet with the families when they pick up their children around 2:30 to 3:00 pm to review progress and set goals for the evening. Individual (daily) and family therapy (one hour per week) are conducted according to the intern's schedule.

FACULTY AND STAFF:

Tara Peris, Ph.D., Program Director
Ben Schneider, M.D., Medical Director

TRAINING PROVIDED:

The psychology intern will have the experience of assessing and treating children with a range of psychopathology. In keeping with the age group, the unit milieu is fundamentally behavioral in its interventions; opportunities for training in cognitive behavioral, mindfulness, and social skills interventions are also provided. Children are seen in individual psychotherapy using a variety of evidence-based treatment modalities (e.g., CBT, DBT). Interns will gain experience in administering child mental status examination to establish psychiatric diagnoses. Standardized psychological tests, rating scales, structural interviews and behavioral checklists are also used to aid diagnosis and to assess treatment outcomes. Finally, our complex patient population is such that many youth present to us with co-occurring medical conditions. Interns will be exposed to information on a range of genetic/neurological conditions and psychotropic drug treatment approaches as well.

The ABC intern will be assigned to the unit for a four-month period. It is estimated that the time required for this is 30 hours per week, which includes carrying cases in both the PHP and IOP programs. The intern will serve as case coordinator for up to three cases at any one time. The intern will conduct intakes and daily therapy with his or her patient and will collate assessment materials/write reports as needed. He or she will also lead discharge planning for each patient. The intern will participate in weekly family therapy in coordination with the unit social worker and will see patients for individual psychotherapy. Supervision is provided in group (with child psychiatry fellows) and individual formats on a weekly basis with the unit attendings and through treatment planning/clinical rounds. The intern will be exposed to approximately 6-8 children per rotation.

In addition, interns will participate in the ABC Intensive Outpatient Program (IOP). As part of the IOP, all patients receive individual and group therapy sessions conducted by the intern and the social work staff. This is an afternoon program (3-5 pm), three days a week for children and families needing a stepped down level of care. It provides CBT groups, social skills training, and parent-interventions, along with twice-weekly individual therapy. Thus, it offers an intermediate level of care for children who need more than a weekly outpatient therapy appointment but who do not require full day treatment services.

SCHEDULES:

ABC PHP schedule of group activities:

Time	Monday	Tuesday	Wednesday	Thursday	Friday
7:45 - 8:15	Community Mtg Topic: Roses and Thorns	Community Mtg Topic: Chaplain Visit	Community Mtg Topic: Mindfulness	Community Mtg Topic: Share Day	Community Mtg Topic: Fun Friday

8:15 - 9:00	CBT 1/ School	CBT 1/ School	CBT 1/ School	CBT 1/ School	CBT 1/ Relaxation Group
9:00 - 9:45	CBT 2/ School	CBT 2/ School	CBT 2/ School	CBT 2/ School	CBT 2/ School
9:45-10:00	Snack	Snack	Snack	Snack	Snack
10:00 - 11:00	School (LAUSD)	School (LAUSD)	School (LAUSD)	School (LAUSD)	School (LAUSD)
11:00 - 12:00	Occupational Therapy	Occupational Therapy	Occupational Therapy	Occupational Therapy	Occupational Therapy
*12:00 - 12:30	Lunch	Lunch	Lunch	Lunch	Lunch
12:30 - 1:15**	Social Skills	Mindfulness	Social Skills	Healthy Habits Group	Art Therapy
1:00 - 2:00	Recreational Therapy	Recreational Therapy	Recreational Therapy	Recreational Therapy	Recreational Therapy
2:00 - 2:30	Earned Free Time 2:30 Pick up	Earned Free Time 2:30 Pick up	Earned Free Time Exchange Store 2:30 Pick up	Earned Free Time 2:30 Pick up	Earned Free Time Exchange Store 2:30 Pick up

Child IOP Schedule

	Monday	**Tuesday**	**Thursday**
2:30-3:00	Community Meeting (with parents) Theme: Weekend Review and Weekly Goals	Community Meeting (with parents) Theme: Mindfulness	Community Meeting (with parents) Theme: Weekend Goals
3:00-3:15	Snack	Snack	Snack

3:15-4:00	CBT Group	Individual Therapy	Social Problem Solving/Individual pull out
4:00-4:15	Skills Practice Group	Skills Practice Group	Skills Practice Group
4:15-4:30	Skills Practice Review with Parents	Skills Practice Review with Parents	Skills Practice Review with Parents

Parent IOP Schedule

	Monday
2:30-3:00	Community Meeting (with children) Theme: Weekend Review and Weekly Goals
3:00-3:30	Parent Training Slot #1
3:45-4:15	Parent Training Slot #2
4:15-4:30	Skills Practice Review with Child
	Tuesday
2:30-3:00	Community Meeting (with children) Theme: Mindfulness
3:00-3:15	Check in with Case Coordinator
3:15- 4:15	Mindfulness Parenting Group
4:15-4:30	Skills Practice Review with Child
	Thursday
2:30-3:00	Community Meeting (with children) Theme: Weekend Goals

3:00-3:30	Parent Training Slot #3
3:45-4:15	Parent Training Slot #4
4:15-4:30	Skills Practice Review with Child

DIVERSITY TRAINING:
A commitment to culturally responsive care runs through all training activities at ABC. From recognizing the poor representation of communities of color in clinical research--and the corresponding limits of the evidence-base-- to systemic factors that shape health outcomes themselves, trainees are encouraged to formulate patient-centered, culturally informed case conceptualizations and treatment plans. Individual and group supervision provide a forum for further discussion about factors that affect the experience of care of in the health system including microaggressions, microinvalidations, and discrimination.

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation (as possible), Case Presentation
Format: Individual and Group
Hours Per Week: 2 (1 hour of individual, 1 hour of group supervision)
Days and Times: Fridays 11-12, Individual
Names of Supervisor(s): Tara Peris, Ph.D.; Ben Schneider, MD

Pediatric Psychology Consultation-Liaison Service

DESCRIPTION :
Interns see patients with a wide variety of psychiatric, behavioral, emotional, and family problems that are complicating their medical care. Trainees gain firsthand experience working with children and families struggling with serious, childhood illnesses and become integral members of the subspecialty teams. They learn how pediatric medical care is delivered and the role that mental health professionals can and should play in this system.

General Child and Health Behavior track psychology trainees are required to do a 4-month rotation on the Pediatric Psychology Consultation Liaison Service. The Pediatric Psychology Consultation-Liaison track intern spends 8 months on the rotation. The Pediatric Psychology Consultation-Liaison, General Child, and Health Behavior track interns also participate in the Adolescent Medicine Clinic on Friday afternoons while on this rotation. The Acute Care track intern can choose to participate in Adolescent Medicine clinic as an elective.

HOURS PER WEEK IN MAJOR ROTATION:
Pediatric Psychology Consultation-Liaison Service: 27 hours for Peds CL + 4 hours for Adolescent Medicine Clinic = 31 hours' total
Child and Adolescent Inpatient Service: 30

PEDIATRIC PSYCHOLOGY CONSULTATION-LIAISON TRACK ROTATION SCHEDULE		
	Pediatric Psychology Consultation-Liaison & Adolescent Medicine Clinic	Child and Adolescent Inpatient Service
Pediatric Psychology C-L Track Intern	July - February 8 months	March-June 4 months

MANDATORY ACTIVITIES:

- Child Grand Rounds: 2nd and 4th Wednesday of the month, 1 hour (Wednesday 9-10am), 0.5 hours per week
- Fundamentals of Child and Adolescent Psychiatry Seminar: 1.5 hours per week (Thursdays 8:00am-9:20am)
- Interdisciplinary rounds (shaded, as needed), attendance encouraged generally, necessary when one of your patients is discussed
- Interns' Seminar, 1 hour per week (Fridays 12-1)
- Meeting with Advisor: 1 hour per week

WEEKLY SCHEDULE:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
		9:00-10:00am Child Grand Rounds (2nd/4th Wed) ***9:00-10:00am*** *Comfort Care Rounds* *Comfort Corner*	**8:00-9:20am** Core Lectures	
	11-11:30am ICU/CT-ICU Multidisciplinary Psychosocial Rounds		**10:30-11:30am** Intern Supervision with Emerson (Zoom)	
	11:30-1:00pm Intern Supervision / Walking Rounds (RR 4265 / Walking)			**12-1:00pm** **Intern Seminar**
1:30-2:15pm	**1:30-2pm+**			

Multidisciplinary Psychosocial Oncology Rounds	Heart Transplant Rounds			
	3-3:30pm Hospitalist Psychosocial Rounds	**3:00-4:00pm** Case Discussion/ Lecture with Psychiatry (Cantwell Library Semel 48-233)		**2:00-5:00pm** Adolescent Med Clinic

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
		9:00-10:00am Child Grand Rounds (2^{nd}/4^{th} Wed) ***9:00-10:00am*** *Comfort Care Rounds* *Comfort Corner*	**8:00-9:20am** Core Lectures	
	11-11:30am ICU/CT-ICU Multidisciplinary Psychosocial Rounds		**10:30-11:30am** Intern Supervision with Emerson (Zoom)	
	11:30-1:00pm Intern Supervision / Walking Rounds (RR 4265 / Walking)			**12-1:00pm** **Intern Seminar**
1:30-2:15pm Multidisciplinary Psychosocial Oncology Rounds	**1:30-2pm+** Heart Transplant Rounds			
	3-3:30pm Hospitalist Psychosocial Rounds	**3:00-4:00pm** Case Discussion/ Lecture with Psychiatry (Cantwell Library Semel 48-233)		**2:00-5:00pm** Adolescent Med Clinic

TOTAL HOURS IN MAJOR ROTATION AND OTHER MANDATORY ACTIVITIES PER WEEK:

While on Pediatric Psychology Consultation-Liaison Service: 31 for Peds CL, Gen Child and Health & Behavior Interns, 27 hours for acute care intern (given no Ado Med clinic)

While on Child and Adolescent Inpatient Service: 30

APPROXIMATE NUMBER OF HOURS PER WEEK FOR ELECTIVES:

While on Pediatric Psychology Consultation-Liaison Service: 5

While on Child and Adolescent Inpatient Service: 6

DURATION:

8 months for Peds CL intern; 4 months for all other interns

FACULTY AND STAFF:
Natacha Emerson, Ph.D., Director
Krista Tabuenca, Ph.D., Associate Director

TRAINING PROVIDED:
Common reasons for consult requests are to evaluate and follow for acute stress disorder (medical trauma), unexplained somatic symptoms, altered mental status, agitation, non-adherence to medical recommendations, anxiety, behavioral problems, family contributions to adjustment in the child, and depression. All trainees are assigned children undergoing bone marrow, liver, or heart transplants. These patients generally require prolonged patient stays, and thus trainees get experience with ongoing treatment and patient/family management issues.

DIVERSITY TRAINING:
Interns evaluate and treat a diverse patient population within Mattel Children's Hospital. Approximately 50% of patients admitted to UCLA pediatric services have public insurance (MediCal, Medicaid or California Children's Services). Almost 50% of Medi-Cal managed care members primarily speak a Language other than English. Over 200 languages are spoken in California and, in Los Angeles County, between one-quarter and one-third of the population is Limited-English Proficient (speak English less than "very well"). Spanish-speaking Latinos make up one-third of California's population. In addition to serving the Southern California region, patients are admitted from distant locations within the Unites States and other countries. UCLA Health has relationships and healthcare initiatives with over 130 countries. Given the emphasis at Mattel Children's Hospital on providing patient-centered care, diversity sensitivity is essential.

Interns on the Pediatric Psychology Consultation Liaison service are asked to adopt an exploratory model's approach to understanding the unique experience of their patients and families. Additionally, interns are encouraged to ascertain patient information related to gender identity, sexual orientation, race, ethnicity, level of acculturation, language ability and preferences, educational background, financial burdens, spiritual beliefs, disabilities, family constellation, trauma and discrimination history, quality of the relationship and communication with the health care team, and potential barriers to health care (transportation, work or child care responsibilities, disability, etc.). They are provided instructions on how to access and work with an interpreter; a list of available spiritual care resources; access to a curated website that includes resources related to the provision of culturally sensitive psychological care, and a lecture on the impact of provider–patient interactions on health disparities. Discussions in team case conference, presentations, and supervision include review of diversity and cultural factors that may impact a patient's clinical presentation, level of trust of and congruence with health care team members, and the development of sensitive treatment plans.

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation by psychology attending during walking rounds and interdisciplinary psychosocial rounds in Pediatrics. Case Presentation on all cases.
Format: Individual and Group
Hours Per Week: Minimum 3.5 hours a week (2.5 group supervision, 1 hour individual weekly)
Days and Times: Monday through Friday; 8am - 5pm
Names of Supervisor(s): Natacha Emerson, Ph.D. and Krista Tabuenca., Ph.D.

Autism & Neurodevelopmental Disabilities-Assessment Track and Autism & Neurodevelopmental Disabilities-Treatment Track

DESCRIPTION:

There are two separate Autism and Neurodevelopmental Disabilities (AND) tracks - The AND Assessment Track and the AND Treatment Track. Both tracks are designed to train psychologists to enter careers in the field of developmental disabilities. Autism and neurodevelopmental disabilities are the focus of most of the internship activities with the goal of further developing expertise in this area.

Offering both depth and breadth, interns in each AND track will receive training in both assessment and treatment for those with neurodevelopmental conditions and complex comorbidities from preschool through adulthood. Additionally, both AND interns will attend mandatory lectures and seminars. Up to 6 hours per week will be dedicated to elective rotations according to interest and choosing.

The AND Assessment Track intern will participate in assessment activities through the UCLA Child and Adult Neurodevelopmental (CAN) Clinic for 20 hours per week and treatment activities through the UCLA PEERS Clinic for 8 hours per week throughout the year (28 hours per week in total).

The AND Treatment Track intern will participate in treatment activities through the UCLA PEERS Clinic and/or UCLA CAN Clinic for 20 hours per week and assessment activities through the UCLA CAN Clinic for 8 hours per week (28 hours per week in total).

HOURS PER WEEK IN MAJOR ROTATION: 28 hours per week

OTHER MANDATORY ACTIVITIES: 6 hours per week

- Interns' Seminar: 1 hour per week (Fridays 12-1)
- Meeting with Advisor: 1 hour per week
- Child and Adolescent Inpatient Service: 2 hours per week
- Child Grand Rounds: 2nd and 4th Wednesday of the month: .5 hours per week (Wednesday 9-10am)
- Fundamentals of Child and Adolescent Psychiatry Seminar: 1.5 hours per week (Thursdays 8:00am-9:20am)

APPROXIMATE NUMBER OF HOURS PER WEEK FOR ELECTIVES: 6 hours per week maximum

FACULTY AND STAFF:

Patricia Renno, Ph.D., Program Director

Elizabeth Laugeson, Psy.D.

Amanda Gulsrud, Ph.D.

Catherine Lord, Ph.D.

Nicole McDonald, Ph.D.

Sara McCracken, Psy.D., B.C.B.A.

Christine Moody, Ph.D.

Elina Veytsman, Ph.D.

Jasper Estabillo, Ph.D.

Sara Bruce, Ph.D.

Blake Warner, Ph.D.

Monica Sanders, Psy.D.

TRAINING PROVIDED:

ASSESSMENT:

AND interns will be required to participate in the UCLA CAN Clinic for approximately 20 hours per week (AND assessment track) or 8 hours per week (AND treatment track) for a full year. The CAN Clinic serves individuals with autism spectrum disorder (ASD), related neurodevelopmental disorders (ND, e.g., intellectual disabilities, fetal alcohol spectrum disorder), neurological conditions, and genetic conditions. The focus of training is twofold: (1) to develop depth in the specialty area of ASD and ND; and (2) to expand training in related psychiatric comorbidities, genetic conditions, and neurodevelopmental disorders to inform the assessment and treatment across the lifespan of this highly complex population.

Interns will conduct both brief consultations and comprehensive diagnostic assessments. Cases are often of high complexity and include co-occurring psychiatric and medical issues, requiring a special focus in differential diagnostic practices. Advanced training in comprehensive assessments will be a core aspect of training and will include autism-specific diagnostic "gold standard" measures [e.g., Autism Diagnostic Observation Schedule-2 (ADOS-2), Autism Diagnostic Interview-Revised (ADI-R)], structured psychiatric interviews (e.g., ADIS, SCID, Vineland-3), and measures of cognitive (e.g., WAIS-V, WISC-V), academic (e.g., WIAT-IV), and neuropsychological functioning (e.g., DKEFS, WMS). To foster advanced competency in the administration, scoring, and interpretation of the ADOS-2 and ADI-R, AND interns will participate in weekly site reliability coding meetings and will be trained and supervised by one of the world's leading autism researchers, Dr. Catherine Lord, developer of the ADOS-2 and ADI-R. AND interns will also learn to conduct functional behavior assessments in addition to traditional standardized measures.

In addition to comprehensive diagnostic evaluations, AND interns will also be involved in comprehensive treatment evaluations. Treatment evaluations may include empirically informed treatment strategies with the patient and family. Interns will also participate in brief treatment consultations to provide families with focused recommendations for augmenting existing treatment and educational programs. Interns will present their diagnostic conclusions and treatment recommendations in weekly multidisciplinary case conferences. Interns will also have the opportunity to work closely with the multidisciplinary team and psychiatry and neurology trainees to provide integrated care.

TREATMENT:

AND interns will be required to participate in treatment activities for 20 hours per week (AND treatment track) or 8 hours per week (AND assessment track) for a full year. Treatment hours for the AND treatment

track intern may be split between the UCLA CAN Clinic and UCLA PEERS Clinic. Treatment hours for the AND assessment track intern must include a minimum of 8 hours per week in the UCLA PEERS Clinic.

Within the CAN Clinic, AND interns will be provided with opportunities for individual and group-based therapies. Treatments include JASPER (Joint Attention, Symbolic Play, Engagement, and Regulation; developed at UCLA), which combines developmental and behavioral principles to treat young children at-risk for ASD; Parent-Child Interaction Therapy (PCIT) adapted for autistic children and their families; and enhanced Cognitive Behavioral Therapy (CBT), which combines effective behavioral strategies with traditional CBT to suit the unique needs of people with ASD. In addition to individual therapy, AND interns may participate in group-based interventions to treat co-occurring anxiety and depression in adolescents with ASD, behaviorally focused interventions to enhance independent living skills in young adults with ASD, and parent-focused groups to support challenging behaviors (i.e., RUBI Parent Training Program). Treatment-focused responsibilities will consist of individual treatment sessions (50 minutes) and/or group-based intervention (60 minutes) each week.

Within the UCLA PEERS Clinic, training will be provided in one of the only evidence-based neuro-affirming group social skills programs for youth with social challenges. Originally developed at UCLA, this internationally recognized program is used in over 150 countries and has been translated into over a dozen languages through numerous cross-cultural validation trials. AND interns will have the opportunity to be trained and supervised by Dr. Elizabeth Laugeson, the PEERS program developer. Groups are provided for autistic youth but are also open to children and adults with social skills challenges who do not have neurodevelopmental disabilities, including those with ADHD, depression, and anxiety. Thus, trainees will have a rich training experience with exposure to individuals with a variety of mental health conditions across the lifespan.

Groups provide instruction on culturally relevant elements of socialization including making and keeping friends (PEERS for Preschoolers, PEERS for Adolescents, PEERS Educational Groups, and PEERS for Young Adults), the development and maintenance of romantic relationships (PEERS for Young Adults and PEERS for Dating) and finding and maintaining employment (PEERS for Careers). Separate social coaching groups for caregivers are conducted concurrently for 90-minutes each week for 16-20 weeks. Sessions are structured to include homework review, didactic presentation, role-play demonstrations, and behavioral rehearsal exercises. Social coaches, which may include parents, caregivers, or peer mentors, are taught how to assist youth in developing appropriate social skills in a culturally sensitive context by providing individualized performance feedback during weekly in vivo socialization homework assignments. Telehealth options and in-person delivery are available across all groups.

DIDACTIC TRAINING:

Interns in the AND assessment and treatment tracks will expand their working knowledge of ASD, ND, and related genetic conditions with particular emphasis on research advancements in these areas. Interns will be provided with and participate in weekly didactic presentations in the CAN Clinic. Faculty attendings and guest speakers will present on a variety of topics, some of which include comorbid medical and psychiatric issues, genetic conditions, neurological conditions, best practice parameters for assessment and treatments, etiology of ASD, community-based resources, and strategies for considering the role of neurodiversity and cultural sensitivity in the practice of assessment and treatment. AND interns will have the opportunity to attend three-day certified training seminars to become PEERS Certified Providers. AND interns are also required to attend lectures and seminars as part of the internship training. In particular, interns will attend Child Grand Rounds, Fundamentals of Child and Adolescent Psychiatry Seminar, Intern's Seminar, and have the option of attending lectures focused on neurodevelopmental disorders,

such as the Center for Autism Research and Treatment (CART) Autism Affinity Lectures, and the Tarjan Center UCEDD (University Center for Excellence in Developmental Disabilities) Distinguished Lecture Series.

TRAINING AND SUPERVISION:

Weekly individual and group supervision, as well as certified training, are provided. Within the CAN Clinic, AND interns will receive advanced training in comprehensive assessments by licensed clinical psychologists, with the opportunity to be trained by the developer of the ADOS and the ADI-R, Dr. Catherine Lord. AND interns will also receive training and supervision in JASPER by program developers, Dr. Connie Kasari and Dr. Amanda Gulsrud. Specific guidance is provided in how to sensitively communicate assessment results, diagnoses, and recommendations to families from diverse backgrounds. In addition, discussions during multidisciplinary team case conference presentations and supervision routinely take into account issues of diversity and cultural considerations in treatment delivery.

Within the PEERS Clinic, AND interns work alongside and receive ongoing individual and group supervision from supervising faculty who are licensed clinical psychologists. During individual supervision, trainees are encouraged to consider cultural, developmental, and familial factors that may be contributing to the client's presentation, as well as the impact of the trainee's own multicultural identity in their response to families. Additionally, AND interns will receive comprehensive PEERS training and supervision by the program developer, Dr. Elizabeth Laugeson, and will be offered advanced training through participation in certified training seminars conducted at the UCLA Semel Institute for Neuroscience and Human Behavior. Certification may be obtained for the following programs: PEERS for Adolescents (Parent-Assisted Program), PEERS for Adolescents (School-Based Program), PEERS for Preschoolers (Parent-Assisted Program), and PEERS for Young Adults (Caregiver-Assisted Program).

CHILD AND ADOLESCENT INPATIENT SERVICE:

Both AND Interns will expand their breadth of training by participating in 2-hours of weekly activities on the Child and Adolescent Inpatient Unit. Interns will gain experience to a range of psychiatric concerns in a high acuity environment, as well as, use their experience in neurodevelopmental disorders to contribute to treatment planning and patient care on the unit. Interns may participate in a variety of activities on the unit depending on their interest and availability. Activities may include: running weekly groups, working alongside the unit's BCBA, leading didactics on neurodevelopmental conditions and/or behavior management strategies, attending group supervision, and administering developmental history interviews.

ELECTIVE CLINICS:

In addition to the mandatory rotations, lectures, and seminars, AND interns are encouraged to participate in other clinics as electives. With electives, interns can gain broader experience with other populations. A full list of electives is provided in this manual. These electives must not conflict with mandatory activities. A specific program plan will be developed by the intern in collaboration with their advisor and presented to the training committee to ensure a breadth of experience as well as specialized training in autism and other neurodevelopmental disabilities. Total time commitment for electives is 8 hours per week.

TRAVEL AWARD:

AND interns will be given special consideration for the Tarjan Center Developmental Disabilities Travel Award, which is granted to two interns on a competitive basis and includes funding for attendance at a scientific meeting up to $1500. The primary objective of the Tarjan Center Developmental Disabilities

Travel Award is to train professionals in the identification of disorders associated with neurodevelopmental disabilities and in interventions targeted for this underserved population.

POSTDOCTORAL TRAINING:

AND interns are encouraged to apply for competitive postdoctoral training fellowships at UCLA upon completion of their pre-doctoral psychology internship. Several postdoctoral fellowships are available within the CAN Clinic and PEERS Clinic. AND interns interested in obtaining additional specialized training in autism and other neurodevelopmental conditions are also encouraged to apply for fellowship training through the Center for Autism Research and Treatment (CART), whose supervisors include some of the world's leading experts in ASD research, spanning basic science to applied clinical research.

MANDATORY SCHEDULE OF ACTIVITIES FOR MAJOR AND MINOR ROTATIONS AND SEMINARS:

AUTISM AND NEURODEVELOPMENT DISABILITIES TRACK: CAN CLINIC MAJOR ROTATION

Time	Monday	Tuesday	Wednesday	Thursday	Friday
8:00-9:00				8:00-9:20 * Fundamentals of Child and Adolescent Psychiatry Seminar	8:00-9:00 Inpatient Sup
9:00-10:00	10:00-2:30 ** CAN Clinic Evaluation	10:00-2:30 ** CAN Clinic Evaluation	9:00 -10:00 * Child Grand Rounds (2nd & 4th week of month) CAN Clinic Evaluation ** (1st & 3rd week of month)	9:30-11:00 CAN Clinic ** ADOS-2 & ADI-R Reliability / CAN Clinic Meeting	9:00-10:00 **** CART Autism Affinity Lecture (1st Friday of the month)

10:00-12:00	12:00-1:00 Tarjan Center Distinguished Lecture (once a month)		10:00-2:30 ** CAN Clinic Evaluation	12:00-1:00 ** CAN Clinic Multidisciplinary Team Rounds and Didactics	10:00-2:30 ** CAN Clinic Evaluation
12:00-1:00					12:00-1:00 * Intern Seminar
1:00-3:00	2:00-3:00 Inpatient Group			1:00-5:00 ** CAN Clinic Family Consultation / Evaluation / Treatment / Supervision	
3:00-8:00	3:30-8:00 *** (telehealth & in-person) PEERS For Young Adults 2:00-6:30 *** (telehealth) PEERS Educational Groups for Teens and Young Adults	2:30-7:30 (telehealth) *** 2:00-5:30 (in person) PEERS for Preschoolers 3:00-8:00 *** (telehealth) PEERS for Careers	3:30-8:00 *** (in person) PEERS for Adolescents	2:00-8:00 *** (telehealth) PEERS for Dating	

* Mandatory activities are in black font

** CAN activities are highlighted in green font (treatment activities and supervision are scheduled on an individual basis)

*** PEERS activities are highlighted in red font (individual supervision is scheduled on an individual basis)

**** Recommended lecture series are highlighted in purple font

***** Inpatient Activities (subject to change throughout the year)

DIVERSITY TRAINING:

Diversity and cultural competency are core values of our programs. Within both the CAN Clinic and the PEERS Clinic, families come from the local community as well as distant national and international locations. Multicultural training, including discussion of the presentation of ASD and developmental disabilities in different cultural and family contexts, is integrated throughout the training year. Trainees are provided with opportunities to work with clients who vary in age, gender, family composition, race, ethnicity, linguistic, religious, and socioeconomic backgrounds, presenting problems, gender identity, sexual orientation, and language and cultural backgrounds.

Didactics are provided on culture, race, and ethnicity on a regular basis for AND interns. Monthly meetings devoted to furthering justice, equality, diversity, and inclusion (JEDI meetings) are an important component of training. Additionally, didactics on understanding disparities in assessment and treatment and training on using interpreter services are provided through the CAN Clinic. AND interns will also be provided group training and individual supervision on how to communicate with patients appropriately and sensitively about their individual differences. Interns will be encouraged to consider diversity and culture competence throughout their training and will be provided assistance in the individualization of treatment based on the unique differences of their patients.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation, Videotape and Case Presentation

Format: Individual and Group

Hours Per Week: 5-13 (PEERS 1 hour of individual, 1 hour of group supervision per week, CAN 1.5 hours of individual, 2 hours of group)

Days and Times: Flexible M-F 9 AM – 5 PM

Names of Supervisor(s): Patricia Renno, Ph.D., Amanda Gulsrud, Ph.D., Nicole McDonald, Ph.D., Sara McCracken, Psy.D., Christine Moody, Ph.D., Elina Veytsman, Ph.D., Jasper Estabillo, Ph.D., Blake Warner, Ph.D., Monica Sanders, Psy.D., Sara Bruce, Ph.D., Cathy Lord, Ph.D., Elizabeth Laugeson, Psy.D.

Pediatric Neuropsychology Track

DESCRIPTION:

The Pediatric Neuropsychology Track offered through the UCLA-Semel Institute and Resnick Neuropsychiatric Hospital's APA-approved doctoral internship program is designed to meet the requirements set forth by Division 40 (Neuropsychology) of the APA for specialty training in neuropsychology with children and adolescents. The primary emphasis will be on neuropsychological assessments conducted through the Medical Psychology Assessment Center (MPAC).

HOURS PER WEEK IN MAJOR ROTATION:

30

OTHER MANDATORY ACTIVITIES:

- Interns' Seminar: 1 hours per week (Fridays 12-1)
- Fundamentals of Child and Adolescent Psychiatry Seminar: 1.5 hour per week (Thursdays 8:00 am-9:20am), except Sept-Dec when Functional Neuroanatomy is taken
- Meeting with Advisor: 1 hour per week
- Neuropsychology Seminars:

  Fall Quarter: September 23rd – December 13th
  Functional Neuroanatomy: 1 hours per week
  NIBBL: 1 hour per week
  Pediatric Neuropsychology: 1 hours per week

  Winter Quarter: January 2nd – March 21st
  NIBBL: 1 hour per week
  Pediatric Neuropsychology: 1 hours per week

  Spring Quarter: March 26th – June 13th
  NIBBL: 1 hour per week
  Pediatric Neuropsychology: 1 hours per week

Additional Recommended Educational Opportunities:

- Departmental Grand Rounds: 1 hour per week (Tuesdays 11-12)
- Child Grand Rounds: 2nd and 4th Wednesday of the month, 0.5 hours (Wednesday 9-10am)
- NP Professional Development (2nd and 4th Thursday of the month, 0.5 hours (Thurs 4-5pm)
- Epilepsy surgery rounds: every Wednesday 1-2:30pm
- Clinical fMRI Interpretation: 1 hours per week (Winter Quarter)
- Brain Cutting: every Thursday 9-10am
- Wada, intraoperative mapping, extraoperative grid mapping (variable times)

TOTAL HOURS IN MAJOR ROTATION AND OTHER MANDATORY ACTIVITIES PER WEEK:

35-35.5

APPROXIMATE NUMBER OF HOURS PER WEEK FOR ELECTIVES:

4.5-5

FACULTY AND STAFF:

Sandra K. Loo, Ph.D., Program Director
Patricia Walshaw, Ph.D., Associate Director
Supervisors: Talin Babikian, PhD, ABPP, Oren Boxer, PhD, Andrea Dillon, Psy.D, Leah Ellenberg, PhD, Karen Schiltz, PhD, Amy Schonfeld, PhD, Janiece Turnbull, PhD, Karen Wilson, PhD, Roger Light, PhD, ABPP-CN, ABPP-PN

TRAINING PROVIDED:

Interns in this track will spend approximately 30 hours per week of their time in activities related to clinical neuropsychology. They will see 4 cases per month. Supervision is provided individually or within a group on each case by the case's primary supervisor. Additional training in neuropsychology is provided through didactics. The trainee's program will be supplemented by general clinical activities including psychodiagnostic assessment, individual therapy patients, group therapy in elective rotations

DIVERSITY TRAINING:

Neuropsychology Interns, and other interns who may elect to see cases for Neuropsychological and/or Psychodiagnostic Assessment, do so within the Medical Psychology Assessment Center or MPAC. MPAC serves as a centralized Neuropsychological assessment hub for adults and children in UCLA Health and serves a wide variety of patients from different backgrounds. Cultural and individual diversity are cornerstones of the MPAC service delivery model, and critical to the conceptualization of every case. Key factors considered in advance for every case include ethnicity/race, sexual orientation or gender identity, educational background, socioeconomic standing, linguistic background, religious affiliation, military/civilian roles, accessibility of educational and vocational opportunities, neurodiversity, and/or other social markers of diversity. The overall philosophy at the MPAC is one that is closely aligned with the AACN 2050 Relevance Initiative and is focused on the complementary relationship of cultural competence and cultural humility in neuropsychology. Ample opportunity and training on interpreter-mediated assessment is provided as many of our patients are bilingual. Several lectures on interpreter-mediated assessment are provided, and trainees are exposed to relevant readings and hands-on training related to working with interpreter services in a neuropsychological assessment context. Individual supervision on each case focuses on cultural and identity factors of the patient that may play a role in case conceptualization and approach to testing. Supervision also provides an opportunity to self-examine identity factors and potential biases that may impact approach to a case as well as factors that relate to the supervisor-supervisee relationship. In addition to "bedside learning" with individual supervisors on cases, MPAC trainees have an opportunity to engage in didactic opportunities focused on diversity interspersed throughout the Thursday seminars, including the quarter-long Cultural Neuropsychology Seminar in the Spring Quarter. Foundational readings related to cultural and linguistic competency in neuropsychology are also disseminated during orientation and serve as a springboard for ongoing discussion with supervising faculty throughout the academic training year. Students are encouraged to process their own journey of developing cultural competence with the MPAC faculty, including those faculty in the Lifespan Assessment Through Integrated Neuropsychology Program

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation and Case Presentation
Format: Individual and Group
Hours Per Week: Typically 2 hours per assessment case of individual supervision; group supervision is held once per week (1 hour)
Days and Times: Variable

Adolescent Serious Mental Illness Track

DESCRIPTION

There is increasing evidence that earlier intervention for serious mental illness (psychotic spectrum disorders, bipolar disorder) can lead to improved long-term outcomes. This has led to a rising tide of interest in studying the early symptomatic manifestations of these disorders and in developing strategies for early intervention and prevention.

The Adolescent Serious Mental Illness (ASMI) track in the NPIH Doctoral Internship Program will include one slot for the 2026-2027 academic year. This position is made possible with the support of the National Institute of Mental Health and foundation funding (the Don Levin Trust and Shear Family Foundation).

The ASMI internship will conform to APA guidelines for training in clinical psychology with ~75% effort dedicated to assessment, treatment, and community outreach in this year-long placement within the UCLA Center for the Assessment and Prevention of Prodromal States (CAPPS), which provides

comprehensive assessment and innovative treatments for adolescents and young adults who are deemed to be at high-risk for developing psychosis. CAPPS is participating in 15-site consortium clinical trial - the Psychosis Risk Compound Assessment Network (ProCAN)as well as conducting long term follow up on psychosis-risk youth and families. Additionally, interns will have the opportunity to assess and treat individuals from other clinical populations with or at risk for severe mental illness (i.e., youth at genetic high risk for psychosis). Interns will have the additional opportunity to provide individual therapy and personalized clinical assessments through the insurance-based CAPPS treatment clinic, as well as provide Family Focused Therapy and serve as a skills group co-facilitator for individuals with or at risk for severe mental illness and their families through a collaborative programwith the UCLA Child and Adolescent Mood Disorders Program (CHAMP) clinic.

ASMI MEETINGS

Mondays 10-11 – Clinical Assessment Team Supervision
Mondays 11-12 – Neuropsychology Assessment Team Supervision / Psychosocial Treatment Team Supervision/CAPPS Didactic Series (alternating weeks)
Clinical Assessment Supervision: 1 hour per week to be arranged with Dr. Adery
Psychological Treatment Supervision: 1-2 hours per week to be arranged with Dr. Adery, and/or Ms. Zinberg, includes some group supervision
Other Clinical Supervision: 1 hour per week to be arranged with Dr. Bearden

OTHER MANDATORY ASMI INTERN ACTIVITIES

Interns' Seminar: 1 hour per week (Fridays 12-1)
Departmental Grand Rounds: 1 hour per week (Tuesdays 11-12)
Child Psychiatry Grand Rounds (2nd and 4th Wednesday of the month, 9-10am) 0.5 hours per week
Meeting with Advisor: 1 hour per week (or as needed)

FACULTY AND STAFF

Carrie Bearden, Ph.D., Program Director
Debha Amatya M.D., Ph.D., Misty Richards, M.D.,Medical Co-Directors
Jamie Zinberg, M.A., Administrative and Psychosocial Treatment Director
Laura Adery, Ph.D., Associate Clinical Director, Treatment and Assessment Supervisor

MORE DETAILS ON TRAINING PROVIDED TO THE ASMI INTERN

Interns will learn through supervised practice, weekly multidisciplinary treatment team case conference meetings and a monthly didactic seminar series. Interns will have the opportunity to participate in the overarching goals of these programs, which include: 1) developing methods for early identification of those at very high-risk for psychosis; 2) characterizing the diagnostic, clinical, and neurocognitive phenomena associated with these conditions; and 3) developing, testing and implementing interventions for these populations. Opportunities are available to conduct clinical assessment and treatment in both English and Spanish.

Clinical Assessment

Interns will receive training in the administration of the Structured Interview for Psychosis-Risk Syndromes (SIPS), the Positive Symptom and Diagnostic Criteria for the CAARMS Harmonized with SIPS (PSYCHS), the Structured Clinical Interview for DSM-5 (SCID), and other clinical rating scales, such as the Brief Psychiatric Rating Scale (BPRS), Negative Symptom Inventory for Psychosis Risk (NSI-PR), Columbia Suicide Severity Rating Scale (C-SSRS) and Calgary Depression Scale for Schizophrenia (CDSS). Interns will administer these and other assessment measures to young people ages 12-30 and/or their parents, and together with other psychologists, psychiatrists, and post-doctoral fellows, will determine working diagnoses and eligibility for participation in a clinical research program for adolescents at imminent risk for psychosis or

with recent onset of psychosis. Interns will also conduct these assessments with youth who are at high genetic risk for serious mental illness (i.e., youth with 22q11.2 disorders). Interns will conduct approximately three assessments per week, will write a brief report following each assessment, and will be asked to summarize findings and to make recommendations for treatment at multidisciplinary team meetings. Interns will be trained in proposing comprehensive treatment plans, which may include school, individual, family, psychiatric and/or group interventions. Interns will participate in approximately 10-15 hours per week of clinical assessment activities, which will be supervised by Laura Adery, PhD and Carrie Bearden, PhD, licensed clinical psychologists.

Psychological Treatment

Interns will be trained to provide early intervention for adolescents and young adults at high clinical risk for developing a thought disorder and their families. Our evidence-based early intervention provides stepped care matched to the needs of our clients, and the focus is on preventing worsening of prodromal symptoms and functional disability. Components include needs assessment interviews; family psychoeducation about the prodromal state; creation of a family-centered, assessment-based risk reduction plan; family empowerment within the service system; ongoing case management (crisis support and consultations with family and outside providers); and fostering strong family communication around symptoms, stressors, and needs. Psychoeducation addresses reasons for early intervention, biological bases for mental disorders, diathesis-stress theories, psychopharmacological and psychological treatments, school interventions, and recommendations for creating a protective environment. Our intervention program is guided by cognitive-behavioral and family systems orientations and has been manualized and adapted from Family Focused Treatment for children and adolescents at risk for bipolar disorder (FFT-CHR; Miklowitz, George, & Taylor 2006). We are now conducting a randomized clinical trial of this family -based intervention; interns will have the opportunity to participate as therapists or co-therapists. Interns will also have the opportunity to co-facilitate client resiliency therapy groups and/or transdiagnostic skills groups for adolescents and parents that use a combined cognitive-behavioral and dialectical-behavioral approach. Interns may also have the opportunity to carry time-limited individual therapy cases with youth enrolled in clinic assessment services with such modalities as CBTp, CBT-I or DBT-informed treatment. Approximately 10 hours per week will be spent providing psychosocial treatment, and interns will be provided individual and group supervision by Laura Adery, Ph.D., Danielle Denenny, Ph.D. and Jamie Zinberg, MA. Interns will also have the opportunity to work closely with psychiatry residents and fellows to learn about psychopharmacological approaches to treating prodromal and first episode adolescents.

Neuropsychological Assessment (Optional)

Interns can also elect to be trained in the administration of a neuropsychological research battery, constructed to test hypotheses regarding functioning during the psychosis prodrome, and in adolescents with psychotic and mood disorders. Interns will conduct approximately two neuropsychological assessments per month, write brief summaries, and report findings at multidisciplinary team meetings. In many cases, interns will be asked to provide feedback to individuals, parents, and treatment providers and to make recommendations for classroom accommodations. Neuropsychological assessment hours are worked into your total track hours and up to 3 hours per week may be spent on neuropsychological assessment, which will be supervised by Dr. Carrie Bearden. Neuropsychological assessment group supervision is held monthly (1 hour), with individual supervision provided as needed.

Community Outreach (Optional)

Interns will be given the opportunity to participate in community outreach efforts. Activities will involve providing talks in the community to staff working with youth (mental health providers, nurses, teachers, etc.), with the goal of educating staff on the early warning signs on psychosis and benefits of early

intervention. Additionally, interns may provide career day talks and fairs for local middle and high school students as well as talks for parents in the community on preventative mental health.

Research

Interns will be given the opportunity to participate in one of several ongoing programs of research focusing on neuropsychological, psychosocial, and/or family factors contributing to the development of psychotic illness in adolescents, and how this knowledge can be translated into more effective, evidence-based treatments of serious mental illness in young people. There are also opportunities for participation in randomized control trials of both group and family interventions.

Seminar/Training

Mandatory training and seminars will be provided to support the training of interns in clinical assessment, neuropsychological assessment, and intervention with treatment – seeking adolescents and their families and attempts to integrate clinical work with relevant research findings. This seminar will be organized by Drs. Carrie Bearden, Laura Adery, and Danielle Denenny and Jamie Zinberg, M.A., and will include presentations by CAPPS team members including Medical Co-Directors Drs. Alaina Burns and Misty Richards. Other participants in this didactic seminar will include doctoral psychology graduate students, medical students, and postdoctoral fellows. Intensive training will take place during the months of July and August.

Seminar topics include:

- Controversies surrounding clinical high risk/"prodromal psychosis" programs
- An introduction to the Adolescent Serious Mental Illness /CAPPS clinical research programs
- Assessment of Psychosis Risk States
- Screening instruments to facilitate research and early intervention during the prodrome
- Neuropsychology and the Psychosis Spectrum
- Genetic high-risk populations
- Family Research conducted on the prodrome and first episode psychosis
- Thought Disorder during childhood and adolescence
- Typical Adolescent Development
- Psychopharmacology in the Prodrome
- An Interdisciplinary Team approach to treating the prodrome
- Individual and Family Evidence-based Treatment of Serious Mental Illness (such as CBT for psychosis, Family Focused Therapy for high-risk youth)
- Mindfulness based therapy for high-risk youth and parents
- Specific treatment considerations and research findings for early psychosis risk in societally marginalized groups such as Black American or LGBTQIA+ youth.
- Crisis Management – Assessing and managing suicidality and homicidality
- School Interventions – Individual Educations Plans, Non-Public Schools and beyond
- Community Resources

DIVERSITY TRAINING

ASMI clients are diverse in terms of ethnicity/race, SES, religion, gender identity, nationality, acculturation, and sexual orientation. Diversity and cultural competency are core values of our program, and we strive to honor the backgrounds of our clients. Towards this end we have recruited diverse staff and trainees and consistently work to ensure that we are welcoming to people from all backgrounds. We expect that trainees will be open to working with clients representing different values, cultural experiences, and lifestyles than they have. Multicultural training starts during orientation and is woven into all aspects of training throughout the year. We train interns in multicultural identity development models and in thinking in a culturally competent way, rather than encouraging them to apply group-level information in

stereotyped fashion. We use supervision to emphasize cultural humility to trainees and to assist them in identifying and working through areas of bias and blind spots. Trainees are encouraged to self-explore and reflect on their own multicultural identity and how that impacts their clinical interpretations and approach to their cases. Trainees are also assisted in sensitively communicating with clients about individual, family, and cultural identities, strengths and differences, and core personal values, and they receive training in communicating with clients through a translator. Additionally, as part of our research team, trainees will have the opportunity to contribute to furthering understanding of the impact of culture and individual factors on psychopathology.

TIME REQUIREMENTS

Clinical & Psychosocial Assessment: 12-15 hours
Neuropsychological Assessment & Community Outreach: Optional
Psychosocial Treatment: 8-10 hours
Seminar and Team meeting: 2 hours
Individual and Group Supervision Total: 3.5-4.5 hours
Research: negotiable
Total: Approximately 29 hours per week

APPROXIMATE NUMBER OF HOURS PER WEEK FOR ELECTIVES:

11

SUPERVISION PROVIDED

The ASMI intern will have a primary advisor, Carrie Bearden, Ph.D., who is the Director of the CAPPS Program and a Professor in the departments of Psychiatry and Biobehavioral Sciences and Psychology. The intern will additionally receive mentorship and training from program supervisors Laura Adery, Ph.D. (Associate Clinical Director, licensed clinical psychologist), Danielle Denenny, Ph.D. (Family Treatment supervisor). The intern may also receive mentorship from other faculty, depending on the specific selections of electives comprising this intern's program.

Method of Supervision: Direct Observation, Video Tape, Case Presentation
Format: Individual and Group
Hours Per Week: Flexible (see Time Requirements) (2 hours of group weekly and 1 hour of individual bi-weekly supervision)
Days and Times: Training experiences are available M-Fr, including some evenings. The intensive daily orientation in July is a foundation.
Names of Supervisor(s): Carrie Bearden, Ph.D. (primary). Laura Adery, Ph.D., Danielle Denenny, Ph.D.

Stress, Trauma and Resilience Track

DESCRIPTION:

There are two Stress, Trauma and Resilience (STAR) tracks- The STAR Track and the STAR-Child Welfare Track. Both tracks are designed to provide training in evidence-based, trauma-informed evaluation and intervention. The STAR track intern will spend approximately 65% of their time dedicated to evaluation, treatment, and community outreach in this year-long placement within the UCLA Nathanson Family Resilience Center (NFRC), which provides family-level interventions for children and families exposed to stress and trauma. The Child Welfare intern will overlap in some STAR related activities 45% of the time and will also participate in assessment and intervention activities through UCLA TIES (Training, Intervention, Education and Support) for Families one day a week (Mondays). This specialty track is designed to

develop leadership pathways for psychologists passionate about advancing care of youth and families within the child welfare system. During the 12- month internship, Child Welfare interns learn to work with youth exposed to trauma and various challenges stemming from their involvement in the child welfare system, including adjustment to foster care, adoption or other placements, attachment issues, depression and grief, anxiety, behavioral difficulties, anger management and family conflict

Interns will learn through supervised practice, multidisciplinary case conferences, research team meetings, and outreach/training opportunities. Interns will have the opportunity to participate in the overarching goals of the NFRC, which include: 1) Developing and testing new interventions for high-risk families, 2) Strengthening support for families through education and training of mental health providers, educators, and medical providers, 3) Using innovative technology to provide support for families, and 4) Improving the quality of care for families through direct service-delivery.

HOURS PER WEEK IN MAJOR ROTATION:

30

MANDATORY STAR MEETINGS:

Stress, Trauma and Resilience (STAR) Clinic: 20 hours
Individual Clinical Supervision & Faculty Advising: 1-2 hours per week
Group Supervision: 1 hour per week
Other training opportunities (Outreach/training, Research): 3-4 hours/week
Stress, Trauma, and Resilience Seminar 1.0 (Wednesday 9-10 AM; alternates with Child Grand Rounds)

The primary advisors for this track are Blanca Orellana, Ph.D., and Nastassia Hajal, Ph.D. Regular meetings with the advisor will support the intern's professional development and career goals, as well as guidance with elective selection and program customization. Interns will also have one hour of individual clinical case supervision per week with their primary clinical supervisor, who may be different from their advisor. Finally, the intern may receive additional mentorship from other faculty members consistent with the intern's interests.

OTHER MANDATORY ACTIVITIES:

Interns' Seminar: 1 hour per week (Fridays 12-1)
Child Grand Rounds: 2nd and 4th Wednesday of the month 9-10am, 0.5 hrs per week
Meeting with Advisor: 1 hour per week

The Stress, Trauma and Resilience intern will spend the remainder of their time in didactic seminars and electives offered through the general internship program to broaden their overall training experience. The required seminars include Child Psychiatry Grand Rounds, Fundamentals of Child and Adolescent Psychiatry Seminar, and the Intern' Seminar.

TOTAL HOURS IN MAJOR ROTATION AND OTHER MANDATORY ACTIVITIES PER WEEK:

34.75

APPROXIMATE NUMBER OF HOURS PER WEEK FOR ELECTIVES:

5.25

STAR CLINIC FACULTY AND STAFF:

Natalia Ramos, M.D., Medical Director
Blanca Orellana, Ph.D., Clinical Director
Nastassia Hajal, Ph.D., Sierra Kuzava, Ph.D., Janine Shelby, Ph.D., Jessica O'Leary, Ph.D, Andrea Tabuenca, Ph.D., Catherine Mogil, Psy.D., Attending Supervisors

TRAINING PROVIDED:

Interns will see patients with a wide variety of behavioral, emotional, and family problems that stem from exposure to traumatic events, such as medical illness, pediatric injuries, sexual abuse, physical abuse, community violence, involvement in the child welfare system, and parental illness/injury related to parental combat exposure. Trainees thus gain first-hand experience working with children and families struggling with trauma-related challenges. Efforts will be made to provide trauma-related cases consistent with the interns' primary area of interest in addition to a breadth of cases to ensure adequate training in various types of trauma.

Trauma-informed Intervention

A family approach is used so that the intern learns how to work across the entire family, with parents (biological, foster and adoptive), siblings of the injured/ill child, and significant others (as applicable). Interns learn how stress related to medical illness or traumatic events reverberates across the entire family. An emphasis will also be placed on collaborating with the systems of care that support the child and family. There is also an opportunity to learn home visiting models. Treatment may include Families Overcoming Under Stress (FOCUS), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent Child Interaction Therapy (PCIT), Dyadic interventions for early childhood, and adoption specific interventions (e.g. Transracial Adoption; Adoption-Specific Prevention Treatment (ADAPT) model; TIES Transition model), for those participating in the Child Welfare Track. and other trauma-informed and family level treatment models. There is also the availability to develop and facilitate group level interventions. Approximately 15 hours per week will be spent delivering trauma-informed interventions.

Trauma-informed Evaluation

Interns gain experience in both brief evaluation and comprehensive assessment for a variety of cognitive and emotional issues that impact child and family functioning and parenting choices. Interns will be trained in assessment procedures, report writing, identifying practical recommendations, and supportive delivery of feedback to parents. Approximately 2 hours per week will be spent in evaluation.

Outreach/Training Experience: Interns will have the opportunity to participate in community outreach and provider trainings to help build community capacity to support children and families affected by traumatic experiences. This may include events or trainings to support military families and children, children with particular medical or developmental challenges, or homeless youth. Outreach and training opportunities vary during the course of the year, but approximately 2-3 outreach or training events will be completed over the internship year (averaging less than an hour/week).

Research: Several research projects take place in the NFRC and Division of Population Behavioral Health. Intervention development and evaluation, translational research, program evaluation, and data analysis/interpretation opportunities are available to the interns to further their research experience. Approximately 2 hours per week may be spent in research related activities, including clinical delivery of interventions, assessment or meetings.

Stress, Trauma and Resilience (STAR) Seminar

Orientation lectures will be provided during the first two months of the internship. Training and trauma-related presentations will be held on the third Wednesdays of each month from 9:00 to 10:00 AM. Interns will alternate attending STAR Seminar and Child Psychiatry Grand Rounds.

Topics include:

- The FOCUS model
- TF-CBT

- The neuropsychological effects of trauma
- Supporting Grieving Families
- Trauma-informed assessment and care
- Developmental guidance
- Resilience factors
- Trauma-informed psychoeducation
- Trauma and loss reminders
- Child development and trauma
- Collaborating with educators and other providers
- Stress and Coping in Families of Medically Ill Children
- Understanding the needs of military families
- Systems of care
- Children's understanding of illness
- Supporting children's social relationships
- Helping parents re-establish the protective shield
- Understanding the needs of resource/adoptive families
- Challenging medical experiences for children and parents

DIVERSITY TRAINING:

The NFRC-Family STAR Clinic's training program is strongly committed to promoting a culture of inclusion and appreciation for diversity. We strive to support trainees across all areas of diversity including (but not limited to) race/ethnicity, gender, religion, gender identity, language, and socioeconomic status in order to expand cultural awareness and sensitivity, as well as to enrich the services we provide to the increasingly diverse populations at UCLA. Training is woven into various aspects of the training experience. Throughout the year STAR Seminar Rounds hosts experts/speakers in the area of child and family trauma to discuss important topics related to the field, including prevention and intervention, diversity, cultural awareness and sensitivity, as well as best practices working with diverse populations (e.g. LGBTQ families, foster/adoptive families, and underserved populations). Trainees are encouraged to engage in reflective conversations about their cultural identity, personal biases, attitudes and values, in both, individual and group supervision, as well as during multidisciplinary team case conferences. In addition, cultural exploration is encouraged in all aspects of case conceptualization to determine how cultural aspects may play a role in symptom presentation, parental reactions, as well as how to incorporate these important factors into diagnosis, assessment and treatment. Trainees are exposed to reading materials and training in working with interpreters, in order to meet the linguistic needs of patients.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation and Case Presentation
Format: Individual and Group
Hours Per Week: 5 (2 hours of group, 1 hour of individual supervision per week)
Days and Times: Tuesdays or Thursdays between 10 AM – 5 PM
Names of Supervisor(s): Blanca Orellana, Ph.D.; Nastassia Hajal, Ph.D.; Catherine Mogil, Psy.D.; Sierra Kuzava, Ph.D. Andrea Tabuenca, Ph.D.

UCLA TIES for Families

DESCRIPTION:

UCLA TIES (Training, Intervention, Education, and Services) for Families is a leading interdisciplinary program dedicated to optimizing the growth and development of children and young people in foster care, kinship care, or adopted through foster care and their families. In partnership with Los

Angeles County Department of Children and Family Services and Department of Mental Health, UCLA TIES serves children from birth to age 25 in foster and adoptive families. Since 1995, UCLA TIES for Families has facilitated the development of foster children and their resource families by providing a range of interdisciplinary mental health and auxiliary services and programs, supplying high-quality local and national training to professionals and families, and developing research to better understand the strengths and challenges for this population. Our team includes professionals from 8 disciplines (psychology, psychiatry, pediatrics, education, social work, speech and language, occupational therapy, and

in-home behavioral services) and diverse backgrounds and experiences to rally around foster/adoptive children and families with trauma and healing informed, child-welfare competent care to enhance stability and optimize outcomes for children. We are sensitive and attuned to an array of cultural contexts and diversity issues. A substantial proportion of children we serve are of color, some of whom are in transracial placements, and approximately one third of the families we serve identify as LGBTQ. Interns will learn through supervised practice, interdisciplinary team participation, research team meetings, and training opportunities.

HOURS PER WEEK IN MAJOR ROTATION: 30

MANDATORY TIES MEETINGS AND OTHER ACTIVITIES:

TIES for Families Clinic: 20 hours Individual
Group Supervision: 3.5 hours per week
Individual Supervision: 2 hours per week
Other training/research opportunities: 2-4 hours/week

Day	Meetings	Time	Hour per Week
Monday	TIES Research Meeting (2nd, 1x/month)	10:00am-11:00am	0.25
	TIES Psychological Testing Didactic (4th, 1x/mo)	10:00am-11:00am	0.25
	TIES ADAPT Group Supervision	11:30am-12:30pm	1.0
	TIES Interdisciplinary Clinical Meeting	12:30pm-2:00pm	1.5
	TIES In-Services (4th, 1x/mo)	1:30pm-3:00pm	0.25
Wednesday	Semel Child Grand Rounds (2nd & 4th)	9:00am-10:00am	0.50
	TIES Developmental Clinic	9:00am-11:30am	2.0
	TIES Infant Mental Health (IMH) Clinical Meeting & Group Supervision	11:30am-12:30pm	1.0
Thursday	Fundamentals of Child and Adolescent Psychiatry Seminar	8:00am-9:20am	1.5
	IMH Reflective Group Supervision	10:30am-12:00pm	1.5
Friday	Interns' Seminar	12:00pm-1:00pm	1.0

Above meetings are weekly unless otherwise noted. Departmental Grand Rounds is optional and occurs every Tuesday from 11:00-12:00 pm.

The primary advisor for this track is Audra Langley, Ph.D. Regular meetings with the advisor will support the intern's professional development and career goals, as well as guidance with elective selection and program customization. The intern may receive mentorship from other faculty or staff members consistent with the intern's interests.

TOTAL HOURS IN MAJOR ROTATION AND OTHER MANDATORY ACTIVITIES PER WEEK: 34.50

APPROXIMATE NUMBER OF HOURS PER WEEK FOR ELECTIVES: 5.50

FACULTY AND STAFF:

Audra Langley, Ph.D., Director
Eugenia Hsu Tsao, Ph.D., Associate & Training Director
Alycia Davis, Psy.D., Clinical Director
Catherine Lippincott, Psy.D., Infant Mental Health Director
Natalie Bencuya, Ph.D., Danielle Perryman, Psy.D., Tiffani Tejada, Psy.D., Supervisors

TRAINING PROVIDED: Interns will provide psychotherapy with foster/adoptive children ages 0-25 with a range of clinical presentations including emotional and behavioral challenges and their families. Interns are expected to carry 6 to 8 weekly in-person or telehealth intervention cases. TIES philosophy involves having as much contact with parents/caregivers as with the children, utilizing evidence-based, culturally competent, trauma and healing informed treatments that take into account the child's often complex history. Our approach involves both CBT-based treatments such as Parent-Child Interaction Therapy (PCIT), Trauma-focused CBT (TF-CBT) and Managing and Adapting Practices (MAP), as well as attachment-based approaches such as Child-Parent Psychotherapy (CPP) and Attachment Regulation Competency (ARC) framework.

Trainees will receive the following specialized training:

TIES Transition Model (TTM): These services are initiated, whenever possible, as children make the transition into a foster/adoptive or relative caregiver home — a particularly vulnerable period for families, which presents opportunities to promote attachment and prevent problems from escalating into crises. Our mental health services combine evidence-based child mental health programs with best practices and literature in child welfare, adoption, attachment and

developmental psychology taking into consideration the children's past traumatic histories. Educational, medical and support services such as speech and language and occupational therapy and in-home behavioral services enhance the mental health services offered. This unique transitional model was designated as Community Defined Evidence Based Practice (CDE) in 2009 by the California Institute of Mental Health (CIMH) and the Los Angeles County Department of Mental Health (DMH).

At least one of the ongoing treatment cases should involve our Adoption-specific Therapy (ADAPT). This approach is a modularized activity-based 20-24 week treatment specifically

developed to combine evidence-based child therapy and parenting interventions with an attachment-based approach that looks at child behavior through the lens of past traumatic history and modifies interventions accordingly. In each module, parents and children meet separately for a couple of sessions, and then come together for a family session. Dr. Langley, Dr. Waterman (Psychology), and Dr. Miranda (Psychiatry) evaluated the manualized mental health component of TTM, ADAPT (Adoption-specific Therapy), through grants from the Annie E. Casey Foundation. American Psychological Association Books published ADAPT in 2018, with the title *Adoption-specific Therapy: Helping adopted children and their families thrive*.

Interns will attend one-day ADAPT training as well as one series of the prospective resource parents (PREP) sessions to learn more about prenatal substance exposure, developing empathy for the birth parents,

child temperament, strategies for managing difficult behaviors, issues about open adoption, and concerns parents have about providing foster/adoptive care. Interns also receive additional training related to specific foster/adoption issues. Examples of topics include shifting the lens from deficits to exquisite adaptation in order to survive chaotic and sometimes abusive environments; grief, loss and divided loyalties in children adopted from foster care; prenatal substance exposure; educational and academic issues for children in foster care and adoption helping children success in the IEP process; and challenges and supports for prospective adoptive parents in concurrent planning.

Infant Mental Health (IMH) Program: UCLA TIES offers the only IMH program in L.A. county specifically aimed at meeting the needs of child welfare-involved infants, many of whom experience prenatal substance exposure and other risk factors, and their families, to promote attachment, access early intervention services, and optimize the children's development. This program offers home based mental health services, developmental evaluation, parenting education, and monthly support groups for resource parents and infants and toddlers age 0-3.

The weekly telehealth IMH meeting combines case discussion and consultation, discussion of readings, and assignment of new cases. In the In-person Developmental Assessment Clinic, children under 3 years of age are assessed with the Bayley Scales of Infant Development as well as behavioral measures. Interns observe and then administer the Bayley Scales of Infant Development. Pediatric, educational, and speech and language consultants participate as-needed for individual cases. Additionally, interns see 1 to 2 home based infant cases monthly in-person or by telehealth to provide parent support, interactional guidance, help with concurrent planning concerns, and help facilitate parent-child attachment and attunement. Interns accompany their IMH mentor to learn about the infant mental health approach for at least one of their cases.

Interdisciplinary Psychological Evaluations and Pre-placement Consultations: UCLA TIES provides interdisciplinary review of records and assessment of children prior to placement to support prospective foster/adoptive parents in making informed decisions about the placement as well as educating them about the child's strengths, vulnerabilities, and service needs. We also provide these assessments for children who are unable to reunify and for whom DCFS is having a difficult time finding an adoptive placement or who have bounced from home to home. Clients of TIES often have complex histories involving abuse and neglect, multiple traumas and frequent caregiver and school changes. Thorough and sensitive psychological evaluations can help their caregivers understand children's strengths and needs to help them determine if they can provide permanency for the children as well as guide mental health and educational interventions. Interns are expected to complete 2 full in-person psychological evaluation batteries over the course of their placement. With supervision by a staff psychologist, the intern will complete the in-person psychological assessment battery, collect and summarize feedback from record reviews by the necessary disciplines such as education, psychiatry and pediatrics, participate in a meeting of the interdisciplinary consultants, DCFS social workers and prospective adoptive parents to outline the child's strengths and needs, and integrate the findings into a report conceptualized within a trauma- and resilience-informed lens.

Research: Interns have the opportunity to engage in a variety of research activities and projects, including but not limited to program development and evaluation, translational research, data analysis and interpretation, and manuscript and presentation preparation. Interns typically dedicate approximately one hour per week to research-related tasks, which may include participating in research meetings or working on a project they are engaged in. Examples of current and past projects include examining the impact of major social events and public health crises on families involved in the child welfare system; exploring the use of telehealth and hybrid service models; identifying long-term predictors of adoption satisfaction among families adopting from child welfare; developing an ethnic-racial socialization module for transracial adoptive families; and evaluating the efficacy of ADAPT and other TIES interventions.

DIVERSITY TRAINING:

UCLA TIES provides culturally responsive, trauma- and healing-informed services, training, research, and advocacy for foster and adoptive families. Because of the complex needs of the children and families we serve (with a large number of children and families of color, 40% of our families are transracial, and 35% of our families are LGBTQ), issues related to individual and family diversity, racism, microaggressions, privilege, policing practice, disparities in care and opportunities, immigration and acculturation, multiple layers of identity, and oppression are interwoven with a child welfare-competent trauma and resiliency lens into our ongoing case conceptualization and services.

As part of the UCLA TIES Orientation, interns will begin to engage in discussions about the historical perspectives of discrimination and disproportionality in child welfare; the role and impact of poverty, racism, mental illness and substance abuse on the child welfare system; and some of the specific issues for the diverse families served at TIES including transracial families, LGBTQ+ parents, LGBTQ+ youth, single parent families, relative caregivers and older parents. A DCFS representative also presents the local disproportionality information, theories on what practices impact it, and how LA County's Eliminating Racial Disparities and Disproportionality (ERDD) board is working to address these issues. Interns will also attend a specialized Cultural

Competency and Sensitivity Training for community mental health practitioners provided by LA County Department of Mental Health. On-going monthly professional development in-services include topics such as cultural humility, sensitivity and competence. Examples of topics include what privilege we hold; historical and current perspectives in the field of Social work related to transracial adoption and the adoption of African American children from public child welfare; understanding disparities in health and mental health care and access to care, and how to work toward cultural competence in clinical treatment with diverse populations; best practice clinical strategies for supporting children in transracial and diverse families; understanding and working with specific diverse groups (e.g., LGBTQ+ youth and families, Latino families) and intersectionality; complex identities and being sensitive to and supportive of children and young people through multilayered identity development; and exploring safety issues and privilege, recognizing inherent bias, and the impact of microaggressions and discrimination on children's development and wellbeing. In addition, reflective supervision is utilized with ongoing exploration of the multiple identities and intersectionality of our clients, therapists and supervisors, and its impact on conceptualization, diagnosis, assessment and treatment.

SUPERVISION PROVIDED

Method of Supervision: Direct Observation, Videotape, Case Presentation Format:

Individual and Group

Hours Per Week: 5.5 (3.5 hours of group, 2 hours of individual supervision per week)

Days and Times: Mondays – Thursdays 9 AM – 7 PM & Fridays 9 AM – 5 PM

Names of Supervisor(s): Eugenia Hsu Tsao, Ph.D., Alycia Davis, Psy.D., Catherine Lippincott, Psy.D., Natalie Bencuya, Ph.D., Danielle Perryman, Psy.D., and Tiffani Tejada, Psy.D.

Adult Tracks

Adult Neuropsychology Track

DESCRIPTION:
The Adult Clinical Neuropsychology Track offered through the UCLA Semel Institute and Resnick Neuropsychiatric Hospital's APA-approved doctoral internship program is designed to meet the requirements set forth by the Society for Clinical Neuropsychology (previously known as Division 40) of the APA. This track follows Houston Conference Guidelines for specialty training in clinical neuropsychology and following the taxonomy for education and training in clinical neuropsychology (Smith, G., Archives of Clinical Neuropsychology, Volume 34, Issue 3, May 2019, Pages 418–431), is considered a Major Area of Study (with more than 50% effort dedicated specifically to clinical neuropsychology. The primary emphasis will be on neuropsychological assessments conducted through the Medical Psychology Assessment Center (MPAC), and when appropriate to individual training goals, complementary experiences in other programs may be arranged.

HOURS PER WEEK IN MAJOR ROTATION:
30

OTHER MANDATORY ACTIVITIES:
Interns' Seminar: 1 hour per week (Fridays 12-1)
Meeting with Advisor: 1 hour per week
Neuropsychology Seminars:

Fall Quarter: September 23rd – December 13th
Functional Neuroanatomy: 1 hour per week
NIBBL: 1 hour per week
Neuropsychological Syndromes: 1 hour per week

Winter Quarter: January 2nd – March 21st
NIBBL: 1 hour per week
Neuropsychological Syndromes: 1 hour per week

Spring Quarter: March 26th – June 13th
NIBBL: 1 hour per week
Neuropsychological Syndromes: 1 hour per week

Additional Recommended Educational Opportunities:

- Departmental Grand Rounds: 1 hour per week (Tuesdays 11-12)
- Cultural Neuropsychology: Thursdays 1-2pm (Fall Quarter)
- Intervention Approaches for Cognitive Impairment: Thursdays 1-2pm (Spring Quater)
- Psychodiagnostic Assessment Seminar: Thursdays 9-10am (Spring Quarter)
- NP Professional Development (2nd and 4th Thursday of the month, 0.5 hours (Thurs 4-5pm)
- Epilepsy surgery rounds: every Wednesday 1-2:30pm
- Clinical fMRI Interpretation: Thursday 10-11am (Winter Quarter)
- Brain Cutting: every Thursday 9-10am

- Wada, intraoperative mapping, extraoperative grid mapping (variable times)

TOTAL HOURS IN MAJOR ROTATION AND OTHER MANDATORY ACTIVITIES PER WEEK:
34-35

APPROXIMATE NUMBER OF HOURS PER WEEK FOR ELECTIVES:
5-6

FACULTY AND STAFF:
Patricia Walshaw, Ph.D., MPAC Director; April Thames, Ph.D., MPAC Associate Director
Supervisors: Susan Bookheimer, Ph.D., Roger Light, PhD, ABPP-CN, ABPP-PN, Andrew Dean, PhD, Charles Hinkin, PhD, Judith Friedman, Psy.D, Diane Schneider, PhD, Philip Stenquist, PhD, ABPP-CN, Nicholas Thaler, PhD, ABPP-CN, Robert Tomaszewski, PhD, ABPP-CN, Heleya Rad, PhD, Maura Mitrushina, PhD, Nancy Kaser-Boyd, PhD, ABAP

TRAINING PROVIDED:
The intern will have the opportunity to complete evaluations on a variety of inpatients and outpatients referred to MPAC by Neurology, Neurosurgery, Psychiatry, Organ Transplant, other medical center clinics/units, and the community at large. Interns will be expected to see 6 cases per month. Our pool of supervisors includes multiple individuals who have received board certification in neuropsychology (ABPP-ABCN). The patient population in MPAC is diverse with many patients speaking languages other than English. Training and experience in interpreter-mediated assessment is provided. The intern will be required to attend select didactic seminars in neuropsychology and are able to participate in a range of other activities along with neuropsychology practicum students and postdoctoral fellows. These activities may include WADA testing, intra-operative brain mapping, extra-operative grid mapping, balloon occlusion testing, and brain cuttings. The remainder of the trainee's program is comprised of general clinical activities including psychodiagnostic assessment, research (typically 4 hours per week), supervision, intern seminars, and elective rotations. A full list of electives is provided in this manual. A specific program plan will be developed by the intern and presented to the training committee in order to ensure a breadth of experience that complements the mandatory specialized training in neuropsychology.

DIVERSITY TRAINING:
Neuropsychology Interns, and other interns who may elect to see cases for Neuropsychological and/or Psychodiagnostic Assessment, do so within the Medical Psychology Assessment Center or MPAC. MPAC serves as a centralized Neuropsychological assessment hub for adults and children in UCLA Health and serves a wide variety of patients from different backgrounds. Cultural and individual diversity are cornerstones of the MPAC service delivery model, and critical to the conceptualization of every case. Key factors considered in advance for every case include ethnicity/race, sexual orientation or gender identity, educational background, socioeconomic standing, linguistic background, religious affiliation, military/civilian roles, accessibility of educational and vocational opportunities, neurodiversity, and/or other social markers of diversity. The overall philosophy at the MPAC is one that is closely aligned with the AACN 2050 Relevance Initiative and is focused on the complementary relationship of cultural competence and cultural humility in neuropsychology. Ample opportunity and training on interpreter-mediated assessment is provided as many of our patients are bilingual. A yearly lecture on interpreter-mediated assessment is provided, and trainees are exposed to relevant readings and hands-on training related to working with interpreter services in a neuropsychological assessment context. Individual supervision on each case focuses on cultural and identity factors of the patient that may play a role in case conceptualization and approach to testing. Supervision also provides an opportunity to self-examine identity factors and potential biases that may impact approach to a case as well as factors that relate to the supervisor-supervisee relationship. In addition to "bedside learning" with individual supervisors on cases, MPAC trainees have an opportunity to engage in didactic opportunities focused on diversity interspersed throughout the Thursday seminars, including the quarter-long Cultural Neuropsychology Seminar in

the Spring Quarter. Foundational readings related to cultural and linguistic competency in neuropsychology are also disseminated during orientation and serve as a springboard for ongoing discussion with supervising faculty throughout the academic training year. Students are encouraged to process their own journey of developing cultural competence with the MPAC faculty, including those faculty in the Lifespan Assessment Through Integrated Neuropsychology Program

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation and Case Presentation
Format: Individual and Group
Hours Per Week: Typically 2 hours per assessment case of individual supervision; group supervision is held once per week (1 hour)
Days and Times: Variable

Health and Behavior Track

DESCRIPTION:

The Clinical Psychology Health and Behavior Predoctoral Internship program aims to train competent, independently practicing Clinical Health Psychologists who will be well prepared to pursue a Clinical Health Psychology career in a hospital, healthcare setting, or academic medical center.

This track focuses on consultation with medically ill patients in ambulatory and inpatient hospital settings through the Adult Consultation-Evaluation Service. The intern in this track spends approximately 50% of his or her time on this service from July through February. Specialty training includes the assessment, treatment and consultation of chronic pain, trauma, sleep disorders, neurobehavioral disorders, and oncology. March through June is spent on the Pediatric Psychology Consultation Liaison (C/L) service and in the Adolescent Medicine Clinic, a primary care clinic serving transitional age youth.

HOURS PER WEEK:

-Hours per week in major rotation while on Adult Consultation-Evaluation Service (July-Feb): 24
-Hours per week in major rotation while on Pediatric C/L Service (March-June): 31
-Hours per week in Medical Psychology Assessment Center (July-Feb): 4
-Hours per week in Medical Psychology Assessment Center (March-June): 3

DAILY ACTIVITIES ON ADULT BEHAVIORAL MEDICINE/ADULT CONSULTATION-LIAISON SERVICE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
C/L PSYCHIATRY TEAM ROUNDS-10:15-11:45	C/L NEUROBEHAVIORAL EPILEPSY ROUNDS-10:30-11:00AM	C/L HEAD NECK & SURGERY ROUNDS 6:30-7:30 AM (Nov-Feb) C/L PSYCHIATRY TEAM ROUNDS 10:15-11:30	C/L PSYCHIATRY - TEAM ROUNDS 10:15-11:45AM	TRAUMA SURGERY CLINIC TEAM ROUNDS-9:30-11:30AM and 1-5
MPAC 1PM-5PM	NEUROBEHAVIORAL EPILEPSY CLINIC 1PM-5PM	INDIVIDUAL SUPERVISION (Mind-Body Medicine) 1-2PM (Nov-Feb) TUMOR BOARD CONFERENCE	INDIVIDUAL MEETING WITH DR. THAMES TBD CASE CONFERENCE	INTERN SEMINAR 12-1PM

		2-3PM (Nov-Feb)	AND GROUP SUPERVISION 9:30-11:30	

MANDATORY ACTIVITIES:

Patient Rounds: 8.5 hours per week
Individual Supervision: 4 hours per week
Interns' Seminar: 1 hour per week (Fridays 12-1)
Clinic: 5 hours per week

OTHER MANDATORY ACTIVITIES:

- C/L Didactic: 1.0 hours per week (Wednesdays 9:30-10:30 am)
- Meeting with Advisor: 1.0 hours per week
- Health and Behavior Case Conference and Group Supervision: 2.0 hours per week
- Interns' Seminar: 1 hour per week (Fridays 12-1 pm)
- Hours per week in Tumor Board Conference: 2 (November-February)
- Hours per week in Head and Neck Supervision: 1 (November-February)
- Hours per week in Medical Psychology Assessment Center (July-Feb): 4
- Hours per week in Medical Psychology Assessment Center (March-June): 3
- Child Psychiatry Grand Rounds: 0.5 hours per week, 2nd and 4th Wednesday of each month (March through June)

Fall Quarter: September-December
C/L Seminar: 1 hour per week

Spring Quarter: April-June
Psychodiagnostic Assessment Seminar: 1 hour per week
OR
Fundamentals of Child and Adolescent Psychiatry Seminar: 1.5 hours per week x 2 months
Neuropsychological Syndromes: 1 hour per week

Recommended Activities:

- Departmental Grand Rounds (Tuesday 11-12)
- Neuropsychological Syndromes: 1.5 hours per week
- Trauma Surgery Rounds: 1.5 hours per week

TOTAL HOURS IN MAJOR ROTATION AND OTHER MANDATORY ACTIVITIES PER WEEK:

C/L Rounds: 8.5 hours
MPAC assessment/consultation: 4
Clinic: 5
Supervision/Advising: 4
Mandatory Seminars/Grand Rounds: 4.5
While on Adult Consultation-Evaluation Service: 30
* Approximate Number of Hours Per Week for Electives while on Adult Consultation-Evaluation Service: 5
While on Pediatric C/L Service: 31
* Approximate Number of Hours Per Week for Electives while on Pediatric C/L Service: 5

ADULT CONSULTATION-EVALUATION FACULTY AND STAFF:

April Thames, Ph.D., Shelley Segal, Psy.D., John Brooks, M.D., Ph.D., David Rapkin, Ph.D., Catherine Julliard, M.D., MPH

TRAINING PROVIDED:
The primary activities involve consultation with the physician and nursing staff on the medical units and outpatient clinics in the Medical Center regarding patient-related psychological problems. This may lead to direct contact with the ill patient and/or the patient's family, or it may lead to more extensive consultation with the healthcare team. Trainees may become involved in short-term or extended evaluations and can also perform short-term or extended psychotherapy in a variety of modalities in the medical setting. In addition, the trainees generally provide regular psychosocial support groups for nursing staff and psychosocial case rounds for the medical house staff.

Interviewing, assessing, and formulation of treatment plans for the psychologically upset or disturbed medically ill patient and family of ill patients is a core part of the experience. The trainee will also learn, via an extensive series of lectures, rounds, and assigned readings, the history and general concepts of psychosomatic medicine.

In addition, the intern will meet for 1-hour weekly with other psychologists working in areas of behavioral medicine. These psychologists are involved in areas such as chronic pain, functional neurologic disorders, pain management, head/neck cancer, and psycho-oncology in general.

The Health & Behavior intern spends the first 8 months (July–February) on the Adult Consultation-Evaluation Service and the last 4 months (March–June) on the Pediatric C/L Service and Adolescent Medicine Clinic. Please see the descriptions of the Pediatric C/L and Adolescent Medicine Clinic elsewhere in this manual.

During their 4 hours in MPAC, they receive supervised practical training in the full spectrum of assessment-related activities, including: instrument selection, administration, scoring and interpretation, report preparation, and provision of feedback to the referring clinician/team and to the patient. Trainees may see cases covering a wide range of neurocognitive, medical, and psychiatric disorders from a diverse patient population referred from the NPI/H, the Medical Center, and the community.

DIVERSITY TRAINING:
The Adult Health and Behavior Track/Consultation Liaison Service offers a broad exposure to diversity in patients and families with whom the trainee will meet and consult. Diversity issues therefore become a defined focus in supervision and team clinical discussions.

PEDIATRIC CONSULTATION-LIAISON SERVICE

FACULTY AND STAFF:
Natacha Emerson Ph.D., Director
Krista Tabuenca Ph.D., Associate Director

DESCRIPTION:
From March-June, the intern in this track will do a 4-month rotation on the Pediatric C/L Service and will also participate in the Adolescent Medicine Clinic on Friday afternoons (2pm-5pm).

TRAINING PROVIDED:
Interns will see patients with a wide variety of behavioral, emotional, and family problems that are complicating their medical care. Trainees thus gain firsthand experience working with children and families struggling with serious, childhood illnesses and become integral members of the subspecialty teams. They learn how pediatric medical care is delivered and the role that mental health professionals can and should play in this system.

Common reasons for consult requests are to evaluate for unexplained somatic symptoms, non-adherence to medical recommendations, anxiety, acute stress disorder, behavioral problems, family contributions to adjustment in the child, or depression. All trainees are assigned children undergoing bone marrow, liver, or heart transplants. These patients generally require prolonged patient stays, and thus trainees get experience with ongoing treatment and patient/family management issues.

MANDATORY MEETINGS:
(may vary somewhat)

Day:	Time:	Meeting or Conference:
Mondays	1:30-2:30pm	*Oncology Multidisciplinary Rounds
Tuesdays	11am-11:30am	*PICU/CT-ICU Psychosocial Rounds
Tuesdays	11:30am-1pm	Group Supervision and Walking Rounds
Tuesdays	1:30-2:00pm	*Heart Transplant Rounds
Tuesdays	3:00-3:30pm	*Hospitalist Psychosocial Rounds
Wednesdays	3:00-4:00pm	Teaching Conference
Thursdays.	10:30am-11:30am	Group Supervision via Zoom
Fridays	2:00-5:00pm	Adolescent Medicine Clinic (for Ped C/L, Gen Child and Health Behavior track interns)
Mon-Fri	8:00am-5:00pm	On call for new consults 2-3 days/week

*These rounds are required for three weeks and thereafter when a patient followed by the intern is being discussed.

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation, Case Presentation
Format: Individual
Hours Per Week: 3 – 4 (1 hour of individual, 1-2 hours of group)
Days and Times: Variable
Supervisor(s): April Thames, Ph.D., Shelley Segal, Ph.D., Perry Nicassio, Ph.D., Ph.D., Natacha Emerson, Krista Tabuenca, Ph.D., Ph.D., David Rapkin, Ph.D., Patricia Walshaw, Ph.D., Christine You, Ph.D., John Brooks, M.D., Ph.D.

Major Mental Illness Track

DESCRIPTION:
The Major Mental Illness track is designed to focus on assessment and intervention training that is suited to patients with serious adult psychiatric disorders, including particularly schizophrenia and related psychoses, obsessive-compulsive disorder, mood disorders, and anxiety disorders. This track is designed to allow the intern to split his or her training approximately equally between assessment and intervention experiences. Keith Nuechterlein, Ph.D., serves as the Track Director and advisor for the intern in this track, with multiple faculty psychologists serving as individual supervisors for therapy and assessment rotations.

HOURS PER WEEK IN MAJOR ROTATION:
20

OTHER MANDATORY ACTIVITIES:
Interns' Seminar: 1 hour per week (Fridays 12-1)
Departmental Grand Rounds: 1 hour per week (Tuesdays 11-12)
Meeting with Advisor: 1 hour per week
Neuropsychology Seminars:

Spring Quarter: April-June
Psychodiagnostic Assessment Seminar: 1 hour per week

TOTAL HOURS IN MAJOR ROTATION AND OTHER MANDATORY ACTIVITIES PER WEEK:
25

APPROXIMATE NUMBER OF HOURS PER WEEK FOR ELECTIVES:
15-20

FACULTY AND STAFF:
Keith Nuechterlein, Ph.D., Program Director

TRAINING PROVIDED:
The assessment experience involves required year-long training in psychodiagnostic and neuropsychological assessment through the Medical Psychology Assessment Center (MPAC).
The experience in the MPAC is approximately 20 hours per week for interns in the Major Mental Illness track, including testing and report writing time. The intern conducts inpatient psychodiagnostic assessments and outpatient psychodiagnostic and neuropsychological assessments with patients with a wide range of diagnoses and presenting problems, with emphasis on major mental illnesses. Supervisors with specialized expertise in each assessment domain are available for these assessment batteries.

The intervention experiences involve selection of elective rotations in outpatient specialty clinics, which focus on therapeutic interventions tailored to individual disorders. The Major Mental Illness intern can select from a broad range of specialty clinics, including the Aftercare Program (first-episode schizophrenia clinic), the Center for Assessment and Prevention of Prodromal States, the Psychosis Clinic, the OCD Intensive Outpatient Program, the Mood Disorders Program, the Anxiety Disorders Clinic, and the Spanish Speaking Psychosocial Clinic. These clinics offer a wide variety of therapeutic orientations and individual and group interventions. The intern is also encouraged to have at least one rotation in an adolescent or child outpatient program, selecting from the many electives listed in this Manual. The Major Mental Illness track intern will typically select two to three specialty clinic electives at a given time.

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation, Case Presentation
Format: Individual and Group
Hours Per Week: Typically, 2 hours per week, more if clinical load indicates (2 hours of individual supervision from different supervisors, 1 hr of group)
Days and Times: Individual supervision at times to be arranged; group supervision Tues, 9-10 and 10-11
Names of Supervisor(s): Keith Nuechterlein, PhD; Luana Turner, Psy.D; Kenneth Subotnik, PhD

Geriatric Psychology – Neuropsychology Track

DESCRIPTION:
The focus of the Geropsychology-Neuropsychology track is on outpatient neuropsychological assessment of adults 65 and older, caregiver education, and group psychotherapy. Individual psychotherapy opportunities and behavior modification assessments arise on occasion, upon request of physicians or family members.

HOURS PER WEEK IN MAJOR ROTATION:

MINOR ROTATIONS:
Group psychotherapy (2 hours per week of clinical work plus 1 hour supervision; 6 months)
Support groups (0.5 hour per week; 6 months)

OTHER MANDATORY ACTIVITIES:
Interns' Seminar: 1 hour per week (Fridays 12-1)
Meeting with Advisor: 1 hour per week
Neuropsychology Seminars:

Fall Quarter: September 23rd - December 13th
Functional Neuroanatomy: 1 hour per week
Neuropsychology Informal Brown Bag Lunch (NIBBL): 1 hour per week
Neuropsychological Syndromes: 1 hour per week

Winter Quarter: January 2nd – March 21st
Functional Neuroanatomy: 1 hour per week
Neuropsychology Informal Brown Bag Lunch (NIBBL): 1 hour per week
Neuropsychological Syndromes: 1 hour per week
Geropsychology Journal Club: 0.25 hours per week

Spring Quarter: March 26th – June 13th
Neuropsychology Informal Brown Bag Lunch (NIBBL): 1 hour per week
Neuropsychological Syndromes: 1 hour per week
Geropsychology Journal Club: 0.25 hours per week

Additional Recommended Educational Opportunities:
- Departmental Grand Rounds: 1 hour per week (Tuesdays 11-12)
- Cultural Neuropsychology Seminar: Thursdays 1-2pm (Fall Quarter)
- NP Professional Development: 2nd and 4th Thursday of the month, 0.5 hours (Thurs 4-5pm)
- Intervention Approaches for Cognitive Impairment: Thursdays 1-2pm (Spring Quarter)
- Clinical fMRI Interpretation: Thursdays 10-11am (Winter Quarter)
- Psychodiagnostic Assessment Seminar: 1 hour per week
- Epilepsy surgery rounds: every Wednesday 1-2:30pm
- Brain Cutting: every Thursday 9-10am
- Wada, intraoperative mapping, extraoperative grid mapping (variable times)

APPROXIMATE HOURS IN MAJOR ROTATION AND OTHER MANDATORY ACTIVITIES PER WEEK:
30.5-33

APPROXIMATE NUMBER OF HOURS PER WEEK FOR ELECTIVES:
7-9.5

FACULTY AND STAFF:
Kathy Tingus , Ph.D. Program Director
Emnet Gammada, Ph.D.
Lucy Wall, Psy.D.

TRAINING PROVIDED:
The focus of the track is largely neuropsychological assessment of outpatient older adults, and it also provides opportunities for other in-depth work with older adults including group and individual psychotherapy, behavior modification, caregiver education and support, and cognitive enhancement. The Geriatric Psychology-Neuropsychology receives outpatient neuropsychology referrals from various sources throughout UCLA including psychiatry (Geriatric Evaluation Clinic), other medical clinics (e.g., Geriatric Medicine, Neurology, Internal Medicine) and community referrals. Trainees will gain experience with and exposure to a myriad of disorders commonly affecting the cognition and mood of older adults (various dementias, delirium, late onset psychosis and depression, and more) and become adept at differential diagnosis. The intern in this track sees six outpatients per month.

Training objectives that can be met by experience in outpatient include:

1. Introducing psychology trainees to the special mental health problems most commonly affecting older adults, including adjustment reactions to aging, coping with multiple losses, late-onset depressive and psychotic reactions, and the dementias, including Alzheimer's disease, Vascular dementia, Lewy Body dementia, Parkinson's disease, among others.

2. Providing each trainee with experience in multidisciplinary assessment and treatment.

3. Providing each trainee with experience in designing behavioral programs to treat problems in behavior that occur in dementia.

4. Providing group therapy for older adults with depression, anxiety, and co-morbid medical conditions.

5. Trainees may be involved in providing caregiver support, either individually or in a group setting.

Supervision for outpatient assessment will generally consist of individual sessions provided at critical touchpoints throughout each case. Generally, this consists of prior to evaluating the patient to review the case and decide on a test battery, during the assessment, and also following the evaluation to review test data and conclusions.

The intern in this track also participates in a geriatric psychotherapy group under the supervision of Lucy Wall, Psy.D. The outpatient psychotherapy group provides a combination of supportive, insight-based and Cognitive Behavioral interventions for older adults. The type of interventions covered include: (a) Deep breathing and relaxation training; (b) Meditation (e.g., body scan, visualization, and guided imagery); (c) Cognitive elements (e.g., cognitive restructuring, addressing distorted thought patterns); (d) Behavioral components (e.g., activation, discussing the connection between increased pleasant events and mood); and (e) Problem-solving & goal setting. Recently discharged patients from 4-North may also be referred to the group for ongoing support.

The intern will rotate through the Caregiver Support Group facilitated through the Easton Center two Tuesdays a month, supervised by Kathy , PhD. There are elective opportunities for interns to co-lead in-person support groups for Spanish speaking caregivers of patients with Alzheimer's disease supervised by Mirella Dios Santos, Ph.D.

DIVERSITY TRAINING:
Neuropsychology Interns, and other interns who may elect to see cases for Neuropsychological and/or Psychodiagnostic Assessment, do so within the Medical Psychology Assessment Center or MPAC. MPAC serves as a centralized Neuropsychological assessment hub for adults and children in UCLA Health and serves a wide

variety of patients from different backgrounds. Cultural and individual diversity are cornerstones of the MPAC service delivery model, and critical to the conceptualization of every case. Key factors considered in advance for every case include ethnicity/race, sexual orientation or gender identity, educational background, socioeconomic standing, linguistic background, religious affiliation, military/civilian roles, accessibility of educational and vocational opportunities, neurodiversity, and/or other social markers of diversity. The overall philosophy at the MPAC is one that is closely aligned with the AACN 2050 Relevance Initiative and is focused on the complementary relationship of cultural competence and cultural humility in neuropsychology. Ample opportunity and training on interpreter-mediated assessment is provided as many of our patients are bilingual. Several lectures on interpreter-mediated assessment are provided, and trainees are exposed to relevant readings and hands-on training related to working with interpreter services in a neuropsychological assessment context. Individual supervision on each case focuses on cultural and identity factors of the patient that may play a role in case conceptualization and approach to testing. Supervision also provides an opportunity to self-examine identity factors and potential biases that may impact approach to a case as well as factors that relate to the supervisor-supervisee relationship. In addition to "bedside learning" with individual supervisors on cases, MPAC trainees have an opportunity to engage in didactic opportunities focused on diversity interspersed throughout the Thursday seminars, including the quarter-long Cultural Neuropsychology Seminar in the Spring Quarter. Foundational readings related to cultural and linguistic competency in neuropsychology are also disseminated during orientation and serve as a springboard for ongoing discussion with supervising faculty throughout the academic training year. Students are encouraged to process their own journey of developing cultural competence with the MPAC faculty, including those faculty in the Lifespan Assessment Through Integrated Neuropsychology.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation and Case Presentation

Format: Individual and Group
Hours Per Week: 3
Names of Supervisor(s): Drs. Tingus, Gammada, and Wall
Method of Supervision: Format: Individual, live, case presentation

Lifespan Assessment Through Integrated Neuropsychology

DESCRIPTION:

The Lifespan Assessment Through Integrated Neuropsychology Track offered through the UCLA Semel Institute and Resnick Neuropsychiatric Hospital's APA-approved doctoral internship program is designed to meet all requirements for exemplary training in clinical neuropsychology as described in the "Adult Neuropsychology Track" description. The primary emphasis of this specialty track is on neuropsychological assessments of Spanish monolingual, English/Spanish bilingual, and culturally self-identified Hispanic and/or Latina/o patients. Thus, trainees on this track MUST demonstrate proficiency in both English and Spanish to be considered for this position.

HOURS PER WEEK IN MAJOR ROTATION:

28.5

OTHER MANDATORY ACTIVITIES:

LATIN Bilingual Case Conference Supervision: 1 hour per week (Thursdays 11am-12pm)

Interns' Seminar: 1 hour per week (Fridays 12-1)
Meeting with Advisor: 1 hour per week
Neuropsychology Seminars:

Fall Quarter: September-December
Functional Neuroanatomy: 1 hour per week
Neuropsychology Informal Brown Bag Lunch (NIBBL): 1 hour per week
Neuropsychological Syndromes: 1 hour per week
Advanced Topics in Adult Neuropsychology: 1 hour per week

Winter Quarter: January-March
Clinical fMRI Interpretation: 1 hour per week
NIBBL: 1 hour per week
Research on Pediatric Neurobehavioral Disorders: 1 hour per week
Neuropsychological Syndromes: 1 hour per week

Spring Quarter: April-June
Psychodiagnostic Assessment Seminar: 1 hour per week
NIBBL: 1 hour per week
Cultural Neuropsychology: 1 hour per week
Neuropsychological Syndromes: 1 hour per week

Additional Recommended Educational Opportunities:

- Departmental Grand Rounds: 1 hour per week (Tuesdays 11-12)
- Pediatric Neuropsychology Seminar: Thursdays 2-3pm
- NP Professional Development: 2nd and 4th Thursday of the month, 0.5 hours (Thurs 4:30-5:30pm)
- Intervention Approaches for Cognitive Impairment: Thursdays 1-2pm (Spring Quarter)
- Clinical fMRI Interpretation: Thursdays 10-11am (Winter Quarter)
- Psychodiagnostic Assessment Seminar: 1 hour per week
- Epilepsy surgery rounds: every Wednesday 1-2:30pm
- Brain Cutting: every Thursday 9-10am
- Wada, intraoperative mapping, extraoperative grid mapping (variable times)

TOTAL HOURS IN MAJOR ROTATION AND OTHER MANDATORY ACTIVITIES PER WEEK:
38.5 APPROXIMATE

NUMBER OF HOURS PER WEEK FOR ELECTIVES:
1.5-6.5

FACULTY AND STAFF:
Paola A. Suarez, Ph.D., Director
Lucia Cavanagh, Ph.D., Associate Director
Carlos Saucedo, Ph.D., ABPP-CN
David Lechuga, Ph.D.
Vindia Fernandez, Ph.D.
Diomaris Safi, Ph.D.
Marcel Ponton, Ph.D.

TRAINING PROVIDED:
The intern will have the opportunity to complete evaluations on a variety of inpatients and outpatients referred to LATIN-C by Neurology, Psychiatry, Organ Transplant, other medical center clinics/units, and the community at large. Our pool of supervisors includes all bilingual and bicultural faculty with various clinical specialties across the lifespan. The intern will be required to attend select didactic seminars in neuropsychology and participate in a range of other activities along with bilingual neuropsychology practicum students and bilingual postdoctoral fellows. These activities may also include bilingual Wada testing and intra-operative brain mapping. The remainder of the trainee's program is comprised of general clinical activities, supervision, intern seminars, and elective rotations. A full list of electives is provided in this manual. A specific program plan will be developed by the intern and presented to the training committee in order to ensure a breadth of experience that complements the mandatory specialized training in neuropsychology. The LATIN-C intern within this track must demonstrate strong proficiency in both English and Spanish to be considered for this unique bilingual internship experience.

DIVERSITY TRAINING:
The LATIN-C Track is organized under the framework of "Socially Responsible Neuropsychology," (Suarez, et. al., 2016), and the LATIN-C serves as the centralized hub for all Spanish bilingual neuropsychological assessment within the UCLA Health System. The LATIN-C goes beyond trying to provide equal care for limited English proficiency patients to focus on providing equitable care, acknowledging the fact that health disparities exist and addressing these head-on. In addition to providing specialized internship training experience in clinical neuropsychology more broadly, the LATIN-C track provides a

comprehensive and responsive bilingual/bicultural model of neuropsychological assessment targeted toward serving the unique cultural and linguistic needs of the historically underrepresented Latina/o/x population. A unique feature of the LATIN-C track is the immersion of trainees in a multilingual and multicultural clinic with patients from all walks of life and educational backgrounds. Trainees on the LATIN-C track also rotate within MPAC to ensure a well-rounded training experience.

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation and Case Presentation
Format: Individual and Weekly Group Case Conference
Hours Per Week: 1 hour of individual/week with advisor; 1 hour group supervision/week; additional individual supervision as necessary; opportunity to attend supervision-on-supervision with fellows
Days and Times: Thursdays, 11:00 to 12:00pm for Group Case Conference; variable for all others
Names of Supervisor(s): As listed above under Faculty and Staff section.

Elective Services and Programs

Although electives are listed by child and adult focus, interns are encouraged to select electives outside of their track focus to broaden their training experience. There are not prerequisites for electives, other than for neuropsychological assessment. Participation is based on trainee interest.

Health Equity Elective

PROGRAM DESCRIPTION:

You may create an elective of up to 6 hours per week focused on Health Equity work (see https://uclahs.app.box.com/file/1237331805810 for more information on existing elective opportunities with Health Equity focus). Speak with your advisor or other faculty and staff to discuss your area of interest and find an activity that matches it or create your own experience. You will then present your elective to the training committee for approval.

DAY, TIME AND LOCATION:
Flexible

HOURS PER WEEK:
Up to 6 hours

DURATION OF ELECTIVE:
Up to 6 months

FACULTY:
Varies

Elective Coordinator: Emily Ricketts, Ph.D.

Child Elective Clinical Services and Programs

4W Child/Adolescent Inpatient Group Elective

26-27 Availability: 1-2 interns per trimester to complete 4-month elective July-Oct, Nov-Feb or March-June

PROGRAM DESCRIPTION:
For this elective, interns serve as co-leaders alongside social work to provide various psychoeducational and skills-based groups (1 group per week) on the child and adolescent inpatient psychiatric unit. The goal of the training is to provide the psychologist with an introductory experience in brief intervention and behavioral management in a group setting of youth presenting to inpatient psychiatric level of care. Patients may have several psychiatric and/or medical comorbidities.

DAY, TIME AND LOCATION:
Groups: Mondays at 4-4:45pm **OR** Tuesdays 2:15-3pm
4West, 4TH Floor Resnick Neuropsychiatric Hospital
Supervision: Fridays 8-9am

HOURS PER WEEK:
2.5

DURATION OF ELECTIVE:
4 months

FACULTY:
Krista Tabuenca, Ph.D.

TRAINING PROVIDED:
Trainees gain exposure to working with youth ages 5-17 years with serious mental illness in a high acuity setting. Common presentations include high risk behaviors, suicidality, depression, anxiety, psychosis, aggression,

school problems, family discord, and developmental disability. All patients are admitted on our high acuity units (Unit B & C) for brief psychiatric stabilization, which vary in lengths, but are on average 7-14 days. Psychoeducation and brief intervention are primary topics of groups, which will be co-led alongside clinical social workers. Any additional impressions of patients from groups will be communicated to the interdisciplinary team, which includes psychiatrists, psychologists, social workers, occupational therapists, recreational therapists, speech pathologists, educational consultants, and nursing. Trainees will receive group supervision to review approaches and hear about general presentations from their colleagues. Trainees will also receive guidance in documentation of mental health concerns in a medical record, as well as culturally sensitive approaches to the diverse populations.

For more information and to sign up for this elective, contact Krista Tabuenca, Ph.D., at ktabuenca@mednet.ucla.edu

SUPERVISION PROVIDED:
Method of Supervision: In person
Format: Group
Hours Per Week: 2.5 (1.5 hours for group/prep/documentation, 1 for supervision)
Days and Times: Groups: Mondays at 4-4:45pm, or Tuesdays 2:15-3pm
Supervision: Fridays 8-9am
Names of Supervisor(s): Krista Tabuenca, PhD

Adolescent Medicine Outpatient Clinic Elective

26-27 Availability: 1 intern per trimester to complete 4-month elective July-Oct, Nov-Feb or March-June

PROGRAM DESCRIPTION:
For this elective, interns serve as the primary mental health professional integrated within a primary care clinic for adolescents and young adults. The goal of training is to provide the psychologist with an introductory experience in evaluation, brief intervention and triage of transitional age youth presenting to an outpatient adolescent medicine clinic. Patients have a range of medical conditions, developmental abilities, and co-morbid psychosocial and/or mental health problems.

DAY, TIME AND LOCATION:
Clinic: Fridays 2:00-5:00pm
200 Medical Plaza, Suite 265
Group Supervision: Thursdays 10:30-11:30am via Zoom

HOURS PER WEEK:
5

DURATION OF ELECTIVE:
4 months

FACULTY:
Natacha Emerson, Ph.D.

TRAINING PROVIDED:
Trainees conduct brief evaluations to target presenting symptoms, which can include symptoms of trauma, depression, anxiety, psychosis, aggression, grief, high-risk behavior, obesity, school problems, family discord, and behavioral problems associated (or not associated) with a developmental disability. Psychoeducation and limited skills building may be provided. Recommendations and referrals for further care are provided to the pediatrician and patient/family. Trainees attend weekly group supervision Wednesdays at 11am which includes review of both adolescent medicine cases and consultation-liaison cases. Trainees are expected to

be done seeing patients by 5pm (or sooner) each Friday. If more than two interns wish to share the elective, a rotating schedule will be creating so that two interns at a time will be in clinic.

This experience is required for the Pediatric Consultation-Liaison intern and the Health Behavior intern while on the Pediatric Consultation-Liaison rotation. For those wishing to elect this experience, please attempt to schedule it during a rotation when you are not also on Peds CL.

For more information and to sign up for this elective, contact Natacha Emerson, Ph.D., at ndemerson@mednet.ucla.edu

SUPERVISION PROVIDED:
Method of Supervision: Case Presentation
Format: Individual (remotely) and Group
Hours Per Week: 4-5 (4 if also on Peds CL; 5 if not on Peds CL,) (2.5 group, 1 individual)
Days and Times: Thursday: 10:30amam-11:30am (supervision); Fridays 2-5pm (clinic)
Names of Supervisor(s): Natacha Emerson, PhD; plus, Pediatrician Attendings on site, under the direction of Martin Anderson, MD

Adolescent Serious Mental Illness Treatment Elective

26-27 Availability: Fall, Winter Spring

DESCRIPTION & TRAINING PROVIDED:
The Adolescent Serious Mental Illness (ASMI) treatment elective is housed within the UCLA Center for the Assessment and Prevention of Prodromal States (CAPPS), which provides flexible opportunities for comprehensive assessment and innovative treatments for adolescents and young adults who are at elevated risk for psychosis. There is increasing evidence that earlier interventions can lead to improved long-term outcomes for these youth, and our ASMI elective offers experience with some best practice interventions for youth with psychosis-risk symptoms.

Interns have the uniquely flexible opportunity to train on a variety of clinical activities within CAPPS, such as the facilitation of our youth resilience-based process group and/or our teen and parent skills groups, rooted in CBT and Mindfulness based cognitive therapy. We are also piloting a lifestyle intervention for at-risk teens. Groups run weekly for 60-90 min., typically in the evenings. Additional optional elective opportunities include shadowing and delivery of our gold standard psychosis-risk diagnostic assessment interviews (SIPS, PSYCHS), participation in weekly case consultation and monthly didactic series, and/or carrying individual therapy or family psychoeducation cases with CAPPS adolescents and young adults. Opportunities are available to conduct clinical assessment and treatment in both English and Spanish.

HOURS PER WEEK:
3-5 (flexible)
*Note: Interns may also inquire about visiting CAPPS outside a formal elective, such as attending a team meeting or shadowing an assessment.

DURATION OF ELECTIVE:
4-6 months

DAY, TIME AND LOCATION:
CAPPS is located on the 2nd floor of the Semel Institute
Multiple groups run weekly, typically in the early evening (days & times tbd)
Supervision for elective interns: 30 min. pre-group and 1 hr. worked into your schedule
Optional meetings: Monday morning didactics (monthly) & clinical team supervision (weekly)
M-F opportunities to shadow psychosis-risk assessments

DIVERSITY TRAINING:

ASMI clients are diverse in terms of ethnicity/race, SES, religion, gender identity, nationality, acculturation, and sexual orientation. Diversity and cultural competency are core values of our program, and we strive to honor the backgrounds of our clients. Towards this end we have recruited diverse staff and trainees and consistently work to ensure that we are welcoming to people from all backgrounds. We expect that trainees will be open to working with clients representing different values, cultural experiences, and lifestyles than they have. Multicultural training starts during orientation and is woven into all aspects of training throughout the year. We train interns in multicultural identity development models and in thinking in a culturally competent way, rather than encouraging them to apply group-level information in stereotyped fashion. We use supervision to emphasize cultural humility to trainees and to assist them in identifying and working through areas of bias and blind spots. Trainees are encouraged to self-explore and reflect on their own multicultural identity and how that impacts their clinical interpretations and approach to their cases. Trainees are also assisted in sensitively communicating with clients about individual, family, and cultural identities, strengths and differences, and core personal values.

FACULTY AND STAFF:
Carrie Bearden, Ph.D., Program Director
Jamie Zinberg, M.A., Administrative and Psychosocial Treatment Director
Laura Adery, Ph.D., Associate Clinical Director, Treatment and Assessment Supervisor
Danielle Denenny, Ph.D., Group and Family Treatment Supervisor

SUPERVISION PROVIDED:
Format: Direct & Videotape Observation
Days & Times: Group supervision 1.5 hours per week (primary); also, by arrangement
Names of Supervisors: Carrie Bearden, Ph.D., Laura Adery, Ph.D., Danielle Denenny, Ph.D.

Child and Adolescent Mood Disorders Program (CHAMP)

Available for the 26-27 Training Year

PROGRAM DESCRIPTION:
The CHAMP Clinic is a UCLA program that focuses on differential diagnosis and treatment of pediatric mood disorders, including bipolar disorder and major depression. The CHAMP Clinic involves three components: comprehensive diagnostic assessment of pediatric illness, pharmacological treatment, and psychological treatment.

The Clinic sees many patients with complicated and highly comorbid clinical presentations and focuses on providing a comprehensive differential diagnostic evaluation, using the "Kiddie" Schedule for Affective Disorders and Schizophrenia (K-SADS) as a format. Under faculty supervision, trainees take lead roles in conducting these evaluations and receive supervision in differential diagnosis.

CHAMP is one of the few rotations where one can get concentrated training in family therapy. Family treatment is manual-guided, evidence-based, and relatively brief (e.g., up to 12 sessions). It is based primarily on the family-focused therapy (FFT) model of care, which is both strategic and psychoeducational in orientation. Mood and behavior management techniques are used to teach families and children effective communication and problem-solving skills. Psychoeducation is used to teach coping skills for managing mood episodes (e.g., manic episodes of bipolar disorder) and prevent future episodes. Often, strategic or structural family therapy techniques are included (e.g., modifying dysfunctional interactions, strengthening alliances between family members). Supervision involves live observation of family intervention sessions via video or Zoom with a team that includes three experienced licensed clinical psychologists.

Medication backup for patients is provided by our child psychiatrist, Drs. Horstmann, and child psychiatry fellows under her supervision. Psychology trainees gain exposure to psychopharmacological interventions

through the co-management of patients with mood disorders who require medication as well as psychological treatments.

CHAMP is a good way to get experience with diagnostic assessment, family therapy or both for adolescents and children with mood disorders, experience which will be essential to future clinical practice

DAY, TIME, AND LOCATION:
Mondays 12 pm - 6pm Semel, Room A8-256
Interns may select either the assessment or therapy elective within the clinic, or they may elect both. The assessment elective (including supervision) runs from 12-2:15 pm and the therapy elective (including supervision) runs from 2:15pm-6pm.

HOURS PER WEEK:
2.25 (assessment) or 3.5 (therapy)

DURATION OF ELECTIVE:
6 months

FACULTY AND STAFF:
David Miklowitz, Ph.D.
Patricia Walshaw, Ph.D.
Sarah Marvin, Ph.D.
Alissa Ellis, Ph.D.
Angus Strachan, Ph.D.
Elizabeth Horstmann, M.D.

TRAINING PROVIDED:
Trainees should expect to have 3-4 assessments during the assessment elective.

The therapy elective includes family therapy sessions, group supervision, and whenever possible, observing others' sessions. The commitment for either option is 6 months. Family therapy trainees should expect to see 2 patients per week either as primary therapist or co-therapist, with 'real-time' group supervision provided before and after (and sometimes even during) sessions. Individual supervision is provided during or outside of clinic hours on an as-needed basis.

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation, Videotape, Case Presentation
Format: Group
Hours Per Week: 3.5 group
Days and Times: Monday 2:15 – 6:00 PM
Names of Supervisor(s): David Miklowitz, Sarah Marvin, Patricia Walshaw, Alissa Ellis, Angus Strachan, and Elizabeth Horstmann

Child and Adolescent OCD Intensive Outpatient Program (IOP)

26-27 Availability: Fall, Winter Spring

PROGRAM DESCRIPTION:

The UCLA Pediatric OCD IOP provides in depth evidence-based treatment for youth ages 5 to 17 with severe obsessive-compulsive disorder. Our patient population primarily includes youths who either have failed outpatient care, need additional treatment following step-down from inpatient or residential treatment, or have traveled from an area where appropriate treatment is not available. Youths also often present with diagnostic co-morbidities, including anxiety, depression, externalizing problems, and autism spectrum disorder. Youths and their primary caregiver attend a program four afternoons per week for intensive individual and group therapy sessions. Primary treatment modality is Exposure & Response Prevention (ERP), a specialized form of cognitive behavioral therapy. Additional treatment techniques include anxiety management, family therapy, parent and patient psychoeducation, and medication management.

DAY, TIME, AND LOCATION:
One afternoon Monday, Tuesday, Wednesday, or Thursday, 12:30-4:30pm
300 Medical Plaza, Rm. 1315

HOURS PER WEEK:
5

DURATION:
4 months or 6 months

FACULTY AND STAFF:
Sisi Guo, PhD, Director
Mina Yadegar, PsyD, Associated Director
Jena Lee, M.D., Medical Director

TRAINING PROVIDED:
Interns who select this elective placement participate on one afternoon per week (12:30–4:30 pm; Monday, Tuesday, Wednesday, or Thursday). The commitment is either 4 or 6 months. It is recommended that Interns also participate in our hospital treatment rounds on Mondays (10:00 am–11:30 pm). The time commitment for this elective does not exceed 5 hours per week. Interns are fully integrated into the treatment team, and participate in co-leading treatment groups, and both group and individual therapy work with patients. Interns are able to work with different youths on different days, depending on the program census. Interns are not responsible for case management. This placement provides real-time live supervision, training in working as part of a multidisciplinary team in a hospital-based intensive outpatient program, and advanced skills in ERP. Interns may also have the opportunity to collaborate with our attending psychiatrist to learn pharmacological interventions for OCD and related conditions. Interns selecting this rotation should have previous clinical experience with child CBT.

DIVERSITY TRAINING:
The OCD IOP team assesses and intensively treats a youth patient population from across the state and country characterized by a wide range of diversity including but not limited to race, culture, ethnicity, religion, and socioeconomic status. Therefore, we prioritize the integration of diversity training into all aspects of the rotation experience. This includes didactics such as relevant readings, talks and consultation with professionals with expertise in salient domains (e.g., gender studies, Latino mental health etc.). Experiential instruction in diversity issues is addressed through a collaborative team-based approach to supervision, which allows for in-depth case conceptualization, assessment and treatment planning that integrates the diverse perspectives of the patient, family, and therapist. The intensive nature of this training experience includes daily live supervision, which allows real time opportunity to address diversity factors that may shape and influence child and family outcomes. Throughout their training experience, trainees are encouraged to synthesize their knowledge base

in empirically supported interventions with cultural competency to effectively serve the needs of their patients and families.

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation and Case Presentation
Format: Individual and Group
Hours Per Week: 5 hours (1 hour of group supervision)
Days and Times: Monday 10:00-11:30 pm (group rounds) and one afternoon per week (Monday – Thursday 12:30 – 4:30 pm); Thursday are on Zoom for treatment generalization
Names of Supervisor(s): Sisi Guo, Ph.D., Mina Yadegar, Psy.D., Jena Lee, M.D.

Child and Adult Neurodevelopmental Clinic (CAN): Multidisciplinary and High Complexity Evaluations and Treatments

26-27 Availability

DESCRIPTION
This elective provides an opportunity to gain experience and familiarity with people with neurodevelopmental conditions, including autism spectrum disorder, and genetic conditions through a 4-month commitment for assessment training as part of our comprehensive assessment team (also involves presenting at our multidisciplinary case conference) or a 6-month commitment for treatment cases—group treatment and/or individual treatments. Caseload can be discussed and tailored to the needs of the trainee.

DAY, TIME AND LOCATION:
Assessment Training: Mondays, Tuesdays, or Wednesdays from 10am to 2pm
Treatment Cases: Mondays through Thursdays in the afternoon
Optional (highly recommended) Multidisciplinary Case Discussion: Thursdays from 12pm to 1pm
Optional ADOS-2 Training: Every other Thursday from 9:30 a.m. to 11:00 a.m.
Location: 300 Medical Plaza.

HOURS PER WEEK:

- Assessment: 6 hours in total; 4-month rotation:

  Conduct assessment in the morning for one day on either Mon, Tue, or Wed, 10am-2 pm. Attend multidisciplinary team case conference on Thursday from 12:00 to 1:00 PM for (1 hour) to present your case. 1 hour for report writing. 1 hour for supervision.

- Treatment: 3.5 hours in total (maximum); 6-month rotation for individual therapy and 4-month rotation for group therapy. Treatment occurs in the afternoon and the day of the week varies each rotation.

  1 hour for individual therapy or 1.5 hours for group therapy. 1 hour for supervision. 1 hour for collateral contacts.

  Group treatments include:
  (1) Teens with ASD coping skills group (16 sessions, 4-5:30 PM)
  (2) Parent Support Group: Education and Support Group for Parents of Children Recently Diagnosed with Autism Spectrum Disorder (8 sessions, 4-5 PM)
  (3) RUBI Parent Training Program

Individual therapy is scheduled in the afternoon depending on availability of family, trainee, and supervisor.

DURATION OF ELECTIVE:
Flexible, 4 - 6 months

FACULTY AND STAFF:
Amanda Gulsrud, Ph.D.
Nicole McDonald, Ph.D.
Patricia Renno, PhD
Sara McCracken, PsD, BCBA
Medical Director: Benjamin Schneider, M.D.

TRAINING PROVIDED:
Assessment: The CAN Clinic provides multidisciplinary assessment and consultation in a collaborative environment to evaluate complex cases of individuals (e.g., co-occurring medical or psychological conditions) with ASD, related neurodevelopmental, or genetic conditions across the ages from young children to adults. The team consists of clinical psychologists, child and adolescent psychiatrists, and child neurologists with additional professionals in the field to consult as necessary. Assessments are based on best practice standards and incorporating diagnostic and treatment considerations based on current research in the field. Trainees will work with individuals and their families in a number of capacities such as conducting intakes and providing feedbacks. Assessments include cognitive, diagnostic (this may include autism diagnostic measures such as the ADOS-2), neuropsychological, achievement, projective, and interpreting informant reports.

Treatment: Training in treatments that are based on evidence-based practices (e.g., CBT, social skills treatments, and naturalistic developmental behavioral interventions) in individuals with ASD is available. Treatments are provided in individual format with parent-training components. The range of presenting issues includes co-occurring emotion regulation difficulties (e.g., comorbid anxiety, depression, behavioral concerns) and ASD related symptoms (e.g., rigid thinking, social skills impairments), as well as the overlap between these two areas.

The following opportunities for group-based treatments are also available:

- ***RUBI Parent Training Program*** (8 sessions). A parent-focused group to support challenging behaviors in young minimally verbal children with ASD.
- ***Parent Support Group: Education and Support Group for Parents of Children Recently Diagnosed with Autism Spectrum Disorder*** (8 sessions). An 8-week education series for parents of children recently diagnosed with autism spectrum disorder (ASD). This group is designed to both inform and support parents in learning about ASD, evidence-based strategies and interventions, and navigating pertinent community resources.
- ***Teen Coping Skills Group*** (16 sessions). For adolescents with autism spectrum disorder with intact verbal abilities experiencing depression and/or anxiety.

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation, Videotape and Case Presentation
Format: Individual and Group
Hours Per Week: 3-6 Hours per week depending on evaluation or therapy focus (1 hour of individual, 1 hour of group)
Days and Times: Flexible M-F 9 AM – 5 PM

Names of Supervisor(s): Patricia Renno, PhD, Nicole McDonald, PhD, Amanda Gulsrud, PhD, Sara McCracken, PsyD, BCBA

Child OCD, Anxiety, and Tic Disorders Program

Available for the 26-27 training year

PROGRAM DESCRIPTION:
The Child OCD, Anxiety, and Tic Disorders Program specializes in the evaluation and evidence-based treatment of children and adolescents with OCD, anxiety, tic, and body-focused repetitive behavior (e.g., trichotillomania, skin picking) disorders.

DAY, TIME, AND LOCATION:
Mondays 1 – 5 pm *or* 1 – 6 pm, plus 30 min for prep/documentation/phone calls
300 Medical Plaza, Room 1208

HOURS PER WEEK:
4.5 or 5.5

ROTATIONS:
6 months (July – December, January – June)

FACULTY AND STAFF:
John Piacentini, Ph.D.
Emily Ricketts, Ph.D.
Margaret Stuber, MD
Juliet Edgcomb, MD
Julia Revillion Cox, Ph.D.
Michael Treanor, Ph.D.

TRAINING PROVIDED:
Treatment is typically manual-guided, relatively brief in nature, and based on cognitive behavioral techniques. Additional anxiety management techniques and family interventions are used to enhance adherence and strengthen and maintain treatment gains. Medication management for patients as needed is provided for in Clinic, by child psychiatry trainees under the supervision of Drs. Stuber and Edgcomb. Psychology trainees gain exposure to psychopharmacological interventions for OCD, anxiety, and tic disorders through the co-management of patients requiring this combined treatment. A structured assessment battery is administered pre- and throughout treatment allowing for the systematic evaluation of treatment outcome.

In addition to ongoing therapy, the Program also provides comprehensive diagnostic evaluations on a consultative basis to youngsters with typically complicated or highly comorbid clinical presentations. Under faculty supervision, trainees have the opportunity to take lead roles in conducting these evaluations. Treatment manuals for some of the disorders seen in clinic are provided to trainees at the start of the rotation.

The first 1-2 hours of clinic are spent in: 1) didactic instruction in the assessment and treatment of OCD, anxiety, tics, body-focused repetitive behaviors, and co-occurring problems, and 2) group supervision for ongoing clinic cases. The remainder of time is spent delivering clinical care to patients. Trainees are expected to carry 2-3 cases at any one time along with occasional 1-2 visit diagnostic consultations. Each session is observed by faculty (and available trainees) via a one-way mirror. Additional real-time supervision and instruction is provided during and between sessions. Individual supervision is provided outside of regular clinic hours on an

as needed basis. The total time commitment is 4.5 or 5.5 hours per week.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation, Case Presentation
Format: Individual and Group
Hours Per Week: 3 - 4 (1 hour for group, live supervision, available for additional time as needed)
Days and Times: Mondays 1 – 5 pm or 1 – 6 pm, plus availability to meet during the week as needed
Names of Supervisor(s): John Piacentini, PhD ABPP, Emily Ricketts, PhD, Margaret Stuber, MD, Juliet Edgcomb, MD, Julia Revillion Cox, PhD, Michael Treanor, PhD

Family Development Program (FDP)

Available for the 26-27 training year

PROGRAM DESCRIPTION:

The Family Development Program (FDP) provides evaluation, consultation, prevention and treatment services for families who are facing early life medical challenges with their infant, including high-risk pregnancies and NICU stays. The mission of FDP is to enhance the ability of family members to care for themselves and each other, and to cope with stressors while bonding with their infant. The rotation provides interns with specialized experience in the following areas:

-Bedside and phone consultations with families currently admitted to the NICU

-Individual weekly outpatient therapy with caregivers

-Couples therapy

-Group Therapy

Interns will receive training in brief and long-term individual and dyadic interventions and will learn to recognize and respond to the unique challenges of parenting medically complex infants and navigating medical trauma during the transition to parenthood. FDP's family-centered approach allows clinicians to tailor trauma-informed treatments to include partners (e.g., couples therapy) and infants (e.g., attachment-based and dyadic therapy). Interns will attend weekly case conference and didactics. Additionally, live supervision will be provided for outpatient psychotherapy cases. Interns who are interested and available may also attend weekly multidisciplinary rounds with the NICU team and assist in providing consultation and training to NICU staff.

Day, Time, and Location

- Didactics (required): Thursdays 11:30am – 12:30pm
- Case Conference and Clinic (required):
  - Tuesdays 12:30pm -5:00pm
    - OR
  - Thursdays 12:30pm – 5:00pm (preferred)
- NICU Psychosocial Rounds (optional): Tuesdays 11am – 12pm

Location:

Nathanson Family Resilience Center, 300 Medical Plaza

Hours per week:

Approximately 4-6 hours

Faculty and Staff:

Catherine Mogil, PsyD

Blanca Orellana, PhD

Sierra Kuzava, PhD

Duration of elective:

6 months

Training provided:

Two opportunities: 1) Interns will see 1-2 individual and/or couples cases as well as family consultations. 2) Interns can choose a blend of group therapy, NICU rounds and family consultations.

Supervision Provided:

Method of Supervision: Direct observation and case presentation

Format: Individual and group

Hours per week: 2

Days and Time: Supervision and team meeting is on Thursdays 11:30-12:30 (plus clients/group on Tuesday or Thursday)

Names of Supervisors:

Blanca Orellana, Ph.D.; Catherine Mogil, Psy.D.; Sierra Kuzava, Ph.D.

UCLA EMPWR Program for LGBTQ Mental Health

Available for the 26-27 Training Year

PROGRAM DESCRIPTION:

The UCLA EMPWR ("empower") Program provides specialized psychotherapeutic interventions to LGBTQ+ adults, youth, and their families dealing with stress and/or trauma in a safe and affirming treatment setting. Specialized individual, family, and group therapies build on personal strengths, foster healthy identity formation, and mitigate the consequences of stressful and/or traumatic experiences. The EMPWR Program implements a multidisciplinary model, closely integrating psychology and psychopharmacology training. The rotation is hosted at the UCLA Stress, Trauma, and Resilience (STAR) Clinic.

Examples of common issues addressed:

- Support around sexual orientation and/or gender identity development
- Recovery from trauma, bullying, and/or discrimination
- Exploration of social and/or medical transitions

DAY, TIME AND LOCATION:

Team meeting & didactics: Wednesday, 1pm-2pm
Clinic: Wednesday, 2pm-5pm
Optional Group: Wednesdays 5:30-6:30PM (8 week sessions)
A Floor, Semel Institute for Neuroscience

HOURS PER WEEK:

3-6 hours

DURATION OF ELECTIVE:

6 months

FACULTY & SUPERVISORS:

Andy Tabuenca, PhD – Clinical Director
Nicole Hisaka, PsyD
Natalia Ramos, MD

TRAINING PROVIDED:

The elective offers trainees the opportunity to gain specialized training in evaluating and treating LGBTQ+ youth within a multidisciplinary (psychology/psychiatry) team led by experts in trauma, resilience, and LGBTQ+ issues. Trainees will conduct comprehensive evaluations of clients presenting with complex psychiatric and psychosocial needs. Trainees will deliver direct patient care under attending supervision, receive weekly supervision, and participate in a weekly team meeting that combines group supervision and didactics pertaining to the field's established best practices for affirming LGBTQ+ care, sexuality and gender related minority stress, and trauma. Trainees will also expand their knowledge of psychopharmacological management of anxiety, depression, and post-traumatic stress disorder.

Individual psychotherapeutic interventions offered include trauma-focused cognitive behavioral therapy (TF-CBT), CBT for anxiety and depression, acceptance and commitment therapy (ACT), and dialectical behavioral therapy (DBT) skills training for improving emotion regulation. Structured family interventions include Family-Focused Therapy (FFT) and Families Overcoming Under Stress (FOCUS), a brief, 8-session, evidence-based intervention to reduce psychosocial stress and improve functioning and resilience within the family system for LGBTQ+ teens who are experiencing mental health symptoms.

The elective also offers the unique opportunity to co-facilitate the LGBTQ+ Teen Resilience Skills Group and/or the Parent/Caregiver Resilience Group. The teen group teaches tangible CBT skills to foster resilience and improve functioning in stressed youth (ages 12-17) over eight weeks. The parent group provides psychoeducation about identity, CBT skills, and parenting strategies applied to parenting LGBTQ+ youth to increase overall family support of teens' identities.
Sessions are co-facilitated with an experienced group leader and directly supervised by attendings, who also provide individual feedback. Group co-facilitation is optional for this elective.

For more information, contact EMPWR@mednet.ucla.edu

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation, Case Presentation
Format: Individual and Group
Hours Per Week: 3-6
Days and Times: Individual and case supervision available Wednesdays 9AM-5PM, Tuesdays 9AM-12PM and Thursday 9AM-5PM; Group therapies occur on Wednesdays 5:30-6:30PM (24 weeks/year)
Names of Supervisor(s): Andy Tabuenca, PhD, Nicole Hisaka, PsyD, and Natalia Ramos, MD

Family Stress, Trauma and Resilience Clinic (STAR)

Available for the 26-27 training year

PROGRAM DESCRIPTION:
The Family Stress, Trauma and Resilience (STAR) Clinic elective is designed to provide trainees with an introduction to traumatized children and their families, with an emphasis on children who are currently or have previously undergone medical traumas (e.g., organ transplant, chronic invasive medical treatment) or other community or family traumas.

DAY, TIME, AND LOCATION:
Tuesday/Thursday between 10am and 5pm
Semel, Rm. A8-221

HOURS PER WEEK:
5

DURATION OF ELECTIVE:
6 months

FACULTY AND STAFF:
Catherine Mogil Psy.D.
Blanca Orellana Ph.D.
Lauren Marlotte, Psy.D.

TRAINING PROVIDED:
The specific goals for trainees are to develop proficiency in the assessment, diagnosis, and brief treatment of traumatized children, adolescents, and their families within a developmental framework. To achieve this end, trainees will be exposed to various experts who will present on diagnostic, research, and intervention issues relevant to traumatized children and families. In addition, it is expected that, with the supervision of the clinic team, participants will evaluate, diagnose, and provide treatment recommendations to families and children. The clinic team will utilize resources and expertise from the UCLA Trauma Psychiatry team as well as the UCLA-Duke National Center for Child Traumatic Stress.

Interns completing the STAR elective commit to at least 5 hours per week on either Tuesdays or Thursdays between 10am–5pm. There is also alternating STAR didactics and Child Rounds on Wednesday mornings that are available as optional educational opportunities. Interns may opt to participate in any of the following clinical activities: 1) Trauma-informed assessment and therapy for STAR patients; 2) Co-facilitation of groups on Tuesday evenings (Super-Parenting Group or Family Trauma Group) and/or 3) Rotation through the Neonatal Intensive Care Unit (NICU), as part of the Family Development Program (FDP) where interns provide consultations and therapy to caregivers, with an infant born in the NICU (days are variable). Interns doing an elective are expected to carry 1-2 cases throughout their rotation. Individual supervision is provided during or outside of clinic hours on an as needed basis. The elective is a 6-month commitment.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation and Case Presentation
Format: Individual and Group
Hours Per Week: 5 (1 hour of group, 1 hour of individual)
Days and Times: Tuesdays or Thursdays between 10 AM – 5 PM
Names of Supervisor(s): Blanca Orellana, Ph.D.; Nastassia Hajal, Ph.D.; Catherine Mogil, Psy.D.

Family Therapy Clinic

Available for the 26-27 training year

PROGRAM DESCRIPTION

The Family Therapy Clinic focuses on treatment and training in Family Therapy assessment, consultation, and ongoing outpatient psychotherapy. It provides weekly systemic strength-focused treatment to families of children and adolescents with a wide range of diagnoses. Patients are referred from the community or after having gone through one of the inpatient or specialized outpatient programs at UCLA (such as those for anxiety or mood disorders) when more complex family dynamics appear.

The Structural Integrative Family Therapy approach utilized is an integration of Structurally focused family therapy with brief attachment-based experiential and emotion focused psychodynamic approaches. Trainees receive ongoing training in the theories and techniques behind this approach through live supervision, readings, and case discussions.

DAY, TIME, AND LOCATION:

Tuesdays 2:30pm-6pm
Zoom (currently via Zoom until further notice, then: 300 Medical Plaza, Room 1214)

HOURS PER WEEK:

4 hrs.

DURATION OF ELECTIVE:

6 months

FACULTY & STAFF:

Veronica Barenstein, PhD

TRAINING PROVIDED:

This elective aims at helping interdisciplinary trainees shift their mindset and expand their therapeutic range to include a systemic focus in their thinking and in their interventions regardless or the presenting problem. Family members' interdependence is highlighted, and interventions have a relational focus.

Trainees who are interested in learning Dr. Barenstein's Structurally-informed family therapy approach to assessment and treatment (anchored in her training at the Minuchin Center for the Family and with Salvador Minuchin), can explore it as a primary treatment to reduce or effectively eliminate individual symptoms. They can learn to use family therapy as the main intervention to produce change, in addition to employing it as an adjunct to other approaches.

Trainees will carry at least one family and will conduct a systemic assessment and weekly family therapy with live one-way mirror supervision including real-time intervention suggestions and consultations as well as pre- and post- session supervision and theory discussion during group and as needed. In addition, they will participate in ongoing live observation and discussion with the supervisor of other trainees' family therapy cases. The clinic begins with 1 hour of supervision focused on the ongoing cases including didactics and theory discussion geared both to the specific needs of the cases being treated and to ongoing training in the Structural Integrative Family Therapy approach. In addition, there is an ongoing focus on stretching each trainee's therapeutic range.

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation & Live One-Way Mirror Supervision of every session, periodic in-session live consultations by Supervisor, Case Presentation & Discussion, tape reviews
Format: Group discussion & group observation, Individual supervision as needed
Hours Per Week: 3-4 (1 hour of group, 10-15 minutes of individual per trainee)
Days and Times: Tuesdays 2:30pm to 6pm
Names of Supervisor(s): Veronica Barenstein, Ph.D.

FOCUS for Spanish-speaking Families

NOT AVAILABLE 26-27 AY

Program Description:

This elective provides the opportunity to contribute to a clinical pilot research study of the Spanish-language delivery of FOCUS (Families OverComing Under Stress) for Early Childhood. The FOCUS-EC Program is a trauma-informed, family-centered, manualized preventive intervention for families who have experienced trauma. It emphasizes positive parent/caregiver-child interactions, caregiver wellbeing & reflective functioning, early developmental guidance, child learning and self-expression through play, and healthy behavior management. FOCUS-EC is designed to reduce psychosocial stress and improve functioning and resilience within the family system. FOCUS has been previously implemented extensively and tested with English-speaking families, including those who identified as Latino/a/x/é or Hispanic, but this is the first systematic translation, cultural adaptation, and formal testing of the Spanish-language delivery of the model.

In this elective, interns would be trained in the original FOCUS for Families model as well as the FOCUS for Early Childhood model (full-day trainings will take place on September 16, 17, and 18, and interns should arrange to attend all days of training). They will participate in weekly Spanish clinical research meetings (including clinical supervision), complete the intervention with participating families, assist with community outreach to Spanish-speaking families throughout California, and contribute to other aspects of the study as needed.

Day, Time and Location:
***NOTE: THIS ELECTIVE IS ONLY AVAILABLE JULY-DECEMBER 2024. Enrollment of participants will end at the end of 2024.**

Intervention Sessions: Each trainee will carry a caseload of 1-2 families at a time. Day and time of intervention sessions (all virtual) will be flexible, coordinated between the trainee and supervisor.

Group Supervision: One hour per week; day/time is decided on group availability. Thirty minutes are with all FOCUS-EC interventionists in English. For the other thirty minutes, interventionists break into two groups to receive supervision in English or in Spanish.
***Note: Interns interested in participating in this elective at any time during the 2022-2023 training year will be required to attend a full-day FOCUS-EC intervention training that will take place in mid- to late-August 2022 (exact day/time TBD).

Hours Per Week:
4-6 hours

Duration of Elective:
4-6 months

***NOTE: Interns participating in this elective will be expected to participate in formal trainings for the original FOCUS for Families model as well as the FOCUS for Early Childhood model. These full-day trainings will take place on September 16, 17, and 18. Interns should arrange to attend all days of training and should utilize their internal training days for this. These trainings will be delivered in English.**

Faculty and Staff:
Blanca Orellana, PhD., Co-director & Co-Principal Investigator
Nastassia Hajal, Ph.D., Co-director and Co-Principal Investigator
Gustavo Rico, B.A., Study Coordinator

Training Provided:
This elective provides interns with the opportunity to develop proficiency in providing FOCUS-EC – a 6 module intervention which includes psychoeducation on trauma and trauma reminders, emotion regulation skills, a narrative timeline and reflective parenting, parent training skills for behavior management, and live in-ear play coaching with parent and child together. Furthermore, there is the opportunity to learn how to conduct this intervention and receive supervision in Spanish. Training also includes exposure to clinical research, including study design, measurement, and outreach to Spanish-speaking communities. Because the intervention is provided as part of a research study, it is provided at no cost to participants and without the need for insurance allowing for increased access to services and greater financial diversity.

Supervision Provided:
Method of Supervision: Direct Observation, Video review, and Case Presentation
Format: Individual and Group
Hours Per Week: 1-2
Name of Supervisors(s): Blanca Orellana, Ph.D. (Spanish and English), Nastassia Hajal, Ph.D. (English as needed)

UCLA Fit for Healthy Weight Clinic

26-27 Availability: Fall, Winter Spring – 1 intern per trimester

PROGRAM DESCRIPTION:
The mission of the UCLA Fit for Healthy Weight Program (www.fitprogram.ucla.edu) is to provide comprehensive promotion of healthy eating, physical activity, psychosocial wellbeing (psychological, social, familial, and educational), and overall wellness for children and adolescents and their families. Our goal is to provide comprehensive care to prevent and manage health complications associated with higher body weight among children and adolescents. We emphasize prevention and treatment both in the community and at UCLA with our multidisciplinary team comprised of a general pediatrician, medical and surgical subspecialists, a dietitian, and a psychologist.

Interns will serve as psychological consultants on the team, evaluating patients for any psychiatric, social, and familial contributors to obesity. Interns will be trained to complete focused psychiatric evaluations and provide brief interventions for the promotion of emotional wellness and sustainable behavioral change (e.g. goal setting, motivation for health behavior change, etc). As the FIT clinic provides services to underserved, under-

insured majority-minority population, this is an excellent training opportunity to learn how to work with families with a variety of psychosocial issues who are psychologically treatment-naïve. The training model provides interns with the opportunity to practice in an integrated, multidisciplinary setting and to learn about the medical and dietary management of overweight, diabetes and other medical complications. Interns will also get the opportunity to shadow psychiatric evaluations of adolescents pursuing bariatric surgery.

DAY, TIME AND LOCATION:
Clinic: Tuesdays 1:00-5:30pm
300 UCLA Medical Plaza, Suite 3300

HOURS PER WEEK:
4.5

DURATION OF ELECTIVE:
4 months to start in July, November or March

FACULTY:
Natacha Emerson, PhD

TRAINING PROVIDED:
On-site participation conducting a multidisciplinary behavioral intervention for children and adolescents and their families. No previous experience in behavioral techniques or participation in a multidisciplinary clinic is necessary.

SUPERVISION PROVIDED:
Method of Supervision: Case Presentation
Format: Individual
Hours Per Week: 4.5 (1 hour of group, 1 hour of individual)
Days and Times: In clinic
Names of Supervisor(s): Natacha Emerson, PhD; plus attending pediatricians and registered dieticians are available for consult.

For more information and to sign up for this elective, please contact Natacha Emerson, PhD: ndemerson@mednet.ucla.edu or 310-794-8416.

MOMS Clinic: Maternal Outpatient Mental Health Services

Available for the 26-27 Training Year

PROGRAM DESCRIPTION
The UCLA MOMS Clinic, part of the Department of OB-GYN, provides outpatient assessment and group-based intervention services to pregnant and postpartum patients who are referred by their OB-GYN for mental health issues. The rotation provides interns with specialized training in evaluating, diagnosing, and treating a wide range of perinatal mood disorders in a multidisciplinary team setting. Interns will assist with evaluating patients for perinatal mood disorders and providing psychoeducation, support, and treatment recommendations. Through the evaluation process, interns will be exposed to a number of unique considerations in the diagnosis and treatment of perinatal mood disorders, including unique symptom presentation, medical/prescribing considerations, attachment, and risk management. Interns may be asked to consult with providers in OB-GYN when there are mental health considerations in medical treatment. Interns will also facilitate a weekly process group, in which 8-12 patients are provided with the opportunity to share their pregnancy and postpartum experiences in a safe and validating environment. Finally, interns will participate in weekly individual supervision

and didactics. Training resources include the Johns Hopkins National Curriculum in Reproductive Psychiatry and materials and expertise from the UCLA OB-GYN and Psychiatry Teams.

DAY, TIME, AND LOCATION:

- Assessment clinic: Tuesdays from 8-10 am
- Weekly Process Group: Day and Time TBD
- Didactics: Day and Time TBD

HOURS PER WEEK:

5-6 hrs.

DURATION OF ELECTIVE:

4- or 6-month rotations are available

FACULTY & STAFF:

Misty Richards, M.D., M.S.

TRAINING PROVIDED:

- Providing assessment, psychoeducation, and treatment recommendations to pregnant and postpartum patients
- Co-facilitating weekly process group
- Consultation with OB-GYN

DIVERSITY TRAINING:

UCLA OB-GYN treats patients from a wide range of races, ethnicities, socioeconomic status, sexual orientations, and religions. Cultural and diversity considerations are a core piece of our work and are integrated into supervision and didactics.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation & Individual/Group meeting
Hours Per Week: 3 (1 hour of group, 1 hour of individual)
Days and Times: TBD
Names of Supervisor(s): Misty Richards, M.D., M.S.

Parent-Child Interaction Therapy (PCIT)

Available for the 26-27 training year

PROGRAM DESCRIPTION:

The Parent-Child Interaction Therapy (PCIT) elective is designed to provide trainees with an introduction to a parent-child dyadic intervention model for children and their families in efforts to improve the quality of parent-child relationships and to teach parenting skills necessary to manage behavioral challenges. Trainees will have opportunities to learn modulated behavioral intervention strategies for children who have experienced maltreatment, parent-child separation or challenges related to attention, neurodevelopmental, and/or behavioral issues, and trauma. PCIT will be delivered virtually and in person in clinic, community and home settings to help families generalize their skills across locations. The trainee will be taught via both observation and direct application of evidence-based practices regarding parent-child relationship enhancement strategies and compliance improvement skills using a co-therapy model.

DAY, TIME AND LOCATION:

Time: Fridays

- Didactics: 10am-11am Friday
- Case Conference: 11:00-11:30am Friday
- Clinic: 10am-3pm Friday (with flexibility to see patients outside of clinic hours on M-Th alongside of PCIT supervisor)

Location: Semel Institute, Floor A

For more information, contact starclinic@mednet.ucla.edu or coordinator, Autumn Campbell afcampbell@mednet.ucla.edu / 310-825-7573

HOURS PER WEEK:

5

DURATION OF ELECTIVE:

6 months

FACULTY AND STAFF:

Nicole Hisaka, Psy.D.
Nicole McDonald Ph.D.
Blanca Orellana Ph.D.
Catherine Mogil Psy.D.

TRAINING PROVIDED:

The specific goals for trainees are to develop proficiency in the assessment, diagnosis, and evidence-based treatment for children with behavioral challenges, ages 2-7, and their families within a parent-child dyadic framework. To achieve this, trainees will be exposed to experts who will present on diagnostic, research, and modulated intervention strategies and issues relevant to parent-child relationships and behavioral management. Additionally, trainees will have opportunities to learn effective strategies to strengthen parent-child dyads and omit severe behavioral challenges to children and families with trauma histories, neurodevelopmental and behavioral disorders, and parent-child relationship disruptions. In addition, it is expected that, with the supervision of the clinic team, participants will evaluate, diagnose, and provide treatment recommendations to families and children.

Interns completing the PCIT elective commit to at least 5 hours per week on Friday between 10am–2pm and must attend PCIT didactics on Friday between 1:00-2:00pm. Interns doing an elective are expected to carry 1-2 cases throughout their rotation. Individual supervision is provided during or outside of clinic hours for 30 minutes of individual supervision/week. The elective is a 6-month commitment. A mini elective can be coordinated that provides exposure to PCIT through attendance at Friday didactics and observing at least one session.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation and Case Presentation
Format: Individual and Group
Hours Per Week: .5 hours individual (as need basis) and .5 hours Case Conference
Names of Supervisor(s): Nicole Hisaka, Psy.D.; Nicole McDonald, Ph.D.; Blanca Orellana, Ph.D.; Catherine Mogil, Psy.D

Parent Training Program

Available for the 26-27 Training Year

PROGRAM DESCRIPTION:
Behavioral Parent Training is specifically aimed at disruptive child behavior problems. It is highly structured and delivered to families in groups as a therapeutic intervention.

Child/teen diagnoses include Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorders (high functioning), DMDD and, less frequently, Conduct Disorder, Anxiety Disorders, Adjustment Disorders, and Encopresis. Most families are referred from the Child Outpatient and Inpatient Services, or community agencies. Many families are concurrently being seen within other modalities (individual psychotherapy for parent or child, psychiatric care, or other family therapy).

DAY, TIME, AND LOCATION:
- Parent Training Groups: Wednesdays 12pm-1pm (Ongoing) or Thursdays 7:00pm-8:30pm (Ongoing)
- PEACE Group: Thursdays 5:30pm-6:45pm or Thursdays 10:30-11:45am (Fall PEACE group dates TBD – please email for specific dates if interested).

HOURS PER WEEK: 1-2.5
Parent Training Observation: 1-1.5 hours (NO SUPERVISION NEEDED)
Parent Training Co-Leading: 2-2.5 hours (INCLUDES SUPERVISION)

FACULTY AND STAFF:
Shilpa Baweja, Ph.D., LCSW, Director
Reina Factor, Ph.D., Attending Psychologist

TRAINING PROVIDED:
Two opportunities: (1) Observe and subsequently co-lead Parent Training groups for 10 weeks or longer as indicated. Parent Training is a family-oriented evidence-based, manualized behavioral intervention for a wide variety of child behavioral problems. Sessions are composed of homework review, didactic presentation of skill with handouts/demonstration/practice/Q & A, and homework assignment. No previous experience in behavioral techniques is necessary.

(2) Observe and subsequently co-lead PEACE (Parents of Early Adolescents Conflict Education) groups for 9 weeks. PEACE is an evidence-based, behavioral intervention to reduce frequency and intensity of parent/young teen conflict. Sessions are composed of homework review, didactic presentation of skill with handouts/demonstration/practice/Q & A, and homework assignment.

Didactics and supervision will be arranged.

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation of groups; Individual supervision on request
Format: Groups--remote telehealth at present; Parenting (PT) for 2-12; PEACE for 12.5-15.5 (PEACE)
Hours Per Week: 1.5-2 hours a week (.5 for individual, .5 for group)
Days and Times: Wednesdays, noon (PT) or Thursdays 7pm (PT); Thursdays TBD (PEACE)
Names of Supervisor: Shilpa Baweja, PhD, LCSW, Reina Factor, Ph.D.

Peds Liver Transplant Clinic

26-27 Availability: 1 intern per trimester to complete 4-month elective July-Oct, Nov-Feb or March-June

PROGRAM DESCRIPTION:
For this elective, interns serve as the primary mental health professional integrated within a primary care clinic for adolescents and young adults. The goal of training is to provide the psychologist with an introductory experience in evaluation, brief intervention and triage of transitional age youth presenting to an outpatient adolescent medicine clinic. Patients have a range of medical conditions, developmental abilities, and co-morbid psychosocial and/or mental health problems.

DAY, TIME AND LOCATION:
Clinic: Thursdays 9:00-12:00pm
200 Medical Plaza, Suite 265
In Vivo Supervision

HOURS PER WEEK:
4

DURATION OF ELECTIVE:
4 months

FACULTY:
Krista Tabuenca, Ph.D.

TRAINING PROVIDED:
Trainees conduct brief evaluations to target presenting symptoms, which can include symptoms of medical trauma, depression, anxiety, psychosis, aggression, grief, high-risk behavior, obesity, school problems, family discord, medication compliance and behavioral problems associated (or not associated) with a developmental disability. All patients are post-transplant and ages range from infancy to 25 years old. Psychoeducation and limited skills building may be provided. Recommendations and referrals for further care are provided to the GI physicianand patient/family. Trainees receive *in vivo* supervision to review clinical approaches as well as interfacing with an interdisciplinary team composed of physicians, nurses, social workers, and dieticians. Trainees will also receive guidance in documentation of mental health concerns in a medical record, as well as culturally sensitive approaches to the diverse populations in clinic.

For more information and to sign up for this elective, contact Krista Tabuenca, Ph.D., at ktabuenca@mednet.ucla.edu

DIVERSITY TRAINING:
Patients seen in clinic range in age from infancy to young adulthood (~1y to 25y) with medical, social, or emotional concerns are seen in the adolescent medicine clinic. The majority of patients seen in this venue have public insurance (predominantly MediCal/CCS). Interns are asked to adopt an exploratory model approach to understanding the unique experience of their patients and families. Additionally, interns are encouraged to ascertain patient information related to gender identity, sexual orientation, race, ethnicity, level of acculturation, language ability and preferences, educational background, financial burdens, spiritual beliefs, disabilities, family constellation, trauma and discrimination history, quality of the relationship and communication with the health care team, and potential barriers to health care (transportation, work or child care responsibilities, disability, etc.) if relevant to the clinical presentation. They are provided access to a curated website that includes resources related to the provision of culturally sensitive psychological care. Discussions in supervision include the review of diversity and cultural factors that may impact a patient's clinical presentation, level of trust of and congruence with health care team members, and the development of sensitive treatment plans or referrals.

SUPERVISION PROVIDED:
Method of Supervision: In vivo
Format: Individual
Hours Per Week: 4 (3 hours in clinic, 1 for supervision)
Days and Times: Thursday: Thursday 9am-12pm (clinic), Individual sup TBD
Names of Supervisor(s): Krista Tabuenca, PhD

PEERS ® Clinic: Evidence-Based, Parent-Assisted Social Skills Program

Available for the 26-27 Training Year

PROGRAM DESCRIPTION:

This program is one of the only evidence-based neuro-affirming social skills programs in the world. PEERS® is an international program, used in over 150 countries and has been translated into over a dozen languages. This program, developed at UCLA by Dr. Elizabeth Laugeson, instructs youth about important elements of socialization including making and keeping friends and handling peer conflict and rejection. Didactic lessons related to appropriate dating etiquette are also provided in the young adult groups. Separate parent/caregiver and child/teen/young adult sessions are conducted concurrently for 90-minutes each week. Sessions are structured to include homework review, didactic presentation, role-playing demonstrations, and behavioral rehearsal exercises. Parents/caregivers are taught how to assist youth in making and keeping friends by providing performance feedback through coaching during weekly in vivo socialization homework assignments. Youth are taught important social skills through didactic instruction, role-plays, and behavioral rehearsal during socialization activities. Interns rotating through this elective will be invited to attend a three-day certified training seminar on PEERS® at no charge to them. Attendance is optional.

Client population served: PEERS® for Preschoolers is appropriate for children 4-6 years of age who are on the autism spectrum or have other social challenges. PEERS® for Adolescents is appropriate for middle and high school teens between 11-18 years of age with a variety of social challenges, including ASD, ADHD, learning disabilities, anxiety disorders, mood disorders, and adjustment disorders. PEERS® for Young Adults is appropriate for individuals 18-35 years of age who are struggling to develop and maintain meaningful relationships. All youth have at least average cognitive functioning, are socially motivated to make and keep friends, are behaviorally and emotionally regulated, and have a parent/caregiver willing to participate in the program.

DAY, TIME AND LOCATION:

- PEERS® for Preschoolers: Tuesdays, In-person: 2:00 - 5:30 pm; Telehealth: 2:30 – 7:30 pm
- PEERS® for Adolescents: Wednesdays, 3:30 - 8:00 pm
- PEERS® Educational Groups: Tuesdays, 3:00 – 7:30 pm
- PEERS® for Young Adults: Mondays, 3:30 – 8:00 pm
- PEERS® for Dating: Thursdays, 2:30 – 8:00 pm
- PEERS® for Careers: Wednesdays, 3:00 – 8:00 pm

HOURS PER WEEK:

PEERS® for Preschoolers is approximately 4-6 hours per week. IN-PERSON GROUPS: Group supervision is conducted for 90 minutes prior to the start of groups (2:00-2:45 PM parent case conference, 3:00-3:45 PM child case conference 45). . Social skills groups are conducted from 4:00–5:30 PM. One hour is allotted each week for prep time and note taking. TELEHEALTH GROUPS: Group supervision is conducted for 60 minutes prior to the start of groups (2:30–3:30 PM). Parent-only social skills groups are conducted over zoom from 4:00–5:30 PM and 6:00-7:30 PM. One hour is allotted each week for prep time and note taking. Trainees can opt to rotate through the clinic for 4, 6, or 12-month rotations and will be directly involved in the implementation of the lessons.

PEERS® for Adolescents is approximately 6 hours per week. Individual supervision is 30-60 minutes per week, depending on the involvement of the trainee in the implementation of the group, and is scheduled on an individual basis. Group supervision is conducted for 45 minutes prior to the groups from 3:30–4:15 PM. Two social skills groups are conducted from 4:30–6:00 PM and 6:30–8:00 PM. 30 minutes are allotted each week for prep time and note taking. Trainees can opt to rotate through the clinic for 4, 6, or 12-month rotations and will be directly involved in the implementation of the lessons.

PEERS® Educational Groups are approximately 6 hours per week. Individual supervision is 30-60 minutes per week, depending on the involvement of the trainee in the implementation of the group, and is scheduled on an individual basis. Group supervision is conducted for 45 minutes prior to the groups from 3:00–3:45 PM. Two social skills groups are conducted from 4:00–5:30 PM and 6:00–7:30 PM. Trainees can opt to rotate through the clinic for 4, 6, or 12-month rotations and will be directly involved in the implementation of the lessons.

PEERS® for Young Adults is approximately 6 hours per week. Individual supervision is 30-60 minutes per week, depending on the involvement of the trainee in the implementation of the group, and is scheduled on an individual basis. Group supervision is conducted for 45 minutes prior to the groups from 3:30–4:15 PM. Two social skills groups are conducted from 4:30–6:00 PM and 6:30–8:00 PM. 30 minutes are allotted each week for prep time and note taking. Trainees can opt to rotate through the clinic for 4, 6, or 12-month rotations and will be directly involved in the implementation of the lessons.

PEERS® for Dating is approximately 6 hours per week. Individual supervision is 30 minutes per week, depending on the involvement of the trainee, and is scheduled on an individual basis. Group supervision is conducted for 75 minutes prior to the groups from 2:30–3:45 PM. Two social skills groups are conducted from 4:00–5:30 PM and 6:30–8:00 PM. Trainees can opt to rotate through the clinic for 4, 6, or 12-month rotations and will be directly involved in the implementation of the lessons.

PEERS® for Careers is approximately 6 hours per week. Individual supervision is 30 minutes per week, depending on the involvement of the trainee, and is scheduled on an individual basis. Group supervision is conducted for 60 minutes prior to the groups from 3:00–4:00 PM. Social skills groups are conducted from 5:30–8:00 PM with breaks at 5:15 PM and 7:00 PM. Trainees can opt to rotate through the clinic for 4, 6, or 12-month rotations and will be directly involved in the implementation of the lessons.

FACULTY AND STAFF:

Elizabeth Laugeson, Psy.D., Director
Christine Moody, Ph.D., Associate Director
Elina Veytsman, Ph.D., Director of Training
Jasper Estabillo, Ph.D., Attending Psychologist
Blake Warner, Ph.D., Chief Clinical Fellow
Monica Sanders, Psy.D., Attending Psychologist
Sarah Bruce, Ph.D., Attending Psychologist

TRAINING PROVIDED:

Training and weekly group supervision are provided for conducting this parent-assisted cognitive behavioral-based social skills program for preschoolers, adolescents, and young adults.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation
Format: Individual and Group
Hours Per Week: 30-90 minutes per week (.5-1 hr group, .5-1 hr individual)
Days and Times: Flexible
Names of Supervisor(s): Elizabeth Laugeson, Psy.D., Christine Moody, Ph.D., Elina Veytsman, Ph.D., Jasper Estabillo, Ph.D., Blake Warner, Ph.D., Monica Sanders, Psy.D., Sarah Bruce, Ph.D.

UCLA Tarjan Center

Available for the 26-27 training year

PROGRAM DESCRIPTION:

The UCLA Tarjan Center is one of 67 federally designated University Centers for Excellence in Developmental Disabilities (UCEDDs) authorized under the Developmental Disabilities Assistance and Bill of Rights Act (DD Act) and funded by the Administration on Intellectual and Developmental Disabilities within the U.S. Department of Health and Human Services. The Tarjan Center's mission is to advance the self-determination, inclusion, and quality of life among the diversity of people with disabilities and their families. Our work is organized around the five core functions outlined in the DD Act: (1) inter-disciplinary pre-service preparation and continuing education, (2) technical assistance, (3) community services, (4) research, and (5) information dissemination. Programs focus on employment, postsecondary education, physical health, and mental health. Additionally, we partner with community and governmental agencies to improve practices, policies, and services for individuals with disabilities.

Trainees develop individualized training plans that provide exposure to a broad range of Tarjan Center activities. Opportunities include participating in the Tarjan Advisory Committee and its subcommittees, attending the Tarjan Center Distinguished Lecture Series and Annual Forum in Neurodevelopmental Disabilities, and engaging in meetings with local, state, and federal agencies and policymakers. Trainees gain experience collaborating with individuals with lived experience (i.e., individuals with disabilities or self-advocates), community-based organizations, and policymakers. They are also eligible to apply for the Tarjan Center Developmental Disabilities Travel Award to support presenting research at a professional conference.

For the 2026-2027 training year, the Tarjan Center is announcing an exciting new training opportunity for interested interns. As part of our partnership with the California Department of Developmental Services (DDS), interns may be involved in the Workforce Preparation and Placement Pathway, which includes the UCLA Advocacy Academy for Emerging Disability Rights Leaders and PEERS for Careers. The Advocacy Academy equips participants with advocacy, storytelling, and testimony skills through a structured 12-week interactive curriculum, with the goal of developing leadership skills in advocacy and policymaking that support individuals with disabilities and their families. PEERS for Careers is a 16-week evidence-based program focused on employment-related social skills needed for workplace success in competitive integrated employment settings.

DAY, TIME, AND LOCATION:

Coordinated with staff

HOURS PER WEEK:

1-5 hours per week (12-MONTH commitment)

FACULTY AND STAFF:

Elizabeth Laugeson, Psy.D., Center Director
Jasper Estabillo, Ph.D., Director of Training
Yasamin Bolourian, Ph.D., Director of Outreach & Dissemination
Rujuta Wilson, M.D., Director of Research
Brandon Ito, M.D., Director of Justice, Equity, Diversity, & Inclusion (JEDI)
Jennifer Arnold, M.H.A., Director of Operations
Blake Warner, Ph.D., Assistant Director

TRAINING PROVIDED:

Upon completion of this training experience, trainees will have:

- A basic knowledge of policy, law, self-advocacy, and diagnostic and treatment implications for individuals with developmental disabilities
- Exposure to and familiarity with current research literature in developmental disabilities

- Exposure to the developmental challenges of individuals with developmental disabilities
- Experience presenting original research at a scientific meeting

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation
Format: Individual and Group
Hours Per Month: 4 hr per month (combination of individual and group)
Days and Times: Flexible
Names of Supervisor(s): Elizabeth Laugeson, Psy.D., Jasper Estabillo, Ph.D.

Tarjan Center Developmental Disabilities Travel Award

Available for the 26-27 training year

PROGRAM DESCRIPTION:

The primary objective of the Tarjan Center Developmental Disabilities Travel Award is to train professionals in the identification of disorders associated with developmental disabilities and in interventions targeted for this underserved population.

Funding for attendance at a scientific meeting, up to $1500, will be awarded to two interns enrolled in this elective on a competitive basis. Applicants will be expected to submit a CV and a 500-word scientific abstract, including background, research objectives, methods, results, and conclusions. Those awarded this travel stipend will be expected to present a poster or oral session, with emphasis on individuals with developmental disabilities, at a scientific meeting.

To be eligible for the Developmental Disabilities Travel Award, trainees must participate in Tarjan Center activities including:

- Tarjan Center Distinguished Lecture Series (at least 6 lectures over the course of the training year)
- Annual Forum in Neurodevelopmental Disabilities (October 2026)
- At least one Tarjan Advisory Committee (TAC) meeting (composed of advocates and other community stakeholders)
    - Interns will be expected to give a short presentation on a topic of the intern's choice related to disability at a TAC meeting
- At least one TAC subcommittee meeting
- Optional: California Arts and Disability Resource Center, UCLA Pathway (a post-secondary education program for college-aged students with developmental disabilities)

DAY, TIME, AND LOCATION:

Coordinated with staff

HOURS PER WEEK:

1 hour per month (.25 per week) (12-MONTH commitment)

FACULTY AND STAFF:

Elizabeth Laugeson, Psy.D., Program Director
Jasper Estabillo, Ph.D., Director of Training

TRAINING PROVIDED:

Upon completion of this training experience, trainees will have:

- A basic knowledge of policy, law, self-advocacy, and diagnostic and treatment implications for individuals with developmental disabilities
- Exposure to and familiarity with current research literature in developmental disabilities
- Exposure to the developmental challenges of individuals with developmental disabilities
- Experience presenting original research at a scientific meeting

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation
Format: Individual and Group
Hours Per Month: 1 hr per month (individuall)
Days and Times: Flexible
Names of Supervisor(s): Elizabeth Laugeson, Psy.D., Jasper Estabillo, Ph.D.

thinkSMART Program

Available for the 26-27 training year

PROGRAM DESCRIPTION:

thinkSMART is a novel, 12-week behavioral intervention, designed to target executive functioning weaknesses in adolescents. The focus of the group is to teach compensatory strategies to teens and their parents (concurrently) to target weaknesses in areas of time awareness/management, planning, problem solving, task initiation/completion, and organization. Teens and their parents are also taught mindfulness strategies, emotion regulation techniques, and provided psychoeducation about executive functioning. Sessions are structured to include mindfulness, homework review, didactic presentation, learning activities, and problem-solving obstacles. Parents are aided in ways to support and prompt their teens for use of the skills.

Client population served: thinkSMART® is appropriate for adolescents ages 12-18 and their parents. Teens often, but are not required to, have diagnoses associated with attention, mood, anxiety or neurodevelopmental disorders. All teens have at least average cognitive functioning and are able to tolerate a mainstream classroom setting.

DAY, TIME, AND LOCATION:

Mondays, 4:00 – 8:15 pm (Fall Session Only)
Mondays, 4:00 – 6:30 pm (Winter/Spring Sessions)

HOURS PER WEEK:

2.5-4 hours per week approximately (2.5 in Winter/Spring, 4.25 in Fall)
This includes an hour for supervision, 90-min session, and 30-min debrief. The supervision hour is flexible and does not have to be in the hour before group. Trainees can opt to rotate through the program for 3, 6, or 12-months.

FACULTY AND STAFF:

Alissa Ellis, Ph.D., Director

TRAINING PROVIDED:

Training and weekly group supervision are provided to learn skills in implementing a cognitive-behavioral intervention for improving executive functioning in adolescents. Trainees will be actively engaged with co-leading the weekly sessions.

SUPERVISION PROVIDED:

Method of Supervision: Direct observation, Didactics
Format: Group and Individual, as needed
Hours Per Week: 1 (.25 of group, .25 of individual)

Days and Times: Mondays 4pm-5pm
Names of Supervisor(s): Alissa Ellis, PhD

Youth Stress & Youth Mood Program (YSAM): Evaluation and Treatment of Suicidal & Self-Harm Behavior and Depression

Available for the 26-27 training year

PROGRAM DESCRIPTION:

This program offers specialized training in the evaluation and treatment of child and adolescent suicide-risk, self-harm, and depression. Training emphasizes evidence-informed and evidence-based treatment strategies, with an emphasis on treatments developed and/or tested in YSAM programs, specifically: emergency evaluation and acute care strategies (Family Intervention for Suicide Prevention/SAFETY-Acute); dialectical behavior therapy (DBT) informed cognitive-behavioral approaches (SAFETY); DBT; and cognitive-behavior therapy for depression. YSAM programs are family-centered and aim to mobilize strengths in the youth, family, and community. YSAM treatment approaches were listed in the National Registry of Evidence Based Practices (nrepp.samhsa.gov) and are listed in federal guides on suicide prevention and treatment (SAMHSA, HRSA).

The YSAM program includes our SAMHSA Center for Trauma-Informed Adolescent Suicide, Self-Harm & Substance Abuse Treatment and Prevention (ASAP) which is part of the National Child Traumatic Stress Network. YSAM clinical care and treatment strategies are also used in our NIMH Zero Suicide trial, a randomized trial of stepped care for suicide prevention in teens and young adults. Trainees electing a research rotation will have opportunities to learn about our national dissemination program through the ASAP Center, as well as our research projects. The YSAM elective provides excellent opportunities for individuals interested in research, clinical service evaluation and quality improvement, and clinical care.

YSAM Clinic & Didactics

2:00pm-6:00pm, Friday. This time includes didactics, supervision, and clinical care. Patient evaluations, individual and family treatment is conducted during this time. Trainees will be offered experience with DBT groups which currently occur on Tuesdays from 5:00-6:30pm, but this is not required and available as space permits. We will work to provide all who are interested some multi-family group experience.

Overview of YSAM Clinical Activities

The YSAM Program provides evaluation and treatment for children and youths presenting with suicidal and/or self-harm behavior, elevated risk for suicide/self-harm, depression, and/or difficulties with emotion regulation and stress management. The clinic operates on Friday (2-6 pm) and Tuesday (5-6:30 pm) in the UCLA 300 Medical Plaza building. Other appointment times may be possible.

YSAM emphasize adolescents, but services for younger children may be offered. Services include:

- Crisis/Acute Care Evaluation & Intervention
- Evaluation
- Consultations
- Individual & Family Centered Treatment
- Dialectical Behavior Therapy, including multifamily group treatment

DAY, TIME AND LOCATION:

Fridays 2:00-6:00, 300 Medical Plaza, Room 1208
DBT group (Not required): Tuesday, 5-6:30

HOURS PER WEEK:
4-5

DURATION OF ELECTIVE:
6-month commitment required; full year blended clinical/research/service preferred

FACULTY AND STAFF:
Joan Asarnow, Ph.D. & Jeanne Miranda, Ph.D., Directors
Lucas Zullo PhD, Jocelyn Meza PhD, Natalia Jaramillo PhD

TRAINING PROVIDED:
Evaluation, and acute care for youths with elevated risk of suicidal/self-harm behavior
DBT
DBT-informed family centered cognitive-behavioral approaches
Cognitive-behavior therapy for depression
Clinical skills with Gender and Sexual Minority Youth.

Minimum commitment: 4 hrs./week if YSAM clinic patients are seen. Participation in didactics only will be considered when appropriate and feasible.

Please contact Dr. Asarnow if you are interested in this option. More information can be found at www.asapnctsn.org and http://www.semel.ucla.edu/mood/youth-stress

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation and Case presentation
Format: Individual and Group
Hours Per Week: 2-6 (.50 of group, .50 of individual)
Days and Times: Friday 2-6 PM; optional Tuesday 3 – 6 PM
Names of Supervisor(s): Joan Asarnow, PhD; and Jeanne Miranda, PhD

Youth Stress & Youth Mood (YSAM) Program: Research Rotation-Treatment and Prevention of Suicidal and Self-Harm Behavior

Available for the 26-27 training year

PROGRAM DESCRIPTION:
This program offers specialized research and dissemination experience on suicide and self-harm in youths, with an emphasis on treatment and suicide prevention services. The YSAM program includes our SAMHSA Center for Trauma-Informed Adolescent Suicide, Self-Harm & Substance Abuse Treatment and Prevention (ASAP) which is part of the National Child Traumatic Stress Network. Through the ASAP Center we have a number of ongoing dissemination, training, and evaluation initiatives aimed at improving emergency/acute care for youths with elevated suicide and self-harm risk across a range of service settings locally and nationally, including Emergency Departments, primary care, schools, and behavioral health. We are also involved in a large randomized controlled trial of stepped care for suicide prevention in teens and young adults, funded under the NIMH Zero Suicide trial. Other ongoing YSAM research projects include studies emphasizing ecological momentary assessment, daily diaries, sleep, the needs of youths endorsing sexual or gender minority status and testing of a digital intervention for reducing access to lethal means. Prior projects include: a large multi-site randomized controlled trial (RCT) of DBT in youths with high levels of suicidality, emotion dysregulation, and repetitive self-harm; a 2-site RCT of family versus individual psychotherapy for childhood depression; an RCT evaluating the Family Intervention for Suicide Prevention (FISP) in two diverse EDs; a multi-site RCT evaluating a quality

improvement intervention aimed at improving access to evidence-based treatment for adolescent depression (primarily CBT and medication) through primary care using a collaborative integrated medical-behavioral health care model; and other studies focusing on depression and suicide risk in children and adolescents.

DAY, TIME, AND LOCATION:
Fridays 2:00-3:00, and TBA,
300 Medical Plaza, Room 1208 & Suite 3310

HOURS PER WEEK:
2-4

DURATION OF ELECTIVE:
6-month commitment required; full year blended clinical/research/service preferred

FACULTY AND STAFF:
Joan Asarnow, Ph.D. & Jeanne Miranda, Ph.D., Directors
Lucas Zullo PhD, Jocelyn Meza PhD, Natalia Jaramillo PhD

TRAINING PROVIDED:
Opportunities to learn about and participate in our ASAP Center national dissemination program (www.asapnctsn.org) and other research. Opportunities are also available using some of our existing data sets. The YSAM research elective provides excellent opportunities for individuals interested in research, clinical service evaluation and quality improvement, and treatment and suicide prevention research.

YSAM Didactics
2:00 pm-3:00 pm, Friday. This time includes didactics, clinical time occurs between 3:00-6:00 and some research activities may occur during this time. Other times are TBA. The program is housed in UCLA 300 Medical Plaza building, Suite 3300.

Minimum commitment: 2 hrs./week

Please contact Dr. Asarnow if you are interested in this option. More information can be found at www.asapnctsn.org and http://www.semel.ucla.edu/mood/youth-stress

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation and Case presentation
Format: Individual and Group
Hours Per Week: 2-6 (2 hours of group, 1 hour of individual)
Days and Times: Friday 2-6 PM; optional Tuesday 3 – 6 PM
Names of Supervisor(s): Joan Asarnow, PhD; and Jeanne Miranda, PhD
Lucas Zullo PhD, Jocelyn Meza PhD, Natalia Jaramillo PhD

Adult and Geropsychology Elective Clinical Services and Programs

Adult OCD Intensive Treatment and Research Program

Not available 26-27 training year

PROGRAM DESCRIPTION:

The Adult OCD Treatment and Research Program provides evidence-based treatment for individuals struggling with moderate to severe Obsessive Compulsive and related disorders. Our training rotation offers the intern an opportunity to learn and conduct exposure and response prevention (ERP), a form of cognitive behavior therapy (CBT) that has consistently demonstrated very strong efficacy in treating Obsessive Compulsive Disorder. Interns will receive training in 1) OCD assessment; 2) ERP, exposure-based approaches for other anxiety and stress disorders, and treatment for compulsive hoarding; and optionally, 3) co-running one of our five groups and 4) conducting research with OCD patients. Interns receive training conducting and interpreting standardized assessments (including the Yale-Brown Obsessive-Compulsive Scale as well as other measures) and creating exposure hierarchies.

Adult patients attend our Intensive Outpatient Program (IOP) Monday-Friday for 6 weeks, from 9am-1pm. Each day, they have 1 hour of therapy, 1 hour of group therapy and 2 hours of ERP. Our program specializes in treating individuals diagnosed with OCD and related disorders. Greater than 90% of our patients with OCD also have a co-morbid mental health disorder, most typically major depressive disorder. In addition, our patients often have co-morbid disorders of social anxiety disorder, panic disorder, generalized anxiety disorder and post-traumatic stress disorder. Another major strength of our program is that we work with individuals with a primary diagnosis of hoarding disorder, with approximately 10-20% of our patients struggling with this problem.

The psychology intern will learn how to do ERP; in this treatment approach, patients are guided through specific situations to come in direct contact with fearful stimuli without engaging in compulsive behaviors or avoidance in order to help patients learn new ways of relating to and handling rapid and prolonged surges in anxiety and other intense negative emotions. ERP training starts out with observation of currently trained students and staff therapists conducting ERP, one-on-one role playing and review. Next, the intern will conduct exposure sessions in conjunction with staff therapists. After this, trainees begin conducting exposures on their own with patients. Based on intern availability and interest, the intern could also assist in one weekly group therapy session (we run 5 different groups covering a diverse set of topics including goal setting, coping skills, didactics, cognitive reframing, and relapse prevention). If interested, the intern also has opportunities for research supervised by Dr. Motivala and program director Dr. Jamie Feusner. We are currently conducting a follow-up study to gauge the durability of treatment effects and an examination of which factors improve or worsen OCD symptoms over time.

Our rotation involves 5 hrs./week on either Mondays, Tuesdays, or Thursdays. This includes 3 hours of ERP work, 1 hour of group supervision and 1 hr. of individual supervision. Group clinical supervision is available on Mondays or Thursdays and individual supervision is set up based on the intern's schedule sometime between 9am-1pm, Monday-Friday.

DAY, TIME, AND LOCATION:

Clinic operates M-F 9am – 1pm. Group supervision is available Mondays or Thursdays at 11am and individual supervision is available with day/time TBD.

HOURS PER WEEK:

SUPERVISION PROVIDED:
Method of Supervision: Direct observation, case presentation
Format: Group; individual available
Hours Per Week: 1 hr. of group
Days and Times: Varies, but currently Mondays, Tuesdays or Wednesdays.
Names of Supervisor(s): Ana Ribas, PhD; Shana Doronn, LCSW, PsyD

Aftercare Program

Available for the 26-27 training year

PROGRAM DESCRIPTION:
The Aftercare Program is a specialty clinic for treatment and research with patients who have recently had a first episode of schizophrenia. Trainees can serve as co-therapists in five different types of groups, a psychoeducational group for new patients, cognitive remediation via computerized training, a Bridging Group that facilitates generalization of cognitive gains to everyday functioning, an aerobic exercise group, and a healthy living skills group. Individual therapy opportunities are also readily available. Supervision for psychology interns is provided by Drs. Nuechterlein, Subotnik, and Turner. Clinical supervision is combined with information on the diagnosis, phenomenology, and treatment of schizophrenia.

The time commitment is 2 to 8 hours per week, depending on what combination of group therapy and individual therapy experience is desired. The time should be committed for at least 6 months and preferably for 12 months. To allow adequate continuity care for patients with a first episode of psychosis, a 12-month commitment is needed for individual therapy experiences.

DAY, TIME, AND LOCATION:
Training opportunities are available Mondays 11-4, Tuesdays, 9-5, and Thursdays, 11-5
300 Medical Plaza, 2nd Fl., Room 2240 is the reception office
Contact Keith Nuechterlein, Ph.D., keithn@ucla.edu, for the group intervention schedule

HOURS PER WEEK:
2-6

DURATION OF ELECTIVE:
6 months for group co-therapy; 12 months for individual therapy

FACULTY AND STAFF:
Keith Nuechterlein, Ph.D., Director
Kenneth Subotnik, Ph.D., Associate Director
Laurie Casaus, M.D., Medical Director
Margaret Distler, M.D., Associate Medical Director
Luana Turner, Psy.D.
Yurika Sturdevant, Psy.D.
Lissa Portillo, B.A., Patient Coordinator

TRAINING PROVIDED:
Trainees can serve as co-therapists in group therapy and as individual therapists with outpatients with a recent

first episode of psychosis. Group therapy focuses on improving the cognitive deficits of schizophrenia, prevention of symptom return, and building effective coping skills for work, school, and interpersonal situations.

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation, Case Presentation
Format: Individual and Group
Hours Per Week: Typically, 2 hours per week (1 hour of group, 1 hour of individual), more if clinical load indicates
Days and Times: Individual supervision at times to be arranged; group supervision Tues, 9-10 and 10-11
Names of Supervisor(s): Keith Nuechterlein, PhD; Luana Turner, Psy.D; Kenneth Subotnik, PhD

BrainSPORT Program

Available for the 26-27 Training Year (2 offerings, NP rotation & CBT rotation)

PROGRAM DESCRIPTION:
The UCLA BrainSPORT program is a multidisciplinary clinical, research, outreach, and educational program focusing on brain injuries, including concussions, in athletes, youth, and adults. The BrainSPORT rotation will be offering two tracks this year, a brief assessment rotation and a brief CBT rotation. Rotating interns in the assessment track will learn to conduct brief neuropsychological screening batteries in a multi-disciplinary concussion clinic and provide feedback to patients and colleagues. Rotating interns in the CBT track will learn to provide a brief (6-week) CBT intervention to select patients who exhibit catastrophizing or avoidance behaviors. Supervision for the assessment track will be on an individual basis, in person and in clinic immediately following patient assessment and prior to feedback with patient/family. Additional supervision may be scheduled as needed. Supervision for the CBT track will be provided weekly between CBT sessions in either individual or small group format.

This program provides a great training opportunity to interact with trainees and fellows in neurology (pediatric and adult), occupational therapy, nutrition, and sports medicine. There are ample clinical and translational research opportunities for interested trainees, as well as weekly research and clinical seminars. Three 4-month rotations are offered each year.

DAY, TIME, AND LOCATION:
Assessment training opportunities are available Tuesdays, 8 -noon, and Thursday afternoons (times vary). Other clinic times are possible upon availability.
The Tuesday morning clinic is off the main Westwood campus, at the pediatric specialty suite in Santa Monica, near the UCLA Medical Center (15th street and Wilshire).

CBT clinic days are TBD depending on the intern and supervisor schedules. CBT services will be provided virtually, with the possibility of in person sessions.

HOURS PER WEEK:
5 - 7

FACULTY AND STAFF:
Talin Babikian, PhD, ABPP
Alexandra Tanner, PhD

SUPERVISION PROVIDED:
Method of Supervision: Direct Supervision

Format: Individual and Small Group
Hours Per Week: 2-3 per week (.50 of group, .50 of individual)
Days and Times: Flexible
Names of Supervisor(s): Talin Babikian, PhD; Alexandra Tanner, PhD

SUPERVISION PROVIDED:
Method of Supervision: Direct Observation and Case Presentation
Format: Individual
Hours Per Week: 1 (0.25 of group, 0.25 of individual)
Days and Times: Flexible
Names of Supervisor(s): Lucy Wall, PsyD

Insomnia Treatment Group: UCLA Student Mental Health Clinic – Adult Psychiatry (SHIP Clinic)

Available for the 26-27 training year

DAY, TIME, AND LOCATION:

Tuesdays 1:00-3:30 PM for 8 consecutive weeks (*there may be some flexibility in day of week and timing of supervision, to fit with intern's ongoing obligations)*.

2-month obligation, offered 4 times/academic year (coinciding with UCLA undergraduate academic calendar)

300 Medical Plaza, Suite 1412

HOURS PER WEEK:

2.5 hours per week: 1.5 hours providing direct clinical care; 1.0 hours in didactics/individual supervision.

FACULTY:

Jennifer Pike, Ph.D., supervising psychologist

Katerina DeBonis, M.D., medical director

PROGRAM DESCRIPTION:

The UCLA SHIP clinic is a multidisciplinary clinic in an outpatient hospital-based medical setting, serving UCLA graduate and undergraduate students with complex chronic psychiatric disorders. Patients are referred from the UCLA Counseling and Psychological Services Center (CAPS) after undergoing brief psychiatric treatment/assessment, for ongoing/consistent care at SHIP.

TRAINING PROVIDED

This elective provides trainees with an opportunity to:

- work with a diverse population suffering from complex psychiatric disorders with co-morbid sleep disorders,
- gain hands-on real-time supervision in delivering *evidence-based treatments* for sleep disorders,
- learn advanced skills for the assessment and treatment of insomnia, hypersomnia, and other sleep problems, which are commonplace across psychiatric disorders, and can be applied across populations/settings they may encounter in the future,
- in the context of working with a multidisciplinary team, in a safe, structured environment.

Assessment: Trainees will learn to administer a semi-structured interview for the assessment of sleep disorders and factors contributing to poor sleep, to assist them with case conceptualization and treatment planning. They will also learn to administer and score standardized questionnaires for the assessment of sleep quality, and other sleep parameters used to assess progress throughout the intervention.

Group therapy: "A Good Night's Rest" is a manualized structured intervention, that makes use of stimulus control, CBT-I, psychoeducation, meditation/relaxation, and other behavioral techniques to help patients understand what "normal" sleep is, what contributes to their unique sleep problems, and provides participants will skills to overcome poor sleep using a patient-centered approach to treatment. It also emphasizes how to overcome barriers to good sleep, and how to adjust their schedules to incorporate new/healthy behaviors.

Interns will serve as co-therapists for the group intervention. They will also learn relaxation techniques, and other behavioral techniques to increase intervention adherence and promote behavioral change.

Expand their knowledge of Sleep, Sleep-related disorders:

Interns will be given a set scholarly articles to read (outside of their time in clinic) to improve their understanding of insomnia, the processes that control human sleep, and behavioral factors that influence sleep. There will also be the opportunity for discussions on sleep and training on the use of CBT to treat this population.

DIVERSITY TRAINING

The UCLA SHIP Clinic serves UCLA undergraduate and graduate students who are diverse in terms of race, ethnicity, gender identity, socioeconomic status, sexual orientation, and religion.

As such, considerations of diversity issues play a central role in assessment and treatment planning. At the outset of training interns are provided with readings related to diversity and cultural competence. They are encouraged to self-examine identity factors and potential biases that may impact case-formulation, their relationship with clients, and the supervisor-supervisee relationship. Supervision and case presentation emphasizes diversity and cultural factors that may impact a patient's clinical presentation, level of trust, and response to treatment interventions. In service delivery we emphasize cultural humility and provide training on how to communicate with patients appropriately and sensitively about their individual differences. Interns are given clinical resources and encouraged to participate in lectures and training on issues related to diversity and ally-ship at the University and in the community.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation and Didactics
Format: Individual and Group
Hours Per Week: 2.5 hours per week: 1.5 hours providing direct clinical care; 1.0 hours in didactics/individual supervision.

Days and Times: Tuesdays, 1-3:30pm
Names of Supervisor(s): As listed above under Faculty and Staff section.

In the event that a group does not fill, interns will be offered the opportunity to do CBT-I in an individual therapy format. Session are 45 minutes in length and are conducted over 8-10 consecutive weeks

For further information contact: Jennifer Pike, PhD, jpike@mednet.ucla.edu

Insomnia Clinic Program

Available for the 26-27 training year

Training Program Description

Insomnia Clinic will offer a 6-month elective of 4 hours/week or a 12-month elective of 4 hours/week, thus 100 or 200 hours in total. Trainees will first have an afternoon of lectures and then shadow an attending delivering individual sessions of CBT-I over 2 weeks; after this intense and close learning opportunity, trainees will deliver 2-3 individual sessions each week with a real time supervision by an attending through a video conference. After the conclusion of each session, there will be individual face-to-face supervision by the same attending. There will also be a monthly didactic meeting for more teaching and interaction between all attendings and trainees.

The training will focus on individual CBT-I, a structured treatment program of 8 weekly sessions. Given the highly structured nature of our intervention, interns will be able to learn and practice CBT-I with high fidelity.

During the clinic rotation (6 or 12 months), interns will have lectures on:

1. Diagnostic assessment of insomnia
2. Selection of CBT-I or MBBT-I based on the patient profile and preference and the characteristics of insomnia
3. Management of hypnotic medications during behavioral treatments (hypnotics usually reduced or discontinued but not newly prescribed)
4. Principles, content, and delivery of CBT-I
5. Principles and content of MBBT-I: lectures about but no training in delivery of MBBT-I will be provided due to the training requirements for this modality.

Day, Time, and Location

Our clinical activities are currently conducted in a hybrid form of virtual and in-person encounters. All in-person CBT-I sessions will take place in 300 Medical Plaza building, but virtual CBT-I sessions via Zoom may be flexibly conducted in 300 Medical Plaza or Semel Institute according to the availability of office space.

Hours Per Week and Duration of Elective

Four hours/week for 6 months or 4 hours/week for 12 months

Most activities will take place on Thursday afternoons (1pm-5pm), but individual CBT-I sessions may be flexibly scheduled beyond Thursdays 1pm-5pm according to the availability of interns' time and attendings' time.

Supervision Provided

Method of Supervision: Direct observation

Format: Individual

All the sessions will be supervised in real time using Zoom chat comments, and there will be a brief face-to face supervision immediately after each session.

Hours of Supervision Per Week: 2.5-3.5 hours per week as trainees will conduct 2-3 therapy sessions per week (each session for 53-60 minutes) with a real time supervision via Zoom (attending present in the Zoom meeting room) and will receive a 15-minute face-to face supervision immediately after each session.

There will be introductory lectures from 1pm to 5pm on Thursday 7/10/25 and Thursday 1/8/26 and then a monthly didactic meeting at 12-1pm on the first Thursday of each month. No patients will be scheduled for didactic times.

Lecture Day

(usually on the first Thursday of July at 1-5pm as live lectures via Zoom and the first Thursday of January at 1-5pm as live lectures via Zoom and/or as recorded lectures)

1. CBT-I Rationale, Intake Evaluation, Treatment Assignment, and Sleep Medication Management: Joshua Cho, MD, PhD
2. CBT-I Sessions 1-3 (3 P's, sleep restriction, stimulus control): Jeffrey Young, PhD
3. CBT-I Sessions 4-8 (relaxation/meditation, mood, thought, sleep hygiene, relapse prevention): Stephanie Kremer, PhD

Monthly Didactic Meeting

(First Thursday of each month from 12pm to 1pm)

There will be a 30-minute lecture by an attending followed by a case discussion, a journal club, or a special topic.

Monthly Case Conference

(Third Thursday of each month from 12pm to 1pm)

We also have a case conference on the third Thursday of each month, led by our therapists and attendings, and trainees are welcome and strongly encouraged to join although this is an optional activity.

Faculty & Supervisors

Joshua Cho, MD, PhD	HJCho@mednet.ucla.edu
Stephanie Kremer, PsyD	SKremer@mednet.ucla.edu
Jeffrey Young, PhD	JEYoung@mednet.ucla.edu
Paul Barkopoulos, MD	drpaul@barkopoulosmd.com
Anthony Reading, PhD	aereading@aereading.com
Ani Vartazarian, PsyD	dr.vartazarian@gmail.com

Neurobehavioral Epilepsy Program

Available for 26-27AY

PROGRAM DESCRIPTION:

This elective involves diagnostic assessment of individuals who have non-epileptic seizures or mixed presentation (both epileptic and non-epileptic seizures).

DAY, TIME, AND LOCATION:

Flexible for assessments and therapy
Rounds are Tuesdays at 11:00am

HOURS PER WEEK:

4

FACULTY AND STAFF:

Patricia Walshaw, Ph.D. - Director
Christine You, PhD – Associate Director
Stephanie Punt PhD – Attending Psychologist

TRAINING PROVIDED:

Trainees will have the opportunity to learn assessment techniques for individuals with conversion diagnoses, issues related to neurological manifestations of psychological issues, and participate in multi-disciplinary rounds in neurology. Trainees will complete one assessment per month, which includes 3 hours of testing and a brief report. Interns will also attend weekly rounds for 1 hour (Tuesdays at 11:00) and supervision regarding each case and report. Trainees will also have the opportunity to engage in individual psychotherapy with patients with PNES, supervised by Dr. Punt. On average, trainees will spend 3-4 hours per week in this elective. Times for assessments are not fixed and can be accommodated to trainee's schedule.

SUPERVISION PROVIDED:

Method of Supervision: Direct observation, case presentation
Format: Individual and multidisciplinary rounds
Hours Per Week: 1.5 (1 hour individual, 0.5 hour group)
Days and Times: Flexible.
Names of Supervisor(s): Patricia Walshaw, PhD, Christine You, PhD, Stephanie Punt, PhD

PEERS ® Clinic: Caregiver Assisted Social Skills Program for Young Adults

Available for the 26-27 training year

PROGRAM DESCRIPTION:

PEERS® for Young Adults is appropriate for individuals 18-35 years of age with a variety of social challenges, including autism spectrum disorder (ASD), ADHD, learning disabilities, anxiety disorders, mood disorders, and adjustment disorders.

This evidence-based neuro-affirming program instructs young adults about important elements of socialization (i.e., conversational skills; peer entry and exiting strategies; handling teasing and bullying; managing reputations; choosing appropriate peers; handling arguments and disagreements; having appropriate get-togethers with peers; and dating etiquette). Separate caregiver and young adult sessions are conducted concurrently for 90-minutes each week. Sessions are structured to include homework review, didactic presentation, role-playing, and behavioral rehearsal. Caregivers are taught how to assist young adults in developing and maintaining meaningful relationships by providing performance feedback through coaching during weekly in vivo socialization homework assignments. Young adults are taught important social skills through didactic instruction, role-plays, and behavioral rehearsal during socialization activities.

DAY, TIME, AND LOCATION:

Mondays 4:00 – 8:00 pm

HOURS PER WEEK: 5 HRS/WK

FACULTY AND STAFF:

Elizabeth Laugeson, Psy.D.
Elina Veytsman, Ph.D., Director of Training
Christine Moody, Ph.D., Associate Director

Jasper Estabillo, Ph.D., Attending Psychologist
Blake Warner, Ph.D., Chief Clinical Fellow
Sarah Bruce, Ph.D., Attending Psychologist

TRAINING PROVIDED:

Training and weekly group supervision are provided for conducting this caregiver-assisted, cognitive behavioral neuro-affirming social skills program for young adults.

PEERS® for Young Adults is a 6 hour per week commitment (MONDAYS, 3:30–8:00 PM). Individual supervision is 30-60 minutes per week, depending on the involvement of the trainee in the implementation of the group, and is scheduled on an individual basis. Group supervision is conducted for 45 minutes prior to the groups from 3:30-4:15PM. Two social skills groups are conducted from 4:30-6:00PM and 6:30-8:00PM. 30 minutes is allotted for prep time / note writing. Trainees can opt to rotate through the clinic for 4, 6, or 12-month rotations and will be directly involved in the implementation of the lessons.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation
Format: Individual and Group
Hours Per Week: 30-90 minutes per week (0.5-1 group, 0.5-1 individual)
Days and Times: Flexible

Names of Supervisor(s): Elizabeth Laugeson, Psy.D., Elina Veytsman, Ph.D., Christine Moody, Ph.D., Jasper Estabillo, Ph.D., Blake Warner, Ph.D., Sarah Bruce, Ph.D.,

Psychosis Clinic

24-25 Availability: Winter and Spring

PROGRAM DESCRIPTION:

The UCLA Psychosis Clinic, directed by Stephen Marder, M.D., provides psychiatric evaluations, medication management and psychosocial interventions that aim to promote recovery and improve the quality of life for patients with psychotic disorders.

DAY, TIME, AND LOCATION:

Fridays, 8:30am-12pm
300 Medical Plaza Rm. 2208

HOURS PER WEEK:

5 hours per week, 4 or 6-month rotation

FACULTY AND STAFF:

Stephen Marder, M.D.
Luana Turner, Psy.D.
Joel Braslow, M.D., Ph.D.
Benaz Jalali, M.D.
Elizabeth Casalango, M.D.
Walter Dunn, M.D., Ph.D.

TRAINING PROVIDED:

This elective allows the opportunity to provide psychosocial interventions while working collaboratively with UCLA psychiatrists and psychiatric residents. Empirically based interventions offered in the clinic that include Mindfulness Meditation, Cognitive Behavior Therapy for Psychosis (CBTp) and Functional Cognitive Behavior Therapy (FCBT), family or individual psychoeducation, Supported Employment and Supported Education, and computer-based Neurocognitive and Social Cognitive Training.

Interns will attend the Friday clinic and will schedule therapy appointments or phone contacts according to their schedules. Supervision will be provided primarily by Luana Turner, Psy.D., who will supervise CBTp and/or Functional CBT, cognitive and social-cognitive training, and psychoeducation. Luana Turner, Psy.D who is a psychology staff member will provide supervision in the areas of supported employment and supported education, and psychoeducation. The majority of the supervision is individual and scheduled mutually by the intern and his/her supervisor.

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation
Format: Individual
Hours Per Week: 1 hour of individual supervision
Days and Times: Flexible
Names of Supervisor(s): Faculty listed above

Please contact the Psychology Services Director Luana Turner, Psy.D., at luana@ucla.edu or office (310) 206-5225 for additional information.

Spanish Language Caregiver Support

Not available 26-27

PROGRAM DESCRIPTION:

This support group is for Spanish speaking caregivers of patients with dementia of any type.

DAY, TIME, AND LOCATION:

Every other Wednesday, 6:30 – 8:00 pm
St. Sebastian Catholic Church

HOURS PER WEEK:

1.25

FACULTY AND STAFF:

Mirella Díaz-Santos, PhD. (lead)

TRAINING PROVIDED:

Co-lead a support group for Spanish speaking caregivers of patients with Alzheimer's disease, supervised by Mirella Díaz-Santos, PhD. Trainees have the opportunity to provide culturally appropriate support for caregivers, as well as psychoeducation about caregiver self-care as well as dementia (e.g., diagnosis, current treatments, and behavioral management).

SUPERVISION PROVIDED:

Method of Supervision: Direct Observation
Format: Individual, Group
Hours Per Week: 1 (0.25 group, 0.25 individual)
Days and Times: Mondays, 3-4:00p
Names of Supervisor(s): Mirella Díaz-Santos

Spanish Speaking Psychosocial Clinic (SSPC) Elective Rotation

Available for the 26-27 training year

DESCRIPTION:

Spanish Speaking Psychosocial Clinic (SSPC) psychology trainees will spend their time dedicated to evaluation, treatment, and community outreach/engagement in a 6 month-long rotation within SSPC. It will provide training and supervision in the provision of culturally responsive and comprehensive mental health services to the rapidly growing and underserved Latino/x community. Patients in the SSPC are across the lifespan and present with the full range of psychiatric diagnostic categories and are provided treatment in a variety of modalities, including individual, group, and family psychotherapy, as well as pharmacotherapy.

Trainees must be fully bilingual in Spanish and English.

The SSPC is staffed by culturally humble, bilingual/bicultural mental health professionals within the disciplines of psychiatry, psychology and social work who have extensive knowledge of Latino/x sociocultural issues related to immigration, acculturation, race/ethnicity, class, socioeconomic status, language, cultural practices, traditions and beliefs that impact the psychological functioning and wellbeing of Latino/x individuals and families.

Interns will learn through supervised practice, multidisciplinary case conferences, team meetings, and outreach/training opportunities. Interns will have the opportunity to participate in the overarching goals of the SSPC, which include: 1) Developing and implementing evidence-based for Latino/x patients and families, 2)

Strengthening support for patients and families through education and training of mental health providers, educators, and medical providers, 3) Improving the quality of care for patients and their families through direct service-delivery.

HOURS PER WEEK IN ELECTIVE ROTATION:

6

MANDATORY SSPC MEETINGS:

Spanish Speaking Psychosocial Clinic: 2 hours (individual/group)

Individual Supervision: 1 hour per week

Group Supervision: 1 hour per week

Spanish Speaking Psychosocial Clinic Multidisciplinary Rounds: 1 hr (Wednesdays 1PM)

Spanish Speaking Psychosocial Clinic Didactics Seminar: 1 hr

OTHER MONTHLY MANDATORY ACTIVITIES:

Group Therapy Seminar: 1 hour per month

Community Engagement: 1-2 hours per month as available

The SSPC intern will spend the remainder of their time in didactic seminars and electives offered through the general internship program to broaden their overall training experience. The required seminars include Psychiatry Grand Rounds

FACULTY AND STAFF:

Erica Lubliner, M.D., SSPC Medical Director

Xavier Cagigas, Ph.D., Didactics

TRAINING PROVIDED:

Interns will see patients with a wide variety of behavioral, emotional, and family problems that stem from traumatic events, medical illness, sexual abuse, physical abuse, community violence, racism/discrimination, immigration, and intergenerational trauma. Trainees thus gain first-hand experience working with Latinos/xs and families struggling with challenges. Efforts will be made to provide culturally and linguistically cases consistent with the interns' primary area of interest in addition to a breadth of cases to ensure adequate training across diverse areas of psychopathology.

Cognitive Behavioral Group Therapy for Depression

A 12-week psychosocial evidence-based intervention will be provided for adolescents (ages 14 to 18) and adults [note: groups will be held separately for the different age groups] to improve mood and overall wellbeing. This 12-week manualized intervention will be led by Dr. Jocelyn Meza and is designed for patients who either have a current diagnosis of major depression or dysthymia, or who have previously met criteria for either of these diagnoses. Topics addressed include psychoeducation on CBT and depression, identifying and changing thoughts, improving relationships to improve mood, and changing behavior to support mood.

Family Systems Intervention

A family approach is used so that the intern learns how to work across the entire family, with parents (biological, foster, and adoptive), siblings of the injured/ill child, and significant others (as applicable).

Interns learn how stress related to medical illness or traumatic events reverberates across the entire family. An emphasis will also be placed on collaborating with the systems of care that support the child and family. Treatment may include Families Overcoming Under Stress (FOCUS) en Español, family structural therapy, and family level treatment models.

Trauma-informed Evaluation

Interns gain experience in both brief evaluation and comprehensive assessment for a variety of cognitive and emotional issues that impact Latino/x patients and family functioning and parenting choices.

Interns will be trained in assessment procedures, report writing, identifying practical recommendations, and supportive delivery of feedback to parents. Approximately 2 hours per week will be spent in evaluation.

OUTREACH/TRAINING EXPERIENCE

Interns will have the opportunity to participate in community outreach and provider trainings to help build community capacity to support Latino/x patients and families. This may include events or trainings to support Latino/x families, caregiver groups, community mental health workers (Promotoras), community-based non-profits, and advocacy. Outreach and training opportunities vary during the year, but approximately 2-3 outreach or training events will be completed over the internship year (averaging less than an hour/week).

RESEARCH

SSPC is developing new research projects that are embedded in clinical practice. Intervention development and evaluation, translational research, program evaluation, and data analysis/interpretation opportunities will be available to the interns to further their research experience.

SPANISH-SPEAKING PSYCHOSOCIAL CLINIC DIDACTIC SEMINAR

Orientation lectures will be provided during the first two months of the internship. Training and culturally relevant presentations will be held every Wednesday from 12-1 PM.

SUPERVISION PROVIDED

Method of Supervision: Direct Observation and Case Presentation

Format: Individual and Group

Hours Per Week: 5 (1 hour of group, 1 hour of individual)

Days and Times: Wednesdays or Thursdays between 9 AM – 5 PM

Names of Supervisor(s): Erica Lubliner, MD.

Seminars

Psychology Interns' Seminar

Fridays from 12-1
Semel: 37-413
Attendance is required for all interns

This seminar is intended to provide an overview on a wide range of topics and to foster group identity and cohesion as the year progresses. The group will discuss current topics in clinical psychology (e.g., psychopathology, diagnostic evaluation, and modalities of treatment). Drs. Walshaw and Ricketts will meet with the trainees quarterly to discuss training issues. This seminar has an open structure to accommodate the needs of the intern and interns provide input regarding topics.

Fundamentals of Child and Adolescent Psychiatry Seminar

Thursdays from 8:00 - 9:20 am
Semel: 37-413
Attendance is required for General Child track interns, AND intern, Peds-CL intern, STAR interns, and H&B intern for two months while on Peds-CL.

This seminar is a survey course in clinical issues and current research in the area of child and adolescent psychopathology, psychopharmacology, and treatment. The course is team taught by psychiatry and psychology faculty.

Neuropsychology Seminars

To obtain a copy of the schedule and the course description of the neuropsychology seminars please contact SemelCPTP@mednet.ucla.edu. These seminars begin in September.

Additional Elective Seminars

A listing and description of elective seminars can be found in the Semel Institute and Department of Psychiatry and Biobehavioral Sciences course catalogue.

Ethical, Legal and Confidentiality Issues

Legal and Ethical Consultation

Consultation regarding emergent clinical ethical issues is available by calling the Ethics Consult Service at pager at #38442. Psychology faculty member, Dr. Patricia Walshaw is Chair of the RNPH Ethics Committee and may be contacted directly for less urgent matters.

Most recent version of APA Code of Ethics can be found at https://www.apa.org/ethics/code/ethics-code-2017.pdf

Patient Advisement by Psychology Interns

Psychology trainees should inform their clients that confidentiality is a fundamental element of the psychotherapist-patient relationship. However, there are certain circumstances in which you will be required by law to disclose to other persons information provided and that you cannot guarantee that the information will

be kept strictly confidential. Admissions of child or elder abuse, threats to physically harm other persons or oneself or statements may not be protected by law and information received may be required by law to disclose to other persons.

Additionally, you must advise patients and families that you will share information with your supervisors, as you are in training.

Release of Information

All requests for written patient information are to be directed to the Medical Records Department. Release of information follows HIPAA guidelines. You may not release any notes or reports directly to your patients or their families.

Abuse Reporting

All employees of the Semel Institute and the Resnick Neuropsychiatric Hospital are mandated by the state of California to report child abuse, elder and dependent adult abuse, and domestic violence/intimate partner abuse.

The Suspected Child and Adult Abuse and Neglect Team (SCAAN) provides consultation to all faculty, staff, and trainees on child abuse reporting. Consultations are available Monday through Friday 8am to 5pm through pager 95818.

After 5pm and on weekends please call Department of Child and Family Services at 1-800-540-4000 to report child abuse or call Adult Protective Services at 1-800-922-1600 to report adult and elder abuse.

Child Abuse cases in Mattel Children's Hospital (from the Pediatric Consultation and Liaison service) are reported to the UCLA Medical Center Scan Team. This team can be contacted through pager 96672.

Please see pages 198-234 of the appendix at the end of this manual for abuse reporting policies and procedures.

Warning of Dangerous Patients

The California Supreme Court has decided in the case of Tarasoff v. the Regents of the University of California that psychotherapists have a duty to warn persons to whom a patient presents, in the therapists' reasonable professional judgment, a serious danger of violence. UCLA Policy NPH 1621 states that "if reasonably possible, the clinician should consult with University legal counsel before making a disclosure to law enforcement."

This legal standard of medical care was described by the Court as follows:

When a psychotherapist determines, or pursuant to the standards of his profession, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of such duty, depending on the nature of the case, may call for the therapist to warn the victim of danger, to notify the police, or to take whatever other steps reasonably necessary under the circumstances.

Although the Lanterman-Petris-Short Act requires adherence to a strict standard of confidentiality in the maintenance of psychiatric records, the Court held that his requirement of confidentiality "must yield to the extent to which disclosure is essential to avert danger to others".

Failure to provide such warning when it may be called for in the Court's ruling, and when injury or death occurs to the intended victim, may result in substantial liability of the therapist and to the University. All persons engaged in the treatment of such patients should be aware of this rule, and the need to follow it.

Please see page 221 at the end of the manual for more information on the Tarasoff Warnings to Law Enforcement.

Policies, Procedures, and General Administrative Issues

Psychology Trainee Administration Office

LOCATION: Semel, Suite B7-357
PROGRAM COORDINATOR: Jewelle Dela Cruz
PROGRAM ASSISTANT: Vanessa Cruz

This office coordinates recruitment, hiring, scheduling, graduation, and termination, and verification of training for the remainder of your career-and all daily activities related to these functions. You must notify Jewelle about vacation and leave plans.

Record Retention

Student records are generally securely maintained online and protected by duo-factor authentication. Electronic copies are secured and encrypted via box. Records of any complaints would be securely stored at Staff Human Resources.

Termination Procedures as outlined by the Graduate Medical Education Office (modified as applicable to psychology internship)

Administrative Actions (non-reviewable and non-reportable)
The following actions are NOT disciplinary in nature and Trainees are not entitled to the due process rights set forth in Section VI below in connection with actions taken in accordance with this Section III. However, failure to correct administrative deficiencies may constitute academic deficiency and may be subject to academic actions in Section IV and V.

A. **Automatic Suspension from Program (Administrative)**
   1. Reasons for Automatic Suspension from Clinical Work. A Trainee will be immediately and automatically suspended from a Program for any of the following reasons:
      a. Failure to complete and maintain medical records as required by the hospital in accordance with the hospital's Medical Staff Bylaws and/or Rules and Regulations;
   2. Reasons for Automatic Suspension from Training. A Trainee will be immediately and automatically suspended from a Program for any of the following reasons:
      a. Failure to maintain proper visa status as required by state or federal law; or
      b. Any unexcused absence from the Program for five (5) or more calendar days.
   3. Status During Automatic Suspension from Clinical Work. In general, the Trainee will not receive academic credit during the period of automatic suspension; however, the Trainee's stipend will

continue to be paid while on automatic suspension status. If the automatic suspension is due to inactive licensure status, the trainee may be assigned vacation or nonclinical duties for academic credit at the discretion of the program and with approval of Program Leadership. The period of automatic suspension under this Section III will not exceed 14 (fourteen) calendar days from the date of the event identified in Section III.A.1. In general, the Trainee may be assigned non-clinical duties during this period at the discretion of the Program Director and Chair. Nothing herein precludes the Program from taking any other action with respect to a Trainee as provided in these Policies and Procedure, while the Trainee is on automatic suspension status.

B. **Automatic Termination from the Program**

A Trainee will be deemed to have resigned from his or her Program effective the fifteenth (15th) day following the event that caused an automatic suspension to be taken under Section III.B.1.b, c or d herein, unless the basis for the automatic suspension has been fully resolved without qualification by that day. A Trainee will be deemed to have resigned from his or her Program effective the fifteenth (15) day following an unexcused absence as provided herein, unless the Trainee has submitted materials to the Chair regarding the basis for the unexcused absence, and the Chair has determined the absence to be excused and within the scope of other applicable UCLA policy.

C. **Administrative Leave and Investigatory Leave**

Administrative Leave and Investigatory Leave are both administrative in nature and are not intended to replace any leave that a Trainee may otherwise be entitled to under state or federal law or University Policy including but not limited to vacation leave, sick leave, family, medical and other leaves related to life events. Investigatory leave may be used to permit the University to review or investigate allegations of trainee wrongdoing which warrants removing the trainee from the work site. Administrative leave is used for situations that require the trainee to be removed from the work site for reasons not investigatory in nature. Please consult the House Staff Leave Policy, your Program Director/Program Coordinator, the GME Office or your departments, Human Resources representative for information about leaves.

Academic Actions – Education Improvement (non-reviewable and non-reportable)

The following actions are non-disciplinary and therefore non-reviewable in nature. Trainees are NOT afforded the due process rights set forth in Section VI herein for actions taken against them under this Section IV. The actions below are not progressive and each can be taken at any time, and can be repeated as determined appropriate, by the Chair or Program Director. These tools are educational and DO NOT constitute disciplinary action and therefore are not reported in response to third party inquiries except as required for medical licensure. The specific Academic Action being utilized must be clearly labelled in the written communication delivered to the trainee.

A. **Educational Letter of Counseling**

An Educational Letter of Counseling may be issued by the Program Director to a Trainee to address an identified deficiency or concern that needs to be remedied or improved. Letters of counseling should describe the nature of the deficiency or concern and specific suggestions for remedial actions or changes required on the part of the Trainee and should be reviewed with the Trainee. Failure by the Trainee to remedy the deficiency or concern to the satisfaction of the Chair or Program Director, or a repetition of the deficiency or concern, may lead to additional actions, including but not limited to disciplinary actions under Section V herein. Educational Letters of Counseling should be used for minor, isolated problems.

A. **Probation**

A Program Director may place a Trainee on probation when the Trainee is in jeopardy of not successfully completing the requirements of the Program, or the Trainee is not satisfactorily meeting Program standards. The Trainee will be notified of the probation in a letter from Program Director (Chair Co-signature required) that will identify the basis for the probation; any required remedial activity necessary to remove the probation status; the expected time frame within which the required remedial activity must occur and information on how the Trainee may appeal the notice of probation in accordance with Section VI of these Policies and Procedures. Failure to correct the identified deficiency(s) within the specified period and to the satisfaction of the Chair may lead to an extension of the probationary period or other academic actions. Probation should be used instead of a Notice of Concern when the

underlying deficiency threatens a Trainee's ability to complete the Program in a satisfactory manner or time frame, and remedial action requires Faculty oversight. The probationary period should be not less than thirty (30) days and its duration should be appropriate for the identified Deficiency.

B. **Suspension**

The Program Director may suspend the Trainee from part or all of the Trainee's usual and regular assignments in the GME training program, including clinical and/or didactic duties, when the removal of the Trainee from the clinical service is required for the best interests of the Trainee and/or the GME training program. The suspension will be confirmed in writing ("Notice of Suspension") from the Program Director (Chair Co-signature required). The Notice of Suspension will identify the reason(s) for the suspension, its expected duration, and information on how the Trainee may appeal the Notice of Suspension in accordance with Section VI of these Policies and Procedures. Suspension generally should not exceed sixty (60) calendar days. Suspension may be coupled with or followed by other academic actions. The Trainee's stipend will continue to be paid while the Trainee is on suspension status.

C. **Adverse Annual Evaluation**

A Trainee may receive an adverse annual evaluation due to overall unsatisfactory or marginal performance ("Adverse Annual Evaluation") at the recommendation of the Program's Clinical Competency Committee. Trainees will be notified in writing by the Program Director of any Adverse Annual Evaluation. Any Notice of Adverse Annual Performance must include the basis for the non-renewal, and information on how the Trainee may appeal the decision in accordance with Section VI of these Policies and Procedures.

D. **Requirement that Trainee Must Repeat an Academic Year**

A Trainee may be required to repeat an academic year due to unsatisfactory progress, as assessed by the Program's Clinical Competency Committee, at the sole discretion of the Program Director (Chair Co-signature required). Notice of a Requirement to Repeat Academic Year must be provided to the Trainee in writing by the Program Director and should identify the grounds for the need to repeat a year, and the right to appeal the decision in accordance with Section VI of these Policies and Procedures.

E. **Non-Renewal of Appointment**

The Trainee's appointment to a Program is for a one (1) year duration, which is renewed annually when there are no educational or clinical concerns. Due to the increasing level of responsibilities and increasing complexity of clinical care over the course of the Trainee's training, satisfactory completion of prior academic year(s) or rotation(s) does not ensure satisfactory proficiency in subsequent years or rotations. A Trainee may have his or her appointment not renewed at any time when there is a demonstrated failure to meet programmatic standards.

The Program Director should provide each Trainee with a written evaluation at least twice per year. The first evaluation should occur by the end of the seventh month of the appointment term. If prior to the end of eight months (no later than February 28th of the academic year), the Program Director in consultation with the Chair concludes that the Trainee's appointment should not be renewed for the following year, the Program Director will notify the Trainee in writing (Chair Co-signature required) that his or her appointment will not be renewed for the following academic year ("Notice of Non-Renewal"). The Trainee will be permitted to conclude the remainder of the academic year unless further academic action is taken. The Chair may also issue a Notice of Non-Renewal after eight months following the start of the academic year if warranted due to the Trainee's performance.

Any Notice of Non-Renewal must include the information set forth in Section VI.B of these Policies and Procedures.

F. **Denial of University Certificate of Completion**

If the Program Director, in consultation with the Chair, decides not to award the Trainee a University Certificate of successful completion of the Program, the Program Director will notify the Trainee in writing of the decision (Chair Co-Signature required) to deny the certificate. Any Notice of Denial of Certificate must include the information set forth in Section VI.B of these Policies and Procedures.

G. **Dismissal from the Program**

Based on the Program Director's discretion as approved by the Chair, a Trainee may be dismissed from a Program for Academic Deficiencies for reasons including but not limited to the following:

1. A failure to achieve or maintain programmatic standards in the Program;
2. A serious or repeated act or omission compromising acceptable standards of patient care, including actions that constitute a medical disciplinary cause or reason;
3. Unprofessional or unethical behavior that is considered unacceptable by the Program; and/or
4. A material omission or falsification of a Program application, medical record, or other University document.

The Trainee must receive a written Notice of Dismissal from the Program Director (Chair Co-signature required) and include the information set forth in Section VI.B of these Policies and Procedures

Due Process Policies and Procedures

Interns who have problems or concerns with any aspect of the training program are encouraged to first speak with their supervisor, if possible. Interns may also choose to speak with their clinic program director and their advisor. Patricia Walshaw, Ph.D., Internship Training Director, Emily Ricketts, Ph.D., Associate Internship Training Director, April Thames, Ph.D., Chief of Psychology are also available at any time during the training year. If there are issues with Dr. Walshaw or Dr. Ricketts, interns may choose to speak with Dr. Bilder. If there are issues with Dr. Bilder, interns may speak with Drs. Walshaw or Ricketts.

Interns may also speak with Monica Rodriguez, Semel Institute's CAAO regarding any grievances. She will listen, investigate, and resolve grievances. All matters are treated confidentially. This information is provided during orientation, on the website, and is also contained in the contract each Intern signs after the APPIC Match.

Mistreatment and Non-Discrimination Policies

We value a workplace environment free of discrimination and harassment. Interns with any concerns related to discrimination, bias, harassment, or violence may contact Drs. Bilder, Walshaw, or Ricketts at any time. There are a number of policies in place to address issues of discrimination, bias, and violence in the workplace.

Community Expectations: Responding to Discrimination in the Clinical and Research Settings

The purpose of this document is two-fold:

First, to describe the shared expectations for the members of our Psychiatry communities for responding to discrimination (including faculty, staff, residents, fellows, postdoctoral- internship- and practicum-trainees, other students, and volunteers), across settings (both clinical and research) both on campus and at affiliated educational/clinical sites outside of UCLA Health.

Second, to guide an appropriate response to reporting and remediating discriminatory or harassing conduct directed towards community members, patients, or research participants (their family members, visitors, or patient representatives) based on those individuals' protected characteristics, as it pertains to education, training, employment, and patient care.

These expectations apply to *all forms* of discrimination and provide a template to help guide personnel in both managing discriminatory or harassing behavior, and requests from discriminatory patients/participants for provider/personnel reassignments.

These expectations do not supersede, but rather supplement, existing departmental, hospital, and other University policies that pertain to responding and reporting of incidents of discrimination based on an individual's protected characteristics.

Please refer to page 224 on the appendix to access the document.

Mistreatment Incident Reporting

One of the most important priorities at the David Geffen School of Medicine at UCLA (DGSOM) is to provide trainees with the very highest quality clinical learning experiences. Mistreatment of trainees is unacceptable and inconsistent with the commitment to zero tolerance for mistreatment of any kind, and of any form of retaliation against those who report mistreatment. Given the complex nature of our training programs, we understand the importance of having a reporting mechanism for confidential or anonymous trainee complaints of mistreatment. Therefore, the medical student Committee on Learning Environment Oversight (CLEO) and the Mistreatment Incident Reporting Form (MIRF) has been expanded to all trainees, including our GME.

What is GME CLEO and the MIRF?

GME CLEO is charged with being responsible for the review of trainee concerns regarding the learning environment and the development of action plans in response to episodes of alleged mistreatment and to prevent future occurrences. The Mistreatment Incident Reporting Form (MIRF) is an avenue for trainees to submit incidents of mistreatment that they have either personally experienced or heard/witnessed of other trainees. Reporters have the option of submitting incidents either confidentially or anonymously. By submitting confidentially, the reporter may be contacted by the CLEO Chairs and receive updates on the case. By submitting anonymously, the reporter will not be contacted but are able to track the status on the MIRF Status Dashboard.

What happens after I file a MIRF? All MIRFs are reviewed within 72 hours of submission by the CLEO Chairs and staff member. When warranted, the CLEO Chairs may refer a MIRF to Title IX or Discrimination Prevention Office (DPO) for review. CLEO members review MIRFs on a monthly basis at their meetings, MIRFs presented at meetings are redacted of any identifying information for both the reporter and the individual being reported. The committee is composed of faculty, trainees and administration. When reviewing MIRFs, each case has a recommended action plan developed, which is then executed by the CLEO Chairs.

How will this impact my learning environment? In addition to reviewing and triaging MIRFs, the committee is charged with maintaining and analyzing data regarding the learning environment. Databases are kept at the level of each CLEO (UME, GME and Research). By sharing databases, the committees are able to observe for trends across learning environments for all trainees and respond accordingly. Data collected will be routinely shared with various stakeholders to address any concerns.

How do I access the MIRF? Please refer to the following website: https://uclahs.fyi/MIRF

SOFI Reporting

Automatically launch SOFI from CareConnect via the new SOFI button

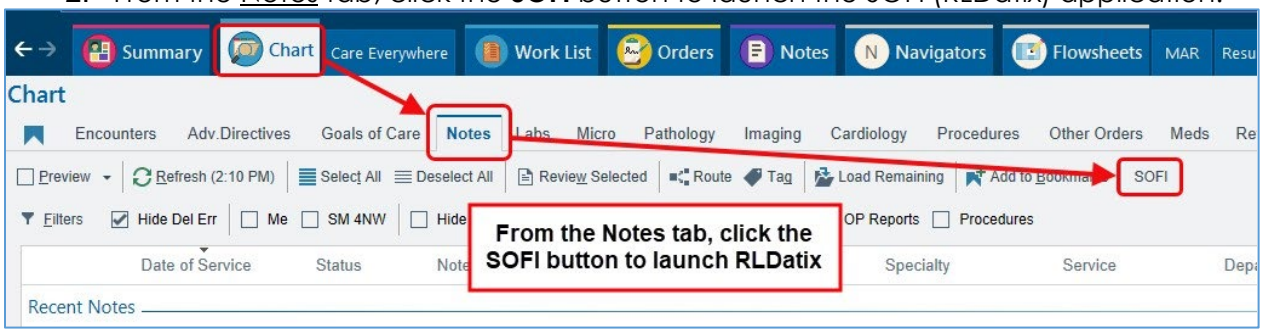
Enter patient-related safety events (Note: Visitor, employee, and DEM events need to be entered through the main SOFI reporting website at sofi.ucla.edu)

Automatically populate the patient demographic information from the patient's chart you have open in CareConnect.

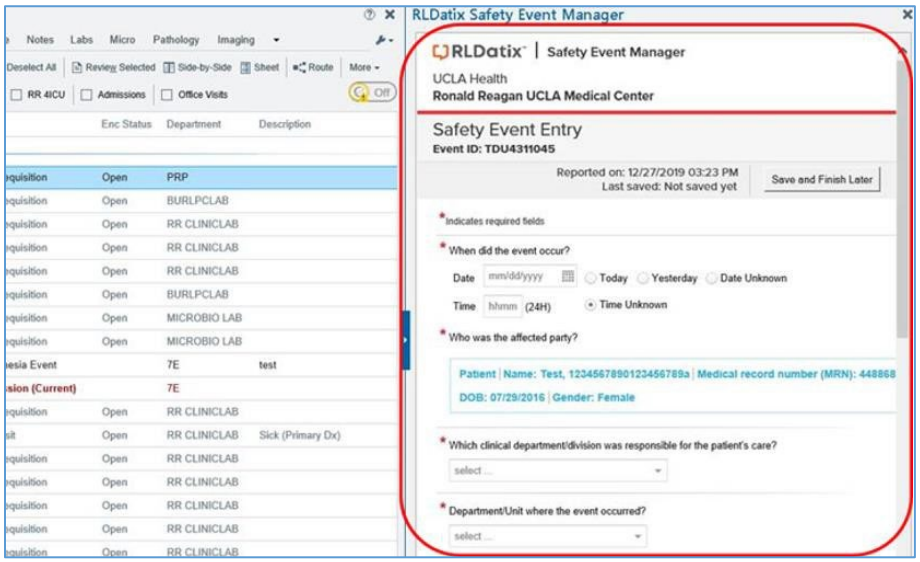
Automatically populate reporter information based on your CareConnect login. (Note: Anonymous reporting is available through the main SOFI reporting website at sofi.ucla.edu)

Chart Activity – SOFI Button

1. Open the patient's chart to the **Chart** activity.
2. From the Notes tab, click the **SOFI** button to launch the SOFI (RLDatix) application.



3. Select the Region and Facility the Safety Event occurred, and click Continue.
4. Complete appropriate documentation on the Safety Event Entry form (right sidebar).



Note that this SOFI report **does not** flow into the patient's chart. It is simply a faster way of launching the SOFI application. For any questions regarding SOFI, please contact SOFI@mednet.ucla.edu.

UCLA Non-Discrimination Policy
https://policy.ucop.remediedu/doc/4000376/DiscHarassAffirmAction

Affirmative Action Policy
https://www.chr.ucla.edu/policies-and-labor-contracts/procedure-14-affirmative-action#:~:text=All%20recruitment%20material%20and%20advertising,identified%20carefully%20and%20documented%20thoroughly

Please refer to the appendix at the end of the manual for documents and policies related to:

- Community Expectations: 224
- Workplace Violence Prevention Plan HS 8703: 246
- Management of Patient Discriminatory Conduct and Reassignment Requests HS 3068: 269

Patient Responsibilities – UCLA Health Experience – Los Angeles, CA: 278

Intern Performance Evaluation, Feedback, Advisement, Retention and Minimal Requirements

Assessment of clinical competency is completed every 4 months by each of the trainee's supervisors through the MedHub online evaluation form (see sample form at the end of this manual). Interns' evaluations are discussed with supervisors and core faculty at an Internship Training Committee meeting. Verbal feedback regarding the evaluations and the Training Committee's discussion of the evaluations is provided to the intern by his or her advisor.

Interns are assessed in the APA required nine PWCs in the areas of ethics and legal issues, assessment and diagnosis, psychotherapeutic intervention, consultation, individual and cultural diversity, integration of practice with research and theory, supervision, professionalism, and communication. The MedHub evaluation form is designed to be developmental in nature and show progress of the intern over the course of the year. It is also designed to be used from the practicum level through the postdoctoral level. As such, the "minimum levels of achievement" (MLAs) for each timepoint of evaluation change through the course of the year. The MLAs are based on the aggregate data of the evaluations for each PWC at that timepoint and are as follows:

- October = 2
- February = 3
- End of May and graduation level = 4

Any intern with low scores that are just above the MLA will receive additional supervision to address the area of deficit. In most cases, this resolves any issues.

Any intern who scores below the designated MLA in a PWC (based on aggregate scores for the PWC), while be initiated on a remediation plan (see Remediation Plan form at the end of the manual). This plan is designed to provide extra support to the intern in the form of additional supervision, guidance, literature, and performance enhancement strategies. The remediation plan will provide concrete goals for improvement. The plan is formed with the relevant supervisor/s, the intern's advisor, and the training director. The advisor will discuss the plan with the intern. Supervisors will then complete more regular MedHub evaluations of the intern to track progress on the plan and ensure that the intern is reaching competency levels in that area.

It is expected that by the final evaluation in June, that interns' scores on all domains assessed will be in the 4 range or higher. A summary Letter is completed at the end of the internship year by the trainee's advisor, based on evaluation from each supervisor throughout the year.

Equitable procedures have been developed by the UCLA School of Medicine and are adhered to by the Resnick Neuropsychiatric Institute and Hospital for those rare instances when training performance does not meet professional standards. Please see Personnel Policies for Staff Members regarding management of interns with difficulty in the program for full text of the policy: UCLA GME ACADEMIC DUE PROCESS POLICY

Campus Safety and Transportation

This link provides information about campus safety programs and services:
https://www.transportation.ucla.edu/traffic-and-safety/campus-safety

Psychotherapy for Interns

Interns may receive short-term therapy and medication management through the UCLA Behavioral Wellness Center. https://medschool.ucla.edu/bwc

Time Off Policy

Vacation

You have three weeks (15 business days) of vacation, which should be taken with careful consideration of impact on clinical services. All requests must be pre-approved which means approval must come from supervisors in major rotations, electives, and training directors. No more than 5 consecutive days in major rotation is allowed. No more than 3 days total in elective rotations; no consecutive weeks in electives unless approved by a supervisor. No vacations during the first 2 weeks and last 2 weeks of rotation. All requests should be made at least 4 weeks in advance. If you are behind on clinical duties, your vacation may not be approved. You must arrange coverage for vacation days.

Sick Leave

You have 12 days of sick leave. You must let your primary supervisors know of your absence, arrange for coverage

Educational Leave

Interns are entitled to take eight days of educational leave for workshops, to present papers or to attend meetings. Education leave may be taken at the discretion of the primary rotation supervisor as these are considered part of your internship training experience. You must arrange coverage for educational leave days

Internal Trainings

Interns are entitled to take three days for participation in UCLA trainings without utilizing vacation, sick or educational leave. This is at the discretion of the primary rotation supervisor, as these are considered part of your internship training experience. You must arrange coverage for internal training leave days and contact the page operator to sign your pager over to the covering person.

Tracking time off on MedHub

You are required to submit any vacation, sick, and educational time off on MedHub. This is our record keeping system. Instructions on how to submit Time Off Requests on MedHub

Jury Duty

If you are called for jury service during internship, you will mark that are regular time worked. You must provide a copy of your summons and verification of service to Semelcptp@mednet.ucla.edu Please keep in mind as an intern you're still expected to maintain your internship responsibilities and complete requirements. Please discuss with your major rotation supervisor your options.

Educational Support Awards for Clinical Psychology Trainees

Interns receive an annual allocation of $1000 to support educational advancement. More information about this can be found here: https://education.semel.ucla.edu/clinical-psychology-training-programs/trainee-life-benefits/

Benefits

As a staff, contract employee, interns are eligible for medical, dental and optometry coverage with the option for additional employee paid benefits. See here for benefits: ucresidentbenefits.com/uc-los-angeles Interns also have15 days of vacation and 12 days of sick leave and will be contributing to an involuntary retirement

plan (DCP) with the option of also enrolling in an additional, employee paid pre-tax retirement plans. For more details about the coverage, please visit http://atyourservice.ucop.edu/

If any injury occurs while at work, employees must go to Occupational Health (x56771), as well as reporting the injury to Human Resources (x50521). http://www.oirm.ucla.edu/workers-comp-fact-sheet.pdf

Professional Liability Insurance

Interns are considered employees of the University for the purposes of the California Tort Claims Act (Government Code section 825). Stated generally, the Regents provide legal representation and indemnification for university employees in all situations where a claimed act or omission occurs in the scope of the employee's employment and no actual fraud, corruption, or actual malice is found to have been involved. Amounts which may be payable by way of settlement of a claim or as the result of a judgment in a litigated matter are paid by the Regents or their insurance carrier. Trainees contacted by attorneys or others regarding malpractice suits are asked to immediately notify their supervisors and the Hospital Risk Coordinator who will coordinate the response on their behalf.

UKG – Bi-Weekly Timesheet

You will be required to submit a bi-weekly timesheet to receive your stipend. Due to restrictions to the UKG system you will be recording any vacation and sick time as "REGULAR HOURS" and will need to write a comment indicating whether vacation or sick time was used. If you submit a timesheet that has vacation and sick, you will not be paid out those hours. https://uclahealth-sso.prd.mykronos.com/

Overtime

Interns are eligible for overtime; however, this must be approved ahead of time by the track director and training director and is used for situations in which an intern is working additional duties outside of their expected caseload/job description. Should additional hours be needed to complete basic duties of your track and electives, a remediation plan will be initiated.

Email Policy

There are specific policies regarding the use of email for communication of restricted information which must be referred to. Please see link for full text of the policy:
http://compliance.uclahealth.org/workfiles/HS%20Policies/HS9453A-Use%20of%20Email%20in%20Communication%20of%20Restricted%20Information%20-%20rev%2020110331.pdf

Technology

All interns are provided with a computer in their office as well as access to a printer. They will need to utilize their personal cell phones at work to receive pages. Personal laptops, iPads/tablets, and cell phones that will be used for work purposes are required to be encrypted by UCLA in order to ensure HIPPA compliance. UCLA provides VPN software to access online medical resources off campus.

SPOK Mobile Policy

UCLA uses Spok mobile app for paging which is installed on your cell phone once it is encrypted. You should be available by Spok mobile to receive pages on your mobile device Monday through Friday during business hours. Your outgoing message should reflect when you might be paged. You may be reached through the UCLA page operator at 310.825.6301, option #1.

Please arrange for coverage of pages when you are away. Please discuss issues related to coverage of pages with your supervisors.

https://it.uclahealth.org/guides/spok-mobile

Telephones

All interns are provided with a phoneline in their office (or jabber) and an office phone number on which patients can contact them. Interns are not provided with work mobile phones. On campus, you may call others on campus using the last 5 digits of a phone number. If you are paged to a 5-digit number and need to return the call from a cell or off campus phone, use these prefixes:

Telephone: (310) 79**4-xxxx (**310) 82**5-xxxx (**310) 20**6**-**xxxx (**310) 26**7-xxxx**

Contact with Patients

Do not share home or cell phone numbers with patients and families or maintain contact post internship.

Dictation Service

Dictation services are available for notes, reports, and other documents in CareConnect.

Dictating
From on campus, dial #30 to access dictation system
From outside dial 1-310-794-2001
Pager number, #
Location code, #
Work Type, #
Patient MRN, #
To mark STAT, press * after you hear the beep.
To pause, press 1; to resume, press 2; to rewind, press 3.

Dictation Codes	
Location Codes	Work Type
1 = Westwood 2 = NPH 3 = Santa Monica	1 = Discharge Summary 3 = Inpatient Procedure Note 33 = Outpatient Procedure Note 4 = Inpatient Consultation 44 = Outpatient Consultation 5 = Inpatient H &P 55 = Outpatient H&P 7 = Inpatient Progress Note 77 = Outpatient Progress Note 9 = Transfer Summary 10 = Death Summary 95 = Goals of Care Note

Interpretation/Translation Service

Interpreter and translation services are available for Ronald Reagan UCLA Medical Center and the Resnick Neuropsychiatric Hospital. Details on ordering these services can be found through this link: https://www.uclahealth.org/interpreters/Workfiles/policy/Interpreter-Services-Policy-English.pdf

You can find more details on page 287 of the appendix at the end of this manual.

Medical Psychology Assessment Center (MPAC)

The Medical Psychology Assessment Center (MPAC) is situated in the C8-700 corridor of the Semel Institute and includes the Frances and Ivan Mensh Memorial Psychological Assessment Laboratory in the Semel Institute (Room C8-746). The laboratory carries a wide variety of psychodiagnostic and neuropsychological assessment materials as well as administration and scoring software for selected instruments. Please note that for interns who are not in a neuropsychology track, prior authorization from Dr. Patricia Walshaw, or the Chief

Neuropsychology Fellow is required to check out materials, all of which must be returned within 24 hours due to the high demand for their use.

Medical References/Libraries

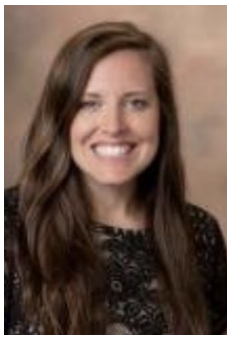
The Mednet homepage link contains links to medical reference resources including PubMed, an online psychiatry reference which includes the DSM, Up-To-Date, and others.
https://mednet.uclahealth.org/ navigate to "Medical Resources" on the top toolbar

The Biomedical Library, 12-077 CHS, serves the entire Center for Health Sciences. Library cards are issued at no cost upon presentation of your ID badge.

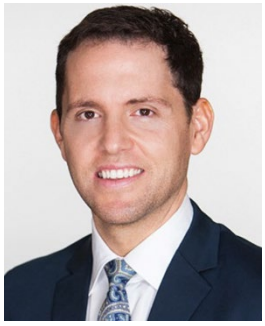
Faculty & Supervisor Roster

Telephone: (310) 79**4-xxxx** (310) 82**5-xxxx** (310) 20**6**-**xxxx** (310) 26**7-xxxx**

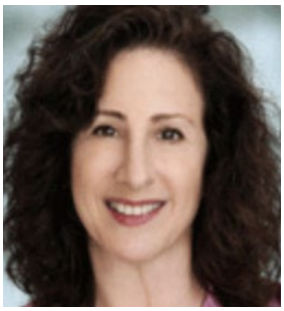
To find other faculty not listed here go to: http://directory.ucla.edu/

	Faculty Name and Email	**Phone #**	**Clinic/Program**	**Research Area**
	Adery, Laura Ladery@mednet.ucla.edu		Center for Assessment and Prevention of Prodromal States (CAPPS)	
	Asarnow, Joan jasarnow@mednet.ucla.edu	50408	Youth Stress & Mood (YSAM) Program, Director	Suicidal & Self-Harm Behavior- Moving Towards the Aspirational Goal of Zero Suicide; Child and Adolescent Depression; Trauma & Stress- National Child Traumatic Stress Center on Trauma-Informed Suicide & Self-Harm Treatment & Prevention; Integrated Medical-Behavioral Health Care; Intervention & Services Research.
	Babikian, Talin tbabikian@mednet.ucla.edu	50983	Associate Director, UCLA BrainSPORT program Training Director, Neuropsychology Fellowship	Pediatric brain injury, neuroimaging, sports related concussions Medical Psychology Assessment Center (MPAC)
	Barenstein, Veronica vbarenstein@mednet.ucla.edu	51246	Family & Couples Therapy Training Program, Director Family Therapy Clinic	

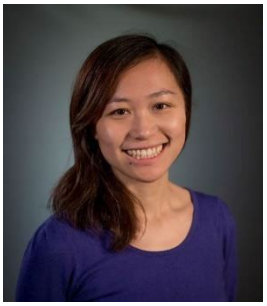
	Barnard, Evangelina EVBarnard@mednet.ucla.edu		Staff Psychologist	MPAC
	Bates, Shannon sbates@mednet.ucla.edu		PEERS -- Clinical Instructor/Attending Psychologist/Director of Training/Certified PEERS Trainer	
	Baweja, Shilpa sbaweja@mednet.ucla.edu	62883	Children's Friendship Program Parent Training Program	Peer victimization, Trauma interventions, Parenting techniques
	Bearden, Carrie cbearden@mednet.ucla.edu	62983	Center for Assessment and Prevention of Prodromal States (CAPPS) Adolescent Brain-Behavior Research Clinic	Neurobiological precursors of adolescent serious mental illness; brain development in unique genetic high-risk populations
	Best, Karin kbest@mednet.ucla.edu	62210	Infant Pre-School Service	Long term outcomes among psychiatrically hospitalized adolescents. Clinical interest: assessment and treatment of infants and preschool age children; application of evidence informed treatment is systems of care

	Bilder, Robert rbilder@mednet.ucla.edu	59474		Neuropsychology, neuroimaging, neurogenetics; biological bases of psychopathology; dimensional models of psychopathology
	Bookheimer, Susan sbookheimer@mednet.ucla.edu	46386	Medical Psychology Assessment Center (MPAC) Director, Center for Cognitive Neurosciences Brain Imaging Lab	Neuroimaging; Autism, movement disorders, Wada testing and electrocorticography; neuropsychology
	Boxer, Oren Oboxer@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	
	Cagigas, Xavier E. xcagigas@mednet.ucla.edu	53731	Hispanic Neuropsychiatric Center for Excellence (HNCE) Spanish Speaking Psychosocial Clinicl (SSPC)	Cultural Neuropsychology; Neurobehavioral Genetics; Bilingual/Spanish neuropsychological assessments; consultation on cultural/linguistic issues in neurocognition; Justice, Equity, Diversity & Inclusion (JEDI)

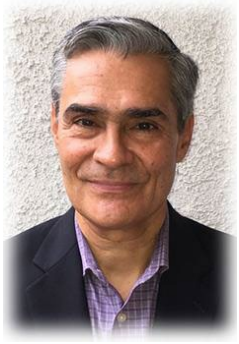
	Cavanagh, Lucia lcavanagh@mednet.ucla.edu	69909	Lifespan Assessment Through Integrated Neuropsychology Associate Director	Cultural neuropsychology, health disparities
	Cox, Julia jrcox@mednet.ucla.edu	66882	Child Anxiety, OCD, and Tic Disorders Program	
	Dean, Andrew acdean@mednet.ucla.edu	55839	Medical Psychology Assessment Center (MPAC)	Brain research Institution (BRI) and Neuroscience Interdepartmental PH. D Program (NSIDP) neuropsychological consequences of substance abuse, particularly methamphetamine abuse.
	Denenny, Danielle Ddenenny@mednet.ucla.edu		Center for Assessment and Prevention of Prodromal States (CAPPS)	Prodromal psychosis, bipolar disorder
	Díaz-Santos, Mirella mdiazsantos@mednet.ucla.edu	40292	Research Director, HNCE Spanish Language Caregiver Support	Neuropsychology; Bilingual/Spanish neuropsychological assessments; Neuroimaging; Alzheimer's and Related Dementia; Caregiver support groups; Qualitative Research

	Dillon, Andrea Adillon@mednet.ucla.edu	25747	Medical Psychology Assessment Center (MPAC)	
	Durbin, Kelly kdurbin@mednet.ucla.edu	68100	Staff Psychologist	Medical Psychology Assessment Center (MPAC)
	Ellenberg, Leah Lellenbergseider@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	Pediatric neuropsychologist, with a private practice in the assessment of children, adolescents and young adult for a variety of disorders including learning disabilities, AD/HD, autistic spectrum disorders, head injuries and medical conditions. research has focused on the neuropsychological sequelae of childhood brain tumors and their treatment.
	Ellis, Alissa aellis@mednet.ucla.edu		Director, thinkSMART® program Child and Adolescent Mood Disorders Program (CHAMP)	Electrophysiological correlates of childhood psychiatric disorders, particularly mood disorders; reward and frustration processing; cognitive mechanisms associated with mood disorder vulnerability

	Emerson, Natacha ndemerson@mednet.ucla.edu	48416	Director, Pediatric Psychology Consultation Liaison Service	Health psychology (hematology-oncology, endocrinology, pulmonology, and general pediatrics); adherence to medical treatments; iatrogenic medical trauma; family-centered and trauma-informed approaches to managing chronic illnesses; early childhood; health disparities.
	Estabillo, Jasper jestabillo@mednet.ucla.edu		Director of Training at the UCLA Tarjan Center PEERS	N/A
	Factor, Reina rfactor@mednet.ucla.edu		Staff Psychologist	Child & Adolescent Psychiatry Division Children's Friendship Program/Behavioral Parent Training Program
	Fernandez, Vindia vfernandez@mednet.ucla.edu	42479	Lifespan Assessment Through Integrated Neuropsychology	N/A
	Gallagher, Colin Cjgallagher@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	

	Gammada, Emnet egammada@mednet.ucla.edu	56449	Medical Psychology Assessment Center (MPAC) Geropsychology	
	Glass, Leila leilaglass@mednet.ucla.edu		PEERS	
	Gulsrud, Amanda agulsrud@mednet.ucla.edu	50575	Clinical Director, Child and Adult Neurodevelopmental (CAN) Clinic	Early identification and treatment for children with ASD, specializing in the JASPER treatment and development.
	Guo, Sisi sisiguo@mednet.ucla.edu		Child OCD IOP, Director	
	Hajal, Nastassia nhajal@mednet.ucla.edu	46073	Stress, Trauma and Resilience (STAR) Clinic Assistant Director, Nathanson Family Resilience Center Early Childhood Care	Child and family traumatic stress; intergenerational transmission of trauma; family-centered intervention; early childhood emotional development; parent emotion regulation

	Hinkin, Charles chinkin@mednet.ucla.edu	84357	Medical Psychology Assessment Center (MPAC)	Cognitive sequelae of HIV
	Hisaka, Nicole nhisaka@mednet.ucla.edu		Stress, Trauma and Resilience (STAR) Clinic Parent-Child Interaction Therapy (PCIT) EMPWR Program	
	Kaser-Boyd, Nancy nkaserboyd@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	
	Kelman, Alex akelman@mednet.ucla.edu	50346	Stress, Trauma and Resilience (STAR) Clinic	
	Kremer, Stephanie skremer@mednet.ucla.edu		Insomnia Clinic	

	Kuzava, Sierra SKuzava@mednet.ucla.edu		Associate Director of the Family Development Program	
	Langley, Audra alangley@mednet.ucla.edu	42460	Director, UCLA TIES for Families Director of Training, Trauma Services Adaptation Center for Resiliency, Hope and Wellness in Schools Bounce Back-Elementary School Intervention for Childhood Trauma	Child traumatic stress; Inter-disciplinary approaches to supporting children and young people in foster care and adoption; Trauma and resiliency informed, child-welfare competent care training; Preplacement education and preparation for foster families; Prenatal substance exposure and adoption
	Laugeson, Liz elaugeson@mednet.ucla.edu	73370	Director, UCLA PEERS Clinic Training Director, Tarjan Center UCEDD Program Director, Autism Center of Excellence	Evidence-based, parent-assisted social skills training for preschoolers, teens and young adults with autism, ADHD, depression, and/or anxiety.
	Lechuga, David dlechuga@mednet.ucla.edu		Lifespan Assessment Through Integrated Neuropsychology	

	Leone-Friedman, Judith Jeleone@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	
	Light, Roger rlight@mednet.ucla.edu	41221	Medical Psychology Assessment Center (MPAC)	
	Loo, Sandra sloo@mednet.ucla.edu	59204	Director, Pediatric Neuropsychology, MPAC Neuromodulation Clinic	Cognitive and electrophysiological correlates of childhood psychiatric disorders; Genetics of ADHD and Dyslexia
	Lord, Catherine clord@mednet.ucla.edu		Child and Adult Neurodevelopmental (CAN) Clinic	how to make the diagnostic process meaningful for families and individuals with ASD across the lifespan from infants to adults, diverse trajectories and how to help families make decisions about treatments and educational services
	Marlotte, Lauren lmarlotte@mednet.ucla.edu	40339	Stress, Trauma and Resilience (STAR) Clinic Assistant Training Director, Nathanson Family Resilience Center	Trauma, resilience, military Families, adolescent intervention, family prevention, school-based prevention, foster families

	Marvin, Sarah smarvin@mednet.ucla.edu	69531	Child and Adolescent Mood Disorders Program (CHAMP)	Early intervention in bipolar disorder and schizophrenia, family factors in mood disorders
	McDonald, Nicole nmcdonald@mednet.ucla.edu	58906	Child and Adult Neurodevelopmental (CAN) Clinic Parent Child Interaction Therapy (PCIT)	Autism spectrum disorder; early developmental trajectories; infant sibling studies; infant brain imaging
	McNeil, Galen Gmcneil@mednet.ucla.edu		ABC Partial Hospitalization Program	
	Meza, Jocelyn Jimeza@mednet.ucla.edu		Spanish Speaking Psychosocial Clinic (SSPC) Youth Stress and Mood (YSAM) Program	Socio-ecological risk and protective factors for suicide and self-harming behaviors among Black and Latinx youth
	Miklowitz, David dmiklowitz@mednet.ucla.edu	72659	Director, Child and Adolescent Mood Disorders Program (CHAMP) Director of Integrative Study Center in Mood Disorders	Early intervention for youth with or at risk for bipolar disorder; controlled trials of family-focused treatment; mentalization-based therapy for youth with suicidality; mindfulness-based cognitive therapy

	Miranda, Jeanne Jmmiranda@mednet.ucla.edu	43710	Interim Director, HNCE EMPWR Youth Stress and Mood (YSAM) Program	Evaluating the impact of mental health care for ethnic minority communities
	Mitrushina, Maura Mmitrushina@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	
	Mogil, Catherine cmogil@mednet.ucla.edu	43518	Family Stress, Trauma and Resilience (STAR) Clinic Family Development Program/NICU Parent Child Interaction Therapy (PCIT)	Trauma, Resilience, Military Families, Early childhood intervention, family prevention, NICU, family-centered care
	Moody, Christine	73377	Associate Director, UCLA PEERS Clinic	
	Motivala, Sarosh smotivala@mednet.ucla.edu		Adult OCD Intensive Treatment & Research Program	Treatment efficacy, durability and clinical course of Obsessive-Compulsive Disorder

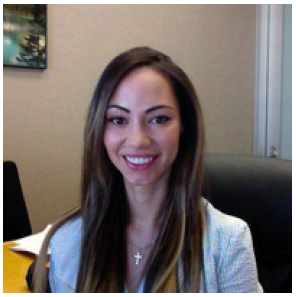
	Murray, Stuart sbmurray@mednet.ucla.edu		Eating Disorders Program	
	Nicassio, Perry pnicassio@mednet.ucla.edu	53141	Adult Consultation Liaison	
	Nuechterlein, Keith keithn@ucla.edu	50036	Director, Aftercare Research Program Director, Postdoctoral Clinical Research Training (T32) in Schizophrenia and Other Psychoses	Schizophrenia, with emphasis on role of neurocognitive, psychophysiological, and stress factors; interventions for initial period of schizophrenia
	Orellana, Blanca borellana@mednet.ucla.edu	70407	Assistant Director, Family Stress, Trauma and Resilience (STAR) Clinic	Stress, Resilience, Family Prevention/Treatment of traumatic stress
	Paley, Blair bpaley@mednet.ucla.edu	50092	Strategies for Enhancing Early Developmental Success	Early childhood, transition to parenthood, foster families, school readiness, prenatal alcohol exposure

	Peris, Tara tperis@mednet.ucla.edu	44347	Co-Director, Child OCD, Anxiety, and Tic Disorders Program Program Director, ABC Partial Hospitalization Program	Developmental psychopathology of youth anxiety and related disorders; treatment mechanisms; family-focused intervention.
	Piacentini, John jpiacentini@mednet.ucla.edu	66649	Chief Psychologist, Child Division Director, Child OCD, Anxiety & Tic Disorder Program	Etiology & Treatment of Child OCD, Anxiety & Tics
	Pike, Jennifer jpike@mednet.ucla.edu	52109	Insomnia Treatment Group	Behavioral medicine, chronic pain, insomnia, and affective disorders in individuals with chronic co-morbid medical disorders
	Polster, Douglas dpolster@mednet.ucla.edu	58944	BrainSPORT	
	Punt, Stephanie spunt@mednet.ucla.edu	68100	Medical Psychology Assessment Center (MPAC) Neurobehavioral Epilepsy Program (NEP) Operation Mend	
	Rad, Heleya hrad@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	

	Rapkin, David drapkin@mednet.ucla.edu	00334	Adult Consultation Evaluation Service	
	Raynor, Olivia oraynor@mednet.ucla.edu	41141	Director, Tarjan Center	
	Renno, Patricia prenno@mednet.ucla.edu	50458	Child and Adult Neurodevelopmental (CAN) Clinic	Autism Spectrum Disorder; Anxiety; Cognitive Behavioral Therapy
	Ribas, Ana acribas@mednet.ucla.edu		Assistant Clinical Director, Adult OCD Intensive Treatment Program	
	Ricketts, Emily ericketts@mednet.ucla.edu	52701	Child OCD, Anxiety, and Tic Disorders Program Associate Training Director, Psychology Doctoral	Phenomenology and behavioral treatment of tic disorders, body-focused repetitive behavior disorders; sleep and circadian intervention

			Internship Program	
	Rivera, Jesus jesusrivera@mednet.ucla.edu	Staff Psychologists	OpMend	
	Safi, Diomaris dsafi@mednet.ucla.edu	42479	Justice in Criminal Neuropsychology Lifespan Assessment Through Integrated Neuropsychology	
	Saucedo, Carlos csaucedo@mednet.ucla.edu		Lifespan Assessment Through Integrated Neuropsychology	Culturally appropriate neuropsychological/psychological assessment of Spanish-speaking individuals
	Schiltz, Karen Kschiltz@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	
	Schonfeld, Amy Aschonfeld@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	

	Schneider, Diane		Medical Psychology Assessment Center (MPAC)	
	Segal, Shelley slsegal@mednet.ucla.edu		Adult Consultation Liaison Service	
	Stenquist, Philip pstenquist@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	
	Strachan, Angus astrachan@mednet.ucla.edu	52836	Child and Adolescent Mood Disorders Program (CHAMP)	
	Suarez, Paola A. psuarez@mednet.ucla.edu	67313	Director, LATIN-C	Neuropsychology; Bilingual/Spanish neuropsychological assessments; consultation on cultural/linguistic issues in neurocognition; Socially Responsible Neuropsychology (SRN)

	Tanner, Alexandra atanner@mednet.ucla.edu		Brainsport Program	
	Tabuenca, Andrea atabuenca@mednet.ucla.edu		Clinical Director of the UCLA EMPWR Program for LGBTQ STAR Clinic	
	Tabuenca, Krista ktabuenca@mednet.ucla.edu		Chief Psychologist, Child Psychiatry Inpatient Unit Director, Acute Care Internship Track Pediatric Consultation Liaison Service	
	Thaler, Nicholas Nthaler@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	
	Thames, April Athames@mednet.ucla.edu	04436	Chief Psychologist, Adult Division Director, Adult Consultation Evaluation Service Associate Director, Medical Psychology	Cognitive health disparities, medical illness and neurobehavioral disorders

			Assessment Center (MPAC)	
	Thrasher, Delany ethrasher@mednet.ucla.edu	45300	Director of Neuropsychology, Operation Mend	Neuropsychological and Psychodiagnostic Assessment (peds and adults); Effects of psychiatric disturbances on cognition; Neuropsychological functioning in Epilepsy; Suicidal Behavior; Application of Evidence Based Practices in Community Mental Health settings.
	Kathleen Tingus KTingus@mednet.ucla.edu Track Director, Geropsychology Track	59989	Medical Psychology Assessment Center (MPAC) Geropsychology	
	Tomaszewski, Robert Rtomaszewski@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	
	Treanor, Michael mtreanor@mednet.ucla.edu	69191	Child OCD, Anxiety, & Tic Disorders Program	
	Turnbull, Jeanice Jturnbull@mednet.ucla.edu		Medical Psychology Assessment Center (MPAC)	Pediatric neuropsychology: 1) intervention and rehabilitation for cognitive and motor weaknesses, especially compromises in executive functioning; 2) using virtual reality as a tool for assessment and intervention, especially incorporating movement into cognitive/learning interventions; and 3) treatment outcomes when using a neuropsychological assessment as a guide and a comprehensive problem-focused intervention approach

	Turner, Luana lturner@mednet.ucla.edu	47340	Aftercare Program	
	Veytsman, Elina eveytsman@mednet.ucla.edu	73377	Director of Training, UCLA PEERS Clinic	
	Walshaw, Patricia pwalshaw@mednet.ucla.edu	50357	Training Director, Psychology Doctoral Internship Training Program Director of Clinical Services & Training, Medical Psychology Assessment Center (MPAC) Director, Neurobehavioral Epilepsy Program (NEP) Co-Director, Child and Adolescent Mood Disorders Program (CHAMP)	Using imaging/EEG techniques and neurocognitive measures to assess for biomarkers of psychopathology and neurological disease

	You, Christine syou@mednet.ucla.edu		Neurobehavioral Epilepsy Program (NEP)	
	Young, Jeffrey jeyoung@mednet.ucla.edu		Insomnia Clinic	
	McCracken, Sara smccracken@mednet.ucla.edu		CAN Clinic	

Sample Evaluation Forms

Evaluation of Interns by Supervisors

Semel Clinical Psychology Trainee Competency Assessment

Insufficient contact to evaluate (delete evaluation)

Competency Rating Descriptions
NA: not applicable
1: Needs remedial work. *Requires remedial work if trainee is in internship or post-doc. Common rating at the beginning of practica.*
2: Entry level/Continued intensive supervision is needed. *Common rating for mid-level practica and beginning of internship. Routine, but intensive, supervision is needed.*
3: Intermediate/Should remain a focus of supervision. *Common rating throughout internship and at the end of practica. Routine supervision of each activity.*
4: High Intermediate/Entry level psychologist at licensure level *Minimum level achievement rating at completion of internship. Basic licensure ready. Competency attained in all but non-routine cases for which consultation is sought; supervisor provides overall management of trainee's activities during training but trainee handles day-to-day operations independently; depth of supervision varies as clinical needs warrant*
5: Advanced/Skills comparable to higher level autonomous practice. *Rating may be achieved by exceptional interns and expected at completion of postdoctoral training. Competency attained at full psychology staff privilege level, however as an unlicensed trainee, supervision is required while in training status.*
6: Advanced/Skills comparable to those practitioners with several years or more of professional practice. *This level of competency may be achieved by those while still in postdoctoral training.*

COMPETENCY IN PROFESSIONAL CONDUCT, ETHICS AND LEGAL MATTERS							
	1	2	3	4	5	6	N/A
1. : PROFESSIONAL INTERPERSONAL BEHAVIOR Professional and appropriate interactions with treatment teams, peers and supervisors, seeks peer support as needed.	May be withdrawn, overly confrontational, insensitive or may have had hostile interactions with colleagues.	Ability to participate in team model is limited, relates well to peers and supervisors.	Progressing well on providing input in a team setting. Effectively seeks assistance to cope with interpersonal	Actively participates in team meetings. Appropriately seeks input from supervisors to cope	Smooth working relationships handles differences openly, tactfully and effectively	Serves as a role model for others, demonstrates exemplary levels of professionalism	

			concerns with colleagues.	with rare interpersonal concerns			
2. : SEEKS CONSULTATION/SUPERVISION Seeks consultation or supervision as needed and uses it productively.	Frequently defensive and inflexible, resists important and necessary feedback.	Needs intensive supervision and guidance, difficulty assessing own strengths and limitations.	Generally accepts supervision well, but occasionally defensive. Needs supervisory input for determination of readiness to try new skills.	Open to feedback, shows awareness of strengths and weaknesses, uses supervision well, occasionally over or under-estimates need for supervision	Actively seeks consultation when treating complex cases and working with unfamiliar symptoms.	Models engagement of other professionals and helps others seek input	
3. : USES POSITIVE COPING STRATEGIES Demonstrates positive coping strategies with personal and professional stressors and challenges. Maintains professional functioning and quality patient care.	Denies problems or otherwise does not allow them to be addressed effectively.	Personal problems can significantly disrupt professional functioning.	Needs significant supervision time to minimize the effect of stressors on professional functioning. Accepts reassurance from supervisor well.	Good insight into impact of stressors on professional functioning, seeks supervisory input and/or personal therapy to minimize this impact.	Good awareness of personal and professional problems. Stressors have only mild impact on professional practice. Actively seeks supervision and/or personal therapy to resolve issues.	Models reflective practice and supports others in coping with stressor; advises others and implements resilience training	
4. : PROFESSIONAL	May seem	Needs consider	Uses supervisor	Maintains timely	Maintains complete	Models appropri	

RESPONSIBILITY AND DOCUMENTATION Responsible for key patient care tasks (e.g. phone calls, letters, case management), completes tasks promptly. All patient contacts, including scheduled and unscheduled appointments, and phone contacts are well documented. Records include crucial information.	unconcerned about documentation. May neglect to document patient contacts. Documentation may be disorganized, unclear or excessively late.	able direction from supervisor. May leave out crucial information.	y feedback well to improve documentation. Needs regular feedback about what to document. Rarely, may leave out necessary information, and occasionally may include excessive information. Most documentation is timely.	and appropriate records; may forget some minor details or brief contacts (e.g. phone calls from patient), but recognizes these oversights and retroactively documents appropriately. Records always include crucial information.	records of all patient contacts and pertinent information. Notes are clear, concise and timely. Takes initiative in ensuring that key tasks are accomplished. Records always include crucial information.	ate maintenance of records and helps others learn methods and strategies	
5. : EFFICIENCY AND TIME MANAGEMENT Efficient and effective time management. Keeps scheduled appointments and meetings on time. Keeps supervisors aware of whereabouts as needed. Minimizes unplanned leave, whenever possible.	Frequently has difficulty with timeliness fashion. Or tardiness or unaccounted absences are a problem.	Highly dependent on reminders or deadlines	Completes work effectively and promptly by using supervision time for guidance. Regularly needs deadlines or reminders.	Typically completes clinical work/patient care within scheduled hours. Generally on time. Accomplishes tasks in a timely manner, but may	Efficient in accomplishing tasks without prompting, deadlines or reminders. Excellent time management skills regarding appointments, meetings and leave.	Models and helps others with time management strategies	

				need occasional deadlines or reminders.			
6. : KNOWLEDGE OF ETHICS AND LAW Demonstrates good knowledge of ethical principles and state law. Consistently applies these appropriately, seeking consultation as needed.	Disregards important supervisory input regarding ethics or law.	Often unaware of important ethical and legal issues.	Generally recognizes situation where ethical and legal issues might be pertinent, is responsive to supervisory input	Consistently recognizes ethical and legal issues, appropriately asks for supervisory input.	Spontaneously and consistently identifies ethical and legal issues and addresses them proactively. Judgement is reliable about when consultation is needed	Serves as a resource to others on issues involving ethical and legal standards and their application	
7. : ADMINISTRATIVE COMPETENCY Demonstrates a growing ability to accomplish administrative tasks. Prioritizes appropriately. Shows a growing autonomy in management of larger administrative, research or clinical projects.	Deadline passes without task being done. Not receptive to supervisory input about own difficulties in this process.	Trainee takes on responsibility, then has difficulty asking for guidance or accomplishing goals within timeframe.	Completes work effectively, using supervision time to identify priorities and develop plans to accomplish tasks. Receptive to supervisory input to develop own skills in administration.	Identifies components of the larger task and works independently on them. May need some supervisory guidance to successfully accomplish large tasks within	Independently assesses the larger task to be accomplished, breaks the task into smaller ones and develops a timetable. Prioritizes various tasks and deadlines efficiently and without need for supervisory input. Makes	Assumes administrative responsibilities and assists other administrative personnel in achieving s	

				the timeframe allotted. Identifies priorities but may seek input to structure some aspects of task.	adjustments to priorities as demands evolve.		

COMPETENCY IN INDIVIDUAL AND CULTURAL DIVERSITY							
	1	2	3	4	5	6	N/A
8. : PATIENT RAPPORT Consistently achieves a good rapport with patients.	Alienates patients or shows little ability to recognize problems.	Has difficulty establishing rapport.	Actively developing skills with new populations. Relates well when has prior experience with the population.	Generally comfortable and relaxed with patients, handles anxiety-provoking or awkward situations adequately so that they do not undermine therapeutic success.	Establishes quality relationships with almost all patients, reliably identifies potentially challenging patients and seeks supervision.	Models rapport-building and helps others develop quality relationship with patients	
9. : SENSITIVITY TO PATIENT DIVERSITY Sensitive to the cultural and individual diversity of patients.	Has been unable or unwilling to	Is beginning to learn to recognize beliefs	Has significant lack of knowledge regardin	In supervision, recognizes and openly	Discusses individual differences with patients when	Serves as a resource to others for consider	

Committed to providing culturally sensitive services.	surmount own belief system to deal effectively with diverse patients.	which limit effectiveness with patient populations.	g some patient groups, but resolves such issues effectively through supervision. Open to feedback regarding limits of competence.	discusses limits to competence with diverse clients.	appropriate. Acknowledges and respects differences that exist between self and clients in terms of race, ethnicity, culture and other individual difference variables. Recognizes when more information is needed regarding patient differences and seeks out information autonomously. Aware of own limits to expertise.	ation of individual and cultural differences. Considers carefully how self-patient interactions may impact assessment and treatment outcomes.	
10. : AWARENESS OF OWN CULTURAL AND ETHNIC BACKGROUND Aware of own background and its impact on clients. Committed to continuing to explore own cultural identity issues and relationship to clinical work.	Has little insight into own cultural beliefs even after supervision.	Growing awareness of own cultural background and how this affects psychological work. Can make interpretations and	Uses supervision well to recognize own cultural background and how this impacts psychological work. Comfortable with some differenc	Aware of own cultural background. Uses supervision well to examine this in psychological work. Readily acknowledges own	Accurately self-monitors own responses to differences, and differentiates these from patient responses. Aware of personal impact on clients	Models appropriate self-monitoring of individual and cultural differences and helps others develop skills and differentiates these	

		conceptualizations from culturally-based assumptions. Responds well to supervision.	es that exist between self and clients and working well on others. May occasionally deny discomfort with patients to avoid discussing relevant personal and patient identity issues.	culturally-based assumptions and discusses these in supervision.	different from self. Thoughtful about own cultural identity. Reliably seeks supervision when uncertain.	from patient responses. Aware of personal impact on clients different from self. Thoughtful about own cultural identity. Reliably seeks supervision when uncertain	

COMPETENCY IN THEORIES AND METHODS OF PSYCHOLOGICAL DIAGNOSIS AND ASSESSMENT							
	1	2	3	4	5	6	N/A
11. : DIAGNOSTIC SKILL Demonstrates a thorough working knowledge of psychiatric diagnostic nomenclature and DSM multiaxial classification. Utilizes historical, interview and psychometric data to diagnose accurately.	Has significant deficits in understanding of the psychiatric classification system and/or ability to use DSM criteria to develop a diagnostic	Basic knowledge of DSM diagnoses and emerging skill in diagnosis.	Understands basic diagnostic nomenclature and is able to accurately diagnosis many psychiatric problems. May miss relevant patient data	Has a good working knowledge of psychiatric diagnoses. Is thorough in consideration of relevant patient data, and diagnostic accurac	Demonstrates a thorough knowledge of psychiatric classification, including multiaxial diagnoses and relevant diagnostic criteria to develop an accurate diagnostic formulation autonomously.	Shows advanced knowledge of both strengths and limitations of current diagnostic taxonomy. Understands alternate formulation and	

	conceptualization.		when making a diagnosis. Requires supervisory input on most complex diagnostic decision-making.	y is good. Uses supervision well in more complicated cases involving multiple or more unusual diagnoses.		how to assess these dimensions.	
12. : PSYCHOLOGICAL TEST SELECTION AND ADMINISTRATION Promptly and proficiently administers commonly used tests/questionnaires in his/her area of practice. Appropriately chooses the tests to be administered. Demonstrates competence in administering selected tests	Test administration is irregular, slow. Or often needs to recall patient to further testing sessions due to poor choice of tests administered.	Emerging skills in accurate test administration and test selection. May still need direct observation of test administration.	Needs continued supervision on frequently administered tests. Needs occasional consultation regarding appropriate tests to administer.	Proficiently administers all tests. Completes all testing efficiently. Occasional input needed regarding fine points of test administration on unusual cases. Occasionally needs reassurance that selected tests are appropriate.	Proficiently administers all tests. Completes all testing efficiently. Autonomously chooses appropriate tests to answer referral question without need for reassurance.	Shows knowledge of subtle problems that impact test administration and ways to mitigate those weaknesses. Goes beyond standard assessments to more specifically target assessment needs.	

13. : PSYCHOLOGICAL TEST INTERPRETATION Interprets the results of psychological tests/questionnaires used in his/her area of practice. Demonstrates competence interpreting selected tests	Significant deficits in understanding of psychological testing, over-reliance on computer interpretation packages for interpretation. Repeatedly omits significant issues from assessments, reaches inaccurate or insupportable conclusions.	Emerging skills for test result interpretation. Working on consistent accurate scoring.	Completes assessments on typical patients with some supervisory input, occasionally uncertain how to handle difficult patients or unusual findings. Understands basic use of tests, may occasionally reach inaccurate conclusions or take computer interpretation packages too literally.	Demonstrates knowledge of scoring methods, reaches appropriate conclusions independently, may seek support from supervision on unusual cases.	Skillfully and efficiently interprets tests autonomously. Makes accurate independent diagnostic formulations on a variety of syndromes. Accurately interprets and integrates results prior to supervision session.	Demonstrates advanced knowledge of interpretive and psychometric issues that impact interpretation, considering individual and cultural differences	
14. : ASSESSMENT WRITING SKILLS Writes a well-organized psychological report. Answers the referral question clearly and provides the referral source with specific recommendations.	Inaccurate conclusions or grammar interfere with communication. Or reports	Emerging writing skills for psychological reports. May be able to write several report	Uses supervision effectively for assistance in determining important	Report is accurate and covers essential points without serious error, may need	Report is clear and thorough, follows a coherent outline, is an effective summary of major relevant	Demonstrates flexibility in report writing across different cases and contexts. Shows	

	are poorly organized and require major rewrites.	sections with supervision.	points to highlight.	polish in cohesiveness and organization. Readily completes assessments independently with minimal supervisory input, makes useful and relevant recommendations.	issues. Relevant test results are woven into the report as supportive evidence. Recommendations are related to referral questions	creativity in developing recommendations.	
15. : FEEDBACK REGARDING ASSESSMENT Plans and carries out a feedback interview. Explains the test results in terms the patient and/or caregiver can understand, provides suitable recommendations and responds to issues raised by patient or caregiver	Does not modify interpersonal style in response to feedback.	Supervisor frequently needs to assume leadership in feedback sessions to ensure correct feedback is given or to address emotional issues of patient or caregiver.	Develops plan for feedback session with the supervisor. Presents basic assessment results and supervisor addresses more complex issues. Continues to benefit from feedback on strengths and areas for improvement.	Develops and implements a plan for the feedback session. May need some assistance to identify issues which may become problematic in the feedback session. May utilize interventi	Plans and implements the feedback session appropriately. Foresees areas of difficulty in the session and responds empathically to patient or caregiver concerns. Adjusts personal style and complexity of language and feedback details to	Demonstrates advanced knowledge of feedback provision and the use of feedback as a therapeutic activity	

				on from supervisor to accommodate specific needs of patient or family on unusual cases.	accommodate patient or caregiver needs.		

COMPETENCY IN THEORIES AND METHODS OF EFFECTIVE PSYCHOTHERAPEUTIC INTERVENTION							
	1	2	3	4	5	6	N/A
16. : PATIENT RISK MANAGEMENT AND CONFIDENTIALITY Effectively evaluates, manages and documents patient risk by assessing immediate concerns such as suicidality, homicidality, and any other safety issues. Collaborates with patients in crisis to make appropriate short-term safety plans, and intensify treatment as needed. Discusses all applicable confidentiality issues openly with patients.	Makes inadequate assessment or plan, then lets patient leave site before consulting supervisor.	Delays or forgets to ask about important safety issues. Does not document risk appropriately. But does not let patient leave site without seeking 'spot' supervision for the crisis. Does not remember to address confidentiality issues, needs	Recognizes potentially problematic cases, but needs guidance regarding evaluation of patient risk. Supervision is needed to cope with safety issues; afterwards trainee handles them well. Can be trusted to seek	Aware of how to cope with safety issues, continues to seek occasional reassurance in supervision. Asks for input regarding documentation of risk as needed. Initiates appropriate actions to manage patient risk, sometimes needs input of	Assesses and documents all risk situations fully prior to leaving the worksite for the day. Appropriate actions taken to manage patient risk situations (e.g. escorting patient to ER) are initiated immediately, then consultation and confirmation of supervisor is sought. Establishes appropriate short-term	Models appropriate risk assessment and management strategies and serves as a resource for others in assessing and managing risk.	

		frequent prompting. Fear may overwhelm abilities in patient crises.	consultation immediately if needed, while patient is still on site. Needs to refine crisis plans in collaboration with supervisor. Needs input regarding documentation of risk. Occasionally needs prompting to discuss confidentiality issues with patient.	supervisor first. May occasionally forget to discuss confidentiality issues promptly, but rectifies these after the fact.	crisis plans with patients.		
17. : CASE CONCEPTUALIZATION AND TREATMENT GOALS Formulates a useful case conceptualization that draws on theoretical and research knowledge. Collaborates with patient to form appropriate treatment goals.	Responses to patients indicate significant inadequacies in theoretical understanding and case formulation.	Emerging skills for case conceptualization. Supervisor provides input on supporting research / literature.	Reaches case conceptualization with supervisory assistance. Aware of emotional issues when they are clearly stated by	Reaches case conceptualization on own, recognizes improvements when highlighted by supervisor. Readily identifies emotion	Independently produces good case conceptualizations within own preferred theoretical orientation, can also draw some insights into case from other orientations	Shows advanced knowledge and integration of research with practice. Shows creativity in setting goals with patients.	

	Misses or misperceives important emotional issues. Unable to set appropriate treatment goals with patient.		the patient, needs supervision for development of awareness of underlying issues. Requires ongoing supervision to set therapeutic goals aside from those presented by patient.	al issues. Sets appropriate goals with occasional prompting from supervisor on unusual cases, distinguishes realistic and unrealistic goals.	. Consistently sets realistic goals with patients.		
18. : THERAPEUTIC INTERVENTIONS Interventions are well-timed, effective and consistent with empirically supported treatments.	Most interventions and interpretations are rejected by patient. Has frequent difficulty targeting interventions to patients' level of understanding and motivation.	Emerging skills on timing and effective implementation of empirically supported treatments.	Many interventions and interpretations are delivered and timed well. Needs supervision to plan interventions and clarify interpretations.	Most interventions and interpretations facilitate patient acceptance and change. Supervisory assistance needed for timing and delivery of more difficult interventions.	Interventions and interpretations facilitate patient acceptance and change. Demonstrates motivation to increase knowledge and expand range of interventions through reading and consultation as needed.	Models the implementation of appropriate interventions and helps others develop patient acceptance and change. Demonstrate motivation to increase knowledge and expand range of interventions	

						through reading and consultation as needed.	
19. : EFFECTIVE USE OF EMOTIONAL REACTIONS IN THERAPY (COUNTERTRANSFERENCE) Understands and uses own emotional reactions to the patient productively in the treatment.	Unable to see countertransference issues, even with supervisory input.	When feeling anger, frustration or other intense emotional response to the patient, blames patient at times. Welcomes supervisory input and can reframe own emotional response to the session.	Understands basic concepts of countertransference. Can identify own emotional reactions to patient as countertransference. Supervisory input is frequently needed to process the information gained.	Uses countertransference to formulate hypotheses about the patient during supervision sessions. Can identify own issues that impact therapeutic process. Interventions may be presented in the following session.	During session, uses countertransference to formulate hypotheses about patient's current and historical social interactions, presents appropriate interpretations and interventions. Able to identify own issues that impact the therapeutic process and has ideas for coping with them. Seeks consultation as needed for complex cases.	Models and discusses with others countertransference issues and helps others develop sensitivity to their own relational challenges and how these may impact their intervention skills and effectiveness.	
20. : GROUP THERAPY SKILLS AND	Defensive or lacks insight	Has significant	Welcomes ongoing supervisio	Seeks input on group	Elicits participation and	Models high level skills	

PREPARATION Intervenes in group skillfully, attends to member participation, completion of therapeutic assignments, group communication, safety and confidentiality. If the group is psychoeducational, readies materials for group, and understands each session's goals and tasks.	when discussing strengths and weaknesses. Frequently unprepared for content or with materials.	inadequacies in understanding and implementation of group process. Unable to maintain control in group sufficient to cover content areas. Preparation is sometimes disorganized.	n to identify key issues and initiate group interaction. Actively working on identifying own strengths and weaknesses as a group leader. Identifies problematic issues in group process but requires assistance to handle them. May require assistance organizing group materials.	process issues as needed, then works to apply new knowledge and skills. May seek occasional feedback concerning strengths and weaknesses. Generally prepared for group sessions.	cooperation from all members, confronts group problems appropriately and independently, and independently prepares for each session with little or no prompting. Can manage group alone in absence of co-therapist/supervisor with follow-up supervision later	in managing group dynamics and helps others develop similar skills.	

COMPETENCY IN SCHOLARLY INQUIRY AND APPLICATION OF CURRENT SCIENTIFIC KNOWLEDGE TO PRACTICE							
	1	2	3	4	5	6	N/A
21. : SEEKS CURRENT SCIENTIFIC KNOWLEDGE Displays necessary self-direction in gathering clinical and	Unwilling to acquire or incorporate new informati	Open to learning, but waits for supervisor to provide	Emerging skills in independent literature searches and	Shows initiative, eager to learn, taking steps regularly	Fully dedicated to expanding knowledge and skills, independe	Models scholarly curiosity and shares resources with	

research information practice independently and competently. Seeks out current scientific knowledge as needed to enhance knowledge about clinical practice and other relevant areas	on into practice. Resists suggestions to expand clinical perspective. Procrastinates on readings assigned by supervisor.	guidance. When provided with appropriate resources, willingly uses the information provided and uses supervisor's knowledge to enhance own understanding	application to clinical practice. Supervisor may provide support and directive assistance.	to enhance own learning. Identifies areas of needed knowledge with specific clients. Asks for and responsive to supervisor's suggestions of additional informational resources, and pursues those suggestions.	ntly seeks out information to enhance clinical practice utilizing available databases, professional literature, seminars and training sessions, and other resources.	others; is sought out for knowledge and information	
22. : DEVELOPS AND IMPLEMENTS RESEARCH PLAN Develops and implements plan for research or other professional writing or presentation.	Does not follow-through with responsibilities in development or implementation of plan.	Emerging skills in developing research plans and/or organization of presentations.	Provides helpful suggestions regarding design and implementation of a colleague's plan. Provides significant assistance in the accomplishment	Provides substantive input into the plan. Demonstrates ability to execute a project independently. May seek assistance when needed.	Develops research plan alone or in conjunction with a colleague. Is a full and equal participant in the project.	Serves as an independent investigator in research and shows independence in formulating scientific questions and plans for their interrogation.	

			of the project.				

COMPETENCY IN PROFESSIONAL CONSULTATION							
	1	2	3	4	5	6	N/A
23. : CONSULTATION ASSESSMENT Performs an assessment of the patient referred for consultation, incorporating mental status exam, structured interview techniques or psychological assessment, as needed, to answer the referral question.	Consultation reports and progress notes are poorly written and/or organized. Fails to incorporate relevant information and/or use appropriate measures of assessment necessary to answer the referral question.	Needs continued supervision regarding appropriate assessment techniques to complete consultations as well as input regarding integration of findings and recommendations	Occasional input is needed regarding appropriate measures of assessment and effective write-up of report or progress notes to best answer the referral question	Independently identifies referral question and selects method for assessment and implements it appropriately. Seeks supervision as needed for unusual cases.	Chooses appropriate means of assessment to respond effectively to the referral question; reports and progress notes are well-organized and provide useful and relevant recommendations with minimal supervisory input.	Shows advanced knowledge of available tools and flexibly implements these strategies; serves as a resource to others minimal supervisory input.	
24. : CONSULTATIVE GUIDANCE Gives the appropriate level of guidance when providing consultation to other health care	Unable to establish rapport.	Needs continued guidance. May need continued input	Requires occasional input regarding the manner of delivery	Able to provide feedback at an appropriate level for the	Relates well to those seeking input, is able to provide high level feedback.	Models positive collegial interactions; flexibly provides consultat	

professionals, taking into account their level of knowledge about psychological theories, methods and principles.		regarding appropriate feedback and knowledge level of other professionals	or type of feedback given.	audience.		ion to others and explains complex formulations to enhance communication.	

COMPETENCY IN SUPERVISION							
	1	2	3	4	5	6	N/A
25. : SUPERVISORY SKILLS Demonstrates good knowledge of supervision techniques and employs these skills in a consistent and effective manner, seeking consultation as needed. Builds good rapport with supervisee.	Unable to provide helpful supervision.	Emerging skills in supervision, of others, may stumble at times in providing feedback to supervisees, continues to need regular consultation	Generally recognizes relevant issues, needs guidance regarding supervision skills. Supervisee finds input helpful. Trainee is rated by supervisee at the satisfactory or higher level in all areas	Consistently recognizes relevant issues, needs occasional guidance and supervisory input. Well thought of by supervisee. Supervisee recognizes at least one significant strength of trainee as a supervisor as documented on	Spontaneously and consistently applies supervision skills. Supervisee verbalizes appreciation of trainee's input	Shows advanced skills in supervision and knowledge of supervision models; helps in supervision of supervision	

				evaluation form.			
26. : Peer Supervision Demonstrates ability to engage in peer supervision including role-play, direct feedback, and an emergence of imparting clinical knowledge in areas of expertise relevant to their specialized clinical training	Does not engage in peer supervision when provided the opportunity	Continued intensive supervision is needed	Provides peer supervision with support/shaping from attending	Able to demonstrate appropriate guidance to peers	Integrates nuanced supervision into clinical setting that is tailored to the ability level of peer and case specifics	Develops and oversees programs that incorporate peer-to-peer supervision	

Supervisor Comments	
27. Summary of strengths, recommendations, and any remediation needed	

* Required fields Option description (place mouse over field to view)

Submit Completed EvaluationSave and Finish Later

Evaluation of Teaching Activities: Supervisor

Evaluator: Evaluatee:
Date: Academic Year:
Rotation:

Teaching Activity:

Individual supervision; advisor/preceptor

Clinical rotation coordinator or attending

Hospital site:

The Department of Psychiatry and Biobehavioral Science is greatly interested in improving the quality of teaching. For each item, please choose the number which best describes the instructor listed above, based on the following scale:

1-3 = Not at all Descriptive
4 = Descriptive
5-7 = Very Descriptive
N/A = Not able to Assess

Has command of the subject; relates topics to other areas of knowledge.
Not At All Descriptive 1 2 3 Somewhat Descriptive 4 5 6 Very Descriptive 7 N/A

Presents material in organized, clear manner; summarizes major points; provides emphasis.
Not At All Descriptive 1 2 3 Somewhat Descriptive 4 5 6 Very Descriptive 7 N/A

Devotes appropriate amount of time and discussion to topic, given participant's level of education and training.
Not At All Descriptive 1 2 3 Somewhat Descriptive 4 5 6 Very Descriptive 7 N/A

Encourages questions, comments and discussion in an open and friendly manner.
Not At All Descriptive 1 2 3 Somewhat Descriptive 4 5 6 Very Descriptive 7 N/A

Enjoys teaching and is enthusiastic about the subject.
Not At All Descriptive 1 2 3 Somewhat Descriptive 4 5 6 Very Descriptive 7 N/A

Deeply interested in patient care; often makes contributions to their management.
Not At All Descriptive 1 2 3 Somewhat Descriptive 4 5 6 Very Descriptive 7 N/A

Possesses excellent clinical acumen.
Not At All Descriptive 1 2 3 Somewhat Descriptive 4 5 6 Very Descriptive 7 N/A

Is an excellent role model.
Not At All Descriptive 1 2 3 Somewhat Descriptive 4 5 6 Very Descriptive 7 N/A

Keeps appointments; punctual; doesn't leave early; attentive during supervision (for supervisors/preceptors).
Not At All Descriptive 1 2 3 Somewhat Descriptive 4 5 6 Very Descriptive 7 N/A

How does this teacher compare with other clinical teachers you have had at UCLA?

Among the very worst						**Among the very best**
1	2	3	4	5	6	7

Comments:

_____

_____

_____

Evaluator Signature: _____

Evaluation of Teaching Activities: Lecture

Evaluator:
Evaluation of:
Date:

1. The learning objectives for this lecture were clearly stated and met. *

1	2	3	4	5
Strongly Disagree				Strongly Agree

2. This lecture contributed to my knowledge, skills, and/ or attitudes on the subject. *

1	2	3	4	5
Strongly Disagree				Strongly Agree

3. This lecturer was engaging and knowledgeable on the topic. *

1	2	3	4	5
Strongly Disagree				Strongly Agree

4. This lecture discussed relevant issues of race, culture, and/or disparities. *

1	2	3	4	5
Strongly Disagree				Strongly Agree

5. Please comment specifically on what made this lecture effective:
(e.g. use of cases, interaction with learners, presentation of data, relevance to my practice, small group activity, skills building exercises, etc.) *

6. Please comment specifically on what would make this lecture better:
(e.g., simplifying PowerPoint slides, limiting content to fit timeframe, use of cases, interaction with learners, small group activity, skills building exercises, etc.) *

Tri-Annual Evaluation Form

Rating Period (circle one)

July-Oct **Nov-Feb** **Mar-June**

Please rate your experience of your internship training using the scale provided below.

Rating Scale

5—outstanding
4—very good
3—average, typical level
2—below expected level
1—very poor
n/a—not applicable

Area of Evaluation

_____Individual Therapy

_____Group Therapy

_____Family Therapy

_____Assessment

_____Testing

_____Consultation

_____Training and Supervision regarding individual and cultural diversity

_____Case Management

_____Didactics

Comments:

_____
_____
_____

Supervision and Training

_____Individual Supervision

_____Group Supervision

_____Seminars

_____Treatment Rounds/Treatment Planning

_____Clinics

_____Training and supervision regarding individual and cultural diversity

Comments:

_____
_____
_____

Professional and Ethical Issues

_____Adherence to APA ethical guidelines

_____Collaboration between faculty, staff, and team members

_____Commitment towards meeting the needs of patients

_____Awareness of cultural and individual differences

Comments:

_____
_____
_____

Training Environment

_____Commitment to training

_____Responsiveness to personal and individual training needs

_____Accessibility of faculty and staff for supervision and consultation

_____Training is not subordinate to service

_____Breadth of experience

_____Depth of experience

_____Atmosphere of intellectual stimulation and professional growth

_____Presence of good role models

Comments:

_____
_____
_____

Recommendations:

_____
_____
_____

How would you rate the training program overall with regard to helping prepare you as a psychologist?

Excellent Above Average Average Below Average Poor

Additional Comments:

_____

_____

_____

Major Rotation Evaluation

UCLA - Semel Institute Psychology Internship Program	
2026-2027 Internship Major Rotation Evaluation	
What follows is a list of the major rotations offered during internship year. Please rank each major rotation you participated in on the following scale: **5 – Outstanding** **4 – Very good** **3 – Average, typical level** **2 – Below expected level** **1 - Very poor**	
Please provide feedback, positive or negative, in addition to your rankings, in the line **below**. (**Expand space to as much as you need**)	**Rating**
MAJOR ROTATION	**1 - 5**
ABC Program	
Adolescent Partial Hospitalization Program	

Adult Consultation-Liaison	
Aftercare Program	
Center for the Assessment and Prevention of Prodromal States (CAPPS)	
Child & Adolescent Inpatient Service	
Child and Adult Neurodevelopmental Clinic (CAN)	

Lifespan Assessment Through Integrated Neuropsychology	
Geropsychology Service	
Medical Psychology Assessment Center (MPAC)	
Pediatric Consultation-Liaison Service	
Stress, Trauma and Resilience Clinic (STAR)	

Clinic Elective Evaluation

UCLA - Semel Institute Psychology Internship Program	
2025-2026 Internship Clinic Evaluation	
What follows is a list of the clinics offered during internship year. Please rank each program you participated in on the following scale: **5 – Outstanding** **4 – Very good** **3 – Average, typical level** **2 – Below expected level** **1 -Very poor**	
Please provide feedback, positive or negative, in addition to your rankings, in the line **below**. (**Expand space to as much as you need**)	**Rating**
CLINIC NAME	**1 - 5**
Adolescent Medicine Clinic	
Adult OCD Intensive Treatment & Research Program	
Assessment & Treatment of African-American Families	
Behavioral Intervention for Anxiety in Children with Autism (BIACA)	
Child & Adolescent Mood Disorder Program (CHAMP)	
Child OCD, Anxiety & Tic Disorders Program	
Geriatric Psychotherapy Groups	
Infant & Preschool Clinic	
Neurobehavior Clinic and Conference	
Neurobehavioral Epilepsy Clinic	
OCD IOP Clinic	

Parent Training Program	
PEERS Clinic – Caregiver-Assisted Social Skills Training for Young Adults	
PEERS Clinic – Parent-Assisted Social Skills Training	
Psychosis Clinic	
Residents Psychotherapy Clinic for Interns	
Sexual Health Program	
Spanish Language Caregiver Support Group	
Telephonic Caregiver Support Groups	
Youth Stress & Mood Program (YSAM)	
OTHER	
OTHER	

Internship Alumni Questionnaire

UCLA Health

Psychology Internship Alumni Questionnaire

Current contact information

Last Name	
First Name	
Email	
Phone number	

1) Please rate the degree to which the internship program developed your proficiency in **professional conduct, ethics, and legal matters.**

	1 = not at all	2 = slightly	3 = moderately	4 = very well	5 = extremely well
PROFESSIONAL INTERPERSONAL BEHAVIOR *Professional and appropriate interactions with treatment teams, peers and supervisors, seeks peer support as needed.*	○	○	○	○	○
SEEKS CONSULTATION/SUPERVISION *Seeks consultation or supervision as needed and uses it productively.*	○	○	○	○	○
USES POSITIVE COPING STRATEGIES *Demonstrates positive coping strategies with personal and professional stressors and challenges. Maintains professional functioning and quality patient care.*	○	○	○	○	○
PROFESSIONAL RESPONSIBILITY AND DOCUMENTATION *Responsible for key patient care tasks (e.g. phone calls, letters, case management), completes tasks promptly. All patient contacts, including scheduled and unscheduled appointments, and phone contacts are well documented. Records include crucial information.*	○	○	○	○	○

EFFICIENCY AND TIME MANAGEMENT
Efficient and effective time management. Keeps scheduled appointments and meetings on time. Keeps supervisors aware of whereabouts as needed. Minimizes unplanned leave, whenever possible.

KNOWLEDGE OF ETHICS AND LAW
Demonstrates good knowledge of ethical principles and state law. Consistently applies these appropriately, seeking consultation as needed.

ADMINISTRATIVE COMPETENCY
Demonstrates a growing ability to accomplish administrative tasks. Prioritizes appropriately. Shows a growing autonomy in management of larger administrative, research or clinical projects.

2) Please rate the degree to which the internship program developed your proficiency in **INDIVIDUAL AND CULTURAL DIVERSITY**

	1 = not at all	2 = slightly	3 = moderately	4 = very well	5 = extremely well
PATIENT RAPPORT *Consistently achieves a good rapport with patients.*	○	○	○	○	○
SENSITIVITY TO PATIENT DIVERSITY *Sensitive to the cultural and individual diversity of patients. Committed to providing culturally sensitive services.*	○	○	○	○	○
AWARENESS OF OWN CULTURAL AND ETHNIC BACKGROUND *Aware of own background and its impact on clients. Committed to continuing to explore own cultural identity issues and relationship to clinical work.*	○	○	○	○	○

3) Please rate the degree to which the internship program developed your proficiency in **THEORIES AND METHODS OF PSYCHOLOGICAL DIAGNOSIS AND ASSESSMENT**

	1 = not at all	2 = slightly	3 = moderately	4 = very well	5 = extremely well
DIAGNOSTIC SKILL *Demonstrates a thorough working knowledge of psychiatric diagnostic nomenclature and DSM multiaxial classification. Utilizes historical, interview and psychometric data to diagnose accurately.*	○	○	○	○	○
PSYCHOLOGICAL TEST SELECTION AND ADMINISTRATION *Promptly and proficiently administers commonly used tests in his/her area of practice. Appropriately chooses the tests to be administered. Demonstrates competence in administering intelligence tests and MMPI-2.*	○	○	○	○	○

PSYCHOLOGICAL TEST INTERPRETATION *Interprets the results of psychological tests used in his/her area of practice. Demonstrates competence interpreting intelligence tests and MMPI-2.*	○	○	○	○	○
ASSESSMENT WRITING SKILLS *Writes a well-organized psychological report. Answers the referral question clearly and provides the referral source with specific recommendations.*	○	○	○	○	○
FEEDBACK REGARDING ASSESSMENT Plans and carries out a feedback interview. Explains the test results in terms the patient and/or caregiver can understand, provides suitable recommendations and responds to issues raised by patient or caregiver	○	○	○	○	○

4) Please rate the degree to which the internship program developed your proficiency in

THEORIES AND METHODS OF EFFECTIVE PSYCHOTHERAPEUTIC INTERVENTION

	1 = not at all	2 = slightly	3 = moderately	4 = very well	5 = extremely well
PATIENT RISK MANAGEMENT AND CONFIDENTIALITY *Effectively evaluates, manages and documents patient risk by assessing immediate concerns such as suicidality, homicidality, and any other safety issues. Collaborates with patients in crisis to make appropriate short-term safety plans, and intensify treatment as needed. Discusses all applicable confidentiality issues openly with patients.*	○	○	○	○	○
CASE CONCEPTUALIZATION AND TREATMENT GOALS *Formulates a useful case conceptualization that draws on theoretical and research knowledge. Collaborates with patient to form appropriate treatment goals.*	○	○	○	○	○
THERAPEUTIC INTERVENTIONS *Interventions are well-timed, effective and consistent with empirically supported treatments.*	○	○	○	○	○

EFFECTIVE USE OF EMOTIONAL REACTIONS IN THERAPY (COUNTERTRANSFERENCE) *Understands and uses own emotional reactions to the patient productively in the treatment.*	○	○	○	○	○
GROUP THERAPY SKILLS AND PREPARATION *Intervenes in group skillfully, attends to member participation, completion of therapeutic assignments, group communication, safety and confidentiality. If the group is psychoeducational, readies materials for group, and understands each session's goals and tasks.*	○	○	○	○	○

5) Please rate the degree to which the internship program developed your proficiency in **SCHOLARLY INQUIRY AND APPLICATION OF CURRENT SCIENTIFIC KNOWLEDGE TO PRACTICE**

	1 = not at all	2 = slightly	3 = moderately	4 = very well	5 = extremely well
SEEKS CURRENT SCIENTIFIC KNOWLEDGE *Displays necessary self-direction in gathering clinical and research information practice independently and competently. Seeks out current scientific knowledge as needed to enhance knowledge about clinical practice and other relevant areas*	○	○	○	○	○
DEVELOPS AND IMPLEMENTS RESEARCH PLAN *Develops and implements plan for research or other professional writing or presentation.*	○	○	○	○	○

6) Please rate the degree to which the internship program developed your proficiency in **PROFESSIONAL CONSULTATION**

	1 = not at all	2 = slightly	3 = moderately	4 = very well	5 = extremely well
CONSULTATION ASSESSMENT *Performs an assessment of the patient referred for consultation, incorporating mental status exam, structured interview techniques or psychological assessment, as needed, to answer the referral question.*	○	○	○	○	○
CONSULTATIVE GUIDANCE *Gives the appropriate level of guidance when providing consultation to other health care professionals, taking into account their level of knowledge about psychological theories, methods and principles.*	○	○	○	○	○

7) Please rate the degree to which the internship program developed your proficiency in **SUPERVISION**

	1 = not at all	2 = slightly	3 = moderately	4 = very well	5 = extremely well
SUPERVISORY SKILLS *Demonstrates good knowledge of supervision techniques and employs these skills in a consistent and effective manner, seeking consultation as needed. Builds good rapport with supervisee.*	○	○	○	○	○
Peer Supervision *Demonstrates ability to engage in peer supervision including role-play, direct feedback, and emergence of imparting clinical knowledge in areas of expertise relevant to their specialized clinical training*	○	○	○	○	○

Overall Internship Evaluation

	1 - poor	2 - Below Expectations	3 - Adequate	4 - Above Expectations	5 - Excellent
Breadth of experience	○	○	○	○	○
Depth of experience	○	○	○	○	○
Overall quality of experience	○	○	○	○	○
Preparation for your current employment	○	○	○	○	○
Major Rotation	○	○	○	○	○
Electives	○	○	○	○	○
Didactics related to your major rotation	○	○	○	○	○
Interns' Seminar	○	○	○	○	○
Other didactic offerings	○	○	○	○	○

Comments:

2) In addressing the following aspects of your Internship experience, please select the appropriate numbers:

	1 - Strongly Disagree	2 - Disagree	3 - Neutral	4 - Agree	5 - Strongly Agree
The supervision I received was of good quality	○	○	○	○	○
I received a sufficient amount of supervision	○	○	○	○	○
Considerations related to culture, race and individual diversity were addressed in supervision	○	○	○	○	○
Considerations related to culture, race and individual diversity were addressed in didactics	○	○	○	○	○
Ethical considerations were addressed in clinical care and didactics	○	○	○	○	○
Training did not seem subordinate to service delivery	○	○	○	○	○
I found sufficient opportunity for professional development	○	○	○	○	○
I received educative and emotional support in my search for post-internship employment	○	○	○	○	○

Employment

1) Licensed as a Psychologist

Yes

No

2) What was your initial post -internship employment? Please write your job title below.

2a. Select all setting types that apply to this position

- Academic Teaching
- Community Mental Health Center
- Consortium
- Correctional Facility
- Health Maintenance Organization
- Hospital/Medical Center
- Independent Practice
- Psychiatric Facility
- School District or System
- University Counseling Center
- Other

3a) Select all activities that apply to the position

- Assessment
- Consultation
- Psychotherapy
- Research
- Supervision
- Teaching
- Unknown
- Other

3b) Select all setting types that apply to this position

- Academic Teaching
- Community Mental Health Center
- Consortium
- Correctional Facility
- Health Maintenance Organization
- Hospital/Medical Center
- Independent Practice
- Psychiatric Facility
- School District or System
- University Counseling Center
- Other

3c) Enter the job title of this position

4) What experience in your internship aided you in obtaining post-internship employment?

5a) Please describe the most satisfying, most worthwhile aspects of the program.

5b) Please describe the most frustrating, least satisfying aspects of the program.

5c) What suggestions do you have for improvement of the internship training program?

6) Additional Comments:

Appendix

i. Abuse Reporting Policies.....page 194

- Child Abuse – Management and Reporting of Suspected Cases – HS 13013: 194
- Suspected Child Abuse and/or Neglect – SCAAN – Case Reporting Responsibilities NPH 1616: 206
- Domestic Violence – Intimate Partner Abuse – HS1331: 215
- Reporting Violent Injury including Domestic Violence Abuse - NPH 1618: 221
- Elder and Dependent Adult Abuse – Reporting of – HS 1314: 225
- Suspected Elder-Dependent Adult Abuse and Neglect Reporting – NPH 1617: 234

ii. Warning of Dangerous Patients ..... page 242

- Tarasoff Warnings to Law Enforcement: 242

iii. Nondiscrimination Policies..... page 245

- Community Expectations: 246
- Workplace Violence Prevention Plan HS 8703: 268
- Management of Patient Discriminatory Conduct and Reassignment Requests HS 3068: 273
- Patient Responsibilities – UCLA Health Experience – Los Angeles, CA: 278

iv. Remediation Plan..... page 286

v. Educational Funds ..... page 288

vi. Guidelines for Using Interpreter Services ..... page 289

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UCLA Health

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Next Review: *3/25/2023*
Owner: *Derek Hoppe: Mgr* **Policy Area:** *Care of Patients*
Reference Tags: *Lippincott*
Applicability: *Ronald Reagan, Santa Monica, & Ambulatory Care*

Child Abuse - Management and Reporting of Suspected Cases, HS 1303

PURPOSE

To specify the procedures which fulfill the legal and Hospital requirements for reporting cases of actual or suspected child abuse and/or neglect.

POLICY

OPY

1. **CHILD ABUSE DEFINITIONS:**

A. "Child" means a person under the age of 18 years.

B. "Child abuse" is defined as any act or omission that endangers or impairs a child's physical or emotional health and development. Child abuse which is required to be reported includes:

1. Physical injury or death inflicted by other than accidental means.
2. Sexual assault on, or the sexual exploitation of, a child (Refer to HS 1303.1).
3. Willfully causes or permits a child to suffer or inflicts unjustifiable physical pain or mental suffering or unjustifiable punishment (including permitting the health of a child to be endangered).
4. Unlawful corporal punishment or injury—willful infliction of cruel or inhuman corporal punishment or injury resulting in a traumatic condition.
5. Severe neglect—failure to protect from severe malnutrition or medically diagnosed non-organic failure-to-thrive or willfully causing or permitting child to be in situation such that their person or health is endangered. Includes intentional failure to provide adequate food, clothing, shelter, or medical care.
   General neglect-- failure to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury has occurred
   The fact that a child is homeless or classified as an unaccompanied youth (Section 11434a of federal McKinney-Vento Homeless Assistance Act) is not, in and of itself, sufficient basis for reporting child abuse/neglect.
6. Abuse and neglect in out-of-home care

C. Suspected endangerment of an infant due to prenatal drug/alcohol exposure concomitant with other risk factors as per California Penal Code Sections 11165.8 and 11165.13. (See Medical Center

Policy, "*Suspected Child Abuse and/or Neglect – Newborn Drug /Alcohol Related Situations*".

D. Emotional abuse—knowledge of or reasonable suspicion that a child is suffering serious emotional damage or is at substantial risk of suffering serious emotional damage, evidenced by states of being or behavior such as severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others may be reported.

E. "Reasonable suspicion" means that it is objectively reasonable for a person to entertain *such* a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse or neglect. "Reasonable suspicion" does not require certainty or a specific medical indication of child abuse or neglect.

F. UCLA SCAN (Suspected Child Abuse and Neglect) Team—Multidisciplinary team that provides case consultation and review to ensure children are protected, mandated reporting responsibilities are met, and appropriate evaluation and case management strategies are employed.

SCAN Referral/Consultation

1. The UCLA SCAN On-Call Consultant is available 24 hours a day to provide phone consultation in cases regarding suspected child abuse or neglect or the health care provider is concerned but unsure whether the situation meets a reporting threshold (See Appendix I). The SCAN On- Call Consultant can be reached through the Medical Center page operator (310-206-6766) or by


paging the SCAN
beeper #96672.

PY

G. Hospital Holds

1. Police Hold-- is a form or written statement provided to the hospital by a law enforcement agency when it has been determined by police that it is unsafe to return the child to the custody of his or her parent(s) or guardian(s). In this case, the child cannot be legally discharged without authorization of the appropriate police agency. Police Holds are

placed on victims of physical or sexual abuse or severe neglect.

2. DCFS Hospital Hold (DCFS Form 164)—is a form issued to the hospital by the Department of Children and Family Services (county child protective services agency) when DCFS has responded to a report and has determined that child is at immediate risk of serious physical harm, sexual abuse, or physical abuse if released to the parent. The child cannot be legally discharged to the parent(s) or guardian(s) unless DCFS provides a written release of the Hospital Hold.
3. If a DCFS Hospital Hold or Police Hold is actively in place and there is an attempt to remove the child from hospital premises then the staff should contact Hospital security and UCPD immediately. Interventions by the hospital staff to delay or stop the removal of the child should only be considered if the safety of other patients, patient families, visitors and hospital staff themselves can be ensured.
4. Medical Incapacity Holds (HS 1491) pertain only to adult patients. Similarly, Medical Detainment orders do not apply to situations in which the child is a suspected victim of abuse or neglect and the parent wishes to remove the child from care AMA (HS 0311 AMA). In these situations the SCAN Team On Call Consultant and Social Worker should be paged immediately.

2. **LEGAL REQUIREMENTS**

A. Any health practitioner, child care custodian or child protective agency employee must report to a child protective service agency, all cases of reasonably suspected child abuse which he or she has knowledge of or observed in his or her professional capacity. "Health practitioner" includes medical

examiners who perform autopsies and others licensed under Division 2, Section 500, of the Business and Professions Code. Non-medical practitioners and social workers are also mandated reporters.

B. This report must be made immediately by telephone to Child Protective Hotline (CPH) and form SS8572 (Suspected Child Abuse Report/SCAR) must also be sent: in writing or on-line submission within 36 hours. Documentation within the Electronic Medical Record (EMR) shall include the child welfare agency's applicable tracking process (i.e. name and/or referral number) along with the name of the contact person, date and time for reference and validation.

   a. Los Angeles County: For telephonic/written reports documentation of the 19-digit referral number in the the EMR is necessary along with the name of the person contacted, date and time. If utilizing the on-line submission process, print a PDF copy of the report and subsequently obtain and document the 16-digit tracking number for inclusion prior to scanning into the EMR.

C. The Mandated reporter may also include the report any non-priviledged documentary evidence relating to the the incident. (See 3c. Reports).

D. After a telephonic report of physical abuse to CPH, if the child is considered to be at imminent risk, contact Law Enforcement (LE) agency who has jurisdiction for where the alleged crime occurred. Additionally a contact to University of California Police Department (UCPD) will be made. Documentation of LE's applicable tracking process shall be included in the EMR.

E. Follow-up regarding completion of SS 8572 and inclusion into the EMR shall be coordinated by the weekly on-call SCAN social worker, SCAN team coordinator, and/or SCAN team medical director.

F. The Emergency Department (ED) social worker, Pediatric Hospitalist, ED physician, on-call SCAN social worker and/or SCAN medical director shall communicate the CPH safety plan and ensure CPH and/or LE have been contacted accordingly prior to discharge regarding disposition.

G. Any person who fails to report as required is guilty of a misdemeanor punishable by 6 months in jail or $1,000.00 fine or both.

H. No health care practitioner/reporter shall be civilly or criminally liable for reporting a suspected instance of child abuse.

I. No supervisor or administrator may impede or inhibit reporting, and no person making such report shall be subject to any sanction for making such report. To the extent that any person obligated to report believes there is an impediment to reporting, he or she should immediately bring this to the attention of the Risk Management Department (310-794-3500) and/or the Chief Compliance Officer (310-794-6763), or if he/she is unavailable, or after hours, the Administrator On-Call by contacting the page operator.

J. Skeletal X-rays and photographs of the child may be taken without the consent of the child's parent or guardian only for purposes of diagnosing the case as one of possible child abuse and for determining the extent of such child abuse. This information can be given only to

those persons authorized to receive it. Photographs are best obtained by utilizing the EPIC Haiku app on an encrypted and secured mobile device which will automatically transmit the images into the patient's chart within CareConnect

3. **SUSPECTED CHILD ABUSE PROTOCOL**

   A. All Ronald Reagan UCLA Medical Center and Santa Monica UCLA Medical Center personnel should be attentive to the possibility of abuse, neglect, or any indication of maltreatment of a minor (refer to Appendix I for Child Abuse Danger Signals).

      1. Notify the Clinical Social Worker

2. Ensure the SCAN Team On Call Consultant is notified by directly paging 96672 or through the Page Operator at 310-206-6766.

B. In cases where a report was filed by another hospital and the child was subsequently transferred to a UCLA Health facility, UCLA personnel are required to (also) make a report if they have reasonable suspicion of abuse/neglect.

C. The specific responsibilities of Medical Center personnel with suspected abuse/neglect cases are outlined in the Action Guidelines section of this policy.

D. The privacy of the child and the family should be protected. Access to information concerning abused or neglected children should be limited to only those persons directly involved in the case, or otherwise authorized by statute.

E. Refer to HS Policy 1303.1 regarding suspected child sexual abuse cases and HS policy 1303.2 regarding newborn drug/alcohol related cases.

F. Suspected Child Abuse & Neglect (SCAN) Team

The SCAN team, medical director or designee, will monitor regularly to ensure all mandated reporting requirements are completed.

SCAN Team On Call Consultant's Responsibility

The SCAN Team On-Call Consultant assists in case management, providing guidance regarding reporting of suspected child abuse or neglect cases. The SCAN Team On-Call Consultant will review the case with the assigned social worker and/or other referral source and together formulate a plan on how to proceed with the case. When there is not an assigned social worker, the SCAN Team On-Call Consultant is available for phone consultation.

SCAN Team Medical Director Responsibility

The SCAN Team Medical Director's role includes medical/forensic consultation in cases of suspected child abuse or neglect. S/he provides medical evaluation and recommendations for additional tests and studies, assists the Primary Medical Team in case management, and facilitates communication between the Medical Center with DCFS and police with regards to medical results.

A. Reports

1. **Telephone Report**
   Known or suspected instances of child abuse shall be reported to a child protection agency immediately or as soon as practically possible by telephone. The SCAN Team On Call Consultant provides guidance on filing the report and contacting the appropriate child protection agency(s).
   The Los Angeles County Child Protection Hotline (800) 540-4000 is contacted for families residing within the county. Contact numbers for outside counties can be obtained from http://www.cdss.ca.gov/Reporting/Report-Abuse/Child-Protective-Services/Report-Child-Abuse.
   UCPD will facilitate law enforcement reporting for suspected sexual abuse and physical abuse cases.

2. **Suspected Child Abuse Report Form**

The California Department of Justice Form Suspected Child Abuse Report *SS* BCIA 8572 must be completed within 36 hours after abuse is suspected. This form is to be completed by the reporting party or by the Clinical Social Worker, when involved. When reporting to the LA County Hotline, the mandated reporter has the option of completing the report form on line through the secure link on the DCFS website for mandated reporters at https://mandrepla.org. The report form for all counties is available at https://oag.ca.gov/childabuse/forms. Scroll down the page to "Suspected Child Abuse Report Form and select Form BCIA 8572, pdf and the instructions link.

3. **Medical Report - Suspected Child Physical Abuse and Neglect Form**
   When a medical evaluation has been performed on a suspected physical child abuse case, the Cal OES Form 2-900: Medical Report: Suspected Child Physical Abuse and Neglect Examination should be completed within 36 hours after abuse is suspected, and forwarded with Form 11166 PC. The Form 2-900 is usually completed by the physician. However, it may be completed by other appropriate medical or professional personnel involved with the case. The report form and instructions, are available online at https://www.ccfmtcorgforensic-medical- examination-forms/

4. The person or department completing any of the report forms shall complete the UCLA Healthcare Report of Mandatory Disclosure of PHI (Form ID# 10468 on the Forms Portal) and forward it to the Privacy Management Office.

5. **Distribution of Report Forms**
   The completed written report forms are given to the investigating agency(s) and a copy to the SCAN Team Coordinator in the Department of Care Coordination and Clinical Social Work. This department is responsible for distributing appropriate copies to the SCAN Team Medical Director and medical record. These records are to be CONFIDENTIAL and must not be disclosed to anyone except as necessary to report cases of suspected abuse as described in this policy.

B. **AC****TION GUIDELINES**

OPY

A. If Medical Center personnel suspect a child is in imminent danger of harm, the physician, nurse and/or social worker taking care of the child should contact the Medical Center Security Supervisor to advise him/her of the potential harm to the child. A discussion should take place between the contacting party and Security to determine the appropriate response from Security, such as remaining with the child or in the Department, or notifying UCPD.

B. Any staff member concerned that a child may be a victim of child abuse/neglect should contact the social worker for the service *or* and ensure that the SCAN Team On Call Consultant is notified. (After hours, on weekends and holidays, contact the Page Operator for the Social Worker on duty.)

C. Physician (Dentist/Optometrist when applicable) Responsibility
When child abuse or neglect is suspected, the physician/dentist should contact the SCAN Team Medical Director for consultation through the SCAN Team On Call Consultant on pager #96672. The Pediatric Hospitalist will also be contacted if the patient is in the ED.
The physician/dentist is responsible for the following unless directed otherwise:

1. Obtaining a detailed history from the child's parent(s) or caretaker(s) and the child;
2. Examining the child after consulting with the SCAN Medical Director for guidance;
3. Charting carefully and accurately the following: the location and description of all injuries, pertinent details concerning the injury, neglect, or sexual abuse such as time, place, sequence of events, people present;
4. Ordering laboratory tests and radiologic procedures as indicated (refer to **Appendix I** for tests/ studies).
5. Ordering consults as indicated, such as pediatric hospitalist, ophthalmology, psychiatry, neurology, hematology, dentistry, child development, child life
6. Informing the parent(s) or caretaker(s) of the medical evaluation of suspected child abuse and neglect unless the child or you or others would be endangered as a result of the disclosure or if it is decided for other reasons that it is not in the best interest of the child or family. Notification

of the parents can potentially increase risk to the child in some circumstances. The SCAN Consultant and SCAN Medical Director can offer guidance in this risk assessment and communication with the parents regarding the evaluation, any reporting, and follow-up contacts.

7. Completing Form BCIA 8572 Suspected Child Abuse Report within 36 hours after abuse is suspected. (The clinical social worker, if available, may complete this form.)
8. When injuries are believed to have been caused by abuse or neglect, and a physical examination is conducted, complete Form OES 2-900: Medical Report of Suspected Child Abuse within 36 hours after abuse is suspected;
9. When sexual abuse is suspected refer to Policy 1303.1 Child Sexual Abuse - Management and Reporting of Suspected Cases
10. When appropriate, recommending to DCFS and/or law enforcement that the child's siblings receive an appropriate medical evaluation.
11. Continuing, when possible, to provide medical follow-up or arranging for alternative on-going medical care for the patient.

D. Nursing Staffs Responsibility
   1. The nursing staff must act to protect the patient for whom the Medical Center has assumed

C

responsibility.

OPY

2. When notified that a hospitalized pediatric patient has been placed on a DCFS/Police Hospital Hold due to child abuse allegations, the Nurse Manager will consult with the SCAN Team On Call Consultant, the assigned Clinical Social Worker, and Security, regarding the level and type of supervision needed for the specific case. This may include the assignment of a Clinical Care Partner or Continuous Observation Aide (COA) and/or changing location on the ward.
   Whenever possible admitted infants/children on Hospital Holds should have a Pediatric Security Sensor placed in order to monitor and ensure patient safety.
3. Infants and children on Hospital Holds must be accompanied by staff whenever they leave the unit.
4. If the parent(s) or caretaker(s) attempts to remove a child who is on a Hold from the Medical Center, the nursing staff should notify the attending physician, Medical Center Security UCLA Police Department (Dial 911 for an emergency) and the SCAN On Call Consultant. If child is missing from the Pediatric unit, call Code Purple. If a newborn is missing from the nursery or NICU, call Code Pink.
5. All significant nursing findings and recommendations related to the child's condition and treatment, and family/caretaker interaction should be recorded objectively in the medical record. These should include any person(s) who accompany and/or visit the child, frequency of visits, and the child's reaction and behavior during and after such visits.

E. UCLA Police Department's Responsibility
   When child abuse or neglect is suspected, the UCLA Police Department is responsible for the following:
   1. Responding to referrals from physicians, nurses, or other Medical Center personnel in suspected cases of child abuse and neglect
   2. Acting as the official referral agency for reporting child abuse and neglect when outside law enforcement is not already involved;

3. Responding at the Medical Center when requested to make a preliminary investigation of the suspected child abuse and neglect cases; and appearing at the Medical Center for all cases of suspected child sexual abuse;
4. Immediately photographing bruises, burns, or other suspicious injury;
5. Contacting, and acting as the liaison with appropriate law enforcement agencies responsible for follow-up action.

F. Clinical Social Work Staff's Responsibility
The social worker is responsible for:

1. Interviewing the parent(s) or guardian(s) or other caregivers who bring the child to the ED, clinic, or hospital, and patient for psychosocial assessment.
2. Consulting with other professionals involved in the evaluation of the case
3. Making the required suspected child abuse/neglect phone report and written reports un[illegible]member of the team is designated [illegible]ular case.
4. Ensuring that the Attending physician, Charge [illegible], Security and SCAN Team On Call Consultant are informed when a child has been placed on a Hospital Hold. Ensures that the Hold is placed in the child's record.
5. Coordinating with the family, Hospital personnel, SCAN Team consultant and the child protection agencies
6. Recording immediately all pertinent findings in the medical record; providing completed BCIA 8572 Suspected Child Abuse Report Form and other related documents such as Hospital Holds or court orders to the SCAN On Call Consultant and providing the Report of Mandatory Disclosure of PHI Form to the Privacy Management Office
7. Arranging and coordinating the discharge conference, as needed, to involve the appropriate persons in planning the discharge of the child from the Hospital and the follow-up care

G. Volunteers Responsibility
Volunteers whose duties require direct contact and supervision of children are encouraged to obtain training in the identification and reporting of child abuse.

FORMS

OES Form 2-900 Medical Report: Suspected Child Physical Abuse and Neglect Examination

California Department of Justice Form Suspected Child Abuse Report Form BCIA 8572.

Report of Mandatory Disclosure of PHI Form ID # 10468

REFERENCES

California Penal Codes, Sections 220, 243.4, 261, 261.5, 264.1, 266c, 273a, 273d, 285, 286, 288, 288a, 289,

647a, 664, 11165, 11166, 11167, 11168, 11169, 11170, 11171, 11172, 11174, 13823.5, 13823.11.

California Welfare & Institutions Code, Section 300, Civil Code 34.9

California Business and Professions Code, Section 500.

UCLA Medical Center Policy HS 1303.1, *Management of Suspected Child Sexual Abuse Cases*

REVISION HISTORY

APPENDIX I

CHILD ABUSE WARNING SIGNALS OR INDICATORS

I. Characteristic features observed in cases of child abuse and/or neglect may help alert physicians and other hospital personnel to possible occurrences. It is important to remember that often times not one or

more symptoms or facts, but certain combinations of them that lead to a determination of child abuse in a particular case.

II. The infliction of injury, rather than the degree of that injury, is the determinant for intervention. According to researchers in the field, there is a 50 percent chance that a parent or caretaker who begins inflicting minor injuries will go on to severe or fatal injury of the child. Therefore, detecting initially inflicted small injuries and intervening with preventive action, may save a child from future permanent harm or death.

III. Observation of family dynamics is important during the evaluation process. However, it is equally important to be cognizant of one's own personal biases and preconceived notions as to the appearance and/or behavior of a potential perpetrator. Child abuse and neglect occurs in all cultures, races, ethnic groups, and socioeconomic classes. When deciding whether to make a report to the child abuse hotline or request consultation from the SCAN Team, **it is critical to focus on objective findings such as an unexplained injury in a young, non- mobile infant. Subjective observations such as the caregiver/ family appearing "nice", well-to-do, or extremely cooperative, are NOT reasons to defer consultation with the SCAN Team** . Understanding the plausibility of a given mechanism as to having caused a child's injury is often challenging and not straight forward. An assessment of the particular child's developmental capabilities is an important factor.
**** Any child ≤ 1 year of age with trauma to the head, chest, abdomen or skeleton without independent eyewitnesses to the alleged incident (excluding family members) or those without an objective mechanism to explain the injury (i.e. motor vehicle accident (MVA) or MVA versus pedestrian**

accident) should require at a minimum consultation with the SCAN Team.**

IV. CHIEF COMPLAINT

A. suspicious trauma, wound, or injury

B. ingestion of dangerous drugs, food, or poisons such as a cleaning fluid

V. HISTORY

Effective Date:	February 1, 1977
Review Date:	May 1, 1981, March 1, 1986, June 1, 1988, 1989, 1990, 1991, March 1,1992, May 1, 1993, July 1, 1994; April 6, 1998; January 25, 2001, May 1, 2004, April 27, 2005, October 31, 2007, July 24, 2013
Revised Date:	June 23, 2005, November 29, 2007, March 2008, August 30, 2013 (systemized).

A. repeated injuries

B. repeated ingestion of dangerous drugs, food or poisons

C. child being described as "accident prone"

VI. AGE

A. Children ≤ 4 years of age, and especially ≤ 6 months of age are at highest risk for death from child abuse and neglect.

VII. SUSPICIOUS FACTORS

A. a major discrepancy between the type and degree of injury and the explanation given for it

B. unreasonable delay in seeking treatment

C. unnecessarily late night arrival at the hospital

D. travel to the hospital from an unusual distance, when medical help is available nearer the patient's home

E. bringing the child to the hospital for unneeded treatment (as a disguised plea for help with fears of potential child abuse)

VIII. PHYSICAL EXAMINATION EVIDENCE

A. C un

explained bruises, s welling, burns, fractures,

a P brasions Y

B. multiple injuries in various stages of healing
C. injuries on several surfaces of the body
D. injuries normally hidden by clothing
E. injuries reflecting the outline of an object or mode of infliction
F. head injuries with subdural hematomas and retinal hemorrhages
G. injuries difficult or impossible to self-inflict
H. evidence of old trauma
I. signs of dehydration, malnutrition, or unexplained failure to thrive
J. signs of hygienic or medical neglect.
K. signs of sexual abuse
L. evidence of fabrication of child's symptoms of illness

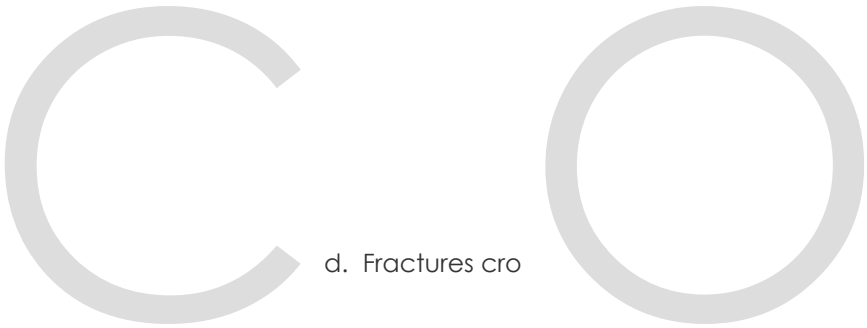
IX. SKELETAL SURVEY

A. A complete skeletal survey should be ordered for all children ≤ 2 years of age who present with injuries suspicious for physical abuse. Between 2-5 years of age a skeletal survey should be considered and consultation with SCAN Team Medical Director may assist in the decision-making process.
B. High Specificity Fractures
    1. Classic Metaphyseal Lesions
        a. Avulsion
        b. Bucket-Handle
        c. Corner chip

2. Posterior rib fractures
3. Sternum
4. Scapular
5. Spinous process

C. Moderate Specificity Fractures

1. Multiple fractures
2. Fractures of differing ages
3. Epiphyseal separations
4. Vertebral body
5. Digits
6. Complex skull fractures
    a. Depressed
    b. Multiple
    c. Comminuted



d. Fractures cro ssing suture lines

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e. Non-parietal skull fractures
f. Diastatic, wide

D. Low Specificity Fractures
1. Clavicular
2. Long bone shaft (in an ambulatory child)
3. Simple linear parietal skull fracture

X. ADDITIONAL TESTS AND STUDIES TO CONSIDER

A. Head Computed Tomography (CT) Scan to rule out intracranial bleeds.

B. Magnetic Resonance Imaging (MRI) to rule out small intracranial bleeds missed on CT, diffuse axonal injuries, shearing injuries.

C. Ophthalmology consult to rule out retinal hemorrhages concerning for abusive head trauma.

D. Three-dimensional reconstruction of the head CT to further assess complex skull fractures.

E. Laboratory studies: Blood and urine tests
1. Complete blood count with differential and platelet count
2. Coagulation panel for those presenting with bruises and/or intracranial bleeds, gastrointestinal bleeds, etc...
3. Liver function tests and lipase to rule out potential intraabdominal injury requiring an Abdominal CT scan
4. Urine toxicology screen and/or serum alcohol level to rule out potential drug ingestion

F. Photography
1. If overt physical injuries are noted the SCAN Team Medical Director should be notified

immediately in order to obtain photographic documentation in a timely manner. Photographs can also be obtained by Law Enforcement (i.e. Los Angeles Police Department (LAPD); UCLA Police Department (UCPD)) or by the hospital staff by utilizing the EPIC Haiku app on an encrypted and secured mobile device which will automatically transmit the images into the patient's chart within CareConnect. If photographs are taken by the hospital staff the SCAN Team Medical Director should be notified and those images transmitted for further evaluation

XI. FAMILY HISTORY

A. irritation with personal characteristics of the abused child (e.g., the child is mischievous, hyperactive, sickly)

B. negative parental attitudes toward patient (the child is seen as unwanted, unrewarding, or demanding too much of the adult(s))

C. inadequate supervision of the child

D. unrealistic expectations of and demands on the child

E. distorted concepts of the nature and limits of discipline (over-punishment is a common form of inflicted physical injury)

F. questionable trauma, hospitalizations or deaths among siblings

G. mental illness; drug or alcohol abuse

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H. physical illness or death in the family

I. parents having been abused or deprived in childhood

J. partner abuse

K. absence of supportive partner relationship; separation or divorce

L. disagreement among adults in household on child-rearing concepts

M. recent tensions or crises in the home

N. long-standing social isolation of parents

O. unavailability of help during times of stress

P. job instability of primary wage earner

Q. income consistently inadequate for family needs

XII. Further clues may be obtained from the SOURCES OF INFORMATION. However, whether the informant is the parent, another adult, a sibling, or the patient, it is important to evaluate the informant as well as the information provided. Interviews with parents, the child and siblings should be conducted separately whenever possible.

XIII. ADULTS

A. manner of responding to questions (defensiveness, abusiveness, denial, vagueness, loss of emotional control)

B. emotional reaction and overt behavior inappropriate to the situation

C. concern focused primarily on the adult's needs and problems rather than the child's

D. possible intoxication

E. verbalization of fears of injuring the child

F. blaming of injuries on others such as siblings

G. justification of injuries in the name of discipline

H. inconsistency or contradictions in account of accident/injury or complete change of story

I. If two or more persons provide information, do their accounts differ markedly or differ on a crucial detail? Is there a discrepancy between the patient's injury and the explanations offered for it?

XIV. CHILDREN

A. emotional behavior inappropriate to the child's age or to the situation (overly passive, aggressive, frightened)

B. marked delay in language development

C. verbalization of fears of being injured

D. behavior in the presence of parents or guardians that contrasts noticeably with behavior in their absence

E. Does the child appear to have been coached for reporting purposes? Does the child's account make sense? Does it conflict with the adult's account?

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Administration Approval- President and CEO, UCLA Health	Johnese Spisso: Ceo Med Ctr [FD]	3/25/2020
Ronald Reagan Medical Staff Executive Committee- Chief of Staff	Carlos Lerner: Assoc Prof Of Clin-Hcomp [FD]	3/25/2020
Santa Monica Medical Staff Executive Committee- Chief of Staff	Roger Lee: Hs Clin Prof-Hcomp [FD]	3/25/2020
Resnick Neuropsychiatric Medical Staff Executive Committee- Chief of Staff	Aaron Kaufman: Hs Assoc Clin Prof-Hcomp [FD]	3/25/2020
Hospital System Policy Committee Chair	Fiona Dunne: Adm Crd Ofcr [KK]	3/20/2020
Hospital System Policy Committee Chair	Jeffrey Bergen: Mgr [KK]	3/13/2020
Policy Owner	Derek Hoppe: Mgr	2/26/2020

COPY

Current Status: *Active* **PolicyStat ID:** *3743873*

Effective Date:	*5/14/2002*
Review Date:	*6/19/2017*
Revised Date:	*6/19/2017*
Next Review:	*6/18/2020*
Owner:	*Thomas Strouse: Prof Of Clin-Hcomp*
Policy Area:	*Care of Patients*
Reference Tags:	
Applicability:	*Resnick Neuropsychiatric Hospital*

Suspected Child Abuse and/or Neglect (SCAAN) Case Reporting Responsibilities, NPH 1616

PURPOSE:

To specify the policy of the Resnick Neuropsychiatric Hospital in relation to the reporting of suspected child abuse and/or neglect cases.

POLICY:

OPY

1. Any person who enters into employment or is a trainee at the Resnick Neuropsychiatric Hospital on or after January 1, 1985, such as a child care custodian, medical practitioner or non-medical practitioner shall sign a statement, on a form provided by Resnick Neuropsychiatric Hospital Human Resources, to the effect that he or she has knowledge of Penal Code Section 11166, which requires:

   Any child care custodian, medical practitioner or non-medical practitioner who has knowledge of or observes a child in his or her professional capacity, or within the scope of his or her employment or training, whom he or she knows or reasonably suspects has been the victim of child abuse, to report the known or suspected instance of child abuse to a child protection agency immediately or as soon as practically possible by telephone and to prepare and send a written report within 36 hours of receiving the information concerning the incident.

   1. Human Resources shall retain the signed statement in the employee's personnel file.
2. Child abuse is defined as any act or omission that endangers or impairs a child's physical or emotional health and development.
   1. Child abuse which is required to be reported includes:
      1. Physical injury or death inflicted by other than accidental means;
      2. Sexual assault, including rape, rape in concert, statutory rape, incest, sodomy, lewd or lascivious acts upon a child, oral copulation, penetration of a genital or anal opening by a foreign object and child molestation;
      3. Sexual exploitation including conduct involving any matter depicting a minor engaged in obscene acts (preparing, selling or distributing obscene matter) or employment of a minor to perform obscene acts; a person who knowingly promotes, aids or assist, employs, uses, persuades, induces, or coerces a child, or a person responsible for a child's welfare who knowingly permits or encourages a child to engage in, or assist others to engage in, prostitution

or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, or live performance involving obscene sexual conduct; a person who depicts a child in, or who knowingly develops, duplicates, prints, or exchanges, any film, photograph, videotape, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies.

4. Willful cruelty or unjustifiable punishment (a situation where a person willfully causes or permits a child to suffer, or inflicts upon a child, unjustifiable physical pain or mental suffering, or having the care and custody of the child, willfully causes or permits the child to be placed in a situation where the child's person or health is endangered)
5. Unlawful corporal punishment or injury resulting in a traumatic condition;
6. Neglect: negligent treatment or maltreatment of a child including both acts and omissions; and severe neglect including severe malnutrition or medically diagnosed non-organic failure-to- thrive;
7. Abuse in out-of-home care. (child abuse is suspected and the person responsible for the child's welfare is a licensee, administrator or employee of a licensed community care or child day care facility or facility licensed to care for children or the administrator or employee of a public or private residential home, school, or other institution.)
8. Child witnessing of domestic violence which is likely to result in emotional or physical harm to the child

2. Additionally, although reporting of mental suffering inflicted upon a child or the endangerment of a child's emotional well being is discretionary and not required by law, such reporting is strongly encouraged.

3. The Resnick Neuropsychiatric Hospital shall report all suspected child abuse or neglect cases.
4. The Resnick Neuropsychiatric Hospital shall designate and publicize Suspected Child and Adult Abuse and Neglect (SCAAN) Committee in order to facilitate recognition and reporting of suspected child abuse and neglect. The Committee shall provide clinical consultation, conduct trainings.
5. The faculty, staff, or trainee who suspects child abuse and/or neglect may contact a SCAAN Committee representative who will provide consultation on the reporting process.
6. Reporting party shall report suspected child abuse or neglect cases immediately by phone (number 800-540-4000) to Department of Child and Family Services (DCFS) and in writing within 36 hours.
7. Physician shall report by telephone, as soon as practically possible, and in writing to the police and L.A. County Health Department, within 36 hours, of the fact of any patient received from a health facility or community care facility who exhibits a physical injury or condition which, in the opinion of the examining physician, reasonably appears to be the result of neglect or abuse.
    1. RN, LVN, or LCSW may make the report if in his/her opinion the patient's injury or condition

reasonably appears to be the result of abuse or neglect. However the physician must confirm this opinion as required for mandatory reporting.

8. The reporting duties are individual, and no supervisor or administrator may impede or inhibit the reporting duties and no person making such a report shall be subject to any sanction for making the report.
9. Reports made under the law are confidential and may be disclosed only to specified agencies. Violation of confidentially provisions is a misdemeanor, punishable by imprisonment in the county jail not exceeding six months, by a fine of not more than $500 or both fine and imprisonment (Ref. Penal Code 1116.75).

1. Reporting party may not release copy of report to any person or entity not authorized under law to receive the report.

PROCEDURE:

1. NPH case identification, consultation and oral reporting procedures are as follows:
    1. The person suspecting abuse/neglect must discuss the case with available treatment team members, e.g., Unit Director, Clinical Nurse Manager, Social Worker, &/or Psychologist.
    2. The person suspecting abuse/neglect may contact the NPH SCAAN representative.
        1. SCAAN consultation is available Monday-Friday, 9am-5pm, pager #95818.
        2. After hours, consultation is available through Department of Child and Family Services (DCFS) hotline 800-540-4000.
    3. As long as it does not jeopardize the clinician's safety, **do not** allow a child to leave the NPH if he/ she appears to be in immediate danger related to a disclosure of abuse or has physical signs of abuse. Call the SCAAN consultant. If the consultant is unavailable, call Campus Police, ext. 51491.
    4. The designated team member immediately telephones report to DCFS Child Abuse/Neglect Hotline 800-540-4000.

2. Wri tten reporting procedure s:

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1. The designated team member shall make a written report of child abuse within 36 hours by completing the CALIFORNIA DEPARTMENT OF JUSTICE SUSPECTED CHILD ABUSE REPORT.
   All parties who have received an allegation of abuse are responsible for making reports. A team member can be designated to make the report, however, all parties with information about the abuse are responsible for ensuring a report is submitted.
    1. Place a copy of form #SS5872 behind the legal tab in the patient's medical record.
        1. Past physical abuse or current physical abuse when **no** injury is observed.
        2. Emotional/psychological maltreatment.
        3. Child abandonment; e.g., with relatives, with unrelated caretakers, in day care center or other similar facility, or child left alone.
        4. Parent refusing to take child home from psychiatric hospital and home evaluated to be safe (Section 270.5 of penal code).
        5. If the home appears unsafe, Department of Child and Family Services should be contacted for the consultation regarding possible temporary custody.
2. Certain cases must be cross-reported to and investigated by Campus Police, ext. 51491, including:
    1. Current physical abuse when an injury is observed.
    2. Severe medical or physical neglect.
    3. Sexual abuse, past or current.
    4. Severe endangerment or exploitation of children.
3. In those cases where a physical examination is necessary due to suspected acute physical and/or sexual child abuse, an inpatient is transported, accompanied by clinical staff, to the Emergency Room at the Santa Monica UCLA Medical Center, 1250 16th Street, Santa Monica, CA 90404, (310)

319-4503 (or after hours (310) 319-4000 request Therapist-On-Call), as soon as possible (preferably within 72-96 hours).

1. Prior to transportation, a clinical staff member provides a general overview of the physical examination with the patient/legally responsible adult, as appropriate, and documents this discussion with the patient/legally responsible adult, including willingness to receive a physical examination at the Santa Monica UCLA Medical Center, in the Medical Record.
2. Signature (patient/parent/conservator/guardian) should be obtained, whenever possible, on the TEMPORARY ABSENCE RELEASE FORM.
    1. The following are notified:
    2. Nurse Manager/Nursing OD
    3. Attending Physician
    4. Campus Police
    5. Department of Children and Family Services
3. Provide Santa Monica UCLA Medical Center with the following patient information:
    1. Patient's first and last name


2. Home addres
s

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3. Home telephone number
4. Social Security Number
5. Date of birth
6. Age
7. Law Enforcement Agency , if any, and contact person

4. After the physical examination is performed, the patient shall be transported back to RNPH with a completed Santa Monica UCLA Medical Center SEXUAL ASSAULT AFTERCARE INSTRUCTIONS form.
    1. File copy of the SEXUAL ASSAULT AFTERCARE INSTRUCTIONS in the Medical Record.
    2. Patient's condition upon return is documented in the Electronic Health Record.
5. Partial Hospitalization patients and outpatients should be referred to an Emergency Room or Rape Treatment Center.
6. Photographs may be taken of a suspected victim of child abuse without parental consent.
7. In cases where a physical examination is necessary due to suspected non-acute physical and/or sexual child abuse, contact the Child Advocate at the Stuart House, 1250 10th Street, Santa Monica, CA 90404, (310) 319-4503.

3. Document in the medical record in detail any injuries or findings such as trauma, bruises, erythemas, excoriations, lacerations, wounds or burns.
4. The Physician reports by telephone and in writing to the police and L.A. County Health Department, within 36 hours, of the fact of any patient received from a health facility or community care facility who exhibits a physical injury or condition which, in the opinion of the examining physician, reasonably appears to be the result of abuse or neglect.
    1. Reports must state character and extent of physical injury or condition.

2. Mail written reports to police and L.A. County Health Department.

FORMS

None

REFERENCES

CHA CONSENT MANUAL
RONALD REAGAN UCLA MEDICAL CENTER POLICY #1303 – Management of Suspected Child Abuse Cases
CALIFORNIA PENAL CODE, Sections 220, 243.4, 261.2, 261.5, 264.1, 266c, 273a, 273d, 285, 286, 288, 288a, 289, 647a, 664, 11164, 11165, 11166, 11167, 11168, 11169, 11170, 11171, 11172, 11174, 13823.5, 13823.11
CALIFORNIA WELFARE AND INSTITUTIONS CODE, SECTION 300
JOINT COMMISSION MANUAL FOR HOSPITALS

REVISION HISTORY

APPROVAL

OPY

Robert Suddath, MD
Chief of Staff
Resnick Neuropsychiatric Hospital at UCLA

Thomas Strouse, MD
Medical Director
Resnick Neuropsychiatric Hospital at UCLA

CHILD ABUSE WARNING SIGNALS OR INDICATORS

1. Characteristic features observed in cases of child abuse and/or neglect may help alert physicians and other hospital personnel to possible occurrences. It is important to remember that, often it is not one or more symptoms or facts, but certain combinations of them, which lead to a determination of child abuse in a particular case.
2. The infliction of injury, rather than the degree of the injury, is the determinant for intervention. According to researchers in the field, there is a 50% chance that a parent or caretaker who begins inflicting minor injuries will go on to severe or fatal injury of the child. Therefore, detecting initially inflicted small injuries and intervening with preventive action, may save a child from permanent harm or death.
3. Chief complaint of suspicious trauma wound or injury or injection of dangerous drugs, food or poisons such as cleaning fluid.
4. History of repeated injuries, repeated ingestion of dangerous drugs, good or poisons, or child being described as "accident prone."

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5. Suspicious factors such as (1) major discrepancy between the type & degree of injury and the explanation given to it; (2) unreasonable delay in seeking treatment; (3) unnecessarily late night arrival at the hospital;
   (4) travel to the hospital from an unusual distance, when medical help is available nearer to the patient's home; and (5) bringing the child to the hospital for unneeded treatment (as disguised plea for help with fears of potential child abuse).
6. Age of under 4 years (the most common period for child abuse, although abuse is not limited to those years, especially under six months)
7. Physical examination evidence of
    1. Unexplained bruises, swelling, burns, fractures, abrasions
    2. Multiple injuries in various stages of healing
    3. Injuries on several surfaces of the body
    4. Injuries normally hidden by clothing
    5. Injuries reflecting the outline of an object or mode of infliction
    6. Head injuries with subdural hematomas and retinal hemorrhages
    7. Injuries difficult or impossible to self-inflict

8. Evidence of old

OPY

9. Signs of dehydration, malnutrition, or unexplained failure to thrive
10. Signs of hygenic or medical neglect
11. Signs of sexual abuse
12. Evidence of fabrications of child's symptoms of illness

8. Family history of
    1. Irritation with personal characteristics of the abused child (e.g. child is mischievous, hyperactive, sickly)
    2. Negative parental attitudes toward child (unwanted, unrewarding or demanding too much of the adult(s))
    3. Inadequate supervision of the child
    4. Unrealistic expectations of and demands on the child
    5. Distorted concepts of the nature and limits of discipline
    6. Questionable trauma, hospitalizations or deaths among siblings
    7. Mental illness, drug or alcohol abuse
    8. Physical illness or death in the family
    9. Parents having been abused or deprived in childhood
    10. Spousal abuse
    11. Absence of supportive spousal relationship (separation or divorce)
    12. Disagreements among adults in household on child rearing concepts
    13. Recent tensions or crises in the home
    14. Long-standing social isolation of parents

15. Unavailability of help during times of stress
16. Job instability of primary wage earner
17. Income consistently inadequate for family needs

9. Further clues may be obtained from other sources of information. However, whether the informant is the parent, another adult, sibling or the child, it is important to evaluate the informant as well as the information provided. Interviews with parents, the child and siblings should be conducted separately whenever possible.
10. In observing a family, it is important also to be aware of one's personal biases and preconceptions. Remember that all forms of child abuse and neglect occur in all cultural, ethnic, occupational and socioeconomic groups.
11. Adults
    1. Manner of responding to questions (e.g. defensive, abusive, denial, vague, loss of emotional control)
    2. Emotional reaction and overt behavior inappropriate to the situation
    3. Concern focused primarily on the adult's needs and problems rather than the child's
    4. Possible intoxication

5. C Verbalization of fears

o f injuring child

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6. Blaming injuries on others such as siblings
7. Justification of injuries in the name of discipline
8. Inconsistency or contradictions in account of accident/injury or complete change of story
9. If two or more persons provide information, do their accounts differ markedly or differ on crucial details? Is there a discrepancy between the patient's injury and the explanation offered for it?

12. Children
    1. Emotional behavior inappropriate for the child's age or situation (e.g. overly passive, aggressive or frighened)
    2. Marked delay in language development
    3. Verbalization of fears of being injured
    4. Behavior in the presence of parents or guardians that contrasts noticeably with behavior in their absence
    5. Does the child appear to have been coached for reporting purposes? Does the child's account make sense? Does it conflict with the adult's account?

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
RNPH Professional Staff Executive Committee (RNPSEC) Meeting	Sherri Martin: Admin Anl Prn 1	6/19/2017
Nursing Leadership	Patricia Matos: Dir [SM]	6/19/2017
	Thomas Strouse: Prof Of Clin-Hcomp [SM]	6/19/2017

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Current Status: *Active* **PolicyStat ID:** *5962153*



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Owner: *Derek Hoppe: Mgr*
Policy Area: *Care of Patients*
Reference Tags: *Lippincott*
Applicability: *Ronald Reagan, Santa Monica, & Ambulatory Care*

Domestic Violence/Intimate Partner Abuse, HS 1331

PURPOSE

To state the Health System's plan for educating health care practitioners about their role in screening for

assault, abuse, or suspected abuse including

domestic violence or intimate partner abuse; To define reporting

domestic violence/intimate partner abuse; To define screening procedures for patients who may be victims of

procedures regarding patients who are victims of assault, abuse, or suspected abuse including domestic

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violence or intimate partner abuse; To define guidelines for appropriate care, referral, protection and follow-up.

DEFINITIONS

Domestic Violence

Abuse committed against an adult or minor who is the spouse, former spouse, cohabitant, former cohabitant or person with whom the suspect has had a child or is having/had a dating or engagement relationship. (California Penal Code §13700 b)

Abuse

Intentionally or recklessly causing or attempting to cause bodily injury or causing reasonable apprehension of imminent serious bodily injury to self or another. (California Penal Code §13700 a).

POLICY

It is the policy of UCLA Health System to screen patients for domestic violence according to the California Health and Safety Code § 1259.5 and to report assault, abuse or suspected abuse pursuant to California Penal Code §11160. In addition, all health care practitioners shall be educated on the criteria for identifying, and the procedures for handling, patients whose injuries or illnesses are attributable to spousal or partner abuse.

I. **Staff Education**

Health care practitioners shall receive appropriate education regarding their responsibilities for screening for domestic violence/intimate partner abuse as well as their reporting obligations. Criteria for identifying abuse shall be included in the Staff Orientation and Information Handbook which is presented to staff at orientation and which is reviewed annually. Department Managers will assure that staff are acquainted with, and comply with this policy. The Emergency Department, which is the area of

UCLA Health System where domestic violence victims are most likely to be seen, shall have department- specific screening and education procedures.

II. **Screening**

All UCLA Health System practitioners who provide medical services to any person for a physical injury shall screen patients, as appropriate for domestic violence or intimate partner abuse. (Refer to attachment, **"GUIDELINES FOR ABUSE RECOGNITION AND REPORTING"** for screening criteria)

III. **Intervention**

A. If it has been determined that the patient is a possible victim of domestic violence, notify the appropriate Social Worker. A Domestic Violence Consultant is available to UCLA Staff for phone consultation (pager # 96000). Any person who accompanies the patient and is a possible perpetrator should be asked to wait in the waiting room.

B. When a patient acknowledges that he or she is the victim of domestic violence or abuse, the patient will be asked if she/he would prefer to use an AKA when registering.

C. Place the patient in a room close to the nursing station if possible.

D. Notify staff that all visitors for the patient will be screened and will be allowed to see the patient with the approval of the primary nurse only.

E.

Notify hospital

security officers.

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F. Maintain patient confidentiality. Give no information about the patient over the telephone including confirmation of patient's presence in the Medical Center.

G. Notify assigned Clinical Social Worker or pager #96000 for a Domestic Violence phone consultation if a Clinical Social Worker is unavailable to assess the patient's immediate safety by ascertaining the following:

1. Where is the abuser now?
2. Does the abuser know victim's whereabouts?
3. Has the abuser threatened to use weapons?
4. Are there weapons available to the abuser?
5. Has the abuser ever threatened to kill victim?
6. Is the abuser intoxicated with drugs or alcohol?

H. Notify the primary service of the presence of a possible victim of domestic violence.

IV. **Responsibility of Social Worker**

A. Interview patient and other parties to complete a psychosocial assessment.

B. Discuss safety planning with the patient and provide resources such as the 24-hour hotline 310-264-6644, counseling referrals, education, and contact information for primary Clinical Social Worker.

C. Inquire about the presence of children in the home and/or if children witnessed Domestic Violence. If children reside in the home and/or were present at the time of the assault, notify the SCAN Team Consultant on Pager #96672 for consultation regarding reporting suspected child abuse or child endangerment.

D. If patient is interested in supportive services, contact the Domestic Violence Consultant on Pager #96000 for both consultation and occasional on-site support. If Domestic Violence Consultant is

unavailable, contact the 24 Hour Hotline at 310-264-6644.

E. The Clinical Social Worker may provide consultation support to the mandated reporter

V. **Responsibility of Health Care Practitioners**

A. Contact your assigned Clinical Social Worker or page #96000 to consult with a Domestic Violence Advocate if a Clinical Social Worker is not available. The Clinical Social Worker will assist in completing the required reports and facilitate the process accordingly; however, UCLA health care practitioners are responsible for charting and completing mandated reports.

B. **If your area does not have a Clinical Social Worker assigned, a Domestic Violence Advocate can be contacted for consultation on Pager # 96000.** If Domestic Violence Advocate is not available, contact the 24-hour hotline at (310) 264-6644.

C. Document clearly patient's account of current injuries using the patient's exact words when possible.

D. If children reside in the home, the SCAN Team Consultant must be contacted for consultation on Pager #96672.

E. File a Suspicious Injury Report (Form OES 920) to law enforcement if indicated according to California Penal Code §11160.

F. Work in collaboration with UCPD to ensure the safety of the victim and the confidentiality of victim's

C location.

OPY

VI. **Procedure for Reporting to Law Enforcement**

A. Any health care practitioner who renders medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a victim of assaultive or abusive behavior must contact law enforcement. California law requires reporting even if the patient is seeking medical attention for another condition not arising from the assaultive or abusive behavior. (Licensed Clinical Social Workers are not subject to this reporting requirement because they are not health care practitioners who render medical services for a physical condition to a patient.)

B. Notify UCPD (or local law enforcement in whose jurisdiction the injury occurred) that a victim of abuse or suspected abuse is on the premises. Inform them if the suspected abuser is with the patient.

C. UCPD will respond to all calls of suspected or actual abuse.

D. Document the name and ID number of the responding officer/dispatcher.

E. The Suspicious Injury Report (OES 920) is completed by the physician and must be given to UCPD or the responding law enforcement agency. A copy of the Suspicious Injury Report (OES 920) is placed in the patient's chart.

F. Complete the Mandatory Disclosure of PHI Report (Form 10468 on Forms Portal) and submit to HIMS per instructions on the form.

FORMS

RR UCLA MC Domestic Violence Reporting Form

Suspicious Injury Form OES 920

Mandatory Disclosure of PHI Form 10468 on Forms Portal

UCLA Health System. Domestic Abuse Reporting Requirement Acknowledgement Form

REFERENCE

UCLA Hospital System Policy HS 9015 *Reporting of Incidents to Law Enforcement Agencies",*

Hospital System Policy HS1303 *Child Abuse - Mgmt of Suspected cases of Child Abuse (Reporting of)*

Hospital System Policy HS1314 - *Elder/Dependent Adult Abuse - Reporting of* UCLA Hospital System Policy HS 9010 - *Mandatory Reporting*

McLeer, S.V., and R. Anwar. 1987. The role of emergency physicians in the prevention of domestic violence. Annals of Emergency Medicine 16:1155-1161.

Penal Code 11160

Penal Code 13700 (a) (b)

Contact:

Director, Department of Care Coordination and Clinical Social Work, UCLA Health System

REVISION HISTORY (PRE-POLICYSTAT)

Effective	April 6, 1998 Systemized w-SM 1303 (10-31-14)

APPROVAL

Johnese Spisso, RN, MPA
President UCLA Health
CEO UCLA Hospital System

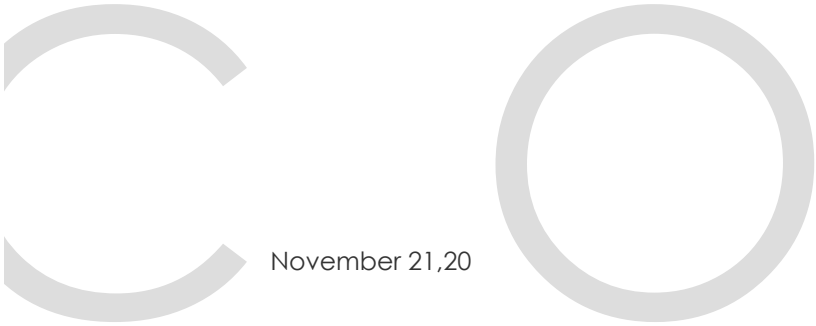
Carlos Lerner, M.D.
Chief of Staff
Ronald Reagan UCLA Medical Center

Roger M. Lee,
M.D.
Chief of Staff
Santa Monica-UCLA Medical Center and Orthopaedic Hospital

Attachments

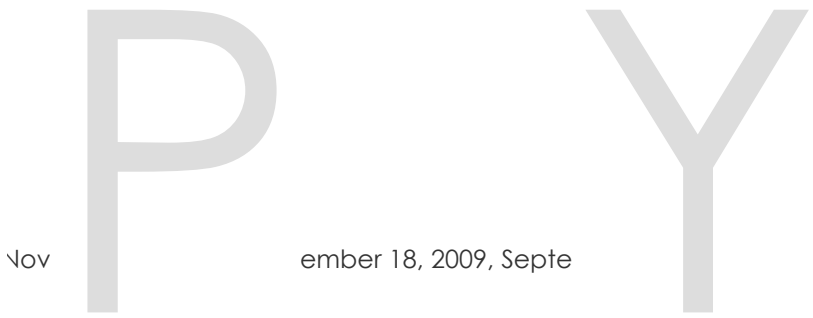
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ember 18, 2009, Septe
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mber 24, 2014

Revision Date: November 21, 2002, April 28, 2005, March 2008, December 29, 2009, July 1, 2013, October 31, 2014

1: General Guidelines for Abuse Recognition and Reporting

1b: Collection of Evidence

Domestic Abuse Reporting Requirement

1a: Physician Guidelines for Examination of a Patient with Actual or Suspected Abuse

Approval Signatures

Step Description	Approver	Date
Administration Approval	Johnese Spisso: Ceo Med Ctr [MW]	2/28/2019
Administration Approval	Carlos Lerner: Speaker-Unex [MW]	2/28/2019
Administration Approval	Roger Lee: Hs Clin Prof-Hcomp [MW]	2/28/2019
Administration Approval	Laurie Casaus: Hs Assoc Clin Prof-Hcomp [MW]	2/28/2019
Executive Medical Boards - MSEC, RNPH PSEC, SMEMB	M Lynn Willis: Mgr [KK]	2/28/2019
Hospital System Policy Committee Chair	M Lynn Willis: Mgr [KK]	2/28/2019
Hospital System Policy Committee	Kailyn Kariger: Admin Anl Prn 1	2/7/2019
	Alaa Badawy: Mgr	2/4/2019

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Owner:	*Thomas Strouse: Prof Of Clin-Hcomp*
Policy Area:	*Care of Patients*
Reference Tags:	
Applicability:	*Resnick Neuropsychiatric Hospital*

Reporting Violent Injury including Domestic Violence/Abuse, NPH 1618

PURPOSE

To outline RNPH Health Practitioners reporting responsibilities for victims of assault, abuse or suspected abuse including domestic violence or intimate partner abuse or injury by a deadly weapon.

POLICY

OPY

I. It is the policy of the Reshick Neuropsychiatric Hospital to comply with the requirements of the California Penal Code 11160 and 11161 that a report shall be made to UCPD when a health practitioner, in his or her professional capacity or within the scope of his or her employment, provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person described as follows:

A. A person suffering from any wound or other **physical** injury (a) inflicted by his or her own act where the injury is by means of a firearm **or** (b) inflicted by another where the injury is by means of a firearm;

B. A person suffering from any wound or other **physical** injury inflicted upon the person where the injury is a result of assaultive or abusive conduct. (Penal Code Section 11160);

C. The duty to report arises where the health practitioner provides medical services to a patient for **a** physical condition or injury arising from the assault, battery or firearm.

   i. The duty to report does not arise when the health practitioner provides only psychological or psychiatric counseling.

   ii. If minors are present and/or exposed to the abusive relationship, a suspected child abuse and neglect report shall be filed with the Department of Children's Services (see RNPH Policy #NPH 1616), regardless of whether or not a domestic violence/spouse/partner abuse report is filed.

D. A health practitioner, for the purpose of this policy only, includes physicians, RNs, LVNs, and LPTs. The term health practitioner, for the purpose of this policy only, excludes professionals whose role is solely psychotherapeutic such as psychologists, clinical social workers, and marriage/family therapists.

E. Examples of domestic violence and firearm injuries include assault, battery, sexual battery, incest, assault with a deadly weapon, spousal rape, abuse of spouse or cohabitant, sodomy, and/or oral

copulation.

F. A patient who acknowledges being the victim of domestic violence has the right to refuse to speak to law enforcement personnel; however a verbal report shall be given to UCPD, immediately, if indicated, and a completed REPORT OF INJURIES BY A DEADLY WEAPON OR ASSAUBLTIVE OR ABUSIVE CONDUCT within two working days.

II. All employees shall sign a statement, on a form provided by Resnick Neuropsychiatric Hospital Human Resources, to the effect that he/she has knowledge of California Penal Code 11160 and 11162.

A. Human Resources shall retain the signed statement in the employee's personnel file.

III. Orientation to recognition, reporting and referral of violent injury including suspected cases of domestic violence and firearm injuries shall be provided to appropriate health providers of Resnick NPH.

PROCEDURE

I. The following factors may indicate assault or abuse:

A. Explanation of injury does not seem plausible.

B. There has been a delay in seeking medical care.

C. There are multiple sites of injury.

PY

D. Patient is pregnant and injury is to breast, abdomen, genitals.

E. History of repeated injuries.

F. Injuries of various ages.

G. Partner accompanies patient, insists on staying close and answers all questions directed toward the patient.

H. If sexual assault is suspected, refer to RNPH Policy/Procedure #NPH 1616 or #NPH 1617.

II. The health practitioner's responsibilities for outpatients include the following:

A. Requests person accompanying the patient, if applicable, to wait in the waiting room in order to interview the patient alone. If staff assesses possible threat by family member/friend accompanying the patient, calls UCPD Threat Assessment Team at ext. 51491.

B. Assesses the patient's safety by ascertaining abuser's location now, abuser's knowledge of patient's whereabouts, if the abuser has threatened to use weapons, if there are weapons available to the abuser, if the abuser has ever threatened to kill the patient, the abuser's mental status including drugs and alcohol.

C. If the outpatient is willing to go to the Emergency Department, the UCLA Domestic Violence Consult Team should be contacted, if applicable, by paging 96000.

i. Determines whether or not hospital security should be called to escort the patient to the UCLA Emergency Department and remain with the patient until she/he has been seen by the Emergency Department Triage Nurse.

ii. The health practitioner should be available for consultation with the physician or other members of the Domestic Violence Consult Team in the Emergency Department.

iii. Documentation of the visit should be made in the patient's chart.

D. Advises that outpatient mental health services are available either through RNPH or through

community agencies.

E. If the outpatient is unwilling to go to the UCLA Emergency Department:

   i. Assesses the patient's immediate needs.

   ii. Helps the patient identify any personal support systems and assist with contacting them if a request is made.

   iii. Provides information that will enable the patient to pursue alternatives and assistance: 24-hour hotlines; shelters for abuse victims; counseling services and support groups; numbers for legal assistance and restraining orders; assist in obtaining an Emergency Protective Order from UCPD if needed; provide a safe place for the patient to use the telephone.

      a. If needed, considers utilizing the Domestic Violence Consult Team (page #96000) to assist with patient education and referral.

   iv. If the outpatient decides to return to the abuser, encourage her/him to develop a safety plan.

   v. Initiates education on the cycle of violence and batterers' syndrome.

   vi. Documents the referrals given and the patient's stated plan in the medical record.

   vii. Inquires about the safety of the children, if any, in the home. If children are at risk, notify the

SCAAN Team.

OPY

viii. Consults with UCPD to determine if a police interview is indicated.

F. If patient declines to file a written report with UCPD, verbally report the incident to UCPD as soon as possible and jointly determine appropriateness of police interview.

i. Completes REPORT OF INJURIES BY A DEADLY WEAPON OR ASSAULTIVE OR ABUSE CONDUCT and mails/faxes to UCPD.

FORMS

PSYCHIATRY EVALUATION/CONSULTATION INITIAL TREATMENT PLAN, NPI Form #2-192
REPORT OF INJURIES BY A DEADLY WEAPON OR ASSAULTIVE OR ABUSIVE CONDUCT, RNPH Form #1-129

REFERENCES

California Penal Code
11160 California Penal
Code 11161 California
Penal Code 11162
UCLA Medical Center Policy #0041, #2004
RNPH Policy #NPH 1616, Suspected Child Abuse and/or Neglect Case Reporting Responsibilities RNPH Policy #NPH 1617, Elder/Dependent Adult Abuse Reporting

REVISION HISTORY

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APPROVAL

Robert Suddath, MD
Chief of Staff
Resnick Neuropsychiatric Hospital at UCLA

Thomas Strouse, MD
Medical Director
Resnick Neuropsychiatric Hospital at UCLA

Attachments

No Attachments

COPY

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UCLA Health

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Reference Tags: *Lippincott*
Applicability: *Ronald Reagan, Resnick, Santa Monica, Ambulatory Care*

Elder and Dependent Adult Abuse (Reporting of), HS 1314

PURPOSE

The purpose of this policy is to establish procedures for reporting abuse of elder or dependent adults who

Center a nd Orthopaedic Hospita l, and the

licensed clinics, and Resnick Neuropsy chiatric Hospital present as

outpatients or inpatients at the Ronald Reagan UCLA Medical Center, Santa Monica UCLA Medical

C O P Y

POLICY

Any administrator, supervisor, employee, licensed staff, or volunteer ("Mandated Reporters") who witnesses

or

suspects that an "elder" or "dependent adult" is being or has been "abused" must report suspected cases to

the county Adult Protective Services (APS) agency (or other appropriate state agency). (See the

Attachments

to this policy for Definitions and Indicators of Abuse). **All employees, including those in unsalaried categories, must sign a statement that they understand and will comply with the elder abuse reporting requirements under California law. (See Attachment C - Elder or Dependent Adult Abuse Reporting Statement and *California Welfare and Institutions Code § 15630)*.**

PROCEDURE

I. **Reporting Procedures**

A. **What to Report:** A Mandated Reporter must report to APS (or other appropriate state agency) any of the following **Incidents of Abuse** that he or she observes in his or her professional capacity or within the scope of his or her employment:

1. Any incident that he or she has observed or has knowledge of that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect; or self neglect or,
2. If an elder or dependent adult says that he or she has experienced behavior, including an act or omission, constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect; or self neglect or,
3. If he or she reasonably suspects abuse.

B. **Exceptions (No Reporting)**
If a Mandated Reporter is a physician, a registered nurse, or a psychotherapist, as defined in Section

1010 of the Evidence Code, he or she NOT is required to report **Incidents of Abuse** where **ALL** of the following four conditions exist:

1. The Mandated Reporter has been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect;
2. The Mandated Reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred;
3. The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; **AND**
4. In the exercise of his/her clinical judgment, the Mandated Reporter reasonably believes that the abuse did not occur.

C. **Reporting**

The report shall be made by telephone immediately or as soon as practicably possible, and the written report must be sent within two working days of the telephone report. Reports shall be made to the Adult Protective Services agency or local law enforcement agency when the alleged abuse occurred in a long-term care facility, other than a State mental hospital or a State developmental center. If the suspected or alleged abuse occurred in a long-term care facility, other than a State mental hospital or State developmental center, reports shall be made to the county Long-Term Care Ombudsman Coordinator-800-334-1USE or to a local law enforcement agency (See Attachment C for listings for Los Angeles County). If the abuse is alleged to have occurred in a State mental hospital or State developmental center, the report shall be made to designated investigators of the State Department of Mental Health, the State Department of Developmental Services, or the local law enforcement agency. Where two or more Mandated Reporters have knowledge of a known or suspected **Incidents of Abuse,** the telephone report may be made by a member of the team selected by mutual agreement, and a single report may be made and signed by the designated member of the reporting team. Any member who has knowledge that the designed member has failed to report shall thereafter make the report. Reports should be made online using the portal unless not available in which case downtime protocol is utilizing the phone number plus written report.

1. **Telephone Report:** The telephone report shall include, if known, the following:
    a. Name of person making the report.
    b. Name, address, and age of the elder or dependent adult.
    c. The present location of the elder or dependent adult.
    d. Any information that led the reporting person to suspect that abuse has occurred.
    e. Nature and extent of the elder's or dependent adult's condition, if known.
    f. The date of the alleged or suspected incident.
    g. Names and addresses of family members or any other person responsible for the elder's/ dependent adult's care.

h. Any other information requested by the agency receiving the report, including that which led the reporter to suspect elder or dependent adult abuse.

i. Note in the patient's medical record the date and time the telephone report is made, the name of the person taking the report, and the address where the written report should be sent.

2. **Written Report (SOC 341):** The written report shall be completed for each victim and each **Incident of Abuse** using the form adopted by the Department of Social Services as required under *California Welfare and Institutions Code §15630(b)1)*. This form is referred to as SOC 341, Report of Suspected Dependent Adult/Elder Abuse. General instructions for completion are listed on the reverse side of the form. Reporting forms are located in the Department of Care Coordination and Clinical Social Work, the Emergency Department, and online at http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC341.pdf. . The written report shall include all areas highlighted on the Report of Suspected Dependent Adult/Elder Abuse Form. In the narrative section of the form, the following should be included:
   The written report shall include all areas highlighted on the Report of Suspected Dependent Adult/Elder Abuse Form (SOC 341). In the narrative section of the form, the following should be included:

   a. Any information that led the reporting person to suspect that abuse has occurred, i[illegible] name of the person, title or relation[illegible](RN, MD, daughter, etc), if different from the re[illegible]rting party.
   b. Na[illegible]nt of the elder's/der[illegible]ndent a[illegible]ult's condi[illegible] if known.
   c. Brie[illegible]narrative, e[illegible]lanation or clarifi[illegible]ation of an[illegible]inform[illegible]pertinent to the incident.
   d. Written repor[illegible]ts are to be filed online at LACSSLiveintake/ secured website: https[illegible]://fw4.harmonyis.net/
      If the SOC 341 Report of Suspected Dependent Abuse/Elder is handwritten, the completed report shall be mailed to: APS Centralized Intake Unit 3333 Wilshire Blvd., Suite 400 Los Angeles, California 90010 unless the site is down, then must be called in to 877-477-346 and a written report must be filed.
   e. If a report was made with the Long-Term Care Ombudsman, a copy of the written report shall be sent to: WISE Senior Services, Ombudsman Program, 1527 Fourth Street, 2nd Floor, Santa Monica, California 90404.

D. **Call APS (or appropriate state agency) and Department of Care Coordination and Clinical Social Work**: All Incidents of Abuse are to be reported directly to APS or the appropriate State agency The Clinical Social Worker ("CSW") assigned to the designated service shall be notified that a report has been made and may assist the mandated reporter in fulfilling their reporting obligation. Police involvement is at the discretion of the CSW, in consultation with Adult Protective Services. Contact with the Department of Care Coordination and Clinical Social Work is only to facilitate reporting and to apprise supervisors and administrators of reports. Reporting duties are individual. No supervisor or administrator may impede or inhibit reporting. No person making such a report shall be subject to any sanction for making the report. To report, contact:

   1. The APS Mandated Reporter Line at-888-202-4248 M-F 8:30 a.m.-5:00 p.m. or the 24-Hour Elder Abuse Reporting Line-877-477-3646. For information or inquiries about the appropriate district office contact 1-800-231-4024 or you may visit the following link:

http://www.cdss.ca.gov/ inforesources/County-APS-Offices

2. The Long-Term Ombudsman Coordinator for elder or dependent adults in Skilled Nursing Facilities or board and-care facilities- 1-800-334-9473.
3. During regular workday hours, (8 a.m.-5 p.m. Mon-Fri), calls should be made to the CSW assigned to the respective service.
   Ronald Reagan-Clinical Social Work is available onsite, 24 hours a day. Contact the Pager

Operator 310-825-6301 and asked to be connected to the Social Worker. A call to Neuro-Psychiatric Hospital (RNPH) CSW is not required. RNPH Suspected Child and Adult Abuse and Neglect (SCAAAN) Team is available for reporting, Monday through Friday 08:00 A.M. - 05:00 P.M. if needed at pager number 95818. Santa Monica-CSW is available 24 hours a day. If Social Work is unavailable, contact the Page Operator 310-825-6301 and ask to be connected with the Administrator on Call for assistance/consultation.

E. **Social Work and Mandated Reporter Responsibilities:**
For reports made to the Long-Term Ombudsman Coordinator, reporting and paperwork procedures remain the same. If the patient is hospitalized, the case will be assigned to the appropriate CSW on the admitting service.

a. The admitting physician or physician providing care for the patient should be notified immediately of suspected or alleged abuse identified by another care provider.

b. The CSW should conduct an interview with the patient, the patient's family members and/or significant other(s) to complete an in-depth evaluation and assessment. A full assessment of the person and the situation should be made. The assessment should be charted in the patient's electronic medical record. The physician caring for the patient must be contacted. If appropriate, the patient's family and/or primary caregiver may be contacted to discuss the assessment and mandatory reporting guidelines. The family may also be informed of the CSW interventions and referrals that will be provided. However, if the mandated reporter or reasonable belief that the patient's family member or personal representative is the abuser or that providing information regarding mandatory reporting to such person could endanger the patient, the mandated reporter or CSW, in the exercise of professional judgment, may determine that it is not in the best interest of the patient to treat the person as the patient's personal representative.

c. The CSW will provide referrals to appropriate agencies and community resources for further evaluation, if needed, and ongoing services to meet patient/family needs of medical care, counseling, advocacy, and other services.

d. For reports made to the Long-Term Ombudsman Coordinator, reporting and paperwork procedures remain the same. If patient is hospitalized, the case will be assigned to the appropriate CSW on the admitting service.

II. **Reporting Responsibilities**

A. The elder abuse reporting duties are individual, and, no supervisor or administrator may impede or inhibit the reporting duties. No person making such a report shall be subject to any sanction for making the report. However, the UCLA Health System may establish internal procedures to facilitate reporting, ensure confidentiality and notify supervisors and administrators of reports, provided these procedures are not inconsistent with California law.

B. No Mandated Reporter who reports a known or suspected instance of elder or dependent

adult abuse shall be civilly or criminally liable for any report he/she is required or permitted to make under law.

C. Any Mandated Reporter who fails to report physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult or self neglect ("Incidents of Abuse") which he or she knows to exist or reasonably should know to exist, is guilty of a misdemeanor punishable by imprisonment in the county jail not exceeding six months, by a fine not exceeding $1,000.00 or by both fine and imprisonment. Any Mandated Reporter who willfully fails to report, where that abuse

results in death or great bodily injury, shall be punished by not more than one year in a county jail or by a fine of not more than five thousand dollars ($5,000.00) or by both that fine and imprisonment. *(California Welfare and Institutions Code §15630 (h))*.

D. Reports made under the law are confidential and may be disclosed only to the agencies specified. Violation of the confidentiality provisions is a misdemeanor, punishable by imprisonment in the County jail not exceeding six months, by a fine of not more than $500.00 or by both fine and imprisonment. *(California Welfare and Institutions Code §15633, 15633.5, and 15634)*.

III. **REPORT TO THE CLINICAL REGULATORY AFFAIRS OFFICE**

If the elder or dependent abuse incident involves a hospital employee inflicting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect upon a patient, notification must be made immediately to the Department of Licensing, Accreditation and Policy-310-794-3043. Based on individual review of the nature of the case, it will be reported to the California Department of Public Health pursuant to Title 22, Section 70737 "Reporting."

IV. **REPORT NOTIFICATION TO THE HEALTH INFORMATION MANAGEMENT SERVICES DEPARTMENT**

A. HIPAA requires that all disclosures for purposes other than for Treatment, Payment or Health Care Operations must be tracked and logged by UCLA Health Systems. UCLA must be able to provide an accounting of such disclosures to

patients upon request. All requests for disclosures to third parties must be referred to Health Information Management Services Department. Certain individuals or departments within UCLA Health Systems may, however, be permitted to disclose PHI to third parties directly provided they:

1. have been authorized by the Director, HIMS Department or designee; or
2. have an individual legal obligation to report and make the report pursuant to such legal

authority

in accordance with UCLA Health Systems policies and procedures; and

3. The individual with the legal obligation to report (such as that of a Mandated Reporter) must notify the HIMS Department of the report by completing the form "Mandatory Reporting of Protected Health Information" (Form ID #10468) so that the disclosure can be included in UCLA Health Systems PHI Tracking system
4. The RNPH HIM Department will remove the written abuse report from the discharged patient record and will enter the required information into the PHI/ROI Tracking System.

B. Be specific in completing this form. You must state that PHI was released in connection with Mandatory reporting of Elder/Dependent Adult Abuse. This facilitates protection of the patient when providing an accounting of disclosures to patient representatives. This form, in addition to the SOC 341, Report of Suspected Dependent Adult/Elder Abuse must be faxed to 310-206-4023 or mailed to Health Information Management Department (HIMS), UCLA Health Systems, 10833 Le Conte Avenue, Room CHS-BH- 921, Los Angeles, California 90095.

C. The report identification number must be documented inside the patient's electronic chart via the mandated report template and flow-sheet once the report has been completed.

D. The department of Care Coordination and Social Work will maintain a log of reported cases for both Ronald Reagan and Santa Monica.

FORMS

Report of Suspected Dependent Adult/Elder Abuse - State of California Form - SOC 341

Mandatory Reporting of Protected Health Information (UCLA Healthcare HIPPA Forms, PHI Management Forms) Form #10468

REFERENCES

California Welfare and Institutions Code, Sections 15600, , 15610, 15630, 15631, 15632, 15633, 15633.5, 15634, , 15637, and Penal Code, Section 368.

Adult Protective Services

California Department of Public Health, Title 22, Section 70737

CONTACT:

Director, Licensing, Accreditation & Policy, Director, Care Coordination Departments, SMH, RR UCLA and R- NPH

REVISION HISTORY (PRE-POLICYSTAT)

Effective Date:	October 1, 1986 Systemized w-SM 1304 (10-3 14)
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Revision November 30, 2009, July 1,2013, October 31,2014
Date:

Attachments

A: Definitions
D: Local Law Enforcement Agencies
C: Statement Acknowledging Requirement to Report Suspected Abuse of Dependent Adults and Elders B: Indicators of Abuse

Approval Signatures

Step Description	Approver	Date
Administration Approval- President and CEO, UCLA Health	Johnese Spisso: Ceo Med Ctr [FD]	3/25/2020
Ronald Reagan Medical Staff Executive Committee- Chief of Staff	Carlos Lerner: Assoc Prof Of Clin-Hcomp [FD]	3/25/2020

Santa Monica Medical Staff Executive Committee- Chief of Staff	Roger Lee: Hs Clin Prof-Hcomp [FD]	3/25/2020
Resnick Neuropsychiatric Medical Staff Executive Committee- Chief of Staff	Aaron Kaufman: Hs Assoc Clin Prof-Hcomp [FD]	3/25/2020

Step Description	Approver	Date
Hospital System Policy Committee Chair	Fiona Dunne: Adm Crd Ofcr [KK]	3/20/2020
Hospital System Policy Committee Chair	Jeffrey Bergen: Mgr [KK]	3/13/2020
Policy Owner	Derek Hoppe: Mgr	2/3/2020
Policy Owner	Alaa Badawy: Mgr	8/12/2019

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Owner:	*Thomas Strouse: Prof Of Clin-Hcomp*
Policy Area:	*Care of Patients*
Reference Tags:	
Applicability:	*Resnick Neuropsychiatric Hospital*

Suspected Elder/Dependent Adult Abuse and Neglect Reporting, NPH 1617

PURPOSE:

To specify the policy of the Resnick Neuropsychiatric Hospital in relation to the reporting of suspected elder/ dependent adult abuse or neglect cases.

POLICY:

OPY

1. All employees of R-RNPH shall sign a statement on a form provided by Reshick Neuropsychiatric Hospital Human Resources to the effect that he or she has knowledge of the provisions of Section 15630 of the California Welfare & Institutions Code and will comply with its provisions.
    1. Section 15630 W&I requires health care practitioners and elder or dependent adult care custodians who, within the scope of their employment or professional capacity, have observed or have knowledge, are told by an elder or dependent adult, or reasonably suspects an incident that appears to be elder or dependent adult abuse or neglect, to report such information to the Los Angeles County Adult Protective Services Agency.
    2. Human Resources shall retain the signed statement in the employee's personel file.
2. Definitions
    1. The law expressly includes any person between the ages of 18 and 64 who are admitted as an inpatient in an acute care hospital or other 24-hour health facility (Ref. WIC 15610.23, 15610.27 & 15701.2).
    2. An elderly person includes anyone who is 65 years of age or older.
    3. Dependent adult means any person resident in California, between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.
    4. Physical abuse means all of the following:
        1. Assault
        2. Battery
        3. Assault with a deadly weapon or force likely to produce great bodily injury.

4. Unreasonable physical restraint.
5. Prolonged or continual deprivation of food and water.
6. Sexual assault, including sexual battery, rape, rape in concert, incest, spousal rape, sodomy, oral copulation, or penetration of a genital or anal opening by a foreign object.
7. Use of physical or chemical restraint or psychotropic medication under any of the following conditions:
    1. For punishment.
    2. For a period significantly beyond that for which the restraint or medication is authorized by a physician licensed in California who is providing medical care to the elder or dependent adult at the time the instructions are given.
    3. For a purpose not authorized by the physician.

5. Neglect means the negligent failure of any person having the care or custody of a dependent adult to exercise that degree of care which a reasonable person in a like position would exercise. This includes:
    1. Failure to assist in personal hygiene

2. Failure to provide food, clothing, or

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3. Failure to provide medical care for physical and mental health needs.
4. Failure to protect from health and safety hazards.
5. Failure to prevent malnutrition or dehydration

6. Self-neglect means the failure of the person themselves to exercise the degree of care that a reasonable person in a like position would exercise.
    1. Self-neglect also applies if the person fails in the items listed in 2.4.1-2.4.5 due to ignorance, illiteracy, incompetence, mental limitations, substance abuse or poor health.
7. Abandonment means the desertion or willful forsaking of an elderly/dependent adult by anyone having care of or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.
8. Financial abuse occurs when a person or entity takes, secretes, appropriates or retains (or assists another to do so) real or personal property of an elder/dependent adult to a wrongful use or with intent to defraud or both. A person or entity shall be deemed to have taken, secreted, appropriated, or retained for a wrongful use faith.if, among other things, the person did so in bad faith. A person or entity shall be deemed to have acted in bad faith if the person knew or should have known that the elder/dependent adult had the right to have the property transferred or made readily available to the elder/dependent adult or to his/her representative. A representative is a conservator, trustee, or other representative of the estate of an elder/dependent adult, or an attorney-in-fact acting within the authority of the power of attorney (W&I Code Section 15610.35).
9. Isolation means:
    1. Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elderly or dependent adult from receiving his/her mail or telephone calls.
    2. Falsely telling a caller or prospective visitor that the elderly or dependent adult is not present or does not wish to talk or meet with the visitor and is made for the purpose of preventing an

elderly or dependent adult from having contact with family, friends or concerned persons.

3. False imprisonment.
4. Physical restraint for the purpose of preventing an elderly or dependent adult from meeting with visitors.

10. Mental suffering means fear, agitation, confusion, severe depression, or other forms of serious emotional distress that Is brought about by forms of intimidating behavior, threats, harassment, or by deceptive acts performed or false or misleading statements made with malicious intent to agitate, confuse, frighten, or cause severe depression or serious emotional distress of the elder/ dependent adult (W&I Code Section 15610.53).
11. Treatment with resulting physical harm or pain or mental suffering.
12. Deprivation by a Care Custodian of goods or services that are necessary to avoid physical harm or mental suffering.
13. Abduction means the removal from California and the restraint from returning to California, or the restraint from returning to California of someone who does not have the capacity to consent to the removal from California and the restraint from returning to California, or the restraint from returning to California, as well as the removal from California, of any conservatee without consent of the


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14. Care Custodian is defined as an administrator, employee, or volunteer of the UCLA Resnick Neuropsychiatric Hospital & Institute including persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff.

15. Health practitioner means a physician, psychiatrist, psychologist, dentist, resident, intern, licensed nurse, social worker, occupational therapist.

16. Adult protective services agency means a county welfare or social department.

3. Physician shall report by telephone and in writing to the police and L.A. County Health Department, within 36 hours, of the fact of any patient received from a health facility or community care facility who exhibits a physical injury or condition which, in the opinion of the examining physician reasonably appears to be the result of neglect or abuse.

    1. RN, LVN, or LCSW may make the report if in his/her opinion the patient's injury or condition reasonably appears to be the result of abuse or neglect. However the physician must confirm this opinion as required for mandatory reporting.

4. The reporting duties are individual, and no supervisor or administrator may impede or inhibit the reporting duties and no person making such a report shall be subject to any sanction for making the report.

5. No mandated reporter who reports a known or suspected instance of elder or dependent adult abuse shall be civilly or criminally liable for any report required or authorized under California Welfare and Institutions Code Sections 15600 (Ref: WIC, Section 15634).

6. Any mandated reporter who fails to report an instance of elder/dependent adult abuse which he or she knows to exist or reasonably should know to exist, is guilty of a misdemeanor and shall be punished by imprisonment in the county jail not exceeding six month, by a fine of not exceeding $1,000.00 or by both fine and punishment (Ref: WIC, Section 15634 (d)). Any mandated reporter who willfully fails to report, where that abuse results in death or great bodily injury, is punishable by not more than one year on a county jail or by fine and imprisonment (Ref. WIC, Section 15630(h)).

1. The duty to report is incumbent on each person with actual knowledge of the abuse. This duty, however, may be discharged by the report of one individual made on his/her behalf and that of others.

7. Reports made under the law are confidential and may be disclosed only to the agencies specified. Violation of the confidentiality provisions is a misdemeanor, punishable by imprisonment in the county jail not exceeding six months, by a fine of not more than $500 or both fine and imprisonment (Ref. WIC, Section 15633, 15633.5 and 15634).
8. If the suspected or alleged abuse has occurred in a long-term care facility (e.g. nursing/community home, residential facility) except a state mental health hospital or a state developmental center, the report must be made to the local long term care ombudsman or the local law enforcement agency.
9. If the suspected or alleged abuse has occurred in a state mental health hospital or a state developmental center, the report must be made to designated investigators of the State Department of Health, or the State Department of Mental Health, or to the local law enforcement agency.
10. If the suspected or alleged abuse has occurred in any other place described in policy #8, the report must be made to Adult Protective Services.
    1. A physician, registered nurse, or psychotherapist as defined in Evidence Code Section 1010 is not required not report an incident where all the following conditions exist:
        1. The mandated reporter has been told by an elder or dependent adult that he/she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse or neglect; and
        2. The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred; and
        3. The elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of court-ordered conservatorship because of a mental illness or dementia; and
        4. In the exercise of clinical judgment, the mandated reporter believes that the abuse did not occur.
11. In situations of extreme physical danger or violence, the report shall be made directly to Campus Police, in addition to mandated agencies.

PROCEDURE:

1. The health care practitioner/care custodian who reasonably suspects, observed, or has actual knowledge of a known or suspected instance of dependent adult abuse immediately makes a telephone report to the Los Angeles County Department of Public Social Services by telephone, 800-992-1660, followed by a written report within 2 working days.
    1. The person suspecting abuse/neglect may contact the RNPH SCAAN representative.

1. SCAAN consultation is available Monday – Friday, 9am – 5pm, pager #95818.

2. The agency to contact if the person resides in Los Angeles County is as follows or call agency for referral to another California cachement area:

   Fax report to: 213-738-6485
   Mail original report to:
   Adult Protective Services

Los Angeles County Community and Senior Services
3333 Wilshire Blvd., Suite 400
Los Angeles, California 90010

3. The telephone report includes:
    1. Name of person making the report;
    2. Name, address, and age of the elder or dependent adult;
    3. Nature and extent of the elder or dependent adult's condition;
    4. Date of the incident;
    5. Present location of the elder or dependent adult;
    6. Information that led reporting person to suspect elder or dependent adult abuse.
    7. Names and addresses of family members or any person responsible for the elder or dependent adult's care.
4. The written report includes:
    1. Reporting party,
    2. Name, address, and age of the elder or dependent adult;

3. Nature and extent

of the elder or

dependent P adult's condition; Y

4. Date of the incident;
5. The present location of the elder or dependent adult;
6. Information that led the reporting person to suspect elder or dependent adult abuse.
7. Brief narrative, explanation or clarification of any information pertinent to the incident.

5. In those cases where there is suspected sexual assault or rape, the patient should be physically examined within 72-96 hours. Arrangements should be made to transport an inpatient, accompanied by clinical staff (Refer to RNPH Policy #7003) to the Emergency Room at the Santa Monica UCLA Medical Center, 1250 16th Street, Santa Monica, CA 90404, (310) 319-4503 (after hours (310)
319-4000 request Therapist-On-Call). Partial Hospitalization patients and outpatients should be referred to an Emergency Room or Rape Treatment Center.
    1. Prior to transportation, a clinical staff member provides a general overview of the physical examination with the patient and documents this discussion, including the patient's willingness to receive a physical examination at the Santa Monica UCLA Medical Center, in the Electronic Health Record.
        1. The victim has the right to the presence of a sexual assault victim counselor and one support person.
        2. A victim of sexual assault shall be informed that he or she may refuse to consent to an examination for evidence of sexual assault, including the collection of physical evidence, but that such a refusal is not a grounds for denial of treatment of injuries and for possible pregnancy and venereal disease, if the person wishes to obtain treatment and consents thereto.
        3. A victim of sexual assault must be informed that he/she may withdraw consent at any time for any portion of the evidentiary examination.

2. Signatures are obtained on the TEMPORARY ABSENCE RELEASE FORM.
3. The following are notified:
    1. Attending Physician
    2. Nurse Manager/Nursing OD
    3. Campus Police
    4. Adult Protective Services
4. Provide Santa Monica UCLA Medical Center with the following patient information:
    1. Patient's first and last name
    2. Home address
    3. Home and work telephone numbers
    4. Social Security number
    5. Date of bi
    6. Age
    7. Law Enfor ement Age y, if any, and cont ct person

6. After the physical exam ination is performed, the patient shall be transpo rted back to INSTRUCTIONS: completed Santa Monica UCLA Medical Center SEXUAL ASSAULT AFTERCARE
    1. Patient's condition upon return is documented in the Electronic Health Record (EHR).
7. A report is completed in the EHR for each victim and each incident of suspected elder or dependent adult abuse and a copy is placed in the medical record.
8. Where the elder or dependent adult is subject to extreme physical danger or violence, the report shall be made directly to Campus Police, Ext. 51491.
9. When two or more persons are required to report are present and jointly have knowledge of a known or suspected instance of abuse of an elder or dependent adult and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected members of the reporting team.
    1. Any member required to make a report who has knowledge that the member designated to make the report has failed to do so thereafter makes the report.

2. The Physician reports by telephone and in writing to the police and L.A. County Health Department, within 36 hours, of the fact of any patient received from a health facility or community care facility who exhibits a physical injury or condition which, in the opinion of the examining physician, reasonably appears to be the result of abuse or neglect.
    1. Reports must state character and extent of physical injury or condition.
    2. Mail written report to police and L.A. County Health Department.
3. If the elder or dependent abuse incident involves a hospital employee inflicting physical abuse,

abandonment, abduction, isolation, financial abuse, or neglect upon a patient, notification must be made immediately to the Department of Licensing, Accreditation and Policy. Based on individual review of the nature of the case, it will be reported to the California Department of Public Health pursuant to Title 22, Section 70737 "Reporting".

4. HIPAA requires that all disclosures for purposes other than for Treatment, Payment or Health Care

Operations must be tracked and logged by UCLA Healthcare (so that it may be able to provide an accounting of such disclosures to patient upon request). All requests for disclosures to third parties must be referred to the Privacy Management Office for handling, except as otherwise provided in UCLA Healthcare Privacy Policy #202. Certain individuals or departments within UCLA Healthcare may, however, be permitted to disclose PHI to third parties directly provided they:

a. Have been authorized by the Privacy Officer to do so by completing a specialized privacy training program; or
b. Have an individual legal obligation to report and make the report pursuant to such legal authority in accordance with UCLA Healthcare policies and procedures; and
c. The individual with the legal obligation to report (such as that of a Mandated Reporter) must notify the Privacy Management Office of the report by completing the form "Mandatory Reporting of Protected Health Information" so that the disclosure can be included in UCLA Healthcare's PHI Tracking system.

Be specific in completing this form. You must state that PHI was released in connection with mandatory reporting of Elder/Dependent Adult Abuse. (This facilitates protection of the patient when providing an accounting of disclosures to patient representatives).

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REFERENCES

CHA CONSENT MANUAL
CALIFORNIA PENAL CODE 368
CALIFORNIA WELFARE AND INSTITUTIONS CODE, SECTIONS 15600, 15602, 15610, 15630, 15631, 15632, 15633, 15633.5, 15634, 15635, 15637, AND 15701 JOINT
COMMISSION MANUAL FOR HOSPITALS

REVISION HISTORY

APPROVAL

Robert Suddath, MD
Chief of Staff
Resnick Neuropsychiatric Hospital at UCLA

Thomas Strouse, MD
Medical Director
Resnick Neuropsychiatric Hospital at UCLA

Attachments

Temporary Absence Release

Effective Date:	March 18, 2008
Revised Date:	June 9, 2017

Indicators of Abuse

Approval Signatures

Step Description	Approver	Date
RNPH Professional Staff Executive Committee (RNPSEC) Meeting	Sherri Martin: Admin Anl Prn 1	6/19/2017
Nursing Leadership	Patricia Matos: Dir [SM]	6/19/2017
	Thomas Strouse: Prof Of Clin-Hcomp [SM]	6/19/2017

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Next Review:	*7/10/2022*
Owner:	*Thomas Strouse: Prof Of Clin-Hcomp*
Policy Area:	*Care of Patients*
Reference Tags:	
Applicability:	*Resnick Neuropsychiatric Hospital*

Tarasoff Warnings to Law Enforcement, NPH 1621

PURPOSE:

To state the policy of the Resnick Neuropsychiatric Hospital to notify individuals and law enforcement agencies of the identity of hospital patients who present a serious danger of violence to a reasonably foreseeable victim(s).

POLICY:

OPY

1. When a patient, in the opinion of his or her psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims, the psychotherapist must take actions to protect any such foreseeable victims, including but not limited to:
    1. Notification, including disclosure of the patient's name and any other needed information, to law enforcement within 24 hours of the psychotherapist's determination. Law enforcement includes UCLAPD and/or any other state or federal law enforcement agencies as may be appropriate under the circumstances.
    2. Notification to the foreseeable victim or victims of the name of the patient and the nature of the threat.
    3. The report should be made by telephone when possible, followed by a written letter documenting the telephone report. The Electronic Health Record (EHR) should reflect the date and time and recipient of these notifications.
2. If reasonably possible, the psychotherapist should consult with University legal counsel before making a disclosure in accordance with this policy. However, if counsel is not immediately available, then the psychotherapist shall immediately take appropriate steps as set forth herein.
3. The psychotherapist shall release to law enforcement all information and records that will assist in the identification and capture of the patient, as well as in the identification and location of any foreseeable victim(s).
4. The information to be released to law enforcement and/or the foreseeable victim(s) shall be limited to that which is required to protect such foreseeable victim(s). Protected patient information and other confidential information shall be appropriately redacted as necessary to ensure that only that information reasonably necessary to protect the foreseeable victims is released in accordance with applicable law.
5. The term "psychotherapist" for purposes of this policy means any licensed physician who practices psychiatry, licensed psychologists, licensed clinical psychiatric social workers, a school psychologist, and

a licensed marriage and family therapist. Where an unlicensed trainee is the primary provider of care, it is the responsibility of the licensed supervisor to assure the enactment of the elements of this policy.

6. Nurses and any other treatment staff shall inform the attending physician or the physician in charge of the service of any patient whose conduct falls within the provisions of policy statement #1.
7. The following information shall be documented in the medical record:
    1. Attempts or actual notification to the foreseeable victim(s) and law enforcement.
    2. Confidential information disclosed to the foreseeable victim(s) and law enforcement).

FORMS

None

REFERENCES

TARASOFF V. THE REGENTS OF THE UNIVERSITY OF CALIFORNIA (1976) 17 CAL.3D 425
Ewing v. Goldstein, PhD, 2004 DJDAR 8707 (7/20/04) WELFARE
AND INSTITUTIONS CODE, SECTION 5328 (S) EVIDENCE CODE,
SECTION 1010

CALIFORNIA BUSINESS AND PROFESSIONS CODE,

SECTIONS 2911, 2913, 2909(d), 4980.03, 4980.40, 4980.44, 4996.20

CALIFORNIA HOSPITAL ASSOCIATION CONSENT MANUAL

REVISION HISTORY

APPROVAL

Aaron Kaufman,
MD Chief of Staff
Resnick Neuropsychiatric Hospital at UCLA

Thomas Strouse, MD
Medical Director
Resnick Neuropsychiatric Hospital at UCLA

Attachments

No Attachments

Effective Date:	July 20, 1987
Revised Date:	July 23, 2019

Approval Signatures

Step Description	Approver	Date
RNPH Professional Staff Executive Committee (RNPSEC) Meeting	Sherri Martin: Admin Anl Prn 1	7/11/2019
Nursing Leadership	Patricia Matos: Dir [SM]	7/11/2019
	Thomas Strouse: Prof Of Clin-Hcomp [SM]	7/11/2019

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Community Expectations: Responding to Discrimination in the Clinical and Research Setting

Table of Contents

Purpose (Section 1) 1

Definitions (Section 2) 1

General Procedure (Section 3) 2

Tools for Communication (Section 4) 5

Response to Discriminatory Patient Requests

For Changes in Personnel (Section 5) 6

Response to Trainee Requests for Reassignment (Section 6) 7

Additional Resources (Section 7) 7

Appendix A: Expanded Definitions of Protected Characteristics (Section 7.1.1) 7

Appendix B: Relevant University, VAMC, and Health Center Policies (Section 7.2) 10

Appendix C: Decision Tree to Address Discriminatory Conduct

in Patients/Participants (Section 7.3). 12

Appendix D: Decision Tree to Address Patient Requests

for Alternative Provider/Personnel (Section 7.4). 13

Appendix E: Additional Communication Tools (Section 7.5) 13

Appendix F: Implicit Bias (Section 7.6) 15

Appendix G: Additional Resources Related to Race (Section 7.7) 15

Appendix H: Additional Resources Related to Sex, Gender, & Sexual Orientation (Section 7.8) 15

Appendix I: Additional Resources Related to Culture and Ethnicity (Section 7.9) 16

Appendix J: Additional Resources Related to Marital Status

and Service in the Uniformed Services (Section 7.10.) 16

Appendix K: Supervisor Checklist for Responding to Discriminatory Events (Section 7.11) 16

Appendix L: Program Director/Principle Investigator Checklist

for Responding to Discriminatory Events (Section 7.12) 18

Appendix M: Upstander Checklist for Responding to Discriminatory Events (Section 7.13) 18

Community Expectations: Responding to Discrimination in the Clinical and Research Setting

1. PURPOSE

The purpose of this document is two-fold:

1.1. First, to describe the shared expectations for the members of our Psychiatry communities for responding to discrimination (including faculty, staff, residents, fellows, postdoctoral- internship- and practicum-trainees, other students, and volunteers), across settings (both clinical and research) both on campus and at affiliated educational/clinical sites outside of UCLA Health.

1.2. and second, to guide an appropriate response to reporting and remediating discriminatory or harassing conduct directed towards community members, patients, or research participants (their family members, visitors, or patient representatives) based on those individuals' protected characteristics, as it pertains to education, training, employment, and patient care.

These expectations apply to *all forms* of discrimination and provide a template to help guide personnel in both managing discriminatory or harassing behavior, and requests from discriminatory patients/participants for provider/personnel reassignments.

These expectations do not supersede, but rather supplement, existing departmental, hospital, and other University policies that pertain to responding and reporting of incidents of discrimination based on an individual's protected characteristics (see 7.2.Appendix B).

2. DEFINITIONS

Protected characteristics: race, color, ethnicity, ancestry, national origin, citizenship, religion, sex, gender [expression/identity/transition status], sexual orientation, physical or mental disability, medical condition [pregnancy, cancer-related or genetic characteristics, genetic information/family medical history], marital status, age, body habitus, political affiliation, or service in the uniformed services (see 7.1.1.Appendix A).

Psychiatry Community Members/Personnel: UCLA-Semel and UCLA NPIH faculty, staff, administrators (and all other clinical supervisors and educators who interface with trainees), trainees (Psychiatry residents, fellows, post-doctoral students, interns, practicum students, other students engaged in training in programs under the direction of the UCLA Department of Psychiatry), and volunteers, engaged in the course of education, research, and/or clinical practice.

Patients/Participants: Any individual seeking medical/clinical care or participating in research protocols at UCLA or an affiliated training or treatment site. For the purpose of this policy we will use these terms interchangeably and include patient/research participant family members, visitors, or patient representatives in this same category.

Affected Individual: person(s) or personnel who are the ***target*** of biased behavior from a either a member of our community, patients/research participants and their family members, visitors, or patient representative.

<u>Observer/Upstander</u>: person(s) or personnel ***who directly or indirectly observes an incident of discriminatory or harassing behavior*** toward another a member of our community, patients/research participants, family members, visitors, or patient representative.

Discrimination: unfair or prejudicial treatment towards someone due to their protected identity characteristics.

Discriminatory conduct: inappropriate behavior based on an individual's protected or social identity characteristics, including, but not limited to: microaggressions (comments, epithets, slurs, negative stereotyping), suggestions of lack of competence, unwillingness to be treated, displays of offensive materials, or unwelcome physical contact.

Harassment: Harassment is unwelcome conduct, including verbal, nonverbal, or physical conduct, based on any protected categories that is *sufficiently severe, pervasive, or persistent* that it adversely affects a person's employment or education or creates an environment that a reasonable person would find to be intimidating, hostile, abusive, or offensive.

Communication Scripts: are *non-punitive but corrective statements* that reinforce institutional values and personnel/patient expectations in a particular setting, in this case setting firm limits against the use of discriminatory hate speech. (see 4.Tools for Communication; and 4.1.Appendix E for example communication guides).

3. PROCEDURE: Discriminatory Behavior perpetrated by a patient/participant

3.1. **Initial Assessment:** While any act of discrimination should be responded to, it is imperative to consider the patient's: severity of illness, decision-making capacity, level of functioning (or, in children, developmental factors), and other clinical or environmental context which may influence their response.

3.1.1. **Assess and address safety concerns -** Patient and community members safety are the primary concern when responding to discriminatory acts, and all appropriate steps should be taken to ensure the safety of all persons involved in or responding to such events.

3.1.2. **Assess the patient's medical condition** (see 7.3.Appendix C):

3.1.2.1. Unstable - if the patient's condition is unstable, then they must receive stabilizing treatment. If an unstable patient is requesting reassignment, then other clinical staff may be permitted to conduct any necessary evaluation or treatment required to stabilize the patient.

3.1.2.2. Stable - if the patient's condition is stable, then the behavior should be addressed as below.

3.1.3. **Assess the patient's decision-making capacity -** (see 7.3. Appendix C) If the person is stable, their decision-making capacity should be assessed by an attending clinician (or most senior member of the team).

3.1.3.1. Lacks Capacity - clinical personnel should address their discriminatory conduct or reassignment request on a case-by-case basis to ensure patient/participant and staff safety.

3.1.3.2. Capacity is established - the discrimination incident should be addressed as below.

3.2. Immediate Response:

3.2.1. **Address discriminatory conduct with the perpetrator -** UCLA Health patients, as well as their family members, representatives, and visitors, are expected to recognize and respect the rights of other patients, visitors, *and staff* as outlined in the Patient Responsibilities guide. (https://www.uclahealth.org/patient-experience/patient-responsibilities). Patients should be reminded of this responsibility. If the

affected individual feels comfortable, and if appropriate to the specific circumstance, the affected individual can respond directly to the offending individual using a communication script (see: 4.Tools for Communication, and 7.5.Appendix E). The

discussion should: a) identify the specific behavior that is problematic; b) the behavioral change that is expected, and c) the consequences of not making these changes.

If the affected individual does not feel comfortable to respond directly, or if this is potentially unsafe or otherwise inappropriate to the circumstance, the affected individual may opt to end the interaction and contact their supervisor/attending clinician/principle investigator for immediate assistance.

Upstander/Observer Response: Community members who witness the discriminatory behavior or are in the vicinity, and able to respond, should immediately take an active role in managing the situation by:

a) Assessing the affected individuals' and patients' safety and taking any necessary steps to ensure the safe management of all parties during and after the event.

b) and supporting the affected individual's statements, using the most clinically appropriate response (directed towards the patient or perpetrator); or intervening with the patient/perpetrator directly (as needed), to provide education and set firm limits against the use of discriminatory behaviors.

3.2.1.1. Patient non-compliance: If the behavior continues the clinical management staff should remind the offending individual of their responsibility not to engage in discriminatory conduct, and their right to seek treatment elsewhere. If the behavior persists, then the clinical management staff (or supervisor, whichever is most clinically appropriate) should contact the UCLA Health Office of the Patient Experience (or other office relevant to that clinical site) for guidance on how to address the patient's behavior; and the supervisor should follow existing clinic/unit policies regarding discharge or transfer of care to another facility (see 7.2.1.2.5. Termination of Patient-Provider Relationships). If the patient's behavior causes team members to feel unsafe, then security should be involved.

3.2.2. **Report the Event** - The affected individual should report the event, both to their supervisor *and* to the appropriate office: UCLA Safety Opportunities for Improvement Reporting System (http://sofi.ucla.edu/) *and* UCLA Office of Civil Rights (https://equity.ucla.edu/report-an-incident/); or the Veterans Affairs Joint Patient Safety Reporting System (https://www.patientsafety.va.gov/about/index.asp);

3.2.2.1. Trainees - If the affected individual is a trainee, the burden of reporting the event to institutional offices lies solely with the supervising faculty/staff member. The trainee may assist in filing the report, if they feel comfortable; however the supervisor is responsible for ensuring a report is filed in a timely manner *and* reporting the event to the Director of Training or Division Director.

3.2.3. **Provide Support for Affected Personnel** (see 3.3.4.University Resources)- It is the *supervisor's responsibility* to debrief with the affected individual

immediately after the event (or, if the affected individual prefers at a different time). The affected individual should be given the opportunity to call a significant other (friend or family) to receive support, and supervisors should offer to assist them with these calls. Supervisors should provide referrals to the most appropriate campus office(s) for additional support.

3.2.4. **Document the Event:** Discussions with the patient should be documented in the medical record, as appropriate. Likewise, supportive interventions for the affected individual should also be documented in an appropriate record for that individual/setting.

3.3. Post-Incident Response:

3.3.1. **Role of Supervisor -** The supervisor is primarily responsible for: supporting and de- briefing with the affected individual; ensuring that an incident report was filed with the appropriate office in a timely manner; following up with the patient (as described above) and notifying leadership about the event (the Program Director, and Director of Training, or Adversity-Resiliency Officer as needed). The identity of the affected individual can be protected and reports can be made anonymously (without fear of repercussion); reports will be handled sensitively, prioritizing the requests and needs of the affected individual.

3.3.2. **Role of Program Director -** The Program Director will confirm that above steps have taken place; notify Vice Chair of Justice, Equity, Diversity, and Inclusion of the incident; and determine the affected individual's needs including both practical (such as work coverage, if necessary) and emotional (meeting with the affected individual and assessing their needs, including possible referrals for support services; and/or setting up a process group or morbidity/mortality conference for staff). They will also arrange for a transfer of care, if needed. Likewise, they ae expected to liaison/refer to UCLA Office of Civil Rights (CRO) and/or risk management/legal if necessary; and determine what longitudinal follow-up with the affected individual (or community members) would be appropriate and provide ongoing support as needed.

3.3.3. **Role of Adversity-Resiliency Officer-** In the event that the Program Director is unavailable; each setting should appoint an adversity-resiliency officer for that clinic/setting, that will assume all of the duties of the Program Director specified above.

3.3.4. University Resources

3.3.4.1. Counseling and Support - UCLA undergraduate and graduate students can seek care through the UCLA Counseling and Psychological Services Center (https://counseling.ucla.edu); medical students can seek counseling through the Bruin Wellness Center (https://medschool.ucla.edu/bwc); faculty and staff may receive counseling through the Faculty and Staff Counseling Center (https://www.chr.ucla.edu/employee-counseling/counseling-consultation), or UCLA Behavioral Health Services using their health benefits (https://www.semel.ucla.edu/npbhs).

3.3.4.2. Title IX Office (https://sexualharassment.ucla.edu/) provides additional information and resources related to discrimination on the basis of sex, gender, or pregnancy status.

3.3.4.3. UCLA Omsbuds Office (http://www.ombuds.ucla.edu/) - provides guidance for resolving conflicts between community members, disputes or complaints, on an informal basis. In order to afford visitors the greatest freedom in using its services, the Office is

independent, neutral and confidential.

3.3.4.4. Office for Equity, Diversity and Inclusion (https://mednet.uclahealth.org/hedi/) - Office for Equity, Diversity and Inclusion provides additional tools for altering the culture of the workplace to be more inclusive and supportive for all members of the community.

4. TOOLS FOR COMMUNICATION

There are a number of tools for confronting discrimination, microaggressions, and bias in the clinical, research and training settings (see 7.5.Appendix E for additional templates and models). Below are *example* communication scripts (adapted from Williams and Rohrbaugh, and Souza, et al.). It is recommended that you familiarize yourself with these scripts and personalize them for your setting. These guides work best if practiced with colleagues, loved ones, or friends.

Once internalized, they can be more readily used. Remember to intervene as an upstander/ally. Our community expectation is that all of us must respond. Waiting for someone in a marginalized group to speak up is a minority tax. If someone says something that upsets you or someone around you, *intervene*.

4.1. Example Communication Script for Confronting Discrimination from a Patient/Participant:

"We do not use language or behavior like that in our hospital/clinic/program/laboratory. UCLA has clear guidance regarding patient responsibilities/The Veteran's Administration has a clear Code of Integrity and Patient Responsibilities, and racist [or sexist, ageist, anti- Muslim, homophobic, etc.] or other disrespectful communication and harassment of anyone in this hospital/clinic/program/laboratory will not be tolerated [and this applies to family members and visitors as well]. Our teams and the patients/people we serve are made up of individuals from many backgrounds. Since we want to provide the best care/experience for you, you must stop using that language or engaging in [X behavior] if you are to remain a patient/under our care here."

4.2. Example Communication Guide for Confronting Discrimination from a Colleague/Psychiatry Community Member: *"O-WTF-D"*

O - Observe. Call the incident to the person's attention by making an observation.

Ask the speaker to elaborate on what that said:

"I noticed that you said_____."

"Can you tell me more about what you mean by_____?"

W - "What did you mean?" Ask the person questions to understand their intent, which underscores the importance of reflection on this incident:

"What did you mean?"

"Can you tell me more about what you mean by

_____?
" "How to others respond to that phrase?"

T - Think. Share your thoughts about this incident. You can also share your experiences from past related incidents, if comfortable.

"I think that term is disrespectful and alienating and should not be used anywhere, especially in the workplace."

"that comment has a great deal of history, one that has been used other and marginalized people who identify as_."

"Because I hear this every day, the cumulative impact of it makes me___."

F - Feel. Share how this incident and/or past related incidents affect you.

"I feel uncomfortable moving forward with clinical supervision right now."

"When you said_[comment]_, I felt__and that matters to me because [describe impact]_."

"I changed supervisors after they kept saying_. It was so distressing that I couldn't work with them anymore."

D - Desire. Express a specific action or change that you would like to see.

"I would like to discuss this with you more at a later time."

"I can tell this affects others in the room. If people are comfortable, could you please share your thoughts?"

"I would like you to acknowledge how what you said affects me and our whole clinical team. All of us should use respectful and inclusive language in the workplace."

"You cannot say_____to me."

"I ask that you refer to my patient/participant using the phrase ____."

5. RESPONDING TO DISCRIMINATORY PATIENT REQUESTS FOR CHANGE IN PROVIDER/PERSONNEL

It is UCLA Health policy that "requests for changes of provider or other medical staff based on that individual's race, ethnicity, religion, sexual orientation, or gender identity will not be honored. Requests for provider or medical staff changes based on gender will be considered on a case-by-case basis and only based on extenuating circumstances" (see 5.1.1.Appendix D).

5.1.1. Decision making process:

5.1.1.1. **Evaluate the nature of the request -** determine whether patient's request involves implicit or explicit bias by the patient, versus a desire for racially, culturally, or linguistically concordant care; religious or cultural considerations (e.g., Muslim women requesting female clinicians); and whether there may be other clinical or ethical concerns.

5.1.1.2. **Evaluate the effect on the provider -** determine the potential effects on the provider if such a request were to be honored (e.g., potential of inadvertently allying with a patient's/participant's expression of bias against the provider). Likewise, as long as patient/participant safety and continuity of care are ensured, a provider should never be forced to remain in a provider-patient relationship that involves racism, or other forms of discriminatory

behavior that they feel causes them emotional or physical trauma. Providers should be clearly informed that
their decision to participate or not in the patient's/participant's care will not impact evaluation of their performance.

5.1.1.3. **Proceed collaboratively -** Faculty/staff supervisors should *never* act on a patient's/participant's request to change providers without first consulting with
the clinician/community member who is currently providing care/supervision for that patient. Such decisions should be made collaboratively with the clinician/community member.

5.1.1.4. **Consult with leadership as needed** - Supervisors should contact the Program Director or Director of Training if relevant questions arise

6. RESPONDING TO TRAINEE REQUESTS FOR REASSIGNMENT FOLLOWING A DISCRIMINATORY INCIDENT

6.1. **Patient considerations** - As long as patient safety and continuity of care are ensured, a provider or patient/participant should never be forced to remain in a provider-patient relationship that involves racism, or other forms of discriminatory behavior that they feel causes them emotional or physical trauma.

6.1.1. Patients should be advised of the change by the supervising clinician or Program Director, whichever is most appropriate, prior to the first meeting with new provider.

6.2. **Trainees considerations** - Trainees should be clearly informed that their decision to participate or not in the patient's/participant's care will not impact evaluation of their performance.

6.2.1. Trainees should not unilaterally terminate care for a patient without first discussing it with their supervisor. Such requests should be handled collaboratively.

6.3. **Considerations if the Supervisor is the perpetrator of a discriminatory act -** Trainees should not be forced to remain in a supervisor-supervisee relationship that involves racism, or other forms of discriminatory behavior that they feel causes them emotional or physical trauma.

6.3.1. Both the trainee and the supervisor should meet, separately, with the Program Director and the head of the clinic or PI/Research Director to discuss the incident and determine the most appropriate solution.

6.3.2. Reporting of the incident/act of discrimination will follow the same process as outlined above.

6.3.3. If the supervisor is the head of the clinic or program or lab, then the Chief Psychologist or Division Director should take part in the above meetings. Likewise, if the Division Director is the perpetrator, then the Department Chair or Vice Chair should be involved in the meeting and discussion process.

6.4. **Consultation** - Community members should contact the Program Director (or appropriate faculty member, as above) if relevant questions arise.

7. ADDITIONAL RESOURCES

7.1.1. APPENDIX A: EXPANDED DEFINITIONS OF PROTECTED CHARACTERISTICS

Sex: Includes, but is not limited to, pregnancy; childbirth; medical conditions related to pregnancy, childbirth, or breast feeding; gender; gender identity; and gender expression, or perception by a third party of any of the aforementioned.

Sex Discrimination[1]: is prejudice or discrimination based on one's sex. Sexism can affect anyone, but it primarily affects women and girls. It has been linked to stereotypes and gender roles and may include the belief that one sex is intrinsically superior to another.
[1]Discrimination on the basis of sex, gender, and sexual orientation are often interrelated. Here we separate them out for the purpose of clarity, with the understanding that individuals whose gender identity/status or sexual orientation or their biological sex falls into one or more minority group(s) may place them at greater risk for prejudice, harassment, and discrimination.

Gender: The sex of a person, including a person's gender identity, and gender expression**.**

Gender Expression: A person's gender-related appearance or behavior, or the perception of such appearance or behavior, whether or not stereotypically associated with the person's sex assigned at birth.

Gender Identity: Each person's internal understanding of their gender, or the perception of a person's gender identity, which may include male, female, a combination of male and female, neither male nor female, a gender different from the person's sex assigned at birth, or transgender.

Transgender: A general term that refers to a person whose gender identity differs from the person's sex assigned at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as "transsexual."

Gender Transition: The process some transgender people go through to begin living as the gender with which they identify, rather than the sex assigned to them at birth. This process may include, but is not limited to, changes in name and pronoun usage, facility usage, participation in employer-sponsored activities (e.g. sports teams, teambuilding projects, or volunteering), or undergoing hormone therapy, surgeries, or other medical procedures.

Gender Discrimination: is discrimination based on the observer's perceived incongruity

between a person's gender identity and their sex assigned at birth, or failure to conform to cisgender norms or stereotypes.

Sexual Orientation Discrimination: includes prejudice, discrimination, and violence on the basis of sexual orientations that are non-heterosexual, and includes homosexuality and bisexuality, and asexuality.

Race: is a social concept, based neither in genetics or biology, but encompasses social and cultural characteristics of a group of people as well as ancestry.

Color: refers to skin tone and has predominately been used to distinguish white from non-white people or (erroneously) as a marker of race based on physical appearance/phenotype.

Racial Violence: "racial violence" is used, in accordance with published recommendations, to signal that incidents of racial violence warrant decision-making algorithms and communication scripts that are designed for urgent and severe incidents, analogous to those used in cases of physical violence in the workplace.

Ethnicity: is a self-ascribed identity with a group of individuals based on shared attributes that distinguish them from other groups such as a common set of traditions, ancestry, language, history, society, culture, nation, and religion.

Ancestry: is a complex construct describing a general connection to people in the past from whom you have descended based on genetic, cultural, or geographical characteristics.

National Origin/Nationality: is a legal identification of a person in international law establishing the person as a subject, or a *national*, of a sovereign state.

Citizenship: refers to the legal status and relation between an individual and a state that entails specific legal rights and duties.

Religion: is a social-cultural system of designated behaviors and practices, morals, beliefs, worldviews, texts, sanctified places, prophecies, ethics, or organizations, that relates humanity to supernatural, transcendental, and spiritual elements. Religious discrimination: is treating a person or group differently because of the particular beliefs which they hold about a religion. This includes instances when adherents of different religions, denominations, or non-religions are treated unequally due to their particular beliefs, either before the law or in institutional settings.

Disability: is a physical or mental impairment (or medical condition, such as cancer, HIV/AIDS, etc.) that substantially limits one or more major life activity (includes, but is not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, sitting, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, and working). This includes people who have a record of such an impairment, even if they do not currently have a disability. It also includes individuals who do not have a disability but are regarded as having a disability.

Ableism: is discrimination and social prejudice against people with disabilities and/or people who are perceived to be disabled. Ableism characterizes people who are defined by their disabilities as inferior to the non-disabled. On this basis, people are assigned or denied certain perceived abilities, skills, or character orientations.

Pregnancy: Includes pregnancy, childbirth, and medical conditions related to pregnancy and childbirth.

Ageism: is discrimination and social prejudice against people based on advancing age. Ageism characterizes these individuals as "set in their ways, unable to change their behavior…ignored or discounted…assumed to be out of touch with popular culture, suffering from memory or physical problems…unworthy of time, attention, or the most innovative medical interventions due to advancing age."

Body habitus: describes the physical characteristics of an individual and include such considerations as physique, general bearing, and body build. Historically, attempts have been made to classify humans into discrete somatotypes (mesomorphic—muscular and

athletic; endomorphic—rounded and stout; and ectomorphic—tall and thin), and to relate habitus to propensity to disease (e.g., habitus apoplectus). These terms have little clinical relevance today, and body size and habitus can be said to encompass the more quantifiable measurements of height, weight, body proportions, skinfold thickness, and mid–upper arm circumference. These measurements do not have true normal or abnormal values but must be interpreted in the context of an individual's age, sex, clinical status, and previous measurements. The values can be plotted as a percentile of a reference population or as a percentage of an "ideal" value:

- *Height* is the length from the plantar surface of the foot to the crown of the head. Heights that fall below the 3rd percentile or above the 97th percentile may require investigation.
- *Weight* is the total weight of the body. Weights greater than 120% of "ideal" suggest obesity, while weights less than 70% of "ideal" may indicate severe malnutrition.
- *Mid–upper arm measurements* are taken at the midpoint between the acromial process and the olecranon process.
- *Skinfold thickness* at this site is a measure of subcutaneous fat and is used to estimate total adiposity. Obesity is indicated by a value greater than 23 mm in men and 30 mm in women. Severe depletion of energy stores is indicated by values below the 30th percentile.
- *Mid–upper arm circumference* is used to calculate *mid—upper arm muscle circumference*. Muscle circumferences less than the 30th percentile suggest severe depletion of protein stores.

Marital Status: is the legally defined marital state. There are several types of marital status: single, married, widowed, divorced, separated and, in certain cases, registered partnership

Service in the Uniformed Services: Includes service in the uniformed services as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as well as state military and naval service. Discrimination on the basis of military status largely involves denying equal employment opportunity to any person because of that person's past, current or future membership, service, or obligation in a uniformed service. In the medical system, it may involve the withholding of services or differential treatment based on their current or past participation in the armed services.

Protected Veteran: A veteran who is protected under the non-discrimination and affirmative action provisions of the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended; specifically, a veteran who may be classified as a "disabled veteran," "recently separated veteran," "active duty wartime or campaign badge veteran," or an "Armed Forces service medal veteran," as defined by 41 CFR 60-300.2.

7.2. APPENDIX B: RELEVANT UNIVERSITY, VAMC, AND RNPH POLICIES

7.2.1.1. **UCOP Policies:**

7.2.1.1.1. UCOP Non-Discrimination Statement (https://www.ucop.edu/operating-budget/fees-and-enrollments/policies- and-resources/nondiscrimination-

statement.html#:~:text=The%20University%20of%20California%2C%20in,%2C%20marital%20status%2C%20citizenship%2C%20sexual

7.2.1.1.2. UC Code of Conduct and Statement of Ethics (https://www.uclahealth.org/compliance/code-of-conduct)

7.2.1.1.3. UCLA Policy HR 18-0378, "Discrimination, Harassment and Affirmative Action in the Workplace" (https://policy.ucop.edu/doc/4000376/DiscHarassAffirmAction

7.2.1.2. **UCLA Health Policies**

7.2.1.2.1. UCLA Patient Rights and Responsibilities (https://www.uclahealth.org/patient-experience/patient-responsibilities

7.2.1.2.2. HS 3068 "Management of Patient Discriminatory Conduct and Reassignment Requests" (https://uclahealth.policystat.com/policy/9064671/latest/)

7.2.1.2.3. HS 8702 "Aggressive or Threatening Behavior By Patients or Visitors" (https://ucla-ronaldreagan.policystat.com/policy/5144991/latest/)

7.2.1.2.4. HS 8703, "Workplace Violence Prevention Plan" (https://ucla-ronaldreagan.policystat.com/policy/5145152/latest/)

7.2.1.2.5. HS 1462 "Termination of Patient Provider Relationship (https://ucla-ronaldreagan.policystat.com/policy/3248748/latest/)

7.2.1.2.6. HS Policy 7313 "Disruptive Behavior Among Employees" (https://medschool.ucla.edu/workfiles/Site-AcademicAffairs/Events/16.Disruptive-Behavior-Among-Employees.pdf

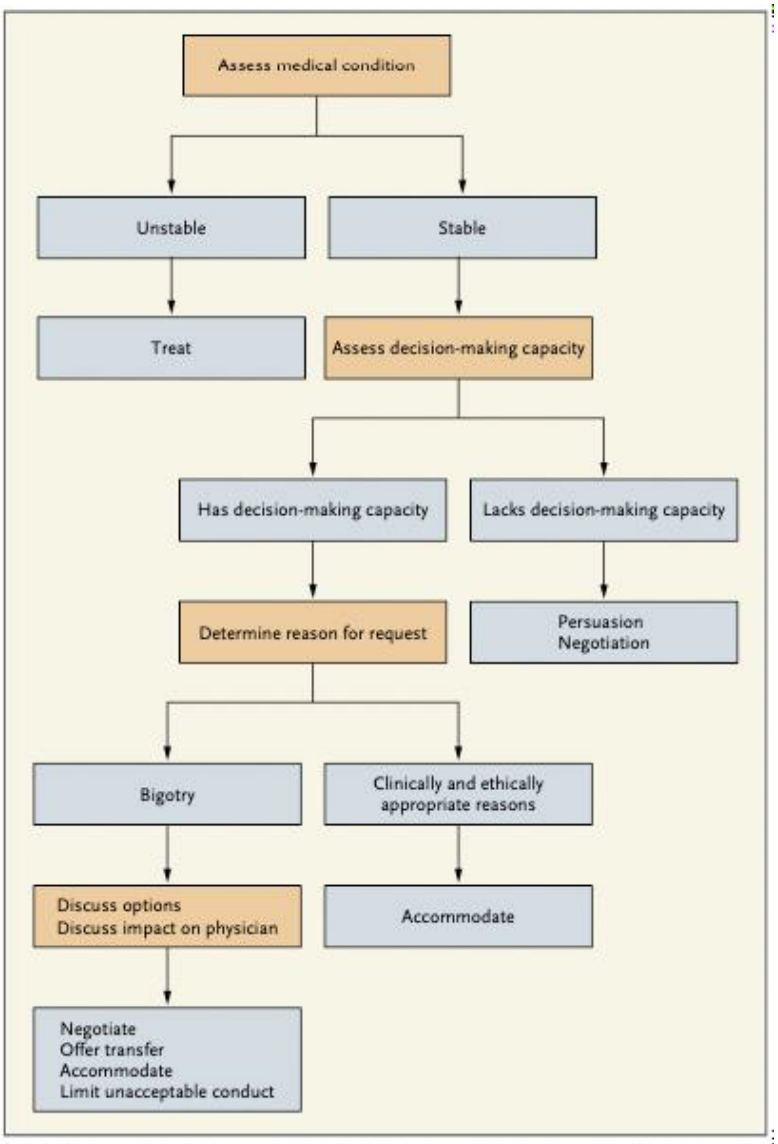
7.2.1.3. **UCLA Resnick Neuropsychiatric Hospital Policies**

7.2.1.3.1. Resnick Neuropsychiatric Hospital Policy 007 (https://www.uclahealth.org/medical-staff/workfiles/policies-rnph/PS%20007%20Initimidating%20and%20Disruptive%20Behavior%20021 52011%20gh.pdf

7.2.1.4. **Veterans Administration Policies**

7.2.1.4.1. Veteran's Health Administration Rights and Responsibilities of VA Patients and Residents of Community Living Centers (https://www.va.gov/health/rights/patientrights.asp);

7.2.1.4.2. Veteran's Health Administration Code of Integrity (https://www.va.gov/HEALTHCAREEXCELLENCE/docs/VHA-Code-of-Integrity- March- 2019-FINAL.pdf);



Considering a Patient's Request for Physician Reassignment Based on Race or Ethnic Background in an Emergency Setting.

Actions in the orange boxes address factors that physicians should consider when confronted with a request to change clinicians because of a clinician's race or ethnic background. Such requests may be deemed to be clinically and ethically appropriate if, for instance, they are motivated by a desire for racial, ethnic, or language concordance or if the patient has specific mental health issues.

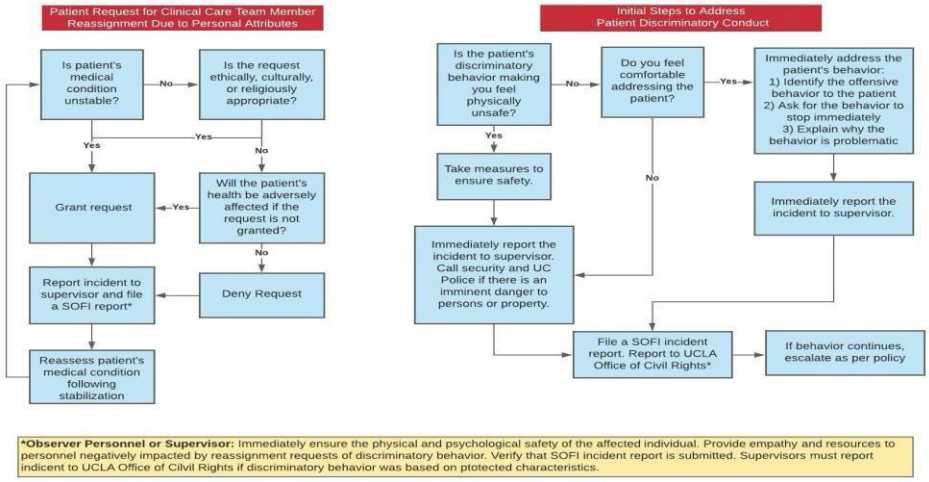
7.3. APPENDIX C: DECISION TREE TO ADDRESS PATIENT DISCRIMINATORY CONDUCT

7.4. APPENDIX D: DECISION TREE TO ADDRESS PATIENT REQUESTS FOR REASSIGNMENT BASED ON PROVIDERS PROTECTED CHARACTERISTICS

Appendix D: Considerations when dealing with racist patients: clinical considerations and reassigning patients based on racial or ethnic background

Workflow as per UCLA Health Policy HS 3067 "Management of Patient Discriminatory Conduct and Reassignment Requests."

Workflow



From Paul-Emile K, Smith AK, Lo B, Fernández A. Dealing with racist patients. New England J. Med. 2016;374:708.

The authors present an algorithm for considering a patient's request for physician reassignment based on racial or ethnic background, starting with the assessment of the patient's medical condition and whether they are stable or unstable. If unstable, it is critical to provide care; if stable then the physician should assess decisional capacity. If the patient lacks decision-making capacity, the authors recommend persuasion and negotiation to continue to provide care for the patient and potentially restore decisional capacity. Barring a medical emergency or impaired decision-making capacity, the authors describe physician wellness should be supported when physicians are subject to racist or racially discriminatory views or behaviors, including latitude to terminate or transfer patient care when other physicians are available to provide those services and when other methods to address the racist or racially discriminatory views or behaviors are ineffective. Excerpts are included below:

7.5. APPENDIX E: ADDITIONAL COMMUNICATION TOOLS AND RESEOURCES

Discrimination, in all its forms, traumatizes and negatively affects to the wellness of both patients and the psychology community. Incidents of discrimination should prompt immediate responses during and after the incident. As outlined in Williams and Rohrbaugh (see: Williams JC, Rohrbaugh RM. Confronting racial violence: resident, unit, and institutional responses. Academic Medicine. 2019 Aug 1;94(8):1084-8):

> *"…the resident and unit staff should feel empowered to name and address the racism and to set limits with the patient in the moment. The purpose of a firm, appropriate, limit-setting communication script is not punitive but corrective, reinforcing the expectations of respect on the unit. For example, using a firm, assertive voice, a resident might say: 'We do not use language like that in our hospital. Our teams are made up of people from many backgrounds, and since we want to provide the best care for you, you must stop using that language.'*
>
> *…Residents should also be taught an arsenal of limit-setting scripts that could be employed when dealing with explicitly racist patients.*
>
> *Although the communication script and clinical approach for racist patients differ from those of the prototypical hateful patient, limit setting is a common therapeutic approach in both. We acknowledge that this approach may be seen as representing a departure from the traditional self-sacrificing, self-denying, objective physician role; for example, Sapién*
>
> *suggested developing an "emotional scotoma" (i.e., blind spot) in response to a racial microaggression so as to focus solely on the patient and their needs. The approach we suggest moves toward a more humanistic approach of thinking about the physician as having a body with valid subjectivity and is, we believe, consistent with recent trends to address physician wellness and burnout."*

Below are a series of articles and communication tools that can be used to guide community members in their shaping both their individual response and site-specific policies/communication scripts:

7.5.1. Resources:

Recognizing Micro-aggressions and the Messages they Send
https://academicaffairs.ucsc.edu/events/documents/Microaggressions_Examples_Arial_2014_11_12.pdf

Practices to disarm and neutralize microaggressions (adapted from: Sue, D. W., Calle, C. Z., Mendez, N., Alsaidi, S., & Glaeser, E. (2021). Microintervention Strategies: What you can do to disarm and dismantle individual and systemic racism and bias. Hoboken, NJ: Wiley)

https://www.uua.org/files/pdf/m/microaggressions_by_derald_wing_sue_ph.d._.pdf

Sotto-Santiago S, Mac J, Duncan F, Smith J. "I Didn't Know What to Say": Responding to Racism, Discrimination, and Microaggressions With the OWTFD Approach. MedEdPORTAL. 2020;16:10971.

UCLA Intergroup Relations Program (www.igr.ucla.edu)

ACTION: Souza T. Responding to Microaggressions in the Classroom: Taking ACTION. Faculty Focus: Higher Ed Teaching Strategies from Magna Publications. 2018 Apr 30. https://www.unmc.edu/academicaffairs/_documents/connected/Take-Action-Against-Microaggression-Infographic-UNMC.pdf

INTERRUPT: DallaPiazza M, Padilla-Register M, Dwarakanath M, Obamedo E, Hill J, Soto- Greene ML. Exploring racism and health: an intensive interactive session for medical students. MedEdPORTAL. 2018 Dec 14;14. https://www.mededportal.org/doi/full/10.15766/mep_2374-8265.10783

OPEN THE FRONT DOOR: Souza T, Ganote C. Open the Front Door: Meeting Microaggressions with Microresistance for Institutional Change? https://www.aacu.org/sites/default/files/files/virtualconference/microaggression- presentation.pdf

7.6. APPENDIX F: IMPLICIT BIAS

Harvard Implicit Bias Test
https://implicit.harvard.edu/implicit/takeatest.html

7.7. APPENDIX G: RESOURCES RELATED TO RACE

From Williams JC, Rohrbaugh RM. Confronting racial violence: resident, unit, and institutional responses. Academic Medicine. 2019 Aug 1;94(8):1084-8 (https://pubmed.ncbi.nlm.nih.gov/30681449/):

"…incidents of racism are not typically incorporated in the current conception of workplace violence. Instead, terms like disruptive or hateful wash over the specific effects of the racial abuse and decontextualize the impact of it, thus allowing for the use of algorithms and communication scripts meant to address disruptiveness (rather than racial violence) that are considered to be "objective" and timeless. We believe that naming the racism as violence and addressing the racism directly may mobilize communication scripts that are more helpful in managing such situations. Naming and addressing the racism represents a decisive confrontation with the nation's legacy of structural racism and an acknowledgment that African Americans, in particular, have been subject to dehumanizing, violent language and stereotypes, and acts of violence, including violence situated in medical settings. Assessing such situations as one of a typical disruptive or difficult patient could result in an ineffective communication script or exacerbation of the racism and represents a violent avoidance, silence, and

complicity to the insidious nature of white supremacy, which is deeply embedded in the structure and culture of medical institutions."

References on racism within healthcare and other systems:

1. Legha RK, Miranda J. An anti-racist approach to achieving mental health equity in clinical care. Psychiatric Clinics. 2020 Sep 1;43(3):451-69.
2. Mensah M, Ogbu-Nwobodo L, Shim RS. Racism and Mental Health Equity: History Repeating Itself. Psychiatric Services. 2021 Jan 12:appi-ps.
3. Jordan A, Shim RS, Rodriguez CI, Bath E, Alves-Bradford J, Eyler L, Trinh N, Hansen H, Mangurian C. Psychiatry Diversity Leadership in Academic Medicine: Guidelines for Success. American Journal of Psychiatry. 2021
4. Boyd RW. The case for desegregation. Lancet. 2019 Jun 22;393(10190):2484-5.
5. Cerdeña JP, Plaisime MV, Tsai J. From race-based to race-conscious medicine: how anti- racist uprisings call us to act. The Lancet. 2020 Oct 10;396(10257):1125-8.
6. Desmond M, Emirbayer M. What is racial domination? Du Bois Review. 2009 1;6(2):335.
7. The Myth of Color Blindness: https://www.apa.org/pubs/books/The-Myth-of-Racial- Color-Blindness-Intro-Sample.pdf

7.8. APPENDIX H: RESOURCES RELATED TO SEX, GENDER AND SEXUAL ORIENTATION

Resources:

APA Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

https://www.apa.org/practice/guidelines/transgender.pdf

UCSF Transgender Center of Excellence
https://transcare.ucsf.edu/guidelines/clinic-environment
https://transcare.ucsf.edu/guidelines/mental-health

7.9. APPENDIX I: RESOURCES RELATED TO CULTURE AND ETHNICITY

Report of the APA Presidential Task Force on Immigration, Executive Summary https://www.apa.org/topics/immigration-refugees/executive-summary.pdf

7.10. APPENDIX J: RESOURCES RELATED TO MARITAL STATUS AND SERVICE IN THE UNIFORMED SEVICES

Resources:

Biases against Single People

https://www.psychologytoday.com/us/blog/living-single/201610/is-there-bias-against- single-people

7.11. APPENDIX K: SUPERVISOR CHECKLIST FOR RESPONDING TO DISCRIMINATORY EVENTS

Initial Assessment:

_**Does the event meet the standard of a discriminating event** (considering patient factors (severity of illness, decision-making capacity, level of functioning, developmental factors), clinical factors environmental context.

_**Assess and address safety concerns** for all present (patient, affected individual, and community members). Involve Security personnel as needed.

_**Assess the patient's medical condition** (see 7.3.Appendix C), and stabilize patient as needed; if the patient is stable proceed with addressing the patient's decision-making capacity.

___**Assess the patient's decision-making capacity** (see 7.3.Appendix C) (typically this assessment is made by attending clinician or most senior member of the team); if capacity is established proceed as below

- *If the person lacks capacity clinical personnel should address their discriminatory conduct or reassignment request on a case-by-case basis to ensure patient/participant and staff safety.*

Immediate Response:

_**Asses affected person's ability to address discriminatory conduct with the perpetrator directly**. If the affected individual feels comfortable, and if appropriate to the specific circumstance, the affected individual can respond directly to the offending individual.

- Supervisor's should support the affected individual's response to the perpetrator, using statements and/or clinically appropriate behavior

_**Address the perpetrator's discriminatory conduct directly** (as above), *or if the affected individual is unable to respond, supervisors should assume primary responsibility for working with the perpetrator.* (see also Tools for Communication and Appendix E; 4)

- Remind the perpetrator of relevant policies regarding the need

to recognize and respect the rights of other patients, visitors, *and staff (i.e.,* Patient Responsibilities guide, or other appropriate policy) (https://www.uclahealth.org/patient-experience/patient-responsibilities**).**

- Identify the specific behavior that is problematic.
- Outline behavioral change that is expected,
- Discuss the consequences of not making these changes.
- Patient non-compliance: remind the offending individual of their responsibility not to engage in discriminatory conduct, and their right to seek treatment elsewhere. If the behavior persists, then contact the UCLA Health Office of the Patient Experience (or other office relevant to that clinical site) for guidance and follow existing clinic/unit policies regarding discharge or transfer of care to another facility (see Termination of Patient-Provider Relationships). If the patient's behavior causes team members to feel unsafe, then security should be involved.

_Report the event to the appropriate office: UCLA Safety Opportunities for Improvement Reporting System (http://sofi.ucla.edu/) *and* UCLA Office of Civil Rights (https://equity.ucla.edu/report-an-incident/); or the Veterans Affairs Joint Patient Safety Reporting System (https://www.patientsafety.va.gov/about/index.asp).

Report the event to the Director of Training or Division Director.

_Provide support for Affected Personnel (see 3.3.4.University Resources)- It is the *supervisor's responsibility* to debrief with the affected individual immediately after the event (or, if the affected individual prefers at a different time).

- Offer the affected individual the opportunity to call a significant other (friend or family) to receive support and assist as needed.
- Provide referrals to the most appropriate campus office(s) for additional support.

_Document the Event. Discussions with the patient should be documented in the medical record, as appropriate. Likewise, supportive interventions for the affected individual should also be documented in an appropriate record for that individual/setting.

Post-Incident Response:

Continue to provide support and de-brief with the affected individual(s) as needed.

- Consider post-incident de-briefing with staff, as warranted
- Work with the Program Director or Principle Investigator to make any necessary arrangements to accommodate the affected individual (i.e., changes in work schedules or duties, arrange for coverage as needed)

Ensure that an incident report was filed with the appropriate office in a timely manner.

_Follow up with the patient/perpetrator (as described above) and make any necessary arrangements for transfer of care/supervision (see also .5, above).

_Notifying leadership about the event (the Program Director, and Director of Training [or Adversity-Resiliency Officer as needed]; or Principle Investigator/Division Director, as appropriate). The identity of the affected individual should be protected and reports can be made anonymously prioritizing the requests and needs of the affected individual.

- Office for Equity, Diversity and Inclusion (https://mednet.uclahealth.org/hedi/) - provides additional tools for altering the culture of the workplace to be more inclusive and supportive for all members of the community.

7.12. APPENDIX L: PROGRAM DIRECTOR/PRINCIPLE INVESTIGATOR CHECKLIST FOR RESPONDING TO DISCRIMINATORY EVENTS

__Confirm with affected individual's supervisor that the procedures for handling the discrimination above steps have taken place.

__Notify Vice Chair of Justice, Equity, Diversity, and Inclusion of the incident

__Determine the affected individual's needs including both practical (such as work coverage, if necessary) and emotional (meeting with the affected individual and assessing their needs, including possible referrals for support services; and/or setting up a process group or morbidity/mortality conference for staff.

__Arrange for a transfer of care/supervision, if needed.

__Liaison/refer to Discrimination Prevention Office and/or risk management/legal if necessary

__Determine and arrange for any longitudinal follow-up, as needed.

7.13. APPENDIX M: UPSTANDER CHECKLIST FOR RESPONDING TO DISCRIMINATORY EVENTS

Community members who witness the discriminatory behavior or are in the vicinity, and able to respond, should immediately take an active role in managing the situation.

___**Assess the affected individuals' and patients' safety,** taking any necessary steps to ensure the safe management of all parties during and after the event

___**Supporting the affected individual's statements,** using the most clinically appropriate response (directed towards the patient or perpetrator); or intervening with the patient/perpetrator directly (as needed), to provide education and set firm limits against the use of discriminatory behaviors (see also Section .4) above

_**Follow-up with the affected individual (or community members) as would be appropriate** and provide ongoing support as needed.

___**Ensure that the Supervisor/most senior member of the Team has been notified of the event.**

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UCLA Health

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Owner:	*William Dunne: Dir*
Policy Area:	*Environment of Care*
Reference Tags:	*Employee Safety, Lippincott, Threat, Violence, Workplace Violence, threat assessment*
Applicability:	*Ronald Reagan, Resnick, Santa Monica, Ambulatory Care*

Workplace Violence Prevention Plan HS- 8703

PURPOSE

Healthcare workers have faced a significant risk of job-related violence and violence continues to increase. This Hospital will provide a means of addressing workplace violence.

PLA C N

OPY

A. The safety and security of UCLA Health personnel (faculty, staff, students, & volunteers), patients and visitors is of vital importance. Therefore, acts or threats of physical violence, including intimidation, harassment or coercion, which in your judgment affects UCLA Health or which occurs on UCLA Health property will not be tolerated.

B. This prohibition against threats and acts of violence applies to all persons involved, including but not limited to UCLA Health personnel, contract and temporary personnel, patients and visitors. Therefore, violations of this policy by any individual on UCLA Health property is considered misconduct and will lead to disciplinary and/or legal action as appropriate.

C. No reprisals will be taken against any employee who reports or experiences workplace violence.

RESPONSIBILITY FOR A WORKPLACE FREE FROM ACTS AND THREATS OF VIOLENCE:

A. All UCLA Health personnel must refrain from engaging in acts of violence and are responsible for maintaining a work environment free from acts or threats of violence.

PROCEDURE

PREVENTION PROGRAM FOR WORKPLACE SECURITY:

A. A prevention program for workplace security will include the following:

1. Complete annual security and safety assessment of hospitals and clinics;
2. Sufficient trained personnel to provide security;
3. Controlling access and freedom of movement;

4. Ensuring adequate security systems including door locks, security windows, physical barriers and restraint systems;
5. Employee training;
6. Effective systems to warn others of a security danger or to summon assistance (i.e., panic buttons);
7. Adequate employee escape routes;
8. Buddy system for specified emergency events.

THE MANAGEMENT RESPONSE TEAM:

A. UCLA Health has established an incident response team which is responsible for the overall implementation and maintenance of the Hospital's Workplace Violence Prevention Plan. Management response team members are management level representatives from the following departments:

1. Human Resources
2. Security Department
3. Risk Management
4. Legal Affairs

5. Administration

OPY

6. Faculty and Staff Counseling
7. Spiritual Care
8. UCLA Police

B. The management response team is headed by Security Services. He/she can be contacted by dialing the page operator x56301.

C. The management response team's duties include, but are not limited to, improving the Hospital's readiness to address workplace violence by:

1. Reviewing past incidents of violence at the Hospital.
2. Reviewing Hospital's readiness to respond to issues of workplace violence.
3. Developing an expertise among management response team members and other appropriate members of management regarding issues of workplace violence.
4. Establishing liaison with local law enforcement and emergency services.
5. Training Hospital personnel.
6. Initial appropriate pre-employment screening of potential Hospital personnel in order to minimize the likelihood of hiring an individual with violent propensities.
7. Establishing and maintaining policies and procedures for dealing with issues of workplace violence among contract and temporary personnel.
8. The management response team may assign all or some of these tasks to other individuals within the Hospital. Nevertheless, the management response team remains ultimately responsible for implementing and maintenance of the Hospital's Workplace Violence Prevention Plan.

MANAGERS AND SUPERVISORS SHALL BE RESPONSIBLE FOR

THE FOLLOWING:

A. Workplace violence prevention training for personnel under their supervision.

B. Assisting management response team with implementing and maintaining the workplace violence program.

C. All Hospital personnel shall obey all approved workplace violence prevention policies.

D. Managers, supervisors and all employees shall be held accountable for reporting all incidents and following-up on violence related reports.

REPORTING REQUIREMENTS:

A. Hospital Personnel:

1. Personnel shall report immediately any acts or threats of violence occurring on Hospital premises to the Security Department, their supervisor, a management response team member or to the Human Resources Department. No employee shall be disciplined or discharged for reporting any threats or acts of violence.

B. Supervisor:

1. Supervisors shall report immediately any acts or threats of violence to the Security Department, their immediate supervisor, management response team member or the Human Resources Department. Supervisors/Managers are additionally required to report the occurrences of each warning sign of violence that they observe (i.e., verbal abuse, aggressive behavior, loitering).

C. Contract Services:

1. Third parties working on Hospital premises, shall be informed of Workplace Violence Prevention requirements by contracting department prior to doing any actual work on Hospital premises.

MEDICAL MANAGEMENT:

A. Employees, who are victims of violence, will be provided with medical and emotional treatment. Employees who are abused by patients, visitors, clients and so on, may experience long- and short-term psychological trauma, post traumatic stress, anger, anxiety, irritability, depression, shock, disbelief, self- blame, fear of returning to work, disturbed sleep patterns, headaches and changes in relationships with family and coworkers.

B. Employees, who have been the victims of violence will receive immediate physical evaluations, be removed from the worksite and treated for acute injuries. Additionally, referrals shall be made for appropriate evaluation, treatment, counseling and assistance both at the time of the incident and for any follow-up treatment necessary.

RECORD KEEPING:

A. Record keeping should be used to provide information for analysis, evaluation of methods of control, severity determinations, identifying training needs and overall program evaluations.

B. Record keeping includes the following:

    1. Entry of injury on the OSHA Injury and Illness Log. Injuries that must be recorded include the following:

2. Loss of consciousness
3. Restriction of work or motions
4. Transfer to another job or termination of employment
5. Medical treatment beyond first aid.
6. All incidents of abuse, verbal attacks or aggressive behavior;
7. Recording and communicating mechanism so that all staff who may provide care for an escalating or potentially aggressive, abusive or violent patient will be aware of the patient's status and of any problems experienced in the past;
8. Gathering of information to identify any past history of violent behavior, incarceration, probation reports or any other information that assists employees to assess violent status;
9. Emergency Department personnel are encouraged to obtain and record information regarding drug abuse, criminal activity or other relevant information;
10. Workers' Compensation and insurance records;
11. Safety Committee Minutes and inspections are kept in accordance with requirements; and
12. Training program contents and sign-in sheets of all attendees are maintained.Start here

REFERENCES

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- UC Statement of Ethical Values and Standards of Ethical Conduct
- UCLA Policy 131, Weapons on Campus
- Faculty Code of Conduct
- Academic Personnel Manual
- Personnel Policies for Staff Members
- UCLA Student Code of Conduct
- UC Sexual Harassment Policy
- UCLA Policy 136: Reporting Child Abuse and Neglect
- UC Whistleblower Policy
- American National Standard – Workplace Violence Prevention and Intervention
- California Code of Civil Procedure Section 527.8
- California Code of Civil Procedure Section 527.6
- Domestic Violence Employment Leave act CAL Labor Code 230.1
- The Federal Equal Employment Opportunity Commission (EEOC)
- California Department of Fair Employment and Housing (DFEH)
- HS Policy 7313, Disruptive Behavior Among Employees
- Cal OSHA Workplace Violence in Healthcare - Section 3342

CONTACT

Threat Management & Work Place Violence Outreach Manager

Approval Signatures

Johnese Spisso, RN, MPA
President UCLA Health
CEO UCLA Hospital System

Carlos Lerner, M.D.
Chief of Staff
Ronald Reagan UCLA Medical Center

Roger M. Lee,
M.D.
Chief of Staff
Santa Monica-UCLA Medical Center and Orthopaedic Hospital

Laurie R. Casaus, M.D.
Chief of Staff
Resnick Neuropsychiatric Hospital at UCLA

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Administration Approval	Johnese Spisso: Ceo Med Ctr [MW]	09/2018
Administration Approval	Carlos Lerner: Assoc Prof Of Clin-Hcomp [MW]	09/2018
Administration Approval	Roger Lee: Hs Clin Prof-Hcomp [MW]	09/2018
Administration Approval	Laurie Casaus: Hs Assoc Clin Prof-Hcomp [MW]	09/2018
Executive Medical Boards - MSEC, RNPH PSEC, SMEMB	M Lynn Willis: Mgr [KK]	09/2018
Hospital System Policy Committee Chair	M. Lynn Willis: Mgr	09/2018
Hospital System Policy Committee	M. Lynn Willis: Mgr	09/2018
	William Dunne: Dir	07/2018

COPY

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Applicability:	*Ronald Reagan, Resnick, Santa Monica, Ambulatory Care*

Management of Patient Discriminatory Conduct and Reassignment Requests HS 3068 (NEW)

PURPOSE

The purpose of this policy is to guide an appropriate response to patient discriminatory or harassing conduct personnel's protected characteristics, such as race, ethnicity, national origin, religion, sex, gender, gender toward UCLA Health personnel (faculty, staff, trainees, students and volunteers) based on the assigned
expression, gender identity, gender transition status, pregnancy, physical or mental disability, medical

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condition, genetic information, ancestry, marital status, age, sexual orientation, citizenship, body habitus,

political affiliation, or service in the uniformed services. This policy also provides guidelines on how to

address

discriminatory-based personnel reassignment requests by patients.

DEFINITIONS

Protected characteristics: race, color, ethnicity, national origin, religion, sex, gender, gender expression, gender identity, gender transition status, pregnancy, physical or mental disability, medical condition (cancer- related or genetic characteristics), genetic information (including family medical history), ancestry, marital status, age, sexual orientation, citizenship, language, body habitus, political affiliation, or service in the uniformed services.

Personnel: UCLA Health faculty, staff, trainees, students, and volunteers

Affected personnel: personnel who are the target of biased behavior from a patient

Observer personnel: personnel who directly or indirectly observes an incident of discriminatory or harassing behavior toward another personnel member

Discrimination: unfair or prejudicial treatment towards someone due to their protected and social identity characteristics.

Harassment: Harassment is unwelcome conduct, including verbal, nonverbal, or physical conduct, based on any of the protected and social identity categories. Harassment is prohibited when it is sufficiently severe, pervasive, or persistent that it adversely affects a person's employment or education or creates an environment that a reasonable person would find to be intimidating, hostile, abusive, or offensive.

Discriminatory conduct: inappropriate behavior based on an individual's protected or social identity characteristics, including, but not limited to: comments, epithets, slurs, negative stereotyping, suggestions of lack of competence, unwillingness to be treated, displays of offensive materials, or unwelcome physical

contact.

POLICY

UCLA Health patients, as well as their family members, representatives and visitors, are expected to recognize and respect the rights of other patients, visitors, and staff Patient Responsibilities. Threats, violence, disrespectful communication, harassment, or other discriminatory conduct towards any UCLA Health personnel, for any reason, including because of an individual's protected and social identity characteristics will not be tolerated Workplace Violence Prevention Plan HS 8703. Consistent with this commitment, UCLA Health is dedicated to protecting patient autonomy and the rights of all personnel to a safe and productive work and learning environment that is free from racism, sexism, discrimination, harassment, and abuse based on their protected characteristics. To meet these obligations, this policy sets forth a process to guide personnel in managing discriminatory or harassing behavior by patients and/or their family, hereafter referred to as "patient", and discriminatory requests for personnel reassignments.

PROCEDURE

A patient's medical condition must be considered when personnel or UCLA Health make decisions regarding a patient's discriminatory conduct or requests for reassignment based on the personnel's

protected characte ristics. When these

circu mstances arise, the affec ted personnel,

observe r personnel, or member of

the clinical management team should intervene immediately to evaluate and address the situation. The

following considerations should be followed when encountering discriminatory conduct or personnel reassignment requests.

A. **Assess Patient's Medical Condition**

Appropriate clinical personnel should evaluate the patient to determine the patient's clinical stability. If the patient is unstable, the patient must receive stabilizing treatment. If an unstable patient demands reassignment based on the assigned personnel's protected identity, other clinical personnel may be permitted to conduct the patient's initial evaluation and stabilization treatment to prevent death or significant harm. Once stabilized, the patient's request for personnel reassignment will be addressed as per the following guidelines.

B. **Responding to Patient Discriminatory Conduct**

UCLA Health is committed to providing the highest quality of care to its patients while also ensuring a safe and respectful work environment for all personnel. If a patient engages in inappropriate discriminatory or harassing behavior, the following protocol should be followed to the extent practicable.

1. *Immediately Address the Discriminatory Conduct*
   The affected personnel, observer personnel, or member of the clinical management team should immediately address the patient's biased behavior (see Appendix A for script responses). Ideally, the most senior personnel present should address the discriminatory behavior and set mutually acceptable expectations for the provision of care based upon the following guidance:
   a. *Affected Personnel*
      If comfortable and practical, the affected personnel should identify the offensive behavior to the offender and request that it stop immediately. In doing so, the affected personnel may discuss the behavior with the offending patient and clarify why the specific behavior is problematic.
      If it is not comfortable or practical for the affected personnel to confront the offending patient directly or if the individual has done so and the discriminatory conduct continues, the

affected personnel should promptly report the behavior to their immediate supervisor or member of the

clinical management team so that they may address the behavior with the patient and report the incident to the UCLA Civil Rights Office.

b. *Observer Personnel*
It is imperative that personnel who witness an incident of patient discriminatory conduct towards other personnel take an active role in identifying the offensive behavior to the offender and request that it stop immediately. In doing so, the observer personnel should discuss the behavior with the patient and clarify why the specific behavior is inappropriate. The patient and their surrogate, family members, representatives, and visitors should be informed that discrimination will not be tolerated at UCLA Health.The observer personnel should promptly report any witnessed incidents of discrimination to their immediate supervisor or member of the clinical management team and ensure that the affected personnel is safe from emotional and/or physical harm.

c. *Incident Reporting*
To facilitate the tracking of incidents, any personnel who has been affected by or witnessed an incident of discriminatory or harassing conduct is highly encouraged to submit an incident report in the UCLA Health RLDatix (SOFI) incident reporting system. Incidents of discrimination should also be reported to the supervisor/manager. Supervisors/manages are obligated to ensure a SOFI report is filed and the incident has been reported to the UCLA Civil Rights Office.

2. *Patient-Personnel Discussion Regarding*

Behavio P *r Expectations* Y

A discussion between the clinical personnel and the patient should be conducted to establish a clear understanding of UCLA Health's policy that prohibits discriminatory or and disruptive behavior. The discussion should include identifying the specific behavior that is problematic, the behavior changes that are expected, and the consequences of not making those changes. Clinical personnel should document these discussions in the medical record as appropriate. If the behavior continues, the clinical management staff should contact the Office of the Patient Experience (OPX) for additional guidance on how to address the patient's behavior.

a. *If the Behavior Expectations Agreement Is Not Followed by Inpatients*
Inpatients, or their surrogates, should be informed by clinical personnel of their responsibility not to engage in discriminatory conduct and their right to seek care elsewhere. If the patient, or surrogate, under circumstances that are non emergent, continues to engage in discriminatory conduct, then discharge as outlined in Aggressive or Threatening Behavior by Patients or Visitors HS 8702 should be considered in consultation with the Office of the Patient Experience and Risk Management. If the patient's behavior causes team members to feel unsafe, security should be involved to manage the situation safely.

b. *If the Behavior Expectations Agreement Is Not Followed by Outpatients*
Outpatients and/or their surrogates should be informed of their right to seek treatment elsewhere if they engage in discriminatory conduct. Depending on the severity of the behavior and/or recurrent inability to follow an established patient care and behavior agreement, personnel should refer to Aggressive or Threatening Behavior by Patients or Visitors HS 8702 for additional management guidelines. The patient may be dismissed and transferred to an outside clinic as per Termination of Patient-Provider Relationship - Dismissal From Care HS 1462.

C. **Responding to Discriminatory Patient Requests for Personnel Reassignments**

To provide the highest quality care to all patients, the organization does not accommodate discriminatory reassignment requests. However, the organization remains available to hear patients' concerns about care and will work tirelessly to provide patients with care of the highest quality. The following outlines how to respond to patient requests for personnel reassignments:

1. *Determine the Reason for the Reassignment Request.*
   Patient requests for clinical personnel changes based on that individual's protected characteristics will not be honored. Requests for provider or medical staff changes based on gender will be considered on a case-by-case basis and only based on extenuating circumstances. If a patient request clinical personnel reassignment, the reason(s) for the request must be determined. Ethical, cultural, or religious appropriate reasons for reassignment include, but are not limited to, requests for gender concordance based on religion or clinically significant conditions such as posttraumatic stress disorder. If the reasons for the patient's request are not clinically, culturally, or ethically justified, the request will be denied. However, UCLA Health will not force any clinical personnel to treat or refrain from providing treatment to a patient who has requested reassignment based on the clinical personnel's protected characteristics that is deemed to be unacceptable.
2. *If the affected clinical personnel wishes to accommodate the patient's reassignment request, the decision is permissible if:*

C O

a. other appropriate medical personnel

are ava P ilable; Y

b. the clinical personnel involved are comfortable with and agree to the decision;

c. accommodations can be made within the practical constraints of providing appropriate care for other patients;

d. procedures are in place to provide institutional support and guidance to the personnel affected;

e. clinical personnel are not required to accommodate a patient's bias-based reassignment request without explicit consent; and

f. the decision does not compromise the provision of quality medical care.

D. **Discriminatory Conduct and Reassignment Requests Involving Students and Trainees**

When patients exhibit discriminatory behavior towards a student or trainee, the following steps should be followed:

1. *Students*

   All incidents of discriminatory conduct towards a student should be immediately reported to the student's immediate supervisor (i.e., attending physician, preceptor) and clerkship director. The immediate supervisor, or other observer personnel, should inform the patient or surrogate of their specific problematic behavior. The student's immediate supervisor should file an incident report via the UCLA Health RLDatix (SOFI) incident reporting system and report the incident to the UCLA Civil Rights Office and the Dean of Students Office.

   Students may continue treating the patient unless they request or consent to reassignment. In all cases, the immediate supervisor should determine how the student wishes to proceed. A student should not be required to provide care to a patient who has caused them emotional harm or trauma. The student should be clearly informed that their decision to participate or not in the patient's care will not impact their evaluation of their performance.

2. *Resident/Fellow Trainees*

All incidents of discrimination towards a trainee should be reported to the trainee's attending physician and their site director or program director. An incident report should also be submitted by the trainee or attending via the UCLA Health RLDatix (SOFI) incident reporting system and to the UCLA Office of Civil Rights. The trainee may continue treating the patient unless they request or consent to reassignment. In all cases, the attending physician or immediate supervisor should determine how the trainee wishes to proceed, including assessing whether is it best for the trainee or attending to inform the patient or surrogate of their specific problematic behavior. A trainee should not be required to provide care to a patient who has caused them emotional or physical trauma. The trainee should be clearly informed that their decision to participate or not in the patient's care will not impact evaluation of their performance.

E. **Support for Affected Personnel**

Support should be offered to all affected personnel when they experience discriminatory or harassing behavior from a patient. Racism, sexism, and other forms of discriminatory behavior can cause significant psychological trauma to the targeted individual and observers. Immediate steps should be taken to ensure the affected personnel feel safe, heard, and supported. When feasible and appropriate, convening a meeting of the personnel involved in the patient's care to discuss the incident, evaluate how the team responded, and discuss how best to address future patient discriminatory conduct can help provide support to all of the personnel and strengthen the team's confidence in responding to discrimination incidents in the future. Individual and team counseling offered by the Office of Health Equity, Diversity, and Inclusion in conjunction with the UCLA Employee Assistance Program, should be offered to the affected care team and the leadership in the specific unit.

F. **Manager or Supervisor Responsibility**

Managers and supervisors have an affirmative duty under this policy to protect personnel from patients' discriminatory conduct and to promptly report to their manager(s) and director(s) any such incidents that they witnessed or become aware of within their own department or another department, regardless of whether the alleged recipient of such conduct makes a formal complaint. The manager or supervisor should also verify that an incident report (SOFI) has been submitted, and if not, submit one. Incidents reported to a supervisor, manager and/or director should verify that a SOFI has been filed and report any complaints of discrimination or harassment to the UCLA Civil Rights Office based on an individual's protected characteristics.

G. **Reporting Procedures and Guidelines**

UCLA Health encourages personnel to report any perceived incidents of patient discriminatory conduct, regardless of the offending patient's identity or position. This policy prohibits retaliation for bringing a complaint of discrimination or harassment pursuant to this policy against any patient. This

policy also prohibits retaliation against a person who assists someone with a complaint of discrimination or harassment or participates in any manner in an investigation or resolution of a complaint of discrimination or harassment. Retaliation includes threats, intimidation, reprisals, and/or adverse actions related to employment.

No person will be adversely affected in their employment or training because of reporting a good-faith complaint of patient discriminatory conduct. All incidents of discrimination directed towards personnel should be immediately reported to the supervisor or manager and an incident report (SOFI) should be submitted to the RLDatix (SOFI) incident reporting system by the affected personnel, observer personnel,

or supervisor. Incidents of discrimination or harassment based on an individual's protected characteristics should also be reported to the UCLA Office of Civil Rights.

H. **Tracking and Data Collection**

Incidents of patient biased behavior and reassignment requests will be tracked via the RLDatix (SOFI) incident reporting system and reported to the Department of Quality and the Office of Health Equity, Diversity, and Inclusion, and the UCLA Civil Rights Office. The RLDatix SOFI reporting portal can be found on the UCLA Health mednet website page. This collected data includes, but is not limited to, the department where the incident occurred, incident response, and personnel support. Tracking and data collection systems for students and trainees will be overseen by educational supervisors and reported both to school and hospital administration.

I. **Data Review**

The Department of Quality and the Office of Health Equity, Diversity, and Inclusion will analyze the data and direct report to appropriate standing committees overseeing relevant matters, including the Disruptive Behavior Committee, UCLA Hospital System Equity Council, and the David Geffen School of Medicine student and graduate medical education leadership. These committees shall review all submitted reports on a regular basis and update health system protocols and policies, as necessary.

Education and Training

OPY

Discriminatory behavior and discriminatory reassignment requests can have a demoralizing effect on personnel. Advance knowledge and training about UCLA Health policies and procedures will better prepare personnel to determine the appropriate course of action in these challenging situations. Accordingly, this policy will be included in regular personnel and trainee education programs. These trainings will be designed to enhance personnel knowledge and skills for identifying discriminatory behavior with the intent of reducing the common tendency to overlook these aggressions; increase awareness of available supports; enable personnel to effectively manage patient discrimination interactions; and understand the need and processes for reporting incidents.

Cross References

HS 1354: Patient Rights and Responsibilities

HS 1462: Patient-Provider Relationship - Dismissal from Care

HS 8702: Aggressive or Threatening Behavior by Patients or Visitors

HS 8703: Workplace Violence Prevention Plan

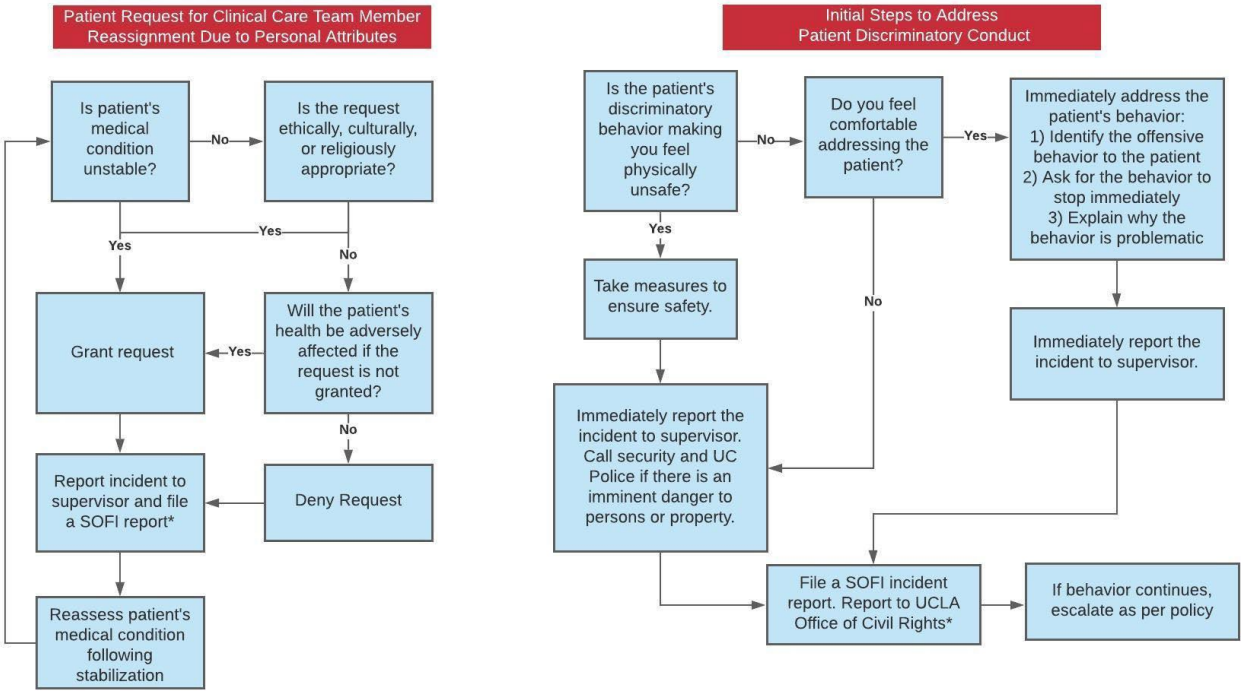
Appendix A: Scripted Responses to Discriminatory Conduct and Requests for Reassignment

Example Responses to Discriminatory Comments or Behavior	Example Responses to Discriminatory Reassignment Requests
• "Help me understand your comment."	• "Help me understand your request."
• "Words/comments such as that can be viewed as offensive. I/we ask	• "We are here to help you as a team. We do not change doctors/nurses/etc. because of

that you	their race/
do not use that word/comment again.	ethnicity/religion, etc.
• "UCLA Health is a place of healing and respect. We do not tolerate words or behavior such as that."	• "All UCLA Health team members are very qualified. Our top priority is that you receive the best care, and I know that our team members can provide that."
• "One of UCLA Health's core principle is to treat everyone with respect and dignity. We do not tolerate disrespectful or offensive comments/behavior."	• "We are confident in each of our team member's ability to provide you with exceptional care. We do not honor requests to reassign people based on their race/ethnicity/sexual orientation/etc."

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Workflow



***Observer Personnel or Supervisor:** Immediately ensure the physical and psychological safety of the affected individual. Provide empathy and resources to personnel negatively impacted by reassignment requests of discriminatory behavior. Verify that SOFI incident report is submitted. Supervisors must report indicent to UCLA Office of Cilvil Rights if discriminatory behavior was based on ptotected characteristics.

REFERENCES

HS 1354: Patient Rights and Responsibilities

HS 1462: Patient-Provider Relationship - Dismissal From Care

HS 8702: Aggressive or Threatening Behavior by Patients or Visitors

HS 8703: Workplace Violence Prevention Plan

Paul-Emile, Kimani, et al. "Addressing patient bias toward health care workers: recommendations for medical centers." *Annals of internal medicine* 173.6 (2020): 468-473.

Warsame, Rahma M., and Sharonne N. Hayes. "Mayo Clinic's 5-Step Policy for Responding to Bias Incidents." *AMA journal of ethics* 21.6 (2019): 521-529.

CONTACT

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Administration Approval- President and CEO, UCLA Health	Johnese Spisso: Ceo Med Ctr [FD]	4/29/2021

Ronald Reagan Medical Staff Executive Committee- Chief of Staff	Carlos Lerner: Prof Of Clin-Hcomp [FD]	4/29/2021
Santa Monica Medical Staff Executive Committee- Chief of Staff	Roger Lee: Hs Clin Prof-Hcomp [FD]	4/29/2021
Resnick Neuropsychiatric Medical Staff Executive Committee- Chief of Staff	Aaron Kaufman: Hs Assoc Clin Prof-Hcomp [FD]	4/29/2021
Hospital System Policy Committee Chair	Fiona Dunne: Adm Crd Ofcr [KK]	3/1/2021
Policy Owner	Medell Briggs-Malonson: Hs Asst Clin Prof-Hcomp	2/15/2021

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Patient Responsibilities

As a patient of UCLA Health, you have the following responsibilities:

Healthcare is a shared responsibility. Engaging in discussion, asking questions, seeking information, and exploring alternatives improves communication and understanding of one's health and treatment.

- Patients, as well as their family members, representatives and visitors, are expected to recognize and respect the rights of our other patients, visitors, and staff. Threats, violence, disrespectful communication or harassment of other patients or of any medical center staff member, for any reason, including because of an individual's age, ancestry, color, culture, disability (physical or intellectual), ethnicity, gender, gender identity or expression, genetic information, language, military/veteran status, national origin, race, religion, sexual orientation, or other aspect of difference will not be tolerated. This prohibition applies to the patient as well as their family members, representatives, and visitors.
- In addition, requests for changes of provider or other medical staff based on that individual's race, ethnicity, religion, sexual orientation or gender identity will not be honored. Requests for provider or medical staff changes based on gender will be considered on a case by case basis and only based on extenuating circumstances.
- To respect the rights and property of other patients and UCLA Health personnel. Just as you want privacy, a quiet atmosphere and courteous treatment, so do other patients. You have the responsibility to follow the organization's rules and regulations, limit your visitors, follow smoking regulations, and use the telephone, television, and lights courteously so that you do not disturb others.
- Following Safety Policies
- Patients and their families or visitors are expected to:
    - To prevent accidental fire due to ignition of a patient's administered oxygen therapy, do not bring any smoking materials (cigarettes/tobacco in any form, electronic cigarettes ["Vaping"], matches, lighters, battery recharger for electronic cigarettes,) into a patient's room.
    - Refrain from conducting any illegal activity on UCLA property. If such activity occurs, it will be reported to the police.
    - Refrain from recording your experiences in the hospital without the consent of everyone involved including Medical Center physicians, nurses, and other staff. Please Note that unauthorized recording violates California state law.
    - For the safety of all patients, visitors, faculty, staff, and students, do not bring any weapons onto health system property including but not limited to guns, knives, pepper spray (or similar), or tazers/stun guns.
- To report to your physician, and other healthcare professionals caring for you, accurate and complete information to the best of your knowledge about present complaints, past illness, hospitalizations, medications, unexpected changes in condition and other matters relating to

your health as well as to provide a copy of your advance directive or POLST to be filed in your medical record, if applicable.

- To seek information about your health and what you are expected to do. Your healthcare provider may not know when you're confused or uncertain, or just want more information. If yunderstand the medical words they use, ask for a simpler explanation.
- The most effective plan is the one to which all participants agree and that is carried out exactly. It is your responsibility to tell your health care provider whether or not you can and want to follow the treatment plan recommended for you.
- To ask your healthcare provider for information about your health and healthcare. This includes following the instructions of other health team members, including nurses and physical therapists that are linked to this plan of care. The organization makes every effort to adapt a plan specific to your needs and limitations.
- To continue your care after you leave UCLA Health, including knowing when and where to get further treatment and what you need to do at home to help with your care.
- To accept the consequences of your own decisions and actions, if you choose to refuse treatment or not to comply with the care, treatment, and service plan offered by your healthcare provider.
- To keep appointments with your healthcare provider. If you need to cancel an appointment, you should do so at least 24 hours before your appointment time.
- To assure that your financial obligations for your healthcare fulfilled by paying bills promptly. Late payments increase overall charges. You are responsible for working with your account representative to make payment arrangements and for providing the information necessary to determine how your hospital bill will be paid.
- To follow UCLA Health rules and regulations affecting patient care and conduct.
- To be considerate of UCLA Health facilities and equipment and to use them in such a manner so as not to abuse them.
- Any abusive or disrespectful behavior could result in dismissal from UCLA care or a visitor being barred from visitation.

If you have any questions regarding these Patient Responsibilities, please contact:

- Ronald Reagan UCLA Medical Center, Office of the Patient Experience (Inpatient/Ambulatory Care) 310-267-9113
- UCLA Santa Monica Medical Center, Office of the Patient Experience (Inpatient/Ambulatory Care) 424-259-9120
- Stewart and Lynda Resnick Neuropsychiatric Hospital at UCLA, Patient Relations 310-267-9092
- These Patient Rights combine Title 22 and other California laws, The Joint Commission and Medicare Conditions of Participation requirements.

These Patient Rights combine Title 22 and other California laws, The Joint Commission and Medicare Conditions of Participation requirements.

REMEDIATION PLAN

The UCLA Semel Institute Psychology Internship Program has a goal of providing you with the best training possible. There have been aspects of your performance that raise concern for the minimum level of achievement for an intern at this point in the year. Our hope is that a remediation plan will help you develop the skills necessary for the satisfactory completion of the internship. You are more than welcome to give us feedback, in writing or verbally, if you have any suggestions in how we may improve your training.

Intern: _____

Issue/s to be addressed:

_____

_____

Contributing factors to the issue/s, if any (e.g. insufficient prior training, absence):

_____

_____

Prior actions that have been taken to improve this issue:

_____

_____

GOAL #1:

ACTION PLAN:

DELIVERABLE:

GOAL #2:

ACTION PLAN:

DELIVERABLE:

GOAL #3:

ACTION PLAN:

DELIVERABLE:

Date: _____

_____

Intern signature

_____

Supervisor signature

_____

Advisor signature

_____

Internship Director

Approval Request for Conference Travel under UC Policy on Travel Regulations (G-28)

To allow adequate time for review and approval, requests for prior approval must be submitted to the program at least 60 days in advance of the presentation or in advance of the submission of materials for consideration of payment/fee for registration.

For details on items eligible for reimbursement, please reference UC Policy
https://policy.ucop.edu/doc/3420365/BFB-G-28

* Required

Name *

Your answer

Internship/Fellowship

___ Psychology Internship Program

___ Postdoctoral Fellowship in Neuropsychology

___ Postdoctoral Fellowship in Clinical Psychology

Conference Name and Location

Your answer

Description of Submission including co-authors and mentor.

Your answer

Description of how this submission relates to professional development

Your answer

Please list any funding sources (awards, PI, travel grants). Financial support/scholarship may be applied to defray travel and registration expenses.

Your answer

Dates of Expected Travel

Your answer

Clinical Rotation at Time of Conference

Your answer

Expected Plan for Clinical Coverage

Your answer

Latest Provider and Staff Information

The following is the latest information on our services and how to obtain them:

- Vendor over-the-phone (*310-267-8001 option 3*) and video-remote (*blue Cyracom iPad carts*) interpretation services remain accessible 24/7.
- Additionally, UCLA staff interpreters are available via MyChart Video Visit, Zoom, and telephone:

Spanish

- UCLA staff Spanish interpreters are available Monday through Friday, 8:00 am to 5:00 pm, to provide service via MyChart Video Visit, Zoom, and telephone.

Whenever possible, please submit requests 48 hours in advance.

  - If you need a Spanish staff interpreter for a MyChart Video Visit or Zoom meeting taking place during business hours, please submit the online request form.
  - If you need a Spanish interpreter for a scheduled Zoom meeting after-hours, including weekends, a request needs to be submitted in advance using the online request form, during business hours, Monday through Friday, 8:00 am to 5:00 pm.

Languages Other than Spanish (including American Sign Language)

- Interpretation services for MyChart Video Visits are currently not available for languages other than Spanish. We suggest converting these encounters to phone or Zoom if an interpreter is needed.
- If you need an interpreter for a scheduled Zoom meeting in a language other than Spanish (including after-hours and weekends) a request needs to be submitted in advance using the online request form, during business hours, Monday through Friday, 8:00 am to 5:00 pm.
- Click here for information on regulations and guidance on communicating with Deaf, Deaf/Blind, and Hard of Hearing Patients and their Caregivers.

Interpretation Services for Last-minute Zoom Meetings

- Interpretation services for last-minute Zoom meetings are available Monday - Friday, 8:00 am - 5:00 pm in the following languages: Spanish, American Sign Language, Arabic, Cantonese, Mandarin, Russian, and Vietnamese. To obtain this service, please contact us at 310-267-8001 and select option 1.

****For critical or exceptional cases where an in-person interpreter is imperative to the communication, please contact us.**

Contact Information

- Click here to access the Interpreter Request Form
- Telephone: (310) 267-8001

- Email: interpreters@mednet.ucla.edu

Additional Resources

- MyChart Video Visit Tip Sheet
- Hoja informativa para videoconsultas por MyChart - Español
- Language Services Policy - *coming soon*

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GUIDELINES OF USING INTERPRETER SERVICES

Helpful information from Brenda Bursch, Ph.D.

Video Tele-Interpreting

This should be your first choice for translation services. The service is available through our partnership with the Health Care Interpreter Network (HCIN). There are more than 200 qualified medical interpreters online within the HCIN network, providing Spanish, American Sign Language, Arabic, Armenian, Cambodian, Cantonese, Farsi, Hindi, Hmong, Korean, Lao, Mandarin, Mien, Russian, Spanish, Thai, Tongan, Vietnamese and more. Ask bedside nurse about equipment availability.

Telephone Interpretation

This is the quickest way to access service, although sometimes calls get dropped and you have to call back in. Call from bedside phone. You will need the patient's name, medical record number and location.

How to Request an in-Person Interpreter

- Identify patient's language. If unknown, please use the language card.
- Schedule interpreters by completing the interpreter request form online, by email or by fax to x47924, at least 48hrs in advance.
- For Deaf and Hard of Hearing patients schedule in advance by calling (310) 267-8001.
- For unforeseen medical interpreter needs during office hours, call extension x78001.
- Off hours and holidays, contact the page operator at (310) 825-6301.

Priority is given to emergency situations, then to scheduled appointments, and then to same day requests.

<u>Information you will need when calling Interpreter Services</u>:

1. Extension/telephone # of the location where the patient will be seen
2. Last & first name of the patient
3. Specific clinic name where the patient will be seen
4. Location of the appointment & room number
5. Patient medical record number
6. Name of the clinician who will be seeing the patient
7. Estimated duration of appointment
8. Time of the appointment

How to End a Call or Video Session with an Unhelpful Interpreter

Thank them for their service, end the call, and then call back for a different interpreter. Report any problems encountered to interpreters@mednet.ucla.edu, along with the name/ID number of the individual.

If You Speak Spanish

Callinterpreters@mednet.ucla.edu to set up a 30-minute language proficiency assessment (to demonstrate basic conversational Spanish competency) in order to be certified to speak Spanish to patients.

Use of Family Members as Interpreters

UCLA Hospital System may not require a patient to use friends, minor children, or family members as interpreters. However, some patients may feel more comfortable when a trusted family member/friend acts as an interpreter. A patient's desire to use an interpreter of his/her own choosing must be respected. If there are concerns regarding the use of a family member or friend serving as the interpreter (i.e. conflict of interest or lack of competency) the Medical Center can request that a qualified interpreter be utilized to ensure accurate interpretation. Children under the age of 15 are prohibited to act as interpreters in medical settings. Children between the age of 15 and 18 may be used as interpreters in emergency circumstances only. It is recommended that providers and staff document the use of an interpreter (or that the family declined use of an interpreter) in the EMR when using on-site, over-the-phone or video interpreters.

Tips: Below you will find tips on how to properly work with an interpreter in a medical setting.

Before seeing the patient:

· If you are unfamiliar with the interpreter, ask if he/she will be interpreting simultaneous or consecutively. (Below find an explanation of the terms.)

Once inside:

· ALWAYS address the patient, and not the interpreter.

· Strive to maintain eye contact with your patient. Although sometimes challenging when an interpreter is present, this will establish that YOU are the clinician, and are interested in the PATIENT, not the interpreter. Your interpreter should also reinforce this by not holding side conversations with the patient and directing any questions to YOU.

· Never make side comments about the patient. You never know how much the patient can understand.

The conversation:

Simultaneous: The interpreter interprets the dialogue immediately after it is spoken.

Consecutive: The interpreter retains what is said in his/her memory and relays it back once the person pauses or stops speaking. When working with consecutive interpretation, you must:

· Speak at a reasonable pace. Allow time for the interpreter to do his/her job.

· Do not interrupt the interpreter while he/she is speaking.

· Do not expect interpreter to clarify information or explain what you say. Mean what you say and say what you mean.

AND YOU SHOULD NEVER:

· Ask patients to bring their own interpreter. This is a violation of federal law.

· Use another patient to interpret.

· Use unqualified staff to interpret.

· Use children to interpret.