CAARE Center
Clinical Psychology Training Program
Department of Pediatrics
UC Davis Children's Hospital
An APA-Accredited Internship Program

Training Program Description

The University of California, Davis CAARE Center Clinical Psychology Training Program offers a one-year predoctoral internship opportunity for students who have attended APA-accredited clinical or counseling psychology programs. For the 2015-2016 training year, there will be two separate training opportunities.

CAARE Center Internship (4 positions)
Psychology interns can receive training and supervised experience in Parent-Child Interaction Therapy (PCIT), Trauma-Focused Cognitive Behavior Therapy (TF-CBT), psychological evaluations, child welfare evaluations, Infant Mental Health Therapy, intake assessments, individual and group therapy, and consultation to local agencies. Most CAARE Center clients range in age from 2 to 18 years, although adults are seen for family treatment, individual therapy, and evaluations.

Trauma-Adolescent Mental Illness Internship (2 positions)
Psychology interns in this tract will receive training in Trauma-Focused Cognitive Behavioral Therapy and assessment and treatment of early psychosis based upon Family-Aided Assertive Community Treatment (FACT) model. Trainees will spend approximately 50% of their time at the CAARE Center receiving training and supervised experience in TF-CBT and psychological evaluations with children and adolescents seen for trauma. Trainees will also spend 50% of their time at SacEDAPT receiving training and supervised experience in the assessment and treatment of early psychosis.

The Training Program, which subscribes to a practitioner-scholar model, emphasizes knowledge of current research to guide assessment and intervention. Psychology interns develop competency in empirically supported treatments and make presentations on current research. In summary, the Clinical Psychology Training Program is a challenging and dynamic internship program with the goal of training ethical and competent future psychologists in the fields of clinical psychology and child maltreatment who will contribute both to the welfare of society and to the profession.

The CAARE Center

The CAARE Center (Child and Adolescent Abuse, Resource, Evaluation Diagnostic and Treatment Center) is an integral part of the Department of Pediatrics of the University of California, Davis Children's Hospital and School of Medicine. The mission of the CAARE Center is to provide superior clinical service to children and families, engage in clinical research, and provide training in the areas of child maltreatment and family violence. Training of pre/post doctoral clinical psychology students and other health professionals has been a longstanding priority. The CAARE Center has been

recognized at the local and national levels as a model program for the evaluation and treatment of child maltreatment.

For over 20 years, the CAARE Center has been committed to offering high quality psychological treatment for abused and neglected children. Approximately 35% of clients are African-American, 33% European-American, 25% Hispanic, and 7% other ethnicities. Although presenting problems typically include a history of abuse, neglect and/or exposure to domestic violence, there is a broad range of presenting diagnoses in both children and parents, including mood disorders, anxiety disorders, adjustment disorders, disruptive behavior disorders, substance dependence, and personality disorders.

Ongoing research and training projects at the CAARE Center include a state funded project to provide crisis intervention and stabilization services for child victims of trauma, a California Emergency Management Agency (CalEMA) grant to develop and coordinate a Trauma-Focused Cognitive Behavior Therapy program, and grants to provide training and consultation in Parent-Child Interaction Therapy at designated mental health clinics throughout California, the United States, and even worldwide. In addition, the CAARE Center has received a DOJ grant to provide services for youth at risk or with history of sexual exploitation and provide training for professionals who work with these youth.

SacEDAPT Clinic

The EDAPT clinic started in 2004 with Dr. Cameron Carter and two additional staff. The program has expanded into two clinics-the SacEDAPT clinic, which provides early psychosis care to underserved families in Sacramento County, and the EDAPT clinic, which continues to provide early psychosis care to families with private insurance.

The University and the Medical Center

The University of California, Davis is one of ten University of California campuses. UC Davis was established in 1908 and the UC Davis School of Medicine in 1965. The UC Davis Medical Center is an integrated, academic health system encompassing a 530-bed acute care hospital, ambulatory care clinics, and an 800-member physician group. The Medical Center is one of five University of California teaching hospitals and is consistently ranked among the top ten medical schools and the top fifty hospitals in the country. The health system cares for approximately 9,000 adults and children each year and provides more charity care than any other hospital in the region. As the primary clinical education site for the School of Medicine and the only area provider of many medical services, the medical center plays an important part in the health and well-being of Northern California and has a major economic impact in the area.

The CAARE Center is located in two locations including the Medical Center campus which encompasses 140 acres in central Sacramento, three miles from the state Capitol, and 20 miles from the main UC Davis campus. SacEDAPT is located near the main hospital. Specialized clinical centers within the health system include the Cancer Center, Children's Hospital, Heart Center, M.I.N.D. Institute, Center for Health and Technology, Pediatric Neurology Program, and Trauma Center. The CAARE Center falls under the auspices of UC Davis Children's Hospital.

The Sacramento Community

Sacramento, California's capitol, is a relaxed, tree-filled suburban city which offers a variety of interesting and distinct activities. With a population of approximately 1.8 million, the Sacramento area provides multiple opportunities for historical, cultural, and recreational outings. Sacramento's rich historical heritage, revitalized in Old Sacramento, includes the Gold Rush era, as well as pioneering work in the mine and railroad industries. Culturally, Sacramentans enjoy theater, art museums, concerts, dance, the world's largest Dixieland Jazz Jubilee, and the recently opened UC Davis Mondavi Center for the Performing Arts. Hiking, cycling, boating, swimming, and other outdoor activities are readily enjoyed in this area of numerous parks, open spaces, two major rivers, and a lake. Professional sports teams including the Kings (basketball), and River Cats (baseball) call Sacramento home. It is this wealth of activities that contributed to *Newsweek* magazine naming Sacramento one of the ten best cities in the United States. In addition, Sacramento's rich ethnic and cultural diversity earned it *Time* magazine's "Most Diverse City" designation several years ago.

Sacramento is conveniently located near a number of Northern California's other beautiful areas. San Francisco is approximately 1½ hours southwest of Sacramento. The Napa and Sonoma Wine Country is within an hour's drive northwest, and Lake Tahoe is approximately 1½ hours northeast of the Capitol City.

APPOINTMENT, STIPEND, AND BENEFITS

Appointment

Four applicants are typically accepted for internship per year for the CAARE Center internship. Two applicants will be accept for the Trauma-Adolescent Mental Illness Tract. The internship begins following application and concludes on in mid July of the following year. This is a July 1st, and is a full-time, 40-hour per week appointment. Clinical moonlighting is not permitted.

Stipend

The stipend for the 2015-2016 training year is $24,000 for the CAARE Center Internship. The stipend for the Trauma-Adolescent Mental Illness Tract is $22,032. Applicable federal and state taxes and social security deductions are withheld.

Benefits

Medical insurance is available under a variety of medical plans for the CAARE Center Internship. Approximately three weeks of vacation, all federal holidays, and five days of extended sick leave are offered. Interns receive time to attend the PCIT conference for professional development (if held in Sacramento). Additionally, interns are provided with workspace, a personal computer, voicemail and email, a pager, administrative assistance, and full access to the University of California, Davis libraries and associated services.

PROGRAM ADMINISTRATION

Co-Training Directors
Dawn Blacker, PhD
Forrest Talley, PhD

Training Supervisors
Anthony Urquiza, PhD
Dawn Blacker, Ph.D.
Tylene Cammack-Barry, Ph.D.
Blake Carmichael, PhD
Jane DuBe, LCSW
Brandi Liles, PhD
Christine Moylan, LMFT
Tara Niendam, PhD
Michele Ornelas Knight, PsyD
J.Daniel Ragland, PhD
Forrest Talley, PhD

Program Administrator
Gina Latour

For additional information, please contact:

Clinical Psychology Training Program
CAARE Center
University of California, Davis Children's Hospital
3671 Business Ave #100
Sacramento, CA 95820
Email: forest.talley@ucdmc.ucdavis.edu

ELIGIBILITY AND SELECTION PROCEDURES

Eligibility:
Applicants must be currently enrolled in an APA-accredited doctoral program in clinical or counseling psychology. Prior to the interview, applicants must have completed at least two years of graduate study, at least 500 hours of supervised practicum work, all doctoral course work as required, and have an accepted dissertation proposal. The vast majority of applicants selected for the program have had practicum experience with children and adolescents.

Selection:
Intern selection is made by a committee comprised of the Co-Training Directors and internship training supervisors . Applicants are rated on the basis of their clinical training (including assessment and psychotherapy), academic coursework, letters of recommendation, clinical and research interests, progress toward dissertation completion, and stated goals for internship. Those candidates assessed by the committee to hold interests and goals most closely matching those opportunities offered by our program will be asked to participate in on site interviews.

All applicants will be notified of their status by December 15. Highly-ranked candidates will be invited for interviews with the Co-Training Directors and supervisors. Candidates also have the opportunity to meet with current interns and post-doctoral fellows as well as tour the clinic. These interviews are very helpful for both the program and the applicants to determine whether the program is appropriate for them. Interviews will take place in January. If, due to economic or other reasons, an applicant cannot travel to Sacramento, other arrangements can be made.

The training program follows the Association of Psychology Postdoctoral and Internship Centers' policies regarding internship offers and acceptances. The internship program agrees to abide by APPIC policy that no person at this training facility will solicit, accept, or use any ranking-related information from any applicant. If you encounter violations of APPIC policy, please consider discussing it with your training director and reporting the violation to *APPIC Standards and Review Committee, 733 15th Street NW, Washington, CA 20005, phone (202) 347-0022*.

Nondiscrimination Policy:
The University of California prohibits discrimination against or harassment of any person employed by or seeking employment with the University on the basis of race, color, national origin, religion, sex, physical or mental disability, medical condition (cancer-related or genetic characteristics), ancestry, marital status, age, sexual orientation, citizenship, or status as a covered veteran (special disabled veteran, Vietnam era veteran, or any other veteran who served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized).

The University of California, Davis, and the CAARE Center Clinical Psychology Training Program are interested in candidates who are committed to the highest standards of scholarship and professional activities, and to the development of a campus climate that supports equality of opportunity.

The program is a member of the Association of Psychology Postdoctoral and Internship Centers (APPIC) and the California Association of Psychology Internship Council (CAPIC).

APPLICATION PROCEDURES

Please submit only the APPI online application located on the APPIC website (www.appic.org). Follow the directions on the APPIC website for submitting your application. Our application deadline is ***November 1st.***

The online application should include the following:

- ✓ Cover letter
- ✓ APPI application
- ✓ Curriculum vitae
- ✓ Three letters of recommendation
- ✓ Official graduate transcripts

No supplemental application materials are required.

DEADLINE: Our application deadline is November 1st

CAARE Center Internship

TRAINING GOALS AND OBJECTIVES

Overview

The training year is viewed as an opportunity for interns to obtain extensive supervised clinical experience, while developing knowledge and attitudes that encourage a scientific approach to practice. The supportive, challenging atmosphere of the CAARE Center fosters the development of skills and a maturing professional identity.

Objectives

Over the course of the one-year program, it is expected that interns will develop the following competencies:

1. Become proficient in conducting intake assessments, making diagnoses, developing treatment plans, and conducting individual and group therapy for children, adolescents, and caregivers with a history of maltreatment.

2. Become proficient in administering, scoring, and interpreting psychological tests and writing comprehensive evaluation reports.

3. Develop cultural competency in assessing and treating a multicultural population.

4. Demonstrate the knowledge and skills needed to conduct two empirically-supported treatments (i.e., Parent-Child Interaction Therapy and Trauma-Focused Cognitive-Behavioral Therapy) competently.

5. Use knowledge of current research in the areas of intervention, assessment, and child maltreatment to guide assessment and treatment.

6. Develop and refine skills in consulting with school and other systems involved in client's life.

7. Develop ability to provide clinical case management as appropriate.

8. Make a professional and scientific presentation of a specific case or topic, and integrate research into case presentations.

9. Work collaboratively as part of a multidisciplinary team of medical and mental health professionals.

10. Become knowledgeable on issues concerning professional psychologists such as reporting laws, confidentiality, ethics, consultation, and supervision.

11. Demonstrate an ability to be self-reflective and make a realistic assessment of strengths and weaknesses.

General Training Duties

1. Interns will have approximately 18-25 clinical contact hours per week comprised as follows:
    a. 10-12 individual therapy clients, 5 of which include designated TF-CBT cases

b. 4 Parent-Child Interaction Therapy cases
c. 1 psychological evaluation or child welfare evaluation
d. 1 therapy group (as co-facilitator) (if interested)
e. Infant Mental Health Cases (if interested)

2. Interns will be responsible for conducting intake assessments.

3. Interns will participate in supervision, trainings, and meetings as follows:
    a. 1 hours of individual supervision per week
    b. 1 hour of TF-CBT supervision per week;
    c. Live supervision as part of individual and TF-CBT seminars
    d. 4 hours of didactic seminars per week;
    e. General all-staff meetings twice per month;
    f. 1 hour Training Director's meeting twice per month for the year;
    g. Weekly supervision for PCIT and evaluations

4. Interns will be responsible for completing all required clinical documentation (e.g., treatment plans, progress notes, discharge summaries) in a timely manner consistent with both professional expectations and specific county guidelines.

5. Interns will have the opportunity to attend conferences sponsored by the CAARE Center, School of Medicine grand rounds, and other training activities.

PERFORMANCE EVALUATION

Intern Evaluations

At the beginning of the internship year, interns complete a self-assessment of their experience relative to training objectives of the internship. This helps focus the intern and supervisor on the intern's needs. Progress is monitored throughout the internship period. At the end of three months and six months, verbal and written feedback regarding the intern's performance is provided by the primary supervisor and/or Training Director. These performance evaluations are used to communicate an assessment of the intern's progress. At the end of the internship year, formal summative feedback is given to the intern and sent to the Training Director. Serious concerns regarding an intern's performance will be addressed through due process procedures (see Appendix A).

Grievance Procedures

Interns are strongly encouraged to address grievances related to training, supervision, or evaluation with their primary supervisor first and resolve concerns informally. Formal procedures are described in Appendix A.

ACCREDITATION STATUS

The Predoctoral Clinical Psychology Internship program is APA-accredited. Any questions about accreditation may be addressed to: Office of Accreditation, American Psychological Association, 750 First Street, NE, Washington, DC 20002. Telephone: (202) 336-5979.

Trauma-Adolescent Mental Illness Internship
TRAINING GOALS AND OBJECTIVES

Overview
The training year is viewed as an opportunity for interns to obtain extensive supervised clinical experience, while developing knowledge and attitudes that encourage a scientific approach to practice. The supportive, challenging atmosphere of the CAARE Center and SacEDAPT fosters the development of skills and a maturing professional identity.

Objectives
Over the course of the one-year program, it is expected that interns will develop the following competencies:

1. Become proficient in conducting intake assessments, making diagnoses, developing treatment plans, and conducting individual and group therapy for children, adolescents, and caregivers with a history of maltreatment and/or early psychosis.

2. Become proficient in administering, scoring, and interpreting psychological tests and writing comprehensive evaluation reports.

3. Develop cultural competency in assessing and treating a multicultural population.

4. Demonstrate the knowledge and skills needed to conduct two empirically-supported treatments (i.e., Trauma-Focused Cognitive- Behavioral Therapy and FACT) competently.

5. Use knowledge of current research in the areas of intervention, assessment, and trauma and early psychosis to guide assessment and treatment.

6. Develop and refine skills in consulting with school and other systems involved in client's life.

7. Develop ability to provide clinical case management as appropriate.

8. Make a professional and scientific presentation of a specific case or topic, and integrate research into case presentations.

9. Work collaboratively as part of a multidisciplinary team of medical and mental health professionals.

10. Become knowledgeable on issues concerning professional psychologists such as reporting laws, confidentiality, ethics, consultation, and supervision.

11. Demonstrate an ability to be self-reflective and make a realistic assessment of strengths and weaknesses.

General Training Duties
2. Interns will have approximately 18-25 clinical contact hours per week comprised as follows:

f. 8-10 individual therapy clients, all of which include designated TF-CBT cases
g. 4 individual early psychosis clients with a trauma history
h. 1 psychological evaluation or child welfare evaluation
i. Conducting standardized assessments for early psychosis
j. Co-facilitate multi-family therapy group
k. Co-facilitate substance abuse therapy group

12. Interns will be responsible for conducting intake assessments at both CAARE Center and SacEDAPT.

13. Interns will participate in supervision, trainings, and meetings as follows:
    h. 1 hours of individual supervision per week through SacEDAPT;
    i. 1 hour of TF-CBT supervision per week;
    j. Live supervision as TF-CBT seminars
    k. 4 hours of didactic seminars per week including TF-CBT didactic and Early Psychosis didactic;
    l. General all-staff meetings twice per month;
    m. 1 hour Training Director's meeting twice per month for the year;
    n. Weekly supervision for evaluations

14. Interns will be responsible for completing all required clinical documentation (e.g., treatment plans, progress notes, discharge summaries) in a timely manner consistent with both professional expectations and specific county guidelines.

15. Interns will have the opportunity to attend conferences sponsored by the CAARE Center, Department of Psychiatry, School of Medicine grand rounds, and other training activities.

PERFORMANCE EVALUATION

Intern Evaluations

At the beginning of the internship year, interns complete a self-assessment of their experience relative to training objectives of the internship. This helps focus the intern and supervisor on the intern's needs. Progress is monitored throughout the internship period. At the end of three months and six months, verbal and written feedback regarding the intern's performance is provided by the primary supervisor and/or Training Director. These performance evaluations are used to communicate an assessment of the intern's progress. At the end of the internship year, formal summative feedback is given to the intern and sent to the Training Director. Serious concerns regarding an intern's performance will be addressed through due process procedures (see Appendix A).

Grievance Procedures

Interns are strongly encouraged to address grievances related to training, supervision, or evaluation with their primary supervisor first and resolve concerns informally. Formal procedures are described in Appendix A.

TREATMENT PROGRAMS

Parent-Child Interaction Therapy (PCIT) – Dawn Blacker, PhD, Coordinator

The PCIT program is an empirically supported treatment program designed to help both parents and children. The program works with caregivers and children together to improve the quality of the parent-child relationship and to teach parents the skills necessary to manage the child's behavior problems. Interns will follow PCIT cases with an experienced therapist and be responsible for four cases. Because interns are taught by an experienced therapist, direct supervision and feedback is ongoing.

Required and Suggested Readings:

Hembree-Kigin, T., & McNeil, C. B. (2010). *Parent-Child Interaction Therapy, Second Edition.* New York, Springer.

UCDMC PCIT Training Center. Urquiza, A., Zebell, N., Timmer, S., McGrath, J., & Whitten, L. (2013). *PCIT: Sample Course of Treatment Manual for Traumatized Children*. Unpublished Manuscript.

UCDMC CAARE Center (2011). *Abbreviated version of the Dyadic Parent-Child Interaction Coding System (DPICS)*. Adapted from the Manual for the Dyadic Parent-Child Interaction Coding System (3rd Ed.). Eyberg, S., Nelson, M., Duke, M., and Boggs, S. (2004).

Timmer, S. G., Urquiza, A. J., Zebell, N. M., & McGrath, J. M. (2005). Parent-Child Interaction Therapy: Application to maltreating parent-child dyads. *Child Abuse & Neglect,*29, 825-842.

Urquiza, A. J. & McNeil, C. B. (1996). Parent-Child Interaction therapy: An intensive dyadic intervention for physically abusive families. *Child Maltreatment,* 1 (2), 134-144.

Eyberg, S. M. (2005). Tailoring and Adapting Parent-Child Interaction Therapy to New Populations. *Education and Treatment of Children,* 28 (2), 197-201.

Dombrowski, S. C., Timmer, S. G., & Zebell, N. (2008). Parent-Child Attunement Therapy for Toddlers: A behaviorally oriented, play-based parent training model. In Schaefer, C. E., Kelly-Zion, K, & McCormack, J. (Eds.) *Play Therapy for Very Young Children,*125-155.

***Note:* The Hembree-Kigin & McNeil book will be available in the library in 1174. All other materials will be provided at the PCIT training during the orientation.

Individual Therapy – Forrest Talley, PhD, Coordinator

The individual therapy program provides therapy to children who have a history of abuse and/or neglect. Ages of children range from 3-18 years, although most of the children are latency age. A broad range of diagnostic presentations are treated (e.g., mood disorders, anxiety disorders, adjustment disorders). Interns also provide consultation to social workers, biological/foster parents, and make recommendations to the court based upon their clinical understanding of the child. Supervision/consultation includes one to one discussion, review of videotapes, and live observation using a one way mirror and audio receiver worn in the ear by the therapist. The ability to develop formulations that guide the therapist towards reflective interventions is stressed.

Suggested Readings:

Epstein, S. (1994). Integration of the Cognitive and Psychodynamic Unconscious. *American Psychologist*, Vol. 49, 8, 709 – 724.

Frankel, F., Cantwell, D. P. and Myatt, R. (1996). Helping Ostracized Children: Social Skills Training and Parent Support for Socially Rejected Children. In Euthymia, D. H. and Jensen, P. S. Psychosocial treatment for child and adolescent disorders: Empirically based strategies for clinical practice. Washington, D.C.: APA.

Kazdin, A. E. (2006). Arbitrary Metrics: Implications for Identifying Evidence-Based Treatments. *American Psychologist*. 61, 42-49.

Kazdin, A.E. & Weiz, J. (2003). Evidence Based Psychotherapies for Children and Adolescents. Guilford Press, NY: NY.

Talley, P. F. (2005) Handbook for the Treatment of Abused and Neglected Children. Haworth Press, Binghamton: NY.

Weisz, J. R. (2004). *Psychotherapy for Children and Adolescents: Evidence Based Treatments and Case Examples*. Cambridge University Press, Cambridge: UK.

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) – Brandi Liles, PhD, Program Coordinator (CAARE Center and Trauma-Adolescent Mental Illness Tract)

TF-CBT is an empirically supported treatment developed for youth with post-traumatic stress disorder, or emotional or behavioral problems (e.g., depression, anxiety) related to traumatic life experiences. This therapy is provided to children ages 3-18 years who have experienced physical abuse, sexual abuse, or other traumatic events (e.g., car accidents, witnessing violence). Treatment involves individual sessions with the child and parent as well as joint parent-child sessions. TF-CBT has been used effectively with children from all socioeconomic backgrounds, living in a variety of settings (e.g., parents, foster care, group home), and from diverse ethnic backgrounds. Interns will be responsible for seeing TF-CBT cases and implementing the entire TF-CBT protocol. To facilitate learning and comfort with the model, interns will be involved in case presentations/discussions and live supervision.

Required readings:

Cohen, J., Mannarino, A., & Deblinger, E. (2006). *Treating Trauma and Traumatic Grief in Children and Adolescents*, Guilford Press.
Required web-based training: TF-CBT *Web* (www.musc.edu/tfcbt) and CTG *Web (http://ctg.musc.edu)*
Miller, A.L., Rathus, J.H., & Linehan, M.M. (2007). *Dialectical Behavior Therapy with Suicidal Adolescents*, Guilford Press (selected chapters).
Childhood Traumatic Grief: Concepts and Controversies, Cohen, Mannarino, Greenberg, Padlo, & Shipley (2002);
Complex Trauma in Children and Adolescents, White Paper from the National Child Traumatic Stress Network Complex Trauma Task Force
Note: Additional readings may be assigned during seminar

Psychological Evaluations – Blake Carmichael, PhD, Coordinator

The Psychological Evaluation Program provides multiple evaluation services for children, adolescents, and families. Evaluations are referred from various entities in the child welfare system, including social workers, treatment providers, and attorneys. Many of the evaluation services are conducted for dependency, juvenile, and family court. Referral questions may include requests for differential diagnoses, developmental assessment, cognitive functioning, and treatment recommendations. Referring parties also ask for input about a child's placement needs. In addition, court ordered evaluations frequently assess the quality and nature of parent-child relationships. This information is used to help the court determine if reunification services are to be offered to a parent and/or if parental rights should be terminated.

Interns are responsible for conducting psychological evaluations throughout the year. Testing instruments include cognitive (e.g., WISC-IV, CMS) and objective personality tests (e.g., PAI, MMPI-2, and MMPI-A). In addition, interns receive training in using the K-SADS (a structured diagnostic interview) and conducting clinical interviews with children. Behavioral checklists (e.g., CBCL, BASC-2, and TSCC), school observations, and collateral contacts with caregivers are also utilized. Readings are provided in the areas of child development, child maltreatment, and measure administration and interpretation.

References:

Speciality Guidelines for Forensic Psychology - APA (2011)

Guidelines for Psychological Evaluations in Child Protection Matters - APA (2010)

Understanding CalWorks - A Primer for Service Providers and Policymakers - California Center for Research on Women and Families (2010)

Goodman, G., "Children's Eyewitness Memory: A Modern History and Contemporary Commentary." *Journal of social Issues*, Vol. 62, No.4, 2006, pp.811-832

Kalich, L., Carmichael, B.D., Masson, T., Blacker, D., & Urquiza, A. Evaluating the Evaluator: Guidelines for Legal Professionals in Assessing the Competency of Evaluations in Termination of Parental Right Cases. (2009). *Journal of Psychiatry and Law.*

London et. al., "Review of the contemporary literature on how children report sexual abuse to others: Findings, methodological issues, and implications for forensic interviewers." *Memory*, 2008, 16 (1), 29-47

Malloy et. al., "Filial Dependency and Recantation of Child Sexual Abuse Allegations." *Journal of the American Academy of Child and Adolescent Psychiatry*. Vol46(2), Feb 2007, pp. 162-170

London et. al., "Disclosure of Child Sexual Abuse, What Does the Research Tell Us About the Ways That Children Tell?" *Psychology, Public Policy, and Law,* 2005, Vol. 11, No. 1, 194-226

Trocme and Bala, "False allegations of abuse and neglect when parents separate." *Child Abuse and Neglect* , 29 (2005) 1333-1345

Lyon, T. "False Allegations and False Denials in Child Sexual Abuse" *Psychology, Public Policy, and Law*, 1995, Vol. 1, No. 2, 429-437

Summit, R. "Abuse of the Child Sexual Abuse Accommodation Syndrome." *Journal of Child Sexual Abuse*, Vol. 1(4) 1992

Summit, R. "The Child Sexual Abuse Accommodation Syndrome." *Child Abuse and Neglect*, Vol. 7. pp. 177-193, 1983

Group Therapy – Forrest Talley, PhD, Coordinator

The group therapy program provides therapy in the format of social skills group and process-oriented groups for abused and neglected children. Groups for preschoolers through teenagers are offered. Interns will co-facilitate at least one ongoing therapy group. Supervision is both indirect and direct in the viewing of videotapes and co-facilitation of groups.

Recommended Readings:
Talley, P. F., & Terao, S. Y. (1998). *UCDMC Social Skills Group Manual.*
Dowd, T., & Tierney, J. (1995). *Teaching Social Skills to Youth.*

Selected readings from the following books/articles:
Bieling, Peter J., McCabe, Randi E., & Antony, Martin M. (2006) *Cognitive-Behavioral Therapy in Groups* New York: The Guildford Press.
Kendall, P., Chu, B., Gifford, A., Hayes, C., & Nauta, M. (1998). Breathing Life Into a Manual: Flexibility and Creativity With Manual Based Treatments. Association for Advancement of Behavior Therapy. (177 – 198)
Malekoff, A., (2004) *Group Work with Adolescents: Principles and Practice,* 2nd Ed. New York: The Guildford Press.
Schechtman, Z. (2007) *Group Counseling and Psychotherapy with Children and Adolescents: Theory, Research and Practice.* New Jersey: Lawrence Erlbaum Associates.

SacEdapt Program – Dr. Tara Niendam, Coordinator (Trauma-Adolescent Mental Illness Tract)

The SacEDAPT program conducts comprehensive assessments where state-of-the-art clinical assessment tools are used to evaluate each client to determine the appropriate diagnosis in order to guide treatment. Assessments of psychosocial functioning also determine areas where targeted treatment is needed. Regular and frequent appointments with a psychiatrist, tailored to control and alleviate symptoms with the fewest amount of side effects. Each client has a clinical case manager who helps to identify the client's unique needs and recovery goals, which will be used to develop a treatment plan that encourages the client to build upon their strengths and take an active role in treatment decisions. Weekly groups for clients are designed to provide support and improve understanding of the illness, develop stress and symptom management techniques, and enhance communication and problem solving skills. Weekly multi-family groups for families are based upon the PIER treatment model. Psychoeducation and support are provided to increase understanding about the illness, improve stress management and communication skills within the family, and develop problem solving skills. Supported Education and Employment services are also provided within the client's home, school or workplace to improve everyday functioning and help clients achieve their goals of social, academic and occupational recovery. With the knowledge of their own lived experience, Peer Advocate provides direct services to clients and families within the clinic and the surrounding community. The Peer Advocate's work targets both mental health & functioning treatment goals, as well as assisting clients in accessing benefits and services in the community.

Interns will learn how to conduct the standardized assessments. They will also be trained in the FACT treatment model; co-facilitate a multi-family therapy group and co-lead a substance abuse therapy group. They will also conduct individual therapy with 3-4 clients with a history of trauma as well as early psychosis. Supervision will include individual supervision and live supervision. Didactic training will also be provided.

Consultation and Research

In addition to providing treatment, interns will provide consultation to social workers, medical staff, foster parents and/or biological parents as appropriate. Postdoctoral fellows will have the opportunity to participate in ongoing research projects.

CAARE Center Internship
SUPERVISION AND TRAINING

The Clinical Psychology Training Program provides a strong supervisory system to ensure that interns obtain individualized attention as they pursue their clinical training at the CAARE Center. In general, interns participate in two hours of individual supervision and two hours of group supervision a week. The use of "live" supervision is an integral part of training through the use of observation mirrors, videotaping of treatment sessions and assessment interviews, and co-facilitation of treatment and assessment for all treatment programs. Opportunities for topic and case presentations occur in seminars, staff meetings, and group supervision.

Individual Supervision
Two hours of individual supervision are provided, one hour devoted to TF-CBT cases, and the other hour devoted to other individual therapy cases. When a case (therapy or evaluation) is assigned, the intern should consult with the supervisor about procedures and relevant information.

Group Supervision
Supervision is provided on a weekly basis for Parent-Child Interaction Therapy and evaluations. Group supervision is provided monthly for the group therapy program.

Didactic and Clinical Presentations

Several required didactic trainings are conducted on a regular basis throughout the training year. These are:

- Clinical staff presentations with topics related to the field of child maltreatment, psychopathology, and professional development
- Psychological Evaluation/Child Welfare Evaluation didactic
- Individual Therapy didactic/seminar
- Parent-Child Interaction Therapy seminar
- Trauma-Focused Cognitive-Behavioral Therapy seminar
- Group Therapy seminar

Training Director's Meeting and Professional Development Seminar
This meeting provides interns an opportunity to share information and discuss problematic issues or general concerns about the internship experience. The meeting is conducted on a bimonthly basis.

Other Training Opportunities
Interns have the opportunity to attend Pediatrics and Psychiatry Grand Rounds offered through the Medical Center as well as the Parent-Child Interaction Therapy Conference if held locally in Sacramento. Release time for attending other professional conferences may be arranged with the Co-Training Directors and primary supervisor.

Post-Doctoral Opportunities
In addition to predoctoral training, there are postdoctoral positions available every year. Please contact Dr. Blacker (dawn.blacker@ucdmc.ucdavis.edu) for information regarding postdoctoral opportunities. Former interns have obtained Postdoctoral

positions are a variety of places including Stanford University School of Medical, University of Oklahoma Health Sciences, and the CARES Institute.

Trauma-Adolescent Mental Illness Tract
SUPERVISION AND TRAINING

The Clinical Psychology Training Program provides a strong supervisory system to ensure that interns obtain individualized attention as they pursue their clinical training at the CAARE Center and SacEDAPT. Interns will participate in two hours of individual supervision (one with a TF-CBT Supervisor) and two hours of group supervision a week. The use of "live" supervision is an integral part of training through the use of observation mirrors, videotaping of treatment sessions and assessment interviews, and co-facilitation of treatment and assessment for all treatment programs. Opportunities for topic and case presentations occur in seminars, staff meetings, and group supervision.

Individual Supervision
Two hours of individual supervision are provided, one hour devoted to TF-CBT cases, and the other hour devoted to early psychosis therapy cases. When a case (therapy or evaluation) is assigned, the intern should consult with the supervisor about procedures and relevant information.

Group Supervision
Supervision is provided on a weekly basis for evaluations conducted at the CAARE Center as well as SacEDAPT. There will also be a monthly group supervision with supervisors from the CAARE Center and SacEDAPT.

Didactic and Clinical Presentations

Several required didactic trainings are conducted on a regular basis throughout the training year. These are:

- Clinical staff presentations with topics related to the field of child maltreatment, psychopathology, and professional development
- Psychological Evaluation/Child Welfare Evaluation didactic
- Early Psychosis Didactic
- Trauma-Focused Cognitive-Behavioral Therapy seminar
-

Training Director's Meeting and Professional Development Seminar
This meeting provides interns an opportunity to share information and discuss problematic issues or general concerns about the internship experience. The meeting is conducted on a bimonthly basis.

Other Training Opportunities
Interns have the opportunity to attend Pediatrics and Psychiatry Grand Rounds offered through the Medical Center as well as the Parent-Child Interaction Therapy Conference if held locally in Sacramento. Release time for attending other professional conferences may be arranged with the Co-Training Directors and primary supervisor.

Post-Doctoral Opportunities
In addition to predoctoral training, there are postdoctoral positions available every year. Please contact Dr. Blacker (dawn.blacker@ucdmc.ucdavis.edu) or Dr. Niendam (tniendam@ucdavis.edu) for information regarding postdoctoral opportunities. Former interns have obtained Postdoctoral positions are a variety of places including Stanford

University School of Medical, University of Oklahoma Health Sciences, and the CARES Institute.

TRAINING STAFF

Anthony J. Urquiza, PhD, Director of Mental Health Services
Dr. Urquiza received his doctorate from University of Washington in 1988. He is the Director of Mental Health Services and provides supervision/consultation on child welfare evaluations. Dr. Urquiza's primary interests and publications center on all types of family violence, the sexual victimization of males, the treatment of children and adult survivors of childhood sexual abuse, mental health psychodiagnostic issues applied to child maltreatment, and cultural diversity. Theoretical orientation: Interpersonal.

Dawn M. Blacker, PhD, Assistant Director of Mental Health Services; Co-Training Director, Clinical Psychology Training Program
Dr. Blacker graduated from the California School of Professional Psychology-Alameda in 1998. She currently serves as Co-Training Director and conducts psychological evaluations, Parent-Child Interaction Therapy, TF-CBT and DBT. Dr. Blacker received postdoctoral training in developmental disabilities and psychological assessment. Current interests include: treatment of child physical and sexual abuse, developmental assessment of maltreated children, complex trauma, implementation of EBT's, CSEC and early intervention. Theoretical orientation: Cognitive-behavioral and developmental.

Tylene Cammack-Barry, PsyD, Supervisor
A graduate of San Diego State University and California School of Professional Psychology – Fresno/Sacramento, Dr. Cammack-Barry specializes in psychological assessment and Parent-Child Interaction Therapy (PCIT). She provides supervision/training of child welfare evaluations, psychological assessments, and PCIT. She also has training and experience with developmental assessments (including the ADOS) and provides consultation to our Infant Mental Health team. Dr. Cammack-Barry has further been working with a local Native American community providing consultation and various mental health services. Current interests include early intervention, treatment of child physical and sexual abuse, cultural diversity, developmental assessment of maltreated children, relationships, and psychotic disorders. Theoretical Orientation: Ecosystemic and Cognitive-behavioral.

Blake Carmichael, PhD, Evaluation Program Coordinator
A graduate of University of California, Davis and Alliant International University, Dr. Carmichael specializes in psychological assessment and group/individual treatment of maltreated children and their families. He has extensive training and experience working with adolescent sex offenders and victims. Research interests include the impact of violence on families, the effectiveness of various parenting/leadership styles, and the biological bases of aggression and psychiatric disorders.

Cameron Carter, M.D., Director of SacEDAPT

Dr. Carter is a Professor of Psychiatry and has been involved in the care of early schizophrenia for the past 12 years. He directs the SacEDAPT Clinic and the Psychosis Research and Education Program in the Department of Psychiatry at UC Davis Medical Center as well as the UC Davis Imaging Research Center

Jane DuBe, LCSW, Supervisor

Jane DuBe is a Licensed Clinical Social Worker and a graduate of the Masters of Social Welfare program at the University of California, Berkeley. She has past experience in crisis services, dual diagnosis treatment, forensic mental health, and inpatient mental health services. In the SacEDAPT Clinic, Jane conducts diagnostic assessments, provides case management services, as well as coordinating individual and family groups

Brand Liles, M.A., PhD, TF-CBT Program Coordinator

Ms. Liles graduated from the Universityof Tulsa (TU) in Tulsa, Oklahoma in 2013. Dr. Liles completed her Predoctoral Psychology Internship at the CAARE Center in 2012 and now serves as the Trauma Focused Cognitive Behavioral Therapy Coordinator and Child Sexual Abuse Grant Program Manager. In addition, she specializes in Parent Child Interaction Therapy and conducts trainings at the CAARE Center and other agencies. Current interests include: trauma, trauma-focused treatment, trauma in young children, dissemination of empirically supported treatments, children with sexual behavior problems, teens who have experienced sexual exploitation, and the effectiveness of PCIT. Theoretical Orientation: Cognitive-Behavioral

Tina Moylan, LMFT, Supervisor

Tina is a licensed Marriage, Family, Child Therapist (LMFT). She received her Masters of Science in Counseling degree from the University of Phoenix, Sacramento Campus. She has past experience working with mental health consumers in day treatment, crisis services, and inpatient treatment settings. In the SacEDAPT Clinic, Tina conducts diagnostic assessments, provides individual, family, and group therapy, and provides case management services.

Tara Niendam, PhD, Director of Operations

Dr. Niendam is a licensed clinical psychologist with specialized training in psychodiagnositic and cognitive assessment in youth at risk for or in the early stages of psychosis. As the Director of Operations, Dr. Niendam supervises clinic activities and staff and coordinates outreach and educational presentations within the community. Dr. Niendam is interested in understanding how deficits in cognition can influence an individual's ability to maintain age-appropriate social and work/school functioning.

Michele Ornelas Knight, PsyD, Associate Director of Mental Health Services

Dr. Ornelas Knight graduated from the University of Denver's Graduate School of Professional Psychology in 1999. Clinical experience includes treatment of children and adolescents with histories of trauma, treatment of adolescent and young adults with complex trauma histories, self-injurious behaviors and suicidal ideation. Current interests include: emotional regulation in children and adolescents, complex trauma, and parenting children with histories of maltreatment. Theoretical orientation Cognitive-behavioral.

J. Daniel Ragland, PhD, Supervisor

Dr. Ragland is a licensed clinical psychologist who completed his Ph.D. in clinical psychology at American University. Dr. Ragland is interested in the role that

organizational abilities play in learning and remembering new information, how schizophrenia disrupts these organizational processes, and how treatment of these deficits may improve patients' daily function. In the SacEDAPT clinic, Dr. Ragland assists with intake assessments.

Forrest Talley, PhD, Individual and Group Treatment Coordinator
Dr. Talley received his doctorate from Vanderbilt University in 1988. He has broad experience in evaluating and treating maltreated children and their families. His current responsibilities include individual therapy supervision and providing individual and group treatment. Research interests include narrative structure in children's play and the therapeutic process. Theoretical orientation: Interpersonal.

Selected Recent Publications of Psychology Staff

Blacker, D. M. (2014). PCIT with a Preschool-Age Boy Exposed to Domestic Violence and Maternal Depression: The Case of Jeremy S. In B. Allen & M. Kronenberg (Eds.), Treating Traumatized Children: A Casebook of Evidence-Based Therapies. The Guildford Press: New York.

Urquiza, A. & Blacker, D. (2012). Parent-Child Interaction Therapy with Sexually Victimized Children. In P. Goodyear-Brown (Ed.), Handbook of Child Sexual Abuse: Intervention, Assessment, and Treatment. Wiley & Sons: New York.

Timmer, S.G., Zebell, N.M., Culver, M.A., & Urquiza, A.J. (2010). Efficacy of Adjunct in-home coaching to improve outcomes in Parent-Child Interaction Therapy. Research on Social Work Practice, 20(1), 36-45.

Herschel, A., McNeil, C.B., Urquiza, A.J., McGrath, J., Zebell, N., Timmer, S.G., & Porter, A. (2009). Evaluation of a treatment manual and workshops for disseminating, Parent-Child Interaction Therapy. Administration and Policy in Mental Health Services Research, 36(1), 63-81.

Kalich, L., Carmichael, B., Masson, T., Blacker, D., Urquiza, A.J., (2009). Evaluating the evaluator: Guidelines for legal professionals in assessing the competency of evaluations in termination of parental rights cases. Journal of Psychiatry and the Law, (in press).

Timmer, S.G., Zebell, N., Culver, & Urquiza, A.J. (2009). Efficacy of Adjunct In-Home Coaching to Improve Outcomes in Parent-Child Interaction Therapy. Research on Social Work Practice, (in press).

Urquiza, A.J., Zebell, N., & Blacker, D. (2009). Innovation and Integration: Parent-Child Interaction Therapy as Play Therapy. In Athena Drewes (Ed.), Cognitive-behavioral therapy approaches to play therapy. Wiley & Sons: New York.

Timmer, S.G., Thompson, D., Culver, M.A., Urquiza, A.J., & Altenhofen, S. (2009). Mother's Physical Abusiveness in a context of violence: Effects on the mother-child relationship. Child Development, (in press).

Urquiza, A.J. (2009). The future of play therapy: Elevating credibility through play therapy research. International Journal of Play Therapy, (in press).

Runyon, M., & Urquiza, A.J. (2009). Treatment of physically abused children and their families. In: J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, C. Jenny, & T. Reid (Eds.), The APSAC handbook of child maltreatment (3rd ed). Thousand Oaks, CA: Sage.

Timmer, S.G., Ware, L., & Urquiza, A. (2009). The effectiveness of Parent-Child Interaction Therapy for victims of interparental violence. Violence Against Women, manuscript under review.

Kalich, L., Carmichael, B.D., Masson, T., Blacker, D., & Urquiza, A. (2007). Evaluating the evaluator: Guidelines for legal professionals in assessing the competency of evaluations in termination of parental rights cases. *Journal of Psychiatry and Law, 35*

Dombrowski, S., Timmer, S.G., & Zebell, N. (2007). Parent-Child Attunement Therapy for Toddlers: A behaviorally-oriented play-based parent training model. In C. Schaeger (Ed.), *Play Therapy for Very Young Children*, in press.

Timmer, S. G., Urquiza, A. J., & Zebell, N. (2006). Challenging foster caregiver-maltreated child relationships: The effectiveness of Parent Child Interaction Therapy, *Child & Youth Services Review*, 28, 1 - 19.

Elliott, K. & Urquiza, A. J. (2005). Conducting culturally responsive research in juvenile justice and child welfare systems. In J. E. Trimble and C. B. Fisher (Eds.), *Handbook of ethical research with ethnocultural populations and communities.* Sage: Newbury Park.

Talley, P.F. (Ed.). (2005). *Handbook for the Treatment of Abused and Neglected Children.* Binghamton, NY: Haworth Press.

Timmer, S. G., Urquiza, A. J., Zebell, N., & McGrath, J., (2005). Parent-Child Interaction Therapy: Application to physically abusive and high-risk dyads. *Child Abuse & Neglect*, 29, 825-842..

Timmer, S.G., Sedlar, G., & Urquiza, A.J. (2006). Challenging Children in Kin vs. Non-kin Foster Care: Perceived Costs and Benefits to Caregivers. *Child Maltreatment.*

Timmer, S. G., Ware, L., & Urquiza, A. (2005). The effectiveness of Parent-Child Interaction Therapy for Victims of Interparental Violence. Violence Against Women, manuscript under review.

Urquiza, A.J. & Blacker, D.M. (2005). Clinical assessment of maltreated children. In P. F. Talley, (Ed.), *Handbook for the Treatment of Abused and Neglected Children.* Binghampton, NY: Haworth Press.

Talley, P. F., & Talley, Jr. C. O. (2003). Sperry's solution to conflict between science and religion. Journal of Psychology and Christianity, 22, 43-48.

Appendix A

Procedures for Handling Performance Issues

Whenever a supervisor becomes aware of an intern's problem area or deficiency that does not appear resolvable by the usual supervisory support and intervention, the following procedures will be followed.[1] These procedures provide the intern and staff with a definition of competence problems, a listing of possible sanctions, and an explicit discussion of the due process procedures. Also included are important considerations in the remediation of problems or competence problems.

I. Definition of Competence Problems

Competence problems are defined broadly as an interference in professional functioning which is reflected in one or more of the following ways:

1) an inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior;
2) an inability to acquire professional skills in order to reach an acceptable level of competency; and/or
3) an inability to control personal stress, interpersonal difficulties, psychological dysfunction, and/or excessive emotional reactions that interfere with professional functioning.

While it is a professional judgment as to when an intern's behavior becomes a competence problem, problems typically become identified as competence problems when they include one or more of the following characteristics:

1. the intern does not acknowledge, understand, or address the problem when it is identified;
2. the problem is not merely a reflection of a skill deficit which can be rectified by academic or didactic training;
3. the quality of services delivered by an intern is sufficiently negatively affected;
4. the problem is not restricted to one area of professional functioning;
5. a disproportionate amount of attention by training personnel is required; and/or,
6. the intern behavior does not change as a function of feedback, remediation efforts, and/or time.

II. Remediation and Sanction Alternatives

It is important to have meaningful ways to address competence problems once they have been identified. In implementing remediation or sanction interventions, the training staff must be mindful and balance the needs of the intern, the clients involved, members of the intern training group, the training staff, and other agency personnel.

1. ***Verbal warning*** to the intern emphasizes the need to discontinue the inappropriate behavior under discussion. No record of this action is kept.
2. ***Written acknowledgement*** to the intern formally acknowledges:
   a) that the Co-Training Directors (CTD) are aware of and concerned with the performance rating;
   b) that the concern has been brought to the attention of the intern;
   c) that the CTD's will work with the intern to rectify the problem or skill deficits, and;
   d) that the behaviors associated with the rating are not significant enough to warrant more serious action.

[1] Adapted from APPIC Due Process Guidelines

The written acknowledgement will be removed from the intern's file when the intern responds to the concerns and successfully completes the internship/fellowship.

3. ***Written warning*** to the intern indicates the need to discontinue an inappropriate action or behavior. This letter will contain:
   a) a description of the intern's unsatisfactory performance;
   b) actions needed by the intern to correct the unsatisfactory behavior;
   c) the time line for correcting the problem;
   d) what action will be taken if the problem is not corrected; and,
   e) notification that the intern has the right to request a review of this action.

A copy of this letter will be kept in the intern's file. Consideration may be given to removing this letter at the end of the internship/fellowship by the CTD's in consultation with the intern's supervisor and Director. If the letter is to remain in the file, documentation should contain the position statements of the parties involved in the dispute.

4. ***Schedule Modification*** is a time-limited, remediation-oriented closely supervised period of training designed to return the intern to a more fully functioning state. Modifying an intern's schedule is an accommodation made to assist the intern in responding to personal reactions to environmental stress, with the full expectation that the intern will complete the internship/fellowship. This period will include more closely scrutinized supervision conducted by the regular supervisor in consultation with the CTDs. Several possible and perhaps concurrent courses of action may be included in modifying a schedule. These include:
   a) increasing the amount of supervision, either with the same or other supervisors;
   b) change in the format, emphasis, and/or focus of supervision;
   c) recommending personal therapy;
   d) reducing or redistribution of the intern's clinical or other workload;
   e) requiring specific academic coursework.

The length of a schedule modification period will be determined by the CTDs in consultation with the primary supervisor and the Director. The termination of the schedule modification period will be determined, after discussions with the intern, by the CTDs in consultation with the primary supervisor and the Director.

5. ***Probation*** is also a time limited, remediation-oriented, more closely supervised training period. Its purpose is to assess the ability of the intern to complete the internship/fellowship and to return the intern to a more fully functioning state. Probation defines the relationship that the CTD's systematically monitor for a specific length of time the degree to which the intern addresses, changes and/or otherwise improves the behavior associated with the inadequate rating. The intern is informed of the probation in a written statement, which includes:

   a) the specific behaviors associated with the unacceptable rating;
   b) the recommendations for rectifying the problem;
   c) the time frame for the probation during which the problem is expected to be ameliorated, and;
   d) the procedures to ascertain whether the problem has been appropriately rectified.

If the CTD's determine that there has not been sufficient improvement in the intern's behavior to remove the probation or modified schedule, then the CTD's will discuss with the primary supervisor and the Director possible courses of action to be taken. The CTD's will communicate in writing to the intern that the conditions for revoking the probation or modified schedule have not been met. This notice will include the course of action the CTDs have decided to implement. These may include continuation of the

remediation efforts for a specified time period or implementation of another alternative. Additionally, the CTD's will communicate to the Director that if the intern's behavior does not change, the intern will not successfully complete the internship/fellowship.

6. ***Suspension of Direct Service Activities*** requires a determination that the welfare of the intern's client or consultee has been jeopardized. Therefore, direct service activities will be suspended for a specified period as determined by the CTDs in consultation with the ADPS and Director. At the end of the suspension period, the intern's supervisor in consultation with the CTDs will assess the intern's capacity for effective functioning and determine when direct service can be resumed.

7. ***Administrative Leave*** involves the temporary withdrawal of all responsibilities and privileges in the agency. If the Probation period, Suspension of Direct Service Activities, or Administrative Leave interferes with the successful completion of the training hours needed for completion of the internship/fellowship, this will be noted in the intern's file and the intern's academic program will be informed. The CTD's will inform the intern of the effects the administrative leave will have on the intern's stipend and accrual of benefits.

8. ***Dismissal*** from the Internship/fellowship involves the permanent withdrawal of all agency responsibilities and privileges. When specific interventions do not, after a reasonable time period, rectify the competence problems and the trainee seems unable or unwilling to alter her/his behavior, the CTD's will discuss with the Director the possibility of termination from the training program or dismissal from the agency. Either administrative leave or dismissal would be invoked in cases of severe violations of the APA Code of Ethics, or when imminent physical or psychological harm to a client is a major factor, or the intern is unable to complete the internship/fellowship due to physical, mental or emotional illness. When an intern has been dismissed, the CTD's will communicate to the intern's academic department that the intern has not successfully completed the internship/fellowship.

III. Procedures for Responding to Inadequate Performance by an Intern

If an intern receives an "unacceptable" rating from any of the evaluation sources in any of the major categories of evaluation, or if a staff member has concerns about an intern's behavior (ethical or legal violations, professional incompetence), the following procedures will be initiated:

1. The staff member will consult with the Co-Training Directors (CTD) to determine if there is reason to proceed and/or if the behavior in question is being rectified.
2. If the staff member who brings the concern to the CTD's are not the intern's primary supervisor, the CTD's will discuss the concern with the intern's primary supervisor.
3. If the CTD's and primary supervisor determine that the alleged behavior in the complaint, if proven, would constitute a serious violation, the TD will inform the staff member who initially brought the complaint.
4. The CTD's will meet with the Intern Supervisors Committee (ISC) to discuss the performance rating or the concern.
5. The CTD's will meet with the Director to discuss the concerns and possible courses of action to be taken to address the issues.
6. The CTDs, primary supervisor, and Director may meet to discuss possible course of actions.
7. Whenever a decision has been made by the Director or CTDs about an intern's training program or status in the agency, the CTD's will inform the intern in writing and will meet with the intern to review the decision. This meeting may include the intern's primary supervisor. If the intern accepts the decision, any formal action taken by the Training Program may be communicated in writing to the intern's academic department. This notification indicates the nature of the concern and the specific alternatives implemented to address the concern.

8. The intern may choose to accept the conditions or may choose to challenge the action. The procedures for challenging the action are presented below.

IV. Due Process: General Guidelines

Due process ensures that decisions about interns are not arbitrary or personally based. It requires that the training program identify specific evaluative procedures, which are applied to all trainees, and provide appropriate appeal procedures available to the intern. All steps need to be appropriately documented and implemented. General due process guidelines include:

1. During the orientation period, presenting to the intern, in writing, the program's expectations related to professional functioning. Discussing these expectations in both group and individual settings.
2. Stipulating the procedures for evaluation, including when and how evaluations will be conducted. Such evaluations should occur at meaningful intervals.
3. Articulating the various procedures and actions involved in making decisions regarding competence problems.
4. Communicating, early and often, with graduate programs about any suspected difficulties with interns and when necessary, seeking input from these academic programs about how to address such difficulties. Instituting, when appropriate, a remediation plan for identified inadequacies, including a time frame for expected remediation and consequences of not rectifying the inadequacies.
5. Providing a written procedure to the intern, which describes how the intern may appeal the program's action. Such procedures are included in the intern handbook. The intern handbook is provided to intern and reviewed during orientation.
6. Ensuring that the intern has sufficient time to respond to any action taken by the program.
7. Using input from multiple professional sources when making decisions or recommendations regarding the intern's performance.
8. Documenting, in writing and to all relevant parties, the actions taken by the program and its rationale.

V. Due Process: Procedures

The basic meaning of due process is to inform and to provide a framework to respond, act, or dispute. When a matter cannot be resolved between the CTDs and intern or staff, the steps to be taken are listed below.

1. Grievance Procedures

There are two situations in which grievance procedures can be initiated. An intern can challenge the action taken by the CTDs or a member of the training staff may initiate action against an intern. These situations are described below.

a. ***Intern Challenge***: If the intern wishes to formally challenge any action taken by the CTDs, the intern must, within five (5) workdays of receipt of the CTD's decision, inform the CTD, in writing, of such a challenge. When a challenge is made, the intern must provide the CTD information supporting the intern's position or concern. Within three (3) workdays of receipt of this notification, the CTD's will consult with the Director and will implement Review Panel procedures as described below.

b. ***Staff Challenge***: If a training staff member has a specific intern concern that is not resolved by the CTDs, the staff member may seek resolution of the conflict by written request to the CTDs for a review of the intern's behavior. Within three (3) working days of receipt of the staff member's challenge, the CTD will consult with the Director and a Review Panel will be convened.

2. Review Panel and Process

a. When needed, a review panel will be convened by the Director. The panel will consist of three staff members selected by the Director with

recommendations from the CTDs and the intern involved in the dispute. The intern has the right to hear all facts with the opportunity to dispute or explain the behavior of concern.

b. Within five (5) workdays, a hearing will be conducted in which the challenge is heard and relevant material presented. Within three (3) workdays of the completion of the review, the Review Panel submits a written report to the Director, including any recommendations for further action. Recommendations made by the Review Panel will be made by majority vote.

c. Within three (3) workdays of receipt of the recommendation, the Director will either accept or reject the Review Panel's recommendations. If the Director rejects the panel's recommendations, due to an incomplete or inadequate evaluation of the dispute, the Director may refer the matter back to the Review Panel for further deliberation and revised recommendations or may make a final decision.

d. If referred back to the panel, they will report back to the Director within five (5) workdays of the receipt of the Director's request of further deliberations. The Director then makes a final decision regarding what action is to be taken.

e. The Training Director informs the intern and if necessary the training program of the decisions made.

f. If the intern disputes the Director's final decision, the intern has the right to contact the Department of Human Resources to discuss the situation.

Due Process Procedures for Handling Intern Grievances

This document[1] provides interns a means to address general grievances related to training, supervision, and performance evaluations. Additionally, complaints regarding a specific university act that adversely affects the trainee's existing terms or conditions of employment are managed in similar fashion.

Step 1 – Informal Review
If an intern has specific concerns regarding training, supervision, and/or a supervisor's evaluations, it is first recommended that the intern attempt to resolve such concerns informally with appropriate persons involved and notify the Co-Training Directors of such concerns prior to filing a formal grievance. If the concern is regarding the one of the Co-Training Directors specifically, the intern should notify the Director of Mental Health Services directly. If the matter is not resolved to the intern's satisfaction, a meeting with one of the Co-Training Directors and Director will be requested and conducted in a timely manner (approximately two to three weeks). The next step, if the issue remains unresolved, is for the trainee to request a meeting with the faculty liaison, the Co-Training Directors and Director.

Step 2 – Formal Review
A grievance that is not resolved by Step 1 may be presented in writing to Human Resources for review and written response by Department Chair. The grievance must be received within thirty calendar days after the date on which the trainee knew or could reasonably be expected to have known of the event or actions which gave rise to the complaint, or within thirty calendar days after the date of separation from the training program, whichever is earlier. A grievance form is available from the Human Resources Administrator. The Department Chair will respond in writing to the resident within fifteen days after the date the formal grievance is provided by Human Resources to the Department for processing.

Step 3- Hearing
A grievance not satisfactorily resolved at Step 2, which alleges violation of written notice of dismissal, may be appealed in writing to Human Resources for a final and binding hearing, within ten calendar days of the date the Step 2 decision was received or due. The appeal will set forth the issues and remedies remaining unresolved.

[1] Adapted from the University of California, Davis Health System Resident Medical Staff Personnel Policy Manual, 7/2000.

Appendix B

Policy on Social Media[1]

Interns who use social media (e.g., Facebook) and other forms of electronic communication should be mindful of how their communication may be perceived by clients, colleagues, and others. As such, it is recommended that interns should make every effort to minimize material that may be deemed inappropriate for a psychologist in training. To this end, interns should set all security settings to "private" and should avoid posting information/photos or using any language that could jeopardize their professional image. Interns should consider limiting the amount of personal information posted on these sites. They should never include clients as part of their social network or include any information that might compromise the confidentiality of a client in any way. Greetings on voicemail services and answering machines used for professional purposes should also be thoughtfully constructed. Interns are reminded that, if they identify themselves as an intern in the program, the internship has some interest in how they are portrayed. If interns report engaging in, or are depicted on a website or in an email as engaging in, anything unethical or illegal, then that information may be used by the internship program to determine possible warning, probation, or other sanction. As a preventive measure, the program advises that interns and supervisors approach social media carefully. In addition, American Psychological Association's Social Media/Forum Policy may be consulted for guidance: http://www.apa.org/about/social-media.aspx.

[1] This policy is based in part on the policies developed by University of Denver, University of Albany, Michael Roberts at the University of Kansa, and Elizabeth Klonoff at San Diego State University.

Appendix C

SAMPLE DIDACTIC SCHEDULES [1]

[1] Schedules are subject to change.

_TF- CBT Seminar*
2012-2013 Training Year
Thursdays, 10:00 a.m. – 11:45 a.m.
Location: Jackson Conference room
Instructors: Clinical Staff
Updated

July 19-20	TF-CBT 2-Day Training – @FSSB Bldg.
August 9th	Overview of TF-CBT procedures, fidelity checklists, & documentation (TF-CBT progress note, etc.)-Ms. Liles
August 23rd	Special Topic - Complex Trauma & TF-CBT Complete assigned reading(s)-Dr. Blacker
Sept. 27th	Special Topic – Multicultural considerations & PTSD Culturally Modified Trauma Focused Treatment-Ms. Torres
Oct. 11th	Special Topic – Special Topic – High Risk Behaviors/DBT Complete assigned reading- Dr. Ornelas Knight
Oct. 25th	Special Topic - Child Traumatic Grief Complete assigned reading-Dr. Carmichael
Nov. 15th	Rescheduled
Dec. 13th	Engaging difficult families in treatment, working with different populations (foster parents, grandparents)-Ms. Liles

* Note: There is flexibility in this schedule to accommodate interns' training needs and other unforeseen events. Please notify me in advance if you will be unable to attend a class.

Dec 27th	*NO MEETING*
Jan. 10th	Treatment applications with TF-CBT-Ms. Liles Complete Assigned Readings
Jan 24th	Special Topic - TF-CBT and Younger Children-Ms. Liles
Feb. 14th	Case consultation/Presentation - Psych Intern #1
Feb. 28th	Case consultation/Presentation
March 14th	Case consultation/Presentation
March 28th	Case consultation/Presentation
April 11th	Case consultation/Presentation
April 25th	Case consultation/Presentation
April 25th	Case consultation/Presentation
May 9th	Case consultation/Presentation

Expectations and Requirements for Seminar:

1) Complete ***TF-CBT WEB*** web-based training in TF-CBT (www.musc.edu/tfcbt) by **July 26, 2012**. Please provide your supervisor with copy of your certificate of completion.

2) Please complete CTGWEB (Child Traumatic Grief web-based training (http://ctg.musc.edu) by **September 27, 2012**. Please provide your supervisor with copy of your certificate of completion.

3) Read *Treating Trauma and Traumatic Grief in Children and Adolescents* (Cohen, Deblinger, & Mannarino, 2006) by December 8, 2012.

4) Read the following materials as assigned. These can be found on shared drive at the following link:
S:\SOM\Pediatrics\CAARE\Mental Health\TRAINING - All Programs\TF-CBT Training\Articles\articles for training\Seminar readings

a. Childhood Traumatic Grief: Concepts and Controversies, Cohen, Mannarino, Greenberg, Padlo, & Shipley (2002);
b. Selected chapters from Dialectical Behavior Therapy for Suicidal Adolescents (2006), Miller, Linehan, Rathus, & Swenson;
c. Complex Trauma in Children and Adolescents, White Paper from the National Child Traumatic Stress Network Complex Trauma Task Force;

Note: Other articles to be announced

4) Please let me know in advance if you are unable to attend seminar.

5) Have fun – keep your sense of humor.

TF-CBT Book Reading
Treating Trauma and Traumatic Grief in Children and Adolescents (Cohen, Deblinger, & Mannarino, 2006)

Pgs. 1- 53 by Aug 23rd
Pgs. 57-74 by Sept 27th
Pgs. 75-106 by Oct. 25th
Pgs 107-118 by Dec 13th
Pgs 119-135 by Jan 24th
Pgs 136-165 by Feb 28th
Pgs 169-204 by March 28th

PCIT Didactic Schedule

July 16 PCIT Webcourse (10 hours) and Intake

July 23 Post Webcourse Skills Building and Review (7 hours)

8/14/13 PCIT Monthly meeting: coding practice, case presentation and research discussion
Reading: please read all other reading assignments (aside from the remainder of the McNeil book) by next didactic.

8/28/13 Clinical Staffing and discussion
Reading: please read pp 103-182 of McNeil book by next didactic

9/11/13 Mid-Treatment Discussion & Giving the PDI Didactic (Be Direct & Strategies for Compliance w/Mr. Bear)
Reading: please read pp 185-437 of McNeil book by next didactic
Homework: Practice giving PDI didactic by next didactic

9/25/13 Week of PCIT Conference

10/09/13 PCIT Monthly meeting: coding practice, case presentation and research discussion

10/23/13 PDI and Time Out Procedure
Reading: Time-out with Parents: A Descriptive Analysis of 30 Years of Research (Everett et al, 2010)

11/13/13 PCIT Monthly meeting: coding practice, case presentation and research discussion

11/20/13 Thanksgiving

12/11/13 PDI Disasters and How to Prevent Them & What to Do
Video Presentation: Techniques to Elicit PDI Opportunities

12/25/13 Holiday

01/8/13 PCIT Monthly meeting: coding practice, case presentation and research discussion

01/22/13 **Cancelled due to Intern Interviews**

02/12/13 PCIT Monthly meeting: coding practice, case presentation and research discussion

02/26/13 Case presentations: Drs. Reichert and Wu

03/17/13 PCIT Monthly meeting: coding practice, case presentation and research discussion

03/26/13 Case presentations: Grant and Korrin

04/09/13 PCIT Monthly meeting: coding practice, case presentation and research discussion

04/23/13 Case presentations: Grace and Anna

05/14/13 PCIT Monthly meeting: coding practice, case presentation and research discussion

05/28/13 Case Presentation: Staff

June didactics cancelled to allow for time for chart review, case closure, etc.
Articles are on the shared drive or will be handed out.

Required Readings:

Hembree-Kigin, T., & McNeil, C. B. (2010). *Parent-Child Interaction Therapy, Second Edition.* New York, Springer.

UCDMC CAARE Center (2009). *Parent-Child Interaction Therapy (PCIT) Training Materials.*

Timmer, S. G., Urquiza, A. J., Zebell, N. M., & McGrath, J. M. (2005). Parent-Child Interaction Therapy: Application to maltreating parent-child dyads. *Child Abuse & Neglect,*29, 825-842.

Urquiza, A. J. & McNeil, C. B. (1996). Parent-Child Interaction therapy: An intensive dyadic intervention for physically abusive families. *Child Maltreatment,* 1 (2), 134-144.

Eyberg, S. M. (2005). Tailoring and Adapting Parent-Child Interaction Therapy to New Populations. *Education and Treatment of Children,* 28 (2), 197-201.

Dombrowski, S. C. , Timmer, S. G., Blacker, D. M., & Urquiza, A. J. (2005). A Positive Behavioural Intervention for Toddlers: Parent-child attunement therapy. Child Abuse Review, 14, 132-151.

Dombrowski, S. C., Timmer, S. G., & Zebell, N. (2008). Parent-Child Attunement Therapy for Toddlers: A behaviorally oriented, play-based parent training model. In Schaefer, C. E., Kelly-Zion, K, & McCormack, J. (Eds.) *Play Therapy for Very Young Children,*125-155.

UCDMC CAARE Center (2009). *Parent-Child Interaction Therapy Course of Treatment Protocol.*

UCDMC CAARE Center (2009). *Abbreviated version of the Dyadic Parent-Child Interaction Coding System (DPICS).*