

The University of Toledo Psychology Clinic

Policy and Procedures Handbook

2018/2019



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HANDBOOK FOR THE UNIVERSITY OF TOLEDO PSYCHOLOGY CLINIC

1. INTRODUCTION

The purpose of the Handbook is to provide a description of the purpose and functions of the University of Toledo Psychology Clinic (hereafter referred to as UTPC or Clinic), as well as the roles and responsibilities of the UTPC staff. The handbook provides general information about the UTPC's role and specific information about policies and procedures, case flow, and duties of UTPC staff. Official UTPC Forms as well as sample templates for documentation are listed and available through the academic and client services coordinator. An annual report describing the number and types of cases seen in the clinic is completed and given to the Chair of the Department. Clinic revenue is also tracked and this information is given to the Chair of the Department on a regular basis.

2. MISSION AND PHILOSOPHY

The majority of Clinical Psychology Doctoral Programs have training clinics. Training clinics play a central role in clinical psychology graduate education. The purpose of this Statement of Philosophy is to explain the role of clinical psychology training clinics in general and of our clinic in particular.

In a real sense, the Psychology UTPC is the classroom/laboratory for clinical psychology. The bulk of clinical graduate students' training during their first two or three years takes place in this context, with clinical faculty members providing the "hands on" practicum training component of students' graduate education through demonstrations of technique, direct and/or recorded observation, and individual and group supervision of training cases. In their first year, graduate students begin by learning to carry out intake interviews, diagnostic assessments, and oral and written reports; students later progress to conducting, analyzing and writing up complex psychological assessments involving individualized test batteries.

In their second year, students continue to build on their intake interviewing and assessment skills and begin seeing therapy cases, generally starting with comparatively straightforward adult, child, or couple cases (e.g., adjustment problems or single symptom/disorder cases). In the third year, students continue their clinical skill building process by adding additional treatment modalities and working with more difficult cases (e.g., cases involving multiple problems, personality disorders, or greater severity of disturbance). During this time, students also typically receive the bulk of their clinical experience through community placements. In this process, graduate students are deliberately exposed to a variety of approaches to clinical assessment and treatment, in order to provide them with a set of basic skills and a wide range of options as a scientist-practitioner. After these experiences, students complete an APA-approved clinical internship (generally in the fifth year), aimed at further broadening and strengthening the skills developed in the training clinic.

The training clinic is a major site of research-practice integration. It is incumbent upon clinical psychologists to utilize an empirical approach and be guided by the best available research when delivering clinical services. The Clinic provides infrastructure to train students in evidence-based assessment and treatment. It is the place where students learn to hone their skill of being able to integrate research and practice. At the University of Toledo this is done by coordinating didactic clinical courses and practicum training; by adopting a scientifically skeptical and inquiring attitude in one's clinical work; by engaging in clinically-relevant research; and by specific exercises in research-practice bridging (e.g., searching out scientific literature relevant to particular cases; using research methods to study one's own cases).

Psychology training clinics must serve three functions: training, research, and service, which inevitably lead to priority conflicts. (a) Training. Clearly, training is the main reason for the clinic's existence and is of the highest

priority. (b) Service. However, to be effective in its training function, the clinic must also be an effective mental health agency. In other words, real clients are seen and general standards for the delivery of mental health services must be maintained. While the clinic describes itself explicitly as a training setting, the services provided must be clinically appropriate and must meet or exceed minimum standards of care. In order to do this, students' lack of experience is compensated for by intensive supervision provided by clinical faculty. Because the training clinic must put itself forward as a mental health agency, it must function as one, which means that clinical service is a very high priority both as an end in itself (as part of the "bargain" with prospective clients), and as a means to the end of providing quality training for students. Students must learn not only techniques of assessment and intervention, but also the standards and practices of mental health agencies, including clinical management, timely and clear report writing, accurate record keeping, standards of care, and thoughtful allocation of limited resources. (c) Research. Research is also an important function of the clinic. In fact, as noted earlier, the integration of research and training/service is an essential part of clinical training. Training clinics typically do this by making space, equipment, and support available for faculty and students to carry out clinical research.

WHO'S WHO IN THE PSYCHOLOGY CLINIC

Administrative and Support Positions

<u>Clinic Director:</u>	<u>Jason Levine, Ph.D.</u>
<u>Academic and Client Services Coordinator:</u>	<u>Kaitlyn Geiger</u>
<u>Clinic Assistant (GA):</u>	<u>Alex Buhk</u>

Licensed Clinical Psychologists and

Clinical Faculty Supervisors:

Wesley Bullock, Ph.D.

Jon Elhai, Ph.D.

Sarah Francis, Ph.D.

Kim Gratz, Ph.D.

Jason Levine, Ph.D.

Gregory Meyer, Ph.D.

Peter Mezo, Ph.D.

Joni Mihura, Ph.D.

Mathew Tull, Ph.D.

Mychail Scheramic, Psy.D. (UCC)

Clinical Trainees:

Clinical trainees include all clinical graduate students enrolled in the program who are seeing clients through the Clinic. An identified clinical faculty supervisor must supervise all Clinic activity carried out by clinical trainees.

Clinic Committee:

The clinic committee is a deliberative body charged by the chair of the Department of Psychology to assist the clinic director with functioning of the UTPC and to make recommendations regarding both long-term and short-term operations of the Clinic. The committee is comprised of the clinic director, director of clinical training, and the chair of the department.

3. SERVICES PROVIDED

The UTPC provides non-medication psychological services to the community (including the University of

Toledo and the greater Toledo metropolitan area).

- A. Assessment: Psychological evaluation and consultation for individuals (children, adolescents, and adults) and groups (couples, families and larger systems). The UTPC has the resources and expertise to provide a wide range of assessment and testing services, including intellectual evaluations, cognitive strengths and weaknesses, academic achievement and learning difficulties and ADHD testing; diagnostic assessments; personality evaluations that identify cognitive, behavior, and emotional needs; presurgical psychological evaluations (e.g. transplant, bariatric). We do not provide neuropsychological assessment for issues related to an organic brain disorder.

- B. Intervention: The provision of evidence-based psychotherapy for individuals, families, and groups.

- C. Education: Educational opportunities for outside groups in the form of workshops, educational seminars, and scientific research of clinical problems are supported by the UTPC. Upon request and contingent upon Clinic resources the UTPC will work with outside groups to support mental health programming. The Clinic will also work (in proportion to its size) to increase the community's awareness of its services.

4. TRAINING NEEDS OF CLINICAL STUDENTS

Skills: Supervised training experiences are provided in psychological assessment, intervention, supervision, and consultation for individuals and groups. Clinical research experience opportunities within the UTPC and in the community are also available.

Clients: The UTPC will attempt to provide clinical students with experience in working with a variety of clients with regard to range of psychopathology, age, gender, education, socio-economic status and cultural diversity. Experiences with adults, children, couples, and families are available.

Education: The UTPC will offer clinical training that is directly related to the provision of services in the Clinic through regular Clinic meetings (e.g., HIPAA/FERPA training, suicide assessment). Additional programming in support of will be offered through the program's Professional Development Series (PDS). See the section on Professional Development Series (PDS) in the Clinical Program Handbook for more information.

5. ADMINISTRATIVE AND PERSONNEL ROLE DESCRIPTIONS

Clinic Director: The clinic director reports directly to the Chair and works in close association with the Director of Clinical Training and the Clinical Training Faculty. The Clinic director oversees the clinical and research activities of the UTPC. Specific duties include managing the day-to-day operations of the clinic, evaluating and improving (if necessary) clinic procedures and determining and monitoring adherence to clinic policies and procedures, working with UTMC compliance to maintain HIPAA compliance, supervising the billing and collection of fees, completing paperwork from the clinic as necessary to maintain APA accreditation, exploring and implementing (if appropriate) the procedures necessary to get the Clinic on insurance panels, supervising the implementation and maintenance of an electronic data management system to improve efficiency and compliance, coordinating with other faculty members the use of clinic data for research purposes, working with externship committee for student placement, acting as a liaison to other departments and programs to increase collaborative opportunities, oversight outreach activities, supervision of assistants assigned to the Clinic.

Academic and client services coordinator: The academic and client services coordinator works under the direction of the clinic director and the Director of Clinical Training. The academic and client services coordinator may also provide support to the Department. His or Her duties include, among numerous others, monitoring and implementing clinic policies and procedures, answering the phone, receiving clients, setting fees and contract for services, orienting clients regarding our HIPAA policies, signing out equipment, ordering testing materials/supplies, client billing, maintaining the Clinic A/V and computer equipment, conducting background checks and other duties to maintain an orderly clinic/office.

Clinic Graduate Assistant: The duties of the teaching assistant may include: helping monitor and coordinate Clinic processes and daily functions, performing screening interviews for prospective clients, stimulating needed referrals, assisting in the administration of new clients, and coordinating the research activities of the Clinic.

Clinic Undergraduate Assistant: On occasion the Clinic will hire a Federal Work-Study student from the University of Toledo. This position is part-time. His or Her duties include assisting the clinic director, academic and client services coordinator, and Clinic Graduate Assistant in various tasks and projects.

Clinical Trainees: During their tenure in the clinical program and the UTPC, each graduate student shall have the designation "Trainee in Clinical Psychology" and shall use this title in signing Clinic reports and correspondence. Clinical trainees include all students who are seeing clients through the Clinic. All Clinic activity must be supervised by a clinical faculty member. All clinic reports and correspondence (including all typed notes and letters) are to be co-signed by the appropriate supervisor

Clinical Supervisors: Clinical supervisors consult with and supervise the clinical work of clinical trainees. They include the full-time clinical faculty, and, on occasion, approved adjunct clinical faculty (see section 21). Supervisors are expected to oversee all trainee clinical activities for those students assigned to them. Final responsibility for students' clinical activities within the Clinic, including research or service projects, rests upon the trainee's supervisor.

6. CLINICAL EMERGENCIES

The UTPC does not provide and is not equip for emergency crisis intervention. Emergency walk-in or crisis-oriented services for UT students are offered by the University Counseling Center (UCC), and thus students should be referred to the UCC or another emergency agency. Non-students who require emergency services may be referred to Rescue Crisis or another emergency agency. While crises may arise during the course of a clinical contact with an established client, clinical trainees and supervisors are required to adhere to the following guidelines.

A clinical emergency is a disruption of baseline psychological functioning, which places the client or other persons at risk of harm.

The clinical trainee is responsible for handling an emergency in the course of a treatment, and he/she will confer with and include other members of the staff as necessary. All emergencies where the client is at risk or involving use of other facilities (such as hospital emergency services) must include consultation with a clinical faculty member immediately. Clinical trainees and Supervisors are required to notify the clinic director as soon as possible.

The Clinic does not have an answering service or an on-call faculty person to field clinical emergencies. Clinical trainees and their supervisors should develop a contingency plan for after-hours crisis support and management for clients that are at risk for clinical emergency.

All emergencies must be carefully documented in the client record.

Follow-up contacts, either by phone or through other mediums, with clients following a clinical crisis must also be documented in the client record.

Suicide Policy:

Clinical trainees and supervisors are required to understand the suicide policy and be able to follow the UTPC Suicide Protocol (Forms section). The Suicide Protocol outlines criteria to follow when and if you conduct a suicide assessment, including the role of the direct supervisor and how to carry out a suicide assessment. The Suicide Protocol also summarizes guidelines when conducting an assessment and procedures to follow when emergency hospitalization is indicated. The UTPC holds an annual training and review of the Clinic's suicide protocol during one of the fall or spring semester Clinic Meetings.

Non-client Requests for Emergency Services:

A person calling the Clinic seeking immediate care is helped to find an agency which provides emergency care (e.g. Rescue Crisis 419.255.9585, Toledo Hospital). Emergency contact information is posted outside the Clinic's office, UH1600.

7. MEDICAL EMERGENCIES

A client may arrive at the UTPC in clear need of medical attention. Moreover, a client may develop a medical problem or be accidentally injured while at the Clinic. In either instance, clinical trainees are required to immediately involve a clinical faculty supervisor or the academic and client services coordinator. First aid equipment is maintained in the Clinic Storage Closet. First aid materials can be offered as a courtesy to an adult client for self-use or a parent who can administer first aid to her/his minor child. Clinical trainees and faculty are not to deliver first aid or give medical advice or treatment. Clinical trainees and faculty may, of course, assist in an emergency. Immediate referrals can be made for student health emergencies by calling the UT Student Medical Center (419.530.3451). For transportation assistance, including transporting student and non-student UTPC clients to a hospital, call the Campus Police at 419.530.2600.

All medical emergencies or minor injuries, such as a minor fall or scrape, must be carefully documented in an Incident Report Form obtained from the academic and client services coordinator.

8. ENVIRONMENTAL EMERGENCIES

The University of Toledo implores students to be aware of their surroundings, report safety risks to the UT Safety and Health Department, emergencies to the Police and Fire Department 419.530.2600, and eliminate or minimize safety risks on campus by working safely at all times and being knowledgeable of safety policies.

The UTPC abides by all university policies as it relates to environmental emergencies. Please read and refer to the following websites for detailed action plans:

<http://www.utoledo.edu/depts/emergency/>

<http://www.utoledo.edu/depts/safety/docs/Misc/safetytips.pdf>

9. LEGAL EMERGENCIES (SUBPOENAS)

If a supervisor or clinical trainee is presented with a subpoena to provide testimony or is contacted by an attorney regarding a UTPC client, the clinical trainee and/or supervisor should not accept the subpoena and defer all communication with the outside party to UT Legal Affairs. The clinic director should be notified as soon as possible.

10. CLINIC LOCATION AND HOURS

The UTPC is housed on the first floor of University Hall in the southeast wing facing the Centennial Mall. There is a private entrance for clients and visitors on the southern side of the building. The Clinic facilities include a clinic office (Rm. 1600), waiting area, a conference room, workroom, and several consultation rooms.

Clinic Hours: Client appointments may be scheduled from 9:00 a.m. to 7:00 p.m. Monday through Thursday and 9:00 a.m. to 5:00 p.m. on Friday. Clinic clients may not be seen outside these hours without a clinical supervisor in close proximity. Clients normally are not to be scheduled for appointments during Clinic Meetings, program meetings, or at other times when an occasional, planned, formally announced group event has been scheduled, at least not without notifying the clinic director.

The UTPC functions as a year-round clinic and will be open to accommodate clients during academic breaks (i.e., winter break, spring break, fall break), with the exception of the week between Christmas and New Years Day. If there will be clinical activities scheduled during breaks, the clinic director and academic and client services coordinator will be notified by the clinical trainee and supervisor.

11. RECEPTION AND WAITING AREA (UH1330)

The reception/waiting room is a public space. Thus, care should be taken to respect the privacy of clients and guests in the waiting room.

There is a tendency for clinic personnel to use the space surrounding the waiting area for casual conversation. This must be kept to a minimum and stopped immediately if a client or guest enters the room. The reception area should be treated like any medical reception area, with professionalism and respect for privacy.

12. CONSULTING ROOMS (UH1340,1350,1360,1440,1450,1460,1680,1700,1710,1730)

Consulting rooms for assessment and therapy must be reserved in advance. It is extremely important that appointments are scheduled in Titanium for many reasons. It is the clinical trainee's responsibility to schedule appointments accurately and in advance.

When circumstances permit, you should arrive for sessions at least 15 minutes early in order to obtain necessary forms and arrange and test all recording devices you will be using, etc. You are expected to end sessions on time to avoid penalizing the next person waiting to use the room. This means that if appointments are scheduled

back-to-back, "50 minute hours" will need to be observed. If your sessions typically take more time or run over, you can schedule longer appointments if this is agreeable with your supervisor.

You are responsible for the condition of a consulting room after using it. It is to be left clean and orderly for the next appointment. A good rule to follow is to leave the room as you would want to find it. If any extra chairs are needed for a session, be sure to return them to where you found them. Ensure that equipment is stored and secured and the consulting room door is closed and locked.

13. AUDIO/VIDEO ROOM AND OBSERVATION ROOMS (UH1720)

Audio and visual equipment that is used to record clinical activities is housed in UH1720. Clinical trainees will receive a tutorial on how to use this equipment during their first year in the program. If technical issues arise with the recording equipment, the academic and client services coordinator should be notified and the LLSS instructional and student technology support team can be called to provide assistance.

The most ideal space to observe clinical activities is through usage of the one-way mirror between rooms UH1700 and UH1680. This will require that both rooms are scheduled during the same time. Additionally, if the group of observers is small the A/V room UH1720 can be used for real-time viewing on the computer. Importantly, please accommodate and allow other trainees and faculty to access the A/V equipment during live supervision or observation.

14. CLINIC WORKROOM (UH1470)

The clinic workroom houses computers and printers to be used when completing progress notes and scoring various tests, a phone with which to call clients and transact other Clinic business, a fax machine to send and receive any confidential information, a locked filing cabinet for active therapy and assessment files, and clinical trainee and faculty mailboxes. UH 1470 is strictly to be used and accessed by clinical trainees and faculty as well as the clinic office staff. The rooms should be locked at all times unless the academic and client services coordinator, a clinical trainee, or faculty member is in the room.

15. CLINIC RESOURCES

The Clinic receives a small budget each year to purchase needed supplies and equipment. Over the years it has acquired a number of psychological tests, computers, programs to computer score various tests, video and audio equipment, reference books, etc. These resources are primarily for the use of the faculty and graduate students working in the Clinic. See the academic and client services coordinator for a listing of these resources.

Testing equipment and materials are located in UH1600; expendable booklets and forms are kept in UH1640 and are to be used for Clinic volunteers and clients only, unless otherwise cleared with the clinic director. Except for expendable material like test protocols, all equipment must be signed in and out with the academic and client services coordinator. Since you are responsible for any equipment you sign out, be sure to have the academic and client services coordinator sign it back in when you return it. If this is not done and any equipment you have signed out is missing or damaged, you will be held responsible and incur the cost of replacing it.

Unfortunately, assessment instruments are expensive and we have only a limited number of each one. Consequently, instruments can be signed out but for a limited period of time depending on how many copies we possess. Since the Clinic is not open on weekends, testing equipment can be signed out over the weekend but must be returned the following Monday so that it is available to others if needed.

The Clinic maintains a small "library" of resources available to faculty and clinical trainees for training

purposes. Certain reference books are often in great demand and, consequently, can only be signed out on weekends and must be returned the following Monday. Other reference material, training audio and video tapes, etc. can be signed out for longer periods of time (e.g., days, weeks) as agreed on with the academic and client services coordinator. The academic and client services coordinator is also the person to contact when signing out any of these materials.

The Clinic GA will show you how to bring up the test scoring programs on the computer. They can also show you how to work the video equipment. None of this equipment may be used until you receive training in its use and care.

In using Clinic resources, please observe these few common sense rules:

- A. Do notify the academic and client services coordinator or Clinic GA of any testing kit that has been damaged or that is incomplete.
- B. Do notify him/her if you notice we are running low on test protocols or Clinic forms that are stored in UH1640.
- C. Please do not use the last copy of a form or protocol.
- D. **DO NOT MARK OR WRITE IN TEST MANUALS OR REFERENCE BOOKS!**
- E. It is also good practice to send an email to your fellow trainees notifying them when you check out a high-demand instrument.

16. CLINIC TELEPHONES

Clinic phones are to be used for business purposes only. A phone call should only be made from within UH1470 when the door is closed.

17. MAILING AND DUPLICATING (UH1470)

Only mail and duplicating directly related to Clinic business will be paid for from Clinic funds. **THERE SHOULD BE ABSOLUTELY NO COPYING OR PRINTING OF DOCUMENTS** (e.g., theses, research lab articles) **UNRELATED TO CLINIC BUSINESS.**

18. SMOKING POLICY

The University of Toledo Main Campus is a smoke-free environment. Clients are politely asked to honor the University policy and refrain from smoking while on campus.

19. PARKING

The Psychology Clinic has a guest parking permit account. Trainees and faculty are responsible for submitting a parking request for their clients at the time of scheduling an appointment. Parking reservations are only good for 3 day spans, and will need to be resubmitted for every session. Trainees and faculty can access the website at: <http://guestparking.utoledo.edu>, and will need to obtain log-in information from the academic and client services coordinator. In order to submit a parking request, you will need the initials of the Client, the vehicle make/model, vehicle year, vehicle color, license plate state and number, know whether or not the plate is handicapped, and the 3 day span for parking. The Clinic has handouts for clients that explain the various parking options on campus. You are encouraged to mail or fax this handout to clients before their first session.

20. CLINIC SECURITY

For ethical reasons and because of the expensive equipment it houses, the Clinic is locked whenever personnel, faculty or clinical trainees are not using it. Keys to the Clinic rooms can be obtained by submitting a request to the academic and client services coordinator.

Those using the Clinic are responsible for the security of both the facility itself and its equipment. Be sure the doors to the consultation rooms are locked after your sessions. If you are the last one to leave the Clinic, be sure all the lights are out and all the doors securely locked. Make certain to return all testing equipment you have been using and ensure you have used the proper sign-out procedure. If anything is damaged or stolen as a result of these guidelines not being followed, the person responsible may have to bear the financial burden of repairs or replacement.

Do not leave Clinic equipment or personal items lying around. Thefts have occurred in this building. If you see anyone in the Clinic whom you feel should not be here, do not hesitate to question the person or notify Clinic personnel.

21. STUDENT LIABILITY AND INSURANCE

UT is insured through a liability policy covering all State employees or representatives, including enrolled clinical psychology graduate students. This coverage applies to faculty and staff whether they are full-time or part-time.

Students engage in on-the-job activities required as part of the academic program are insured under this coverage, so long as they are not employed by the individual, company, or agency for whom they are working. The University's insurance coverage will not apply if the student becomes the employee of another party. If they are paid by the State they are State employees and thus covered.

As such, general liability insurance coverage is afforded to students provided they meet the following criteria:

Are enrolled in the university.

Are performing activities (practicum, Traineeships, on-the-job training) that are required as a part of their course of study.

Are not employed by the organization or for the purpose for which they are performing the work.

If a client is seen for therapy without regard for policies set forth in this manual and by the clinical faculty and Supervisors (such as policies about when and where therapy can occur, what should be done in therapy, and reasonable efforts to keep charts up to date), the trainee may be forfeiting the insurance coverage and legal protection otherwise afforded. The client, the supervisor, and the UTPC may also be put at risk. Please direct any questions about UT liability coverage to UT Legal Affairs, Thomas Claire, 419.383.4570.

Students may purchase their own additional liability insurance through a professional organization. The Trust Risk Management Services, Inc., a wholly owned subsidiary of the APA Insurance Trust, at www.apait.org, offers a high level of student coverage for \$35-\$50 per year.

22. CLINIC MEETINGS

All clinical trainees enrolled in a clinical practicum and/or who deliver or plan on delivering psychological services that are considered by the State Board of Ohio to be a "serious hazard to mental health" are required to attend scheduled Clinic Meetings. The primary purpose of Clinic meetings is to review Clinic policies and procedures including HIPAA compliance, disseminate updates or changes, and provide a structured forum for trainees to provide feedback and input regarding Clinic operations.

23. PROFESSIONAL CONDUCT

What We Expect of Trainees

With the joys and fulfillment of clinical work come the responsibilities and standards of good practice. These form the moral and ethical structure which safeguards our work with patients, and as we describe these guidelines, you will find that the presentation has a different, more prescriptive tone. Ultimately, however, we trust that these guidelines are yours, a vital part of your identity as a professional clinician, and not a set of external strictures imposed upon you.

The Clinic is a professional organization. We educate students to be professional psychologists, and we expect and require professional and ethical attitudes and behavior from our Trainees, faculty supervisors, and support staff. We recognize that no one is perfect, and that Trainees are here to learn. The first and preferred approach to ethical issues is educational and remedial. However, you should know that persistent or severe ethical lapses may be grounds for dismissal from the training in the Clinic or from the Clinical Program. In addition to the Clinic Handbook, you should read and are expected to know and abide by the APA's Ethical Principles of Psychologists and Code of Conduct and the Ohio Administrative Code 4732-17-01.

Professional Conduct

The Faculty and Staff at the UTPC are committed to training competent and conscientious practitioners and researchers. As such, we are interested in your holistic development as a student, person, and professional. We believe this focus is consistent with graduate training at a top-tier institution. Although you are still in training, the public, the Staff, and Faculty have already started to identify you as a professional in the areas of psychology. For this reason, we require that our students act in a manner consistent with their role as emerging representatives of the profession. Specifically, this would include but not be limited to the following:

Promptness: in attending any therapy session, practicum, or meeting at the UTPC is expected of all clinic staff. Please contact the academic and client services coordinator if you are ill and cannot attend, or find that you cannot avoid being late.

Punctuality: is also especially important in ending therapy and assessment sessions on time. Other clients or Trainees may be waiting and deserve to be able to have a full session.

Flexibility: is another critical quality required of clinical trainees. Evening hours can become crowded, mishaps involving scheduling of rooms can occur, and sessions can overrun scheduled times because of clinical necessity. For these reasons, along with other unforeseeable events, cooperation and compromise become important for the UTPC to run smoothly as possible.

Respect: for the clinical environment: each client and trainee has the right to expect a therapeutic environment that is neat and consistent. Hence, it is your professional responsibility to return all therapy and assessment rooms to their original condition before leaving the room. This includes moving chairs and tables back to where they were initially positioned, throwing away trash, etc. Additionally, your fellow clinical trainees will appreciate the same approach and standards applied to the observation/videotaping rooms.

Conscientiousness: Return all assessment material or other items borrowed from Clinic library immediately following their use so that others may have access to them. It is vital that all components of the assessment materials of the same test be kept together and returned. Do not use the last copy of a form, booklet, or protocol; inform the academic and client services coordinator that materials need to be replenished.

Timeliness: Supervisors and Trainees are responsible for ensuring that assigned clients are contacted no later than 7 days after Clinic staff assigned the case. Clinical trainees facilitate scheduling the first session themselves or by arranging for the academic and client services coordinator to make the initial contact and schedule a client's first session.

Sign out all assessment and treatment materials, books, manuals, etc. by completing a sign-out from provided to you by the academic and client services coordinator. Return items borrowed from the cabinets immediately following their use so that others may have access to them. It is vital that all assessment and treatment materials be kept in good shape and returned.

Completion of Therapy Documentation: See section 44g for documentation timelines. Submit final signed reports to the academic and client services coordinator so they can be scanned into Titanium. Getting paperwork done on time and keeping progress notes up to date is your professional responsibility. Failure to do so can adversely affect the client's treatment in an emergency.

Completion of Assessments: Assessments are to be completed in a timely manner with the fewest number of sessions necessary to complete the assessment. In other words, clinical trainees should make every effort to schedule longer blocks of time (e.g. 3+ hours) to administer complete test batteries. The final report, or summary if the assessment is incomplete, should be completed and submitted to the academic and client services coordinator within the timeframe set by the supervisor and communicated to the client during the informed consent process. This ensures that the client's expectations for when an assessment will be completed, and a report produced, are met.

Diligence: Part of your clinical responsibility is to respond promptly to any and all memos or e-mails sent to you by the staff of the UTPC. Please check your UTPC mailbox and e-mail on a regular basis. Be judicious when disclosing information in public domains (e.g., posting information on personal websites such as Facebook). In addition, refrain from posting unprofessional statements or pictures that may be viewed by clients, supervisors, instructors, or colleagues.

Respect for others: Turn your cell phone off or to vibrate while attending meetings or class at the UTPC, and during therapy sessions. Abstain from inappropriate use (e.g., text-messaging, emailing) of personal computers or other electronic devices during class, sessions, and meetings.

Wellness and self-care: If you are unable to honor a professional or academic commitment, seek guidance your instructor or supervisor. Doing so will often provide a more positive resolution of whatever difficulty you may be experiencing and will likely facilitate an opportunity for professional growth and development. Difficulties may include, but are not limited to illness – physical or mental. Students who do not seek advisement in a timely manner are often disappointed by the outcome and may potentially be subject to disciplinary action.

Professional Dress: The UTPC does not have a specific policy for what types of clothes a trainee should wear. A number of factors including current style, lack of knowledge or feedback, lack of a decent income, and most importantly, the therapeutic goal of the Client preclude a definitive and strict dress policy. In general, all UTPC personnel, including students, faculty, and staff, should be dressed professionally when in the UTPC. When clients come to the UTPC, they are looking for professional help. Dressing appropriately aids in giving the client confidence that you can be of help.

Dress for professional activities is based on sensitivity to client values and norms as well as consideration of the communication function of one's appearance and attire. As the focus of professional interactions is on the client, the professional's appearance and dress should be generally conservative to avoid distractions from the process of therapy or assessment. It is safe to say that most Supervisors prefer professional casual dress. Further, appearance and attire should be respectful of the client's cultural background and sensitivities.

24. ETHICAL CONDUCT

Ethics are moral standards that ensure that professionals provide quality services and are respectful of the rights

of the people with whom they work. Acting in an ethical manner also involves following the laws and rules governing one's profession. Trainees must realize that their Supervisors and the training program they represent must adhere to the laws and rules of the profession and that they must follow standards of ethical behavior. The Clinical Program provides the student with coursework, supervision, clinical practica, and available resources by which to learn to identify ethical dilemmas, avoid potential dilemmas, and make appropriate decisions. More specifically, the trainee is required to take the graduate level course in Ethics; Clinical Supervisors, who are all licensed, are required by the state's professional regulations to have continuing education in ethics per year; the clinic director is available for consultation and supplementary supervision on all ethical matters; and the UTPC maintains a comprehensive and current collection of books, chapters, and articles on the topic of ethics.

The profession of psychology has developed ethical codes that are intended to protect the consumers. These codes provide us with assistance regarding the best action to take in challenging, confusing, or novel situations. The American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (2010) can be found on the APA Web site, <http://www.apa.org/ethics>. Trainees can request hard copies of the Ethics Code from the APA Order Department, 750 First Street, NE, Washington, DC 20002-4242. This code delineates basic ethical principles to which professional psychologists follow. (See also Appendix M of the Clinical Program Handbook)

Ethical Principles: Many ethical codes and the literature on ethics stress the importance of six basic ethical principles: autonomy, beneficence, nonmaleficence, justice, fidelity, and veracity. Below is a brief description of each of these basic principles. The trainee is referred to Foundations of Ethical Practice, Research, and Teaching in Psychology by Karen S. Kitchener (2000) for a detailed description of each of these principles.

- A. Autonomy: refers to the right of both the consumer and the provider to make choices and take actions, provided the results do not adversely affect others.
- B. Beneficence: refers to the intent "to do good" by helping and promoting growth in others.
- C. Nonmaleficence: can best be described in the phrase "above all, do no harm".
- D. Justice: defined as fairness or ensuring equality of opportunities and resources for all people.
- E. Fidelity: refers to keeping promises and being trustworthy in relationships with others.
- F. Veracity: refers to telling the truth.

Ethical Guidelines: The above six ethical principles outline general rights that individuals have in therapy situations. These principles, in conjunction with APA's Code, not only help to protect clients who seek assistance in resolving problems, but also provide the foundation for Trainees and Supervisors with developing guidelines for addressing ethical dilemmas.

- A. Recognize your limits. It is critical that the trainee recognizes and practice only within the areas for which you have been trained in some fashion either through prior supervised experience, coursework, workshops, seminars, and/or under the close supervision of a competent professional.
- B. Be honest about your qualifications. Tell the client you are in training to learn skills and do not yet have an advance degree or license.
- C. Consult with your supervisor about any possible ethical issue.
- D. Focus on the needs of the client. Help the client understand the nature of the therapeutic relationship including educating clients about the clinic, fees, confidentiality, privacy, taping, team approach, techniques used, treatment goals, and name of your supervisor.
- E. Understand the role of culture. Be mindful of differences among individuals and use basic therapeutic skills that reflect an understanding of the people with whom you are working with.
- F. Be aware of your values. Utilize the supervision process to be aware of the influence of your values and beliefs in the interactions with clients.
- G. Avoid harmful dual relationships.

- H. Act in a virtuous manner. Virtue differs from ethics in that one is not as concerned with laws and rules as much as striving to be a person of positive moral character.
- I. Take care of yourself to ensure that you can care for others.

Ethical Decision Making Process: Although a trainee may not encounter many ethical dilemmas, learning how to work through these situations can be helpful so that Trainees can be prepared when ethical dilemmas do arise. Ethical dilemmas occur when there are competing ethical reasons to act in ways that are mutually exclusive. At times, actions that uphold one ethical principle could violate another ethical principle. For example, ethical codes often ensure a client's right to privacy and confidentiality. They also endorse the importance of working to minimize harm to others. These important standards can, at times, be in conflict with one another; an adolescent client who is threatening to kill herself but does not want the trainee to discuss this with her parents. The following strategy is a suggested ethical decision making process that can be followed when a trainee is confronted with an ethical dilemma.

- A. Determine that the matter or situation presents an ethical dilemma. Consult with your supervisor if have any doubt.
- B. Consult APA's Ethics Code and other available professional guidelines that might apply.
- C. Consider, as best as possible, any personal factors that might influence your objectivity or affect your decision.
- D. Evaluate the rights, responsibilities, and vulnerability of all affected parties.
- E. Generate a list of possible decisions; note which are most ethically appropriate; enumerate the consequences of making each decision.
- F. Consult with your supervisor. Consult with the clinic director. Document all consultations.
- G. Make the decision, per your supervisor's instruction.
- H. Implement the decision.
- I. Document the decision-making process.

Ethical dilemmas are sometimes described in terms of mutual danger and opportunity. Ethical dilemmas can be dangerous in that the welfare of the client may be compromised. However, they also present an opportunity for Trainees to reflect on what they have learned and what they value and then to act in a manner that is consistent with the mores of the profession and their personal values. Ethical dilemmas provide the unique challenge for Trainees to confront and resolve important questions and to ensure, to the best of their abilities, that clients' needs are served.

Special Ethical Topics:

Multiple Relationships: A multiple relationship occurs when a trainee is in a professional role with a client and (1) at the same time is in another role with the client, (2) at the same time is in a relationship with a person closely associated with the client, or (3) promises to enter into another relationship in the future with the client or a person closely associated with the client. Trainees should refrain from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the trainee's objectivity, competence, or effectiveness in performing his/her functions as a clinical trainee, or otherwise risks exploitation or harm to the client. Multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical.

Because clinical trainees perform a variety of roles in our program including seeing clients, teaching students, and conducting research, clinical trainees may become aware that their friends, acquaintances, colleagues, subjects, or students are being seen at the UTPC or that some other multiple relationship issue exists. It is the responsibility of each staff person to maintain appropriate boundaries in such situations and not allow personal issues to impinge upon services received by the client. For example, a clinical trainee should remove oneself from practicum team during the time a known acquaintance is being staffed or discussed. If such conflicts of

interest occur, the staff member should discuss it with her/his supervisor or the clinic director.

It is worth noting that APA's Ethics Standard for multiple relationships does not prohibit such things as attending a client's family funeral, wedding, or graduation; gift giving or receiving; or from entering into a social relationship with a colleague as long as these types of interactions or relationships would not reasonably be expected to lead to role impairment, exploitation, or harm. Clinical trainees should discuss such possible situations with their supervisor before taking action.

Incidental encounters with clients at religious services, town events, restaurants, health clubs, or similar places are not unethical. Nonetheless, Trainees should always consider whether the particular nature of the professional relationship might lead to misperceptions regarding the encounter. If so, it may be wise to document such encounters.

25. PRIVACY AND CONFIDENTIALITY

Privacy: refers to freedom from unauthorized intrusion of others upon the identification of or information about an individual. Individuals have the freedom to choose (authorize) the time and the circumstances under which, and the extent to which, their beliefs, behavior, and opinions are to be shared or withheld from others.

Confidentiality: is the principle in medical ethics that the information a patient reveals to a health care service provider is private and has limits on how and when it can be disclosed to a third party.

An extremely important legal, ethical, and clinical responsibility to our clients is confidentiality. Since the concept of confidentiality is not only important, but also varied and complex, it is discussed in detail below.

Overview. The therapeutic relationship is built on trust, and confidentiality is of utmost importance in building and maintaining that trust. These policies of confidentiality apply to all activities with clients, including supervisory contact between clinical trainees and supervisors. For example, it would be a breach of confidentiality to even indicate to an unknown caller over the phone whether an individual is a client at the UTPC.

Cases are not to be discussed with colleagues when the possibility exists of being overheard. Case material should be discussed in private only and in rooms with doors closed within the Department of Psychology. Discussion of cases is limited to members of the supervision team (i.e., Faculty supervisor and Supervisee seen in group supervision) or other supervisory consultants (i.e., faculty members and/or professional colleagues with expertise in a particular area of psychological difficulties). Consultations should be undertaken with the express permission of the supervisor of record, except in the case of emergency (i.e. suicide threat and supervisor is unreachable).

As a general rule, therefore, do not discuss clients in any way outside of supervision. The workroom is not a "safe haven" for such discussions because of its proximity to the waiting room, therapy room, and bathroom. If you must mention client information (e.g., requesting appointment information at the reception desk), please avoid use of the client's name, and do not discuss the case further in any way.

It is inappropriate to discuss case material at any time with nonprofessionals (e. g., partners and roommates) or with any persons unrelated to the operation of the UTPC. If case information is used for research, case presentations, or other educational purposes, it must be carefully edited so as to disguise the identity of the client(s).

If other clinical trainees want to observe a session for training purposes, they must obtain permission beforehand from the trainee. It is recommended that observers schedule time for discussions with the trainee

and his/her supervisor after the session.

Breaches of privacy and confidentiality often occur in a seemingly innocuous manner. For example: whether on the phone or in-person, never make your client(s) an item of casual gossip or chitchat, even when names are not mentioned. Never discuss a case in a public area, even a public area within the Clinic, since you always run the risk of being overheard. Never answer questions on the phone about your clients except when the caller is known and clearly identifiable to you, and you have the written consent of your client to do so. In general, such matters should be done in writing and, of course, always on the basis of proper authorization.

The principle of confidentiality requires that your client must be informed that recording devices are employed during sessions and that a colleague, assistant or supervisor may be observing behind the one-way mirror prior to using recording devices. When conducting therapy or an assessment, it is incumbent on you to discuss this with your client before you begin recording and when you present the consent form explaining Clinic policy regarding confidentiality for his or her signature.

Therapy clients are informed by the Clinic GA of the dual training/service functions of the UTPC and the use of observation and recording devices for purposes of training. However, you are expected to also explain Clinic policy regarding confidentiality during your initial contact with your clients and answer any questions they might have. Since clients can inquire at any time who is observing them, you should always know who is in the observation room during your sessions.

Finally, there are several legal exceptions to confidentiality. They are listed on the consent form your clients sign. In the case where your client voluntarily consents to the release of information about himself or herself, you are responsible for assisting the client in specifying exactly what information will be released and to whom, so that only that material which will benefit the client is shared. In the case of children, parental consent is always required.

Minors. According to Ohio law Ohio Administrative Code (OAC) Rule 4732-17-01 (c) (2), any person with legal rights pertaining to a child (e.g., legal guardian or non-custodial parent) may have the legal right to terminate the child's therapy. Please note one exception to the above rule, Ohio Revised Code (ORC) 5122.04, which is quoted below:

(A)

Upon the request of a minor fourteen years of age or older, a mental health professional may provide outpatient mental health services, excluding the use of medication, without the consent or knowledge of the minor's parent or guardian. Except as otherwise provided in this section, the minor's parent or guardian shall not be informed of the services without the minor's consent unless the mental health professional treating the minor determines that there is compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and if the minor is notified of the mental health professional's intent to inform the minor's parent or guardian.

(B)

Services provided to a minor pursuant to this section shall be limited to not more than six sessions or thirty days of services whichever occurs sooner. After the sixth session or thirty days of services, the mental health professional shall terminate the services or, with the consent of the minor, notify the parent or guardian to obtain consent to provide further outpatient services.

(C)

The minor's parent or guardian shall not be liable for the costs of services which are received by a minor under division (A).

(D)

Nothing in this section relieves a mental health professional from the obligations of section 2151.421 of the

Revised Code.

Importantly, the legal guardian of a minor (under 18 years of age) can request information about assessment and treatment, and can request to examine the minor's clinical records. Clinical trainees and supervisors are to discuss guardian's rights to access records and are required to document this disclosure to the minor client.

Even though parents have a legal right to information about their child's therapy, privacy in therapy is often crucial to successful progress, particularly individual therapy with adolescents. In such cases, the trainee may request that parents agree to limit the level of information given to them. Typically, the best level of communication in individual therapy between a child's trainee and his/her parents is general information about the progress of the child's treatment. Other communications will require child/adolescent assent, unless the trainee feels it is a crisis situation including personal risk, self-destructive behavior, or physical danger to the minor or others. An example may be telling an adolescent that if he/she has tried alcohol at a few parties, you would keep this information confidential, whereas if they tell you that they are drinking and driving then you would not keep this information confidential from their parent/guardian. If possible, such disclosures should be discussed beforehand with the minor to minimize his/her objections and concerns.

Couples, Families, and Groups. If the clinical trainee provides couple, family, or group therapy, she/he (in consultation with their clinical supervisor) should discuss their proposed policy regarding confidentiality. It is the baseline or default policy that the trainee may not reveal any information revealed by any member of the client unit (i.e., the couple, the family members in therapy, or the group members) to anyone outside the client unit without prior written permission or in mandated situations described in the Limits to Confidentiality section. However, it is a therapeutic axiom that open and honest communication between all individuals involved in therapy results in the most beneficial outcome. Hence, it is important that in the first session when discussing confidentiality, to identify issues that are particularly important in couples or family therapy. It is recommended in couples' therapy that partners agree to not be provided with confidentiality from one another. It is recommended in family therapy that all parties involved agree that the trainee is allowed to convey information to other members of the client unit based on the rights and overall well-being of all members. The trainee should always consult with their supervisor regarding any questions of confidentiality with minors, couples, or families prior to the first session. The clinic director is also available for consultation on issues of confidentiality with minors, couples, families, or groups.

26. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This section provides a brief overview of HIPAA and provides definitions for key terms as they relate to UTPC policies and procedures under HIPAA. Clinical trainees will receive additional information and specific training on HIPAA compliance prior to providing any clinical services. Clinical trainees, supervisors, and staff will also be provided continuing education on both federal and state regulations regarding the use and protection of patient/client information.

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law designed to protect health information by establishing standards for the use and disclosure of identifiable health information, known as Protected Health Information (PHI) that is created or received by a health care entity, such as the Psychology UTPC and Training UTPC. HIPAA was passed by Congress in 1996 to set a national standard for electronic transfers of health data. At the same time, Congress saw the need to address growing public concern about privacy and security of personal health data. The task of writing rules on privacy eventually fell to the U.S. Department of Health and Human Services. HIPAA has several parts including privacy, security, and computerized claims processing of PHI. The HIPAA Privacy Rule is effective as of April 14, 2003, for most health care providers, health plans, and health care clearinghouses. The main goal of the Privacy Rule is to protect the use and sharing of PHI of a patient.

The HIPAA compliance officer for the Psychology UTPC is the Director of the Psychology Clinic. The clinic director informs the UTMC Compliance Office of any known disclosures or breaches of protected health information (PHI).

Protected Health Information (PHI)

Any individually identifiable health information regarding a patient, including demographic or descriptive information (name, employer, email address), diagnosis, test results, treatment plan, payment information, or clinical supervision information.

PHI cannot be disclosed unless the patient has given specific written authorization to do so, or unless it is required or allowed by law (e.g., child abuse reporting, or serious threat to health or safety).

"Consent" refers to the Psychotherapist-Client Services Agreement that is read and signed by the client prior to receiving professional services. Further consent is not required when the clinician providing services consults or interacts with other professionals within a healthcare entity, such as within the UTPC, or with other healthcare providers directly involved in the client's care (e.g., client's primary care doctor, referring physician).

"Use" versus "Disclosure" of PHI

"Use" refers to sharing, employing, using, applying, examining, or analysis of PHI within an entity (e.g., the UTPC). Patient PHI may be used within a health care entity provided the patient has provided "consent" prior to receipt of services.

"Disclosure" refers to release, transfer, provision of access to, or divulging in any manner, PHI outside of the entity holding the information, or with healthcare providers directly involved in the client's care. Disclosure of PHI is permitted only when the patient has given specific written authorization to do so, unless it is required or permitted by law.

Any person who discloses or misuses PHI is subject to dismissal from the clinical training program, in addition to civil or criminal penalties provided by the law.

What you must do if you breach PHI?

(<http://www.apapracticecentral.org/business/hipaa/breach-notification.aspx>): If you breach, or witness a breach of, protected client information, you must first notify your supervisor AND the clinic director. The clinic director will communicate reports of disclosure or breach of PHI to the UTMC Compliance Office.

HIPAA Training Requirement: All clinical trainees, clinical faculty, clinic office staff, and non-clinical researchers working in the Clinic are required to complete an annual UTMC HIPAA training workshop. The Clinic will schedule a training session at the beginning of each fall semester. If a trainee or clinical faculty member is unable to attend the scheduled meeting, then they must complete an online training workshop offered through the Compliance Department.

http://www.utoledo.edu/offices/compliance/HIPAA_Training.html.

Individuals are required to submit annual documentation of their completed HIPAA training to the clinic director prior to working with PHI or de-identified clinic research data.

Confidentiality and Recording Devices: All clinical trainees are required to video and/or audiotape all clinical contacts with clients. Although you are expected to record and review clinical contact sessions, to ensure confidentiality these recordings must remain in the Clinic or with your supervisor at all times. Encrypted flash drives approved by the clinic director may be used by faculty and clinical trainees and must be securely stored

in the clinic mailbox room, NEVER IN DEPARTMENT MAILBOXES OR OFFICES.

Video files are considered protected health information. Video files are stored to a closed-circuit computer system for three months. Files are cataloged by room number and date. ***The clinic office staff will remove files from the computer which are 3-months or older.*** It is the clinical trainees' responsibility to "back-up" video files that they wish to keep for research or other educational purposes; and can only do so if and only if they receive approval from their faculty mentor. Once video files are deleted from the Clinic's closed-circuit computer system, the Clinic is no longer responsible for copies that were made.

27. SUPERVISION

During your tenure in this program, all of your clinical work must be supervised at all times. Trainees should only deliver clinical services to a client who has been approved by the clinic director AND when a supervisor has agreed to take legal responsibility for the case. It is critical that trainees keep their supervisor informed at all times as to the status of the client and any concerns the client might express to you. When supervisors are ill or on vacation, back-up supervision arrangements should be made with available clinical faculty and documented in the client chart.

Appropriate use of supervision itself involves implicit ethical mandates. For example, ethical problems in supervision might include: operating at an inappropriate level of autonomy, intentional nondisclosure of important information, mismanagement of clinical notes, failure to address personal biases as they relate to multicultural issues, and using inappropriate methods to manage conflict or differences with supervisors. Psychology trainees are encouraged to become familiar with the supervision literature and consider supervision as an area for their further development. It is by reflecting on the supervisee role and discussing expectations with their supervisors that clinical trainees will obtain the most benefit from their pre-doctoral training experiences. Please refer to the Handbook of the Clinical Psychology Program – Training Program Overview, Clinical Training, for program requirements regarding training in supervision.

Supervisors: Supervisors include all core-clinical program faculty members who supervise psychological procedures that create a "serious hazard to mental health".

Any non-core clinical faculty member must be approved by the clinic committee prior to providing psychological training supervision in the Clinic. The clinic director shall notify the core-clinical faculty when a non-core faculty member has been approved to supervise trainees. Contrariwise, the clinic director shall notify the core-clinical faculty when a supervisor no longer has approval to supervise in the Clinic.

Supervisors are expected to oversee all clinical trainee clinical activities for those trainees assigned to them through clinical labs/practicum or outside of a clinical practicum. Final responsibility for trainee's clinical activities within the Clinic, or within community research or service projects, rests upon the clinical trainee's supervisor.

Supervisors are responsible for the accuracy, completeness, and timeliness of their trainees' documentation.

Supervisors complete formal evaluations at the end of each semester for all trainees they have supervised through a practicum. These evaluations are reviewed orally with the clinical trainee, co-signed by trainee and supervisor, submitted to the academic and client services coordinator, and then entered into the student's departmental file.

The clinic director will schedule a staffing meeting with practicum supervisors at the beginning of the academic year and meet as needed throughout the semester. The purpose of this meeting is to discuss issues related to the Clinic's support of training during practicum courses. The clinic director will also check-in with supervisors

throughout the semester, and supervisors are encouraged to contact the clinic director to communicate issues or training needs.

Supervisor Contact Plan: The supervisor of record is the primary contact supervisor and it is up to the supervisor and clinical trainee to develop a comprehensive supervision plan. The trainee and supervisor will develop a “fool-proof” procedure to communicate with one another as part of their supervision plan, which may include back-up supervisors if necessary. In the case of a clinical trainee needing immediate supervision and is unable to get in contact with his or her supervisor, the clinical trainee should locate a clinical supervisor nearby in the psychology department or contact the clinic director by phone.

Supervision Hours: Consistent with the Handbook of the Clinical Psychology Program and Ohio Board of Psychology (OAC 4732-9-01), supervisors must provide a minimum of 1 hour of face-to-face supervision for every 10 hours of clinical (on site) activities per week for each trainee; a three-credit hour practicum course involves 10 hours of clinical activities per week. Of this minimum requirement for each trainee, at least 30 minutes must be acquired in the context of face-to-face individual supervision provided by a supervisor who is a licensed psychologist. Any supervision beyond this minimum 30-minutes of face-to-face individual supervision may be obtained in an individual or group context. For example, a therapy practicum team consisting of one supervisor and four trainees shall meet as a group for 2-hours per week AND hold 30-minute individual supervision meetings per week. This arrangement would satisfy the State of Ohio Board of Psychology’s requirement. Please refer to the Handbook of the Clinical Psychology Program for specific requirements.

28. CLIENT PROCEDURES – SCREENING INTERVIEW AND ASSIGNMENT

Screening Interview: The academic and client services coordinator is typically the first person to receive phone calls from potential clients and receive walk-in referrals. When a potential client is interested in receiving services, the Clinic follows a sequential process of pre-screening a case, assigning a case to a supervisor, and supervisor approval and assignment to a clinical trainee:

1) the academic and client services coordinator enters client demographic information into Titanium. A “Client ID number” is automatically assigned to the potential client in Titanium, and a “File Number” file is assigned after the first initial session - after Informed Consent is obtained potential clients become “active clients”. Titanium keeps a running record of all referrals and their status, and the Clinic keeps an “official” list of all active and inactive clients on a shared network drive. If the UTPC is not currently accepting referrals (e.g., for LD assessments), then the academic and client services coordinator will provide an outside referral to that client.

2) The Clinic GA provides initial call-backs to potential clients and conducts screening interviews. Exceptions are made and alternative procedures are followed at the request of the supervisor. All prospective therapy and assessment clients who are seen in the Clinic undergo a screening interview. This initial screening procedure is to ensure that, as much as possible, individuals seeking services here can benefit from the level of service offered and that they will make reasonably appropriate training cases. The Clinic screening process has certain criteria that typically contraindicate receiving services from the Clinic, these criteria include: 1) clients who are actively psychotic, 2) have a moderate to severe substance use disorder, 3) clients involved in an ongoing legal case, 4) actively suicidal clients or clients engaging in self-injurious behavior, 5) clients with severe psychopathology and/or unstable mood (e.g., mania or deep depression) that are deemed inappropriate for training. The screening interview is not intended to supplant the intake interview or a thorough assessment.

At the time of the screening interview Clinic GA will ask if the client needs a parking permit, and if necessary, will obtain vehicle information from clients. Clinic TAs will enter parking information on the client’s contact information/face page in Titanium.

3) The clinic director will review all completed screens at the subsequent meeting with the Clinic GA. For assignment to psychotherapy practicums, the clinic director makes the initial matching decision with GA input based upon clinical trainee and supervisor requests, experience and training needs, client variables and length of wait time, and practicum needs and availability. Upon request, the Clinic GA may meet with a supervisor to discuss the availability of cases and case assignment.

Assignment of Cases: Potential clients who complete a screening interview and are approved by the clinic director will be referred and assigned to a supervisor through email. If a supervisor approves of the case and accepts the case, he or she will then assign the case to a trainee and discuss with the trainee how to proceed. Once a client is assigned to a clinical trainee by the supervisor the supervisor will also add the clinical trainee to the client's list in Titanium. Clients are to be contacted by the trainee or supervisor OR the supervisor will send the case back to the Clinic (through email to the Clinic GA) within **7 days of the initial assignment**.

It is a requirement that before a client receives psychological services in the UTPC, the client has completed a screening interview with the Clinic GA and has been approved by the clinic director.

The clinic director and/or GAs will check in with Trainees and Supervisors on their case loads on a regular basis, at the beginning of semester meetings, and through ongoing communications. Clinical trainees and supervisors are encouraged to bring to the attention of the clinic director any training needs or to make specific requests.

For assignment of psychotherapy cases outside of practicums (e.g., a supervisor is not teaching a practicum) a clinical trainee requesting a client will need to identify a faculty supervisor that will take on the client before a case can be assigned. Psychotherapy practicums have first priority for cases. A clinical trainee (and their supervisor) will only be assigned cases outside of practicum if the case is not a good fit for any of the current practicums, practicum caseloads are full, or the client demands to be seen under the supervision of a faculty member not teaching a practicum. Clients have the right to request that a specific faculty member supervise their case. As such, when circumstances permit, the Clinic will make efforts to accommodate client requests. The clinic director and clinical faculty member will make this determination. For example, a client might be interested in receiving services from a clinical trainee under a specific supervisor based on that supervisor's area of expertise.

Practicum caseloads: The Clinic GA will monitor caseloads on practicum teams and will continue to assign clients until the practicum supervisor informs the GA through email that the team is "full". Practicum supervisors shall then notify the Clinic GA when they are ready to accept new clients by emailing the Clinic GA. Practicum supervisors determine student caseloads. The target caseload for 2nd years is two per team. Given that 2nd years are on two teams, they should aim to keep 4 clients total. 3rd years are on one team and should aim for 1-2 cases at a time. Of course, discretion is given to practicum supervisors to fulfill a student's training needs; as such, supervisors can modify these targets as appropriate.

Waitlist: When practicum caseloads are full and there are no trainees interested in picking up a case, the Clinic offers clients the option of being waitlisted. Clinic staff (typically the Clinic GA) provide waitlisted clients an update on their status and estimated wait time approximately every 3 weeks. The UTPC has one official waitlist that is managed by the Clinic staff - Supervisors or practicum teams are not to establish their own unofficial waitlist. This means that if a client can't be seen in a timely manner (7 days) the case will be reassigned, unless there are extenuating circumstances. As noted earlier, Supervisors and their teams need to be timely in their communications with clients, including following the Clinic timeframe for contacting newly assigned clients.

29. CLIENT PROCEDURES – INITIAL CONTACT

Clients are to be contacted by the supervisor or assigned trainee, or someone else delegated by the supervisor no later than 7 days after the case was assigned to the supervisor. Trainees are responsible for calling the client to set up the first session unless alternative methods are agreed upon with the academic and client services coordinator. During this phone call, advise clients to arrive 30 minutes early to complete intake paperwork. If the client needs a parking pass, ensure their vehicle information is documented in Titanium and request a guest parking permit online. It is the trainee's responsibility to request guest permits prior to each session. Refer to Section 19 for parking information.

When calling the client, identify yourself by name only until you are sure the person on the other end of the line is, in fact, your prospective client. For reasons of confidentiality never reveal your Clinic affiliation to anyone but the client. If the person answering the phone is not the client and asks you to identify yourself, avoid vague responses like "a friend" or "never mind, I'll call later." One response might be to say something like "I'm from UT and am returning (client's name) call to me." Unless you are told it is okay to provide further information, leave only your name and that you are from UT on an answering machine as well. It is better to call a second time rather than leave the Clinic's phone number. In addition, you should first dial *67 and then the client's telephone number to block the Clinic telephone number from appearing on the client's caller ID.

Nobody (including Trainees) should be calling potential clients (i.e. clients on a waitlist in Titanium) unless that case was assigned to the trainee by a supervisor per the above process.

30. CLIENT PROCEDURES – BEFORE THE FIRST SESSION BEGINS

Always arrange to meet your clients in the reception area 15 minutes prior to their appointment and prepare any required measures you would like the client to complete. Always escort clients to one of the assessment or therapy rooms. In the case of client delays, it is recommended that you wait or work in the student workroom that is directly across the hall from the reception area.

You should expect, as part of your contact with your clients, to be available for the entire time specified for a session. After an initial wait, you may return to your office rather than wait in the Clinic, but let the academic and client services coordinator know your whereabouts and phone number so you can be contacted if and when your client arrives.

When clients arrive late, they are typically seen for only the amount of time remaining for their appointment. However, if you arrive late, you will need to offer your client his or her entire time and then consult with the academic and client services coordinator to ensure that the room is or can be made available.

Children may not be left unattended in the waiting room. The Clinic does not provide child care and it is up to the clinical trainee to see that clients are mindful of this policy. Please communicate this policy to the parents of small children prior to their first session so that they can arrange for child care. If an adult client unexpectedly shows up with a young child for a therapy appointment, it is usually best to reschedule the session rather than try to do therapy with the child in the room. With approval from the guardian, the clinical trainee may choose to find another clinical trainee to supervise the child during the therapy hour.

You will be responsible for explaining to your clients the Clinic's policies and procedures regarding fees, determination of their payment, establishing the contract for services, the HIPAA privacy policy and directing any business related questions to the Clinic Office Staff. This will be conducted at the client's first session.

You should be thoroughly familiar with the following forms, instructions, and pertinent information: 1) Informed Consent – Statement of Policies, Client Services Agreement, 2) Ohio Notice HIPAA Privacy Policy and Acknowledgement, 3) Fee Policy and client fee determination, 6) E-Mail Permission, 7) Medical History,

8) release of information, and 9) documentation notes - progress notes, assessment notes, telephone notes, consultation notes, treatment plan form, quarterly summary notes, termination/transfer summary. Forms can be found in the Clinic Workroom and digital copies are kept in the Clinic office.

Before the first session begins, it is your responsibility to orient the client to the clinic and its procedures, and review the following forms: Informed Consent, Ohio Notice, Fee Policy, and Email Permission. In particular, you should make sure the client understands HIPAA's privacy policy and reasons why information would be released without permission, and how to contact the clinic director for any questions/concerns.

In regards to the email permission, if applicable, discuss with clients how that will be used, e.g., to submit homework or re-schedule appointments. It is suggested clients do not discuss therapy issues via e-mail.

It is recommended to schedule a subsequent appointment prior to the client leaving the clinic. When scheduling an appointment, schedule the appointment in one of the consultation rooms (ensuring that the room is added as an "attende"e"), and add yourself and any other relevant faculty or clinical trainees as attendees. Double-check the time and date of your scheduled appointment.

31. CLIENT PROCEDURES – FEE SETTING

The UTPC is a non-profit training facility that charges fees in order to support its operations. Collection of fees is vital to maintaining and improving the work of the Clinic. In accordance with our desire to be maximally accessible to the economically disadvantaged, the Clinic establishes modest rates at the low end of the income range, with fees increasing as the client's income increases. However, clinic fees are consistently lower than prevailing rates for similar services in the community.

The academic and client services coordinator and/or Clinic GA set fees during the screening interview. Fees are based off of our 2017-2018 Sliding Fee Schedule and are noted at the bottom of each client's screening interview report. If a fee is not noted in the screening interview, please notify the Clinic GA or academic and client services coordinator.

Regarding billing procedures, you should review with the client their agreed upon fee and the UTPC payment procedure. Explain that fees are handled exclusively by Clinic Office staff and are to be paid at the time of service. We do not accept credit or debit cards, only checks or cash. It is preferred clients pay at the time of service. Clients will submit payment to the staff person working in the Clinic Office UH1600.

If a clinic staff person is not available to receive payment, clients shall utilize the drop box outside of the clinic office door. White envelopes and pens are stored in the black file holder outside of the clinic office door. Clients will write their information on the exterior of the envelope (lines are printed on the envelopes), include their payment inside, and place the envelope in the drop box (make sure it drops to the bottom of the box). The drop box will be tended to by clinic staff on a daily basis.

As needed, trainees should provide assistance for clients as they complete payment envelopes.

Inform clients that upon request the Clinic Office staff can provide them with invoice and balance statements. Also, if the clients are having trouble making their payments you and/or the client may discuss a fee reduction with the academic and client services coordinator.

The billing section in Titanium will be completed and monitored by clinic office staff.

32. CLIENT PROCEDURES – INFORMED CONSENT FOR SERVICES

One of the most important functions of the trainee in the first session with any client is to provide and obtain informed consent for services. The fundamental underlying concept of the Informed Consent is that clients have the right to be informed about certain things before they consent to receive mental health services. The APA Ethics Code has long required psychologists to protect the informed consent rights of their clients. The Ohio Board of Psychology states that psychologists must inform clients of professional services, fees, billing arrangements, limits of confidentiality, and foreseeable risks before rendering services.

The UTPC has a purposefully lengthy and detailed informed consent. Given we are a training center we want to ensure that both the clinical trainee and client have a clear understanding of the nature and limits of our services. The UTPC informed consent covers the following areas:

Purpose of the UTPC

Supervision

Purpose of Psychological Services

Quality Assurance and Research

Fees/Billing/Payment

Communications and Emergency Situations

Cancellations and Missed Appointments

Confidentiality

Record Keeping

Patient Rights

Minors and Guardians

Ethics and Professional Standards

Written Consent

Process of Obtaining Consent: A clinician has the ethical and legal responsibility to insure that the decision to enter into psychological evaluations or treatment with us is an “informed” decision and that the informed client gives (or refuses to give) consent to receive our services. In other words, a signature on a consent form does not, in itself, qualify as “informed” consent. Consequently, the trainee must not only get the written consent but also have an informed consent conversation with the client. Regardless of what services are requested or provided, both a written and signed informed consent and an informed consent conversation with the client(s) must occur. As such, the process of obtaining informed consent should have the following components:

The client is given the written informed consent, asked to read it over carefully, and to sign it if they do not have any questions.

The trainee must verbally inform the client about our services, elicit questions, and provide honest answers.

The informed client freely gives (or refuses) consent to accept services on that basis.

This understanding is documented in the initial progress note in the client’s record.

In the case of minors, the informed consent should be signed by parent(s) or legal guardian. If the minor’s parents or guardians, regardless of marital status, have joint legal custody, then every effort should be made to have both parents sign the consent for services form. In cases where there is any question of legal guardianship or custody issues, the trainee, with agreement from their supervisor, should ask for the court documentation (e.g., divorce decree, custody agreement, visitation agreement) of the judge’s decision (not a statement from a lawyer) and a copy should go into the client’s chart. If there is any possibility that one parent may disagree with the child being in treatment, it is strongly recommended that treatment not begin until both parents sign the consent form and any authorizations.

In multiple-person therapy, the initial conversation related to consent and confidentiality can be more complex than with individuals. The trainee, with the help of a supervisor, is required to clarify at the outset which of the individuals is the client(s) and the relationship the clinical trainee will have with each person. This clarification

includes the role of the clinical trainee, the probable uses of services provided or information obtained, and how records of the services will be maintained, who has access to the records, and any limits of access to the records. This client's understanding of these points is to be documented in the client record.

33. CLIENT PROCEDURES – THE FIRST SESSION

Intake Interview: All psychology trainees complete intakes as part of the therapy process. A psychological intake involves initial sessions that include obtaining informed consent, identification and clarification of presenting issue/s, data collection and information gathering, and concluding with a case conceptualization and treatment plan.

In general, continuity of clinical services is sought by having the same clinical trainee provide assessment or therapy services following the completion of the intake. Exceptions to this may include assignment of cases to a different clinical trainee in a specialized assessment or therapy practicum following the intake, but in general cases are assigned to clinical trainees on the basis that the intake will develop into an appropriate assessment and/or therapy case for that same clinical trainee.

Typically intake sessions require more than one session to identify the presenting problem/s, gather pertinent information, and formulate a treatment plan. Sessions should be coded in Titanium as “intake note” if the majority of time spent involved intake activities. Sessions where most of the time spent involved intervention activities should be coded as “progress note” in Titanium. All notes should be numbered consecutively.

34. CLIENT PROCEDURES – TREATMENT PLANNING AND CONSULTATION

In accordance with the APA's Standards for Providers of Psychology Services, the first concern of treatment is the development of an established plan for the delivery of psychological services. This plan is to specify your client's problems, establish a priority of therapeutic goals, and list the procedures for working toward these goals.

The plan, signed by you and your supervisor is to be presented to your client as soon as possible, as agreed upon by the clinical trainee and supervisor. His or her signature on the Treatment Plan document indicates your client's agreement. Signed Treatment Plans will be scanned into Titanium by Clinic staff. If goals or problems change as therapy progresses, addenda may be added to the original plan and scanned by Clinic staff into Titanium as a revised treatment plan.

Medication: You should know the medication status of your clients, including what medications they are taking, the intended effects of said medications, the extent to which a physician is supervising these medications, and possible side effects of said medications.

If, in your judgment, your client might benefit from or require medication as part of his or her treatment plan, and your client is a UT student, refer the person to the Student Medical Center (419.530.3451). When making such a referral, please utilize the following procedures:

Ask your client to call the Student Health Center and request a psychiatric consultation. Ask the client to mention being referred by the Psychology Clinic.

Be sure to have your client find out whom he or she will see so you can send the psychiatrist information you deem relevant and pertinent.

Ask your client to sign two release forms; one giving you permission to communicate with the psychiatrist and the other, which will be included in the information sent to the psychiatrist, giving him or her permission to

communicate with you.

Along with the release form and pertinent clinical information, send a letter explaining the reason for the referral. Be sure to send all this information well in advance of your client's scheduled appointment with the psychiatrist.

If your client is not a UT student and needs a psychiatric referral, first find out if they have health insurance since this may determine who your client will agree to see. If there is no health insurance, consult with your supervisor who will assist you in making a referral. Once the decision is made to whom your client will be referred, follow the same referral procedures just described above.

If the psychiatrist places your client on medication, your client becomes part of the psychiatrist's practice. The psychiatrist then becomes responsible for that aspect of your client's treatment. However, unless your client makes other arrangements, you remain responsible for any continuing psychotherapy. Maintain ongoing contact with the psychiatrist as needed to be fully aware of your client's condition.

Consultation: When a healthcare provider refers therapy clients to the Clinic, trainees should establish and maintain an ongoing consulting relationship with the referral source. First, trainees should discuss the reason for referral with their client and agree on the extent of communication between the referral source and trainee. It is typically good practice to make at least three contacts with the referring provider over the course of treatment (depending on the length of treatment). The first contact should occur once you've established care with the client. Inform the referral source that you have started treatment and collect additional information. More times than not, you will likely speak with a provider's staff person or assistant. Leaving a message for the referring provider is usually sufficient. The second contact should be made once a treatment plan has been formulated. Provide the provider with a diagnostic impression and practical recommendations. The third contact should be at termination or transfer. Lengthier treatments may call for additional contacts and communication with referring providers, which may include changes in treatment or progress updates.

Clients who are self-referrals often ask that a report be sent to a doctor, agency, etc. Be sure to discuss with them what information they wish sent and what information they wish withheld from the report as well as when it will be sent.

All reports sent to outside agencies or professionals must first be approved and signed by your supervisor, co-signed by you, and a copy placed in the client's file. Of course, a "release of information" form must be signed by your client before the release of any information, with one exception. As stated in the Informed Consent document, "For treatment purposes, we may consult with, report back to, or disclose information to other providers who are directly involved in your care, including but not limited to your primary care physician or a UTMC medical student's referring provider," disclosure of PHI to treatment providers is permitted when a client is referred by an agency that is directly involved in the client's treatment or care. If you are unsure about whether or not a release of information is required to disclose PHI, consult with your supervisor or clinic director.

35. CLIENT PROCEDURES – TREATMENT

Once a client's problem has been thoroughly assessed, treatment as agreed upon between the client and the trainee ensues. Cases vary widely in terms of duration. The essentials of treatment are discussed and agreed upon with the practicum team; Trainees should anticipate that different supervisors will have different approaches to the conduct of therapy. In the context of the program's philosophy, an emphasis will be placed upon scientifically based methods of therapy, or empirically based interventions.

36. CLIENT PROCEDURES – OUTCOME MEASURES

(For adult and child clients) Beginning with an initial intake assessment session and every therapy session thereafter, all Trainees will administer at least one routine outcome questionnaire using the web-based OWL Outcomes platform. OWL training will be offered to Trainees and Supervisors at the beginning of each fall semester. Therapy process and outcome data (i.e., summary total scores) should be recorded in progress notes and paper reports.

Supervisors and clinical trainees may decide, and are encouraged, to utilize additional objective measures that are clinically useful. Ongoing assessment and integration of objective data into case conceptualization is a true reflection of the scientist-practitioner.

37. CLIENT PROCEDURES – VACATION TIME AND COVERAGE

Clinical trainees are expected to discuss vacation and conference time plans with their supervisor, and inform their clients of planned time away as soon as possible. Arrangements for back-up coverage should be made for each client and documented in the client's treatment record. Similarly, supervisors will inform trainees of expected time-off and will work with trainees to develop a suitable supervision plan. Any changes in supervision need to be documented in the client's treatment chart (enter as a "blank note"). Clients need to be informed of any changes in supervision, including temporary changes. It is also important to notify the Clinic Staff of any expected or unexpected absences.

Clinical trainees and supervisors should be mindful that they are obligated to keep delivery of client care and client needs as the highest priority. Maintaining continuity of treatment and assessment services is of utmost priority. Trainees and supervisors will discuss the appropriateness of time away and vacations keeping in mind the best interest of the client.

38. CLIENT PROCEDURES – TERMINATION

Some clients are seen during the academic year and terminate at the end of the second semester, if not before. Others require long-term therapy that necessitates planning on how to provide coverage over the summer, which may include registering for the summer practicum. A number of options are available:

You might continue to see your client during the summer under the supervision of your current supervisor.

Supervision of your case is transferred temporarily or permanently to another supervisor and you remain as the client's clinical trainee.

Arrangements are made to refer your client to another agency, in which case your client is no longer a UTPC client.

You refer your client to another trainee working in the Clinic, in which case your client remains a Clinic client but is no longer your client.

You arrange to discontinue seeing your client for a specified period of time over the summer during which time another individual covers for you, seeing your client on an as needed basis. If your current supervisor will be unavailable when you resume therapy with your client, you will also need to arrange for supervision from another supervisor.

39. CLIENT PROCEDURES – TRANSFERS

Transfer of a client within the UTPC occurs when a client who is already receiving services changes clinical

trainee and/or supervisor. Only with approval from the clinic director, the supervisor currently supervising the case, AND the incoming supervisor if applicable may clients transfer from one trainee to another or from one supervisor to another. Transferring situations include, but are not limited to; when a client is being seen within a psychotherapy practicum and the psychotherapy practicum supervisor will no longer be supervising the case; if a trainee will no longer be seeing a client because they are leaving for internship or are no longer able to continue therapy with the client for other purposes; trainees may also “transfer” an assessment case to another trainee for treatment if treatment is indicated.

For a transfer to occur, a Transfer/Termination Summary must be written and signed by the current trainee, current supervisor, incoming supervisor, and clinic director and submitted to Clinic staff who will scan it into the client’s record. Any transfer must be documented in the client’s chart in Titanium. If the transfer is from one supervisor to another, a supervisor change note must also be completed in Titanium.

40. CLIENT PROCEDURES – GROUP THERAPY

Experience conducting group therapy is encouraged. If you would like to form a group, you may do so by arranging for supervision and providing a brief written summary to the clinic director of the type of referral/s you anticipate needing. If your group is an open one, clients will be referred on an ongoing basis until you inform the clinic director that your group is full. Clients seen for individual therapy in the Clinic may also be referred to a group when this is clinically appropriate.

41. CLIENT PROCEDURES – ASSESSMENT

All psychology trainees will complete assessment cases in the UTPC as a part of their clinical training. The clinical faculty determines assessment and therapy caseload guidelines, and clinical trainees and supervisors are responsible for updating the Clinic GA on caseload needs.

Assignment of Assessment Cases: All pre-screened assessment referrals are assigned to a supervisor and clinical trainee. If you receive an assessment referral from your practicum supervisor, the supervisor must add the clinical trainee to the client’s list in Titanium.

Referral Questions: If your client is a self-referral, your supervisor will give you instruction on how to obtain information pertaining to the reason for referral. If your client has been referred by an agency, you will need to seek out how to obtain the reasons for the referral and referral questions from the referral source. Continuity of care and direct communication with the referral source is integral when completing assessments from outside referral sources.

Appointments: Clients are to be contacted by the supervisor or assigned clinical trainee no later than 7 days after the case was assigned to the supervisor. Trainees are responsible for calling the client to set up the first session. During this phone call, advise the clients to arrive 15 minutes early to complete paperwork.

Completion of Assessments: Assessments are to be completed in a timely manner with the fewest number of sessions necessary to complete the assessment. In other words, clinical trainees should make every effort to schedule longer blocks of time (e.g. 3+ hours) to administer complete test batteries. The final report, or summary if the assessment is incomplete, should be completed and submitted to the academic and client services coordinator within the timeframe set by the supervisor and communicated to the client during the informed consent process. This ensures that the client’s expectations for when an assessment will be completed, and a report produced, are met.

Feedback session: Every client who receives assessment services shall be offered a feedback session to discuss

findings and recommendations from their assessment.

Reports: In the case of someone who has been referred, when you call the referral source to obtain the referral questions, ask how the report will be used since this may affect what recommendations you will need to make. Also inform the referral source when your report can be expected. Professional courtesy demands that you notify the referral source immediately if the report will not arrive when expected. Inform the referral source of the reasons for the delay and when the report can be expected.

Clients who are self-referrals often ask that a report be sent to a doctor, agency, etc. Be sure to discuss with them what information they wish sent and what information they wish withheld from the report as well as when it will be sent.

All reports sent to outside agencies or professionals must first be approved and signed by your supervisor, co-signed by you, and a copy placed in the client's file. Of course, a "release of information" form must be signed by your client before the release of any information, with one exception. As stated in the Informed Consent document, "For treatment purposes, we may consult with, report back to, or disclose information to other providers who are directly involved in your care, including but not limited to your primary care physician or a UTMC medical student's referring provider," disclosure of PHI to treatment providers is permitted when a client is referred by an agency that is directly involved in the client's treatment or care. If you are unsure about whether or not a release of information is required to disclose PHI, consult with your supervisor or the clinic director.

Completed reports are to include signatures by the clinical trainee and supervisor and scanned by Clinic staff into Titanium. In the instance that an assessment is unfinished or incomplete, a trainee only needs to complete a summary report (summarizing data and findings, if any, to accompany the "case-closing" note in Titanium. Summary reports are to be signed by both the clinical trainee and supervisor.

Inform the academic and client services coordinator or Clinic GA when the report is completed and your assessment case is ready to be closed.

42. CLIENT PROCEDURES – CLOSING CASES

Clients who have not started treatment

- A. Case Closing Note: When termination occurs prior to the start of treatment (e.g., during the intake sessions), a trainee may summarize therapy activities in the *case closing note data form* (e.g. reason for referral; frequency and dates of contact; status at initial evaluation; diagnostic impression; summary of session activities; status at, and circumstances of, termination; disposition including referrals) in place of completing a Termination/Transfer summary. Forward case closing notes to your supervisor for their signature.
- B. Client paper charts or folders are to be submitted to the Clinic Manager.
- C. A client will be deselected from lists only once the case closing note is complete and the client paper chart or folder (if applicable) has been submitted to the Academic and client services coordinator.

Clients established in treatment

- A. Letter: a letter should be mailed to the client if multiple no-shows or client calls to say they will not be returning. Letter explains that therapy has ended/will end and makes necessary referrals. Copy of letter should be scanned into Titanium.
- B. Case Closing Note: both a *case closing note* and *case closing note data form* will be completed in Titanium. The case closing note is to identify that a case is to be closed; it is not a therapy progress

note. The last therapy session should have its own therapy progress note and data form. Forward case closing notes to your supervisor for their signature.

- C. Submit client paper chart or folder to Clinic GA.
- D. Termination/Transfer Summary: signed by trainee and supervisor within 7 days of the last session and placed in the scanned documents basket. The academic and client services coordinator will scan the document into Titanium and update trainee and supervisor client lists. A client will be removed from lists only once the Termination/Transfer Summary is entered into the client's file and the client paper chart or folder (if applicable) has been submitted to the Academic and client services coordinator.

Assessment Cases

- A. Case Closing Note: both a case closing note and a case closing note data form will be completed in Titanium. The case closing note is to identify that a case is to be closed and should be signed by the trainee and supervisor.
- B. In the instance that an assessment is unfinished or incomplete, a trainee will complete the Treatment/Assessment Summary section in the case closing data form (brief summary of data and findings, if any).
- C. Report: Completed reports are to include signatures by the trainee and supervisor and scanned into Titanium (placed into scanned documents basket).

The academic and client services coordinator and/or clinic director will audit client charts periodically throughout the year. Near the end of spring semester, the clinic director will compose an initial list of outstanding tasks and email each clinical trainee and their supervisor a list of clients their assigned clients with any outstanding tasks or missing documentation. Clinical trainees have 1 week to address and complete any outstanding tasks. The clinic director will revise the initial list and bring the updated listed to the end of the year student evaluation meeting with the clinical faculty. In the event of a discrepancy or disagreement, clinical trainees or supervisors shall follow the grievance policy procedures outlined in section 46 of this handbook.

43. CANCELLATIONS AND MISSED APPOINTMENTS

At the outset of treatment or an assessment evaluation (during the initial session) it is imperative to discuss with your client expectations and rules regarding attendance and scheduling. Trainees should consult with their supervisor to determine a policy and procedure for dealing with cancellations and missed appointments. It is not uncommon for Trainees to struggle with establishing and enforcing rules concerning attendance. Repeated cancellations or missed appointments indicate a clinical issue that should be addressed, not avoided.

If your client calls to cancel more than 24 hours prior to their appointment time, be sure to mark the client's status in Titanium (e.g. "client no show," "client cancelled"). If your client calls to cancel less than 24 hours prior to their appointment time or is a no-show, mark the client's status in Titanium. Never delete client appointments. When your client shows up for his or her appointment, mark the appropriate client status (e.g. "attended"). Please advise all clients to submit payment to the clinic staff person. If a clinic staff person is not available to receive payment, you are responsible for assisting the client with the payment deposit drop box located outside the Clinic Office door. Deposit envelopes are stored in the file holder and the receipt book is kept in Workroom 1 (Rm. 1710). All clients must be provided a receipt for their payment, and the carbon copy should remain in the receipt book.

44. CLIENT CHARTS AND RECORD KEEPING

The UTPC uses a HIPAA compliant electronic medical record (EMR). The EMR, Titanium, is the primary and complete medical treatment record for clients. Trainees and clinical supervisors are provided with login credentials to access the EMR, and are required to electronically submit all PHI into the treatment record. Documents with written signatures (e.g. informed consent, release of information) are to be scanned into the

EMR by clinic office staff. Documents and information not required to be part of the mental health treatment record (e.g. process notes, supervision notes, assessment raw data, and assessment booklets) are filed in a separate paper file associated with an official treatment record. Paper files that are not an official treatment record are created by the Clinic Office staff and stored in the locked file cabinet in the Clinic Workroom. This cabinet is locked at all times except when a trainee, academic and client services coordinator, clinic assistant, or clinic director is accessing the cabinet.

During the Spring of 2011 the UTPC transitioned from paper charting to an electronic health record. Since that time all new cases originated from the electronic health record as the Clinic strives to be “paperless.” Notwithstanding, there are several active cases that began prior to the transition to the electronic health record. For these cases, Trainees and Supervisors are permitted to continue utilizing the paper charting method and to store client records in the locked file cabinet in the Clinic Workroom.

All records of clients that are past 10 years of having been terminated are boxed, transferred to, and stored on the Health Sciences Campus with the Medical Records Department and retained in compliance with the state of Ohio requirements. When a trainee, supervisor, Client, or Agency has a signed Release of Information, the academic and client services coordinator will submit a request to Medical Records 419-383-4982.

Chart Procedures: Psychology trainees are responsible for maintaining their client records and preparing these records for periodic chart audits by their supervisor, the clinic director, and Clinic staff.

Client charts are an important part of the UTPC records. It is extremely important that these charts be regularly reviewed and signed by the supervisor, since they become legal documents and may be subpoenaed by a court of law. Also, since the exchange of information between agencies may occur or be required by certain parties (e.g., parents of a child client), it is important that the information contained in the chart be accurate and up to date. Questions concerning the use of specific forms should be directed to either your supervisor or the clinic director.

As noted previously, client mental health treatment records are maintained using Titanium, an electronic health record. Titanium has a separate secure server with limited access. No client records with identifiable information are ever to leave the Clinic, except with client authorization (e.g., sending assessment reports to other agencies; client data for IRB approved research purposes). If trainee’s and Supervisors exchange notes or reports in paper form, they should use their Clinic mailboxes. Client reports in electronic form (e.g., saved on disk) can only be removed from the clinic (e.g., to work on a report at home) if on a password-protected file and identifying client information is removed. Any clinic data provided to supervisors (e.g., progress notes, video files on thumb drives, reports) should be placed in their Clinic mailbox or given to the supervisor in person. Video files older than 90 days or if no longer being used for training purposes should be destroyed or deleted. Any raw data from psychological assessments and Clinic evaluation research are the property of the Clinic and are kept in Clinic files.

In accordance with guidelines employed in health clinics, a chart should have only one identified client. Even if the clinical trainee is seeing a family or a couple, the clinical trainee should decide who the "identified client" is, and the contents of the chart should focus on that client. If necessary and clinically indicated, the clinical trainee may create one chart for a couple or a family.

44a. INTAKE SUMMARY REPORT

The intake summary report is a detailed yet concise account of the presenting issue/s, relevant psychosocial, developmental, and academic history, psychiatric and psychological history, medical history, behavioral observations and mental status exam, detailed problem list, diagnostic impression, case conceptualization and treatment recommendations.

44b. TREATMENT PLAN

In accordance with APA's Standards for Providers of Psychology Services, the first concern of treatment is the development of an established plan for the delivery of psychological services. This plan is to specify your client's problems, establish a priority of therapeutic goals, and list the procedures for working toward these goals (see the Treatment Plan Template for an example). The written plan should be signed by you and your supervisor and discussed with your client as soon as possible. Your client is required to be informed of the plan and give consent to it; the client's signature on the plan is required. If goals or problems change as therapy progresses, addenda may be added to the original plan, again with client consent.

44c. THERAPY PROGRESS NOTE

Progress notes can serve a variety of functions. Some of these include:

- A. Re-acquaint you with what transpired in the previous session as well as with your original impressions of the therapeutic process.
- B. Track progress in meeting treatment goals
- C. Help another clinical trainee, who may inherit your case, to understand the developmental nature of your contacts with the client and the treatment approach utilized and its effectiveness.
- D. Use a self-learning device to help you check yourself against any tendencies you might have to be restricted, preoccupied or sterile in your contacts. Progress notes can also have the utility of promoting a greater psychological understanding of your client's behavior. Most of this can be accomplished by attempting to put into words your impressions and feelings about your client that you may have been implicitly assuming.
- E. Utilized in research and evaluation. Progress notes can aid in acquiring ideas about the therapy process itself as well as movement by the client when certain techniques are used.
- F. Progress notes are protective since they provide a rationale for decisions and can clarify what you actually did in the treatment sessions.
- G. Documentation: Complete therapy progress notes should be entered immediately after each session. However, if circumstances prevent you from writing the progress note immediately after a session, you must enter the complete note within 24 hours of the session. If however, your client discloses information that implies threat to self or others (even in instances deemed low-risk), you are required to document this immediately after session. There are no exceptions and such incidents deserve priority over other personal or professional activities.

44d. PSYCHOTHERAPY PROCESS NOTE

Psychotherapy process notes include notes recorded in any medium (written, audio-taped, or video-taped) that document or analyze the contents of a conversation with a patient(s) during a private session or a group, joint, or family session.

Psychotherapy process notes also include raw data and/or forms used for recording responses to psychological testing materials (e.g., copy-written intelligence testing forms with raw responses recorded on them).

Psychotherapy process notes are maintained separately from the rest of the patient/client mental health treatment record (UH1470 houses a separate file cabinet for process notes and memory sticks).

Psychotherapy process notes have a special level of privacy protection (e.g., insurance companies cannot require authorization to release psychotherapy notes as a condition of reimbursement), although they may be used for training program purposes in which trainees learn under supervision to practice or improve their professional skills.

44e. QUARTERLY SUMMARY

Psychology trainees are to complete quarterly summaries. Quarterly summaries shall summarize treatment progress and goals; identify active symptomology and improvement/deterioration using clinical data, summarize an in-person discussion of progress with the client, and include an initial and current diagnostic impression. Quarterly Summaries are to be completed every three months from the first session, signed by both you and your supervisor and will be scanned into Titanium. It is the clinical trainee and supervisor's responsibility to ensure that these reports are submitted to the academic and client services coordinator in a timely manner.

44f. TERMINATION AND TRANSFER SUMMARY

Termination occurs when, for whatever reasons, your client decides to discontinue therapy or you decide to no longer see your client. A referral within the UTPC to another clinical trainee necessitates a termination/transfer report just as a referral to another agency would. When termination occurs and your client will not be referred to another clinical trainee, follow the procedure in Section 42 (Closing Cases) of this Handbook. It is your responsibility to notify the academic and client services coordinator and Clinic GA of such after submitting the termination summary so your client's records can be pulled from the active files and placed in the closed files.

Termination/transfer summaries contain a synopsis of pertinent and relevant information about the course of treatment and include not just a global summary of treatment but also goals achieved, current status, and recommendations. Together with the quarterly summaries, this report should provide a complete summary of the client's course of therapy.

See section 44g for timeline of documentation.

44g. TIME DEADLINES

Timeliness of completing the following documentation will be tracked by periodic chart audits and reviewed at the end of the spring semester.

Intake Summary: Completed and due to the supervisor based on the timeline set by the supervisor. Reviewed, revised if necessary, signed by the supervisor, and submitted to the Clinic office staff in a timely manner.

Progress Notes: Completed and forwarded to the supervisor in Ti within 24 hours of the session or activity (e.g. telephone contact, consultation notes).

Treatment Plan: Completed and due to the supervisor based on the timeline set by the supervisor. Reviewed, revised if necessary, signed by the supervisor, and submitted to the Clinic office staff in a timely manner.

Quarterly Summary: Due to the supervisor every third calendar month from the initial session. Reviewed, revised if necessary, signed by the supervisor, and submitted to the Clinic office staff in a timely manner.

Termination/Transfer Summary: Due to the supervisor within a reasonable amount of time after the termination session. Reviewed, revised if necessary, signed by the supervisor, and submitted to the Clinic office staff in a timely manner.

Other Forms and Documents Part of the Treatment Record:

Informed Consent – scanned into Ti by office staff.

Release of Information - scanned into Ti by office staff.
Email Consent Form - scanned into Ti by office staff.
Referrals or other medical or mental health records - scanned into Ti by office staff.

Forms and Documents Not Part of the Treatment Record:

Raw test data
Process notes
Supervision notes
Trainee/Student evaluations

The American Psychological Association designed and published broad record keeping guidelines in the American Psychologist in 2007. These guidelines are the minimum standard of practice for the UTPC. <http://www.apa.org/practice/guidelines/record-keeping.pdf>. You are expected to familiarize yourself with these thirteen guidelines and use them as a frame of reference for record keeping actions and practice.

Once documents requiring signature are completed (informed consent, release of information, email permission, intake summary, treatment plan form, quarterly summaries, termination/transfer summaries), you may place the forms in the “to be scanned” basket in the Clinic Workroom. Clinic Office staff will scan documents into the clients’ electronic chart and place the original in your clinic mailbox. Trainees are not permitted to scan the aforementioned documents into Titanium.

You are responsible for updating your client's electronic chart with respect to changes in address and/or phone number. Such information should be entered directly into the client's file and then brought to the attention of the academic and client services coordinator.

45. STUDENT GRIEVANCE AND APPEALS

Graduate clinical training is a complex activity involving a high order of student-faculty, or trainee-supervisor, relationship factors. It follows that the evaluation of the graduate clinician’s progress is, and must be, dependent in large part on the judgment of the supervisor, augmented by the collective judgment of the members of the clinical faculty. Hence, the crucial agency in the clinical trainee’s evaluation is the UTPC where the trainee’s work is centered, and the crucial evaluator is the faculty supervisor.

It is assumed that most disputes over evidence of unsatisfactory performance or progress will be informally discussed and reconciled at the student trainee-faculty supervisor level. Indeed, most discussions of this kind will commonly occur between the clinical trainee and the primary supervisor. Furthermore, the clinic director and the DCT are available for consultation on any dispute or issue. If a supervisor or the clinic director identifies a violation of procedure or policy, the faculty member shall use their discretion and good judgment to determine the severity of violation and distinguish the violation as “minor” or “major.” Minor violations are less serious and the supervisor or clinic director shall communicate the violation directly to the student and supervisor. Major violations will require an in-person meeting between the clinic director, supervisor, and clinical trainee. If an agreement cannot be reached, the issue will be brought to the attention of the DCT who will hold a meeting with all parties involved.

The University of Toledo Psychology Clinic Procedure: Whenever a clinical trainee believes that any work has been improperly evaluated, or believes that there has been unfair treatment, it is expected that the student will take up the questions directly with the faculty member involved. This is likely the student’s primary supervisor for clinical practicum. If, after earnest inquiry, the matter remains unreconciled, the graduate student should bring the matter to the clinic director of the UTPC for reporting purposes, advice, suggestions, and/or help in the matter. If the student views the matter as serious and would like follow-up from or an investigation by the

clinic director, he or she must submit a written request (e.g. email) to the clinic director with the subject line "Formal Appeal". The clinic director will then consult with the Director of Clinical Training (DCT), and submit his/her recommendations in writing to the Director of Clinical Training who shall take all reasonable and proper actions to resolve the issue at the level of the Clinic. If the clinic director of the UTPC or the Director of Clinical Training is part to the grievance, the Department Chair will assume this responsibility. The student shall be informed in writing of the results no later than one month after the appeal to the clinic director of the UTPC.

On these occasions the UTPC will follow the due process for graduate student grievance procedures set forth by Department and the Graduate School.

Students and faculty should become aware of, and fully understand, the student grievance procedures as stated by the Graduate School. This means that students and faculty need to understand what type of situations are appropriate for grievances and the steps involved in the grievance process.

The University Grievance Policy is available in the student handbook which is available online at:

http://www.utoledo.edu/graduate/forms/Hbk_2012_2013.pdf

1. Definition of academic grievance.

An academic grievance is a complaint originated by a graduate student about an evaluation or decision made by a faculty member regarding the student. Examples: (a) A student receives a C in a course, and she regards this grade as unjust. (b) A student receives a letter of academic warning, indicating that he or she is behind schedule on the M.A. thesis and will be put on probation and lose assistantship support at the end of the semester if the thesis is not completed; he or she believes this decision is unjust.

2. Summary of steps in the grievance process.

Step 1. To initiate resolution of an academic grievance, the student discusses the problem with the faculty member who the student believes has taken improper action. The student should discuss the student's grievance with the faculty member promptly.

Step 2. If resolution is not achieved with the intervention of the DCT, or if the grievance is with the DCT, then the student discusses the problem with the Department Chair. The Department Chair consults, as appropriate, with faculty and area coordinators.

Step 3. If satisfactory resolution is still not achieved, the student should present the grievance to the Dean of the College of Languages, Literature, and Social Sciences.

Step 4. If a resolution has been unsuccessful at the College Dean's level, the student should present the grievance to the Graduate School, to be heard by the Dean or Associate Dean of Graduate Studies.

Step 5. A final appeal can be made to the Committee on Academic Standing of the Graduate Council and its decision shall be binding on all parties involved in the grievance.

The initial grievance must be filed with the faculty member and a copy to the Department no later than one semester after the occurrence of the incident. If students desire to proceed to the next level of appeal, they must file within fourteen days of the last rendered decision of the grievance. At each step within the Department, a decision must be given to the student who initiated the grievance no later than 10 days after the grievance is received.

46. REVISION OF HANDBOOK

The clinic director formally updates the handbook once a year, usually during summer so a revised version is available for the start of the fall semester. The faculty and/or student representatives are encouraged to submit to the clinic committee their recommendations for revisions. At the May clinic committee meeting, submitted revisions will be discussed and reviewed. The clinic committee will solicit feedback from the clinical faculty and make final determinations for revision. An updated version of the handbook will be ready for the start of fall semester. If there are major policy issues that arise throughout the academic year, the Clinic Committee will handle these on an ad hoc basis.

Closing Cases - Requirements

Clients who have not started treatment

- **Case Closing Note:** When termination occurs prior to the start of treatment (e.g., during the intake sessions), a trainee may summarize therapy activities in the case closing note data form (e.g. reason for referral; frequency and dates of contact; status at initial evaluation; diagnostic impression; summary of session activities; status at, and circumstances of, termination; disposition including referrals) in place of completing a Termination/Transfer summary. Forward case closing notes to your supervisor for their signature.
- Client paper charts or folders are to be submitted to the Academic and client services coordinator.
- A client will be deselected from lists only once the case closing note is complete and the client paper chart or folder (if applicable) has been submitted to the Academic and client services coordinator.

Clients established in treatment

- **Letter:** a letter should be mailed to the client if multiple no-shows or client calls to say they will not be returning. Letter explains that therapy has ended/will end and makes necessary referrals. Copy of letter should be scanned into Titanium.
- **Case Closing Note:** both a case closing note and case closing note data form will be completed in Titanium. The case closing note is to identify that a case is to be closed; it is not a therapy progress note. The last therapy session should have its own therapy progress note. Forward case closing notes to your supervisor for their signature.
- **Submit client paper chart or folder to Academic and client services coordinator.**
- **Termination/Transfer Summary:** signed by trainee and supervisor within a reasonable amount of time after the last session and placed in the scanned documents basket. A client will be deselected from lists only once the Termination/Transfer Summary is entered into the client's file and the client paper chart or folder (if applicable) has been submitted to the Academic and client services coordinator.

Assessment Cases

- **Case Closing Note:** both a case closing note and a case closing note data form will be completed in Titanium. The case closing note is to identify that a case is to be closed and should be signed by the trainee and supervisor.
- In the instance that an assessment is unfinished or incomplete, a trainee will complete the Treatment/Assessment Summary section in the case closing data form (brief summary of data and findings, if any).
- **Report:** Completed reports are to include signatures by the trainee and supervisor and scanned into Titanium (placed into scanned documents basket).

Summary of Clinic Paperwork Expectations

At Intake (i.e. first session):

Forms to complete:

- Informed Consent
- Review with client the Ohio Notice HIPPA Privacy Policy and Acknowledgement
- E-Mail Permission (if indicated)
- Release of information (if indicated)
- OWL Outcomes measure/s

Paperwork Timeline:

- Intake summary report is to be signed by both the trainee and supervisor and placed into the scanned documents basket based on the timeline set by the supervisor.

Throughout therapy (sessions 2 – 99):

Forms to complete (adults only):

- OWL Outcomes measure/s

Paperwork

:

- Progress notes in Ti – sent to supervisor **within 24 hours**, unless threat to self or others transpired, in which case you need to document immediately after the session.
- Treatment plan (signed by trainee and supervisor) and placed into the scanned documents basket based on the timeline set by the supervisor
- Quarterly summaries are signed by trainee and supervisor scanned into system **every three months** from the initial session.

Termination or Transfer:

Forms to complete:

- Termination/transfer summary

Paperwork Timeline:

- Termination or transfer summary scanned into Titanium within **1 week** of last session

Trainee Quick Reference Sheet (9 pages with templates)

Documentation	Due (section 44g in Handbook)
Informed consent	Signed by client and therapist during first session
Intake summary*	Due date set by supervisor
Treatment plan*	Due date set by supervisor
Progress note**	Within 24 hours of session
Quarterly summary*	Every 3 months from first session
Termination/transfer summary*	Due date set by supervisor
Release of information	As needed
Outcome Measures***	Administration
At least one routine measure from OWL	Before every session

*Templates for the above documentation are provided on subsequent pages. Also included below is “The Spiel,” a handy reference of major points that should be discussed with your client during the intake session.

**Templates for progress notes are not provided. Preferred method for writing progress notes varies by supervisor. However, various templates are included within Titanium.

***Adult clients only

What should you be tracking for internship?

1. Intervention
 - Group
 - Individual
 - Couples
 - Families
 - Intakes/structured interviews
2. Assessment
 - Psychodiagnostic
 - Cognitive
3. Supervision
 - Group
 - Individual
 - Supervision of other students
4. Support activities
 - Assessment report writing, scoring, interpretation
 - Case conference presentations
 - Chart review
 - Clinical writing
 - Professional consultation
 - Scholarly research
 - Workshops, didactic training

“Spiel” for first session

1. I want to take a few minutes and tell you about the Psychology Clinic here at the University, and **explain how it is different from other clinics.**
2. Intake interviews, assessments, and therapies are provided by graduate students in clinical psychology. Because we are graduate students, we are supervised by a licensed clinical psychologist. **I am supervised by Dr. XXXXXX.** We are also part of a supervisory team – what this means for you is that you will receive my expertise as well as the expertise of others.
3. The supervision itself may take the form of videotaping, audio-taping, or direct observation (mention they may have already noticed the cameras in the corner of the room).
4. The focus of the supervision/videotaping is on me and how I’m doing. This allows us to provide the best quality of services to you and helps me become a better clinician.
5. **Any questions so far?** [Turn on video tape.]
6. We take confidentiality very seriously, and everything we discuss today is **confidential within the clinic staff.** There are, however, **limits to your rights of confidentiality:** (1) If you tell me that a child or elderly individual is being harmed by physical or sexual abuse, then I’m required by law to report that. (2) If you tell me that you are a serious threat to yourself or someone else, I would need to report that also. **The purpose of this is to keep people safe.** 3) if a judge asks UT to turn over your record.
7. In either case, I would **try** to talk about the issue with you before I did anything. Is that clear? Any questions?
8. Today is what we call an intake interview. The **plan for today** is to talk generally about what brings you into the Clinic and get some background information, do a clinical interview that’s fairly structured, and then you’ll fill out some questionnaires to determine your expectations regarding therapy and ensure our clinic can provide you with the services you want and need. The whole process will take about 1-2 hours (depending on format of intake), and we may have to finish up next session. We are going to talk about a **wide range** of things, that may not all seem completely relevant to what brought you here, but it will help us get a better picture of how you are doing overall.
9. Attendance – treatment is terminated after X no shows or X cancellations without rescheduling the same week. Attendance is critical to your well-being and if you’re not here, I’m not giving you what you need and my training is compromised as well.
10. Now I’m going to give you a few minutes to read over the informed consent for treatment and the HIPAA form/Ohio Notice Form.
11. Do you have any questions about the **consent for treatment form or the HIPAA form?** If you’re comfortable with that information you can **sign the form** and we can begin.
12. Do you have any questions or concerns about the **fees** we discussed on the phone?
13. OK, the paperwork is done – **Any questions before we begin?**

[DO INTAKE INTERVIEW]

END OF INTERVIEW

14. Give them heads-up that time is coming to a close... is there anything that you want to tell me that we haven’t covered already?
15. [Briefly summarize your understanding of why they came in and what they want us to do]

INTAKE SUMMARY

CONFIDENTIAL

Client:

Dates Seen for Intake:

Referral Source:

Therapist:

I. Identification and Behavioral Observations

- A. Include age, sex, race, marital status, religion, occupation and any other identifying characteristics that seem important/relevant.
- B. Include relevant behavioral observations (e.g., a client child who has a temper tantrum in the waiting room, or an adult client who shows up 30 minutes late.) **DO NOT** include physical description here. Put relevant physical information in mental status section.

II. Presenting Problem and History of Presenting Problem

- A. What is the problem? (Be specific.)
- B. What is the context of the problem? Is it chronic, episodic, reactive, etc.?
- C. **WHY NOW?** Why is the client asking for help **NOW**?
- D. What has been done already to address the problem?
- E. What are the person's strengths, coping skills, resources and supports?

III. Social History

- A. *For individual adults:* What is the client's current living situation? What is his/her educational and occupational level? Current schooling/employment status? Current financial situation? If not addressed in item IIE: Current relationships/supports (e.g., family, friends, significant others)?
- B. *For children/couples/families:* Who is in the family? Who lives in the household? Where do other family members live (if relevant)? What is the educational, occupational, and financial level of the family? What are relationships like within the family (e.g., supportive, abusive)?
- C. *For child clients: Developmental history:* Note developmental milestones (e.g., length of gestation, pregnancy/birth complications, age of walking, talking, toilet training, etc.). What grade (or pre-school/day care situation) is the child in? How is he/she performing in school academically and socially? Were there any early childhood problems (e.g., parents' divorcing, separation from parents or caregivers, difficulty in attachment) or challenges adjusting to school or in relationships with peers? Note number of siblings and gather information regarding sibling(s)' development.
- D. What is the socio-cultural context and history? Do race, ethnic background, religion, sexual orientation, socio-economic status, or other environmental factors contribute to the client's sources of support or distress? (For example, for couples, are there misunderstandings as a result of differences in partners' backgrounds?)

University of Toledo Psychology Clinic

Mail Stop 948 • 2801 W. Bancroft St. • Toledo, OH 43606-3390

Clinic Phone: 419.530.2721 • Fax: 419.530.2959 • <http://psychology.utoledo.edu/clinic.html>

IV. Mental Health History and Family History

(Phrasing of questions and amount of detail gathered can be guided in part by the presenting problem and client reports on initial questionnaires.)

- A. Family history of mental health concerns (e.g., depression, “nervous breakdowns,” substance abuse). Treatment history of family members (e.g., “Did they seek help/see a counselor?” “Were they ever hospitalized?”)?
- B. Personal history of mood or perceptual difficulties, such as depression, anxiety (e.g., panic, social anxiety), mania, a “nervous breakdown,” psychotic symptoms (e.g., “Have you ever seen/heard things that turned out to not be there?”)? Family history?
- C. History of alcohol/drug use/abuse? Current substance use?
- D. History of psychotropic medications? Current medications? (List, including dosage, frequency, duration.)
- E. History of counseling/psychotherapy for client? (List names and dates; at end, ask client to sign release of information and send for records.)
- F. History of psychiatric hospitalizations?
- G. History of physical or sexual abuse in client or family?
- H. History of dangerousness to self or others? Previous suicide attempts?

V. Medical History of Client and Family

- A. Relevant medical conditions or current concerns? (If applicable, obtain release of information for physician.)
- B. History of serious medical illnesses or hospitalizations in client and family?
- C. In addition to psychotropic meds (see item IV-D.), current medication(s). Include name of medication, dosage, frequency, and duration.

VI. Mental Status Exam

Note: For the purpose of this intake, the main goal of this section is to note anything atypical.

- A. Mood (client’s self-reported mood)
- B. Affect (e.g., euthymic vs. flat, incongruent with mood report)
- C. Cognitive processes (e.g., linear, clear vs. circumstantial, confusing)
- D. Intelligence (e.g., appropriate use of vocabulary)
- E. Judgment (e.g., good, fair, poor; use example to anchor your observations)
- F. Insight (e.g., good, limited; use example to anchor your observations)
- G. Physical description if relevant to the presenting problem (e.g., an exceptionally thin young woman who presents with the problem of “feeling fat”)
- H. Motor Skills (e.g., slowed, hyperactive)
- I. Speech (e.g., slowed, pressured, inaudible)
- J. Psychotic processes (delusions or hallucinations)
- K. Suicidal or homicidal ideation, plans and actions
- L. Vegetative signs of depression (e.g., change in sleep, appetite, decrease in memory, concentration, increase in hopelessness, worthlessness)

VII. Problem List

VIII. Diagnostic impression – DSM-IV

- A. Complete a DSM-IV diagnosis, using all five (5) axes.
- B. Articulate your reasoning, both in terms of what you already know and in terms of what needs to be assessed further. Avoid stating your diagnoses in terms of “rule outs” (r/o). In the first two sessions, aim to collect enough information to make an accurate diagnosis.

IX. Preliminary Treatment Recommendations

Include treatment modality (individual, couple, family, group) and anticipated goals of treatment. (Treatment plan will be presented in greater detail in a separate document.)

X. Signatures

Your *Intake Summary* must be signed by **BOTH** you and your supervisor.

Signature of Therapist: _____ **Date:** _____

Signature of Supervisor: _____ **Date:** _____

TREATMENT PLAN CONFIDENTIAL

Client Name(s): _____ **Date:** _____

For Minors: Parent(s)' Name(s): _____

For each client goal, problem, and/or diagnosis, state the proposed treatment plan. The treatment plan must include measurable goals, spelled out in specific, behavioral terms.

You may write your treatment plan in list form, or use the following grid (which contains an example):

Problems	Goals	Plan
1.	a.	
2.	a.	

I understand the above treatment plan. I agree with the goals specified and also with the procedures proposed to assist in the attainment of these goals.

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

QUARTERLY SUMMARY

CONFIDENTIAL

Client Name(s): _____ **Date:** _____

For Minors: Parent(s)' Name(s): _____

Therapist Name: _____

Supervisor Name: _____

I. Problem List/Changes in Problem List

II. Diagnoses/Changes in Diagnoses

- C. Complete a DSM-IV diagnosis, using all five (5) axes.
- D. Articulate your reasoning, both in terms of what you already know and in terms of what needs to be assessed further. Avoid stating your diagnoses in terms of “rule outs” (r/o).

III. Summary of Treatment since Treatment Plan or Last Quarterly Summary

- A. Include specific interventions utilized

IV. Summary of Progress toward Goals

- A. Should reflect goals indicated on last treatment plan/quarterly summary.
- B. Describe changes as indicated by standardized measures.
- C. Include qualitative summary of progress as well.
- D. Anchor statements with examples.

V. Recommendations

_____ Continue therapy _____ Recommend referral _____ Successful termination
Other: _____

VI. Signatures

Therapist Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

TERMINATION/TRANSFER SUMMARY CONFIDENTIAL

Client Name(s): _____ Date: _____

For Minors: Parent(s)' Name(s): _____

Therapist Name: _____

Supervisor Name: _____

Amount of Time in Treatment: _____ Number of Sessions: _____

I. Identifying Information and Problem List

- A. Presenting problems
- B. Subsequent additional problems
- C. Brief summary of test results
- D. Diagnoses

II. Summary of Treatment Approach/Interventions

- A. General approach to treatment (e.g., once weekly individual cognitive-behavioral therapy; once monthly family systems therapy with identified patient, mother, father, and younger sibling)
- B. Primary specific interventions used
- C. Note any changes in approach during the course of treatment and rationale (e.g., treatment initially focused on behavioral strategies for coping with panic attacks; once panic attacks subsided, shifted to focus on client's family conflict)

III. Summary of Treatment Progress

- E. Describe changes in symptoms or functioning, as indicated by standardized measures, therapist observations, and/or client self-report
- F. Note any major barriers to treatment
- G. Comment on any notable client strengths

IV. Current Status

- A. Complete a DSM-IV diagnosis, using all five (5) axes.
- B. Present problems, if any, and how these may affect future functioning.

V. Recommendations

- _____ Recommend transfer to a new therapist as soon as possible
 - _____ Client will continue therapy at a later time (specify amount of time: _____)
 - _____ Successful termination
- If transfer/referral has already been arranged, specify new arrangement:

List any other recommendations/comments: _____

VI. Signatures

Therapist Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____