PSYCHOLOGICAL CONSULTATION CENTER

POLICY AND PROCEDURES MANUAL
2018-2019

Psychological Consultation Center
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PCC Clinicians:

This manual provides an introduction to the operation, procedures, and policies of the Psychological Consultation Center (PCC) at the University of Rhode Island. This manual will answer questions about how the PCC operates, and should serve as a reference throughout your training. A psychology training clinic can be an exciting, but potentially chaotic place. The yearly turnover in graduate assistants, undergraduate work-study students, post-doctoral and pre-licensure clinicians, and licensed practica supervisors can challenge our ability to simultaneously meet the training needs of graduate clinicians and the service needs of our clients. As a program and as a clinic, we are most helpful to clients entering the clinic-setting by being clear and consistent in our policies and systematic about meeting guidelines and expectations. Adherence to PCC policies by staff clinicians is essential to the maintenance of a smoothly operating, high quality service and training setting.

We are excited to have the opportunity to collaborate, supervise, and work with all of you. Please never hesitate to ask questions, seek clarification, and/or ask advice as you progress in your training. We’re so happy that you are here!

Warmly,

Lindsey R. Anderson, PhD
Director, Psychological Consultation Center
PART I. INTRODUCTION

The University of Rhode Island is a coeducational, state-supported institution that offers programs in the liberal arts and career-directed fields. As Rhode Island's State University, it offers undergraduate, masters, and doctoral courses of study and conducts extensive research programs in numerous fields. The University is the state's land-grant institution founded in 1892; it became a university in 1951; was named one of the nation's first four Sea Grant colleges in 1971; and was named an Urban Grant college in 1995.

The University of Rhode Island employs 609 full time faculty members and enrolls approximately 2,972 graduate and 13,641 undergraduate students. It has 94 undergraduate programs, 83 graduate programs, and 16 certificate (non-degree) programs.

DEPARTMENT OF PSYCHOLOGY

The Psychology Department collectively decided to leave the College of Arts and Sciences and join the new College of Health at the University of Rhode Island. Reflecting the integral role that Psychology plays in health behavior change and educational growth, the Psychology department is actively seeking opportunities for greater collaboration with other health-related disciplines on campus, and focusing its energies (both graduate and undergraduate) on the provision of research, service, and education. The department is comprised of tenure track faculty members and additional special instructors, practicum supervisors, research faculty, and other teaching faculty; approximately 800 undergraduate majors; and over 100 graduate students, the majority of whom are enrolled in doctoral programs. The department offers training leading to the Ph.D. in three areas: clinical psychology, behavioral science, and school psychology. The Clinical program is fully accredited by the American Psychological Association (most recent reaccreditation expected Fall 2018). The Psychology Department is the only source of doctoral-level training in applied psychology available in Rhode Island, and its doctoral program is the largest Ph.D. program at the University.
II. OVERVIEW OF THE PCC

MISSION OF THE PCC

The Psychological Consultation Center (PCC) serves two primary functions: it is a training site for applied masters- and doctoral-level psychology graduate students in both Clinical and School psychology, as well as a resource for individuals on campus and in the community seeking psychological services.

As a training site, the PCC’s purpose is to expose graduate students to the diverse activities and interventions associated with professional psychology. As the on-campus applied training facility for the Department of Psychology, the PCC trains students to provide psychological services under intensive supervision from licensed Psychologists within (and beyond) the Psychology department. As students progress in their Program of Study, the PCC (Director, Supervisors, Administrative staff) help to coordinate other exciting training opportunities relevant to clinicians’ professional interests and goals. Historically, some of these externship opportunities have included placement at nearly all major RI Hospitals, several community health centers (incl. Providence Community Health Center and RI Free Clinic), Eleanor Slater Hospital, Wyatt Federal Detention Center, RICBT and myriad others. Additionally, in partnership with the Couples and Family Therapy Clinic in the Department of Human Development and Family Studies (HDF), the PCC is now offering clinical services at the URI Providence Campus (CCE). These services were born out of a growing need for support services at CCE and in growing collaboration with other parts of the URI campus and community.

To maximize clinical training, the PCC is committed to the use of observation as a means of broadening clinicians’ direct clinical encounters. Through the use of both direct and recorded observation, clinicians have the opportunity (and are expected) to spend time observing others and being observed (both by peers and by supervisors). Because of our belief in the importance of observation and our commitment to utilizing observation to enhance learning, the clinic is outfitted with one-way mirrors and audio/video equipment to ensure excellence in clinical care and supervision. The extent to which these tools are utilized will vary by individual clinician and supervisor; but it is highly encouraged that clinicians and supervisors take advantage of the opportunity to augment clinical training through use of these technologies.

As a community consultation center, the PCC strives to provide a range of direct services (e.g., psychotherapy and psychoeducational assessments) and indirect services (e.g., community and campus-wide workshops) aimed at developing the competencies of individuals and groups within the community. As a part of the larger Rhode Island community, the PCC seeks to understand the salient issues that impact the mental health and wellbeing of our community, and to find meaningful ways to educate, support, and collaborate with others (clients and professionals alike).

Finally, as part of URI’s academic community, the PCC believes in the necessity of integrated and applied research. Through these research efforts, the PCC helps to demonstrate ways that clinical services and research activities inform and strengthen one another. The PCC is an atmosphere that encourages students to identify a research interest/need and explore ways of
collecting and analyzing data that helps to further educate and advance the clinical services being provided.

SERVICES PROVIDED BY THE PCC

The PCC works collaboratively with the Couples and Family Therapy Clinic (HDF) to offer comprehensive services to all those seeking treatment. Clients who present to the PCC for individual treatment may benefit from broader family- or couples-based treatment as well. In addition to serving as referral sources for one another, the graduate student therapists working in the Couples and Family Therapy Clinic are available for consultation services when Psychology graduate students believe that a family/couples intervention/consultation would be appropriate to advance individual treatment.

In response to client and community needs, the PCC offers assessment and intervention services. Assessments may take the form of a single consultation with an individual, family, or institution, or may involve cognitive, neuropsychiatric, personality, and/or psychoeducational assessment. During the course of an evaluation, information is gathered about an individual’s intellectual, educational, emotional and social functioning, as well as their medical history and biological development. The information is synthesized, interpreted, and used to generate recommendations for appropriate treatment interventions or academic accommodations. Exclusively psychodiagnostic evaluations (eg. SCID evaluations) are limited to those clients seeking ongoing psychotherapeutic services in the PCC.

Over the years, the PCC has provided low-cost evaluation and diagnostic services for individuals ranging in age from preschool-age to more senior adults. Most recently, diagnostic evaluations have been largely limited to college-age and adult populations; pediatric referrals are discussed with the Assessment Team supervisor to determine the appropriateness of PCC resources. In the event that a referral is inappropriate for the PCC, a list of community referrals will be provided. Results from evaluations conducted in the PCC frequently serve as the basis for academic/professional intervention recommendations and consultation services. Clients seeking evaluations are referred by myriad sources: schools, doctors, parents, and other agencies. Some of the most common reasons for referral include: suspected learning disabilities, attentional difficulties, disruptive behavior at home and/or school, lack of school interest or motivation, poor peer relations, anxiety, school phobia, depression, and school readiness and retention. Evaluations are conducted by Clinical and School Psychology students enrolled in a supervised Assessment Practicum. **The PCC does not provide psychological evaluation for the purpose of purchasing guns or other firearms** (not to law enforcement agencies nor to the broader RI community), and does not routinely offer court-mandated evaluations.

Psychotherapy services through the PCC have included child therapy, individual adult therapy, multicultural psychology, behavioral health, forensic psychology, interpersonal psychology, and/or applied clinical research. All psychotherapy services are conducted in the context of supervised Practica and are thus subject to change from one semester to the next depending on which clinical frameworks are being offered as Practica experiences. The predominant theoretical orientations used in psychotherapy services at the PCC include Cognitive Behavioral
Therapy, Motivational Interviewing, and Interpersonal therapies. The Child Anxiety Program (CAP), directed by Dr. Ellen Flannery-Schroeder, operates within the PCC and provides short-term, intensive, manualized treatment for anxious children and adolescents. In addition, CAP offers workshops to parents and caregivers of anxious children and often gives talks and presentations to physicians, other clinicians, and members of the community. Drs. Flannery-Schroeder and Anderson work closely with the Washington County Children’s Coalition to identify areas of clinical need in Southern Rhode Island, and collaborate to do research and intervention development for community implementation.

The PCC has also provided a variety of time-limited, structured workshop experiences designed to help individuals and families deal with specific issues such as stress management, health behavior change, parenting skills, targeted interventions for the emotional and educational needs of learning-disabled children, coping with chronic illness, the more general survey workshops for professionals and local agencies.

The PCC does not offer specific, family/couple’s therapy training opportunities. For those clinicians looking for clinical training in family and couple’s therapy, academic and clinical collaboration is possible with the Couple’s and Family Therapy clinic on campus (874-5956).

GUIDELINES FOR PRACTICA ASSIGNMENTS

Practica request forms for the following year are distributed every Spring in March. Clinicians anticipating PCC involvement in the coming year are asked to rank order their top 3 practica choices. Students are not guaranteed their first choice practica experiences, and should prioritize those training experiences most important to progressing in their program of study.

Students are assigned to PCC practica based on 3 primary criteria:
- 1. Indicated preferences (on practica request forms)
- 2. Seniority
  - a. Advanced students’ requests are prioritized given the need for specific courses in order to apply for internship.
- 3. PCC contracts with externship training sites
  - a. Several PCC practica have students placed in external training sites to expose clinicians to specific populations relevant to that practica (ie. Multicultural practicum, Health Practicum, Forensic Practicum). For these settings, a certain number of student clinicians are necessary to fulfill the collaborative mission between the PCC and that setting; other settings have a strict limit on the number of clinicians it can accommodate in a meaningful and productive training experience.

* Special Note about the Multicultural Practicum (Dr. Jasmine Mena, Spring 2015)
- For those students requesting to complete the MC practicum at an alternate site (not currently affiliated with PCC Practica or the MC practicum specifically):
  1. Student should establish extenuating circumstances that prohibit participation in established MC practicum sites
2. Students will continue to be required to enroll in PSY 643 and PSY 672 simultaneously during the academic year in which they participate in the MC practicum.

3. Student should be “externship ready” (as defined by the clinical manual):
   a. Thesis defended or dissertation proposed
   b. In good standing with their program of study
   c. In good standing with their PCC paperwork and documentation

4. Identify a site that meets the following requirements:
   a. At least 50% of the clients are from ethnic minority groups (additional diversity is appreciated)
   b. On-site supervision is conducted using a multicultural framework
   c. Student enrolls in PSY 643 the same year as the externship is taking place

5. If the above is met, students may petition the clinical faculty to approve the alternative site placement.

**Note Excerpt from the 2014-2015 Clinical Manual**

“All students are required to either take the Multicultural Psychology practicum (a 3-credit practicum which serves an ethnically diverse clinical population) or to complete an externship which includes all of the following: 1) a culturally relevant treatment, 2) supervision from a multicultural framework, and 3) work with an ethnically diverse population. Both the practicum and the externship must include didactic training in multicultural treatment issues. A student opting to use an externship to fulfill this requirement must submit a proposal to the clinical faculty. The program must then deem that the externship satisfactorily fulfills this requirement.” (p.26)

**POPULATIONS SERVED BY THE PCC**

Families and individuals seek services at the PCC for a variety reasons including: depression, anxiety, marital and sexual problems, difficulty managing children’s anxiety, difficulty in coping with stressful life events (academics, employment challenges, illness, separation, divorce, death of a family member), or other interpersonal difficulties. The PCC clientele often has constrained financial resources, so therapy is offered on a sliding scale (to meet economic realities) as well as address the stresses and difficulties associated with financial need in the context of the therapy process.

Occasionally, the PCC will receive court-ordered referrals (eg. domestic violence, substance use/abuse, anger management, etc.). The PCC also receives referrals from the URI Conduct Board for students looking for resources following an academic/social sanction, probation, and/or suspension. Each of these referrals is individually evaluated for appropriateness for the PCC. In the event that a referral is not appropriate for the PCC (a training clinic), a list of community resources is provided.

Some of the following types of clients are generally seen as not appropriate for treatment at the PCC through practica teams:

1. Individuals with histories of chronic, serious mental health issues who might benefit from a more long term, stable, therapeutic relationship;
2. Individuals requiring ongoing and close psychiatric/ medical evaluation (e.g., individuals on Lithium; individuals with severe, medically unstable eating disorders, etc);

3. Individuals in acute crisis who require access to 24 hour emergency response;

4. Individuals requiring some specialized form of treatment that the PCC may not be equipped to provide, for example, treatment of primary, acute (and impairing) substance abuse or sexual offenders.

In addition to these general guidelines, each phone screen and subsequent intake are examined to ensure that there is a good match between the potential client and the prospective clinician. As described below, student clinicians interested in long-term therapy or other specialized clinical experiences can make these arrangements by signing up for PSY 670 and coordinating supervision with the Director of the PCC (or other appropriate supervisor with expertise in a specialized area).

**ORGANIZATION OF THE PCC**

The PCC is staffed by faculty and students involved in various aspects of applied training and service. The bulk of psychotherapy services are offered through clinical practica, supervised by clinical faculty or other adjunct clinical psychologists. Graduate students receive academic credit for participating in academic practica teams. Generally, 4 to 6 students and 1 faculty supervisor make up each practicum team. Clinical practica are offered in such designated content areas as child anxiety, individual, health, multicultural, and forensic psychotherapy, and workshops. Practicum teams meet weekly for supervision, and all staff members meet twice a semester for PCC staff meetings.

Additional meetings and communication between supervisors and the PCC Director happen frequently, but on an *as-needed* basis.

Some advanced students provide services in the PCC outside the practicum teams, with supervision (usually) from the PCC Director (see “Specialized Clinical Experience,” pg. 15) with given enrollment in 670.

The staff of the PCC consists of administrative staff, graduate assistants, clinical supervisors, graduate students in clinical and school psychology, a full time Administrator, and undergraduate work/study students. Collaboration with the College of Nursing is being explored in order to provide medication consultation to PCC clients.
**Brief Description of PCC Staff:**

**Director of the PCC:** Lindsey R Anderson, PhD

The Director is responsible for implementing training, service, and research objectives by assuming administrative responsibility for all direct and indirect services within the PCC. Specific duties include: developing policies for the Center, directing clinical services, coordinating appropriate disposition of intakes, hiring supervisors, coordinating supervision, and enhancing the training and research capacities of the PCC.

**Office Manager:** Cheryl (Cherie) Taylor

The Office Manager manages the PCC office and coordinates a variety of office tasks, including: initial phone contact with clients, coordinating work-study students, hiring work-study students with the PCC, purchasing and requisitioning PCC items (including assessment and testing materials), assisting with the management of PCC finances (cross referencing documented payments in Titanium with scheduled deposits).

**Graduate Clinic Assistant:** Ciara James (2018-2019)

The Graduate Clinic Assistant is an upper-level (3rd year+) graduate student in clinical psychology. The Clinical Assistant aids the Director in several areas: initial telephone screening of cases, presentation of cases, review of clinician record-keeping, supervision of less experienced students when appropriate, training and management of Titanium.

The Graduate Clinic Assistant is also responsible for running the Student portion of Student-Supervisor PCC meetings and documenting minutes. The GSA will then transcribe these minutes and distribute them to all graduate student clinicians. Additionally, the GSA will serve as one (of several) graduate student liaisons to the QCTC and communicate issues/concerns discussed during Student meetings.

**Clinical Supervisors:** Faculty

Clinical Supervisors are usually faculty in the clinical area that supervise a team of graduate students through the mechanism of practicum therapy courses. Current supervisors include: Drs. Ellen Flannery-Schroeder (Child Anxiety Program; Director of the Clinical Psychology program), Dr. Nicole Weiss (Multicultural Psychology), and Dr. Lindsey Anderson (off practicum cases; Director of the PCC).

**Adjunct Clinical Supervisors:**

Adjunct Supervisors are licensed Psychologists working at the University of Rhode Island, or within the larger Rhode Island community. Current Adjunct Supervisors include: Dr. Caitlin Burditt (Behavioral Health), Dr. Jared Minkel (Cognitive Behavioral Therapy), Dr. Andrea Lavigne (Assessment), and Dr. Mary Clair-Michaud (Forensic Psychology).
PART III. INITIAL CASE MANAGEMENT ISSUES

All incoming referrals, regardless of referral source, are routed to the PCC Graduate Student Assistant or PCC Director. Usually a client’s first contact with the PCC is by telephone, but an increasing number of walk-in clients are beginning to present to the PCC. Walk-in clients are welcome to do an in-person “phone screen” with the PCC Graduate Assistant and/or Director, but **no walk-in clients will be screened after 4pm**. The PCC Graduate Assistant informs the prospective client of the types of services offered, the sliding-scale fee schedule, and the nature of services at the training facility (i.e. observation and video recording; faculty and student staff; limits of confidentiality). If appropriate, a phone screen is conducted by the PCC GSA to gather initial information to determine whether the PCC is an appropriate treatment facility for the client. Each phone screen is reviewed with the PCC Director within two business days (ideally less) and assigned to a graduate clinician with the approval of their practicum supervisor (approval depends on the status of clinician paperwork, and a clinician’s current caseload). If it is decided that the client is not appropriate for the PCC, then the client is referred to other community agencies/providers.

**Client Processing and Case Assignment**

**Initial Contact**
- When a client contacts the PCC, the Office Manager routes the call to the Graduate Assistant who informs the potential client about the nature of the PCC as a training clinic, gathers basic contact information, and conducts a standardized Phone Screen.
- All information is collected and recorded in Titanium.

**Phone Screen**
- The Graduate Assistant completes a Phone Screen with the potential client and records this information in Titanium.
- The Graduate Assistant reviews all phone screens with the PCC Director.
- If the client is not appropriate for the PCC, they are provided with referral sources in the community.
- If the case is appropriate for the PCC, it will be assigned directly to a graduate clinician pending approval from their practicum supervisor.
- The Graduate Assistant will notify the clinician, PCC Director, and practicum supervisor that a clinician has been assigned a new case.
- The Graduate Assistant adds the case to the assigned clinician’s “client list” in Titanium.
- Assigned phone-screens will be made available to clinicians and their Practicum supervisor.

**The Intake**
- After being assigned a new case, a graduate clinician must make contact with the client **within 24 hours** to schedule an intake.
- The assigned clinician will find their new case added to their “client list” in Titanium and will have access to all contact information and phone screen data in order to prepare for the intake.
- Intakes should be scheduled **within 1 week** of being assigned.
- Intake appointments **must** be scheduled in Titanium.
Post-Intake

- The therapist notifies their practicum supervisor, the Clinic Assistant, and the PCC Director when the Intake was completed.
- After completing the intake, a formal intake report must be completed/submitted within 1 week. A draft of a report (including bulleted notes) must be documented immediately following an intake.
- Any hard-copy documents obtained during the Intake (hand written notes) must be filed with the chart until the formal report is completed. Please see “Detailed Steps in Completing a PCC Intake” below for details.
  - For liability purposes, all notes must be submitted in a timely fashion.
- The clinician will discuss the Intake during Practicum supervision.
- If consultation/supervision would be helpful prior to a clinician’s Practicum supervision, students should contact with their direct Supervisor. If their direct Supervisor cannot be available, all clinicians are welcome to consult with the PCC Director.

Under no circumstances may PCC staff see clients or make a commitment to provide services in the PCC without the knowledge and consent of their supervisor and the PCC Director.

Under no circumstances may PCC staff see clients outside of normal PCC business hours unless explicit permission is granted by the PCC Director.

All clinical sessions must be scheduled in Titanium.

- For safety purposes, no clinician is ever to see a client in the PCC alone. Anytime a client session is scheduled, secondary (support) staff (clinicians, supervisors) must be in the clinic in case of an emergency.

Clinicians enrolled in 672 should expect to have 3-4 direct contact hours per week (a caseload of 4-6 clients)

In order to successfully complete/pass a semester Practicum, each clinician must complete a certain number of direct-care hours (as determined by their practicum supervisors) and complete all case-related documentation in order to satisfy the course requirements. If this does not happen, clinicians will receive an Incomplete for that semester and will be expected to make up any hours during the summer or subsequent semester.
Detailed Steps in Completing a PCC Intake Interview

Below are the required procedures for preparing and completing an intake:

**Step 1: Before the Intake**

- Contact the client **within 24 hours** of case assignment to schedule an appointment.
  - All attempts to contact a client must be documented in the Phone Log in Titanium (date, time, if left a message). If calls are not documented they “**did not happen**.”
  - If you need to leave a message, state that you are calling from the University of Rhode Island to schedule an appointment (see guidelines for calling clients below).
  - The Phone Log is found on the Client Info Page on Titanium (use the drop-down menu) *see Directions on How to Use Titanium
  - If unable to reach the client after three attempts, clinician must notify the PCC Director (Lindsey Anderson) so that a clinic-initiated phone call (#4) can be made.
  - If a client does not return phone messages after 3 clinician-initiated calls and 1 clinic-initiated call, it will be assumed that the client is no longer interested in services and no further attempts to schedule an intake will be made.

**Step 2: Scheduling the Intake** (*See Appendix A: Directions on How to Use Titanium*)

- When scheduling the intake, clients should be reminded about the **$30 Intake fee**, **directions**, and **parking** (they will have been given this information during the phone screen, but often need reminding).
  - At the intake meeting, the sliding fee scale will be used to determine the ongoing treatment fee
  - It is important to note that all clients are **required** to pay some fee for service. If a client is unable to afford the fee designated by the fee schedule the clinician and client may discuss alternative financial options with the PCC Director.
  - As an informal policy, the PCC only charges URI Students $5 (the rationale for this flat-rate is that URI students have the option to receive services for free through the URI Counseling Center. If, for whatever reason, they chose not to seek those services, we try to be sensitive to the other options they have available to them and the likelihood of limited financial resources)

- Intakes are scheduled for **1.5 hours**. It is important to notify the client that the Intake session will run longer than most 50min sessions due to required paperwork and the nature of gathering extensive and comprehensive background information to maximize targeted treatment and provide a context for seeking treatment.
• All clients should be given the option of having their pre-intake paperwork sent to them via email/mail (so that they can complete it ahead of time). Given the extensive nature of questions asked in this documentation, clients often find it helpful to complete it in a less formal environment and when they have other resources (ie. Medication names/doses, family member input) to help them.

• **Clinicians are responsible for reserving rooms on Titanium.** Clinicians are asked to reserve rooms well in advance to avoid any scheduling conflicts.
  
  o Individual Therapy Room 4 has been designated for clinical work specifically with URI Student-Athletes.
  
  o Priority for reserving Family Therapy Rooms should be given to CAP and Assessment cases.

• Therapists should **review the phone screen** prior to the Intake session in order to familiarize themselves with the basic presenting problem and limit unnecessary redundancy.

• Please see Appendix A for specific directions on How to Use Titanium

• Therapists should arrive at the PCC **30 minutes ahead of an Intake**, review Intake documentation in folders in the phone room, and review phone screen data
  
  o **All clients are given a PHQ-9, ISI, and GAD-7 at ALL appointments.** Gathering this information at intake provides baseline data for us to evaluate treatment progress. Additional measures may be used to evaluate other specific issues/concerns. Clinicians should discuss the use of additional measures with their supervisors and/or the PCC Director.

**Step 3: The Intake**

There are several **general purposes** for a comprehensive Intake interview:

1. To gather enough information regarding the nature and degree of the client’s difficulties to confirm that the PCC is an appropriate service facility for the client (and if not, what an appropriate referral source might be).
2. To develop rapport with the client and communicate a sense of hope about the outcomes of engaging in treatment.
3. To address administrative logistics (e.g., informed consent, fees) so that treatment can get off to a smooth start.

• **The clinician must be in the clinic 30 minutes before the scheduled appointment**
  
  o It is unprofessional and inappropriate for the clinician to be late to any therapy appointment (barring an emergency).
• Clinicians are expected to attend each therapy session wearing appropriate, professional attire (sneakers, ripped clothing, flip-flops, revealing clothing, fitness apparel, etc. are unacceptable).

• Clinicians should not eat or drink during session (unless it is a clinically indicated exposure designed specifically for treatment purposes). This includes coffee (water is fine).

• Clinicians are expected to gather session payment at the start of each session.

Informed Consent

- The client must read and sign the Informed Consent Form and any necessary Releases and/or Requests for Information.
  - Even when you believe that clients are sufficiently familiar with the process of Informed Consent (even if they assure you that they do not need to review the process, even if they sign the form before you have started to review it), you must go through the steps of reviewing Informed Consent with each client.
  - Child-clients will provide their assent to treatment but parents must sign the consent to treat. Be sure to sign these forms as a witness as well.
- When reviewing the Informed Consent Form with clients, make sure to indicate the limits of confidentiality and instances where confidentiality may be violated.
  - It is important to note – with CAP cases – that parents are part of the treatment team and (when necessary) confidentiality is limited in this regard.

• Forms to use during Intake include:
  - New Patient Packet (completed by client prior to Intake session)
  - Consent Form (x2 – one for the clinical file, one for the client to keep)
  - Patient Privacy and Rights (in development)
  - Intake Form (for clinician)
  - Fee Schedule
  - Request/Release of Information (x2)
  - Patient Health Questionnaire – 9 (PHQ-9)
  - Generalized Anxiety Disorder – 7 (GAD-7)
  - Other outcome measures that may be appropriate based on referral (AUDIT, Y-BOCS, EAT-22, etc)

• ALL Request/Release of Information forms must be completed, signed, and faxed (by the clinician, not the PCC Office Administrator) to the appropriate person. The original document and confirmation of sent fax must then be filed in the “To Be Scanned” file.
  - It can be useful to remember the following individuals when determining the number of ROI that may be useful to facilitate treatment:
    - Past clinical providers (therapists, psychiatrists)
    - Primary Care Doctors, Nutritionists
    - Family members, or other significant support people
    - The Dean of Students Office
• Dr. Jacqueline Tisdale, Director of Outreach and Intervention Disability Student Services
  • Results of the PHQ-9/GAD-7 must be calculated and included in the Intake Report. Additionally, there is a template of both of these measures in Titanium. Results should be entered into the Titanium-template for each session.

* Clinicians are expected to use the PHQ-9/GAD-7 to conduct regular re-evaluations of client progress throughout treatment. Supervisors will monitor the use and appropriateness of such assessments and encourage use at every session. Since the program is based on a scientist-practitioner model it is imperative for students to operate as scientists-practitioners and regularly evaluate their clients’ progress to monitor overall effectiveness.

Helpful Suggestions for Meeting Your Clients for the First Time:

  o **Introduction:** Your client may be unsure of how to address you. You need to make your preferred address clear when you first introduce yourself (Mr./Ms., first name, etc.). At the same time, find out what the client prefers to be called. There is an implied power structure in our society, culture, and profession. Clinicians may want to consider these issues and discuss them with supervisors prior to an intake session.

  o While clinicians may understand the reasons that they are not yet entitled to be addressed as “Doctor;” clients may not. It is essential that clinicians not allow clients to use this term because it implies a level of expertise that, at least in the legal and licensing sense, clinicians providing treatment at the PCC are not yet able to provide.

  o **Therapy expectations:** At some point in the first session, you should find out how your client feels about therapy, their expectations for treatment, and what they know about the structure of therapy (e.g. purpose, session duration, cancellation policies, session fees, communication with clinician, “client rights”). Providing clear, succinct, and transparent psychoeducation to your clients about the therapy process, your use of a specific treatment modality (e.g., CBT), and the risks/benefits of treatment is critical in helping clients be informed “consumers” and assume appropriate treatment expectations.

  o **Session length:** Generally, individual sessions last for 50 minutes. The “fifty-minute hour” is a standard for private practice, and allows clinicians to schedule clients on the hour and still have 10 minutes between clients to complete necessary documentation. Learning to manage time in treatment is an important skill and something that you should attend to closely. Consult with your supervisor if you feel anxious about how to structure your session and your relationship with your client in order to stick to a 50min session.

    • It is also important to adhere to this time structure in order to help provide clear expectations to your client about your commitment to treatment (showing up for session on time, being “present” during treatment, and ending sessions on time) and to communicate clear boundaries for the future.
Additionally, maintaining a 50min session structure prevents awkward encounters with other clients/therapists who may be waiting to use the treatment rooms. Efficient functioning of the PCC necessitates that clinicians start and end sessions on time (and schedule the therapy rooms accordingly).

Step 4: Post Intake

- If the potential client "no-shows" or "cancels" their intake:
  - The clinician must indicate the attendance status in Titanium (eg. “no attendance” “client cancelled”). **Do not simply delete the appointment!**
  - Ideally, contact the client immediately. If immediate contact is not possible, clinicians should contact the client within 24hrs to reschedule the intake appointment and address any easily identifiable barriers to the client’s attendance (eg. unsure of directions, forgot their clinician’s name, didn’t have money for the session fee, etc.).
  - If the potential client no-shows their **second** intake appointment (or is unresponsive after 3 attempted phone calls to reschedule the intake), no additional attempts are made to reschedule the intake.
    - Notify the PCC Graduate Student Assistant that the client never came in.

- If the client “attends” their intake session,
  - The therapist must indicate the client’s attendance status (e.g., “attended”) in Titanium.

- A draft of the Intake Report needs to be completed using the template provided in Titanium. All Intakes must include a “Provisional Diagnosis” (note that, with the new DSM 5, no multiaxial diagnoses are required).
  - The PCC has copies of the DSM 5 available for clinician use in the PCC Office, in the office of the PCC Graduate Student Assistant, and in the office of the PCC Director.

- Once a draft is completed, the clinician sends it to their supervisor for review.

- **For legal, liability, and ethical reasons, it is imperative that the Intake Report is completed as soon as possible (1 week at the outside).**
  - If a completed draft of an intake is not possible immediately following the Intake session, clinicians should **at least** document a few notes and bullets in Titanium (to be further fleshed-out when writing the formal report).

- All paperwork completed during the intake (and during any additional sessions) must be filed in the “TO BE SCANNED” folder in the phone room filing cabinet. PCC Administrators will take this documentation and scan it directly into the client’s electronic Titanium record.
PARKING

Given the complicated and evolving nature of URI construction and available parking, the PCC has been asked by URI Parking Services to have all clients (who are physically able) to use the Visitor Center or Fine Arts parking lots. Maps of campus and directions (once on campus) to the PCC can be found on the PCC Sakai site for clinician use and distribution. Directions include:

DIRECTIONS TO THE PCC
Due to University policies, parking for the PCC prior to 4pm must be in either the Visitor Center parking lot or the Fine Arts parking lot, both of which are an 8-10 minute walk from the clinic. Appointments after 4pm can use any available parking on campus (*this can be complicated by evening classes on campus for which URI undergraduate students also have unrestricted access to campus parking lots).

All visitors are required to stop at the Visitor Center (on Upper College Road) and pick up a temporary parking pass. The PCC will provide you with a pass after the first session, so you will only have to do this once.

DIRECTIONS TO THE VISITOR CENTER:
From Route 138, turn onto Upper College Road.
At the first stop sign, the Visitors Center will be on the RIGHT.
Clients can turn RIGHT at this stop sign and pull into the parking lot for the Visitors Center.
Clients should walk into the Visitors Center and get a temporary parking pass.

*The administrator at the Visitor Center will likely direct clients to park in the Fine Arts Lot.

DIRECTIONS TO THE FINE ARTS LOT:
Leave the Visitor Center and turn RIGHT onto Upper College Rd
Continue straight to Bills Rd
Turn RIGHT onto Bills road
The entrance to the Fine Arts Lot will be on the LEFT

The PCC is located in the 2-story low-rise section of the Chafee Building, an 8-story, smoked-glass building. The PCC office is located on the ground (1st) floor, in Suite 100. Signs will be posted inside Chafee to help direct you to the PCC. If you have any trouble finding your way, call us at 401-874-4263 and we will help you find your way.

A map showing the location of the Fine Arts Lot as well as a walking path to the Chafee building (highlighted in blue) should be attached.

For those clients with physical limitations or other logistical issues parking at-a-distance, the PCC has been given a small number of temporary “swipe” cards to grant clients access to the Rodman and Chafee parking lots. If you believe that your client needs (or would benefit from) use of these access cards, please speak with the PCC Director.
SUPERVISION

Supervision is a critical component to all clinical work in the PCC. Clinicians and their supervisors must develop a working relationship in which clinicians are encouraged to talk about difficult issues (personal, professional, ethical, ideological, etc), and the supervisory experience is a safe place to do so. Clinicians and their supervisors must address both process and content, and they must sort out what seems like reasonable, clinical expectations for the training experience given the duration of practica and client flow. Although it is the supervisors’ responsibility to provide a map of how supervision will proceed (and this will vary by supervisor), clinicians are encouraged to continually communicate to their supervisor about their supervisory needs/interests, and the kind of feedback and issues that are most important to discuss given personal and professional development.

- Self- and Supervisor-Evaluations, as well as semester hours sheets are due at the end of each semester
- Supervisors may utilize PCC Technologies to varying degrees to augment the supervision experience (this includes the audio/video equipment and/or remote conferencing capabilities when clinicians/supervisors) are unable to make it to campus.
- Just as supervisors are encouraged to consult with the PCC Director if they have questions or concerns about the Supervision process and/or PCC clinicians, PCC clinicians are encouraged to consult with the PCC Director if they have questions, concerns, or suggestions about Supervision.

Peer Supervision

For clinicians who have completed a full year of training on a clinical practicum and who would like to continue their work on that practicum, the opportunity to serve as a Peer Supervisor may be available. The decision about whether or not a clinician can serve in a Peer Supervisory capacity would be made by the clinician’s practicum Supervisor and the PCC Director. Some considerations that would be taken into account when making this decision would be: 1) clinical competence and leadership, 2) number of direct-service hours on that practicum, 3) demonstrated capacity for case conceptualization and collaboration with peers/colleagues, 4) professionalism (including communication with clients, completion of all documentation, etc.).

Peer supervisors serve many, varied functions. Depending on the practica team and the direct Supervisor, Peer Supervisors may be able to provide direct case consultation with clinicians, didactic training in areas related to the treatment modality/population, direct observation of sessions, initial note review (licensed Supervisors maintain final signature authority), and more. The opportunity to serve as a Peer Supervisor is an important one and one that we hope clinicians will capitalize on. Many Psychologists – at some point or another – provide formal or informal supervision and consultation during their careers. Having an opportunity to provide formal, collaborative supervision with a licensed Psychologist (during your training years) is an excellent introduction to this important, professional role.
CONTRACTING WITH CLIENTS:

Semester Breaks/Vacations/Length of Treatment

It is important to discuss the structure of treatment at the PCC during the first few treatment sessions. Among these issues are:

- Length/duration of treatment sessions and treatment course
- Availability of clinicians outside of treatment sessions
- Modes of appropriate communication with clinicians
- Parking and attendance (e.g., cancellations, showing up on time)
- PCC schedule (with regard to being a part of the larger URI campus).
  - PCC is closed for 2 weeks over the Winter Holidays
  - PCC is closed for 2 weeks in August
  - PCC is closed for 1 week in March

- The clinic will be closed on all federal holidays observed by URI:
  1. Labor Day (September)
  2. Columbus Day (October)
  3. Election Day (November – as relevant)
  4. Veterans Day (November)
  5. Thanksgiving Day (November)
  6. The day after Thanksgiving the clinic will remain closed
  7. Christmas Day (Clinic Closed for 2 week Winter Vacation)
  8. New Years Day (Clinic Closed for 2 week Winter Vacation)
  9. Martin Luther King Jr. Day (January)
  10. Memorial Day (May)
  11. Independence Day (July)
  12. Victory Day (August)

Although clinicians are graduate students at URI, they are not granted the same holiday/vacation schedule as undergraduates. Outside of these specific PCC closures, clinicians are expected to maintain a regular treatment schedule with their clients.

When URI Classes are cancelled, but offices are open, the PCC is OPEN.

When URI Classes are cancelled and offices are closed, the PCC is CLOSED.

When URI Classes are running, but offices are closed, the PCC is CLOSED.

Long-Term Treatment: While practica formally end after the Spring exam period, it is not uncommon that certain cases necessitate (or clients want) ongoing treatment. Under these circumstances, several options are available:

1) Continued treatment with the current clinician (who will be provided with supervision by the PCC Director during the summer months).
2) A gradual transition to a new clinician who will provide ongoing treatment through the summer months and into the new academic year.

3) A referral to an outside agency/clinician who can provide the type/level/duration of treatment necessary to meet the clinical needs of the client.

Specialized Clinical Experiences: Cases may be assigned independent of specific practica. These experiences may involve long-term therapy, as well as other kinds of specialized clinical experience (for example, interpersonal therapy or group therapy in a year when those practica not being offered). Such arrangements are subject to clinician’s progress on their Program of Study, clinician’s track-record of adherence to PCC policies and timeliness of documentation, and availability of appropriate cases and supervisors.
ESTABLISHING FEES

- All clients in the PCC are expected to adhere to a sliding scale fee schedule. Clients will discuss their financial abilities with their clinician during Intake and will complete a fee-worksheet in order to determine an appropriate per-session fee. **All clients in the PCC are expected to pay a session fee (including undergraduate students at URI).**

- In the PCC, there is a **$30 fee for the intake session**. This Intake-fee is fixed, and not subject to the sliding scale.

- **All billing and receipts are tracked on Titanium.** Therapists must record “fee” OR “no fee” for EACH session. This is critical for the PCC to track client payments and to cross-check PCC funds/deposits.

- Session fees are collected, recorded on Titanium, and deposited after each session in PCC office. Checks or money orders should be **made payable to "University of Rhode Island."** If paying by cash, the payment is placed in an envelope with the date, name of the clinician, initials of the client, and payment amount written on it. This envelope must be placed in the SAFE in the wall of the Phone Room.

- **Clients are charged the full fee for missed sessions unless 24 hour notice is provided.**

- Any fee changes/adjustments must be discussed and cleared through the PCC Director.

- If the client reports concerns about meeting the identified session fee, you should notify them that you will discuss their circumstances with the PCC Director. Similarly, should an ongoing client describe a change in financial circumstances and request a change in the fee, the therapist should discuss this matter with the Director. The fee scale ranges from $10 to $55 per session; the majority of clients have fees in the $15-$20 per session range. The minimum fee is $10 per session (if this amount is impossible for a client, please discuss with the PCC Director)

  - It is important to note that some clients may have reasons for seeking treatment in the PCC – even if they have insurance coverage for services in other outpatient settings. In this event, it is common for clients (many of whom have small copays) to request a session fee equivalent to their insurance copay (rather than what may be determined by the sliding fee scale). **It is RARE** for the PCC to make these types of accommodations, for ethical reasons:

    - If a client has sufficient income/benefits to have insurance, they have an option of service locations to choose from (that will accept their minimal copay). Those clients who do not, however, have these benefits/options, may be strapped with multiple financial hardships, no treatment alternatives, and yet end up paying a session fee larger than a client with insurance who has requested a fee that is equivalent to their copay. For these reasons, we do not accept insurance copays (as payment) and work (within reason) to adhere to our sliding scale for all clients.
• The importance of collecting fees and writing receipts in Titanium cannot be overemphasized. Revenues from clients are used as demonstration that the PCC is fulfilling its mission and deserves appropriate space, work-study student support, and staffing. Receipts must be completed for every session.

• Nonpayment of fees is an important issue both clinically and financially. If a client goes for two weeks without paying for services, discuss the situation with your supervisor, the PCC Director, and plan to raise it during a session. If the client refuses to pay, discuss the implications with your supervisor and inform the Director of how you propose to manage the issue.
PART IV: MAINTAINING AND PROTECTING CLIENT RECORDS

Philosophy Regarding Record Keeping in the PCC

• Intake Report templates, Diagnosis Tabs, Session Note templates, Termination templates, and checklists should serve to help you think about your cases. They provide prompts to help you organize and summarize what’s happened in treatment, clarify treatment goals, and identify treatment progress.
  
  o The Intake Report should be a comprehensive document that provides sufficient history and current status to justify the client’s need for services. **Intake reports should include a clear case formulation and provisional diagnoses.**
  
  o The treatment plan should be consistent with the client’s goals for therapy, appropriate for the presenting issues/symptoms, and aligned with your case formulation.
    
    ▪ Additionally, **treatment goals should be observable and measurable over time** – so that it is clear (to you and your client) when treatment goals are being met (and/or progress toward treatment goals is being made).

• **Session notes** serve as a record of treatment progress and help clinicians evaluate the course of treatment and modify case formulations as necessary/appropriate. **Clear and concise** session notes are a critical component of the clinical training provided at the PCC and should include ongoing data that has been collected through PCC outcome measures (eg. PHQ9/GAD7).
  
  o **Session notes must be completed, entered into Titanium, and submitted to supervisors:**
    
    ▪ **In the clinic**
    ▪ **At the end of every treatment session**

• **Client files on Titanium should provide enough information so that a different therapist or a consultant can review the case in your absence and have a good idea of why the client is in treatment, interventions you have implemented to achieve treatment goals, progress made in therapy.** Clear and concise records are important since they are also read by colleagues who see your clients while you are away on vacation/in an emergency, or to whom you have referred your client for further treatment.
  
  o The PCC frequently gets requests for documentation from hospitals and clinics that are treating past clients. The intake report, treatment plan, session notes and termination summary provide other clinicians with important information about the client’s work in therapy – even years later.
  
  o In light of the frequent requests for documentation that the PCC receives, it is even more critical that intake reports, session notes, and termination summaries be complete promptly.

• **You must construct this record in a way that – if made public (including to the client) its disclosure would not be unnecessarily damaging.** Although records for
medical and psychological treatment are supposed to be confidential, there are many avenues by which they can become public information: Insurance companies may require the client to release information from the chart before they will pay for the services rendered, and subpoenaed psychological testimony has become fairly commonplace in the courts in both civil and criminal cases. Careful consideration should be given to the quality and extent of information that is included in a client’s chart. Respecting the client’s right to privacy remains essential for the secure client-therapist relationship that psychotherapy requires.

- **Only information that is necessary for diagnosis and treatment should be put into the file.** Only information which is demonstrably related to the client’s presenting issues should be recorded. **Consider the following:**
  - The proper names of third parties (husbands, children, parents, etc.) should not be mentioned in the record unless absolutely necessary.
  - Knowledge about family and personal relationships should be made in general terms unless more specific information is essential to the therapy.
  - Details about personal, sexual, possible criminal behavior, and other very sensitive areas are best omitted unless there is a compelling reason to document them.
  - Do not **use session notes for speculations.** If you feel it is important to document unconfirmed information (e.g. alternative diagnoses), it should be with the intent of following it up with an assessment or an intervention and, finally, a concluding statement regarding the accuracy of your speculation.

- **The files should document that reasonable standards of care have been followed.** In order to protect oneself (and the PCC) from malpractice litigation, it is important to document the quality of care that is being provided. This includes ongoing safety assessments, quantitative assessments to track symptoms related to the clients’ diagnoses, a log of client contacts (including phone and email contacts), and appropriate consultation when indicated.

- Rather than being an afterthought to treatment, one's approach to record keeping reflects the values one holds about the treatment process. Developing clear formulation, logical and specific treatment plans, and writing timely session notes suggest a thoughtfulness and seriousness in trying to understand what’s happening in therapy. If someone is letting record keeping slide because of conflicting demands, it is also likely that not much planning is being put into the case outside of the actual sessions themselves. Similarly, therapists who take the care to avoid documenting unnecessary or speculative material that could in some way be damaging to the clients are showing respect for the clients with whom they're working. The staff and supervisors in the PCC view therapists' style of record keeping as revealing quite a bit about their values and approach as therapists; **therapists’ adherence to documentation policies and procedures is taken into consideration when semester evaluations and internship references are being written.**
Maintaining Client Files via Titanium

- The PCC uses **Titanium Scheduler** to manage client information. Titanium Scheduler is a complete management system designed specifically for psychological department teaching clinics. It is a secure, confidential database that allows the PCC to operate in a nearly paperless fashion.

- **Therapists are responsible for maintaining accurate and comprehensive records once they have been assigned a case and are required to keep their files up-to-date**, so that in the event of an emergency, any qualified professional could use the file to guide them in an appropriate interaction.

- **Every contact** with the client should be documented in the file. Contacts include not only sessions, but also significant telephone contacts and letters (e.g. no-show or multiple cancellation notices). These records must be kept up to date and are considered part of the clinician’s adherence to documentation policies. Such notes are particularly important in the event of an emergency during the clinician’s absence.
  - It is also important to note that **any and all email communication with clients:**
    - Must be documented in either a phone contact note or the phone log
    - Must include a confidentiality statement (embedded in the signature line of your email) noting the limits of confidentiality when communicating via email (the PCC has a standard statement that is available on Sakai)
    - **MUST** be limited to **scheduling purposes only.** Email is **not** to be used for clinical purposes, to “check in” with your clients, or to invite clinical updates. In the event that clients are using email contact for clinical purposes, clinicians need to discuss the matter with their Supervisor and/or the PCC Director so that it can be addressed.
      - (see Social Media section on pg. 97 for additional information about use of email with clients).

- In general, the PCC adheres to a DAP note formate (Data, Assessment, Plan). Incoming students will receive a formulation and DAP-training before they begin seeing clients in the PCC.
  - DATA: Information discussed in session (e.g: updates since previous session, changes in mood/outlook/functioning, documentation of behavioral, affective, systemic (relational), or historical content that is relevant to understanding treatment progress/adherence, and completion/review of homework assignments)
  - ASSESSMENT: The clinician’s evaluation of how session content relates to the larger case formulation; interpretation/understanding of DATA in the context of the client’s larger, clinical picture.
  - PLAN: Given information presented by the client, and the clinician’s assessment of how this information ties to the larger case formulation, the PLAN section should include homework assigned (and rationale), and anticipated interventions
to address barriers to treatment and/or to advance treatment progress. This is a section to evaluate and plan for short- and long-term treatment directions.

- If it feels clinically important, it is a good idea to include information from consultation with supervisors or other people potentially involved in the case (case workers, lawyers, medication providers, etc.). This information can be included directly into the note (DATA) or can be added at a later point in the form of an addendum (if, for example, further reflection or additional information leads the clinician to a different interpretation of the data).

- It is also permissible to add a progress note after a supervision session. These types of additional progress notes are best written when, as a result of supervision/consultation, there is a change in case formulation treatment plan, clinical approach, or policy.

- It is ethically and legally important that termination reports be completed within 1 week of treatment termination. A termination summary includes basic client demographic data, the nature of the presenting problem, duration and course of treatment, notable changes/outcomes, plans for referral, and final recommendations. The termination summary is the most frequently requested document by subsequent providers (lawyers, case workers, etc.). It is particularly important that this document be written with care and consideration.
  - Please note, unless explicit discussion with a supervisor and PCC Director occurs, any case that take hiatus for 2 or more months must have a termination summary written. For legal and liability purposes, the PCC cannot continue to be the agency providing treatment to a client who has not been seen for more than 2 months.

- It has happened that the PCC has received subpoenas ordering the release of treatment records. Once a subpoena is received, the existing record cannot be altered. The former PCC therapist can also be subpoenaed, and can be put in the position of defending statements made (or not made) in the record. For this reason (among many), it is imperative that clinicians make documentation high priority.

**Please note. A subpoena is a request. The PCC still has a responsibility to its clients to obtain a Release of Information when a subpoena is received. Unless the PCC receives a court-order, acquiring a Release of Information is the first step.**
**File Reviews**

Client folders at the PCC are reviewed on a regular and random basis to ensure adherence to PCC procedures and policies and that record keeping reflects a high level of professional standards. Since record-keeping is an important professional activity for all practicing psychologists, supervisors will be informed when records are incomplete or deficient.

**Continued delinquencies or substandard documentation will result in:**

1. **A verbal warning (to be documented in the PCC Director’s Student Files).**
   a. This document will require the signature of both the student and PCC Director. A verbal warning is also made known to the Director of Clinical Training.

2. **A written warning with a remediation plan.**
   a. This document is reviewed by the clinician, the PCC Director, and the Director of Clinical Training. This is considered clinical probation and will be filed in the student’s Clinical File with the Psychology department.

3. **Withdrawal from Practicum (“unsatisfactory”), 1y absence from clinical activity in the PCC, required reapplication for enrollment in PCC practica. Suspension of all other clinical externship training arrangements.**

In addition, any student applying to participate in off-campus externships and/or Internship must have all documentation up-to-date before the PCC Director will sign the necessary readiness documentation (eg. an externship agreement form [EAF]).
Transferring a Client

When a therapist wishes to transfer a client, they should:

1. Inform the PCC Director of the need to transfer (typically this occurs at the end of an academic year when a clinician does not plan to continue taking PCC practica but the client needs/wants to continue in treatment).
2. The PCC Director will discuss the case with the PCC Assistant, identify an available clinician (whose clinical documentation is up-to-date), and then pass the chart to the appropriate Practicum supervisor.
3. The transferring clinician should discuss plans to transfer with their Practicum team and, ultimately, with the client.
4. The transferring clinician and the planned clinician should meet to discuss the case and to schedule 1-2 transition session with both therapists present.
5. The therapist who is accepting the case should schedule the first meeting with the transferred client and document the transfer in Titanium.
6. The former therapist is responsible for completing a **Transfer Summary** to clearly document the reason for transfer.
   - No formal “termination” summary is necessary given ongoing treatment.
Termination

- **Premature Termination**: When a client stops coming to therapy without an agreement between the therapist and client. This can happen at any point after the intake interview. A client who misses more than two sessions without notifying the therapist should be seen as initiating a premature termination. At this point, clinicians are asked to complete a Discharge Note rather than a Termination Summary.
  - **Discharge Note**: To be completed after unanticipated termination of services before clear treatment goals can be established. Use when clients have attended fewer than 2 treatment sessions (after Intake. A total of 3 sessions *including* an Intake session).
  - **Termination Summary**: To be used when treatment is terminated or *plans* to be suspended beyond 6 weeks (i.e., Over the summer). Use this template when clients have attended and completed more than 3 sessions (including Intake).

**Procedure for Client missed appointments/no shows:**

b. Clinician is to make 3 phone calls to client within 1 week of missed/no show appointment (*all calls must be documented in Titanium Call Log*)
   i. Clinician must leave phone messages whenever possible indicating that the client should contact the clinic to reschedule their appointment

c. If unable to reach the client (x3), clinician must notify the PCC Director and PCC Assistant so that a clinic-initiated phone call (#4) can be made.
   i. This call will be made by the PCC Assistant and documented in Titanium
   ii. This call will indicate that, if the PCC does not hear from the client within 1 week, their case will be closed.
   iii. Clients are always reassured that they can return to the PCC at a future point if resumption of services is desired.

d. If the client contacts the clinic, an appointment should be scheduled
e. If the client does not contact the clinic within 1 week, a termination summary should be written and submitted in Titanium.

- **Client initiated termination**: When a client elects to end treatment before the clinician believes that treatment goals have been met.
  - A client’s decision to terminate is important. It can be valuable to utilize any remaining treatment time to process their decision, treatment progress, and any relevant referrals (if the client is interested). It is also important for clinicians to spend time in supervision discussing the implications of the client’s decision to end services on the clinician’s sense of efficacy as a provider, the clinician’s own feels about the termination (e.g., anger, sense of failure, betrayal, loss, relief, etc.), and any questions/concerns about navigating this type of termination process.

- **Mutually agreed upon termination**: When client and clinician agree that the client has achieved their treatment goals. There may be a bittersweet element to the ending of a good therapy relationship. It is important to try and incorporate treatment "good-byes" into the client’s final few session. As in all other elements of therapy, termination may provide the client with a model for handling a significant aspect of other relationships.
• **Do not Delay Closing Cases:** A case is considered terminated when there is no longer any regular, sustained contact between a client and clinician. **Clinicians should avoid keeping cases with little or no contact open indefinitely in the hopes that the client will re-engage.** To do so leaves the therapist and clinic open to questions regarding liability and professional responsibility for any dangerous or self-destructive behavior during this period. **As long as the case remains open, the therapist implies that their professional obligation to the client is in effect.**

**Termination Summary AND Checklist** must be completed in Titanium (See Appendix A for *How to Use Titanium*). A final, Termination Summary (including signatures), should be in the client file within one week of the last therapy session with a client. The Termination Summary should be clear and complete enough to serve as a complete summary of the case should a report of services be needed by another agency.
PART V: ONGOING CASE MANAGEMENT ISSUES

Confidentiality

Protecting the confidentiality of clients is an essential ethical and legal responsibility for any service agency. Confidentiality is vital in developing a good working relationship with a client. The reputation of the PCC and our ability to develop working relationships with other agencies also depends upon the trust the public has in the agency's ability to preserve confidentiality. Special care is required in protecting client confidentiality at the PCC, given the small-town setting in which the University and most of our clients are located.

During the intake interview, the clinician must carefully walk through the consent form and clearly discuss the client’s rights and the conditions under which confidentiality can be assured. The therapist should also outline some of the conditions under which confidentiality will be broken:

1. When it is believed that the client poses a danger to themselves (either because of inability to care for themselves, or due to suicidal risk)
2. When the client poses a danger to others
3. When there is a concern regarding child or elder abuse or the abuse of an individual with disabilities.
4. When a court of law mandates clinical documentation

Additional information about the limits of confidentiality is provided under the sections on “Assessing/Reporting Child Abuse and Neglect” and "Clinical Emergencies.”
Release of Information

As part of the intake paperwork, clinicians should always inquire about other providers, family members, or stakeholders (lawyers, teachers, case workers, etc.) with whom the clinicians are allowed to discuss the client’s case. Clients must complete a **release of information for each individual** that the clinician has permission to speak with. If, during the course of treatment, it becomes clear that consultation or collaboration with other providers would be beneficial and clinically indicated, the clinician should have the client complete an additional **release of information** for that person at that time.

**Releases of Information** must be signed by the client(s) before a clinician is allowed to communicate with **anyone** (outside of the clinician’s Practicum team) about the client’s case. These Releases must use the client’s **legal name**. The Release form must be dated and have a date of expiration (usually 1y), and should state as specifically as possible what information is requested and why the information is needed. Similarly, clinicians **should not** release information to those requesting information about clients unless the clinician has a signed copy of the Release of Information in their hands.

Whenever written documentation is mailed/faxed/released to anyone (including the client), the Practicum Supervisor or PCC Director should be consulted. All written documentation **must** be co-signed by the Practicum Supervisor or PCC Director.

As part of the clinical training in PCC, it is expected that clinicians will discuss cases with each other. However, cases **are not** to be discussed anywhere other than a closed, sound-proofed room/office or with **anyone** other than a Supervisor, Staff Therapist (student clinicians), or PCC Director. Any clinicians overheard discussing client information in a public area (hallways, waiting rooms, phone/computer room with the door open, etc) or with anyone other than those indicated above will be given:

1. A verbal warning (to be documented in the PCC Director’s Student Files). This document will require the signature of both the student and PCC Director.
2. A written warning
3. A grade of “unsatisfactory” on the semester, documentation of unprofessional behavior on their Practicum evaluations, and subsequent requirement to re-take the Practicum.

**All records are confidential and MUST remain in the PCC.** All notes must be written directly into Titanium. Any hard-copy files must be filed in either: a) the To Be Shredded folder (where the PCC Office Manager will shred them) or, b) into the To Be Scanned folder (where the PCC Office Manager will scan paper documents directly into a client’s file in Titanium).

**NO CLINICAL MATERIAL/DOCUMENTATION MAY BE KEPT ON A PCC COMPUTER DESKTOP or PERSONAL COMPUTER at any time.**

- In the event that you need to download documents with client-sensitive information onto the desktop of one of the PCC laptops, you must then **SECURE DELETE** the file from the desktop and **SECURE DELETE** the file from the download memory.
To do this, you can use a command called **srm**, which can “securely remove files”

- Open Terminal (go to **Go > Utilities**); it's in the Utilities folder
- Type the following: **srm -v**
- Type a space after the above command. Drag a file that you want to delete into the Terminal window; you’ll see that Terminal adds its file path.
- Press Return, and the file will be securely deleted. If the file is very large, this may take a while.
- If you want to delete a folder, then use this command: **srm -rv**

Should records be used/needed for case presentations, research purposes, or as work samples, they are to be de-identified, carefully edited to guarantee anonymity and confidentiality, and can be used only with the express permission and review of the PCC Director.

**NOTE:** You may NOT release confidential materials obtained FROM another clinic/agency. When clients sign a release, it is for PCC records ONLY (ie. you cannot release a report that you obtained from a previous provider as part of a case file from your work with a client).
Observation and Client Video Taping

At the time of the initial intake (and initial telephone contact) clients are informed that the PCC is a training clinic and that they can expect to be audio recorded, observed by supervisors and team members, and possibly videotaped. Some clients may express concerns or reservations about this process; as the therapeutic relationship is established, the issue of observation becomes less apparent and/or important. Clinicians are encouraged to show any client the observation rooms and/or introduce them to any observing clinicians. It can be helpful to remind clients that any observation is of them (the clinician), not the client themselves.

Audio:

All therapy rooms are equipped with speakers/intercoms to facilitate observation.

Video:

Therapy rooms are equipped with video recording capabilities to facilitate observation and supervision. Students will have access to all videos recorded by clinicians on their practicum team.

All PCC Clinicians must be participate in a required “Technology Training” before they are allowed to use any audio/video equipment. *If you have questions, concerns, or problems with any of the audio/video equipment, please see the PCC Director, PCC Assistant, or PCC Office Manager for help.*

- To view videos of cases seen on your practicum, please see the PCC Director for access information.
Case Responsibility

Once a supervisor accepts a case for assignment to a team member, the supervisor is ethically and legally responsible for the quality of care that is provided. Student clinicians have the responsibility to meet regularly with their supervisors and make sure supervisors are clearly informed about the progress of each case. The PCC Director ensures that the overall training and service goals of the PCC are met (e.g., adequate supervisory resources are available, PCC policies are followed, regular review of PCC procedures, policies, and trainings).

Practica: Students taking practica at the PCC for academic credit are required to devote time each week to providing direct services to clients, attend weekly PCC staff meetings, attend weekly Practicum supervision, participate in informal peer supervision, observe other clinicians providing treatment, maintain client records, and do appropriate and adequate session preparation.

- Full Practica:
  - Students on “Full Practica” are required to be involved in 9 hours/wk of clinical activity outside of their “class time” related to their practicum:
    - 4-6 direct care hours
    - 1-2 hours for case-related research, preparation, and documentation

- Half Practica:
  - Students on “Half Practica” (Multicultural) are required to be involved in 4-5 hours/wk of clinical activity related to their practicum:
    - 3-4 direct care hours
    - 1+ hour for case-related research, preparation, and documentation

Less experienced and/or first year students who are not assigned cases are expected to attend all PCC Meetings and are encouraged to spend at least 1 hour a week observing clinical work. Clinicians can use the Titanium “room scheduler” to determine when/where sessions are taking place and can be observed.

Supervision: All clinicians seeing clients in the PCC must attend weekly supervision. This is not optional. Clinicians are expected to be ontime for supervision, attend for the duration of supervision, and engage actively with their supervisors and colleagues. Clinicians are asked to sign a PCC Clinical Practice Contract at the start of each academic year and will be held responsible for abiding by this contract. Unsatisfactory evaluation by PCC and/or Externship supervisors (re: supervision and clinical/professional behavior) will result in a 3 phase remediation plan:

1. First incident: A verbal warning (to be documented in the PCC Director’s Student Files). This document will require the signature of both the student and PCC Director. The Director of Clinical Training is notified of concerns.
2. Second incident: A written warning, (which will go into a clinician’s student file). The clinician, Director of the PCC, and Director of Clinical Training will discuss the nature of concerns and the plans for remediation.
3. Third incident: Suspension from clinical activities.
PCC Meetings: All first, second, and third year students are required to attend weekly PCC Staff meetings from 3:00 to 4:30 on Thursday afternoons. Students beyond the third year, who are seeing clients in the PCC, are also required to attend weekly PCC meetings. Attendance at PCC staff meetings is mandatory and attendance is taken.

- Students enrolled in any PCC practica (even if those students are beyond the 3rd year) are required to attend PCC meetings on Thursday afternoons. This is particularly relevant for students enrolled on the Multicultural practicum team. Although some of the administrative discussions may not be relevant to your training site, many/most of our clinical trainings, case presentations, and general professional development discussions continue to be an important part of your training experience with the PCC.
Guidelines for Psychological Consultation Center (PCC) Case Presentations

The Clinical Psychology Program requires the successful completion of two case conference presentations. In most cases, students will complete the first case presentation during their second year and the second case presentation during their third year. Typically, these presentations take place during the regularly scheduled PCC meetings. Students may choose either a client who is being or was seen in a practicum in the PCC or a client seen in an outside placement. If a client from an externship site is selected, students must first review their case presentations with their site supervisors and have their site supervisors sign the Externship Case Presentation Approval form. In addition, it is a great idea for students to invite their clinical supervisor to the case presentation. Successful completion of both case presentations is a prerequisite for internship applications.

Case presentations are evaluated by 2-3 clinical faculty and/or PCC supervisors. This evaluation committee will use the Clinical Case Conference Evaluation Rubric to determine whether or not a presentation has “passed”. In addition, each student will be asked to rate themselves using the same form in order to provide a self-evaluation. Evaluator-and student-completed forms will be co-signed and placed in the student’s clinical file. In the event that 3 clinical faculty/supervisors are not available for case presentation evaluation, a recording of the case presentation will be made and a third faculty/supervisor will review and evaluate.

Case presentations are expected to be 20 minutes long, with 5-10 minutes for questions/discussion. Powerpoint presentations are strongly encouraged.

When planning your case presentation, a client’s name should always be fictitious; all other client data, however, should be real unless there is a danger of violating the client’s confidentiality. In that case, potentially identifying information should be changed.

Sample Outline

- Referral and identifying information: Referral source, age, gender, ethnicity, marital status, religion, sexual orientation, family composition, living arrangements, occupation, education level, and other essential information.

- Presenting problem: A brief description of why the client sought help, information on timing (i.e., why now?), significant events leading to the referral, client’s perceptions of their problems and how they relate to their life.

- Behavioral observations and mental status: Client’s appearance, dress, style of presentation and/or speech, interpersonal presentation, mood and affect, cognitive functioning, etc.

- Brief history - Personal, Social, Family, Mental Health, and Medical: Description of childhood/adolescence, adulthood including marriage, children, other relationships, work history, history of family, medical, and psychological problems, chronic illnesses or complaints, hospitalizations, medications, substance use, high risk behaviors, etc.

- Diagnoses: Diagnostic assessments, DSM 5 diagnoses, discussion of differential diagnoses.
○ **Rule Out:** Not enough information to determine if the client meets criteria for a specific diagnosis. Needs additional assessment (usually comes up with multiple diagnoses across categories. E.g. A depressive disorder and an anxiety disorder). Likely means that a client is presenting with comorbid issues.

○ **Differential Diagnosis:** Client presents with symptoms that cut across multiple diagnoses (usually within the same category) and gathering additional information will help to determine which (but probably not both) diagnosis is most appropriate.

- Case conceptualization: Formulation about the salient factors involved in the case (e.g., cultural values, how the client processes cognitive and emotional information, handles emotional reactions, behaves in a variety of settings, embraces values and beliefs, navigated developmental issues, family dynamics, views themselves, client strengths, readiness for change).

- Treatment goals and plan: Identify the goals of treatment (short and long-term), initial treatment plan and rationale, and modifications to the plan as treatment progresses; note treatment alternatives (what other treatment approach/technique might you have chosen, if applicable); note how client was involved in treatment planning; briefly note or discuss the empirical support for your treatment approach.

- Course of treatment: Summarize the treatment to date, review mid-treatment assessments and how that data guided treatment; describe progress in treatment as it relates to treatment plan.

- Summary, conclusions, and recommendations: Summarize present status of case; present post-treatment assessment data when available; note what are you proud of, what has gone well, what did not go well, what resources you used to enhance your work with this case, what might be improved in your work with this case, on what questions would you like feedback from audience; note ethical, legal, and cultural consideration (alternatively, these may be noted throughout the presentation).

- Didactic component: One of the purposes of case presentations is to make known to students clinical resources of which they might otherwise be unaware. Please provide two readings related to your case - at least one should be empirical in nature. The readings may be presented in hard copy at the case conference or emailed to the PCC listserv beforehand.

**Tips for Success**

- Try to prepare for your case presentations as if you are presenting a case in a clinical grand rounds. The case presentation should be professional in tone and content. Similarly, you should dress as you would for a case conference with an audience of professionals.
One of the most difficult skills to master in a case presentation is distilling what information, from each case, is the most important to discuss. Your goal is to be concise but thorough. Teasing apart the important and relevant from the unnecessary is not always easy – but that is why we practice!

A good presentation presents case information and presenting problems along with the rationale for which treatment approach was used. Given that students in the PCC are placed onto practica teams with singular theoretical approaches to treatment, students often neglect to identify how and why treatment approaches and strategies were selected. That is, even though a student is on the CBT team, they should describe how and why CBT was a good approach for treating this particular individual. If another theoretical approach might have been called to mind for a particular client, you should briefly discuss this while noting that the team assignment ultimately dictated the approach to treatment.

Try to avoid reading the slides. Your slides should be presentation prompts that allow you to fill in the details during your presentation. Presenting information this way better holds an audience's attention and makes your presentation style more compelling.

An essential component of good clinical treatment is assessment. As you can see on the evaluation form, the ability to integrate assessment data and knowledge/skill in the assessment of treatment progress and outcome are valued competencies in our program. Assessment should be integrated into the treatment of every case - regardless of in what practicum you are placed. If you are treating clients and have not used a formal or empirically-supported assessment before, during, or after treatment, you should be asking yourself "Why not?" Pre-treatment assessment information should be discussed relative to its use in choosing, designing, and/or refining your treatment. Assessments during the course of therapy should be used to justify changes or modifications to treatment techniques or strategies. Discussing your use of assessment measures helps to demonstrate that you have made data-driven treatment decisions.

The best case presentations are presented in a chronological, linear fashion. It is often difficult or confusing to follow the treatment of a case when important information is presented out of order. For example, you may not wish to begin the presentation with how the case ended, rather, it may be better to leave that for the big finish! Similarly, try not to present information relevant to diagnosis late in the presentation (as you describe the treatment progress, for example).

Be sure to note the ethical issues that were brought to the fore with your case. It is not sufficient to say that there were no ethical issues that arose during treatment. Every case involved ethics.

A general rule is that your case presentation will be too lengthy if you have more than 15 slides. This is not to say that 15 is a magic number; rather, it is probably an upper limit. In reality, it depends upon how much information is on each slide and how long you spend on each.
● Please include a discussion on differential diagnoses. Your thinking behind your diagnosis should be clear and your rationale for assigning one diagnosis versus another should be noted and should be based on the client’s presentation and self-report.

● One of the most important tips for a successful case conference presentation is practice, practice, practice (preferably with a practice audience). Practice will help you to determine if your organization and level of detail is sufficient. You should have your current supervisor (or the supervisor of the case you are presenting) provide you with feedback on your case presentation prior to the scheduled presentation date. This will require that you prepare your case presentation well in advance of your scheduled date.

● As you prepare your case presentation, think ahead to the discussion. Try to anticipate the types of questions that might be asked and consider your responses. This will enable you to do your best in responding to audience questions and comments.

**Scoring the Presentation**

The Clinical Case Conference Evaluation Rubric is composed of two parts. Part A allows the rater to evaluate a student on clinical competencies (e.g., case conceptualization, formulation of diagnoses, integration of assessment data). For each competency, behavioral descriptions clearly delineate what “does not meet standard”, “meets standard”, and “exceeds standard”. A competency may also be rated as “not applicable”. Part B allows the rater to evaluate a student's presentation skills (e.g., voice quality, holds audience attention). Eight items are rated on a scale of 1 (not very successful) to 5 (superior). An item may be rated as “not applicable”.

**To pass the case conference, a student must meet the standard on 90% of all items (excluding items rated as “not applicable”), on Part A AND receive an average rating of 3 on Part B.**

Case conference evaluation members’ ratings will be averaged (e.g., average percent meeting competency on Part A and average rating on Part B) to determine whether or not a student has received a passing grade. If only one or two case evaluation committee members are present during the actual presentation, other evaluators will review and rate your videotaped presentation.

**If You Are Asked To Do Another Presentation**

Have no worries. You are not the first to be asked to do another case presentation. The case presentation is a skill to be learned and, as everyone knows, practice improves skill. Please view the opportunity as another occasion to improve and perfect this skill. The Director of the PCC will work with you to schedule a date for another presentation. You may be asked to do this additional case presentation during a PCC meeting, or for the Faculty/Supervisors during a Student/Supervisor meeting. Due to scheduling constraints, your presentation may need to occur within the following academic year. You may not present the same case.
Malpractice and Professional Liability

Although no PCC Student Clinician has been sued for Malpractice to date, you should be aware of several facts.

1. The number of lawsuits against psychologists is increasing. This trend is likely to continue, given the increasing activism of mental health consumers, the changing expectations of the courts regarding mental health professionals' legal obligation to act in the "public interest" (e.g., prediction of dangerousness, warning of intended victims, reporting of suspected child abuse), and the continuing litigiousness of society in general.

2. Clinicians’ status as student trainees (supervised by a licensed psychologist) does not provide protection from a malpractice lawsuit. It is common legal practice to sue all parties involved in a case (e.g., therapist, supervisor and head of the agency). The best defense is (1) to be able to document thoroughly that the treatment met reasonable, professional standards, and (2) to make sure that one’s activities are covered through liability coverage (including having a signed Externship Agreement Form (EAF) before initiating any Externship and/or summer clinical activity)

   a. EAFs must have pre-approval before students contact a training site. This pre-approval includes signatures from students’ Major Professor (first) and the PCC/Externship Director (second).

      i. Once pre-approval is obtained, students can contact sites, discuss training options, and input training details.

      ii. Students and their site supervisors must sign the final portion of the EAF before the faculty/campus supervisor can/will sign. The purpose of this ordering is to confirm that students and site supervisors are in agreement about expectations and so that the Externship Supervisor (on campus) has a copy of the form with all required signatures (should disputes or concerns arise).

   b. Externship Agreement Forms (EAFs) are design to ensure that the training expectations (for both the student and the site) are clearly defined and can be evaluated at intervals throughout student training (i.e. at the end of each semester).

   c. EAFs can be (and perhaps should be) modified for those sites where students are training for a full academic year (+/- the summer months). The purpose of these modifications is to try and demonstrate and document a progression in training experiences over the course of an extended period of time; by doing this, students avoid hitting a plateau in their training.

      i. In order to facilitate this kind of review of training goals and expectations, EAFs must be renewed each semester/summer. In doing this, students do not need to obtain pre-approval again. Students can input the site
information and the word “RENEWAL” at the top of the form. All signatures at the bottom of the form must be obtained with each renewal.

ii. It is recommended that students doing year-long externships include these EAF renewals in the documentation that is completed at the end of each semester (i.e., Hours forms, student/supervisor evaluations).

**Student Liability Insurance**: All students/staff seeing clients in the PCC are required to obtain student liability insurance.

All students/staff who have access to clinical materials (including first year students who may not yet be seeing clients but who have full access to the PCC and who are encouraged to begin observing therapy sessions) must obtain student liability insurance.

- APA Insurance Trust (or the American Professional Agency) offers student liability insurance with rates ranging from $19 to $45 for a calendar year’s coverage. Information is available from the PCC Assistant. Students are asked to submit copies of the first page of the approved insurance policy to the PCC Assistant by the start of each Fall Semester.

**Students are NOT allowed to see clients without proof of insurance**

**Background Checks**

All students working with clients in the PCC and acting as representatives of the Department on Externship will be required to undergo a regional and national background check. Consistent with best-practice in working with vulnerable populations, this is a clinic policy that applies to all graduate clinicians enrolled in either Psy672 or Psy670. The PCC and Department of Psychology will be coordinating with AccuSource to complete these required background checks during the 2018-2019 academic year. Students will receive follow up information regarding this policy as details are confirmed.

* Assuming background checks are unremarkable, the PCC and Department of Psychology receive no personal information about any graduate student.

**Flu Shots**

All students working with clients in the PCC are expected to get a seasonal Flu Shot. Doing so maintains the health and safety of everyone involved with the PCC. If there are reasons that you object to getting a Flu Shot, please contact the PCC Director to discuss options.

As with the general University policy about illness on campus, the PCC must be an environment where staff are being conscientious about their own wellbeing, as well as the wellbeing of those around them. If a clinician is unwell, it is encouraged that they contact the PCC Director to make arrangements with scheduled clients and then stay home.
Dress Code and Professional Conduct

As in all professional settings, all graduate student clinicians working in the PCC are expected to maintain a clean and well-groomed appearance. Clinicians are expected to wear professional (business-casual is acceptable) attire; this includes skirts/dresses of appropriate length, and shirts with appropriate coverage. Dark denim jeans are permitted, but must be in excellent condition (no fraying, tears, etc.). Exercise clothing, dirty or frayed/torn clothing, exposure of one's midriff and/or undergarments, and/or sneakers/flip-flops are not considered acceptable attire for seeing clients. Students are expected to dress appropriately for the setting and to comport themselves in a manner consistent with the nature of the professional services being offered in the PCC.

It is important to consider the following when making decisions about attire:

- As graduate students, you will frequently be younger than many of the clients served through the PCC. Professional attire can go a long way to securing respect from your clients and helping to establish credibility as a professional.

Professional Conduct:

- Clinicians are required to arrived at the PCC a minimum of 30 minutes prior to the start of an Intake session
- Clinicians are required to arrived at the PCC a minimum of 20 minutes prior to the start of a session
- Clinicians are expected to complete all documentation according to PCC policies and procedures
- Clinicians are expected to contact all Intakes within 24 hours of case assignment

Professionalism and Social Media/Networking

In the current culture of social media and social networking, graduate students are likely to have personal social media accounts and/or webpages. Given the nature of your professional work as clinicians and the role that you each play as representatives of our Psychology Graduate Programs, here are some general guidelines for the use of social media:

- Your personal use of social media is personal...so long as you do not discuss your role as a clinical psychology doctoral student, your clinical work/cases, your clinical sites/supervisors, or the URI graduate training programs.
- With the depth of available information on social media, more and more people (universities, internship sites, patients, family members, employers) actively use social media sources to gather information about people they are – or may be – working with. The information that you make available on social media may become available to internship sites who are making decisions about match, clients who are deciding whether or not to continue their clinical work with you, and/or employers who are thinking about making faculty/job offers.
There are myriad anecdotes about well-qualified PhD graduates who fail to secure post-doctoral or faculty offers because of inappropriate or objectionable posts on social media sites or webpages.

• Before you post anything on the web as a representation of yourself (and everything that you post on the web should be considered a representation of yourself), please seriously consider how that material may be viewed by current supervisors, clinical training sites, department faculty, future employers, internship sites, and clients.

• If your webpage/social media site does identify you as a clinical psychology graduate student – or otherwise affiliated with the doctoral programs at the University of Rhode Island – than the program/department does have some responsibility for how you (or it) is portrayed.

• Your webpage/social media site must meet all legal and ethical guidelines from the Board of Psychology and the APA

• Your webpage/social media site must be professional in its content and must not contain objectionable material (including pictures)

• You should never “friend” clients or post about your clinical work

  ▪ These types of posts undermine public trust in mental/behavioral health and the belief that providers will/do respect their clients’ dignity and confidentiality.

• Although we will not actively search our graduate students’ social media sites, if we become aware of a page/post/blog that identifies you as a clinical psychology student or as a student in the program – and that page/post/blog is considered by the faculty to be unethical, illegal, or to contain objectionable material, we will ask you to modify or remove the problematic material.

• Should you choose not to remove the material, the faculty will follow the existing procedures for addressing student misconduct or unethical behavior.

*Please see the Use of Social Media Policy at the end of this Manual.

Clinical Manual 2015-2016: Policy on Use of Social Networking & Social Media

It has become common for people to have a significant presence on or usage of electronic social media (e.g., Facebook, Twitter, Tumblr, personal webpages, YouTube, Instagram etc). The purpose of this policy is to provide some guidelines about any public representation of you or the URI Clinical Psychology program in social media. While this policy applies to current common and popular forms of social media, nothing here is intended to limit it to only these public presentations.

1. If your social media posts do not include any mention or indication of the fact that you are a clinical psychology doctoral student or that you are part of the URI PhD program in Psychology (Clinical), You can represent yourself as you wish in the public domain. However, increasingly, universities, internship sites, and even patients are seeking out information about people on the web and social media before they make faculty offers, final match decisions, or even decide to see someone clinically. There are now numerous anecdotes of well-qualified Ph.D. graduates not getting post-doc or faculty offers because someone viewed something that was considered to be inappropriate or objectionable on the candidate’s Facebook page or in Twitter; similar stories about internship sites deciding not to match someone also exist. For your own potential future, we
would advise that before you put anything up on the web as representing yourself, you seriously consider how that material may be viewed by future employers, internship sites, or patients.

2. Decisions to connect socially with former or current patients online should be made as if the patient were in person, i.e., by keeping professional boundaries very clear. Under no circumstances should you “friend” a former or current patient on social networking sites, or otherwise accept or solicit personal connections with former or current patients online. Your relationships with former and current patients must remain strictly professional.

3. Under no circumstances should you discuss patient cases or share patient identifying information in emails, listservs, websites, web groups, or blogs, include any information that could lead to the identification of a patient, or compromise patient confidentiality in any way. Even if you think you have de-identified patient information, consider how such communication could be viewed if seen by the patient or someone who knows the patient. You are not in control of this information once it is released to the hundreds or thousands of people on a listserv or web group discussion board, for example, or on a website that will “live” electronically online for years.

4. If your social media posts DO identify you as a clinical psychology graduate student or as affiliated with the URI Psychology PhD program, then the URI PhD program does indeed have some responsibility for how you (or it) is portrayed. Your social media posts must meet all legal and ethical guidelines from the Board of Psychology and the American Psychological Association (e.g., you cannot represent yourself as a “psychologist” in the State of Rhode Island); your posts must be professional in their content and must not contain objectionable material. We will not actively search out URI PhD students’ social media posts. However if we become aware of posts that identify you as a clinical psychology student or as a student in the program and that post(s) is considered by the program faculty to be unethical, illegal, or to contain objectionable material, we will ask you to modify or remove the problem material. Should you choose to not modify or remove the material, the Director of Clinical Training in consultation with the Clinical Faculty and Department Chair will follow the existing procedures for dealing with student misconduct and/or unethical behavior.
PART VI: RESOURCES FOR RESPONDING TO VARIOUS CLINICAL SITUATIONS

Psychiatric Consultation

The PCC does not employ a psychiatrist or other medication provider. If a clinician believes that their client would benefit from a medication consultation:

1. Discuss your thoughts, observations, concerns with your supervisor
2. Consult with the PCC Director
3. Obtain an appropriate community referral. These often include:
   a. URI Health Services (for those clients who are also URI Students)
   b. South County Hospital Behavioral Health
   c. Angell St. Psychiatry (Providence and EG)
   d. Young Adult Behavioral Health (RIH, EG)
   e. RIH Residents’ Clinic (for those without insurance)
   f. RI Free Clinic

Assessing and Reporting Child Abuse and Neglect

The public policy for the State of Rhode Island is to protect children whose health and welfare may be adversely affected through injury and neglect, to strengthen the family, and to make the home safe for children by enhancing the parental capacity for good child care. For these reasons, mental health professionals are required by law to report known or suspected child abuse and/or neglect to the Department of Children, Youth and Families (DCYF). It is the policy of the PCC to adhere to the requirements of the law while trying also to maintain a therapeutic and advocacy relationship with the family.

It is important that you make clear to the family your own position and responsibilities. PCC clients are informed at the time of intake of our limits of confidentiality, especially in regard to situations of suspected abuse and neglect of children. If you are beginning to touch upon an area in which abuse or neglect may arise, you should remind the client of the seriousness with which we must regard such incidents and the limits of confidentiality. Should it become necessary to make a report, you should:

• share your concerns and discuss openly the ramifications of mandatory reporting prior to the actual report.

• emphasize that a mandate of DCYF is to provide assistance to families, and that you can serve as an advocate for the family both with DCYF and with regard to the problems requiring attention.

• encourage the client to make the actual call to DCYF in your presence and with your support (i.e., to the Child Abuse Hot Line at 1-800-742-4453; or 1-800-(R)hode (I)slad (CHILD)). Instruct your client to inform the Hot Line worker of their involvement with you by giving your name and agency affiliation, and to further request that you be included in the follow-up investigation and treatment plan by DCYF.
Such a process increases the likelihood that DCYF will recommend that the client continue in treatment with you, and that DCYF will maintain a relatively low profile in regard to the direction and course of your relationship with the client.

DCYF both encourages and supports your consultation and inquiry prior to making a report to their Department. Calling 800-RICHILD does not necessarily mean that a DCYF investigation will ensue. The Hot Line worker will ask questions regarding clinical concerns and reasons for calling. They will then assess the need for additional evaluation/investigation and notify you (while you are on the phone) what the next steps will be (including, the possibility that a DCYF investigation is not warranted).

- When you are unsure of whether or not a situation constitutes abuse/neglect, it is always better to call and ask rather than make assumptions and be found negligent in your clinical care.

**Immediately follow up any telephone report/inquiry with documentation in Titanium and a brief written report to DCYF.**

*If in doubt about the disposition of a situation of suspected abuse or neglect, consult your supervisor or PCC Director immediately. Reporting of abuse and neglect to DCYF is required within 24hrs of notification to a mandated reporter.*
Clinical Emergencies

All clinicians working in the PCC are required to attend a training on Suicide Risk and Prevention during the first two weeks of the Fall semester. This training is offered annually by the Director of the PCC.

As a training clinic, the PCC does not accept clients who are in acute crisis (requiring IOP, PHP, or in-patient level care) or need the availability of a 24-hour emergency response. The PCC does not have a 24-hour phone line through which emergency calls can be received and immediately relayed to clinicians. There are times, however, when PCC clients experience stressful events that put them in crisis, and require hospitalization. Some guidelines for responding to emergency and crisis situations follow.

Anticipating Crisis Situations. Student clinicians are expected to consult with their supervisors in monitoring clients’ ongoing risk for suicidal, assaultive, and/or self-destructive behavior. For clients who are at risk, therapists can arrange for such actions as:

1) Regular utilization of the Columbia Suicide Severity Rating Scale
2) More frequent therapy sessions,
3) More frequent phone contact,
4) Psychiatric Consultation
5) More directive action by the therapist to reduce stress
6) Identification of available supports
7) Family/support system session
8) Contracts with the client not to take self-destructive action until further options are tried.

If a therapist suspects that they might need consultation during a therapy session, they should arrange beforehand to have a supervisor accessible in person or by phone. Because it is impossible to anticipate all possible emergency situations, it is strongly advised that student therapists arrange that their sessions be observed by others as often as possible.

This is also part of the rationale for the PCC policy that no Intakes may be seen after the 5pm hour and no ongoing client session after the 6pm hour unless explicit permission is granted by the PCC Director and arrangements are made to heighten safety procedures (for both clients and clinicians).

Assessing the Need for Hospitalization. When a therapist believes the client to be a danger to themselves or others, the following procedures should be used:

1. The usual professional standards of confidentiality do not remain in cases where the therapist believes that there is a real danger to the individual or others. If the client is in a therapy session when a suicidal threat is made/insinuated, make a clear statement that you want the client to live and that your primary concern is to see that they are safe, and consequently you may have to break confidentiality to achieve this. Likewise, if the client seriously threatens another individual, state that you are obligated to take actions to protect the other person.
2. **While your client is still in the office**, contact your supervisor or PCC Director to discuss the situation. If the direct supervisor and PCC Director are not physically available for immediate consultation, clinicians should utilize the “double ring” policy for the PCC Director to reach her off-site. With supervision, make a decision as to whether hospitalization is appropriate.

3. Whether or not the client is insured affects the type of hospital into which they can be admitted. However, all hospitals are obligated to see anyone if they are brought to the ER.

4. If the decision is made to send a client to the hospital, and the client will *voluntarily* go with to a local emergency room, work with the client to reach out to local supports (parent(s), spouse, or any other responsible, significant other) who can transport the client. If possible, have the significant other come and take responsibility for transporting the client to the hospital.

   a. If this is not possible, call the campus police (4-2121). Tell them what the problem is and let them provide the ride, or have them contact EMS for assistance. *Do not drive the patient yourself.*

**Note:** You *cannot* release information to the hospital if the client has *voluntarily* admitted themselves, nor can the hospital release information to you. *If possible, have the client sign a Release of Information form and a Request for Information form before they leave the office, authorizing you to communicate with the hospital to facilitate continuity of care after the crisis is resolved.*

1) If the decision is made to hospitalize, and the client will *not* voluntarily admit themselves, then arrangements must be made for an *involuntary admission*. Contact the campus police (4-2121) and let them arrange to transport the client to a facility where they can be evaluated. Since many of the clients in the PCC do not have insurance, this will typically mean an evaluation by a crisis intervention specialist at one of the community mental health centers or South County Hospital’s Emergency Department.

2) Once a decision has been made to hospitalize and arrangements have been made for hospitalization, the clinician should contact their supervisor and the clinic Director to inform them about the progression of the case.

3) The clinician should make themselves available to talk with the admitting physician and/or members of the family. You can give the clinic number and your name as the clinician, to the family member to give to the hospital/admitting psychiatrist to facilitate hospitalization and discharge planning. You can also call the hospital to inform them about the client coming in to facilitate the admission process for the client and their family.

4) Once a client is en route to a hospital for evaluation, a clinician should *immediately* document events in Titanium (even in rough form. Additional addendums, clinical notes, logs can be included in more “final” form once all of the information has been fully processed).
Psychological Consultation Center
Suicide Risk Assessment

Things to consider:

1. **Previous Suicidal Behavior**
   - Suicidal ideator
   - Single attempter
   - Multiple attempter (risk perpetually elevated)

   Dates, Nature, Lethality of previous attempt(s):

2. **Nature of Current Suicidal Symptoms**

   A. **Resolved Plans and Preparations**
      - A sense of courage to make an attempt
      - A sense of competence to make an attempt
      - Availability of means to and opportunity for attempt
      - Specificity of plan for attempt
      - Preparations for attempt
      - Duration of ideation (fleeting, min, hrs, days)_____
      - Intensity of suicidal ideation

   B. **Suicidal Desire and Ideation**
      - Reasons for living (absent or minimal)
      - Wish to die
      - Frequency of ideation is: _____ per ____
      - Wish not to live / no wish to live
      - Passive attempt (e.g., driving recklessly)
      - Desire for attempt
      - Expectancy of attempt
      - Lack of deterrents to attempt
      - Talk of death and/or suicide

3. **General Symptomatic Presentation**
   - DSM Diagnosis (esp. MDD, Bipolar, Psychosis, BPD, Antisocial PD)
4. **Precipitant Stressors (in last 6 months)**
   - Personal loss (job, relationship, residence)
   - Interpersonal discord
   - Legal trouble
   - Physical or emotional abuse

5. **Other Predispositions to Suicidal Behavior**
   - Chaotic family history
   - History of physical or sexual abuse
   - History of psychiatric illness

6. **Impulsivity**
   - Impulsive behavioral style (e.g., act before thinking, nonfatal self-harm after stressor, incarceration history, drive recklessly, spend $ impulsively, tend to hurt self wo/meaning to resulting in falls/bruises, see themselves as - or others say they are - a risk taker or dare devil)

7. **Protective Factors**
   - Social support
   - Problem-solving ability
   - Self-control
   - Spiritual beliefs / practices
   - Reasons to live: __________________________________________________________

8. **Some other risk factors**
   - Male (especially older men) (more completed suicides)
   - Caucasian
   - Live alone, divorced, never married, widowed
   - Social isolation / lack of social involvement and integration
   - Feel like burden to loved ones; feel ineffective or incompetent or lack of control over life
   - Lack of belongingness with valued group or relationship
   - Acts contributing to an “acquired capacity to enact lethal self-injury”
     - Aborted suicide attempts with or without injury
     - Self-harm (e.g., cutting, burn self)
Potential habituation to pain (e.g., multiple surgeries, multiple tattoos/piercings, exposure to violence, self-injections, fights, physical/sexual abuse, anorexia)

- Family history of suicide
- Physical illness (cancer, HIV, MS, epilepsy, SCI...)
- Mental rehearsal of death, funeral, etc.
- History of resolved plans/preparation
- Feel like a source of shame for family or significant other