**INDIANA STATE UNIVERSITY PSYCHOLOGY CLINIC**

**POLICIES AND PROCEDURES MANUAL**

**Updated 6/20/2016**

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**Introduction**

The Psychology Clinic at Indiana State University was established as part of the graduate training program in clinical psychology. This manual is a reference for student clinicians. It details the policies and procedures of the Clinic. The manual is divided into three sections and appendices. The first contains information to orient students to the Clinic. The second contains information about using the Clinic and its resources. The third section tells students what is expected of them in terms of procedures related to providing services to clients.

**Orientation to the Clinic**

**MISSION STATEMENT**

The Psychology Clinic is a nonprofit professional training facility for doctoral students pursuing a Psy.D. The Psychology Clinic is operated by the Indiana State University (ISU) Department of Psychology. The Psy.D. program at ISU is accredited by the American Psychological Association (APA). Questions related to the program’s accreditation status should be directed to the Commission on Accreditation:

 Office of Program Consultation and Accreditation

 American Psychological Association

 750 1st Street, NE, Washington, DC 20002

 Phone (202) 336-5979

Goals Related to the Mission Statement:

1. The primary mission of the Psychology Clinic is to be a setting for clinical psychology graduate students to receive supervised training from licensed faculty and staff. Students are trained in the application, development, and refinement of psychotherapy and assessment skills. Our training standards include:
2. Maintaining the highest level of professional ethics, as established by the American Psychological Association (APA).
3. Following all legal mandates established by federal and state regulations.
4. Modeling professionalism, collegiality, and mentorship.
5. Facilitating multicultural awareness and clinical competence in working with diverse populations.
6. Secondarily, the Psychology Clinic is dedicated to offering high quality, affordable, clinical services to the Terre Haute community and those in surrounding areas. We serve both adults and children, and establish fees that are based upon the particular resources of each client. The mission of the Psychology Clinic is consistent with ISU’s mission of engaging students in community and public service.
7. Thirdly, The Psychology Clinic supports clinical research that advances the practice of psychology. All research conducted meets standards for the protection of human participant, as established by the APA and the ISU Institutional Review Board (IRB).
8. Fourthly, the Psychology Clinic is a practice setting for the licensed clinical faculty and staff in the Department of Psychology. Through the Faculty Practice Plan and Professional Practice Policy, qualified staff and faculty may provide clinical services to private clients. The Plan exists so that faculty and staff may practice and hone the professional skills that they teach, while modeling those skills for clinical doctoral students.

**HOW THE CLINIC WORKS**

**Staff**

The Clinic is staffed by a Director, an Office Manager, and Graduate Assistants. In general, two students are assigned to the Clinic as GA’s for the academic year. Students may also be hired to work in the Clinic during the summer.

**Clients**

Our clients are people from Terre Haute and surrounding communities. ISU students may receive services at the Clinic, but are advised that they are entitled to services at the ISU Counseling Center. ISU Human Resources refers clients to the Clinic. Faculty and staff may receive six sessions in the Clinic paid for by the University’s Employee Assistance Program.

We are committed to ensuring that students develop the knowledge, skills, and attitudes to work effectively with clients who embody intersecting demographics, attitudes, beliefs, and values. Consistent with this principle, Clinic policy prohibits discrimination of clients on the basis of age, gender, gender identification, race, ethnicity, culture, national origin, religion, sexual orientation, disability, or socioeconomic status. Student clinicians should be alert to the possibility that value-or belief-related differences could have a negative impact on services provided. Thus, student clinicians must maintain awareness of personal values and beliefs that may impact delivery of services, and discuss diversity related issues with supervisors as well as clients.

**Hours of Operation**

The Clinic is typically open Monday from 8-4:30, and Tuesday, Wednesday, and Thursday from 8-8. During the summer, however, there are only two days when the Clinic is open until 8 p.m. The Clinic closes for holidays and a day in August when students take preliminary exams.

**After Hours Coverage**

The Clinic does not provide after-hours coverage. At the end of each working day, incoming calls go to a voice mailbox. Clients may leave a message to be received the next business day. The voice mailbox greeting also instructs callers to contact community and other resources in the event of an emergency. New clients to the Clinic are informed that the Clinic does not provide emergency services. Clients are given a list of resources to call in the event of an emergency.

**Fees**

The base fee for therapy is $50.00 per hour, but fees are adjusted on the basis of client’s annual income and number of persons in his/her family. The Clinic staff establishes each client’s fee before s/he receives services. Any special circumstances or deviation from the standard procedure of assessing fees will be reviewed by the Clinic Director. Fees for assessment are determined by the Director, and vary depending on the referral question and number/type of tests required.

It is the policy of the Clinic to charge for appointments not canceled by the client within twenty-four (24) hours of the scheduled time of the appointment. Clients are informed of this policy in the Consent to Treatment form that they sign. Emergency cancellations are the exception. Enforcement of the policy is at the discretion of the student clinician and his/her supervisor.

**Preliminary Documents**

When a client arrives for his/her first appointment the Clinic staff will ensure that the client signs a number of preliminary documents. These include 1) a letter indicating that s/he has been offered a HIPAA Notice and the emergency policy notification, 2) an informed consent document, and 3) a confidentiality statement. Additionally, minor clients may be asked to sign a contract, and clients who are seeking couples’ therapy will be asked to sign an additional consent document. In the event that a client wants someone else to join them for a session, there is a form that the client and person they have invited can sign that specifies the role of the visiting person in the therapy session.

**The Faculty Practice Plan**

The Faculty Practice Plan was developed so that clinical faculty in the department of psychology may practice the professional skills they teach, and involve student clinicians in their work. Therefore, some of the faculty see clients for therapy and/or conduct assessments in the Clinic.

**Campus Emergency Procedures**

In the event of an emergency on campus (e.g., shooter, severe weather, etc.), the ISU Police activate a “rave” alert. This involves sounding a loud siren, and sending out an emergency alert notice to all campus computers. You may also sign up to have a “rave” alert text message sent to your cell phone. Everyone in the Clinic at the time of a rave drill or real emergency (including clients) should go immediately to rooms B-137, B-138, or B-139. If we determine that the emergency is weather related, we will relocate to the basement hallway.

**ETHICAL AND PROFESSIONAL STANDARDS**

**American Psychological Association Ethics**

Everyone working in the Clinic is required to follow the ethical standards put forth by the American Psychological Association. The details of this code are covered in coursework, but student clinicians should also familiarize themselves with the code prior to seeing clients in the Clinic. A copy of the code may be obtained online and in several references in the Clinic library.

**Maintaining Confidentiality**

***Discussion of Clients***

Any discussion of client should take place in a private area of the Clinic. This means that clients should not be discussed in hallways, the reception area, or any other semipublic or public area. Client names should not be spoken in or around the reception area.

***Viewing Sessions***

Observations of student therapy sessions via the one-way mirrors are restricted to student clinicians and clinical faculty. When recordings of therapy sessions are played, the volume should be low and care should be taken to be discrete. Clients of faculty should not be viewed unless it has been established that they have agreed to being observed.

***Written Material***

All written material pertaining to clients is highly confidential and must be handled with care. Students may work on client documents only in the Clinic (i.e., not at home, in a GA office, or anywhere else). Each student clinician has an encrypted flash drive to use when creating written material related to clients. These drives and client files stay in the Clinic at all times. The only exception to this is if a drive or file is taken to a faculty office for supervision. Never leave client materials lying around the Clinic. Documents to be discarded should be shredded if they contain any client information.

For further information about confidentiality and how to handle client’s private health information, refer to the Clinic’s HIPAA Manual (Available online and in the Clinic Library).

***Social Media Guidelines and Standards***

Professionals, especially in a field like psychology, should exercise caution when using social media (see the Program Guide). For example, clinicians should be mindful of the fact that their clients may gain access to their postings. Additionally, clinicians in the Clinic must adhere to the following standards:

* Never give a client access to your social media
* Information about clients – however vague – should never be posted on social media. Even generic comments about one’s clinical work should be avoided.

**Maintaining a Professional Atmosphere**

***The Reception Area***

Students who are not working at the desk or helping client at the desk should not be in the reception area. The reception area should also not be used as a hallway. Students should walk around the back of the Clinic to access rooms on either side of the Clinic.

***Dress Code***

Clinicians should dress neatly and appropriately when seeing clients in the Clinic. Although there is no specified dress code, students should dress in a manner that reflects professional judgment.

***Sound Considerations***

Special care should be taken to be quiet when in the hall that is used to access treatment rooms. Voices should be kept at a low volume when in the workrooms and other areas of the Clinic.

***Closing Doors on the Main Hall***

The Clinic has a recording system that is triggered by motion-detection. In order to avoid having the recording system triggered, the doors to the play room, group room, and all of the treatment rooms should be closed.

**Clinic Resources**

**KEYS**

The Clinic Director issues keys to the Clinic. Clinic keys open the back entrance, and most of the rooms in the Clinic. The key must be returned to the Clinic Director when the student no longer works in the Clinic (i.e., when leaving the program or going on internship).

**WORKROOMS**

The two workrooms in the Clinic are for student use. Students who want greater privacy may use the computer stations in B-111 and B-112 (so long as the adjoining treatment room is not in use). B-113 through B-118 do not have computers, but are equipped with desks and chairs for a quiet workspace.

All Psy.D. graduate students are welcome in the Clinic, but space priority must be given to students who are working on client-related tasks that have to be completed in the Clinic. Therefore, students who are merely socializing should be mindful of seating limitations and noise level, and relocate when necessary.

**COMPUTERS**

There are six computers in the Clinic that are dedicated to students (one in the small workroom, three in the large workroom, one in B-111 and one in B-112). There are also two laptops to use for watching sessions on Milestone. It is essential that students refrain from downloading documents to the hard drives of these computers. Furthermore, students should not use the Clinic printer to print anything other than documents related to their clients, as the Clinic budget cannot cover printing expenses.

**TELEPHONE CALLS**

To make a call to someone on the ISU campus, simply dial the last four digits of the person’s phone number. To place an outside call, dial 97 followed by the number. Long distance calls can be made by dialing 97, 1, area code, number, and then the long distance code.

Personal long distance phone calls should not be made from the Clinic, as we are charged for long distance.

Student clinicians should never give their personal phone numbers to clients. In those instances in which the client needs to talk to a clinician who is not in the Clinic, the Clinic staff may be able to “patch” the call to the clinician so the client cannot see the clinician’s personal number.

**ELECTRONIC AND PAPER FILES**

The Clinic uses Titanium, an electronic medical records system designed specifically for university counseling centers and psychology training clinics. Each client has his/her primary file on Titanium. Additionally, all clients have a paper file to hold their preliminary documents, raw test data, ROIs and such. All other documents pertaining to a client should be in their Titanium file.

**CLINIC FLASH DRIVES**

Students write reports about clients on encrypted flash drives that are used in the Clinic only. The documents are then transferred to Titanium. The documents should then be erased from the Clinic flash drive.

**MYPSYCH TRACK**

MyPsychTrack is an online tool that allows student clinicians to log their clinical experience. Having a record like this is extremely helpful when applying for internship and licensure. In addition, the Director of Training will verify clinical hours that students enter on their internship application (AAPI) by reviewing information in MyPsychTrack. Students have free access to MyPsychTrack for as long as they are students (through their internship year).

**FAX MACHINE, SCANNER AND COPIER**

There is a small fax machine, scanner, and copier in the Office Manager’s office. Specific policies related to faxing client information are detailed in the HIPAA Manual, but in general, client private health information should not be sent by fax. The copier has very limited capacity and should be used sparingly and only for Clinic business.

**CLINIC LIBRARY**

The Clinic has a library of books on various topics concerning the assessment and treatment of children, adults and couples. Books are not to be removed from the Clinic.

**FREQUENTLY USED HANDOUTS**

There is a magazine stand at the end of the main hallway in the Clinic. This stand contains multiple copies of handouts for clinicians to use with clients.

**Clinical Procedures**

**LIABILITY INSURANCE**

Students are required to obtain their own personal malpractice/liability insurance in the amount of a 1 million/3million policy. A copy of the policy must be given to the Clinic Director in order to begin seeing clients in the 2nd year of the program. Copies of renewal policies must also be submitted to the Clinic Director at the beginning of each academic year.

There are several agencies that offer this insurance at a reasonable price. The first is The APA Trust, and to acquire their coverage for $35 a year you must be a graduate student member (yearly fee is $55). Their contact information is:

 (877-637-9700) <http://www.trustinsurance.com/products/professionalliability/>

A second option is to purchase the coverage through American Professional Agency, Inc. Their policy is $35 and does not require any sort of membership. Their contact information is:

(800) 421-6694 <http://www.americanprofessional.com/profession-page/student/>

**SUPERVISION**

Each academic year student clinicians are assigned to a supervisor, and together with several other students they form a “team.” Students seeing clients must receive a minimum of one hour face-to-face individual supervision per week. In addition to the required individual supervision, supervisors hold weekly group supervision sessions with the team. During the summer, students are assigned to faculty who are providing summer supervision. Summer supervision may consist of individual meetings only, or may be group supervision with individual meetings as necessary. It is the responsibility of the student clinician to keep the supervisor apprised of all significant information and events concerning his/her clients. Decisions concerning assessment and treatment approaches, termination, transfer, referral, or consultation with a physician or psychiatrist should always be discussed with the supervisor.

**CASE ASSIGNMENTS**

The Clinic Director maintains a file of client Referral Forms (basic information about clients awaiting services). Beginning clinicians are assigned a caseload, but thereafter it is the student’s responsibility to let the Clinic Director know when they are available to take a new client. The Director helps students select cases that are appropriate for their level of training, and students may make specific requests for cases based on interest and training needs. The student’s supervisor gives final approval for the case to be taken.

Once approval has been given, the student should use a phone in the Clinic to contact the client and schedule an intake appointment. Intake appointments should be scheduled for two hours because there is some preliminary paperwork for the client to complete, and this first session can sometimes take a bit longer. The Referral Form should be kept in the Director’s file until contact with the client is made.

If the client cannot be reached, do not leave a phone message unless the Referral Form indicates that you may do so. If a message is left, it should be brief, giving only the student’s name, saying that the call is from “The ISU Clinic,” and leaving the number for return calls (237-3317). Keep the referral form in the Clinic Director’s file until the client is reached. If the client cannot be reached after trying for three days, inform the Clinic Director.

Once contact is made, note the appointment date and time on the Referral Form and give the form to the Office Manager so that the Clinic staff can create a paper file for the client and an electronic file can be established.

**CASELOADS**

Second-Year Student’s Caseload:

Typically, students begin to see clients in the fall of their second year. The Clinic Director assigns beginning clinicians one or two cases (often clients who have been in treatment with third year students and want to continue services). Over the course of the semester, students are expected to add to their caseload until they have three or four cases. Establishing a caseload can take time, so the minimum number of required contact hours is two hours per week, with a minimum of 15 contact hours per semester, in order to receive a grade for practicum. Second year students are also required to complete one psychological evaluation per semester in order to receive a grade. It should be noted that these are the minimum expectations, and that carrying a fuller caseload and completing more evaluations enhances one’s competitiveness for internship.

Students are expected to carry their case-load throughout the summer.

Third-Year Student’s Caseload:

It is expected that third year students will assume increased clinical responsibilities including number and difficulty level of cases. Generally, students are expected to carry four or five cases. Because caseloads may vary due to many different circumstances, third year students are required to have a minimum of three hours of client contact per week, and a minimum of 25 contact hours of contact per semester in order to receive a grade for practicum. Third year students are also expected to complete a minimum of one psychological evaluation per semester in order to receive a grade. It should be noted that carrying a fuller caseload and completing more evaluations enhances one’s competitiveness for internship.

Students should continue with their caseload during the summer, and consult with their supervisor about picking up short-term cases in the spring and early summer if their caseload is low. Clients who are continuing in the Clinic are typically transferred to 2nd year clinician who will begin to work with the client when fall semester starts. Third-year students must therefore continue to work with those clients until transfers can take place.

**RECORD MAINTENANCE**

It is the responsibility of each clinician to maintain an up-to-date file on all of his/her clients. Paper files for each client are kept in the file cabinet in the Clinic library, and are to store raw test data and forms that the client has signed. This cabinet is to be locked when the Clinic is closed. The door to the library is also to be locked. All other aspects of the client’s record are maintained via Titanium. Every client should have the following documents in their Titanium record:

Intake Report

Psychological Assessment Report (if applicable)

Treatment Plan(s)

Termination Form

Progress Notes

Additionally, every client’s Titanium file should the client’s demographic information and diagnosis. Instructions for how to do this are in Appendix J.

**INTAKE INTERVIEWS**

When the client arrives for the intake appointment he/she is greeted by a staff member who gives them a parking permit and asks them to complete some preliminary paperwork. Students should familiarize themselves with these documents (which are stored in the Clinic file room).

One of the documents clients are given to complete is the Outcome Questionnaire (OQ). Prior to meeting with the client, score the client’s OQ to get a sense of their level of distress (scoring guidelines can be found on the bulletin boards in both workrooms). Consider asking the client to also complete one of the Symptom Checklists available on the Frequently Used Handouts shelf at the end of the hall.

When ready, the student clinician should greet the client and introduce him/herself. In the therapy room, remind the client that the session is recorded and will be observed by the clinician's supervisor or other graduate clinicians. The client should be told the name of the supervisor. The client has signed a document explaining the limits to confidentiality, but students should review these points with the client. The interview then proceeds with a discussion of the client's presenting problem.

Following the interview, the clinician should accompany the client back to the reception area and let the staff know when/if the client is to be rescheduled. The staff will collect fees and make the next appointment. Clients may also schedule testing at that time if appropriate (See Standard Psychological Assessments below).

Students should then complete the Titanium demographic information for their client. Titanium also has a diagnosis section, and this should be completed after consultation with one’s supervisor. A note on Titanium about the intake interview experience, with a statement that the intake will be summarized in an Intake Report, is a sufficient entry for the progress note for that session. When the Intake Report is complete, it should be attached to the Intake session note in Titanium.

**Intake Reports**

Students are required to write an Intake Report summarizing the intake interview. This report should be completed shortly after the intake session, and a final copy of the report (approved by a supervisor) should be uploaded to the client’s Titanium file within two weeks of the intake (attach the report to the intake session note or create a separate document). Some supervisors have models for Intake Reports that they want their students to follow. Otherwise, a template for an Intake Report can be found in Appendix A. The report should be on letterhead.

**PROGRESS NOTES**

It is strongly recommended that students develop the habit of writing client progress notes on Titanium immediately after a session. Ending sessions after 50 minutes allows clinicians time to make their notes. Some supervisors have guidelines for how to write notes. Otherwise, suggestions for progress note format can be found in Appendix B.

**STANDARD PSYCHOLOGICAL EVALUATIONS**

Most clients of the Clinic are given a standard psychological assessment. The purpose of this is to enhance student training and to assist in the conceptualization and treatment of the client.

There are times when a supervisor knows, prior to the intake interview, what tests should be given to the client. When this is the case, clients may schedule a time to take the tests when s/he checks out with the Clinic staff after his/her intake interview. At other times the student clinician will need to review the client’s intake information with his/her supervisor, and schedule testing later.

The standard assessment components are the MMPI and/or the MCMI, both of which the client completes on the computer. The Clinic staff set up the computerized testing for the client, and the test results are placed in the client’s file.

**Psychological Evaluation Reports**

When testing has been done, a report of the client’s psychological assessment must be uploaded to Titanium. It is important to upload this as a separate document (as opposed to being attached to a session note). Instructions for how to do this can be found in Appendix K. In general, reports of the standard psychological assessment should be completed within a month of testing. Some supervisors have models for report writing that they want their students to follow. Otherwise, a template for the Psychological Assessment Report can be found in Appendix C. Reports should be on letterhead.

**OTHER PSYCHOLOGICAL ASSESSMENTS**

The Clinic has a variety of tests and questionnaires (See Appendix D). In general, testing materials are to be used only in the Clinic. However, under some circumstances (such as when learning a test), materials may be checked out with the approval of the Clinic Director. Clinic test materials are NOT to be used at external practicum placement sites unless permission is given by the Clinic Director.

**TREATMENT PLANS**

All clients must have a current Treatment Plan on file, both uploaded in Titanium as a separate document (e.g., not attached to a session note) and in the paper file. A Treatment Plan is to be completed as soon as possible after the intake interview and psychological testing. This plan is devised in conjunction with one’s supervisor. Treatment planning books and resources are available in the Clinic library.

Once a Treatment Plan has been approved by the supervisor it should be reviewed with the client. Treatment plans reflect the goals of therapy that are mutually agreed upon by the therapist and client. Therefore, the client should make changes to the plan if desired. New treatment plans may be written when additional treatment goals are identified. Some supervisors have models for treatment plans that they want their students to follow. Otherwise, a template for a Treatment Plan can be found in Appendix E.

**OUTCOME QUESTIONNAIRE ASSESSMENTS**

All new clients are asked to complete the Outcome Questionnaire (OQ) prior to their intake session. There is a version of the questionnaire for adults, and one for children. Follow-up OQ’s should be given to clients every third session and at termination. OQ scores should be noted in the client’s Progress Note. Scoring guidelines for the OQ are posted in both of the workrooms.

**THERAPY SESSION PROCEDURES**

**Preparing for Sessions**

Student clinicians are expected to be on time for appointments with clients. Clinicians should arrive at least 10 minutes early in order to set up their therapy room (e.g., adjust lighting and seating), gather materials they may need, and so forth. It is the clinician’s responsibility to check for the client in the waiting room, as the Clinic staff is often not able to notify clinicians when their client has arrived.

**Session Parameters**

Clients are typically seen once a week, for a 50 minute session. In order to maximize the use of space in the Clinic, sessions are usually scheduled on the hour, and end 10 minutes to the hour.

Clients are never to be seen when the Clinic is not open.

**Recording Sessions**

All therapy and assessment sessions must be video and audio recorded. The audio and video equipment in the treatment and assessment rooms is motion activated. Clinicians must simply turn on the light switch closest to the door to activate the hall “IN USE” light, and turn this light off after the session.

**Session Cancellations**

From time to time clients need to cancel appointments, and this is to be expected. However, the Clinic has the policy that if a client does not cancel his/her appointment within 24 hours of the scheduled time s/her may be charged for the appointment. In practice, the Clinic staff rarely assesses a fee to clients who cancel sessions within a shorter time frame.

When a client has excessive cancellations (i.e., cancelled appointments have disrupted treatment and clinical training), this should be discussed with the supervisor and addressed with the client. If both supervisor and student clinician think that assessing a fee to a client is clinically warranted, inform the Clinic staff so the cancellation-fee policy may be implemented.

**Changing Session Times**

Clients sometimes call and ask to have their session changed to another day during the same week. Most of these requests are for legitimate reasons and it is recommended that the student clinician accommodate the request if possible. However, some clients will ask to change sessions capriciously and excessively. Those requests are best not accommodated.

Given that the Clinic staff cannot know which requests are legitimate and which are capricious, they will not offer a client a different appointment time, but will instead take a message and have the student clinician call the client to discuss schedule changes.

**“No Shows”**

A “no show” means that the client did not come to the session and did not notify the Clinic of the cancellation. It is the policy of the Clinic that clients may be terminated if they “no show” for three appointments (consecutive or non-consecutive). Clients are informed of this policy via the consent to treatment form.

When a student clinician has been waiting for a client for 15 minutes, s/he should call the client to determine if the client is alright and plans to attend the session. If the client cannot be reached, and s/he has given permission for messages to be left, the student clinician should leave a message stating that the appointment was missed and the client should call the Clinic to confirm that s/he plans to attend the session the following week. Students should then wait 10 or 15 minutes longer to be sure the client is not simply running late.

All “no show” appointments should be addressed with the client during his/her next session, and the client should be reminded of the Clinic’s policy that after three “no shows” the client can be terminated. If a client has “no showed” for two consecutive appointments, the student clinician should send a letter (or call the client) explaining that a third “no show” appointment will likely result in his/her case being terminated.

Actual termination is at the discretion of the supervisor and student clinician. If a client has been terminated because of three “no show” appointments, s/he may be accepted for services at a later time (pending a review by the supervisor and student clinician, in consultation with the Clinic Director).

**Lack of Contact**

When a client has not contacted the Clinic for a period of time, the student clinician should send a letter asking the client to call the Clinic and communicate his/her intention to continue in therapy (see a sample of such a letter in Appendix F). All correspondence should be on letter head and approved by the case supervisor, and a copy of the letter should be put in the client’s paper file.

**Client Termination**

When a client is no longer going to be receiving services in the Clinic their paper file should be closed. A Termination Form (See Appendix G) should be completed on Titanium, and a paper copy placed in the file. The file should then be given to Clinic staff to store securely.

**CLIENT EMERGENCY PROCEDURES**

General guidelines for managing emergencies are given here, and guidelines for dealing with specific crisis situations can be found in Appendix H.

1. Explain to your client that you need to leave him/her briefly to contact a supervisor for help with the situation.
2. Inform the Clinic staff of the emergency.
3. Enlist the help of the Clinic Director if he/she is in the building.
4. If the Director is not available, ask the Clinic staff to contact your supervisor (if your supervisor is not available, the staff will contact any other clinical faculty member in the building. If clinical faculty is not available, staff will contact the Clinic Director and/or clinical faculty by telephone).
5. Return to your client and remain with him/her until a faculty member or the Clinic Director has consulted with you. In the event that your client will not stay in the Clinic, and you deem him/her to be a lethality threat, contact Campus Security at x 5555 on a university phone. Do not use a cell or other phone. Under no circumstances should physical actions be employed to restrain or challenge a client.

**REQUESTS FOR INFORMATION**

If a student clinician and supervisor think it is appropriate to obtain information about a client from another provider or agency, the student clinician should ask the client to request his/her records from that provider/agency. The other provider/agency will have a Release of Information (ROI) form for the client to sign. Alternatively, they may accept a ROI from the Clinic that has been filled out and signed by the client.

When other providers or agencies request information about a client of the Clinic they typically provide a ROI that the client has signed. If a client wants his/her information sent to another provider/agency and has not signed a ROI provided by that party, s/he may complete and sign a ROI supplied by the Clinic. All ROI’s should be kept in the client’s paper file.

Most ROI’s from other providers/agencies request that all records pertaining to the client be released. If the client has signed a document allowing this, the entire record may indeed be sent. HOWEVER, most other providers/agencies do not actually need the entire record to conduct their business. It is therefore advised that caution be exercised when responding to requests for information. For example, it is typically not necessary (or appropriate) to send client Progress Notes. It is also inappropriate to send raw test data. Therefore, the procedure for responding to ROI’s sent to the Clinic is as follows:

1. Write a cover letter to the requesting provider/agency explaining that the entire record will be produced if necessary, but pertinent and typically sufficient documents will be sent immediately. A template for this letter can be found in Appendix I.
2. Copy all supervisor-approved documents (such as the Intake Report, Psychological Assessment, and current Treatment Plan)
3. Write a brief “Summary of Treatment Report” to accompany the other documents. A template for this report can be found in Appendix J.
4. These documents should be mailed. Alternatively, the provider/agency requesting the information may pay to have the documents sent by express mail.

**PSYCHIATRIC REFERRAL**

There may arise an occasion when a student clinician wants to refer a client to a physician for psychotropic medication. The clinician should always consult with his/her supervisor prior to making such a referral. Most primary care physicians are willing to prescribe basic medication. For clients who require the services of a psychiatrist, the Clinic maintains a psychiatric referral list.

**SEMESTER BREAKS AND VACATIONS**

Students should take no more than two weeks of vacation during semester breaks or the summer. Supervisors must be informed of all intended breaks well in advance. Student clinicians are responsible for their clients, and it is up to the student to ensure that adequate measures have been taken to provide for the clients during absences. Such provisions may include providing the Clinic Director with a summary of cases that might require attention during the absence and check in calls with clients.

**Appendices**

**A: Intake Report Template**

**B: Progress Note Formats**

**C: Psychological Evaluation Report Template**

**D: Clinic Test Inventory**

**E: Treatment Plan Template**

**F: Sample Letter for No-Show Clients**

**G: Termination Form**

**H: How to Manage Specific Emergencies**

 **Suicidal Crisis**

 **Threat to Harm Others**

 **Aggressive Behavior**

 **Client Intoxication/Under the Influence**

 **Emergencies over the Phone**

**I: ROI Cover Letter**

**J: Summary of Treatment Report**

**K: Titanium Instructions**

**L: Milestone Basics**

**A: Intake Report Template**

NAME OF CLIENT: THERAPIST:

INTAKE DATE: SUPERVISOR:

DATE OF BIRTH:

AGE:

I. IDENTIFYING INFORMATION

A. Full name, age, sex, race, marital status, residence

B. Referral source

II. PRESENTING PROBLEM

A. Brief outline of presenting problem(s)

B. Symptoms

III. HISTORY OF THE PROBLEM(S)

A. Onset/duration/history of presenting problem

B. Coping strategies; why treatment sought now

IV. PSYCHOSOCIAL HISTORY

A. Family history; interpersonal/social relationships

B. Relevant education/vocational/military history

C. Other factors (e.g., social support; history of abusive relations)

D. Relevant medical/psychiatric/drug history

E. Previous treatment

V. MENTAL STATUS EXAM

VI. PROVISIONAL DIAGNOSIS

VII. SUMMARY

VIII. PLAN

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Name, degree Date Supervisors Name, degree Date

Graduate Student Clinician Psychologist/Clinician Supervisor

**B: Progress Note Formats**

Clinicians may simply write a brief summary of the session and contain information pertaining to themes discussed during the session, the client’s behavior, the process or interactions between clinicians and client, and plans or goals for future sessions.

Another popular format is the SOAP outline. SOAP is an acronym for the sections of a clinical note:

S = Subjective (The counselor describes his/her impressions of the client, and what the therapist understood the client to say)

*Mr. Apgar reported that he is sleeping 2-3 hours a night. He noted feeling sad, crying intermittently, and having suicidal ideation.*

O = Objective (A factual account of what was observed)

*Mr. Apgar appeared lethargic. He rarely made eye-contact. His affect was flat, and he spoke only when queried.*

A= Assessment (A synthesis of the Subjective and Objective portion of the note that includes diagnosis and clinical impressions)

*Mr. Apgar appears to be experiencing a major depressive episode.*

P = Plan (The counselor describes the treatment plan that follows from the Assessment)

*Mr. Apgar will be referred for a medication evaluation. He has been put on suicide watch. He will be seen again tomorrow for further assessment.*

**C: Psychological Evaluation Report Template**

NAME OF CLIENT: THERAPIST:

INTAKE DATE: SUPERVISOR:

DATE OF BIRTH:

AGE:

IDENTIFYING INFORMATION:

This is a brief section which includes such information as name (full), age, sex, race, physical appearance, job, address, etc.

REFERRAL:

Write a few sentences stating the purpose for testing; referral questions to be answered. Name the referral source if there is one.

PRESENTING PROBLEM:

Write a paragraph explaining the client’s reason for seeking treatment, current problems, symptoms, as well as the history of the problem, onset, previous treatment, and previous psychological contacts. You may include dates of service, previous test results, and previous diagnoses and recommendations.

BACKGROUND INFORMATION:

Psychosocial history data that is relevant to the referral question. The interested reader can be referred to the Intake Report for a detailed history.

EVALUATION COMPONENTS:

List clinical interview, tests and other techniques used.

BEHAVIORAL OBSERVATIONS:

Include general behavioral observations as well as mental status examination data deemed useful in interpreting and/or complimenting test findings in contributing to the diagnostic information. Be detailed only regarding the remarkable. The following is a suggested checklist of areas to be covered:

Mental Status Examination

1. Appearance

2. Behaviors (motor/activity pattern)

3. Speech (manner of speech, accents, etc.)

4. Emotion (mood, affect, congruency)

5. Thought processes and content (word usage -- neologisms, stream of thought, continuity of thought -- loose associations, content -- delusions)

6. Perception (hallucinations)

7. Attention and concentration

8. Orientation (time, place, name)

9. Memory (remote, recent, immediate)

10. Judgment (able to appreciate the consequences of their behavior)

11. Intelligence

12. Insight (concerning the nature of their difficulties)

13. Suicidal/homicidal tendencies (lethality assessment)

EVALUATION RESULTS:

Write a synthesis of the evaluation findings (test results and other data) that answers the referral question.

ICD- 10 DIAGNOSIS:

SUMMARY AND RECOMMENDATIONS:

The summary should be brief and concise, and not introduce any new information. It should stand by itself as a statement of the diagnostic findings.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Name, degree Date Supervisors Name, degree Date

Graduate Student Clinician Psychologist/Clinician Supervisor

**D: Clinic Test Inventory**

Tests of Intelligence

Kaufman Brief Intelligence Test, KBIT-2

Wechsler Abbreviated Scale of Intelligence, WASI-II

Wechsler Adult Intelligence Scale, WAIS-IV

Wechsler Intelligence Scale for Children, WISC-IV

Wechsler Intelligence Scale for Children, WISC-V

Wechsler Preschool and Primary Scale of Intelligence, WPPSI-III

Wechsler Preschool and Primary Scale of Intelligence, WPPSI-IV

 Tests of Achievement

Peabody Individual Achievement Test, PIAT-R

Wechsler Individual Achievement Test, WIAT-III

Wechsler Individual Achievement Test Abbreviated, WIAT-II ABB

Wide Range Achievement Test, WRAT-4

Woodcock Johnson Test of Achievement, WJ-III

Tests of Executive Functioning and Neurocognitive Ability

Barkley Executive Functioning Scale (BEFS-Adult)

Behavior Rating Inventory of Executive Functioning (BRIEF) (Parent Form)

Behavior Rating Inventory of Executive Functioning (BRIEF) (Teacher Form)

Conner’s Continuous Performance Test

Delis-Kaplan Executive Functioning System, D-KEFS

Developmental Neuropsychological Assessment, NEPSY-II

Repeatable Battery for the Assessment of Neuropsychological Status, RBANS

Rey Complex Figure Test, RCFT

Trails A and B

Wechsler Memory Scale, WMS-IV

Wide Range Assessment of Memory and Learning, WRAML-2

Autism Spectrum Disorder Measures

Gilliam Autistic Rating Scale, GARS-2

Social Responsiveness Scale (Parent form), SRS

Social Responsiveness Scale (Teacher form),SRS

ADHD Tests and Inventories

ADHD-IV Rating Scale (parent report)

ADHD-IV Rating Scale (teacher report)

Barkley Adult ADHD Rating Scale (BAARS)

Barkley Functional Impairment Scale (BFIS-Adult)

Conner Adult ADHD Rating Scale, Self-Report (long form), CAARS

Conners Continuous Performance Test

Conners Adult ADHD Rating Scale, Self-Report (long form), CAARS

Tests of Visual Motor Integration

Bender Gestalt

Berry Visual Motor Integration Test, VMI (long form)

Berry Visual Motor Integration Test, VMI (short form)

Projective Measures

Adolescent Apperception Cards (white)

Adolescent Apperception Cards (black)

Children’s Apperception Test (CAT)

Roberts TAT (white)

Roberts TAT (black)

Rorschach

Rotter’s Incomplete Sentence

Thematic Apperception Test (TAT)

Adult Objective Measures

Beck Depression Inventory, BDI-II

Beck Anxiety Inventory, BAI

Beck Suicidal Ideation Scale, BSS

Beck Hopelessness Scale, BHS

MacArthur Competence Assessment Tool – Criminal Adjudication (MacCat-Ca)

Minnesota Multiphasic Personality Inventory, MMPI –II

Millon Clinical Multiaxial Inventory, MCMI - 4

Myers Briggs Type Indicator, MBTI

NEO Psychological Personality Inventory, Neo PI-3

Outcome Questionnaire (Adult), OQ

Personality Assessment Inventory (PAI)

Symptom Checklist, SCL-90-R

Child/Teen Objective Measures

Behavior Assessment System for Children-2 (Self Report form), BASC-2

Behavior Rating Inventory of Executive Functioning (BRIEF) (Parent Form)

Behavior Rating Inventory of Executive Functioning (BRIEF) (Teacher Form)

Child Behavior Checklist (ages 6-18)

Child Depression Inventory 2 (Child form)

Child Depression Inventory 2 (Parent form)

Child Depression Rating Scale - R

Child Symptom Inventory

Conner-March Developmental Questionnaire (CMDQ)

Conduct, Hyperactivity, Attention, Oppositional Scale (CHAOS)

Minnesota Multiphasic Personality Inventory – Adolescent, MMPI-A

Outcome Questionnaire (Youth), Y-OQ

Revised Children’s Manifest Anxiety Scale (RCMAS)

Social Responsiveness Scale (SRS)

Health Related Measures

Addiction Severity Index

Alcohol Use Inventory

Binge Eating Scale (BES)

Brief Alcohol Screening Intervention for College Students

BUILT Bulimia Inventory

Drug-Taking Confidence Questionnaire (DTCQ)

Eating Disorder Inventory-2

Eating Attitudes Test

Rand 36 Health Status Inventory

Substance Abuses Screener, SAS-SR

Substance Abuse Subtle Screening Inventory SASSI-3

Relationship Scales

Areas of Change Questionnaire

Dyadic Adjustment Scale

Marital Disagreement Scale

Weekly Marital Satisfaction Checklist

**E: Treatment Plan Template**

CLIENT NAME:

DATE:

THERAPIST:

**Problem** **1**: (describe using specific terms)

Goal/Desired Outcome: (describe as specifically as possible, and ideally in measurable terms)

Objective: (what client will do to reach goal)

Intervention: (what therapist will do to reach the goal; treatment strategies):

Target Date:

**Problem** **2**: (describe using specific terms)

Goal/Desired Outcome: (describe as specifically as possible, and ideally in measurable terms)

Objective: (what client will do to reach goal)

Intervention: (what therapist will do to reach the goal; treatment strategies):

Target Date:

 (Use as many problems as needed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s signature, Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Graduate Clinician’s signature, Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor’s signature, Date

**F: Sample Letter for No-Show Clients**

 **Department of Psychology**

 **Psychology Clinic**

 ***Terre Haute, Indiana 47809***

 ***(812) 237-3317***

Date

Dear CLIENT,

I am writing to inquire about your wishes regarding our work together. You missed our last session and have not responded to the phone messages I have left you. If you would like to continue our work, please call the Clinic and make an appointment with me. On the other hand, if you no longer want services, please consider making one final appointment so that we may review the work we have done and say our goodbyes. If I don’t hear from you by DATE I will close your file. Please know, however, that our door is always open to you.

I wish you well,

CLINICIAN

**G: Termination Form**

**Indiana State University**

**Psychology Clinic**

**Client Name: Date of Termination:**

**Therapist Name:**

**History of Treatment**

Date of Intake Interview \_\_\_\_\_\_\_\_\_\_\_

Date of Last Session \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Number of Sessions Scheduled (including Intake and Termination Session\_\_\_\_\_
 Number of Sessions Attended \_\_\_\_\_\_\_\_\_\_\_

 Number of Client Cancelled Sessions \_\_\_\_\_

 Number of “No Show” Sessions \_\_\_\_\_\_\_\_\_

 Number of Clinician Cancelled Sessions\_\_\_

**Main Reason for Termination**

\_\_ The planned treatment was completed

\_\_ Client no longer wishes to participate in treatment

\_\_ Parent no longer wishes to have their child participate in treatment

\_\_ Client moved

\_\_ Therapist transferred the case

\_\_ This is a planned pause in treatment

\_\_ The client requires services elsewhere (briefly describe why and to whom) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Other

**Source of Termination Decision**

\_\_ Client Initiated

\_\_ Therapist Initiated

\_\_ Mutual Decision

\_\_ Other

**Treatment Goals and Outcomes** ((include first and last OQ data)

|  |  |
| --- | --- |
| Goal | Outcome |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Other Notable Aspects of Treatment**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Name, degree Date Supervisors Name, degree Date

Graduate Student Clinician Psychologist/Clinician Supervisor

**H: How to Manage Specific Emergencies**

**Suicidal Crisis**

If you deem your client to be at risk for suicide, follow the emergency General Guidelines and also take these steps with your client:

* Explain to your client that you need to leave them briefly to contact a supervisor for help with the situation.
* When you return to your client, attempt to have him/her create and sign a “no harm” contract. While these documents have not been empirically validated they may be helpful for some clients. Guidelines for how to create a contract are on the Frequently Used Handout stand. Give a copy of the contract to the client and save the original for the client’s file.
* Create a “safety plan” with the client. Guidelines for how to create a plan are among the Frequently Used Handouts.
* Consider having the client contact a loved one to inform them of the situation and assist in the removal of means of self-harm.

With the help of your supervisor, the clinic director, or a clinical faculty member you will assess whether your client can be sent home or if ISU Campus Security (x5555) needs to transport your client to the hospital for further evaluation.

**Threat to Harm Others**

If you deem your client to be at risk for inflicting serious harm to another person, follow the General Guidelines and also take these steps with your client:

* Explain to your client that you need to leave them briefly to contact a supervisor for help with the situation.
* Return to your client and, if not already known, make a reasonable attempt to find out the identity and whereabouts of the threatened individual.
* Attempt to get the client to create and sign a “no harm” contract. This entails having the client agree not to harm the targeted person, and agreeing to give any weapons to someone else for safekeeping. Give a copy of the contract to the client and save the original for the client’s file.
* With the help of your supervisor, the Clinic Director, or a clinical faculty member you will assess whether your client can be sent home or if ISU Campus Security (x5555) needs to transport your client to the hospital for further evaluation.
* If it is determined by faculty or Clinic Director consultation that your client’s threat is credible, he/she will assist you in contacting ISU Campus Security (x5555) and assuring that individuals identified as targets of your client’s threat are notified.

**Aggressive Behavior**

If a client is in an aroused, hostile, and/or impulsive state and you believe they pose a threat to your physical safety, do the following:

* Terminate the session immediately, and ask the client to leave the Clinic.
* Leave the room.
* Contact ISU Campus Security (x5555)
* Follow the General Guidelines

**Client Intoxication/Under the Influence**

If your client arrives to the clinic intoxicated or under the influence of drugs, proceed as follows:

* Meet with your client briefly and explain that the session needs to be rescheduled.
* Ask the client to contact someone to drive them home.
* Alternatively, ask the client to wait in the Clinic until they are able to drive safely.
* If the client insists on driving while impaired, call ISU Campus Security (x5555) to report this.
* Contact your supervisor

**Emergencies over the Phone**

If someone calls and reports that they are in crisis, follow these procedures:

* Enlist the help of the Clinic Director if he/she is in the building.
* If the Director is not available, and the caller is a current client, contact the relevant supervisor.
* If the supervisor is not available or the caller is not a current client, contact any other clinical faculty member in the building.
* If clinical faculty are not available, contact the Clinic Director and/or clinical faculty by telephone.
* If the person taking the call is not the client’s therapist, the therapist may be enlisted to help if they are in the Clinic but should not otherwise be summoned.
* If the caller is of danger to self or others the ISU Campus Security (x5555) should be contacted. Otherwise, the caller should be directed to community emergency services (found on all Clinic bulletin boards and at the reception desk).

**I: ROI Cover Letter**

Date

Name and address

of the person who

wants the record

Dear Ms. NAME:

We have received your request for a copy of our records for CLIENT NAME. Enclosed please find an Intake Report, a Psychological Evaluation, and a current Summary of Treatment. These documents fully represent the work that has been done with Mr. CLIENT LAST NAME. Mr. CLIENT LAST NAME has granted permission for all his records to be sent to you, and we will indeed comply with that request if necessary. However, in accordance with ethical standards and best practices, it is our preference to withhold progress notes, test data, and other sensitive aspects of the client’s private health record.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Name, degree

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Name, degree

**J: Summary of Treatment Report**

Indiana State University

Psychology Clinic

SUMMARY OF TREATMENT REPORT

Client: Therapist:

Date of Birth: Supervisor:

Date of Report:

CLIENT was first seen in the Clinic on DATE OF INTAKE, and has been seen for a total of # psychotherapy sessions. S/he was last seen on DATE. Mr. CLIENT LAST NAME initiated services to address BRIEFLY LIST THE PRESENTING PROBLEM(S).

THEN WRITE A PARAGRAPH OR TWO SUMMARIZING THE TREATMENT.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Name, degree

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Name, degree

**K:** **Titanium Instructions**

**Navigating Titanium**

You will be given a user name (your first initial and last name), and will then create a password to enter Titanium.

After you logon, the “Schedule Viewer” screen appears. This is the primary screen in Titanium and will always open on the current date. You can easily move to another date by using the blue “week” and “day” arrows on the upper left-hand corner of the screen.

Now, looking at the individual columns, you’ll see that after the column for the “Front Desk,” clinician names are listed in alphabetical order by first name. Faculty who practice in the Clinic are placed at the end of the list. You move across columns by clicking the green arrows at the top-center of the screen. Note that you can move one column, or several, at a time.

You may also switch to “Single Schedule View” and see just your appointments. To do this, simply click once on your name. To exit that mode, click on your name again.

The appointments that the Clinic staff schedule for you, and that you put into Titanium yourself, come up as colored blocks. For example, green blocks indicate individual therapy sessions and purple blocks denote psychological assessment appointments. To get a quick view of a particular client appointment, simply move the cursor over the box. This will tell you the time of the appointment, the client’s name, and the number of appointments of that kind that have been scheduled with that client.

If you want to see a client’s file, you can click on one of his/her appointments, and the first window of the file will open. Note that you cannot enter further into a file for which you do not have clearance. This generally means that you may only see the files of your own clients.

If you want to see a client’s file and can’t find an appointment block to click on, you may find the file by clicking on the “Open” tab at the very upper-left corner of the “Schedule Viewer” screen. Then scroll down and select “Clients.” This will give you a window where you can enter a client’s last name or first name, or even just their initials. Click “Find” and if they are in the Titanium system they will come up. You then highlight your client’s name and select “Okay” to bring up the record.

From that same “Open” tab you can select “Task List” which gives you a list of all the notes that need your attention (such as your signature).

**Creating Your Schedule**

You should add all your appointment information into Titanium so that the Clinic staff can schedule your clients when you are free. To add to your schedule, simply go to your column, right-click on the beginning of the time you want to block out, and click “Add.” From there, select an “Other” appointment that is either one-time, recurring, or a placeholder. This brings up the “Appointment Information” window. Go to the “Code” box, and select one of the options under the drop-down menu (i.e., class, supervision, out of office). Indicate the appointment length in the box above “Code.” Then save and exit.

**Creating Your Client’s Record**

To make a progress note or otherwise work in a client’s electronic file, go to the date you wish to make the entry and double click on your client’s appointment box. You will come to the “Appointment Information” screen. There are two tabs to the right of the “Appointment Information” tab (“Scheduling” and “Additional Information”). These are rarely used, so ignore them.

However, the menu at the top of the page is used frequently. Let’s review each function (from right to left):

* **Exit** (self-explanatory)
* **Edit** is used whenever you wish to add information to the client’s record (note that when you click “edit” the places on the window where you may type go from gray to white). After entering information, you must click the “save” button on the top-left of the page, or the “cancel” button beside it if you don’t want to save your work. After saving or cancelling, you click “exit.”
* **Delete** (self-explanatory)
* **Recurring** (IDK what this is, ignore it)
* **Client Note** is your most used tab. Clicking on it will take you to the “Narrative” window. You can do many things within this window.
	+ Enter your clinical note here, in whatever form your supervisor approves. Be sure to indicate the “Type of Note” in the box just under the client’s name. Do this by selecting “Progress Note” from the drop-down menu.
	+ As soon as you know your client’s diagnosis, be sure to enter his/her diagnostic information by selecting the “Diagnosis” tab beside the “Narrative” tab. Then click “add” on the upper right-hand side of the window. This opens a window where you can select a DSM-5 diagnosis from a drop-down menu.
	+ You may also attach documents to your client’s record from this window. The last button on the upper-right is “Attach.” Selecting this, and then “Attach a File” will allow you to upload your Intake Report so that the report is attached to your intake session.
	+ Other documents should also be uploaded via the Client Note window. When you have a completed Treatment Plan, and Psychological Evaluation, they should be added to the client file by selecting the appropriate “Type of Note” and attaching the document. Your Termination Form should also be attached in this manner. DO NOT attach any of these documents to a progress note because doing will not make them distinct, and thus not easily found within the client’s electronic file.
	+ When you are finished with your progress note or other work, go to the bottom of the window and click on the #1 next to “Sign.” Your name should appear.
	+ Be sure that the “Forward to” tab below your signature contains the name of your supervisor so that the record and/or document is sent to him/her for review and cosigning.
	+ When you are finished, click the “Save” button at the top-left of the window. You will then be directed to exit the window by clicking the X at the top-right of the window.
* **Client** is another often used tab. Clicking on this will open the “Client Information” window. Your client’s birthdate, phone numbers, and address are entered here by the Clinic staff. It is your responsibility to enter additional information to your client’s record.
	+ You are required to enter demographic information about your client. To do so, go to the “Demographics” tab at the top of the window and use the drop-down menus to enter all the information you have. When you are finished, “Save” and “Exit.”
	+ If you or your supervisor wishes to record medical information about your client, you may use the “Medical Information” tab that is next to the “Contact Information” tab.
* **Waitlist** is not a function we use.
* **Billing** is used by the Clinic staff, but you may click here to see your client’s fee and balance.

**Checking Your Caseload Data**

It’s possible to check Titanium for your caseload data. To do so, click on “Reports” which is the third tab from the top left of the screen. On the right-hand side of the menu that comes up is a section titles “Counselor Activities.” Within that there are options to view your activities by appointment code, by caseload, and by client contacts.

**Appendix L: Milestones Basics**

Milestone is loaded on all the computers in the Clinic except the one at the front desk and those in the Client Services Assistant/Office Manager office. To access the system, click on the Milestone icon.

In the window that pops up, put your user name as ISUAD\student, and the password that you will be given. Another window will pop up. Simply select “okay.” You will then enter the system.

In the upper left-hand corner you can select “Live” to view a session as it is happening. More often you will select “Playback” to view a session that’s been recorded.

To find a recorded session go to the bottom of the screen, just above the red line, and click on the date. Using the calendar that pops up, select the date you want. Below the calendar is a box with time noted. Simply enter the time (be sure to note AM or PM – if you want to change AM or PM, click on it and then click on the up or down arrow to make the change). Then click on “Go To”

All the sessions that were conducted during the time you chose will appear in the boxes that start on the right and continue on the bottom of the screen. Double click on the session you want and it will appear in the large center box.

Use the arrows at the bottom of the screen to start, pause, and advance or rewind the session. You can also click and drag the red line to move within the recording.

Be sure to exit the system when you are finished.