

**INDIANA STATE UNIVERSITY PSYCHOLOGY CLINIC
POLICIES AND PROCEDURES MANUAL**

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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:
 - a. Maintaining the highest level of professional ethics, as established by the American Psychological Association (APA).
 - b. Following all legal mandates established by federal and state regulations.
 - c. Modeling professionalism, collegiality, and mentorship.
 - d. Facilitating multicultural awareness and clinical competence in working with diverse populations.
2. Secondly, 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.
3. 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).
4. 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 may also seek services at the ISU Counseling Center for a yearly fee. 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 evening hours may vary, depending on the number of clinic workers. The Clinic closes for University holidays. Clients can only be seen if a clinic worker is at the front desk, during our operational hours. Students can see volunteers in the Clinic during off hours, only if there is another student present in the clinic (and not in a session).

After Hours Coverage

The Clinic does not provide after-hours coverage. At the end of each working day, incoming calls go to voicemail. Clients may leave a message to be received the next business day. The voicemail 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. A list of resources to call in the event of an emergency is available at the clinic front desk.

Fees

The base fee for therapy is \$80.00 per hour, but fees are adjusted on the basis of client's annual income and number of persons in the family. The Clinic Director establishes each client's fee

before services begin. If during the course of treatment you and your supervisor believe there are special circumstances or need to change a client's fee, please review with the Clinic Director. Fees for assessment are also determined by the Director, and vary depending on the referral question and number/type of tests required.

Parking Lot

The parking lot in front of the Clinic is for client use only. **A valid parking tag issued by the Clinic is required at all times.** Parking Services police the lot and they make all decisions regarding enforcing parking restrictions. They will tow cars that do not have a Clinic parking tag. Your University parking permit does not allow you to park in this lot. In order to obtain a temporary tag, please see Marty. She will approve use of the lot for short periods of time if there is availability and extenuating circumstances. Students and faculty need to get parking tags from Marty only as the student graduate assistants are only authorized to give out client permits.

Preliminary Documents

When a client arrives for their first appointment the Clinic staff will ensure that the client signs a number of preliminary documents. These include 1) a letter indicating that they were 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.* During the COVID-19 pandemic, a consent for face-to-face services must also be signed.

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 an 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. Relocate outside in case of a fire.

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 here: <http://www.apa.org/ethics/code/>

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

When recordings of therapy sessions are played, the volume should be low and the door closed. Clients seen through the Faculty Practice Program should not be viewed unless the faculty member has asked you to observe the session.

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. **It is against clinic policy to take client files or flash drives out of the clinic, and removal may lead to disciplinary procedures.** 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 unattended, as this is a security violation (including client assessment data.) All client charts should be put away in the client chart room (library) at the end of the day. Documents to be discarded should be shredded if they contain any client information. If you are sending a de-identified report to a supervisor, it must follow the HIPAA guidelines for PHI (*see Appendix M*).

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).

Reporting Child Abuse and Neglect

All reports of Child Abuse and Neglect will be discussed with one's supervisor prior to making a report and documented in Titanium. Please see Appendix N for DCS reporting guidelines.

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.
- Do not look up a client's information using Google or other search engine, or search your client in social media-- unless you are with the client and they ask you to do this for clinical reason.

Maintaining a Professional Atmosphere

The Reception Area

Students who are not working at the desk or helping clients to check out should not be behind the front desk area. The front desk 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 when clients are in the waiting room. The front desk is a place where we need to be aware of client needs and exercise professionalism at all times. Please do not discuss any clinic business or program concerns/criticisms at the front desk, as clients can easily overhear this and will personalize any information heard (i.e. complaining about/discussing a client no show, program criticism).

Please use the back door to the clinic to enter, rather than use the door that leads to the Clinic lobby. This will maintain a comfortable setting for clients waiting in the front lobby and will prevent seeing people you know (i.e. current students) waiting for appointments, thus enhancing confidentiality.

Dress Code

Clinicians should dress neatly and appropriately when seeing clients in the Clinic. Business Casual is the appropriate dress standard and reflects professional judgment. Jeans and shorts are not allowed when seeing clients. Leggings should be covered by a tunic-length shirt. Do not dress as you would when going out, but maintain professional modesty. Professional, not fashionable.

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 (especially the quiet workroom) and other areas of the Clinic.

Noise masking machines are in use in the treatment room hallway to reduce sound travel and enhance client confidentiality.

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 treatment rooms should be opened slightly and the lights should be off when not in use.

The door from the front desk to the treatment room hall should be kept closed to help enhance privacy and confidentiality in the treatment rooms.

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

There are five group workrooms in the Clinic for student use, in addition to five private workrooms. There are Clinic computers in all the group workrooms, in addition to the private rooms B-111 and B-112. The group workrooms located near the treatment rooms (B-131, B-133, B-134) and the private rooms adjacent to the treatment rooms are all quiet workspaces, given their proximity to the treatment rooms.

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.

COMPUTERS

There are several computers in the Clinic that are dedicated to students located in the workrooms (and a laptop located in the storage room). It is essential that students refrain from downloading documents to the hard drives of these computers. The clinic computers are often updated and any information left on the hard drive will be erased. Furthermore, students should not use the Clinic printer to print anything other than documents relate to their clients, as the Clinic budget has limited 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 1, followed by area code and number.

Student clinicians should never give their personal phone numbers to clients. When a client needs to talk to a clinician who is not in the Clinic, the Clinic staff can reach you and connect you to the client. Texting clients is never allowed.

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 their primary file on Titanium. Additionally, all clients have a paper file to hold their preliminary documents, raw test data, release of information forms and such. All other documents pertaining to a client should be in their Titanium file. Titanium files and paper files contain client PHI are subject to the clinic's HIPAA policy.

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. These drives and client files stay in the Clinic at all times. The only exception to this is if a flash drive or file is taken to a faculty office for supervision. **Do not change the password on the flash drive.**

TIME2TRACK

Time2Track is a record keeping system that students have used to keep track of clinical hours. There is a yearly cost for this service.

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. *Marty is the only person to use this machine during the COVID-19 pandemic.

CLINIC ASSESSMENT LIBRARY

All assessment measures used in the Clinic are kept in the assessment room. The Clinic has a variety of tests and questionnaires (See Appendix E of the Clinic manual). **Test kits need to be returned immediately after use and put away carefully.**

In general, testing materials are to be used in the Clinic only. 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 field placements unless permission is given by the Clinic Director. There is a sign out sheet on the door of the assessment storage room. Test kits may not be borrowed if the Clinic does not have more than one kit.

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, however if you need to take a book to review please sign it out (sheet on the wall) so we can keep track of resources. **Books may only be borrowed overnight or over a weekend.** Please be sure to return books immediately after use so all may use them when needed.

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 Trust. Cost for coverage is \$35 a year. Their contact information is: (877-637-9700)
<https://www.trustinsurance.com/Products-Services/Student-Liability>

A second option is to purchase the coverage through American Professional Agency, Inc. Cost for coverage is \$35 a year. 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 clients. Decisions concerning assessment and treatment approaches, termination, transfer, reporting child abuse or neglect, 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.

If possible, second year students will get one transfer client and one new client. Transfer clients already have an Intake Report and Psychological Assessment completed. If you get two new clients, ask your supervisor if you can stagger your starting date with them so you don't have too many reports to write at the same time.

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. Once an appointment has been made, note the appointment date and time on the Referral Form and give the form to the Office Manager so that a paper file can be made for the client and the client can be entered into Titanium.

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 (812-237-3317). Leave the Referral Form with the Office Manager (blue notebook in her lateral file) until the client is reached. If the client cannot be reached after trying for three days, inform the Clinic Director.

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 two cases (often one is a transfer cases who has been in treatment with a third-year student 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 (four weekly

cases maximum). 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. The expectation is that at least 2 assessments are completed each semester, with a maximum of 4-5 assessments per semester (in addition to assessments that are completed with therapy clients.) This number includes those assessments conducted as part of ADHD clinic. If there are no-shows through ADHD clinic, additional assessments may be completed, but not to exceed the maximum recommendation.

The no show rate is extremely high for transfer cases and new cases for second year students. Do not worry if it takes you some time to build up your caseload, as this is typical in the second year. Also know that you will acquire plenty of clinical hours while on placement, so do not worry about your number of clinical hours.

Students are expected to carry their caseload 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 (not to exceed five weekly 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. The expectation is that at least 2 assessments are completed each semester. Only one evaluation (outside of therapy client assessments) should be done at a time, with a maximum of 4-5 evaluations per semester.

Students should continue with their caseload during the summer, and pick up short-term cases in the spring and early summer if their caseload is low. Cases should not be transferred until the beginning of the fall semester when second year students are available to pick up clients.

RECORD MAINTENANCE

It is the responsibility of each clinician to maintain an up-to-date file on all of their clients. Records are maintained in electronic and paper form. Paper files are kept in the file cabinet in the Clinic library. This cabinet is to be locked when the Clinic is closed (key is located in right hand drawer in Clinic library). The door to the library is also to be locked at the end of the day. Electronic files are maintained in Titanium. Clinic staff will monitor client records to ensure all electronic and paper files are complete.

Every client should have the following documents in their Titanium record:

Intake Report
Demographics

Diagnosis
Psychological Assessment Report (if applicable)
Treatment Plan(s)
Termination Form
Progress Notes

Instructions for how to enter demographics and diagnosis are in Appendix M. A chart checklist is located in Appendix L that lists all charting requirements for cases.

The following documents will be kept in the paper file:

Left side of file

Signed preliminary paperwork (consent for treatment, etc.)
Signed release of information forms
Records received from other entities/agencies

Right side of file

Signed copy of the treatment plan(s)
Testing protocols with Psychological testing report on top
Client homework (please keep this to a minimum, as all homework is not needed in the chart)

INTAKE INTERVIEWS

When the client arrives for the intake appointment they are greeted by a staff member who gives them a parking permit and asks them to complete some preliminary paperwork, which include information about the clinic, consent for treatment and a document outlining confidentiality. Fees are collected at this time.

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 guides are posted in all workrooms. Consider asking them to complete one of the Symptom Checklists available on the shelf in the Office Manager's office.

When ready, the student clinician should greet the client and introduce themselves. 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 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.

A full Mental Status Exam is NOT appropriate for an intake interview, unless you have suspicion of impairment that needs to be more formally assessed (i.e. memory problem, not oriented to day/time/place, etc).

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 make the next appointment. Clients may also schedule testing at that time if appropriate (See Psychological Evaluations below).

Students should then complete the Titanium demographic information for their client. A brief note on Titanium indicating that an intake interview took place and will be summarized in an

Intake Report is appropriate for the progress note for that session. As soon as the intake report is written and approved by the supervisor, a copy should be uploaded to the Titanium record.

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. 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 of the Clinic manual (and in Titanium). The report should be on Psychology Clinic letterhead (located in Appendix D). Please upload the report as a new note as this makes it easy to find in the record.

Titanium also has a diagnosis section, and this should be completed after consultation with one's supervisor when a diagnosis is given. A diagnosis is added by adding a new client note/diagnosis tab.

PROGRESS NOTES

It is strongly recommended that students develop the habit of writing client progress notes on Titanium immediately after a session. 24-48 hour timelines for entering notes are common at most placement settings, therefore this standard is recommended. Ending session after 50 minutes allows clinicians time to document their session. Some supervisors have guidelines for how to write notes. Otherwise, suggestions for a progress note format can be found in Appendix B of the Clinic manual.

PSYCHOLOGICAL EVALUATIONS

Most clients of the Clinic are scheduled for psychological testing following the intake 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 they check out with the Clinic staff after the intake interview. At other times, the student clinician will need to review the client's intake information with their supervisor and schedule testing later. Assessment measures are chosen with the client's specific clinical needs in mind.

You will need to be available to set your client up for testing and check in with them when they are completing these assessments.

Psychological Evaluation Reports

When testing has been completed and the report has been approved by your supervisor, the psychological report must be uploaded to Titanium. In general, this report 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 of the Clinic manual. Reports should be on Psychology Clinic letterhead (Appendix D). Please upload the report as a new note as this makes it easy to find in the record.

TREATMENT PLANS

All clients must have a current Treatment Plan on file, both uploaded in Titanium and a signed copy in the paper file. A Treatment Plan is to be completed as soon as possible after the intake interview. This plan is devised in conjunction with one's supervisor. Treatment planning books and resources are available in the Clinic.

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. *Uploaded treatment plans should have client name, therapist name, and supervisor name. The signed treatment plan may also be uploaded.* 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 F of the Clinic manual. Please upload the report as a new note as this makes it easy to find in the record.

TERMINATION REPORTS

When a client is no longer going to be receiving services in the Clinic their file should be closed (both paper and in Titanium --demographics). A Termination Form (See Appendix H) should be completed and added to Titanium. You will also update the demographic screen to report the client is terminated and add the termination date. The paper file should then be given to Clinic staff to store securely. Please upload the report as a new note as this makes it easy to find in the record.

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 and shared with clients and supervisor.** Scoring guidelines for the OQ are posted in all of the large workrooms.

THERAPY SESSION PROCEDURES

Preparing for Sessions

Student clinicians are expected to be on time for appointments with clients. Clinicians should arrive 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. If you have Titanium open, a pop-up alert will tell you that your client has checked in.

Session Parameters

Clients are typically seen once a week, for a **50 minute session**, however clients may also be seen for half hour sessions if that is clinically indicated (and approved by your supervisor). In order to maximize the use of space in the Clinic, sessions are usually scheduled on the half hour. This may also be flexible given client needs.

Clients cannot be seen when the Clinic is not open. A Clinic staff member or another clinician must be in the Clinic at all times if a client is being seen by a student/faculty clinician.

Recording Sessions

All therapy sessions must be video and audio recorded. The audio and video equipment in the rooms is motion activated.

Session Cancellations

From time to time clients need to cancel appointments, and this is to be expected. The Clinic has the policy that a client needs to cancel an appointment within 24 hours of the scheduled time.

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 a 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 (or next 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 excessively and this may become a clinical issue. Please write a note in the comment box of the appointment if you do not want the client to be rescheduled for clinical reasons. Otherwise, the client will be rescheduled in an open time in your schedule. You will be contacted via email to be aware of the session time change.

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 our attendance policy on the consent to treatment form, and have agreed to this policy.

When a student clinician has been waiting for a client for 15 minutes, they should call the client to inquire about the missed appointment. If the client cannot be reached, and they have 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 reschedule.

All no show appointments should be addressed with the client during their next session, and the client should be reminded of the Clinic’s policy. 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 may result in their 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, they 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 their intention to continue in therapy (see example in Appendix G in Clinic manual). All correspondence should be on Psychology Clinic letterhead and co-signed by the 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 file should be closed (both paper and in Titanium --demographics). A Termination Form (See Appendix H in Clinic manual) should be completed and added to Titanium and the demographic screen should be updated. Place a copy of the termination report in the center of the paper file and then place the file in the large file room for 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 I of the Clinic manual.

1. Explain to your client that you need to leave 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 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 them 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 them to be a lethality threat, contact Campus Police at x 5555 on a university phone. Do not use a cell or other phone to call Campus Police. Under no circumstances should physical actions be employed to restrain or challenge a client.

If it is determined that your client's level of lethality may require hospitalization, you will ask a Clinic staff person to call Campus Police at x 5555 on a University phone. Campus Police will come to the Clinic and manage both a person voluntarily seeking

hospitalization or, if involuntary, they will pursue an Immediate Detention and transport them to the nearest hospital (or call an ambulance if needed).

This policy is for all ages, both children and adults.

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 talk to the client to about requesting records from that provider/agency. The student clinician or Clinic staff can have the client complete/sign a Release of Information (ROI) form allowing records release.

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 information sent to another provider/agency and has not signed a ROI provided by that party, they 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. 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 not necessary (or appropriate) to send client Progress Notes unless the release specifies "psychotherapy notes" to be released. 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. All records requests will be initiated and sent out by the Office Manager.
2. When you receive a records request, the Office Manager or student clinician will write a cover letter to the requesting provider/agency outlining the documents that will be sent. A template for this letter can be found in Appendix J of the Clinic manual.
3. All summary and supervisor-approved reports can be sent.
4. A brief Outpatient Treatment Report can be written to summarize treatment to date and can accompany the other documents. A template for this report can be found in Appendix K of the Clinic manual.
5. These documents will be mailed by the Office Manager. Records are rarely faxed for confidentiality reasons.

PSYCHIATRIC REFERRAL

A student clinician may want to refer a client to a physician for psychotropic medication. The clinician should always consult with their 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 list of local psychiatrists at the reception desk, and posted on the workroom bulletin boards. There is also a form letter that can be used for this purpose, available from the Office Manager.

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 scheduling with a substitute provider for the absence.

Appendices

A: Intake Report Template

B: Progress Note Formats

C: Psychological Evaluation Report Template

D: Psychology Clinic Letterhead template

E: Clinic Test Inventory

F: Treatment Plan Template

G: Sample Letter for No-Show Clients

H: Termination Form

I: How to Manage Specific Emergencies

Suicidal Crisis

Threat to Harm Others

Aggressive Behavior

Client Intoxication/Under the Influence

Emergencies over the Phone

J: ROI Cover Letter

K: Summary of Treatment Report

L: Chart Checklist

M: HIPAA Guidelines for PHI (De-identification of documents)

N: DCS Reporting Guidelines

O: Titanium Instructions

P: Milestone Basics

A: Intake Report Template



PSYCHOLOGY CLINIC
TERRE HAUTE, IN 47809
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NAME OF CLIENT:
INTAKE DATE:
DATE OF BIRTH:
AGE:

THERAPIST:
SUPERVISOR:

IDENTIFYING INFORMATION

Full name, age, sex, race, marital status, residence
Referral source

PRESENTING PROBLEM

Brief outline of presenting problem(s)
Symptoms

HISTORY OF THE PROBLEM(S)

Onset/duration/history of presenting problem
Coping strategies; why treatment sought now

PSYCHOSOCIAL HISTORY

Family history; interpersonal/social relationships
Relevant education/vocational/military history
Other factors (e.g., social support; history of abusive relations)
Relevant medical/psychiatric/drug history
Previous treatment

MENTAL STATUS EXAM (if clinically indicated)/BEHAVIORAL OBSERVATIONS

PROVISIONAL DIAGNOSIS

SUMMARY

PLAN

Clinician Name, degree
Graduate Student Clinician

Date

Supervisors Name, degree Date
Psychologist/Clinical Supervisor

B: Progress Note Formats

1. 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.
2. Another template for notes
 - a) What happened in the session
 - b) New problems/issues/ needs that surfaced
 - c) Interventions used
 - d) Homework, including new referrals, plans, or recommendations made
3. 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



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NAME OF CLIENT:
INTAKE DATE:
DATE OF BIRTH:
AGE:

THERAPIST:
SUPERVISOR:

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
Graduate Student Clinician

Date

Supervisors Name, degree
Licensed Psychologist

Date



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E: Clinic Test Inventory (6/30/21)

Cognitive Ability & Memory

- WPPSI-IV
- WISC-V
- WAIS-IV
- WASI-II
- KBIT-II
- WMS-IV
- Stanford Binet 5th Edition
- Woodcock Johnson IV Test of Cognitive Ability

Specific Ability Tests

- Bender-Gestalt
- BNCE – The Brief Neuropsychological Cognitive Exam
- Developmental Profile 3 –DP-3 Interview Form and Manual
- D-KEFS
- Expressive One Word Vocab
- NEPSY-II
- PPVT 4
- RBANS
- Rey Complex Figures
- Receptive One Word Vocab
- TOMM
- TONI-2
- WRAM-L2
- Trail Making Part A
- Trail Making Part B
- Vineland-3 Interview Form
- Berry VMI-Short
- Berry VMI-Long

Academic Achievement

- KTEA-3
- WIAT-IV
- WRAT- 5
 - Green Test Form
 - Blue Test Form
- Woodcock Johnson Tests of Achievement IV

Personality Measures

- MACI-2
- MCMI IV

- MMPI-2
- MMPI-2 RF
- MMPI-3
- MMPI-A
- MMPI-A-RF
- Myers-Briggs
- NEO-PI-3
- PAI
- PAS
- 16 PF Questionnaire & Manual

Adult DSM 5 & Interview Checklists

- Adult Checklist of Symptoms
- SCL-90-R
- Cultural Formulation Interview
- Supplementary Modules to the Core Cultural Formulation Interview
- Cultural Formulation Interview Informant Version
- Assessment of Spirituality and Religious Sentiments
- DSM-5 Long Form Adult (PID-5)
- Personality Inventory DSM-5 Adult Informant Form (PID-5-IRF)
- Level 2 –Repetitive Thoughts and Behaviors-Adult Adapted from the Florida Obsessive-Compulsive Inventory (FOCI) Severity Scale (Part B)
- Level 2 –Sleep Disturbance-Adult-PROMIS – Sleep Disturbance Short Form
- DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure Adult
- The Personality Inventory for DSM-5 Brief Form (PID-5-BF) Adult
- Level 2 – Anger – Adult PROMIS Emotional Distress – Anger (Short Form)
- Level 2 – Anxiety – Adult PROMIS Emotional Distress – Anxiety (Short Form)
- Level 2 – Depression – Adult PROMIS Emotional Distress – Depression (Short Form)
- Severity of Posttraumatic Stress Symptoms Adult National Stressful Events Survey PTSD Short Scale (NSESS)
- Level 2 – Somatic Symptom – Adult Patient Health Questionnaire 15 Somatic Symptom Severity Scale (PHQ-15)
- Severity Measure for Agoraphobia Adult
- Severity of Acute Stress Symptoms Adult National Stressful Events Survey Acute Stress Disorder Short Scale
- Level 2 – Mania – Adult (Altman Self-Rating Mania Scale [ASRM])
- Severity Measure for Depression-Adult Patient Health Questionnaire (PHQ-9)
- Severity Measure for Generalized Anxiety Disorder Adult
- Clinician-Rated Severity of Nonsuicidal Self-Injury
- Severity Measure for Panic Disorder Adult
- Severity Measure for Separation Anxiety Disorder Adult
- Severity Measure for Social Anxiety Disorder (Social Phobia) Adult
- Clinician-Rated Severity of Somatic Symptom Disorder

- Severity Measure for Specific Phobia Adult
- Severity of Dissociative Symptoms Adult Brief Dissociative Experiences Scale (DES-B)
- Clinician Rated Dimensions of Psychosis Symptom Severity
- WHODAS 2.0 World Health Organization Disability Schedule 2.0 36-item version, self-administered

Adult Symptom Measures

- ADHD-Adult
- ADHD Adult Structured Interview
- AMAS Adult Manifest Anxiety Scale
- Avoidance Behavior
- BAI – Beck Anxiety Scale
- Barkley Forms
- Binge Eating Scale (BES)
- Bipolarity Index
- B-IFF
- Bipolar Spectrum Diagnostic Scale
- Bulimia Test (BUILT)
- Beck Depression Scale (BDI)
- Beck Hopelessness Scale
- Beck Scale Suicidal Ideation
- CAARS – Self-Report Long Version (CAARS S:L)
- CAPS-Clinical Admin PTSD Scale
- Checklist of Strategies for Coping with Grief
- Conners ADHD Adult
- Dissociative Subtype of PTSD Scale
- Eating & Exercise Patterns of Food & Fitness Evaluation
- Eating Attitudes Test
- Eating Disorders Questionnaire
- Eating Record
- Eating Inventory – Answer Sheets
- Eating Habits Checklist
- EDI-1 Eating Disorder Inventory 2
- Hamilton Depression Rating Scale
- Health Status Inventory RAND – 36
- IPF
- Mac-Cat-CA
- MacArthur Competence: Criminal Adjudication
- Mindful Eating Program
- M-FAST
- Mood Disorder Questionnaire
- OQ Adult
- Penn State Worry Questionnaire
- Rumination Scale

- SAFE-T
- Sleep Quality Assessment
- STAXI-2 (State-Trait Anger Expression Inventory)
- Suicide Behaviors Questionnaire-R
- Tests of Memory Malingering
- Trauma & Attachment Belief Scale
- TSI-2 (Trauma Symptom Inventory)
- Weiss ADHD Adult/ADD Functional Impairment
- Yale/Brown OCD Scale

Thought Records & Behavioral Tracking

- Weekly Anxiety
- Daily Record of Positive Thoughts
- Daily Record of Automatic Thoughts
- Problem Solving Communication Training
- Distorted Thinking
- Relaxation Profile Sheets
- Dysfunctional Thoughts
- Thought Monitoring
- List of Emotion Words

Marital Checklists

- Areas of Change Questionnaire
- Weekly Marital Satisfaction Checklist
- Dyadic Adjustment Scale

Adult Projective Measures

- Rorschach cards
 - Rorschach: Mini Blots – Color
 - Rorschach – mini Blots B/W
 - Rorschach: Record
 - Rorschach Structural Summary
- RIAP & Scoring Manual
- Rotter Incomplete Sentences
- TAT (several sets)

ADHD Clinic Forms & Measures

- Academic Performance Rating Scale (Teacher)
- Teacher Medication Statement
- Teacher Comment Form
- Teacher Letter
- ADHD School Rating Scale
- ADHD Rating Scale Home
- TOF

- TOF Profile Form
- Child Interview
- ADHD Clinic Measurer Checklist
- Consent for Research for Parent
- Parent Interview
- Parent Letter
- Developmental Questionnaire
- Consent to Release for School Parent
- Young Person Contract for Assessment 7-17
- Parent Confidentiality Statement for a Minor
- Consent for Assessment for a Minor
- Welcome Letter

Child DSM 5 Interview Checklists

- DSM-5 Inventories Child

Child/Parent Symptom Measures

- PRQ (Parenting Relationship Questionnaire)
 - Ages 2-5
 - Ages 6-18
- PSI-4 (Parenting Stress Inventory)
- BASC 3
 - Parent report
 - Teacher report
 - Self-report
- BRIEF 2
 - Parent report
 - Teacher report
- Children Traumatic Events Screener
- Child PTSD Symptoms Scale for DSM-5
- Parent Checklist of Child Symptoms
- Parent Checklist of Adolescent Symptoms
- Weiss ADHD Functional Impairment
- Behavioral Anger Response Q
- SSRS – Preschool Forms (Social Skills Q)
- SSRS – Child Forms (Social Skills Q)
- Social Responsiveness Scale 2 (parent and teacher)
- Social Adjustment Scale
- School Refusal Assessment Scale
- Revised Children’s Manifest Anxiety Scale
- Parenting Scale
- Outcome Questionnaire child
- GARS-2 Gillian Autism Rating Scale
- GADS

- Conners ADHD Rating Scale
- Child Symptom Inventory (Teacher)
- Child Symptom Inventory (Parent)
- Child Sleep Habits
- Children's Depression Rating Scale
- Child Depression Inventory 2
- Child Behavior Checklist (CBCL)
- Childhood Autism Rating Scale
- CAPI (Child Abuse Potential Inventory)
- Brief Symptom Inventory
- ASRS
 - Teacher Rating
 - Parent Rating
 - Short Form

Child/Adolescent Projective Measures

- Sentence Completion
- Roberts-2
- Roberts Apperception Test for Children test pictures
- Projective Qs
- Gardner Children's Projective Inventory
- Children's Apperception Test Cards
- Adolescent Apperception Cards white and black versions

Substance Abuse/Misuse

- Alcohol Use Inventory & Resource Manual
- Alcohol Inventory Test Booklet
- ASSIST
- CAGE
- DAST
- Hogan Drug Attitude Inventory
- Michigan Alcohol Screening Test
- Pregnancy and Harmful Drinking
- Drug-Taking, Situation Inventory (IDTS) – Illicit Drugs
- Drug-Taking Confidence (DTCQ)
- Drug-Taking Situation Inventory (IDTS) – Hand Scoring Form
- Drug-Taking Confidence (DCTQ) – Hand Scoring Form
- Drug-Taking Confidence (DCTQ) – Client Confidence Profile
- Drug-Taking IDTS Client Profile Situation Profile
- Drug-Taking IDTS Client Profile Situation Profile
- Drug-Taking Confidence (DTCQ) – ETOH
- Drug-Taking Situation Inventory IDTS – ETOH
- Drug-Taking Confidence Questionnaire
- Level 2 – Substance Use – Adult Adapted from the NIDA – Modified ASSIST

- Nicotine Dependence Assessment
- Smoking Record
- SASSI 1-4 Substance Abuse Screening Inventory & User Guide & Manual

Multicultural Measures

- Cultural Identity Assessment
- MEIM-6
- Cultural Formulation
- Culturally Responsive Assessment Questions for CBT+
- Trauma Symptoms of Discrimination Scale
- UConn Racial/Ethnic Stress and Trauma Survey
- UnRESTS Short

F: Treatment Plan Template



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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

G: Sample Letter for No-Show Clients



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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 complete treatment. If I do not hear from you by DATE I will close your file. Please know, however, that you may return to the clinic to start therapy again in the future if needed.

I wish you well,

CLINICIAN

H: Termination Form



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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 (information to know if client decides to return to treatment at a later date).

Clinician Name, degree
Graduate Student Clinician

Date

Supervisors Name, degree
Psychologist/Clinical Supervisor

Date

I: How to Manage Specific Emergencies

Suicidal Crisis

If you deem your client to be at risk for suicide (following a risk assessment), 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. Have the Clinic staff contact a supervisor while you return to your client. This same procedure will be used if seeing a telehealth client in the clinic.
- 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 remove weapons or things they may use for self-harm.
- If your client is willing to have a voluntary assessment for hospitalization (if you and your supervisor determine this would be useful), have the Clinic staff contact ISU Campus Police (x5555) and they will assist with hospitalization and arrange for transportation (they will transport or call an ambulance).
- If your client is at risk and cannot keep themselves safe but does not want to be hospitalized, you will also have the Clinic staff contact ISU Campus Police and they will arrange involuntary procedures.

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. Have the Clinic staff contact a supervisor while you return to your client. This same procedure will be used if seeing a telehealth client in the clinic.
- Return to your client and, if not already known, make a reasonable attempt to find out the identity and whereabouts of the threatened individual.
- 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 Police (x5555) need to be called and transport your client to a hospital for further evaluation.
- If it is determined by faculty or Clinic Director consultation that your client’s threat is credible, ISU Campus Police (x5555) should be contacted they will assist with notification of the possible target.

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 Police (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 they are in the building.
- If the Director is not available, and the caller is a current client, contact the relevant supervisor and send a message to the therapist. Document your contact in Titanium.
- 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 can be called to help if they are in the Clinic, or emailed about the encounter if they are not in the Clinic. Document the encounter in Titanium.
- If the caller is of danger to self or others the ISU Campus Police (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).

J: ROI Cover Letter



PSYCHOLOGY CLINIC
TERRE HAUTE, IN 47809
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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, Treatment Plan and a current Summary of Treatment. These documents fully represent the work that has been done with Mr. CLIENT LAST NAME.

Sincerely,

Clinician Name, degree

Supervisor Name, degree

K: Summary of Treatment Report



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SUMMARY OF TREATMENT REPORT

Client:
Date of Birth:
Date of Report:

Therapist:
Supervisor:

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

L: Chart Checklist

Chart Checklist

Client initials _____

	Yes	No	NA	Notes/comments
Intake report completed and uploaded to Titanium				
Demographics added to Titanium				
Diagnosis added to Titanium				
Psychological Report completed and uploaded to Titanium				
Treatment plan completed and uploaded to Titanium				
Release of Information forms in chart if needed				
Progress notes are up to date				
OQs are completed every 3 rd session and results shared with supervisor and client				
Paper file is in order. <u>Left side</u> = consents, releases, records from other agencies <u>Right side</u> = clinical information: treatment plan, psychological testing protocols and report, client homework (kept to minimum)				
Termination form completed at the end of treatment, uploaded to Titanium and printed/placed in the middle of the chart. Chart is pulled and placed 'to be filed' with closed records.				

M: HIPAA Guidelines for PHI (How to de-identify client documentation)

The following items need to be removed from a document to de-identify it and meet HIPAA standards:

(A) Names

(B) All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes.

(C) All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.

(D) Telephone and fax numbers

(E) Email addresses

(F) Social security numbers

(G) Medical record numbers

(H) School name/city

(I) Any other unique identifying number

N. DCS Reporting Guidelines

When there is suspicion of child abuse or neglect (including domestic violence within the family) a call to the Department of Child Services (DCS) hotline should be made **1-800-800-5556**. All decisions to contact DCS should be made in collaboration with your supervisor.

Of note, please remember that suspicion of abuse or neglect are all that is needed to make a report. DCS will investigate to determine if abuse or neglect are present.

Sexual activity may also be considered neglect, if the parent has allowed such activity.

Ages 13 and under = not able to consent to sexual activity. All sexual activity would be reportable to DCS.

Ages 14 and 15 = able to consent to sex with another minor, but not able to consent to sex with anyone 18 and over. Sexual activity with anyone 18 and over is reportable to DCS.

Age 16 is the age of consent. One can consent to sexual activity with any age, unless the person is an authority figure (e.g. teacher, clergy, police officer, parent or guardian, grandparent). If sexual activity is with a person of authority, DCS should be contacted.

When documenting reporting abuse or neglect, please enter a separate note in Titanium to identify the event.

O: Titanium Basic 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. I have created a default password that will be changed when you first log into 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.

Your view is the “Single Schedule View” and you can see just your appointments.

If you are at the front desk, 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.

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 and will know when you are available. 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** (closes the window)
- **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. Be sure to sign your note before forwarding to your supervisor.
 - 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. In the progress note section you may write "diagnosis added."
 - 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 documents.
 - Other documents should also be uploaded via the Client Note window. When you have a completed the Intake Report, 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. Please upload intake reports, psychological evaluations, treatment plans, and termination reports as new notes—this makes them easy to identify in the record.
 - 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 them 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 titled “Counselor Activities.” Within that there are options to view your activities by appointment code, by caseload, and by client contacts.

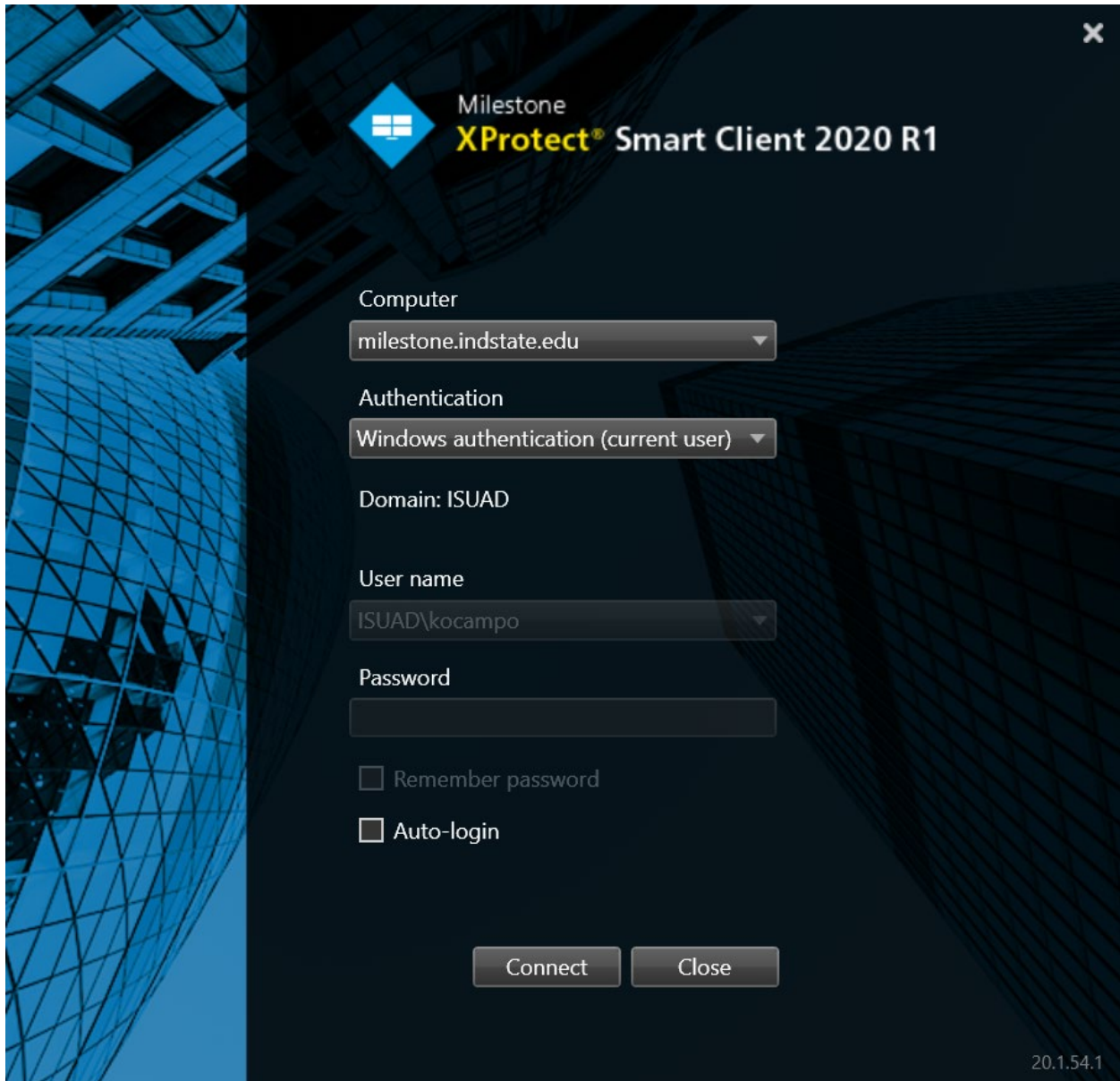
Calendar Sync

Appointments in Titanium can be set up to sync with your Google calendar. All appointments listed in your Google calendar will not list client names, but show up as a block in your schedule. We cannot sync to your university Microsoft Exchange calendar.

Appendix P: Milestones Basics

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

In the window that pops up, user name will be listed as ISUAD\your log in ID. **The first time you log into Milestone from a new computer you will need to change the info after **Computer:** to "milestone.indstate.edu".** There is no drop down box—you will just type this in over the default entry. Click "connect". You will then enter the system.

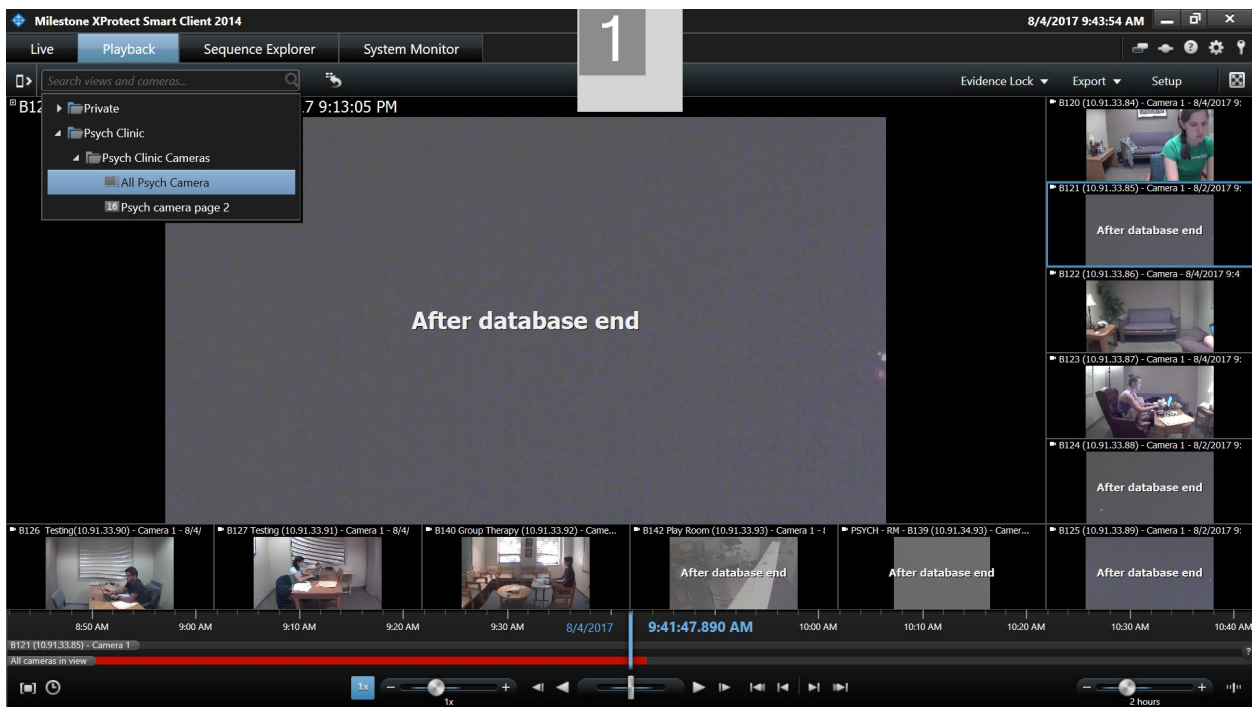


In the upper left-hand corner you can select "Live" to view a session as it is happening. More often you will select "Playback" to view a session that's been recorded.

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.

In order to view room 139, you will need to click the down arrow at the top left (where it says all Psych cameras) and choose Psych camera page 2. Room 139 will then be visible. Room 139 is listed as 137, and 137 is listed as 139.



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. When listening to a session, be sure to either use headphones (necessary in quiet work rooms) or close the door to prevent sound from leaving the room.