

PSYCHOLOGICAL CONSULTATION CENTER

POLICY AND PROCEDURES MANUAL

2009 - 2010

Psychological Consultation Center

University of Rhode Island

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**REVISED
8/09**

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Dear Reader:

This manual provides an introduction to the operation, procedures, and policies of the Psychological Consultation Center (PCC) at the University of Rhode Island. For new students, this manual will answer some of the additional questions about how the PCC operates. For PCC "veterans," this can be a reference manual, as well as an opportunity for you to review current policies and come up with suggestions. We will be glad to speak with you about questions, concerns, and ideas you may have.

A psychology training clinic can be an exciting, but potentially chaotic, place. The yearly turnover in graduate assistants, undergraduate work-study students, and some staff therapists complicates the job of simultaneously serving the training needs of students and the service needs of clients. We have found that we can be most helpful to clients entering the setting by being clear and consistent in our policies. Similarly, adherence to PCC policies by staff therapists is essential in the maintenance of a smoothly operating, high quality service and training setting.

We hope to make your training at the PCC as rewarding as possible. Please refer to this manual for questions about PCC policies and procedures. Have a good year.

Sincerely,

Ann M. Varna Garis
Director

PART I. INTRODUCTION

UNIVERSITY OF RHODE ISLAND

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

The University of Rhode Island employs 850 full time faculty members and enrolls approximately 3600 graduate and 12,500 undergraduate students: 13,000 on its Kingston and Narragansett Bay campuses, and another 3,200 in continuing education courses throughout the state.

DEPARTMENT OF PSYCHOLOGY

The Psychology Department is one of the largest departments within the College of Arts and Sciences, the largest college in the University. The department has 30 tenure track faculty members and additional special instructors, practicum supervisors, research faculty, and other teaching faculty; approximately 800 undergraduate majors; and over 100 graduate students, the majority of whom are enrolled in doctoral programs. The department offers training leading to the Ph.D. in three areas: clinical psychology, behavioral science, and school psychology. The clinical program is fully accredited by the American Psychological Association. The Psychology Department is the only source of doctoral level training in applied psychology available in Rhode Island, and its' doctoral program is the largest Ph.D. program at the University.

II. OVERVIEW OF THE PCC

MISSION OF THE PCC

The Psychological Consultation Center (PCC) serves two primary functions. It is both a training site for applied masters and doctoral level psychology graduate students, and a resource for those in the community seeking psychological services.

As a training site, the PCC's purpose is to expose graduate students to the diverse activities and interventions in which psychologists are involved. As the on-campus applied training facility for clinical and school graduate students in the Department of Psychology, the PCC allows students to provide psychological services under intensive supervision from the Department's faculty. A variety of diverse training opportunities in the community, including Providence Community Health Centers, Wyatt Federal Detention Center, Msgr. Clarke School, Progresso Latino, MAP Alcohol and Drug Rehabilitation Services, etc. are coordinated under the auspices of the PCC.

As a training facility, the PCC is highly committed to the notion of observation as a method of learning. From the graduate clinician's initial contact with the PCC as a first year student, and throughout their training, it is expected that observation of others, and by others, will be a regular and part of the student's training experience.

As a community consultation center, the PCC strives to provide a range of direct services (e.g., psychotherapy and psychoeducational assessments) and indirect services (e.g., stress management workshops, parenting workshops, child anxiety workshops for parents and for health professionals, and school consultations) aimed at developing the competencies of individuals and groups within the community.

Finally, the PCC strives to provide an atmosphere in which applied research is encouraged. In the past, PCC clients and staff have participated in studies of the psychotherapy process. Although the PCC population is small, staff members are encouraged to generate and consider research opportunities.

SERVICES PROVIDED BY THE PCC

In response to client needs, the PCC offers assessment and intervention services. Assessments may take the form of a single consultation with an individual, family, or institution, or may involve intelligence, personality and/or psychoeducational assessment. During the course of an evaluation, information is gathered about an individual's intellectual, educational, emotional and social functioning, as well as their medical history and biological development. The information is synthesized, interpreted, and used to generate recommendations for appropriate treatment intervention.

Over the years, the PCC has evaluation services involving individual assessments of preschool and school-aged children as well as adults from Rhode Island and surrounding

communities. Clients were referred by parents, school personnel, physicians, and other agencies. Examples of the most common problems leading to such a referral included: suspected learning disability, academic problems, disruptive behavior at home and/or school, lack of school interest or motivation, poor peer relations, anxiety, school phobia, depression, school readiness, retention and attentional difficulties. Presently, the school psychology program's practica are in flux, and evaluations are being conducted off-site in the community instead of in the PCC.

One of the services of the PCC is to provide low-cost diagnostic evaluation services and to provide useful recommendations for intervention. In addition PCC staff may also provide: consultation services for parents, schools, and other agencies and a variety of other consultative services.

Psychotherapy may involve child therapy, individual therapy, marital therapy, family therapy, and/or group therapy. The predominant orientations toward treatment represented by clinic supervisors include interpersonal, cognitive/behavioral, and systemic approaches.

The Child Anxiety Program (CAP), directed by Dr. Ellen Flannery-Schroeder, operates within the PCC and provides short-term, manualized treatment for anxious children and adolescents. In addition, CAP offers workshops to parents and caregivers of anxious children and often gives talks and presentations to physicians, other clinicians, and members of the community.

Finally, at times the PCC provides a variety of time-limited, structured workshop experiences designed to help individuals and families deal with such issues as stress management, health-related issues, single-parenting skills, step-parenting, working with the emotional and educational needs of learning-disabled children, dealing with families of the chronically ill, the pros and cons of grade retention, and workshops specially designed for professionals on a variety of topics (e.g. orientation to the use of the DSM IV.).

POPULATIONS SERVED BY THE PCC

Families and individuals seek services at the PCC for a variety of reasons including: depression, anxiety, marital and sexual problems, difficulty in managing behavior problems in children, difficulty in coping with stressful life events (such as illness, separation, divorce, death of a family member), or other interpersonal difficulties. The PCC clientele tends to have minimal economic resources, so therapists also help clients with life stresses and difficulties associated with financial need.

Occasionally, we receive court ordered referrals following, for example, domestic violence difficulties; each of these referrals are individually evaluated as to their appropriateness for the PCC. We also receive requests for help in dealing with more specific problems, such as the evaluation of the status of parent-child relationships which previously have been court involved for a variety of reasons.

The PCC accepts as psychotherapy clients for Psych 672 practica teams, those families and individuals whom we believe could benefit from short-term, outpatient treatment. Some of the following types of clients are generally seen as not appropriate for treatment at the PCC through practica teams:

1. Individuals with histories of chronic mental disorder who might benefit from a more long term, stable, therapeutic relationship;
2. Individuals requiring ongoing and close psychiatric/ medical evaluation (e.g., manic-depressive individuals on lithium; severely anorexic individuals);
3. Individuals in acute crisis who require 24 hour emergency response;
4. Individuals requiring some specialized form of treatment that the PCC may not be equipped to provide, for example, treatment of anorexics or sexual offenders.

In addition to these general guidelines, each phone screen and subsequent intake are examined to ensure that there is a good match between the potential client and the prospective therapist. As described below, student therapists interested in long term therapy or other specialized clinical experiences need to make these arrangements by signing up for PSY 674 and arranging for supervision through the Adjunct Supervisory System.

ORGANIZATION OF THE PCC

The PCC is made up of faculty and students involved in various aspects of applied training and service. The bulk of psychotherapy services are offered through clinical practica, supervised by clinical faculty. Graduate students receive academic credit for participating in academic practicum teams in which faculty provide supervision as part of their normal teaching load. Generally, 4 to 6 students and 1 faculty supervisor make up each practicum team. Clinical practica are offered in such designated content areas as child anxiety, individual, health, multicultural, and family psychotherapy, and workshops. Practicum teams meet weekly for supervision, and all staff members meet in a weekly PCC staff meeting.

Some advanced students provide services in the PCC outside the practicum teams, with supervision (see “**Specialized Clinical Experience**,” **page 20**).

The staff of the PCC consists of administrative staff, graduate assistants, clinical supervisors, graduate students in clinical and school psychology, a full time office manager, and work study students. A psychiatric consultant is also available on a limited basis to provide consultation and psychopharmacological services.

Brief Description of PCC Staff:

Director of the PCC: Ann M. Varna Garis, Ph.D.

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

Office Manager: Jean Maher

The Office Manager manages the PCC office. She coordinates a variety of office tasks: supervising work-study students, performing chart reviews, purchasing and requisitioning PCC items, coordinating and tracking students clinical hours, and managing the office's finances. In addition, Jean provides initial phone triage and ongoing support and coordination for all PCC clients, a huge task in and of itself!

Administrative Assistants: 2 Graduate Students

The two Administrative Assistants are graduate students in school and clinical psychology, respectively. The administrative assistants aid the director in several areas: initial telephone screening of cases, presentation of cases, review of therapist record-keeping, supervision of less experienced students when appropriate, and coordination of psychoeducational and psychological evaluations.

Clinical Supervisors: Faculty

Clinical Supervisors are usually faculty in the clinical and school psychology area that supervise a team of graduate students through the mechanism of practicum therapy courses.

Psychiatric Consultant: Sharon DeLuca, MS, RN, CS

The Psychiatric Consultant is available six hours every month for medical evaluation of clients and consultation with students on problem case situations. **See page XX for details.**

Adjunct Clinical Supervisors:

Adjunct Supervisors are licensed psychologists in the community who provide clinical supervision to students regarding clients seen in the PCC. Such arrangements are prompted by the individual needs of a student (e.g., a student who is seeking supervision in a specialized area, or a student who wishes to continue seeing clients but is no longer registered for a practicum team). Supervisory arrangements **must** be made prior to clinical contact. Interested students should speak with the Director of the PCC for assistance.

The School Psychological Teams: Currently operate in the community and are comprised of faculty and graduate students involved in various aspects of applied training and consultation.

PART III. INITIAL CASE MANAGEMENT ISSUES

All incoming referrals, regardless of referral source, are routed to the PCC administrative assistants or the PCC Director. Usually a client's first contact with the PCC is by telephone. The Office Manager or the PCC Assistant informs the prospective client of the types of services offered, the fee schedule, and the nature of the training facility (i.e. observation and tape/video recording; faculty and student staff). If appropriate, a phone screen is conducted by the PCC Assistant to gather initial information to determine whether the PCC is an appropriate treatment facility for the client. Each phone screen is reviewed with the PCC Director within two business days (ideally less) to evaluate whether the client is appropriate for the PCC. If it is decided that the client is not appropriate for the PCC, then the client is referred to other facilities in the community.

If the client is determined to be an appropriate case for the PCC, the client is scheduled for an intake – during the Fall semester, the client is assigned to the Intake Team (PSY642) and during the Spring semester, the client is assigned directly to a therapy team.

The Intake Team (PSY 642) – Fall Semester:

This team is comprised of all first year clinical students in their first semester. The purpose of the team is to provide students with an introduction to the clinic processes and to give them the opportunity to interact with clients in a structured setting. When the Intake Team is running and a client is determined to be appropriate for the PCC, the *supervisor* of that team will decide which student therapist conducts the intake interview.

Client Processing and Case Assignment

Step 1: Initial Contact

- When the client contacts the PCC, the Clinic Assistant or the Office Manager informs the potential client about the nature of the PCC and completes the *Initial Telephone Screening Form* (colored paper) **Appendix XX**. This is comprised of basic contact information.

Step 2: Phone Screen

- The Clinic Assistant then completes a Phone Screen with the potential client
- The *Initial Telephone Screening Form* (colored paper) and the *Phone Screen* are filed together in the Clinic Assistant's Binder (white)
- The Clinic Assistant reviews the phone screen with the PCC Director
- The Clinic Assistant presents the phone screen at the next PCC meeting
- If the client is not appropriate for the PCC, s/he is referred elsewhere by the Clinic Assistant.
- If the case is appropriate for the PCC, either: 1) an intake will be scheduled for the Intake team, or 2) the case is assigned directly to a therapy team

Step 3: The Intake

See "Steps in Completing a PCC Intake Interview" **(page XX) for a detailed description**

- The therapist conducting the Intake must obtain contact information and learn more about the client's presenting problem by reviewing the phone screen forms in the Clinic Assistant's binder in Jean's office.
- During the spring semester, (No Intake Team), the therapist must also notify the clinic assistant **and** record on the colored initial phone screen form the **therapist name**, as well as the **date** and **time** of the **scheduled intake** and keep the clinic assistant informed of any scheduling issues.
- If the potential client "no-shows", note it in the colored sheet and contact client to reschedule. If the potential client no-shows again or is unresponsive, no more attempts are made to reschedule the Intake. Policy: 2 strikes, you're out!
- **???**The clinic assistant updates the Intake Tracking Form to record whether or not the client attended the Intake appointment.

Step 4: Post-Intake

- All paperwork completed during the intake is filed in a manila file folder with the client's full name on it and filed in the front of the top drawer of the active clients file cabinet (left cabinet) in room 152.
- The student therapist must also complete a *Client Contact Note* (Appendix XX) the same day the Intake is completed. This is to summarize the presenting problem and any other important information and is added to the client file.
- The therapist must also notify Jean that the client needs to be assigned a number and needs a binder made. (*If Jean is not in her office, please leave her a note on her computer keyboard with the client's initials so she knows to prepare a binder).
- The therapist must discuss the Intake during the next scheduled group supervision. In addition, the therapist must review the intake with the Director of the PCC within 2 business days (ideally less).
- The therapist who conducted the intake must present the intake at the weekly PCC meeting.
- The therapist must also complete a draft of an *Intake Report* (see AppendixXXX). The supervisor must review the report. A *final draft* of the report is due in the client binder within 3 weeks of the Intake appointment.

During the Fall Semester...(INTAKE TEAM IS RUNNING)

- The Director will assign the case to a therapy team and will contact the supervisor of that team. The supervisor will assign a therapist within 24hrs.
- The therapist is then required to contact the client within **24hrs** of assignment, to schedule the first appointment.
- Once the first appointment has been scheduled, the therapist must notify the PCC Assistant and record the **date** and **time** of the scheduled appointment.

* **No more than 1 WEEK** should elapse between when the Intake is conducted with when the therapist contacts the client to schedule the first appointment.

During the Spring Semester...(NO INTAKE TEAM)

- After the Phone Screen is completed, the Director will assign the client directly to a team.
- The Director will contact the supervisor and the **supervisor assigns** a therapist **within 24hrs**
- The therapist is required to **contact the client within 24hrs**, to schedule the Intake.
- The therapist must then follow the "Client Processing and Case Assignment" steps (above)

- Once the first appointment has been scheduled, the therapist must record the **date** and **time** of the scheduled appointment. and notify the Clinic Assistant.

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

Ideally, therapists in 672 practica have 2-3 direct contact hours per week.

Psychological and Psychoeducational Assessments;

Requests for psychological and psychoeducational assessments through the PCC are handled on a case-by-case basis depending on the availability of interested/available students and supervisors. The majority of referrals are typically made by school personnel, but requests also come from lawyers, physicians, and child welfare agencies. Students are informed of the opportunity to pick up an assessment case via email and/or at weekly staff meetings. If a student volunteers to pick up the case and a supervisor is available to supervise the case, the student clinician will contact the client within 24 hours of picking up the case and arrange an intake date. The fee for a psychoeducational assessment is determined by a sliding scale and is payable by check or cash at the intake, or by the last testing session (before the report is written).

Steps in Completing a PCC Intake Interview

There are several general purposes to the intake interview. First, you need to gather enough information regarding the nature of the client's difficulties to determine whether the PCC is the appropriate service facility (and if not, what the appropriate referral source might be). Second, you want to develop a positive relationship with the client and communicate some realistic sense of hope about the outcomes of engaging in treatment. Third, you want to address enough of the nitty-gritty logistics (e.g., fees, informed consent) so that treatment can get off to a smooth start. Below are the steps the PCC therapist should follow in preparing and organizing the intake:

Before the Intake

If the assigned therapist is conducting the Intake:

1. Contact the client **within 24 hours** of case assignment to schedule an appointment.
 - Appointments with clients may be arranged by telephone.
 - If you need to leave a message, state that you are calling from the University of Rhode Island to schedule an appointment (**DO NOT STATE THAT YOU ARE CALLING FROM THE PCC, AS THIS VIOLATES CONFIDENTIALITY**).
 - If unable to connect with the client or leave a message on the first try, call again at a different time, or on the following day. Be persistent.
 - When the responder is not the client, the therapist should identify himself or herself by name and URI affiliation, not revealing PCC name or the purpose of the call. Vague responses like, “a friend” or “never mind, I’ll call later,” may create an uncomfortable, ambiguous situation at the other end of the line. Care must be exercised to protect the confidentiality of the client. Thus, the therapist should leave only a name and phone number or choose to call back later. In order to avoid “phone tag” it may be helpful to ask the client to leave a message letting the therapist know the best times to call.
 - If you do not hear back from the client after two phone calls or voice messages, assume that the client is no longer interested and discontinue attempts to schedule the appointment. Notify the clinic assistant.
 - **All contacts should be recorded on the Colored Initial Telephone Screening Form until an intake is completed. This form is in the Clinic Assistant’s Binder in Room 150.**
2. When scheduling, inform the client about the **\$25 Intake fee**, (after, the sliding fee scale will be used to determine the fee)

3. Inform them about directions and parking.
 - Client should call the PCC from the rotary if the gates are down, and the therapist should be in the clinic area **10-15 minutes before the scheduled appointment** so that the therapist will be available to run out and swipe them in.
 - If the client does not have a cell phone, the therapist should find out the make and color of the client's car and watch for the client's arrival.
 - The client should be given a red hangtag to hang from the rearview mirror during the appointment. **The therapist MUST retrieve this hang-tag at the end of session**
4. **Reserve a room** for the Intake several days in advance by signing therapist and client initials, and other information, in the Room Scheduling book, located in Room 150. The reservation allows office staff to contact the therapist if there is a scheduling problem, as well as to respond to clients who are confused about their appointment time. This also provides relevant information for observation purposes.
5. The assigned therapist will **contact the client the day before the scheduled Intake to remind them of the appointment.**

The Day of the Intake

1. Review the phone screen to be prepared for the presenting problem and to limit unnecessary redundancy.
2. Obtain an Intake Packet from the form room (Rm. 151).
 Intake Packet includes:
 - Intake Form (for therapist)
 - Adult (green) or Family (yellow) Intake Packet
 - 2 Informed Consent Forms
 - Support Services List
 - Fee Schedule
 - Request for Information and Release of Information Forms
 - Beck Depression Inventory (BDI) –kept with Jean
 - Brief Symptom Inventory (BSI) – kept with Jean
 - Beck Anxiety Inventory (BAI) (optional) – kept with Jean
 Additional Forms included:
 - Diagnosis and Treatment Plan
 - Children and Adolescent Background Forms (if necessary)
 - Log Sheet for Client Contact Form

**It is expected that therapists will use these assessments to re-evaluate client progress throughout treatment. Supervisors will monitor the use and appropriateness of such assessments and encourage re-evaluation at suitable intervals. Since the program is based on a scientist-practitioner model it is imperative for students to operate as scientists-practitioners and regularly evaluate their clients' progress to monitor overall effectiveness.*

3. Arrive at the PCC office (Rm. 150) early for your intake to be available to swipe the client in when they call from the rotary (or to watch for them at the rotary if they don't have a cell phone). Provide them with a red hang tag.
4. If the client does not show for his/her appointment, note that fact on the colored phone screen sheet and let the clinic assistant know.

During the Intake

1. During the intake interview, it is important to obtain the client's signature on the Informed Consent Form and any necessary Releases and/or Requests for Information. **Be sure to sign these forms as a witness as well.** In reviewing the Informed Consent Form, **make sure to indicate the limits of confidentiality and instances where confidentiality may be violated.**
 - When an intake interview involves treatment for multiple parties, **all** individuals involved must sign Informed Consent Forms.
 - Also, be sure that you list the client ID # and client name on the top of all completed forms. **Forms cannot be entered into the computer without this information.** In addition to this information, make sure that the intake date, therapist name, and supervisor name are included at the top of the Intake Report.
2. Several issues should be considered and addressed when meeting the client for the first time:
 - **Introduction:** Usually your client will be unsure how to address you. You need to make your preferred address clear when you first introduce yourself. At the same time, find out what she/he prefers to be called. There is an implied power structure in names in our society: women, minorities, the elderly, children and those people who are considered lower status individuals tend to be called by their first names. You may want to consider addressing the client at Mr./Ms./Mrs. until you clarify what they prefer to be called.
 - You are aware that you are not yet entitled to be addressed as "Doctor;" your clients may not understand this. It is essential that you **not** allow them to use this term because it may imply that they think they are getting a certain level of expertise that, at least in the legal and licensing sense, they are not.
 - **Therapy expectations:** At some point in the first session, you should find out how your client views therapy. You should also explain to them your conceptualization of therapy, the length of sessions, your expectations about cancellations, fee payment, and their rights as a client.
 - **Session length:** Generally, individual sessions last for 50 minutes. The "fifty-minute" hour is a standard for private practice, which allows the clinician to schedule clients on the hour and yet have a short break between clients. These 10 minutes can be

especially useful for writing notes about the preceding session. Do not run over the time you have set up with the client or for the room. Doing so may put a fellow therapist in an awkward position by requiring him/her and his/her client to wait.

6. There is a \$25 fee for all Intake appointments. The client can pay by cash or check (made out to URI). For more details on how to process payment, please see the section on “Collecting Fees.”
7. If the therapist is conducting the Intake, use the Fee Schedule form to set the fee according to the client’s ability to pay (See “ESTABLISHING FEES,” page 19).
8. If the assigned therapist does not do the intake, be sure to inform the client that he/she will be contacted by the assigned therapist within one week.
9. File all Intake paperwork in a manila folder in the front of the top drawer of the Active Client filing cabinet in Room 151.
10. If the therapist conducts the intake, he/she should notify Jean that the client needs a number assigned and a binder made.

After the Intake

1. It is expected that the information needed to complete an intake summary can be obtained in one session. This session will likely take between 1h/15m and 1h/30min depending on how much time the client needs to complete the paperwork.
2. If the Intake is not completed by the assigned therapist, the Intake clinician should write a brief Client Contact note the day of the appointment summarizing the most important pieces of information from the Intake (e.g., presenting problem, etc.).
3. Within 1 WEEK of the Intake, a draft of the Intake report should be turned into the supervisor and another copy placed in the client’s file. Within one week of receiving the Intake report, the supervisor should return the draft with edits to the clinician. A final draft of the report should therefore be completed 3 weeks after the Intake, at the latest. *Please be sure to have (final copy) page 1 of all intake and termination summaries on PCC letterhead.*
4. If the assigned therapist does the Intake, the **Client log Sheet** should be begun and the **Initial Diagnosis and Treatment plan** form should be completed (make sure to fill out the back page as well).

SUPERVISION

Supervision is like therapy in a number of ways. The therapist and supervisor must develop a working relationship in which there is the safety to talk about difficult issues, they must address both process and content, and they must sort out what seems a reasonable amount of progress to make in the length of time they have to work together. Although it is the supervisor’s

responsibility to provide a map of how supervision will proceed, therapists will be well served if they can continually communicate to their supervisor the kind of feedback and issues that are most important to them for their personal and professional development.

CONTRACTING WITH CLIENTS:

Semester Breaks/Vacations/Length of Treatment

An important issue in one's initial sessions with a client is his/her implicit expectations regarding the length and duration of treatment and the availability of the therapist during that time. For those clients who are unclear about what treatment might involve, it's important to spend an initial period of time exploring goals and discussing possible treatment options. The therapist needs to be clear about his/her own availability and such issues as semester breaks and vacations. All of this may be part of a therapy contract between the therapist and the client.

Semester Intercession: Although classes will not meet during the semester intercession, the PCC office is open and the Director and/or the clinic assistant are present. It is expected that therapists and teams will continue to see clients through the semester break when clinically indicated. Be sure to arrange supervisor with the PCC Director if your supervisor is unavailable during breaks.

Long-Term Treatment: Practica formally end after the spring exam period, and it is expected that many practicum cases will be completed by that time. However, the PCC office remains open and treatment of some clients continues beyond that time. Ideally, the need for long-term treatment would be apparent from the beginning, so that appropriate assignments could be made. However, when this is not a possibility, arrangements can be made in one of the following manner...with the understanding that clinically, terminations, with the option to return most times work more effectively than transfers. The following options should be explored with the supervisor and clinic director.

1. When transfer seems absolutely necessary, the case can be transferred from the p to a therapist and supervisor who can make a long-term commitment;
2. The case can be transferred to a new therapist and/or modality to begin at the beginning of the fall semester.
3. The therapist may continue with the client following the end of the practicum if arrangements are made for long-term supervision (which must be done prior to making such a commitment to the client);
4. Referral can be made to a therapist/agency outside the PCC.

Specialized Clinical Experiences: Cases may be accepted independent of any involvement on a team. These experiences may involve long-term therapy, as well as other kinds of specialized clinical experience. (For example, marital therapy in a year when that practicum is not being offered; short-term individual treatment for those not on an individual therapy team). Such arrangements are subject to the availability of appropriate cases and supervisors.

Establishing Fees

It has been demonstrated that payment of an equitable fee is part of the therapeutic process. The client needs to complete and fulfill a contract, based upon economic abilities.

In the PCC, there is a \$25 fee for the intake session. The standard fee for individual psychotherapy session provided by a graduate student is \$55 per session, although this fee can be reduced by the intake worker according to a sliding scale (i.e. Appendix: Fee Schedule) for those clients with no reimbursable insurance and more limited financial means. Fees may be reduced below what the scale specifies only with the approval of the Clinic Director and student's supervisor. If a client has insurance, the fee will be the typical amount of their co-payment, although their insurance company will not be billed.

***There is no session fee for URI undergraduate students.**

If the client describes difficulty in meeting the specified fee, state that you will take this up with the Director. Similarly, should an ongoing client describe a change in financial circumstances and request a change in the fee, the therapist should discuss this matter with the Director. The fee scale ranges from \$10 to \$55 per session; the majority of clients have fees in the \$15-\$20 per session range. The minimum fee is \$10 per session.

Consultation with the psychiatric consultant, Sharon DeLuca, MS, RN, CS, is considered an additional session; the regular session fee is charged. The therapist is responsible for collecting the fee.

Fees for group psychotherapy sessions are set at one half the fee for individual sessions, with \$10 per session as the minimum fee. For clients (or families) who are receiving multiple types of services (e.g., individual and marital therapy) simultaneously (e.g., more than one session per week), they will be charged their regular fee for the first service and 50% for each additional service.

Collecting Fees

Fees are charged on a per session basis, and are collected by the therapist after each session. Checks or money orders should be **made payable to "University of Rhode Island."** If paying by cash, the payment is placed in an envelope with the date, name of the client, initials of the clinician, and payment amount written on it. Cash envelopes and checks should be deposited in the safe in the PCC Office. The clinician provides the client with a dated and signed receipt of payment from the receipt book. Clients are charged the full fee for missed sessions unless 24 hour notice is provided. Conversely, if a therapist misses a session without giving 24 hours notice, the client may receive a credit for 1 free session (discuss this policy with your supervisor first).

The importance of collecting clients fees and recording client contact in the receipt book and in the log in front of each file cannot be overemphasized. Revenues from clients are used as demonstration that the PCC is fulfilling its mission and deserves appropriate space, work-study student support, and so on. Every client session must be recorded in the Client

Receipt Book, regardless of the fee charged. **Even if a client does not pay for a session**, a receipt must be filled out, recording "zero" payment.

Non-Payment of Fees

Nonpayment of fees is an important issue both clinically and financially. If a client goes for two weeks without paying for services, raise it during a session and explore why. If he/she believes the fee is too high, discuss it with the Director and your supervisor, and explore the likelihood of financial hardship versus lack of commitment. If the client refuses to pay, discuss the implications with your supervisor and inform the Director of how you propose to manage the issue.

Since PCC staff therapists are not licensed psychologists, they are generally not able to bill third party insurers for the services provided.

HOW TO WRITE A RECEIPT (see Appendix XX)

1. Get receipt book from top right-hand drawer of the extra desk in Jean's office
2. Record the following information:
 - Client's full name
 - Type of treatment (individual, child, family, intake, etc.)
 - Amount due (in 2 places)
 - Amount paid
 - Balance due
 - Form of payment (cash, check)
 - Sign it LEGIBLY!
3. Offer the client a copy of the receipt.
4. Put receipt book back in the drawer

Quick Overview of Billing and Payment:

1. The intake fee is \$25.00.
2. Per session fee is determined by sliding scale, and set at the intake.
3. Session fee is collected, recorded in receipt book, and deposited after each session in the safe (in an envelope if cash, no envelope if check)(make receipt even if no payment is collected).
4. "24 Hour Cancellation Rule" of payment is maintained.
5. An additional session fee is charged for consultation with psychiatric consultant.
6. 1/2 session fee is charged for any other additional services.

7. Fee changes are cleared through the Director.

Assessment Fees

There is an initial intake interview fee of \$25. A complete psychoeducational evaluation, including consultation with parents and appropriate school or clinic personnel, is provided on a sliding scale basis:

For those with an income of 0 – 18,999/year	\$100.00
For those with an income of 19,000 – 29,000/year	\$200.00
For those with an income of 30,000 – 39,000/year	\$300.00
For those with an income of 40,000 or more/year	\$400.00

The clinician is also responsible for collecting the \$25 intake fee during the first session and the remaining balance before or during the final testing session, and BEFORE the out-take appointment is SCHEDULED Receipts MUST be provided upon collection of fees, as explained in the preceding section.

PART IV: MAINTAINING AND PROTECTING CLIENT RECORDS

Philosophy Regarding Record Keeping in the PCC

In the process of seeing a client, the therapist must come to terms with several compelling but potentially conflicting requirements with regard to charting. The therapist may at various times be told to use the chart as a device to clarify his/her thinking about the treatment process, to document the standard of care in a way that will hold up to legal scrutiny, and yet to avoid inclusion of information potentially damaging to the client. Listed below are the current forms and some principles to be followed in completing charts within the PCC.

Intake interview summaries, treatment plans and session notes should serve as a catalyst for helping you to think about the case. They should help you summarize what's happened, clarify where you're going, and point out whether the treatment plan you've laid out is going as expected. The intake summary should be comprehensive enough to clearly define the client's need for therapy and to indicate a reasonably definite course of treatment. The treatment plan should be specific enough to guide the therapist directly toward stated goals and to give a clear indication of when treatment might be terminated. The session notes serve as a record of the therapy to which the therapist can refer when evaluating the course of treatment. **Clear** and **concise** session notes are especially important since completion of the termination summary may occur a year or more after the therapy has begun.

Charts should provide enough information so that a different therapist or a consultant can review the case in your absence and have a good idea of why you were treating the client, how you tried to help them, and how successful you were. Clear and concise records are important since they are also read by colleagues who see your clients while you are away on vacation or to whom you have referred your client for further treatment. We continually get requests from hospitals and clinics that are treating people who were seen here years ago. The intake summary, treatment plan, notes and termination summary provide a clinician with important information about what was helpful or not in your work with a client long after you are gone.

You must construct this record in a way that its public disclosure (or disclosure to the client) would not be unnecessarily damaging. Although records for medical and psychological treatment are supposed to be confidential, there are many avenues by which they can become public information. Insurance companies may require the client to release information from the chart before they will pay for the services rendered, and subpoenaed psychological testimony has become fairly commonplace in the courts in both civil and criminal cases. In order to function smoothly, clinics and hospitals must allow client information to pass through the hands of many others who are not directly involved in treatment. Clerical staff and all others who have access to the clients' charts are also supposed to maintain confidentiality. Although this is generally the case, there is always the possibility that it will be released intentionally or by mistake. For these reasons, careful consideration should be given to the quality and extent of the information that you put into the clients' charts. The stigma associated with psychological problems is still a significant threat to employment in some professions. Although educating the public has reduced this prejudice, respecting the client's right to privacy remains essential for the secure client-therapist relationship that psychotherapy requires.

Only information that is necessary for diagnosis and treatment should be put into the chart. Only information which is demonstrably related to the solution of the client's problem should be received, recorded, or released. The proper names of third parties should not be mentioned in the record unless absolutely necessary. Caution should be taken to focus upon the client's concern in the relationship rather than to provide explicit details of the other party/parties' involvement in the relationship. Knowledge about family and personal relations should be alluded to in general terms unless more specific information is essential to the therapy and for future treatment. Details about personal, sexual, possible criminal behavior, and other very sensitive areas are best omitted unless there is a compelling reason to document them. Since the chart is a record of the treatment, **it is not a good idea to use session notes to record and remind yourself of your speculations following a therapy session.** If you feel speculation, such as an alternative diagnosis, should appear in an intake or a session note, it should be with the intent of following it up with an assessment or an intervention and, finally, a concluding statement regarding the accuracy of your speculation.

The charts should document that reasonable standards of care have been followed. In order to protect oneself (and the PCC) from malpractice litigation, it is important to document the quality of care that is being provided.

Rather than being an afterthought to treatment, one's approach to record keeping reflects the values one holds about the treatment process. Developing logical and specific treatment plans and writing timely session notes suggest a thoughtfulness and seriousness in trying to understand what's happening in therapy. If someone is letting record keeping slide because of conflicting demands, it is also likely that not much planning is being put into the case outside of the actual sessions themselves. Similarly, therapists who take the care to avoid documenting unnecessary or speculative material that could in some way be damaging to the clients are showing respect for the clients with whom they're working. Thus, the staff and supervisors within the PCC view therapists' style of record keeping as revealing quite a bit about their values and approach as therapists.

Maintaining Client Files

ALL files must be kept in PCC **at all times**. Files should always be up-to-date and orderly, so that in the event of an emergency, any qualified professional could use the file to guide them in an appropriate interaction.

For those clients in multiple treatment modalities (i.e., individual and marital), separate charts must be kept for each modality; material from one cannot be confounded with material from another. This is a crucial matter of confidentiality. For example, if a client's individual and marital session notes were in the same chart, the subpoena by a spouse for marital treatment records would also reveal individual treatment material. Additionally, each separate chart must contain appropriate signed consent forms.

The clinician is responsible for maintaining accurate and comprehensive records once they have been assigned the case.

1. **Client Contact Log** - Record all contacts with client (i.e. phone calls, sessions) and also all collateral contacts (i.e. consultation with psychiatrist or external agency). This allows the secretary to straighten out billing problems and gives another therapist a quick overview of client treatment.
2. **Intake Summary** - A rough draft (3 pg. form) should be in the file within one week following the intake, and a copy should be provided to the supervisor. **Supervisors are expected to provide feedback within one week of receiving the draft** (i.e., two weeks of the Intake appointment). Thus a final copy should be completed within three weeks of the final intake session. The summary includes basic demographic data, a description of the presenting problem and the therapist's formulation and diagnosis. (See example in the Appendix).
3. **Diagnosis and Treatment Plan** – The therapist should complete this form shortly after the Intake appointment, during consultation with his/her supervisor. This entails you complete the 5 Axis DSM-IV diagnosis as well as some preliminary treatment goals. Although the treatment plan may change over the course of treatment, the specification of written goals at the outset is useful in formulating a plan of action and in assessing client progress over time. (See example in the **Appendix**).

Generally, the treatment plan is a dynamic document, in that new goals and new approaches to the treatment will lead to statements or addenda to the original document. When this happens, the treatment plan in the client's file should be modified to reflect changes. Fill out the Change in Diagnosis and/ Treatment form.

4. **Session Notes** (see **Appendix**) - Complete a Client Contact Form after each session and have it signed by your supervisor. Each client contact note must be completed “in a timely manner” – typically the same day as the contact and no more than 48 hours after the contact. Notes must be turned into the supervisor at the next supervision meeting after the session. The supervisor is expected to return the note with feedback (if necessary) by

the next supervision meeting (i.e., within one week of receiving the draft). Thus the final draft of the note should be completed and signed by the third supervision meeting (at the latest) after the session. Once your supervisor signs the Contact Form, file it immediately in the client binder kept in the file room.

Every contact with the client should be documented in the chart. Contacts include not only sessions, but also significant telephone contacts and letters. These records must be kept up to date. Such notes are particularly important in the event of an emergency during the clinician's absence. *Note: If the assigned therapist is NOT conducting the Intake (e.g., the Intake Team is running), the Intake clinician should complete a session note immediately after the Intake summarizing the important points of the case.*

Content of a contact note:

- This will depend in part on the orientation of your clinical supervisor. **If there is any sort of crisis or potential crisis (such as suicidal ideation in the client), the documentation must be especially thorough.**
- It is legitimate to include a note on consultation with supervisors or other people potentially involved in the case. It is also legitimate to add an addendum to client contact notes, if upon reflection of a session you decide on a different interpretation of the data. Such an addendum should be added as a regular progress note, but should be clearly labeled as an addendum.
- It is also permissible to add a progress note after a supervision session. You should definitely document a supervision session in the file if the result of the supervision session is to change a policy, treatment plan, or clinical approach.

A good way to maintain the kind of quality that should be a part of a client contact note is to imagine that if something were to go wrong with the case and, as a result, your professional competence is being questioned in a courtroom. The quality of care provided to a client will be judged almost entirely on the basis of the client contact notes and Intake or Termination Summaries.

It is strongly recommended that the following information be included in client contact notes:

- * **Data** - behavioral (including people present), affective, systemic, or historical data, which is relevant to treatment planning.
- * **Assessment** - interpretation/clinical understanding of above data in context of treatment.
- * **Plan** - short and long term directions/goals/homework.

It is required that each client contact note be:

- * dated
- * signed by the therapist and supervisor

It is recommended that the following be avoided:

- * Speculations, impressions, hunches and names of third parties

5. **Termination Form (blue)**- As soon as you decide to close a case, please fill out the colored Termination Form and **return it to the clinic assistant**. The form asks the date

of the last session, the number of sessions, and the type of termination. Please fill this out promptly, since it is the only means of knowing quickly which cases are active and which are closed.

6. **Initial Psychiatric Consult Form (pink)** – When a therapist refers a client to the Psychiatric Consultation, he/she must complete the top portion of this form documenting referral information. In cases where a client is receiving medication prescribed by the PCC Psychiatric Consultant, the name of the medication along with the dosage must be recorded as well as other relevant information. It is also important to record other medications that the client is taking. The

7. **Termination Summary** - Therapists are expected to submit a draft of the discharge summary at the next supervision meeting after termination with the client. The supervisor should return this draft with feedback at the following supervision meeting (i.e., within one week of receiving it). Thus the final draft should be completed and signed by the third supervision meeting after the client terminated. It is important that termination reports be done in a timely manner, since, **until a case is officially terminated, the therapist and clinic retains liability for the treatment of the client.** The termination note includes basic client demographic data, the nature of the presenting problem, duration and intensity of treatment, course of treatment, outcome, plan for referral, and final recommendation. **It is particularly important that this summary be done with care; it is often the part of the client's record that is sent out to other agencies in response to requests for information.**

General Points for Record Keeping

In updating client charts in the clinic, the therapists should keep the following points in mind:

1. Staff members should complete all chart work at the clinic, and Intake summaries should ALWAYS be completed in the clinic due to the need to include the measures completed by the client.
 - Notes that are written electronically can have **no identifying information** until it is ready to be printed for signature (i.e., final draft). (*Only include the client ID #.*)
2. Charts are **NOT** to be removed from the clinic **UNDER ANY CIRCUMSTANCES. BY ANYONE,.....THERAPIST or SUPERVISOR**
 - If you have supervision in the PCC, you should leave notes in the supervisor's folder in Jean's office (behind the door) between supervision meetings.
 - If you have an outside supervisor, write client contact notes without identifying information, have your supervisor sign them, and then add identification information and insert into chart.
3. All charts should be kept in the locked file cabinets in room #152.
4. Each chart entry must be signed by therapist and supervisor, dated (year too), and have the client's name on it.
5. Supervisors must co-sign Contact Notes, Intake Summaries, Diagnoses and Treatment Plans, Termination Summaries and any correspondence related to the client.
6. Paperwork must be completed by the first supervision meeting following the session. **Timely completion of paperwork is necessary for satisfactory evaluations and continuation in the program.**

We have occasionally received subpoenas ordering us to present the records of former PCC clients in a court proceeding. Once a subpoena is received, the existing record cannot be altered. The former PCC therapist can also be subpoenaed, and can be put in the position of defending statements made (or not made) in the record. Therefore, therapists should avoid the tendency to give record-keeping a low priority. In addition, it is prudent for therapists to be succinct and complete in documenting treatment, and careful to avoid potentially damaging information that is superfluous to the case or speculative statements that one would have a difficult time justifying in front of colleagues or in court.

Client folders at the PCC are reviewed on a regular basis to ensure that procedures and policies of the Center are being implemented and that record keeping in charts reflects a high level of professional standards. Since record-keeping is an important activity of a professional psychologist, supervisors will be informed when records are incomplete or deficient.

Continued delinquencies in record-keeping can result in a student being assigned an

"Incomplete" or an "Unsatisfactory" for the practicum course. In addition, a student may not be approved to apply for internship unless all PCC paperwork is up-to-date.

Transferring a Client

When a therapist wishes to transfer a client, he/she should inform the PCC Assistant of the need to transfer. The PCC Assistant will then pass the name on to the appropriate team and therapist. The therapist who is accepting the case should schedule the first meeting with the transferred client; complete a Client Contact form noting that the client is a transfer and fill out a **Transfer Client Record form**.

The former therapist must complete a **Transfer Summary** *within two weeks* of the last session. As soon as a first draft is completed, it should be placed in the client file while a copy is being reviewed by the supervisor.

Internal Referrals

In the past, cases have been referred from Assessment teams to treatment teams, and vice versa, when the teams handling those cases felt that different or additional services were needed. When making a referral, the team initiating the referral will fill out an internal referral form and present the case to the receiving team. The receiving team should complete the Internal Referral Form. The receiving team (and supervisor) will then decide whether the case is appropriate for them.

Termination

Each stage of therapy has important ramifications for the client's motivation, growth and self-esteem. Termination, although an ending of therapy, is a part of the development of the therapeutic relationship.

Premature Termination: When a client stops coming to therapy without an agreement between the therapist and client. This can happen at any point after the intake interview. A client who misses more than two sessions without notifying the therapist should be seen as initiating a premature termination.

The following protocol must be followed in the event of a Premature Termination:

1. A notation must be made in the Client Contact Log of missed sessions and of any attempts to contact the client to reschedule
2. A letter must be sent to the client stating the assumption that the client has decided to end therapy or has sought help elsewhere and that the client's case will be closed if he/she fails to contact the center within 10 days
3. Copies of the letter should be put in the client's file along with the termination report

Client chooses to terminate: It may or may not be at a time when the therapist feels it is in the best interest of the client. The client's decision to terminate is a response to therapy and therefore can be handled like any other therapy material. It is important to try to get the client to come in for a final session after the client has announced his/her intention to quit, so that you can discuss the reasons leading to the decision, the course of therapy and any relevant referrals.

It is important for the therapist to work through any of his or her own feelings about the termination (e.g., anger, sense of failure, betrayal, loss, relief, etc.) before meeting with the client. Supervision is a good time to discuss any of these issues.

Mutually agreed upon termination: Occurs when client and therapist agree that the client has achieved his/her goals. There may be a bittersweet element to the ending of a good therapy relationship. It is important to try to make the "good-byes" part of therapy. As in all other elements of therapy, this may provide the client with a model for handling a significant aspect of other relationships. The way that termination is handled may reflect to the client a larger picture and understanding of the professionalism of the mental health field and of therapy, helping the client seek and use therapy better in the future, if the need arises.

A case is considered terminated when there is no longer any regular sustained contact following a specified treatment plan. **Therapists should avoid keeping cases with little or no contact open indefinitely in the hopes that the client re-engages.** To do so leaves the therapist and clinic open to questions regarding their professional responsibility were the client to engage in self-destructive behavior during this period. **As long as the case remains open, the therapist implies that his/her professional obligation to the client is still in effect.**

The following protocol must be followed:

1. Termination Form must be completed and placed in the client's binder. As soon as a first draft of the Termination Summary is complete, it should be placed in the chart while a copy is being reviewed by the supervisor. A final report, including signatures, should be in the client records within three weeks of the last therapy session with a client (see prior description of the timeline in the "Maintaining Client Files") It should be clear and complete enough to serve as a complete summary of the case should a report of services be needed by another agency.

PART V: ONGOING CASE MANAGEMENT ISSUES

Confidentiality

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

During the intake interview, clients will be advised of their rights and of the conditions under which confidentiality can be assured. The therapist should also outline some of the conditions under which confidentiality will be violated. Some of the exceptions include:

1. when the client is dangerous to himself/herself, either because of inability to care for himself/herself, or suicidal risk
2. when the client represents a danger to others
3. when there is suspicion of child abuse

Additional detail is provided under the sections on "Assessing/Reporting Child Abuse and Neglect" and "Clinical Emergencies."

If a staff member wishes to consult with a teacher, counselor, social worker, or other person associated with the client, a Release of Information must be signed by the client(s) before such contacts can be made. The release form must be dated and have a date of expiration, and should state as specifically as possible what information is requested and why the information is needed. The client must sign a separate release for each person contacted. Similarly, staff therapists should not release information to those requesting information about clients unless the staff therapists have a copy of the signed Release of Information in their hands.

When a situation arises where a letter of summary concerning a client needs to be mailed, the Director of the PCC or Team Supervisor should be consulted. Letters must be countersigned by one of these individuals.

It is part of the training process for staff therapists to spend considerable time discussing cases with each other. However, cases are not to be discussed with colleagues where the possibility exists of being overheard. Therapists should exercise special care in Chafee Hall, where non-PCC staff members and other students may inadvertently wander into PCC space. Equally important, it is inappropriate to discuss identifiable case material at any time with nonprofessionals, including spouse, friends, relatives, and colleagues who are not PCC staff members. Therapists should be aware that client descriptions are much more recognizable here in the "small world" atmosphere of southern Rhode Island than such descriptions might be in other more urban settings.

All records are confidential. Case folders or any case material bearing identifying information are not to be taken from the PCC. After using a folder at the PCC, return it immediately to the files. These files are locked at all times when not in use. Should records be used for case presentation or research purposes, they are to be carefully edited to guarantee the anonymity and confidentiality of the client. Therapists wishing to retain a work sample (e.g., psychological assessment) with identifying material deleted may do so only with the express permission of the Director and only after this material has been examined personally by the Director. **NOTE: You may not release confidential materials FROM another clinic/agency. When clients sign a release, it is for PCC records ONLY.**

Logistics – Reserving Therapy Rooms, Messages, Phone Protocol

PCC Office (Room 150) contents:

- Center's administrative records, supplies, staff schedule books, room scheduling books, old client files, etc.
- Staff message board, where messages are placed. **Clinician's are professionally responsible for checking in and/or calling frequently to pick up messages.** They should also let the PCC Office Manager know if they are going to be deviating for any extended period from the schedules listed in the Staff Schedule book, so that they can be contacted if necessary. Filling out phone numbers and schedules in the Staff Schedule Book is critical so that you can be contacted in a timely fashion.

Phone:

- A phone is available in room 151 for therapists to make local (i.e., state of RI), PCC-related calls. Please do not use the phone in the main office, since this blocks incoming calls and distracts others trying to work in the office. **Phone is not to be used for personal calls!**

PCC Therapy Rooms:

- PCC therapy rooms designated for use by PCC staff and clients:
 - Rooms 107, 108, 109, 113, 147, 148, 149, and 167
- These rooms must be reserved by signing in the Room Schedule book in PCC office.
 - Please sign in pencil; if there is a cancellation, please remove your name as soon as possible so that the room can be made available for others. As the clinic gets busier, there is increased competition for rooms.
 - Individuals seeing clients have priority over other events (e.g., team meetings)
 - Therapists working with children and families have priority for rooms 107 and 113.
 - Sign out rooms as early as possible. Reserving a room will help the clinician in the event that a client calls the PCC asking about the day or time of his/her appointment.
 - Room 107 is considered the "Child Therapy" room. It houses a closet accessible by office key, which contains toys for use in therapy. All games and toys must be returned to the closet at the end of the session.

- To ensure a presentable and comfortable environment, it is important that all staff take time to leave the rooms neat, clean, and furnished appropriately. Please do not remove or switch chairs and tables from these rooms. If you must move furniture for a session, please **return it to its proper place** at the end of the session.
- If any room seems in need of cleaning or replacement of light bulbs inform the PCC secretary, and she will inform the janitorial staff. Since there is usually a delay in cleaning after a request, cleaning materials are available in the PCC secretary's office for staff use.
- Always double check to make sure that **all rooms are locked** when you leave, the lights are turned off, and the “In session” sign is removed. *Moreover, when leaving the PCC, always make sure that all doors are closed , especially at night. When in doubt, close and lock all doors behind you in order to protect client confidentiality.*

*All new PCC students should obtain keys from the PCC Secretary to allow them to enter the PCC office and therapy rooms.

*The PCC is a no smoking area, consistent with University policy. Given the sometimes poor air circulation in the rooms, staff should be especially sensitive to making sure that no smoking takes place.

***DO NOT "hang out" in room 150** ...use the student lounge or kitchen area for this purpose.

***DO NOT bring clients into 150, to avoid their exposure to confidential material.**

Observation and Client Video Taping

At the time of the initial intake (and also, during the initial telephone contact) clients are informed that the PCC is a training clinic and that they can expect to be audio recorded, observed by supervisors and team members, and possibly videotaped. Most people are initially somewhat uncomfortable, but as the therapeutic relationship is established, the issue of observation becomes less important. The therapist should feel free to show the client the observation rooms and introduce him/her to the observers, if the client wishes, and the therapist feels that this will be beneficial.

Wireless Intercoms:

All therapy rooms are set up to facilitate observation. Most rooms have wireless intercoms. In order for them to work, the intercom within the therapy room must be turned on first, before the intercom in the observation room. The easiest way to ensure that this happens is to leave the intercoms in the therapy rooms on all the time and only turn the ones in the observation rooms on and off. When they are working properly, the intercom in the therapy room should have a light on next to “transmit” and the one in the observation room should have a light on next to “receive.” If the intercom in the therapy room gets turned off, turn it on and press “lock” when it is set to transmit. If you have any questions, concerns, or problems, please see PCC staff.

Video Recording: Rooms 107, 109, 113, 147, and 149 have brand new digital equipment for recording purposes and are ready to be used. **In order to use this equipment, students and staff must be trained by one of the PCC staff before using it.** Instructions are posted and also included in this manual (see Appendix XX) Under no circumstances is anyone authorized to change the plugs around or from one machine to another. **DO NOT TRY TO FIX IT YOURSELF; if something is not working please see one of the Assistants, the Director, or Jean. The equipment is BRAND NEW; DO NOT TRY TO FIGURE IT OUT YOURSELF...ASK FOR HELP**

Case Responsibility

Once a supervisor accepts a case for assignment to a team member, the supervisor is responsible for overseeing the quality of care that is provided and has ultimate clinical responsibility for the case. Staff therapists have the responsibility to meet regularly with their supervisors and make sure supervisors are clearly informed about the progress of each case. The PCC Director ensures that the overall training and service goals of the PCC are met (e.g., adequate supervisory resources are available, PCC policies are followed, alternative procedures/ policies for service and training are reviewed).

Practica: Students taking practica at the PCC for academic credit are required to devote time each week to providing direct services to clients, attending the weekly staff meeting (PCC Meeting), attending supervision, participating in informal peer supervision, observing others/ being observed, maintaining client records, and doing whatever other preparation is necessary. Practicum students in direct service teams are expected to carry an average of two hours of direct contact at any given time. Less experienced first year students who are not assigned cases are expected to attend staff meetings and are encouraged to spend at least 1 hour a week observing clinical work. The Clinic Assistant and Director will assist in arranging observation opportunities.

PCC Meetings: All first and second clinical practicum students are required to set aside 3:00 to 4:30 on Thursday afternoons as the regular PCC staff meeting time during the academic year. **More advanced students are required to attend PCC meetings from 3-3:30** in order to be informed re ongoing clinic practice issues. Attendance at the weekly PCC staff meeting is mandatory because this is the only opportunity for the entire PCC staff to present cases, discuss policies or problems, and hear outside speakers.

Schedule Sheets: Schedule sheets are distributed at the beginning of each semester. Staff therapists **MUST** keep these schedules current, so that they can be contacted should an emergency arise.

Malpractice and Professional Liability

Are students likely to be sued for malpractice? Although this has not happened to a PCC staff member thus far, you should be aware of several facts. First, the number of lawsuits against psychologists is increasing. This trend is likely to continue, given the increasing activism of mental health consumers, the changing expectations of the courts regarding mental health

professionals' legal obligation to act in the "public interest" (e.g., prediction of dangerousness, warning of intended victims, reporting of suspected child abuse), and the continuing litigiousness of society in general. Second, one's status as a student trainee supervised by a licensed psychologist does not provide protection from a malpractice lawsuit. It is common legal practice to sue all parties involved in a case (e.g., therapist, supervisor and head of the agency). The best defense is (1) to be able to document thoroughly that the treatment met reasonable, professional standards, and (2) to make sure that one's activities are covered through liability coverage.

Student Liability Insurance: All students/ staff seeing clients for treatment or assessments in the PCC are required to obtain student liability insurance which can be obtained through APA Insurance Trust or the American Professional Agency. Insurance rates range from \$19 to \$45 for a calendar year's coverage. Information is available from the Clinic Assistant. Students are asked to submit copies of the first page of the approved insurance policy to the Clinic Assistant. **Students are NOT allowed to see clients without evidence of insurance.**

Dress Code and Professional Conduct

How those from our program represent themselves in the professional world is obviously an area of concern for the program, both in terms of how the program is viewed, and in terms of how different clients from a variety of cultural backgrounds may experience your presentation.

What is expected may differ from setting to setting, with some settings necessitating more formality, however, the overall expectation is that one's appearance be clean, neat, and in non revealing, non-sexualized (no excessively tight clothing, no plunging necklines or visible underwear) – basically, business casual. Students are expected to dress appropriately and to comport themselves in a manner consistent with the location and nature of their activities. *It is strongly recommended that students keep "business attire" clothes in their office or car, in the event of inclement weather, forgetting an appointment, and/or any other unexpected events.*

When interacting with patients, families, and health care professionals, the following is expected:

- Be professional in appearance, both in dress and conduct
- Students must be physically clean, well groomed, and neat.
- Inappropriately short shorts, blue denim jean pants, and exercise or workout clothing, are not considered appropriate attire
- Tank tops or tops that leave the midriff or back exposed or other clothing that expose undergarments or could be perceived as sexually provocative are inappropriate
- Be punctual and practice professional courtesy when communicating with clients
- Clearly identify him/herself as a student when interacting with the public or with other health professionals

PART VI: RESOURCES FOR RESPONDING TO VARIOUS CLINICAL SITUATIONS

Psychiatric Consultation

The PCC's psychiatric consultant, Sharon DeLuca, MS, RN, CS, is available for 3 hours every other Thursday afternoon during the academic year.

Procedure:

- The **initial appointment** with the psychiatric consultant **requires an hour** and the therapist must also attend this appointment. Therapists may schedule their client to meet with the psychiatric consultant by writing in an appointment in Sharon's schedule book in Room 150.
- Once the therapist has scheduled a client to see the psychiatric consultant, he/ she should complete the Initial Psychiatric Consult referral information which states the purpose of the consultation, outline the referral questions for the psychiatric consultant, and put this in white schedule folder for the psychiatric consultant.
- The therapist is expected to be available to sit in on the consultation and to discuss the situation afterward with the psychiatric consultant. The client is charged an additional fee for the psychiatric consultation, equivalent to the cost of one therapy session. Student therapists are responsible for collecting this fee.
- Subsequent appointments are 1/2 hour in length. Typically, PCC clients are referred for medication evaluation and diagnostic questions. However, students should also feel free to use the psychiatric consultant's time to consult on difficult cases or to discuss more general therapeutic issues.

Assessing and Reporting Child Abuse and Neglect

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

It is important that you make clear to the family your own position and responsibilities. PCC clients are informed at the time of intake of our limits of confidentiality, especially in regard to situations of suspected abuse and neglect of children. If you are beginning to touch upon an area in which abuse or neglect may arise, you should remind the client of the seriousness with which we must regard such incidents and the limits of confidentiality. Should it become necessary to make a report, you should share your concerns and discuss openly the ramifications of mandatory reporting with your client prior to the actual report. You should emphasize that a mandate of DCYF is to provide assistance to families, and that you can serve as an advocate for the family both with DCYF and with regard to the problems requiring attention. Finally, you should encourage the client to make

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

If in doubt about the disposition of a situation of suspected abuse or neglect, consult your supervisor. In addition, DCYF both encourages and supports your consultation and inquiry prior to making a report to their Department. **Immediately follow up any telephone report with a brief written report to DCYF.**

Clinical Emergencies

The PCC generally does not accept clients who are in acute crisis or need the availability of a 24-hour emergency response. The PCC does not have a 24-hour phone line through which emergency calls can be received and immediately relayed to therapists. However, it does sometimes occur that ongoing clients experience stressful events that put them in crisis, and some PCC clients have required hospitalization in the past. Some guidelines for emergency and crisis situations follow.

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

- 1) More frequent therapy sessions,
- 2) More frequent phone contact,
- 3) More directive action by the therapist to reduce stress
- 4) Contracts with the client not to take self-destructive action until further options are tried, and so on. In particular, the therapist should arrange a psychiatric consultation for with Sharon DeLuca, MS, RN, CS.

If a therapist suspects that he/ she might need consultation during a therapy session, he/ she should arrange **beforehand** to have a supervisor accessible in person or by phone.

Because it is impossible to anticipate all possible emergency situations, it is **strongly advised** that student therapists arrange that their sessions be observed by others on a routine basis.

Assessing the Need for Hospitalization. When a therapist believes the client to be a danger to him/ herself or others, it is time to seriously consider hospitalization. The following procedures should be used:

- 1) The usual professional standards of confidentiality do not remain in cases where the therapist believes that there is a real danger to the individual or others. If the client is in a therapy session when a suicidal threat is made, make a clear statement that you want the client to live and that your primary concern is to see that he/ she is safe, and consequently you may have to break confidentiality to achieve this. Likewise, if the client seriously threatens another individual, state that you are obligated to take actions to protect the other person.

- 2) **While your client is still in the office**, contact your supervisor and discuss the situation with him/ her. If the supervisor is unavailable, the therapist should try contacting those individuals who have been involved with the case. This could include the psychiatric consultant, the Director, or other PCC supervisors. With supervision, make a decision as to whether hospitalization is appropriate.
- 3) Ask the client about his/her insurance coverage and number. Whether or not the client is insured affects the type of hospital into which he or she can be admitted. However, all hospitals are obligated to see anyone if they are brought to the ER.
- 4) If the decision is made to hospitalize, and the client will **voluntarily** admit himself/ herself and has insurance, then try to get family members involved in admitting them to the hospital (e.g., Butler, Fuller, Rhode Island Hospital, etc.).

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

- 5) In terms of transportation, try to secure the client's permission to contact his/ her parent(s), spouse, or any other responsible, significant other who can transport the client. If possible, have the significant other come and take responsibility for transporting the client to the hospital. If this is not possible, call the campus police. Tell them what the problem is and let them provide the ride, or have them contact the ambulance service for assistance. Do not drive the patient yourself.
- 6) If the decision is made to hospitalize, and the client will not voluntarily admit himself/ herself, then arrangements must be made for an **involuntary admission**. Contact South Shore Emergency Services (789-3545) or call the campus police (4-2121) and let them arrange to transport the client to a facility where he/ she can be evaluated. Since most of the clients in the PCC do not have insurance, this will typically mean an evaluation by a crisis intervention specialist at one of the community mental health centers or a local hospital's Emergency Department.
- 7) Once a decision has been made to hospitalize and arrangements have been made for hospitalization, the therapist should continue to call his/ her supervisor **and** the clinic Director to inform them about the progression of the case.
- 8) The therapist may or may not choose to go to the hospital, depending upon the clinical situation. In any case, the therapist should make himself/ herself available to talk with the admitting physician and/ or members of the family. You can give the clinic number and your name as the therapist, to the family member to give to the hospital/-admitting psychiatrist to facilitate hospitalization and discharge planning. You can also call the hospital to inform them about the client coming in to facilitate the admission process for the client and his/ her family.

APPENDICES

**APPENDIX A:
FEE SCHEDULE**

Date of Intake: _____ Clinician: _____
 Client Name: _____ Supervisor: _____
 Client ID #: _____ Team: _____

The standard fee for therapy sessions is \$55 per session. For clients who have no insurance, and who feel that this fee is a financial burden, the clinician can reduce the fee according to the sliding scale below. If clients wish to reduce the fee beyond this, the therapist must consult with the PCC Director.

Please circle the weekly session fee that your client will pay.

<u>Annual Income</u>	<u>Number of Dependents in Household</u>			
	0	1	2	3
0- 9,999	\$10	10	10	10
10,000-12,999	15	13	11	10
13,000-15,999	19	17	15	13
16,000-18,999	23	21	19	17
19,000-21,999	27	25	23	21
22,000-24,999	31	29	27	25
25,000-29,999	35	33	31	29
30,000-34,999	39	37	35	33
35,000-39,999	43	41	39	37
40,000-44,999	45	43	41	39
45,000-49,999	50	48	46	44
50,000-and up	55	53	51	49

Insurance

If a client has insurance, he/she may pay a fee equivalent to whatever the co-pay would be were they to see a clinician who accepted their insurance, *even though we will still not process through their insurance.*

Please record the fee that the client will pay here: _____

Intake Interview is always \$25.00.

**APPENDIX B:
AREA RESOURCES FOR CLIENTS**

One of the therapist's responsibilities is to help the client develop a support system for crisis periods, stressful events, and personal growth. In particular, some of the following resources are ones that, with adequate preparation, can be used by the client at times when the therapist may be unavailable. Some important resources include:

AA (Alcoholics Anonymous) Central Service Committee live help 9:30-4:00 M-F, answering service nights and weekends	1-800-439-8860	
Alcohol 24-hour Helpline	1-800-252-6465	
Gay / Lesbian/ Bisexual/ Transgender Helpline of RI 7-10 PM	751-3322	
Sexual Assault and Trauma Resource Center of RI 24-hour helpline in English and Spanish	421-4100	
National Suicide Prevention Lifeline	1-800-273-8255	
Samaritans of Rhode Island 24-hour helpline for individuals feeling distressed or suicidal	272-4044	
South County Hospital Emergency Room	782-8010	
South Shore Mental Health Center/ Emergency Services (general mental health emergency services) 24-hour hotline	364-7705	
Phoenix House of New England (National number)	1-800-378-4435	
Sympatico / Marathon House 24-hour help for substance abuse	539-7474	
URI Chaplain	874-2324 (Catholic) 874-2740 (Jewish) 874-2739 (Episcopal) 874-4784(Protestant)	
Domestic Violence Resource Center 24-hour hotline	782-3990 or 866-782-3990	1-

A wide variety of support groups and services in Rhode Island address issues such as eating disorders, caregiving, bereavement, single parenting, and youth problems. Please see the PCC director or assistant if you would like to learn more about support resources available to your clients.

**APPENDIX C:
AREA HOSPITALS AND MENTAL HEALTH CLINICS**

Bradley Hospital - Providence, RI 434-3400

Butler Hospital - Providence, RI 456-3710

Community Counseling Center - Pawtucket, RI 722-5573

East Bay Mental Health Center - Barrington, RI 246-1195

Fuller Memorial Hospital - South Attleboro, MA 761-8500

Institute of Mental Health - Cranston, RI 464-1000

Kent County Mental Health Center - Warwick, RI 738-4300

Mental Health Services of Cranston, Johnston, and Northwestern RI - Johnston, RI 273-8741 24 hr Emergency number 273-8100

Newport County Community Mental Health Center - Middletown, RI 864-1213

Newport Hospital - Newport, RI 253-4063

Northern Rhode Island Community Mental Health Center - Woonsocket, RI 766-3330
Emergency number 762-1577

Providence Center for Counseling and Psychiatric Services - Providence, RI 274-2500

Rhode Island Hospital - Providence, RI 277-4000

South County Hospital - Wakefield, RI 782-8000

South Shore Mental Health Clinic - Charlestown, RI 364-7705

APPENDIX D: SUGGESTIONS FOR WRITING SESSION NOTES

Probably the most difficult skill to develop when learning to write a session note is keeping the note brief. The second most difficult skill is writing clearly and concisely. The best advice regarding these problems is not to go beyond the space provided in the chart. The general format (three sections of each contact note) to be used is: D (DATA), A (ASSESSMENT) and P (PLAN). A general goal (except in special circumstances of high risk) on which supervisors may differ ...is to keep the note brief...possibly limited to several sentences/section.

Suggestions for the content of the note are:

1. Client name, the date, the session #, and the participants
2. Extent to which the session focused on goals listed in the treatment plan
3. Comments about significant content or processes such as your interventions and the client's reaction to them
4. Client mood and affect
5. Chief complaint for the session and the theme of the session
6. Information that would question, clarify or support the intake diagnosis

Other material that may be important to include:

1. Length of session, if unusual
2. Mental status, if unusual
3. Changes in personal appearance, behavior or quality of speech
4. Significant behavior or events occurring between sessions or otherwise outside of therapy
5. Progress of other treatments or therapies

If you make a statement that is diagnostic in nature (ASSESSMENT) it is important to include observations of behavior and/or events that offer concrete support for your conclusions (DATA) (e.g., if you think that the client is more depressed, what symptoms led you to this conclusion).

Finally, some questions that might be helpful to ask yourself when you are done writing your note:

- * "Would another clinician, who does not know me or the client, understand what happened in this session and why?"
- * "Does the note communicate progress toward known treatment goals?"
- * "Would I want this note read in court?"
- * "Would I want the client to read this note?"
- "Would I want to review a year's worth of session notes written like this one?"

Words of wisdom for completing paperwork in a timely, professional manner: "...delaying gratification is a process of scheduling the pain and pleasure in life in such a way as to enhance the pleasure by meeting and experiencing the pain first and getting it over with. It is the only decent way to live."

M.S. Peck, "The Road Less Traveled"

**APPENDIX E:
GUIDELINES FOR WRITING
INTAKE SUMMARY: BRIEF OUTLINE**

ID NUMBER:

INTERVIEWER:

CLIENT NAME:

SUPERVISOR:

CLIENT ADDRESS:

DATE OF INTERVIEW:

DATE OF REPORT:

CLIENT PHONE NUMBER:

REFERRAL

Description of client: age, ethnicity, marital status and occupation; primary complaint; and relevant details regarding referral process.

PRESENTING PROBLEM

Nature and severity of the presenting problem and the impact on the client's social and occupational functioning.

HISTORY OF PRESENTING PROBLEM

Events surrounding the development of the current episode; long term history of the problem, if any.

PSYCHIATRIC & MEDICAL HISTORY

Previous psychiatric and psychological treatment received, including precipitants and responses to treatment. Also include level of functioning between episodes/treatment.

Medical history, including significant illness and hospitalizations, as well as current medications.

PERSONAL, SOCIAL, & FAMILY HISTORY

Childhood and adolescent development, academic and vocational history, marital and social relationships. Include current living and job situation, especially with regard to stressors and social supports.

For families and couples, describe family constellation and functioning, including alliances and communication patterns.

BEHAVIORAL OBSERVATIONS & MENTAL STATUS

Client's general appearance and behavior (e.g., distracted, nervous, cooperative). Describe mental status of client: mood, affect, thought organization, sensorium, etc.

ASSESSMENT

Summary of results from measures or assessments administered (e.g., BDI, BSI, SCID, BAI).

FORMULATION & DIAGNOSIS

Summary of what you see as the client's central problem; comment specifically on the client's current coping style and adaptive capacities. Provide a DSM-III-R diagnosis, with a code for each axis.

RECOMMENDATIONS

Recommendations for treatment, whether in the PCC or elsewhere. Include specific steps, if any, that need to be taken to resolve disposition of the case.

FEE

Intake fee is always \$25. If Intake conducted by assigned therapist, also discuss the weekly session fee and include it in this section.

SIGNATURES

Signatures of therapist and supervisor.

APPENDIX F:
INTAKE SUMMARY: DETAILED DESCRIPTION

The first purpose of this annotated interview guide is to give you an idea of the general format of the intake report. The numbered statements (capitalized statements) represent the essential ideas about which you should comment. The second purpose of this guide is to provide a checklist of issues that can be used to stimulate your ideas about the case. The remarks following each numbered statement represent examples of the typical kinds of content that you might find important. However, the goal is neither to provide detail on every issue mentioned, nor to report masses of detail for their own sake. The goal is to think through all the detail and put together a coherent picture of the individual that will be useful for those trying to provide treatment. The following outline for doing intakes may be longer than many of the intakes you'll actually be completing.

A. PRESENTING PROBLEM

1. **IDENTIFYING INFORMATION ABOUT THE CLIENT.** This should involve a short descriptive statement regarding client's appearance and present family and living situation (e.g., Mr. X is currently 42 years old, married with two children [ages 5 and 10], but currently separated.) Include age, sex, ethnicity, marital status, occupation, and other relevant demographic data.
2. **STATEMENT OF PROBLEM IN CLIENT'S OWN WORDS.** Try to state complaint in terms of client's own words or his/her own experience of the problem. Also, mention any specific expectations about treatment raised by the client. (Even if the client's description of the problem is vague or misleading, this information is important).
3. **PERTINENT OR UNUSUAL ASPECTS OF REFERRAL PROCESS.** Why is treatment being sought now and why at this particular agency? Include information about unusual aspects of referral process (e.g., court-ordered referral; parents called to make appointment for adult son).

B. HISTORY OF PRESENTING PROBLEM

1. **DETAILED DESCRIPTION OF NATURE AND SEVERITY OF PRESENTING PROBLEM.** Describe symptoms/areas of distress in more detail, mentioning most serious symptoms/problem areas first; if major category of disorder is mentioned (e.g., depression), provide detail as to the specific nature of the disorder (e.g., weight loss, withdrawal from social relationships, etc.). Or, if alcohol abuse is mentioned as a problem, get specific data on frequency, amounts, and timing of alcohol use. Also, comment on the degree to which the presenting problem is causing impairment in social roles and social functioning.
2. **RECENT HISTORY OF THE PRESENTING PROBLEM.** Provide a narrative summary of the current episode of illness/distress, detailing the appearance of the symptoms or problem, changes in the symptoms/problem

over time (e.g., more intense, less intense, increasing cynicism), and any critical factors that seem to precipitate and/or maintain the problem. Describe any concurrent, related life events, and how they relate to the problem.

If psychological/ psychiatric services have been received, they should be mentioned here and detailed in section C.

3. **LONG TERM HISTORY OF THE PROBLEM, IF ANY.** Provide a general summary of all previous episodes of the presenting problem. Has this been a problem in the past? Is this current episode part of a long-standing, chronic or intermittent process? This should include some mention of the typical ways in which the client has tried to handle the problem in the past, and the success of these strategies. Similarly, briefly mention whether there has been treatment for this condition in the past and describe in more detail in Section C.

Describe whether there have been marked changes in the degree of impairment over time. How does the client's present level of functioning compare with his/her poorest and best levels of adaptation?

C. PSYCHIATRIC AND MEDICAL HISTORY

1. **PREVIOUS TREATMENT THAT THE CLIENT HAS RECEIVED.** Provide a more detailed accounting of previous psychological or psychiatric services, if any, with greater attention to more recent episodes. This should include dates, therapist names, locations, major symptoms, major precipitants, treatments (psychotherapy, medication, hospitalization, etc.), the client's responses to treatment and the nature of the terminations of treatment.

Mention members of the client's family of origin who were treated for serious psychological disorder or displayed hints of such disturbance.
2. **SIGNIFICANT MEDICAL EVENTS.** Mention significant hospitalizations or illnesses. Be as specific as possible about types and amounts of medications used.

D. PERSONAL, SOCIAL AND FAMILY HISTORY

1. **CLIENT'S DEVELOPMENTAL YEARS.** Describe in a paragraph the important events of the client's childhood and adolescence. List and describe the members of the client's family of origin and significant family events (e.g. divorce, bankruptcy, death). Comment upon client's biological development, social relationships, academic history; in particular, comment upon the client's ability to form positive and satisfying friendships.
2. **CLIENT'S ADULT HISTORY.** Describe in a paragraph the significant milestones in the client's adult history, including vocational experience, military service, criminal history (if any), substance abuse (if any) intimate

relationships, relationships with family members, and so on. Assess psychosocial stressors, capacity to form close interpersonal relationships, and the client's typical style and overall capacity for adaptation, coping and dealing with adversity.

3. **CLIENT'S CURRENT LIFE SITUATION.** Describe the client's current occupational and relationship situation, psychosocial stressors, adequacy of his/her support systems, and any disparities between vocational aspirations and achievements. Make particular note of any social resources that can be used as assets in treatment.
4. **FUNCTIONING OF FAMILY OR COUPLE.** When describing an intake of a family or a couple, there will be more of a focus on the process of how family members deal with each other and their problems. Some dimensions to consider in assessing family functioning:
 - a. Cohesiveness of the family unit
(e.g., enmeshed, disengaged, balanced)
 - b. Significant subgroup operation
(e.g., scapegoating, alignments of parent-child against other parent).
 - c. Equilibrium-disequilibrium
(i.e., patterns of dominance, role complementarity, leadership: for example, an adolescent overfunctioning as caretaker)
 - d. Patterns of communication and expression of emotion (e.g., open, comfortable, inhibited, blocked, distorted, displaced)
 - e. Integration of family in the community
(e.g., balanced, isolated, overcommitted, nomadic)
 - f. Family tolerance of deviant behavior
5. **ASSESSMENT OF CLIENT'S CAPACITY TO DEAL WITH CURRENT PROBLEM.** In light of the material regarding the client's life history, provide a general assessment of how the balance between the client's psychosocial stressors, support systems, and coping skills influence his/her capacity to deal with the presenting problem.

E. BEHAVIORAL OBSERVATION AND MENTAL STATUS

1. **CLIENT'S GENERAL APPEARANCE AND BEHAVIOR.** Provide brief description of the client's overall appearance and behavior. Did the client's appearance seem to match his/her description of his/her life situation? Did his/her affect seem appropriate given his/her description of the problem (i.e., showing tearfulness or sadness when depression is mentioned as the primary complaint)?
2. **CLIENT'S STYLE OF RELATING TO THE INTERVIEWER.** Comment on client's interpersonal style during the interview (e.g., antagonistic, assertive, withdrawn, dependent, cooperative) and whether the client's level of comfort or discomfort changed as the interview progressed. If there are implications for the client's ability to engage in treatment or for approaches that might engage him/her in treatment, please mention them here or in the formulation section.
3. **MENTAL STATUS OF THE CLIENT.** The aim here is to come up with a summary statement regarding the client's overall level of psychological organization and the intensity of psychological disturbance. A typical mental status exam includes review of the client's appearance and behavior, mood and affect, thought content and processes (e.g., logic of associations, flow of speech, delusions, hallucinations) and intellectual and cognitive organization (e.g., judgment, memory, orientation, comprehension). This statement can be quite brief with relatively well-functioning clients.

F. ASSESSMENT

1. **SUMMARY OF RESULTS.** This should include at least a few of the items or symptoms endorsed by the client for each measure. This could also include the total score for certain measures (i.e., BDI/BAI).

FORMULATION AND DIAGNOSIS

1. **CENTRAL FACTORS CONTRIBUTING TO THE PRESENTING PROBLEM.** Please describe your understanding of the central factors leading to the development, exacerbation, and maintenance of the presenting problem. If some factors seem unclear and/or conflicting, state that.
2. **PROVIDE A DSM-IV DIAGNOSIS; COMPLETE ALL AXES**

G. RECOMMENDATIONS

1. **TREATMENT RECOMMENDATIONS.** Please include recommendations regarding modalities, type and duration of treatment, and any additional kinds of information needed (e.g., medical work-up).

If additional steps are being taken before a disposition of a case can take place, please note this. (For example, if the results of a medical evaluation

are to be obtained and examined before a decision about treatment is made, be clear about who will be doing the follow-up).

H. FEE

1. If the intake is conducted by the assigned therapist, please list the agreed-upon fee. You must discuss this, since some clients' decisions about treatment are influenced by the fee.

I. SIGNATURE

1. Name and signature of interviewer and supervisor must appear at the bottom.

6/92

**APPENDIX G:
SAMPLE INTAKE REPORT**

This Intake Report was constructed using a hypothetical client and family.

CLIENT NAME: Mary Jones	INTERVIEWER: Bill Anderson, MA
CLIENT ID #: 86999	SUPERVISOR: Sally Smith, Ph.D.
CLIENT ADDRESS: 123 Any Street Anytown, RI 02123	DATE OF INTAKE: July 23, 1986
CLIENT PHONE: (H) 999-1234	DATE OF REPORT: August 3, 1986
(W) 999-5678	

REFERRAL PROCESS: This is the first psychotherapy referral for Mrs. Jones, a 45 year-old Irish Catholic woman who works part-time as a bank clerk and lives with her two daughters, Susan and Jane (ages 18 and 23), and a granddaughter, age 3. She was referred by a local clergyman because of depression over a recent marital separation. She hoped that therapy would help her "to not feel so upset and hopeless," and to figure out what to do about her marriage. Her husband refused to accompany her to therapy.

PRESENTING PROBLEM: Mrs. Jones reported that she first began feeling depressed about 5 months ago, when marital problems between she and Mr. Jones increased. About 3 months ago, Mr. Jones announced that he had to get away in order to "think things through," and moved in with a cousin in a neighboring town. Mrs. Jones reported feeling depressed, a loss of appetite, a loss of interest in getting together with friends and occasional difficulty getting to sleep. She denied suicidal ideation, or any attempts to use alcohol or drugs to deal with her depression. She had initially missed several days of work because of her distress, but now felt that she could at least continue with her daily routine. She stated that her depression had become less intense over time because of support from her sister. An additional concern of Mrs. Jones was the "anxiety and panic" that arose whenever she tried to think about confronting her husband regarding a resolution of the situation.

HISTORY OF THE PRESENTING PROBLEM: Mrs. Jones sees her depression as stemming from difficulties with her husband. About 18 months ago, he was laid off from a well-paying engineer's job and forced to take a less prestigious position. As is his style when under stress, he became less communicative, more depressed and more abusive of alcohol. Their relationship suffered as he began staying up late at night, drinking and brooding. About 8 months ago, their eldest daughter, Jane, separated from her husband of four years and returned home with her three year-old child. Since Jane had left her husband because he had abused alcohol, she became increasingly critical of her father's drinking and incommunicativeness. As tension in the household increased, Mrs. Jones felt torn between her allegiances to her husband and to her daughter. Mr. Jones left the home after an argument with his daughter. He continues to support Mrs. Jones, to visit when she initiates contact and to deny involvement with another woman. However, he refuses to discuss his drinking or the status of their marriage. She reports trying to understand, but is increasingly embarrassed and angered by her husband's refusal to acknowledge her needs. She said that she can no longer tolerate a continuation of their present situation but is ambivalent about asking him for a divorce.

Mrs. Jones denies ever experiencing an episode of depression before. However, she states that her apprehension and anxiety about communicating honestly with her husband has been a problem of long standing.

PSYCHIATRIC AND MEDICAL HISTORY: Mrs. Jones reports no previous treatment for depression. However, in 1980, Mr. & Mrs. Jones sought help in dealing with Jane's truancy and drug use during her junior year in high school. Mrs. Jones, her husband and their two daughters were in family treatment, including conjoint and individual sessions, with a psychologist, Dr. John Brown, at XYZ Community Mental Health Center from approximately February through August 1980.. Mrs. Jones said that the therapy was quite helpful for her, although her husband stopped attending the sessions, and the therapist worked primarily with their daughter.

PERSONAL, SOCIAL AND FAMILY HISTORY: Mrs. Jones reported that she had a happy childhood, although her parents did not have much money, and her father was alcohol-troubled. She recalled being an avid reader during her childhood and adolescence, and doing quite well in the relatively strict parochial school she attended. She described herself as being the "good child" among her 3 brothers and one sister, and being very dutiful to her parents. Her father died in 1980 of liver disease complicated by alcohol use, and her mother died in 1984 of cancer. Her relationships with her brothers are pleasant but not close, and she is particularly distant from her eldest brother that drinks heavily. She views her sister, Lucy, who lives nearby and whom she sees frequently, as her primary support in the family.

Mrs. Jones was married at age 20 to her husband, a local boy of whom her family approved. She describes her early married years, when she supported her husband through engineering school, as being happy. She suffered through several miscarriages before becoming pregnant with her two children. Although she spent most of her time caring for her children, she worked part-time as a health aide, a retail sales clerk, and a bank clerk. She reported that she and her husband started drifting apart as he became more involved in his work and as she became more involved with child-rearing. Their relationship became more strained as they assumed the financial and emotional burden of caring for her two sick parents. She said that she and her husband had a difficult time communicating when things became stressful. Her style was to avoid bringing up unpleasant subjects and "just try to carry on."

At present, Mrs. Jones has a job as a head bank teller. Although she takes pride in being known as a competent and dependable worker, she says that she is "not ambitious." Her two daughters live at home. Susan, 18, is doing very well in County High School and plans to go to college. Mrs. Jones describes Jane as "troubled" and "withdrawn" as she struggles to care for her child and work part-time as a medical technician. Both daughters have expressed anger at their father about his leaving. Mrs. Jones currently reports spending most of her time at home with her children or by herself, since she has few close friends. However, she said that she felt disappointed that some of her friends had not contacted her to find out how she is. She states that since childhood people have regarded her as strong, competent and dependable, and she has found it difficult to ask for help or express her own needs for support and reassurance. Mrs. Jones felt that finances were manageable at present, but she wondered how she will cope if her husband does not return.

BEHAVIORAL OBSERVATIONS AND MENTAL STATUS: Mrs. Jones was casually dressed and well-groomed. Her posture and gait were unremarkable. An intelligent, articulate, and perceptive woman, she exhibited good insight and a wide range of appropriate affect. She presented as a warm and friendly individual and maintained good eye contact. Her concentration, attention and memory were above average. Her speech was clear, goal-directed and moderately paced. When asked to verbalize her feelings of nervousness, she did so without resistance. Her impulse control appeared to be within normal limits. Her insight was good and her judgment was fair.

ASSESSMENT: The Mini International Neuropsychiatric Interview was used during this interview. Mrs. Jones endorsed some symptoms of Major Depression, such as a decrease in appetite, difficulty falling asleep, lack of energy, and a decrease in pleasure from activities she used to enjoy. Mrs. Jones also reported a few symptoms of Panic Disorder, including shortness of breath and chest pain. However, she did not report enough symptoms in either of these areas to meet criteria for diagnoses.

Mrs. Jones also completed the Beck Depression Inventory, and her total score (21) was in the moderate range. She endorsed changes in her sleeping pattern (difficulty falling asleep), self-blame, loss of pleasure, and difficulty concentrating, among other symptoms.

On the Brief Symptom Inventory, Mrs. Jones' responses were within normal limits.

FORMULATION AND DIAGNOSTIC IMPRESSION: Mrs. Jones seems to be a competent, personable woman who is struggling with depression resulting from serious marital distress and other family stressors. Much of her distress seems to result from a long-standing pattern of trying to gain affection by avoiding conflict and taking a supportive and caretaking role towards others. Although this may have been successful earlier in her life, this style has proved maladaptive in helping her directly confront problems with her husband and express her own needs. She currently experiences conflict regarding her "need to be supportive" and her anger toward her husband. This conflict leads her to put herself in situations where she can be overwhelmed (e.g., caretaking for her parents, her daughter). However, she seems to have the motivation and coping skills needed to address these issues in therapy.

Axis I: 309.28 Adjustment Disorder with Mixed Emotional Features
V61.10 Marital problem

Axis II: V71.09 No diagnosis on Axis II

Axis III: None

Axis IV: Psychosocial stressors: marital separation, return of oldest daughter to home, social isolation.

Severity: 3-moderate.

Axis V: Current Global Assessment of Functioning (GAF): 60
Highest GAF in the past year: 80

RECOMMENDATIONS:

1. Mrs. Jones should become involved in individual therapy to address the following issues:
 - a. decreasing depression
 - b. expressing anger and needs more directly
 - c. clarifying options and feelings: marriage
 - d. decreasing social isolation & increasing social support
2. Mrs. Jones should be encouraged to involve herself with Al-Anon to get support in dealing with her husband's alcohol abuse.
3. The option of family and/or couples therapy should be further explored.

FEE: \$15 per session

William Anderson, MA
Staff Therapist

Sally Smith, Ph.D.
Supervisor

**APPENDIX H:
SAMPLE TERMINATION SUMMARY**

This Termination Summary was constructed using a hypothetical client and family.

CLIENT NAME: Mary Jones **THERAPIST:** Bill Anderson, MA
CLIENT ID #: 86999 **SUPERVISOR:** Sally Smith, Ph.D.
DATE OF INTAKE: July 23, 1986 **DATE OF REPORT:** August 15, 1987

Mrs. Jones is a 41 year-old, divorced, Irish Catholic woman who currently works as a bank clerk and lives with her two children and one granddaughter. Mrs. Jones came to the Psychological Consultation Center approximately 1 year ago, on 7/23/86, for help with feelings of despondency, anger and confusion that developed when her husband left home and established a separate residence. She was seen in individual therapy for 45 sessions during this period. Therapy was terminated on August 7, 1987, when Mrs. Jones felt that she had satisfactorily resolved the issues that had caused her to seek treatment.

PRESENTING PROBLEM: Mrs. Jones came to the PCC describing symptoms of anxiety and depression (i.e., insomnia, appetite loss, nervousness) following the departure of her husband from the home in order "to think things through". Although she did not report suicidal ideation, Mrs. Jones was in considerable distress. She had few close friends and was unclear what to do about her marriage. Mrs. Jones reported never having experienced an episode of depression previously.

HISTORY OF PRESENTING PROBLEM: This marital separation had been preceded by a lengthier period of marital strain which had been exacerbated by several events: her husband's loss of stature in his job and his subsequent alcohol abuse; her daughter's return to the home with a new-born child following her marital separation; and, her daughter's criticism of Mr. Jones' alcohol use.

Although Mrs. Jones seems to be a competent woman in many ways (e.g., ability to hold a responsible job and to be a caretaker for her elderly parents), her difficulty in expressing anger and in directly communicating her emotional needs seems to have contributed to her marital problems. Mrs. Jones described a long-standing pattern of trying to gain affection and security by avoiding conflict and taking on a supportive and caretaking role toward others. Thus, she found herself hesitant to confront her husband's alcohol abuse, and in conflict regarding her "need to be understanding" and her anger regarding her husband's alcohol abuse and abandonment.

Mrs. Jones reports no previous psychiatric treatment for depression. However, in 1980, Mr. & Mrs. Jones engaged in family therapy to deal with their eldest daughter's truancy and drug use during her junior year in high school. She reported that this treatment at XYZ Community Mental Health Center was successful in resolving the situation.

SERVICES PROVIDED: Mrs. Jones was seen in therapy weekly for 45 individual sessions with occasional breaks due to vacations and illness. Attempts to invite Mr. Jones in for conjoint sessions were unsuccessful. Individual therapy took a cognitive therapy and social learning approach in dealing with the following issues:

1. Depression
2. Difficulty in communication (i.e., expressing anger, asking for help, acknowledging emotional needs to others)
3. Clarification of options and feelings concerning her marriage
4. Social isolation
5. Helping her children to deal with the alcohol and marital difficulties in her family

Mrs. Jones was evaluated for anti-depressant medication, but because of her strong feelings against "taking pills" she did not avail herself of this aid. She was quickly able to use therapy for emotional support, and her depressed mood diminished rather rapidly. Mrs. Jones was able to recognize that her cognitive style of avoidance and of internalization of "fault" for her marital difficulties contributed to her depression. She was able to use role-playing exercises to explore ways to be more clear, direct, and consistent in her communications with her husband.

In addition to "formal" therapy, Mrs. Jones was encouraged to join an Al-Anon group. After three months of therapy, Mrs. Jones began attending Al-Anon regularly twice a week. The meetings provided quick relief for Mrs. Jones from her feelings of loneliness and offered her both a network of social support and an educative experience that further assisted in lifting her depression. As Mrs. Jones used her Al-Anon friends for support, she was able, in turn, to provide support, understanding and education for her children.

Six months into her treatment, Mr. Jones informed her that he was going to seek a divorce. Mrs. Jones spent many therapy sessions sorting through her feelings and planning strategies to cope with the economic changes that the divorce would cause. In addition, she explored questions about raising her children alone and maintaining a satisfying co-parenting relationship with her husband. As she became less preoccupied with her depression, she began to see the children's needs more clearly and became more emotionally available to them. She encouraged her two children to attend Al-A-Anon and Al-A-Teen. These organizations helped all the members of Mrs. Jones' household to deal more effectively with Mr. Jones' behavior and with the impact it had on their lives.

CURRENT STATUS: Mrs. Jones has shown significant improvement over the course of therapy. She has not shown signs of depression since early in her treatment, and is less anxious when confronting her ex-husband about emotionally charged issues. She has improved her support system and improved her relationships with her daughters.

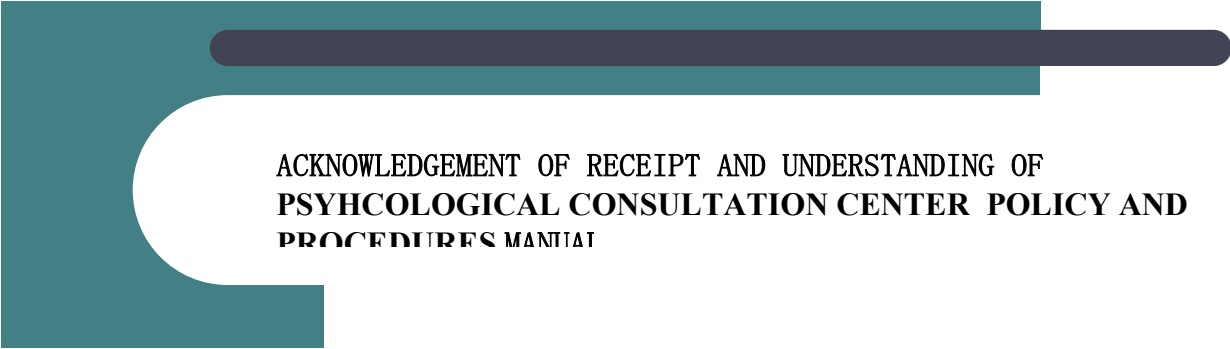
RECOMMENDATIONS:

1. Mrs. Jones should maintain involvement herself in Al-Anon as a way of continuing to deal with the presence of alcohol-abusive men in her life.
2. Mrs. Jones should continue to broaden her social relationships. She is still highly dependent on her daughters for companionship, and may be at risk for depression when and if these daughters leave the home.

3. if Mrs. Jones decides to enter treatment in the future, she responds well to cognitive approaches within a context of emotionally supportive therapy. She is able to observe her behavior and to use insight to make behavioral changes.

William Anderson, MA
Staff Therapist

Sally Smith, Ph.D.
Supervisor



**ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING OF
PSYCHOLOGICAL CONSULTATION CENTER POLICY AND
PROCEDURES MANUAL**

I have read and understand the Psychological Consultation Center at University of Rhode Island's Policy and Procedures Manual. My signature indicates my awareness of the following:

1. It is my responsibility to be familiar with Program, Department, and University regulations regarding student and faculty roles and responsibilities as well as degree and program requirements;
2. The Psychological Consultation Center expects both faculty and students to conduct academic, clinical, and research activities according to the American Psychological Association's (APA) Ethical Principles of Psychologists and Code of Conduct and within the laws and regulations governing the activities of psychologists in the state of Rhode Island;
3. All research activities involving human participants must receive approval from University of Rhode Island's Institutional Review Board on Human Subjects; and
4. Violations of Program, Department, University, APA, or Rhode Island codes, regulations, policies or law may lead to sanctions including termination from the Program.

Student signature _____ Date _____

NOTE: This signed form should be given to the PCC Assistant too keep on file.

