THE CREATION OF A POLICY AND PROCEDURE MANUAL FOR A UNIVERSITY
PSYCHOLOGICAL SERVICES CENTER

A Project

Presented to the faculty of the Department of Psychology
California State University, Sacramento

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF ARTS

in

Psychology
(Counseling Psychology)

by
Melissa Kuhl

SPRING
2013
THE CREATION OF A POLICY AND PROCEDURE MANUAL FOR A UNIVERSITY

PSYCHOLOGICAL SERVICES CENTER

A Project

by

Melissa Kuhl

Approved by:

__________________________________, Committee Chair
Larry Meyers, Ph.D.

__________________________________, Second Reader
Rebecca Cameron, Ph.D.

Date
Student: Melissa Kuhl

I certify that this student has met the requirements for format contained in the University format manual, and that this project is suitable for shelving in the Library and credit is to be awarded for the project.

__________________________, Graduate Coordinator
Jianjian Qin, Ph.D.

Department of Psychology
Abstract

of

THE CREATION OF A POLICY AND PROCEDURE MANUAL FOR A UNIVERSITY PSYCHOLOGICAL SERVICES CENTER

by

Melissa Kuhl

Graduate psychology students preparing to become professional therapists often work in an on-campus psychology clinic as an introduction to the field of therapy. At California State University, Sacramento, the counseling program in psychology no longer exists; however, a model policy and procedure manual was written as a theoretical exercise. In the event that this program is ever reinstated, this manual might serve as a basis for clinic operation. Twenty-five policy and procedure manuals from universities across the United States were analyzed for this purpose. Additionally, a literature review of research on practicum experiences and university clinics was undertaken. The results verify that more research on this topic is needed to make the best use of this important time in a graduate psychology student’s career.

_____________________, Committee Chair
Larry Meyers, Ph.D.

_____________________
Date
ACKNOWLEDGEMENTS

I would like to express my gratitude to my friends, family, and CSUS faculty who provided me with so much support and encouragement through the past four years. To my project chair, Dr. Larry Meyers, thank you for your constant guidance and your ready feedback, which always helped get me back on track. To Dr. Rebecca Cameron, thank you for first inviting me to create a policy and procedure manual for the Psychological Services Center; your idea was the genesis of this project. Finally, I would like to extend a special acknowledgement to Dr. Lee Berrigan, my advisor and mentor, who has been integral throughout my graduate career. Thank you for teaching me how to be a student, training me how to be a therapist, and demonstrating how to be a professional.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>vi</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chapter</strong></td>
<td></td>
</tr>
<tr>
<td>1. WAYS OF LEARNING</td>
<td>1</td>
</tr>
<tr>
<td>Modes of Education</td>
<td>1</td>
</tr>
<tr>
<td>University Clinics</td>
<td>2</td>
</tr>
<tr>
<td>Practicum Defined</td>
<td>4</td>
</tr>
<tr>
<td>2. ANALYSIS OF CLINIC MANUALS</td>
<td>7</td>
</tr>
<tr>
<td>Necessity of Policy and Procedure Manuals</td>
<td>7</td>
</tr>
<tr>
<td>Description of Sample</td>
<td>7</td>
</tr>
<tr>
<td>Introductory Material</td>
<td>8</td>
</tr>
<tr>
<td>Student Therapists</td>
<td>12</td>
</tr>
<tr>
<td>Prior to the First Session</td>
<td>14</td>
</tr>
<tr>
<td>The First Session</td>
<td>17</td>
</tr>
<tr>
<td>Client Records</td>
<td>22</td>
</tr>
<tr>
<td>Termination</td>
<td>23</td>
</tr>
<tr>
<td>Supervision</td>
<td>24</td>
</tr>
<tr>
<td>Safety and Emergencies</td>
<td>25</td>
</tr>
<tr>
<td>Legal Policies</td>
<td>33</td>
</tr>
<tr>
<td>Ethical Principles</td>
<td>36</td>
</tr>
</tbody>
</table>
3. DISCUSSION OF CLINIC MANUALS ................................................................. 40

4. A THEORETICAL UNIVERSITY CLINIC POLICY AND PROCEDURE
   MANUAL ........................................................................................................ 47

References ........................................................................................................... 85
Chapter 1
WAYS OF LEARNING

Modes of Education

Learning, the acquisition of knowledge, is the fundamental process by which our species functions and evolves over the course of generations. We call the structure that oversees learning in our society education. Due to the importance of education, the type of information that is learned and the method by which that knowledge is transmitted are worthy of consideration. In a university setting, this question might take the form: What knowledge is worth having and how should students be taught such knowledge (Booth, 1967)?

At the undergraduate level, a wide breadth of knowledge, in the form of general education courses, is often mandated. A variety of subjects must be studied to enhance areas such as verbal and analytical abilities, whether or not they relate to the student’s chosen major. Undergraduate students primarily attend lecture-style classes, with grading determined by memorization ability in the form of in-class tests. Occasionally, laboratory classes are utilized, allowing these students to gain more hands-on experience.

Once a student reaches graduate school, he or she chooses an area to study exclusively. A graduate psychology student might take classes as varied as statistics, ethical practices, multicultural studies, and research methods, but each of these subjects will be tailored to the student’s field and ultimate career goal. Although some classes
will still be lecture-based, the student is given a much larger role than passively taking notes. Often, students take partial responsibility for teaching the class or will engage in lengthy group discussions. Laboratory and on-the-job learning become increasingly important as the student must prepare to join his or her chosen field.

The difference between the systems of education used in undergraduate and graduate school programs can be found in the theories of Socrates, who described the learning of any craft as consisting of two parts: practice and theory (Booth, 1967). Theory is represented by classes consisting mainly of lectures, while practice is found in hands-on classes. The two forms of education unite in student-run psychology clinics, which rely on both passive (theory) and active (practice) forms of knowledge.

**University Clinics**

A university clinic is a unique educational setting due to the mixture of worlds that occurs there. The clinic is at once both a part of the college and the greater community surrounding it, which means that it must respond to the needs of educating students while serving clients at the same time (Babbage, 2008). Although there are many challenges to this dynamic, the advantages of the real-world experience that students gain in these clinics are invaluable.

University clinics fall into a category of education called experiential learning, which may be defined as a type of learning in which the student “is directly in touch with the realities being studied,” (Keeton & Tate, 1978, p. 2). In a lecture, students will only read about how various mental illnesses manifest themselves. In a clinic, students are given the opportunity to both observe and treat mental illnesses firsthand. The
disadvantages of experiential learning include the greater involvement of both professors and students necessary for such an approach to be successful (Keeton & Tate, 1978). In traditional, classroom learning, nothing more than a bad grade is at stake. In clinics, the safety of both students and clients might be compromised if incompetence is allowed to go unchecked. Additionally, it is more difficult to judge levels of mastery in experiential learning situations than in traditional learning, where knowledge is measured as easily as a grade on a test. How should students working in a clinic be “graded?” An objective system of evaluation is often impossible. Nonetheless, the advantages of experiential learning are numerous. These include an increased flexibility in tolerating new situations (which are commonly encountered in psychology clinics), the opportunity for evaluation based on real-world situations, and increased confidence in the student’s ability to practice successfully in the field (Byrne & Wolfe, 1980).

One of the greatest advantages of university clinics is the opportunity for students to gain competence under the guidance of their professors and supervisors. Competency, as defined by Byrne and Wolfe (1980), involves three steps. In the first, students must gain a conceptual grounding. It is here that lecture and theory are of most use – how can a student begin to treat clients without having some knowledge of how to do so? Once this has been accomplished, students begin to learn the craft beyond theory. At this point, experiential learning must be employed. Students work at the on-campus clinic or find external internships; they begin to put theory into practice. During this step, feedback from professionals is vital. In the final stage of achieving competence, the individual has obtained his or her degree and become a practicing member of the field. Even here,
however, the value of continued consultation cannot be underestimated. Competency, like all learning, is a continuous process (Byrne & Wolfe, 1980).

**Practicum Defined**

A graduate psychology student’s time spent working in the university clinic is referred to as “practicum.” This is intended to be the student’s introduction to professional therapy. The fundamental goal of practicum is to improve the student’s abilities as a therapist, while also preparing him or her for an internship outside the university (Council of Chairs of Training Councils (CCTC), 2007). Although it is natural for students to be nervous seeing clients and unsure of their abilities at the onset of practicum, it is expected that they will grow in both comfort and competence over the course of this experience. To assist in this aim, weekly supervision is provided by professionals on either a group or individual basis (CCTC, 2007).

Practicum has existed almost from the inception of psychology as a field of study (Hatcher, Grus, & Wise, 2011). The first university training clinic opened at the University of Pennsylvania in 1896 (Babbage, 2008), and the American Psychological Association (APA) officially instated the word “practicum” in 1950 to describe clinical experience gained prior to receiving one’s degree (APA, 1950). At this time, the APA identified the opportunities to work with clients and receive supervision from professionals as the two main goals of practicum; however, they also suggested that practicum should teach students how to identify and treat various pathologies; write reports; understand basic research methods, social problems, and legal policies relating to mental illness; and act in accordance with ethical principles (APA, 1950).
Although practicums may take place at external agencies, the majority are located on the campuses of universities, at clinics which are usually called Psychological Services Centers (PSCs) (Kramer & Ryabik, 1981). There are many advantages to the PSC model of practicum over outsourcing to other clinics. To list a few: PSCs provide access to a greater variety of clients, demographics, and pathologies than other clinics do; the student may always elect to take further semesters of practicum at a PSC (enrollment allowing) for additional experience; and the university setting allows for consultation with professors who have a wide array of specialties (Kramer & Ryabik, 1981). There are, of course, limitations to the PSC model. These include a potential lack of resources if the clinic is financially dependent on the university, the possibility of unethical early termination due to most cases being closed at the end of the semester, and a potential artificiality to the clinic environment that might not match real world situations (Murrell, Steel, Gaston, & Proudfoot, 2002). However, perhaps the greatest benefit of the PSC model is its accessibility to clients of lower socioeconomic status. With the cost of mental health services steadily rising, many individuals find themselves unable to afford therapy, even at agencies with a sliding-scale fee schedule. Being run by students, most PSCs charge clients very little in exchange for therapy – some are even free of cost. This provides an invaluable service to the community.

At California State University, Sacramento (CSUS), practicum has made use of an on-campus PSC. In the past, students from the graduate psychology counseling track were required to enroll in two semesters of practicum. However, with the recent demise
of this program, the PSC is now slated for use by students in the Applied Behavior Analysis track of the psychology department.
Chapter 2

ANALYSIS OF CLINIC MANUALS

Necessity of Policy and Procedure Manuals

Due to the importance of practicum, it is advised that PSCs have clear and comprehensive policy and procedure manuals (Hatcher et al., 2011). Although it is required by the APA that graduate programs have a written policy and procedure manual, not all are compliant (around 8% report not having a manual) (Hatcher et al., 2011). Even among programs that do have manuals, 40% of program directors identify weaknesses in at least one area of the manual that require improvement (Hatcher et al., 2011). Additionally, the majority of clinical directors acknowledge that their manuals are not as thorough as they should be (Dinoff, Ronan-Fields, Frankel, & Rickard, 1985).

Clinic policy and procedure manuals are used primarily by members of the faculty, clinical staff, and students; however, since students are most in need of the guidelines offered by a manual, it is recommended that students be addressed as the manual’s main audience (Dinoff et al., 1985).

Description of Sample

For this analysis, twenty-five university clinic manuals from across the country were utilized. These represented a mixture of masters and doctoral programs, with ultimate degree being in either psychology, counseling, or marriage and family therapy. All manuals were found online, available to the public. The academic years of the manuals range from 2006-2007 to 2012-2013.
Clinic manuals were from the following institutions: East Carolina University, University at Buffalo, University of North Texas, Marshall University, University of Toledo, Nova Southeastern University, University of Georgia, Utah State University, East Central University, Southern Illinois University Carbondale, University of Louisiana at Monroe, University of Florida, Georgia Southern University, Indiana State University, Texas A&M University, Regis University, Eastern Kentucky University, University of New Mexico, University of Santa Barbara, University of Northern Colorado, University of Rhode Island, University of Denver, University of Hawaii, Hofstra University, and Brigham Young University.

**Introductory Material**

**Clinic Philosophy/Purpose/Mission Statement**

The first item that most manuals discuss is the philosophy of the clinic (also called the Purpose or Mission Statement). This section typically includes the full name of the clinic and university, as well as the year that the clinic began operation. Services provided, such as whether or not a clinic has the capability to administer psychological testing and types of clients (e.g., individual, couple, family, groups) that will be accepted for treatment are often mentioned. Intended audience for the manual (e.g., students, professors, clinical faculty) might also be addressed here.

If the clinic operates under an official theoretical orientation; such systemic, psychodynamic, or behavioral; it will be discussed in this section. Most clinics do not constrain students to using a single orientation; however, some clinics, such as Nova
Southeastern University (2012) train their students in a specific modality, in this case, brief psychodynamic therapy.

The bulk of the Clinic Philosophy section usually discusses the differing functions of a university clinic. Almost all clinics have the same three uses: training, research, and public service. Although most clinics do not attempt to rank these functions in terms of importance, the University of Toledo (2010) states their priorities as, in order from most to least importance: training, service, and research. One aspect of the service function that many clinics mention is the attempt to provide low-cost mental health services to the community. Most clinics do charge clients a fee, but a sliding scale is typically offered. Fees are discussed in more detail further in the manual.

**Clinical Faculty/Staff**

In this section, names and contact information for all of the clinical faculty and staff are listed. The clinic director is always identified, and sometimes (University of Florida, 2007) the clinical duties for the director and all other clinic employees are described. Contact information is usually confined to just an office phone number, but other information that might be listed are email addresses, personal phone numbers, and office locations. Nova Southeastern University (2012) also lists important emergency services numbers in this section for easy access.

**Commitment to Diversity**

Although not included in many manuals, some, such as the University of Louisiana at Monroe (2011), include a section discussing the university’s antidiscrimination policy, applying both to members of the university and clients served.
at the clinic. The policy states that the clinic, “serves a diverse population rich in various cultural, contextual, socioeconomic, ethnic, sexual, gender, religious orientations, backgrounds, belief systems, and family systems. All clients will be treated with the utmost respect, compassion, and professionalism and will not be discriminated against for any reason,” (p. 10).

**Clinic Facilities**

A description of the location, layout, and equipment of the clinic is included in most manuals. Almost all clinics are located somewhere on university property; the building and room number should be listed. Some manuals will list the different rooms of the clinic, which often include a client waiting area, a staff/faculty office, a research library, and therapy rooms of varying sizes to better accommodate different numbers of clients.

All clinics must have the ability to be locked, which means that all students working in the clinic must be issued keys. Manuals describe how to check out these keys, the cost of a replacement if keys should be lost, and policies relating to which doors should be kept locked/unlocked.

All clinics have an office phone. Although some clinics hire a secretary to take client messages, often students are responsible for processing voicemail that is left on the phone. This section of the manual often explains how to access voicemail and policies for confidentially letting other students know when their clients have left them a message. Although these manuals are available for public viewing online, East Carolina University (2011) even includes the password for its office phone.
All clinics are equipped with audio or video recording ability for supervision purposes. This section of the manual describes how to use recording equipment and instructions for destruction of recorded material after use. Recorded material is not allowed to leave the clinic for reasons of confidentiality and typically must be destroyed at the end of the semester.

Some clinics, such as Marshall University (2012), require that students use white noise machines to help prevent clients in the waiting room or other therapy rooms from hearing each other. This equipment must be turned off at the conclusion of a session.

**Hours of Operation**

Most clinics operate only during the university semesters, which means that they are closed over summer and for a few weeks in winter. Typical clinic days of operation are Monday through Friday only, although some clinics, like the University of New Mexico (2012) allow the possibility for exceptions to be made with approval from the Clinic Director. Clinics typically open at 9:00 A.M. and close between 4:00 and 6:00 P.M. Clinics are always closed on university holidays. Almost all clinics require that another student or faculty member be present in the clinic while a student is conducting a therapy session. This is for the student’s safety.

**Dress Code**

Student therapists are always expected to dress professionally when in the university clinic, whether they are seeing clients or not. This means that even if the student is in the clinic office working on client files, he or she should be dressed professionally. Clothing that is usually not considered acceptable includes jeans, shorts
or cutoff pants of any kind, revealing clothing, t-shirts, casual shoes (e.g., tennis shoes, flip flops, work boots), formal wear, and hats. Student therapists who do not follow the dress code might be asked to leave the clinic, not to return until wearing appropriate clothing.

**Confidentiality**

Although confidentiality will be discussed throughout the manual, its importance often means that it will be addressed in the introductory section. Client information shared in therapy is confidential with several exceptions that must be explained to clients in the first session. These exceptions include when clients are a danger to themselves or others and child, elder, or dependent adult abuse. Student therapists must take action when one of these exceptions occurs, either by calling Child Protective Services, Adult Protective Services, or the police. In all other instances, student therapists are responsible for safeguarding all material that is shared in therapy.

**Student Therapists**

**Eligibility for Practicum**

This section lists the courses that students must have passed in order to be eligible for enrollment in the practicum. The definition of a passing grade and the necessary classes will vary from one institution to another. Additionally, this section might describe the enrollment capacity of the practicum and how enrollment will be addressed in the event of more students wanting to enroll than there is space for. Usually, this situation will be handled by offering enrollment first to those students who are nearest to
graduating and still have not met the minimum number of client contact hours required. Other institutions might handle over-enrollment with a lottery.

**Expectations while Enrolled in Practicum**

This section is only included in a few manuals, but it is an important description of any assignments that student trainees might be expected to complete. At the University of Denver (2012), for example, student therapists are must submit both a proposal for clinic improvement and a statement of professional goals sheet every semester. Other universities require students to conduct literature reviews on issues relevant to those faced by their clients. If students are expected to carry a minimum client load or spend a certain number of hours working in the clinic per week, this must also be specified (Kramer & Ryabik, 1981).

Therapist absence is another issue usually addressed in this section. Typically, it is expected that therapists should not miss a session except in cases of illness or emergency, which are unavoidable. The therapist must call any clients who might be affected by his or her absence to cancel sessions with as much notice as possible. Georgia Southern University (2011) does allow therapists to take vacation periods of several weeks per year, but only if they are scheduled at the beginning of the semester during which they are to take place. If therapists are frequently absent, dismissal from practicum is a typical consequence.

**Evaluation**

Many universities have a formal procedure of evaluation for therapist trainees. At the University of North Texas (2012), a Practicum Evaluation form is completed by the
supervisor at the end of each semester, discussed with the student, and then given to the Clinic Director for review. If student performance is found to be unsatisfactory, several actions may occur. A plan for remediation might be instated (which might include extra supervision, reading assignments, or written papers), the student might receive a non-passing grade in the practicum, or the student might be removed from either the practicum or the graduate program if infractions are severe enough.

**Insurance**

All student therapists are required to have liability insurance. At some institutions, such as Southern Illinois University Carbondale (2011), students are covered under the university’s general liability insurance. At most clinics, however, students will have to purchase their own policies.

**Prior to the First Session**

**Selection of Clients**

Clinics must have a formalized method for recruiting clients. This might include advertising in local media, affiliations with other agencies, or word of mouth (Thibadeau & Christian, 1985). Most university clinics do not accept walk-in requests for therapy. Typically, prospective clients will call the clinic office and leave an identifying message. It is important that the answering message on the phone remind clients that if they are experiencing an emergency, they should hang up and dial 911. Depending on the size and individual rules of the clinic, a full-time staff member (usually the clinic secretary), a student clinic coordinator, or the student therapists themselves might return client calls. Calls should be returned as quickly as possible; clients often call in a distressed state and
will be anxious to hear back from the clinic (Regis University, 2012). When calls are returned, a preliminary intake interview is usually conducted to ensure the suitability of the prospective client for the clinic.

The number of clients seen in a university clinic varies greatly depending on the resources available (such as the amount of therapy rooms) and number of therapist trainees. One study of clinics found that patients seen in a given year ranged from 20 to over 2000 (Babbage, 2008). The client population accepted at a student-run clinic usually will not include individuals with severe mental illness. 65% of university clinics do not accept clients with histories of violence, 59% do not accept clients who engage in any type of self-harm, and 45% refuse treatment to clients with a history of psychosis (Bernstein et al., 1991). Although not all diagnoses will manifest themselves immediately, it is hoped that screening for the most volatile of disorders will protect the client, the clinic, and the student therapist from encountering situations for which the therapist is not prepared.

University clinics are not able to prescribe psychiatric medication, nor (except in rare cases) can they provide testing or official diagnostic services. Individuals for whom ordinary, weekly therapy sessions are not the recommended method of treatment (such as those who have been diagnosed with an eating disorder or substance abusers), should be referred to a more appropriate agency in the community. If the individual’s difficulties are deemed suitable for work with a student therapist, an intake session is scheduled.
Case Assignment

At some clinics, the therapist who provides the intake will be the client’s therapist. Other universities, however, make assignment decisions after the initial intake has been completed. Case assignment is often based primarily of student caseload. For example, it is usually expected that students carry a caseload of three to five clients. If one student therapist only has two clients, while all of his or her colleagues have three or more, the next new client will logically be assigned to the student with fewest clients. Exceptions to this occur in cases where the client has a special request or need. Requests might be for a therapist of a certain gender, race, ethnicity, religion, or sexual orientation. If a student therapist is available who matches the criteria requested by the client, the clinic director may choose whether or not to grant the client’s request at his or her discretion. An example of client need would be a request for a therapist who speaks a certain language. If there are no student therapists in the clinic who speak the client’s language, referral is necessary. One final issue in considering case assignment is the level of difficulty that a given client may be expected to present. Student therapists with more experience should be assigned more complicated cases, whereas student therapists who are newer to the clinic should be assigned clients who have less severe mental illness. It is worth noting, however, that it is impossible to predict after a single intake how the dynamics of the client will play out over time.

Parking

As parking on university lots is never free, most clinics offer free or reduced-cost parking permits for client use. Some clinics mail these permits to the client prior to the
first session, while others present the permit to the client with the rest of the paperwork that is discussed in the first session. Some universities (CSUS among them) will only issue complementary parking passes that are valid for the specific time of the client’s weekly appointment. In these cases, it is necessary to wait until after the first session to apply for the client’s permit, as this information is usually not established until that time.

Fees

Although the clinic at CSUS saw clients free of charge, almost every university in the sample requires clients to pay a weekly fee. Standard fees range from $20 a session (University of Louisiana, 2011) to $75 a session (U.C. Santa Barbara, 2007), but almost all clinics offer a sliding scale based on income. With the sliding scale, weekly fees can be as low as $5 a session (Georgia Southern University, 2012). Although multiple manuals mention that no client will be turned away for financial reasons, it is unclear if any of these clinics would accept clients free of charge should even the sliding scale prove too expensive.

The rule that clients must pay for therapy necessitates that student therapists be responsible for managing their clients’ accounts. Clinics usually only accept cash or check payments. Payment is due at the end of every session. If the client is unable to pay his or her fee, the Clinic Director must decide how to proceed.

The First Session

Room Assignment

University clinics must have an organized system for students to reserve therapy rooms; this is especially important in settings with a high volume of clients. At most
clinics, this is handled either through a physical logbook or a digital spreadsheet.

Students enter their name into the hour slot or, at the University of Georgia (2008), the client’s unique ID number. If the clinic has a secretary on staff, room reservation is often among his or her professional duties. The standard length of a therapy session is 45 to 50 minutes for individual clients. For couples or families, sessions might go as long as an hour and a half. Many manuals mention the importance of not letting sessions run long, as it is likely that another therapist will have reserved the room for the immediately following hour.

Preparation of the Therapy Room

Regis University (2012) is unique in including a section describing how to prepare the therapy room prior to the start of each session with a client. The therapy room should appear neat and tidy. Each room should contain a box of tissue and a working clock. Student therapists must remember to turn on recording equipment and indicate that the room is not available (at Regis University, a sign hangs on each door designating the room as either “open” or “in use”). White noise machines should be turned on. When the session has ended, student therapists should return the room to an orderly condition, turn off all equipment, and indicate that the room is now available.

Consent to Treatment

Every manual in the sample includes a section explaining that prior to the start of the intake session, therapists are mandated by law to describe the limitations of confidentiality to clients. This discussion should begin by defining confidentiality, which means that what the client says in therapy will remain private between the client and the
therapist. The only exceptions to confidentiality are if the client is seriously considering harming him or herself or someone else. Additionally, if the client mentions any sort of child, elder, or dependent adult abuse, this must be reported. The client should be asked if he or she has any questions about this information.

At all university clinics some sort of recording of the session will be involved, so therapists must also begin the session by reminding clients of this. Ideally, clients will have first been informed of the taping protocol in the initial phone contact, so that any clients who are adamantly opposed to the taping will have already made the decision not to come to the clinic. Therapists should inform clients of the purpose behind the recording (so that the therapist may receive additionally insight on the case from his or her supervisor) and compassionately respond to any concerns that the client might have. At East Carolina University (2011), clients who do not wish to be recorded may instead opt for live supervision, where the session is observed by the supervisor from behind a one-way mirror. Clients who do not consent to either recording or live supervision cannot be seen by student therapists.

One final topic that must be addressed in the consent to treatment portion of an intake interview is a discussion of the trainee’s qualifications. Students must tell clients that they are not licensed therapists; however, they are receiving supervision from a licensed therapist. The client has a right to know the supervisor’s name and might opt to discuss any concerns with the student’s supervisor.

Once this information has been discussed, the client must sign an informed consent form, which repeats the information that the therapist has just said. It is
mandated that all clients over the age of 18 sign an informed consent form prior to the onset of treatment; however, it is recommended that younger clients be given an age-appropriate form to sign also. Clients under the age of 18 must have their parents or guardians sign an informed consent form as well. In cases where the child’s parents are divorced, both parents must consent to treatment unless one parent has full physical and legal custody of the minor. Copies of these forms are usually available in the clinic manual’s appendices.

**Additional Forms**

Although only the informed consent form is mandated by law, most clinics request or require that clients fill out other forms in the first session. One of the most common is an intake form that the client is requested to fill out in the waiting area prior to the start of the session. These forms may cover a range of information including the names and ages of other individuals living in the client’s household, physical health concerns, physical and mental illnesses that run in the client’s family, substance use, suicidality, and goals for therapy (University of Northern Colorado, 2010). Therapists may quickly review the information before bringing the client into the therapy room; the goal of these intake forms is to guide the therapist’s focus and highlight areas of concern.

Many clinics also require clients to sign a fee and cancellation policy form. Fees should be discussed in the initial phone contact with the client, but it might be helpful to have the client sign a form in which he or she agrees to the weekly fee. Most clinics have a 24-hour cancellation policy for sessions. If the client cancels his or her weekly session
at least 24 hours in advance, the fee for that session will be waived. However, if the client is a “no show” to the session, he or she will be billed.

Clients who have previously seen a therapist should sign a release of information form, allowing the current student therapist to contact the previous therapist for treatment records. Reviewing the course of previous therapy can be very helpful in assessing and treating clients. The student therapist might also request that the client sign this form for release of medical or educational records (Eastern Kentucky University, 2011). The release of information form can be used to obtain client consent for sending the current treatment information to other institutions, as well.

**No-Show and Cancellations**

A client is typically considered a no-show if he or she has not arrived fifteen minutes past his or her scheduled appointment time. Most clinics require a client to contact either the clinic staff or the client’s therapist within twenty-four hours of the scheduled appointment to cancel. If this is not done, the client will be billed for the missed session.

At Georgia Southern University (2011), if a client fails to attend two consecutive sessions without notifying the clinic twenty-four hours in advance, the student therapist will mail the client a letter informing him or her of the clinic’s policy to discontinue treatment after two missed sessions. The letter should also include appropriate referrals to other mental health agencies. The therapist should place a copy of this letter in the client’s file.
Client Records

Contents of Client Files

Each client must have a file compiling their therapy information. Files should be stored in a locked file cabinet, preferably behind a locked office door for increased security. The client’s file should include whatever forms were obtained in the first session, an official intake report written by the student therapist, and weekly progress notes. The University of Hawaii suggests that “these notes should clearly indicate coverage of any client homework assignments, session themes, problems discussed, and any interventions undertaken as well as their effectiveness. They should indicate assignments and plans for the next session,” (2006, p. 22). Additionally, a termination form should be filled out at the conclusion of treatment summarizing what approaches were utilized with the client and if therapy was effective in resolving the client’s presenting problems. It is extremely important that client files be kept organized and up to date.

Documentation of Client Contact

The University of Florida (2007) mentions the importance of every contact (or attempted contact) with the client being recorded. For example, if an individual leaves a voicemail at the clinic requesting therapy but does not respond to a series of three phone calls made by clinic staff, most clinics would assume that the individual has changed his or her mind and no longer is interested in therapy. Documentation of all attempts to reach this person, including date, time, and contents of the message left, would protect
the clinic in the event of the individual claiming that his or her request for therapy was ignored. Thorough recordkeeping is the backbone of modern day therapy.

**Disposal of Client Files and Session Tapes**

Most university clinics mention in their manuals that client files should never leave the clinic under any circumstances. Student therapists should complete all paperwork in the clinic office and immediately return the client file to the locked file cabinet as soon as recordkeeping is complete. This policy also pertains to any audio or visual record of the client’s sessions, be they tape recordings, VHS, or DVD (different clinics are equipped with different levels of technology). These records should also never leave the locked file cabinet unless they are being reviewed by the student therapist or the student’s supervisor.

Different states vary in the length of time that clinics are required to retain client records. In California, therapists must retain client records for seven years after the final session. If the client was a minor at the time of therapy, the clinic must retain the client’s records for seven years after the client has turned eighteen. When client files are disposed of, they should be either shredded or burned to ensure that all confidential material is entirely destroyed. Most university clinics destroy all recordings of clients at the conclusion of the semester. This should be done by recording over the client’s sessions or shredding DVDs (Nova Southeastern University, 2012).

**Termination**

At a university clinic, duration of treatment is often determined less by resolution of the client’s presenting problems than it is by the limitations of the university calendar.
Most clinics operate by receiving new clients at the beginning of the semester and terminating all cases at the end of the semester. University clinics do not operate when the university is closed, which means that no clients can be seen during gaps between semesters. Although clients are welcome to reapply for the following semester, they are not guaranteed readmission.

To ready clients for the end of treatment, student therapists should begin preparation for the final session over a course of several weeks. This means that the client should be discouraged from delving into new issues unless these are unavoidable; the focus should remain on pre-established goals. For clients with more severe issues, it is recommended that a list of appropriate referrals in the community be provided.

Some universities request that clients fill out an evaluation of their therapists. This is to provide the student therapists with better feedback about their performance. This evaluation might include such areas as the client’s assessment of the therapeutic alliance, the therapist’s competence, and whether or not therapy helped (University of Georgia, 2008). Additionally, a follow-up assessment is sometimes sent out to clients six months after termination to assess if any gains made in therapy are still present.

**Supervision**

Therapist trainees working at university clinics are required to receive at least two hours of group supervision or one hour of individual supervision per five hours of client contact. The quality of supervision provided to students has been cited as the most important factor influencing the student’s performance (APA, 1950). Larson (1987) suggests a series of steps for supervisors to follow in assisting therapist trainees. First,
the supervisor must observe the student conducting therapy either through a one-way mirror or watching tape recordings of the therapy sessions. From this observation, the supervisor determines what skills the student is lacking. During weekly supervision, the supervisor suggests an intervention to help the student improve in a specific area of weakness. Then, the supervisor monitors the student’s progress to evaluate the success of that intervention. If the intervention was not effective, the supervisor should attempt another strategy to help the student gain the same skill. If the intervention was effective, the supervisor should target another area in which the student could use improvement. It is advised (Hatcher & Lassiter, 2007) that supervisors receive special training in this area. Supervisors should be licensed, with clinical psychologists preferred over marriage and family therapists (Hatcher & Lassiter, 2007).

A final issue to consider in supervising student therapists at a university clinic is the issue of multiple roles. Especially in smaller clinical programs, a supervisor might also be the clinical director and a student’s professor or even advisor. Where possible, this should be taken into consideration among faculty.

**Safety and Emergencies**

**Child Safety**

In general, children should not be brought to sessions unless they are partaking in the therapy. Nova Southeastern University’s (2012) policy is that no child under the age of twelve may be left alone in the waiting room. Client’s should be made aware of this prior to the first session so that they may make arrangements for child care. If a client
brings his or her young child to a session anyway, he or she should be politely reminded that the session that day will have to be cancelled.

**Student Therapist Safety**

Although most clinics screen clients such that no one with a history of violence may enter therapy at the clinic, reasonable precautions must still be taken for therapist safety. At many clinics, students are not allowed to see clients at times when there is not another student, supervisor, or staff member in the clinic. This is especially important for evening appointments, when very few other people are still on the university campus.

As a privacy precaution, Georgia Southern University (2011) forbids students from releasing their personal phone numbers or addresses to clients. Clients may reach their therapists through the clinic office phone. Additionally, student therapists should never meet with clients outside of the clinic or offer transportation to clients.

Although not common, some university clinics equip each therapy room with a “panic button.” At East Carolina University (2011), for example, student therapists are instructed to press the panic button in the event of a client emergency; pressing the button automatically contacts campus police, who will then dispatch an officer to the clinic. Eastern Kentucky University (2011), which also utilizes this system, advises that student therapists not inform clients that the police have been summoned.

**Emergency Calls**

University clinics do not provide after-hours emergency services. If an individual who is not a client calls in crisis, he or she should be told to call 911 or other appropriate emergency numbers (Texas A&M University, 2010). Although the individual answering
the clinic phone should be as helpful as possible, non-clients in crisis are not the responsibility of the clinic.

Most manuals recommend that clients be informed at the beginning of treatment about the limitations of the clinic (i.e. that they are unable to provide twenty-four hour emergency coverage and phones are often unmanned over weekends, so an emergency call might conceivably go unanswered for days). Some universities provide clients with a list of the contact information of local emergency services in the hopes of avoiding these calls.

If a client does call the clinic with an emergency, the student therapist should consult with his or her supervisor or the clinic director as to how to proceed. Indiana State University (2011) does allow clients to be seen outside of normal clinic operating hours with the permission of either the clinic director or the student therapist’s supervisor, but with the provision that the staff member giving permission be present during this session.

**Client in Danger of Self-Harm**

Therapists are obligated to take action if they believe a client is suicidal; this is one of the situations in which confidentiality gives precedence to safety. Although some manuals, such as the manual for the University of New Mexico’s (2012, p. 9) clinic, provide no more guidance than, “In case of a crisis or emergency, students should attempt to notify the Director of the Clinic and/or their supervisor,” most manuals give much more detailed instructions for handling a suicidal client.
The University of Santa Barbara (2006) provides an especially detailed procedure for student therapists facing a suicidal client. Their manual first lists risk factors for suicide, such as age, ethnicity, and social factors. Students are instructed to keep these factors in mind while asking the client three main questions: Do you have a plan to kill yourself?; do you have the means to follow through on that plan?; and do you really intend to go through with the plan? Other questions are listed to assess how intensely suicidal the individual is and how well-thought out his or her plan is.

All of the manuals that discuss procedures for a suicidal client agree that the client should not be left alone or allowed to leave the clinic if the student therapist has determined that he or she is acutely suicidal. Even a trip to the bathroom should be accompanied by a clinic worker. The Clinic Director or the student’s supervisor should be contacted, and, if the client demonstrates an intent to act on his or her plan, the campus police should also be notified. The client may need to be hospitalized (either voluntarily or involuntarily). If it is determined that the client does not require hospitalization, some manuals suggest anti-suicide contracts, safety plans, more frequent therapy sessions, or family sessions to alert other family members of the client’s suicidal state. It is extremely important that the student therapist documents whatever action was taken and his or her rationale for proceeding in that way.

**Violent Clients**

When a client demonstrates intent to harm another person, therapists must take appropriate steps to both warn and protect the intended victim; this is another instance where confidentiality does not apply. The University of Santa Barbara (2006) provides a
list of factors to consider in evaluating risk including obvious issues, such as whether or not the client has an intended victim and a specific plan of action, to less commonly considered elements of violent individuals, such as a sense of entitlement and a tendency to hold grudges. If it is determined that a specific individual is in imminent danger, the student therapist must ask the client for the intended victim’s contact information and make every possible attempt to warn the individual of possible violence. Then the student therapist must contact the police and give them the intended victim’s contact information. If the student therapist determines that there is not a significant risk (e.g., the client does not have a specific plan or the means to carry out the plan), he or she must document his or her rationale for not taking action. As with a suicidal client, the student’s supervisor or the Clinic Director should be contacted immediately for further consultation.

If a client is acting aggressively toward his or her therapist, Indiana State University’s policy is to have the therapist immediately terminate the session, ask the client to leave the clinic, and go to a safe place (2011). From there, the student therapist should contact campus security and follow whatever instructions are given. Student therapists should always sit closer to the door of the therapy room, with the client situated farther in the interior of the room; this is to protect the student in the event of the client becoming combative (Indiana State University, 2011).

**Clients Whom Abuse Substances Prior to the Therapy Session**

The University of Northern Colorado (2010) provides the only manual of the sample to discuss a procedure for dealing with a client who comes to the clinic clearly
showing the effects of recent substance use. Student therapists are required to ask clients suspected of abusing substances what substance was used and how much as well as how they got to the clinic. If the client is clearly not sober, it is inappropriate to proceed with the therapy session. The student therapist should make sure that the client has a ride home, either via public transportation or a friend/relative. If the client becomes belligerent, it may be necessary to call the campus police. As with all emergency situations, the student therapist must contact his or her supervisor and carefully document what occurred. In the following session with the client, this issue should be discussed.

**Child Abuse**

Reportable abuse in children under the age of eighteen includes physical, sexual, and verbal mistreatment, as well as neglect. Almost all manuals describe a procedure for handling suspected or confirmed child abuse. At Regis University (2012), it is recommended that the student therapist inform the client (or parents of the client) that a child abuse report will be made to help preserve the therapeutic alliance and avoid the shock of a surprise Child Protective Services (CPS) visit. The student therapist must file a verbal report with CPS by phone within twenty-four hours of learning about the abuse and mail in a written report within thirty-six hours. Regis University also provides guidelines for instances where the student therapist judges that it may be unsafe for the child to return home; this would include cases where the abuse is extremely severe or the therapist suspects that the child might face retribution for disclosing the abuse (2012). In these cases, the police should be contacted and law enforcement will determine if the child should be placed in protective custody.
Elder and Dependent Adult Abuse

In California, therapists must report the abuse of elderly persons sixty-five years of age or older as well as dependent adults between the ages of eighteen and sixty-four. Categories of abuse in these populations that mandate reporting are physical abuse, neglect, abandonment, isolation, or financial abuse. Procedures for reporting these types of abuse closely resemble reporting child abuse, though fewer manuals mention them. Student therapists must call Adult Protective Services (APS) within twenty-four hours to make a verbal report of the incident and send APS a written report within two working days.

Other Emergency in the Clinic

Although relatively few manuals discuss miscellaneous emergencies that might be encountered in a university clinic, these are also important procedures to consider. In the event of a medical emergency in the clinic, Eastern Kentucky University (2011) requires students to immediately call the campus police, followed by the Clinic Director. If the individual involved is a client at the clinic, a detailed report of the incident, all steps taken, and the outcome should be included in the client’s file.

If a fire alarm sounds during a session with a client, Marshall University’s (2012) procedure is to have student therapists instruct clients of the exit route and ask them to return to the clinic once the all-clear has been sounded. Student therapists should check that the clinic is locked before exiting. Due to issues of confidentiality, it is inappropriate for a therapist to wait with a client outside; however, if the client is a child unaccompanied by any adult, the therapist should remain with the client. In the event of
an actual fire, multiple manuals stress the importance of having a predetermined exit route from the clinic. Student therapists should immediately evacuate, assisting others if it is safe to do so.

In the event of an earthquake or weather emergency, each clinic should determine the safest place for student therapists, faculty, and clients to go. At Southern Illinois University Carbondale (2011), this is the materials library, as it is a room with no windows and no large, moveable furniture.

**Summary of Emergency Procedures**

Even manuals that include very little detail about handling emergencies mention the importance of immediately contacting the Clinic Director or a supervisor as soon as an urgent situation arises. These individuals should make a priority of giving student therapists their contact information and attempt to be reachable at all times, should an emergency situation arise (Southern Illinois University Carbondale, 2011). Utah State University’s manual (2012) also emphasizes the importance of taking steps to address client crises before they occur, such as not accepting individuals to the clinic who are likely to have crises, informing clients at the onset of treatment what services in the community to contact if an emergency does arise, and monitoring the client during treatment for any sudden changes in functioning.

Above all, manuals reinforce that student therapists should err on the side of caution when human lives are at stake. For example, if the therapist even suspects that abuse is taking place, it would be better to file a report than remain silent and face tragic consequences later. Consultation with experienced faculty members can help with these
difficult decisions. In every emergency situation, student therapists must be sure to
document the actions that they take and their reasoning behind those actions. This is
extremely important should the client’s files ever need to be examined in court
(University of Santa Barbara, 2006).

Legal Policies

Court-Mandated Therapy

Of the sample manuals, only the University of Louisiana at Monroe (2011)
addresses the issue of court-mandated therapy. A court might order an individual to
receive a certain number of sessions of therapy as part of his or her probation agreement;
these sessions are expected to focus on a goal related to the individual’s crime. For
example, a man arrested for domestic violence might be ordered to attend twelve sessions
of therapy that will teach him anger management skills. The University of Louisiana at
Monroe’s (2011) policy is to accept mandated clients just as they would any other
individual; however, they advise that the student therapist proceed with care. The case
referral should be closely reviewed with the supervisor, and once release of information
forms have been signed by the client, the student should contact the client’s judge or
probation officer, as well. The manual explains that “every effort should be made to
clarify and assist in meeting the goals of both the referral source and the client in cases

Subpoenas and Court Orders

Of the sample, only the University of Rhode Island, Nova Southeastern
University, the University of Louisiana at Monroe, and Marshall University include
sections in their manuals describing how to respond to subpoenas or court orders. Marshall University (2012) advises students to immediately consult with their supervisor if a subpoena is received. Even if the subpoena specifically requests copies of the client’s records, the student therapist should not comply; a subpoena only requires a response from the student. Nova Southeastern University (2012) elaborates that in order to comply with a request for the student therapist to appear in court or a request for client records, the student therapist must receive either authorization from the client or a court order.

Because a subpoena could occur in any therapy case, the University of Rhode Island (2012, p. 27) warns that “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 the court.” Many manuals stress that student therapists should write client progress notes with the knowledge that the notes might someday be seen by the client, a court, or the Board of Behavioral Sciences. The student therapist should keep this in mind while working on client files and choose what to write with extreme care.

Requests for Litigation Support

Although licensed Marriage and Family Therapists are often asked to appear in court on behalf of a client, this is not typically in the experience of a therapist trainee. Only the University of Louisiana at Monroe (2011) addresses this issue in their clinic manual. The university’s policy is to not offer “divorce mediation, child custody evaluations, or litigation support services. Expert witness and legal support services must
be directly performed by a licensed therapist,” (p. 46). Should individuals apply to the clinic with the intent of seeking a child custody evaluation, or with child custody as one of their primary concerns, the clinic should refer them to a therapist who would be able to assist them in court.

**Client Access to File**

Only Eastern Kentucky University (2011) has a formalized procedure to follow in the event of a client asking to see his or her treatment record. First, as usual in difficult situations, the student therapist should consult with his or her supervisor. Then, the student therapist should discuss the situation with the client and ask why the client wants to see the record. If the client has a specific question (e.g., the client might be curious if the therapist has labeled the client with a diagnosis), the student therapist might be able to answer without letting the client view the records. If the client persists, the student therapist might provide the client with a summary of the case file written in terms easily understandable by a layperson. If this is still not sufficient, the clinic is not permitted to deny access to the file itself, though it is recommended that the student therapist or even the supervisor of the case prepare the client and view the records together to fully explain all of the material. Although the information in the file belongs to the client, the file itself belongs to the clinic, so the client may not remove the file from the clinic.

**Parent Access to the File of A Minor Client**

In California, parents are permitted to view the file of their child if the child is under the age of eighteen. However, for the sake of the therapeutic relationship, it is advised that parents not use this privilege (University of Santa Barbara, 2006). Should
the client be harming him or herself or others, parents should always be informed, but in all other instances, the therapist should only share the major themes of treatment.

**Ethical Principles**

Although ethical principles are mentioned throughout manuals, due to the importance of this issue, it is often elaborated on. It is common for manuals to link students to the American Psychological Association’s webpage with the official code of ethics; students are expected to be familiar with these principles. Prior to enrolling in practicum (the class that encompasses work as a student therapist), students will have been required to pass a class on ethical principles, so this information should be a review.

**Confidentiality**

The most common issue discussed in this section is that of confidentiality. It is appropriate for a student therapist to discuss his or her clients with the Clinic Director, a supervisor, or other student therapists currently enrolled in the practicum. The purpose of such discussions is to aid the student therapist in treating the client. For example, a fellow student therapist might be aware of resources in the community that even the supervisor does not know of. Discussion of a client should always be professional in nature. It is not appropriate to gossip about clients or share detailed information about the client for purposes other than consultation.

Supervision or client consultation should always take place in a private area to ensure that other individuals will not overhear. At California State University, Sacramento, the large, group therapy room was set aside for this purpose, as it allowed space for all of the student therapists but was also locked, so others could not intrude.
Student therapists should never discuss clients in other classrooms, hallways, or the clinic waiting area; this is disrespectful and unprofessional (University of Santa Barbara, 2006).

**Phone Contact with Clients**

At the time of the initial interview (either over the phone or in person), many universities recommend that the student therapist ask the client if he or she comfortable with receiving voicemail or letters identified as coming from the clinic. For privacy reasons, such as if other members of the client’s household are not aware that he or she is receiving therapy, the client might not wish for messages to include mention of the university clinic. In this case, the therapist should leave messages identified only by the therapist’s first name and the name of the university. It would be prudent for the therapist to inform the client of what potential messages will contain to ensure that the client is satisfied. In the event that the client has not been asked about his or her preferences regarding voicemail or letters, the student therapist should err on the side of caution and not include any information implying that the message is coming from the clinic.

**Phone Contact with Non-Clients**

Nova Southeastern University’s manual mentions in this section the issue of phone contact with other individuals in the client’s life (2012). Unless the client has filled out the release of information form for this specific individual, not only can the therapist not discuss the client’s case: the therapist can neither confirm nor deny that the client is even a client. It is recommended that in the event of receiving such a message, the student therapist first consult with his or her supervisor, then respond to the caller by
saying that no information can be given until the clinic receives the appropriate authorization from the client. Depending on the nature of the call, this should be discussed with the client in the following session.

**No Secrets Policy**

The University of Santa Barbara (2006) describes a “no secrets” policy for couples and family therapy in this section of the clinic manual. This policy means that anything one member of the couple or family says to the student therapist in private can be disclosed to any other member of the group. For example, if a teenage client tells the therapist that she has been smoking marijuana, the therapist then has the right to bring this to the attention of the teenager’s family. This policy should be brought to attention at the beginning of any couples or family therapy. An exception to the rule of no secrets is if one member of the couple or family is also receiving individual therapy at the clinic under the care of a different student therapist. In this case, whatever the individual shares during his or her session would fall under the normal rules of confidentiality and not be shared with anyone else.

**Confidentiality with Child Clients**

Confidentiality with clients under the age of eighteen is very different than with adult clients. For young children, university clinics often permit the child’s parents to watch sessions from behind a one-way mirror, fully divulging the contents of the child’s therapy. Even if observation of sessions is not permitted, student therapists will often brief the client’s parents on what the child discusses during therapy, or at least the major themes. This is to help parents carry any interventions developed in therapy back into the
child’s home life for maximum reinforcement. Naturally, any concerning material that a child shares (such as an intense wish to die) should be brought to the attention of both the therapist’s supervisor and the child’s parents immediately.

Although children are used to having little privacy, this issue is much more relevant to adolescents. With teenage clients, it is imperative that they can trust their therapists not to share personal matters with their parents. In general, the same rules of confidentiality with adult clients should apply to teenage clients with the only additional exception that if the client is frequently engaging in behavior that is highly destructive or illegal, the parents should be notified (Gardner, 1975). This stipulation should be explained to clients at the beginning of therapy. Destructive behavior might involve regular use of illicit substances, unprotected sex, or cutting oneself.
Chapter 3
DISCUSSION OF CLINIC MANUALS

From this review of policy and procedure manuals, it is clear that not all universities have equal strengths in this area. To assist in creating more rigorous policy and procedure manuals for university clinics, Hatcher et al. (2011) have suggested six major areas that must be addressed: administrative set-up and policies, student evaluation, elements of the practicum experience at the university clinic, elements of the practicum experience at external clinics (if applicable), the balance between the university clinic and off-campus practicum sites (if applicable), and the basic features of the practicum. However, even Hatcher et al. have not highlighted what is perhaps the most ignored area in clinic policy and procedure: the handling of emergencies.

Manuals and strict guidelines are at their most useful during emergency situations due to the high potential for inexperienced clinicians to act out of panic and the real likelihood that lives might be at stake (Dinoff et al., 1985). The handling of emergencies in university clinics is an issue that is rarely addressed in the literature, which becomes all the more worrisome when combined with the results of one study which found that only 6 out of 34 policy and procedure manuals even mentioned emergency protocol (Bernstein et al., 1991). The current analysis of policy and procedure manuals echoed these findings – although most manuals do mention crisis situations, some are much more thorough than others. The most common emergency situations mentioned in the current sample of manuals were a client in danger of self-harm and the necessity of reporting child abuse.
Although these issues are important to consider, there are many other equally crucial emergencies that should also be mentioned. Not a single manual addressed every emergency situation considered in Chapter 2 of the current report. Additionally, manuals varied greatly in the depth of the procedures offered for handling emergency situations. Some only said that in the event of an emergency, the student therapist should contact either the clinic director or the student’s supervisor. Although that is doubtless important, it does not address the urgency of a crisis or provide for the – hopefully rare – situation where neither the clinic director nor the supervisor can be reached. The best policy and procedure manuals include a thorough, numbered list of steps that a student therapist should follow in the event of an emergency.

It appears that clinic directors understand the importance of including emergency procedures in their manuals, but there is a major discrepancy between what the directors acknowledge manuals should contain and what they actually do contain. In one study, for example, 95% of clinic directors reported that the clinic manual should include information related to the handling of emergency intakes, but only 19% of manuals cover this topic (Dinoff et al., 1985). Of even more concern, 93% of clinic directors believe that manuals should contain information pertaining to emergency client hospitalization, but less than one-third of manuals do (Dinoff et al., 1985). The Georgia Supreme Court case *Emory University v. Porubiansky* (1981) established the precedent that any training clinic offering services to the public must offer “a standard of reasonable care comparable to other professionals in the community,” (Bernstein et al., 1991). Although that case involved a college dental program, it has implications for university clinics as
well. If student therapists are found lacking in knowledge of emergency protocol, this could be interpreted as below the standard of care by the court system.

Clinic policy and procedure manuals are used primarily by members of the university faculty, clinic staff, and students; however, since students are most in need of guidelines offered by a manual, Dinoff et al. (1985) suggests that they be addressed as the manual’s main audience. This approach has its benefits and drawbacks. Although Dinoff et al. are correct in their assumption that students are the most likely group to need familiarization with the policies and procedures manual, focusing on students can lead to an unnecessary narrowing of the manual’s topics. For example, the University of Denver (2012) devotes almost three-quarters of their manual to a discussion of student expectations, evaluation procedures, and professional development plans. Although this is an important area to cover, the manual fails to mention any kind of emergency protocol, information about ethical responsibilities, or even basic procedures for conducting therapy sessions. This limited focus causes the manual to read more like a course syllabus than a professional document.

Although most manuals provide a description of expectations for student therapists and evaluative procedures, one issue that is rarely addressed is what to do with students who do not meet those expectations. Therapist trainees might fall short in their clinical abilities, in meeting ethical standards, or in completing assignments. In a five-year period, Shen-Miller et al. (2011) discovered that 98% of faculty and 85% of students could identify at least one student in their programs with serious competence problems. This is especially disheartening given that the majority of students surveyed felt that their
supervisors did not handle such student problems appropriately; the overall effect of having these students in the program was one of demoralization (Shen-Miller et al., 2011). Thibadeau & Christian (1985) recommend performance contracts or checklists in helping solve these problems. A performance contract should be used to evaluate all students at the end of every semester. If the student is not making sufficient progress, increased supervision, extra study, or (in severe cases) expulsion from the program may be warranted. This is a very important area to include in the clinic’s policy and procedures manual, as such guidelines must be made available to students before problems arise.

An ideal university clinic would be available to clients year-round, but this analysis of clinic manuals has revealed that very few are. The typical university clinic only operates when the university itself does; substantial breaks occur in both winter and summer. This is likely due to budgetary restrictions, as the cost of operating the clinic is probably higher than its revenue, especially in larger clinics that hire staff members. However, this discontinuity of treatment is harmful to clients. The two primary factors that influence the success of student-given therapy are length of treatment and the way that treatment is terminated (Murrell et al., 2002). In general, longer-lasting treatment has more favorable outcomes than shorter durations of treatment, and therapy that is terminated by mutual consent has more favorable outcomes than therapy that is terminated by either the client or therapist alone. Client-terminated therapy is difficult to study because it typically happens without warning, but when the student therapist elects to terminate therapy it is usually not a result of the client’s no longer needing treatment.
but rather due to time constraints (Murrell et al., 2002). The constraints of time caused by the university system can be very difficult to conduct treatment schedules around. One study found that only 8% of clients at a university clinic were satisfied with their termination (Bernstein et al., 1991).

Client satisfaction is extremely important to consider in determining the effectiveness of a university clinic, but very few policy and procedure manuals include any sort of protocol for this area. The University of Georgia (2008) addresses this issue the most thoroughly, conducting surveys with clients after every fourth session, immediately upon termination, and six months following termination. Student therapists are not allowed to see the surveys until after termination so as not to contaminate treatment. These surveys provide a quality check not only for the individual students, but for the clinic as a whole. Those studies that have examined client satisfaction show favorable results; research by Murrell et al. (2002) found that 68% of clients at one anonymous clinic reported at least some improvement by the end of treatment. A study at another university revealed that 84% of clients surveyed in follow-ups report that no new problems have arisen, indicating that therapy at university clinics can lead to lasting gains (Messer & Boals, 1981). Including procedures in a clinic manual to gauge client attitudes toward the therapy is a very helpful step toward catering to client needs instead of just the needs of students and faculty.

In every area of clinic operation, the best manuals are those that are the most thorough and consider the needs of all four groups who are affected by its contents: students, faculty, staff, and clients. Although clients are not the intended audience of the
manual, it is prudent to consider that a client might see the manual at some point, especially if the manual is freely available online (as all of the manuals in this sample are). The manual should be reviewed as if a client were reading it; the author of the manual should ask himself or herself if potential problems could arise from a client seeing a portion of the manual. For example, the University of Toledo (2010) includes the location of a hidden emergency key to the clinic. Should a client at their clinic read this information, problems could easily arise. The University of Hawaii (2006) includes a five-page “mini manual” within the greater policy and procedure manual called “A Client’s Guide to Psychotherapy.” This guide describes, in layman’s terms, the purpose of therapy, confidentiality, how to address dissatisfaction with one’s therapist, and other questions that it is suggested the client should ask the therapist such as what are the therapist’s personal values and does the therapist have a contingency plan for emergency situations. The inclusion of such information in the manual is intended as a handout at the beginning of therapy, but should a client (or potential client) encounter the information online, this might increase his or her confidence in the university’s sensitivity to client needs.

Graduate training has been consistently identified as one of the most stressful times in a therapist’s career (Shen-Miller et al., 2011). One way to make this difficult time less uncertain is to have a clear policy and procedure manual in every university clinic. By describing in detail what is expected of supervisors and students, the mundane details of clinic operation, and contingencies for emergency or legal situations, much of the guesswork of practicum can be removed. The practicum experience can be both
intimidating and intensely rewarding for beginning therapist trainees; these manuals can make the difference between a failed clinic and a successful one.
Chapter 4

A THEORETICAL UNIVERSITY CLINIC POLICY AND PROCEDURE MANUAL

What follows is a theoretical manual for the Psychological Services Center (PSC) at California State University, Sacramento (CSUS). As previously mentioned, this clinic was operated by students enrolled in the counseling track of the graduate psychology program until 2011. It is located in Amador Hall, Room 241, and is currently used by members of the Applied Behavior Analysis program.

This manual recreates the clinic environment as it was in years past. A maximum of eight counseling psychology students could be enrolled in practicum per semester. One faculty member served as the Clinic Director, while two faculty members switched off as the students’ supervisor each semester. One student was elected by the clinical faculty (a total of four individuals as of 2011) each semester to serve as the PSC’s Clinic Coordinator. The Clinic Coordinator was usually, but not always, currently enrolled in the practicum.

This manual is a composite of the twenty-five manuals used in the sample analysis. Forms have been created both from existing forms used by the CSUS PSC and additional forms used by other university clinics. Although there is no longer a practicum offered through the graduate psychology program at CSUS, should the counseling track ever be reinstated, this manual might serve as a guide for clinic policy and procedures.
California State University, Sacramento

Psychological Services Center

Policy and Procedure Manual

2012-2013
Mission Statement

The Psychological Services Center (PSC) is a professional training facility for masters students in the counseling track of the graduate psychology program. The PSC is operated by clinical faculty members of California State University, Sacramento (CSUS); it is located on CSUS’ campus, in Room 241 of Amador Hall.

The PSC aims to provide high quality, free counseling services to individuals, couples, and families in the Sacramento area who seek treatment. The PSC’s other primary function is to serve as a training facility for graduate students in their development as professional therapists. Additionally, the PSC is often used as a research facility for students and faculty.

This manual is intended for use by practicum students and clinical faculty. Students enrolled in practicum are expected to have a thorough knowledge of the policies and procedures discussed here.

Contact Information

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>Clinic Director</th>
<th>Student Supervisor (Fall Semester)</th>
<th>Student Supervisor (Spring Semester)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dr. Rebecca Cameron</td>
<td>Dr. Lee Berrigan</td>
<td>Dr. Marya Endriga</td>
</tr>
<tr>
<td>Office Phone Number</td>
<td>916-278-6892</td>
<td>916-278-7364</td>
<td>916-278-6735</td>
</tr>
<tr>
<td>Campus Email Address</td>
<td><a href="mailto:cameron@csus.edu">cameron@csus.edu</a></td>
<td><a href="mailto:lberrigan@csus.edu">lberrigan@csus.edu</a></td>
<td><a href="mailto:mendriga@csus.edu">mendriga@csus.edu</a></td>
</tr>
</tbody>
</table>

Clinic Phone Number: 916-278-6887

Clinic Address: Psychological Services Center
California State University, Sacramento
6000 J Street
Sacramento, CA 95819-6007

Campus Police: 916-278-6851
Hours of Operation

Monday-Thursday: 9:00 A.M. – 9:00 P.M.
Friday: 9:00 A.M. – 5:00 P.M.

Notes:

- The clinic is not open during Summer or Winter Intercessions, nor is the clinic open on university holidays.
- Students should not schedule clients during times when no other students or faculty will be in the clinic.

Commitment to Diversity

The PSC, like all of CSUS, strives to foster a diverse and inclusive atmosphere. Students, faculty, and clients will not be discriminated against based on race, ethnicity, gender, disability, religion, sexual orientation, gender identification, or age.

Confidentiality

The PSC is committed to maintaining client confidentiality. Students are responsible for safeguarding all material that is shared in therapy, with the exception of the following situations: the client is in danger of harming himself/herself; the client has clear intentions to harm another person; or the client reveals that a child under the age of eighteen, an adult over the age of sixty-five, or a dependent adult is being abused. Students are bound by law to take action when one of these situations arises. For more information, see Safety and Emergencies.

Clinic Facilities

The clinic is located on the second floor of Amador Hall in Room 241. It consists of a client waiting area, a student/faculty office, a research library, three individual
therapy rooms, and one larger therapy room that is used for seeing families and group supervision. Clinic room F is a fourth individual therapy room; however, it is only equipped with audio recording, and is therefore not used for sessions. The clinic annex is located behind the clinic itself and consists of observation areas to watch sessions in progress behind a one-way mirror, storage space, and recording equipment.

All of the clinic doors require the same key. At this time, students are not allowed to check out keys themselves; only faculty members may submit key requests. The cost for replacing a lost key is $50, which the student is responsible for paying should his or her key be misplaced.

The doors to the clinic office, clinic annex, and individual therapy rooms lock immediately upon being closed. The main door into and out of the clinic does not automatically lock. This door should be kept unlocked when clients are expected, but locked at all other times. The group therapy room has two doors. The door leading into the corridor of Amador Hall does not automatically lock when closed; it should be kept locked at all times. The only time this door is used is when student therapists are in supervision. Clients being seen in the group room will use the second door, which opens from the end of the clinic’s hallway. This door does not have a lock; student therapists must hang the “in use” sign on the doorknob while in session.

The clinic is equipped with two white noise machines, located on the floor of the clinic’s hallway. During client sessions, both of the white noises machines should be on to avoid leakage of sound from any of the therapy rooms.
The office phone should not be answered by anyone other than the clinic coordinator or a faculty member. Each student therapist will receive an individual voicemail number and password to access voicemail on the first day of practicum. Students are responsible for checking voicemail every day and should return client calls promptly. Students should not give clients their personal phone numbers; all clients must contact student therapists through the clinic voicemail.

Clinic voicemail is confidential, which means that the clinic coordinator or a faculty member might leave detailed information via a voicemail message. However, students’ personal phones are not considered confidential. Therefore, if a student therapist should need to discuss confidential information with another student, he or she should leave a detailed message only on the student’s clinic voicemail. A message left on the student’s personal voicemail informing him or her to check the clinic voicemail account would also be appropriate.

All client sessions must be audio and video recorded. The three individual therapy rooms (C, D, and E) and the group therapy room are each connected to a television and VCR located in the clinic annex. Before each session, students must plug in the video camera outside the therapy room, switch on the audio tower in the clinic annex, and set the VCR to record. For taping in the group therapy room, a camera located in the clinic annex must be wheeled into group room and plugged in. After the therapy session is completed, the student is responsible for turning off all equipment that has been used. VHS tapes that have been used for client sessions should never leave the clinic. Unless otherwise specified, all tapes should be erased at the end of the semester.
The clinic supervisor will cover detailed recording instructions in the first practicum meeting.

Dress Code

Student therapists must project a professional image at all times when in the clinic, whether or not they are there to see a client. A business casual dress code should be adhered to, with slacks and a button-down shirt or sweater appropriate attire for men and slacks, a skirt, a dress, or a blouse appropriate for women. The following clothing is not acceptable for the clinic: jeans, shorts or cutoff pants, t-shirts with logos, casual shoes, formal wear, hats, and revealing clothing (including tank tops, low-cut shirts, short skirts, etc.). Should the student therapist have any questions about these guidelines, he or she should contact either the clinic director or the clinic supervisor. Student therapists who do not follow the dress code might be asked to leave the clinic.

Student Therapists

*Eligibility for Practicum*

In order to qualify for enrollment in practicum, students must have passed each of the following courses with a B- or better: PSYC 201, 223, 227, 268, and at least one of the following: PSYC 225, 235, or 253.

Eight students at a time may be enrolled in practicum. In the event of nine or more students wishing to enroll in a given semester, the clinical faculty will choose students based first on who has already achieved the mandatory 150 client contact hours needed for graduation. Students who have already met this requirement will be given lower priority than students who still need these hours. Next, clinical faculty will
consider the students’ anticipated dates of graduation, with students who are closer to graduation receiving priority for enrollment over students who are farther from graduation. In the event of these measures not being sufficient, a lottery will be employed to choose which students will be enrolled.

One student therapist per semester will serve as clinic coordinator. Students may nominate themselves for this position or be nominated by clinical faculty. The clinic coordinator is responsible for fielding calls to the clinic, writing detailed requests for therapy and presenting these to the clinic supervisor to assist in client selection, and maintaining the clinic environment. As of 2012, the holder of this position does not receive a stipend.

*Expectations while Enrolled in Practicum*

Student therapists are expected to see at least three clients per semester, with a maximum client load of five clients at any given time. However, this requirement is dependent on the number of individuals who seek counseling from the PSC, which can vary greatly from semester to semester.

In addition to the regular duty of maintaining a client’s file, students are expected to submit a detailed intake report for each client to the clinic supervisor within two weeks of the client’s first session. During some semesters, students might be expected to complete additional assignments, such as literature reviews. More detailed information on these assignments will be given on the first day of practicum.

In general, student therapists should not miss any client sessions except in cases of illness or emergency; absences due to vacation or leisure should be discussed with the
clinic director or supervisor, who may allow or dismiss these requests at their discretion. Student therapists should cancel sessions with any clients who might be affected by the absence with as much notice as possible. Unexplained or repeated absences by the therapist are unacceptable and constitute grounds for dismissal from the practicum.

Evaluation

During Week 8 (the halfway point) of each semester, every student therapist will have a joint meeting with the clinic director and clinic supervisor. During this meeting, the faculty members will discuss the student’s performance thus far and suggest ideas for improvement. If the student is found to be performing satisfactorily over all, this is where the meeting will end. However, if the student is having significant difficulties and the faculty members deem his or her performance to be unsatisfactory, a plan for remediation will be instated. The student’s individualized plan will be handled at the discretion of the faculty members. Possible options include, but are not limited to, extra supervision for the student, reading assignments with accompanying book reports, and joint therapy sessions where a faculty member sits in and helps conduct the student’s session. Should the student fail to improve, more serious measures might be taken, such as removal from the practicum.

Insurance

Each student therapist is responsible for purchasing liability insurance prior to seeing any clients. Insurance must cover $1,000,000 per claim and $3,000,000 aggregate. It is recommended that students apply for insurance from Healthcare Providers Service
Organization (HPSO). As of 2012, HPSO charges therapist trainees $20 for a year of coverage at these standards.

Prior to the First Session

Selection of Clients and Case Assignments

The PSC advertises for clients in the publication *Parenting Magazine* and on Sacramento’s local NPR radio station. Occasionally, if client volume is low, an advertisement will be placed in the *Sacramento News and Review*. Many clients are referred from other agencies due to not being able to afford a weekly fee. Additionally, word of mouth from previous clients is responsible for many new client referrals.

The PSC does not accept walk-in requests for therapy. Individuals seeking therapy must contact the clinic office. It is the clinic coordinator’s responsibility to field these calls. The clinic coordinator speaks to each prospective client to ascertain his or her reason for seeking therapy. Based on this conversation, the clinic coordinator completes a Request for Counseling Form (see Appendix A), which is assessed by the clinic supervisor, who then determines if it would be appropriate to offer services. In cases where an individual cannot be accepted into treatment, the clinic coordinator contacts him or her again and offers referrals to other low-cost agencies in the region.

Once a Request for Counseling has been accepted, the clinic supervisor assigns the case to a student therapist. Often, the selection of a student therapist is determined by which student currently has the fewest clients. Should the client have a special request for his or her therapist (e.g. requesting a therapist of a specific ethnic background), the supervisor will usually attempt to match the request with an appropriate student, if
possible. Once a client has been assigned to a student therapist, the client should be contacted within one week and an intake appointment scheduled as soon as possible.

With a full enrollment of eight students, between 24 and 40 clients may be accepted into treatment. When a client limit has been reached, new requests for counseling will be placed on a waitlist or offered referrals to other agencies.

Parking

Clients of the PSC are eligible to receive a complementary parking permit that is valid for the time of their weekly appointments. During the first phone contact after the client has been accepted for therapy, the student therapist should inquire as to the client’s method of transportation. If the client will be parking on campus, the student therapist should request the license plate number of the car that the client will be using. The student therapist then submits a parking request to the clinic coordinator; these requests are located in a binder in the clinic office. The client’s full name, license plate number, and dates/times of sessions will be necessary for this request. Should a client need to change his or her weekly appointment later in the semester, a new permit request will be necessary.

Parking permit requests might take several weeks to fulfill. During this time, clients will have to pay for a daily permit ($6) or a two-hour permit ($3). As most sessions last only 50 minutes, the two-hour permit option should be sufficient.

Fees

The PSC at CSUS does not charge clients any fees for treatment.
The First Session

*Room Assignment*

A logbook is located on the desk of the clinic office. Here, students are expected to write their first name (using pencil only) in the appropriate square for the room, time, and day of the week that they are requesting. Prior to scheduling a client, student therapists should make sure to consult the room assignment book to check if there is an open room for the timeslot they are considering. Once a client has a regular meeting time, the student therapist should mark that time in every week for the remainder of the semester. Should a client cancel a session or end treatment at the PSC, the student should erase any room reservations for that client from the logbook.

A therapy session with an individual client or couple should last between 45 and 50 minutes. For sessions with families, 90 minutes is the typical duration. Student therapists must be careful not to let sessions run long, both because this is unprofessional and because another student might have the room reserved for the immediately following timeslot.

*Preparation of the Therapy Room*

While setting up recording equipment prior to the start of each session, student therapists should make a quick inspection of the therapy room that will be used. The clock should display the correct time. If the box of tissues only has one or two tissues left, it should be replaced with a new one (found in the clinic office). The room should appear neat and orderly. The student should turn on both white noise machines and
check that an image of the therapy room appears on the corresponding television monitor in the clinic annex (indicating that the recording equipment is working correctly).

Consent to Treatment

Prior to the start of the first session with a client, student therapists must describe the limits of confidentiality and receive the client’s signature on a Consent to Treatment Form (see Appendix C). This is mandated by law.

A discussion of confidentiality should begin with the explanation that everything the client says in therapy will remain private between the client and the therapist. The only exceptions to confidentiality are the following instances: the client is seriously considering self-harm, the client is seriously considering harming someone else, or the client mentions abuse of a child, elder, or dependent adult. After listing these exceptions, the therapist should ask the client if he or she has any questions.

Next, the therapist must explain to the client that all sessions will be videotaped. The client should have already been told this information by the clinic coordinator during the initial phone conversation, so this should not be a surprise. The client must be informed that the tapes will only be watched by the small group of students in practicum and the clinic supervisor, and that the tapes will be erased at the end of the semester. Again, the student should ask if the client has any questions about this information.

Finally, the therapist must tell the client that he or she is a therapist trainee under the supervision of a licensed therapist. Once these three factors (confidentiality, videotaping, and the therapist’s qualifications) are discussed, the client must sign an informed consent form. All clients over the age of 18 must sign this form prior to the
beginning of therapy. If the client is under the age of 18, all adults with legal custody of
the client must sign an informed consent form. A modified version of the informed
consent form (see Appendix D) is also given for younger clients to sign. Although this is
not legally necessary, it allows the client to feel that he or she is taking part in the
process. For adolescent clients, the student therapist may decide if the normal or modified
informed consent form is more appropriate.

Additional Forms Used in the First Session

Once the client has arrived at the clinic but prior to the start of the first session,
the student therapist has the option of asking him or her to complete an intake
questionnaire (see Appendix E). When the client has finished, the student therapist
should quickly scan the information given before bringing the client into the therapy
room. Although it is not required that student therapists use an intake questionnaire,
these can be helpful in bringing issues of concern to the therapist’s focus and giving more
structure to the intake session.

If the client has previously been in therapy, the student therapist should request
that the client sign a Release of Information Form (see Appendix F). This form allows
the therapist to contact the previous therapist for the client’s treatment records, which can
be helpful in forming a treatment plan. The Release of Information Form will also be
needed if, at any point in treatment, the client asks for the therapist to send his or her
treatment information from the PSC to another institution. Prior to accepting this request,
the student therapist must obtain a signed copy of this form for the client’s record.
No-Shows and Cancellations

In the first session, the student therapist should explain that the client is responsible for leaving a message on the student’s voicemail if the client is unable to attend a regularly scheduled session. If possible, this cancellation should be given at least 24 hours in advance. The client should also be warned that missing three consecutive sessions is grounds for terminating the treatment agreement.

If a client misses a session without notifying the therapist, the therapist should attempt to contact the client and inquire as to why the session was ignored. If a client fails to attend three consecutive sessions, with the clinic supervisor’s approval, the student therapist should mail the client a letter (see Appendix H) reminding him or her of the clinic’s policy regarding missed sessions and informing the client that treatment has now been discontinued. Included with this letter should be a list of referrals to other low-cost mental health agencies in the region. The therapist should place a copy of this letter in the client’s file.

Client Records

Contents of Client Files

Client files are kept in a locked file cabinet located in the clinic office. It is extremely important that the student therapist keep client files up to date with weekly progress notes summarizing each session. All paperwork related to the client, as well as the VHS tape with client sessions taped on it, should be stored in the client file. This file should never leave the PSC for any reason.
**Documentation of Client Contact**

Any contact, or attempt to contact, the client should be noted in the client’s file. The student therapist should document the date and time of any calls as well as a summary of the conversation or a description of the message left. Likewise, all instances of the client contacting the student therapist should be similarly noted.

**Disposal of Client Files and Session Tapes**

The PSC is mandated by California law to retain client records for seven years after the termination of treatment. If the client was a minor at the time of treatment, the PSC must retain his or her records for an additional seven years after the client has turned eighteen. Clinical faculty are responsible for the appropriate retention and destruction of client records. Student therapists, however, are responsible for destroying all recordings of clients at the end of the semester. The most effective way to do this is to record over the entirety of the VHS tape.

**Termination**

The PSC does not operate over the intercession between academic semesters. This means that all client treatments must be discontinued at the end of the semester. Clients are welcome to return to the PSC in the following semester, but they must reapply to the clinic and are not guaranteed to be admitted again.

Student therapists should begin the termination process two to four weeks prior to the end of the semester. The client should be encouraged to focus on achieving goals that have already been established and discouraged from delving into new issues. The student therapist should ask the client about his or her plans for the future, whether or not the
client perceives therapy to have been helpful, and if the client intends to seek further therapy in the future, either at the PSC or elsewhere. Officially, the last week for students to see clients is the week before finals begin. However, should an emergency arise in the final scheduled session, students may offer an additional session during finals week. This option should only be offered to the client with the permission of a clinical faculty member.

Whether or not a client voices an interest in returning to the PSC the following semester, if his or her issues are moderate or severe, the student therapist should provide a list of referrals in the final session. The student therapist should encourage these clients to look for therapy that can be of longer duration, or at least to consider another agency to fill the interim between semesters.

Student therapists must fill out a Termination Report (see Appendix I) for each client after the completion of treatment. This should be the last item to go in the client’s file.

**Supervision**

Therapist trainees must receive weekly supervision in order to see clients. For a maximum of five client hours per week, students must receive either two hours of group supervision or one hour of individual supervision. The clinic supervisor will contact all students enrolled in practicum the week before the beginning of the semester to inform them if supervision will be held in a group, individually, or as a combination of both formats. If the student therapist is unable to attend supervision for a given week, the student should not see his or her clients that week.
During supervision, new clients are assigned, student therapists share videotapes of their clients for discussion, therapeutic techniques are discussed, or videotapes of famous therapists are watched.

Safety and Emergencies

Child Safety

Clients should be discouraged from bringing their children to therapy unless the child is taking part in the sessions. In the first session, the student therapist should inform the client that no child under the age of twelve may be left alone in the waiting room. If a client ignores this policy by bringing a young child to the clinic anyway, he or she should be politely reminded that the session for that day will have to be cancelled.

Student Therapist Safety

For the protection of student therapists, clients should never be scheduled for a time when no one else is expected to be in the clinic. Students should release no personal information to clients such as personal phone number or home address. Clients are encouraged to call the therapist by his or her first name; the therapist may choose to reveal his or her last name or to keep it private. Student therapists should never arrange to meet with clients anywhere other than the PSC or offer clients transportation to the PSC.

Emergency Calls

The recorded message on the clinic voicemail informs callers that if they are currently experiencing an emergency, they should call 911. Clients should be informed in the first session that the PSC does not provide after-hours emergency services.
Therefore, if the client is in acute crisis, leaving a voicemail for the therapist is usually not the most effective way to receive help. When appropriate, student therapists might decide to give clients the contact information for local emergency services or suicide hotlines.

In the event of a student therapist receiving a voicemail from a client in crisis, the student should first consult with either the clinic director or the clinic supervisor. Although clients still cannot be seen outside of normal operating hours, it might be possible to see the client sooner than his or her next scheduled appointment. Depending on the nature and severity of the crisis, the student’s supervisor might elect to take part in the client’s next session.

*Client in Danger of Self-Harm*

Student therapists are obligated to take action to protect a client who is in danger of self-harm. While assessing for suicide, the student should consider three major factors: does the client have a plan, the means to carry out that plan, and the intention to act on the plan. For example, a client who says that he will shoot himself is of much more concern if he does own a gun than if he does not. If the client admits feeling suicidal but says that he does not think he would act on those feelings, he is of less concern than a client who says he doesn’t know if he would act on his feelings or not.

If, from this assessment, the student therapist determines that the client is actively suicidal, the client should not be left alone or allowed to leave the clinic, even to use the bathroom. The student therapist should immediately contact the clinic director or the clinic supervisor and the campus police. The clinical faculty can help the student
therapist to determine if the client will need to be hospitalized. If the client does need to be hospitalized, the campus police will escort him or her to the nearest hospital. If the client does not need to be hospitalized, the clinical faculty can help the student therapist to develop a new plan for the client’s treatment, such as increasing the frequency of therapy sessions or inviting the client’s family to participate in therapy to help create a safety plan.

When working with suicidal clients, it is even more important than usual to document every decision made. Whatever actions the student therapist takes, the rationale behind each decision should be thoroughly documented.

**Violent Clients**

Student therapists are obligated to take action when a client expresses intent to harm another person. As with a suicidal client, there are several factors that must be considered in evaluating level of risk, such as if the client has an intended victim and a specific plan of action. If the student therapist determines that another person is in imminent danger, he or she must ask the client for the contact information of the intended victim. Therapists are obligated to both warn and protect potential victims of client violence. To warn the victim, therapists make every attempt to contact the person and inform him or her of what they know. To protect the victim, therapists contact the police and give them the victim’s contact information as well as what the client has said regarding the intended violence.

If the student therapist decides that there is no significant danger present, the rationale for not taking action must be documented. As with suicidal clients, when a
student therapist is concerned that a client poses a danger to another person, he or she should immediately contact either the clinic director or the clinic supervisor.

In the event of the client becoming aggressive toward the student therapist, the therapist should immediately discontinue the session and ask the client to leave the clinic. If the client is not compliant, the therapist should call the campus police. Once the client has left (either voluntarily or by force), the therapist should follow instructions from security officials. Student therapists should always sit in the chair closest to the door in a therapy room, with clients situated in chairs farther away from the door, so that the therapist has an easier escape in the event of the client becoming combative.

*Clients Who Abuse Substances Prior to the Therapy Session*

If a student therapist suspects that a client has been using substances prior to the therapy session, the client should be asked what substance was used, how much, and how he or she arrived at the clinic. If the client is clearly not sober, the therapist should inform him or her that it would be inappropriate and unproductive to continue the session. The student therapist should help the client arrange for a ride home if he or she drove a car to arrive on campus. If the client becomes belligerent, the student therapist may need to contact campus police. Once the client has left, the student should contact either the clinic director or the clinic supervisor. In the client’s next session, this issue should be discussed. If the client is habitually abusing substances, therapy at the PSC is not appropriate. The client should be referred to local substance abuse programs and informed that they will be welcome to apply for counseling at the PSC again when they can control their substance use.
Child Abuse

Child abuse can occur in physical, sexual, verbal, and neglectful forms. If a client mentions any of these types of mistreatment occurring to a child under the age of eighteen, the student therapist is mandated to make both a verbal and written report of the incident. In most cases, the student therapist should inform the client that a report will have to be made so that the client has a chance to ask questions and the therapist can attempt to preserve the therapeutic relationship. The only times clients should not be informed of an abuse report are when the student therapist suspects that the client might take out his or her rage over the report on the therapist or the abused child.

After the end of a session in which child abuse is uncovered, the student should immediately contact his or her supervisor to discuss what will be reported. After consulting with the clinic supervisor, the student should call Child Protective Services (CPS) to file a report; this verbal report must be completed within 24 hours of discovering the abuse. CPS’s local phone number is (916) 875-5437. Within 36 hours of discovering the abuse, the student therapist must complete a written child abuse report. These forms are stocked in the clinic office, and they can also be found online at CPS’s website.

Elder and Dependent Adult Abuse

In California, an elder is defined as an individual over the age of sixty-five; a dependent adult is between the ages of eighteen and sixty-four. Physical abuse, neglect, abandonment, isolation, and financial abuse all constitute reportable mistreatment of these populations. As with child abuse, student therapists should inform clients when a
report of abuse will be made. Immediately after the session ends, student therapists should contact the clinic supervisor to discuss the incident. Then, therapists must contact Adult Protective Services (APS) within twenty-four hours of learning of the abuse to file a verbal report. APS’s local phone number is (916) 874-9377. A written report of abuse must be sent to APS within two working days. These forms are stocked in the clinic office, and they can also be found online at APS’s website.

*Other Emergency in the Clinic*

In the event of a medical emergency occurring in the clinic, students should immediately call the campus police (help will arrive more quickly than by calling 911). If the individual suffering an emergency is a client, a detailed report of what occurred should be placed in the client’s file.

In the event of a fire alarm sounding during a therapy session, the student therapist should show clients how to safely exit the building and ask that clients return to the clinic once the all-clear has been sounded. Before exiting the clinic themselves, therapists should check to make sure that the clinic is empty and be sure that all doors are locked. To protect clients’ privacy, therapists should not wait with clients outside the building. The only exception to this is if the client is a child unaccompanied by a parent, in which case the therapist should remain with the child throughout the fire alarm.

In the event of a fire in the clinic, student therapists should immediately exit the clinic and attempt to assist others only if it is safe to do so.
Summary of Emergency Procedures

- Take steps to prevent problems before they arise. If a student therapist suspects that a client might be facing a crisis, this should be dealt with immediately.
- Remain calm when handling emergency situations. It is of even more importance than usual during these times to document all actions taken and the rationale behind these actions.
- Contact the clinic director or the clinic supervisor immediately when an urgent situation occurs.
- Always err on the side of caution when human lives are at stake. If a student therapist is unsure if a given incident qualifies as reportable abuse, it is better to contact the appropriate agency for consultation than to ignore the issue and possibly leave a victim in danger.

Legal Policies

Court Mandated Therapy

On occasion, the PSC will accept individuals who are referred for court-mandated therapy. The decision to accept these referrals is based upon the nature of the crime and the focus of therapy requested by the judge. For example, it would be inappropriate to accept as a client a woman arrested for selling heroin who has been ordered to receive substance abuse treatment. When the PSC does accept a court-mandated individual, the clinic supervisor and the student therapist who has been assigned to the client should work closely to ensure that the goals of both the judge and client will be met in treatment. The student therapist should ask the client to sign a Release of Information Form.
enabling the therapist to contact the client’s judge or probation officer for additional information.

*Subpoenas and Court Orders*

A subpoena is a request for information sent from a court of law. Therapists are only obligated to respond to a subpoena; they should not comply with any request for client information unless they have received authorization from the client or a court order. Should a student therapist receive either a subpoena or a court order, the clinic director or clinic supervisor should immediately be contacted before any action is taken. Subpoenas and court orders are extremely serious and must be handled carefully.

Student therapists should be mindful that a subpoena or court order could arise with any client; this should always be considered when entering information into client files.

*Requests for Litigation Support*

The PSC does not accept for clients any individuals who apply for therapy with the intent of requesting legal services. Should a client request legal assistance, the student therapist should contact the clinic director or the clinic supervisor. The clinical faculty will make an effort to refer the client to a therapist who can provide litigation support.

*Client Access to File*

Should a client request access to his or her treatment record, the student therapist should contact the clinic supervisor and ask why the client wants to view his or her file. If the client has a specific question, the student therapist should attempt to answer it. If
the client is interested in more general information, the therapist should suggest providing a short summary of the records instead. However, if the client is adamant about seeing the file, the PSC is not allowed to deny the request. In this case, the student therapist or the clinic supervisor should view the records together with the client to fully explain it and ensure that nothing is misunderstood. The client is not permitted to take the file from the clinic.

**Parent Access to the File of a Minor Client**

Parents of clients under the age of eighteen are permitted to view the file of their child; however, should such a request be made, the student therapist should attempt to persuade the parent that such an invasion of privacy would damage the therapeutic relationship. If the client is engaging in self-harm or harming others, parents should immediately be informed of this. In general, parents of minor clients (especially if the client is an adolescent) should only be told the general themes that are brought up in therapy.

**Ethical Principles**

**Confidentiality**

Upholding the principle of confidentiality is the most fundamental obligation of a therapist. Student therapists should never discuss client information with anyone other than a member of the clinical faculty or another student therapist in practicum. Such discussions should only take place in private, enclosed areas, such as the clinic office or the group therapy room. Student therapists should only discuss clients for purposes of
professional consultation. Any deviation from this policy is grounds for removal from practicum.

*Phone Contact with Clients*

When the clinic coordinator conducts the initial phone conversation with prospective clients, the coordinator will ask if the individual is comfortable with detailed messages being left that identify the call as coming from the PSC. If this is agreed to, then the student therapist assigned to the case may feel free to leave such messages. However, if the individual does not agree to this, student therapists should only use vague messages that identify the call as coming from CSUS. If a therapist is not sure if it is appropriate to leave a certain message, it is always best to err toward less detailed messages.

*Phone Contact with Non-Clients*

If a student therapist receives a message from another individual asking about a client, the therapist can only respond that it can be neither confirmed nor denied that the person in question is a client without an appropriate release of information. This should be discussed with the clinic supervisor and also with the client.

*No Secrets Policy*

When working with couples and families, student therapists should explain in the first session that the PSC holds a “No Secrets” policy. This means that anything one client confides in privacy to the therapist can also be disclosed to other members of the group. The therapist should explain that therapy requires complete honesty and will rarely work if members are hiding secrets from one another. The only exception to this
policy occurs when members of the couple or family are also receiving individual therapy at the PSC under different therapists. In those cases, as with any other individual therapy, information shared is confidential.

Confidentiality with Child Clients

With pre-pubescent child clients, it is appropriate to share major topics covered in therapy with the child’s parents. At times, parents might even take part in sessions with their children. With adolescent clients, privacy becomes much more important. Both the client and his or her parents should be informed that, in addition to the normal exceptions of confidentiality, if the client is regularly engaging in illegal or self-destructive activities, the parents will be immediately informed. Self-destructive behavior includes substance use, unprotected sex, and self-harm.

Appendices: Forms

It is the responsibility of the clinic coordinator to keep the following forms stocked in the clinic office at all times. These forms will be used frequently throughout treatment.
Appendix A. Request for Counseling
Psychological Services Center
Director:
Clinical Supervisor:

Date: 

Assigned Counselor: 
Intake Appointment Date: 
Intake Appointment Time: 

Name(s): 
Age(s): 
M/F: 
Address: 
Telephone: 
Okay to leave an identifying message? Y/N 

Type of Counseling Desired: 
Counselor Preference: 

Describe reason(s) for interest in therapy at this time: 

Additional information (medications, history of therapy, etc.): 

Days and times available: 

Intake by:
Appendix B. Comprehensive List of Low-Cost Therapy Agencies

Center for Counseling and Diagnostic Services
(916) 278-6252

Adult Access Team
(916) 875-1055

Cross Creek Family Counseling
(916) 722-6100

Terra Nova
(916) 344-0249

Asian Pacific Community Counseling
(916) 383-6783

El Hogar
(916) 441-0226

The Effort
(916) 368-3080

New Horizons Counseling Center
(916) 485-1211

Visions Unlimited
(916) 393-2203

White House
(916) 971-7640

Alta Regional
(916) 978-6400

New Pathways Counseling
(916) 452-7481
Appendix C. Informed Consent and Agreement Form

Psychological Services Center  
Department of Psychology  
Faculty Supervisor: ____________________

Counselor: ____________________  
Date: _________________

Client’s Name: __________________________________

Name(s) of those accompanying you for counseling: __________________________________
________________________________

Confidentiality:

The following information complies with the State of California and Federal Privacy Acts.

I understand that my counselor works with other counselors in training, under the direct supervision of a Department of Psychology faculty member. I also understand that because my counselor is completing his/her professional training, my counselor will videotape our counseling sessions and the faculty supervisor and/or members of this particular training group may observe me. Information will be kept strictly confidential within this group.

Exceptions to confidentiality are reports of child, elder, or dependent adult abuse; a report of an imminent intention to harm self or others; or a legal requirement for disclosure of records. I also understand that the only information regarding me which will be kept on file in the Psychological Services Center will be a summary of why I have sought counseling, this form, brief notes summarizing my counseling session, and a treatment summary when I finish my counseling.

Signature(s): _______________________________
Appendix D. Modified Informed Assent Form for Children

Psychological Services Center
Department of Psychology

Faculty Supervisor: __________________

Counselor: ______________________

Date: ______________________

Client’s Name: __________________________

I understand that counseling is a safe place for me to talk about any problems or issues that may be bothering me. Sometimes these things might be difficult to talk about, but talking about them will often make me feel better. My counselor will do his/her best to help me.

My parents or guardians have given permission for me to be here, but I do not have to receive counseling unless I want to. By signing this page, I agree to come to counseling.

Signature: _____________________________
Appendix E. Optional Intake Questionnaire

Confidential Client Information Questionnaire

Psychological Services Center
California State University, Sacramento

Today’s Date: ___________________

Name: ______________________  Age: _________  Birthdate: _________

Referred to the clinic by: ______________

Please describe your reason for seeking counseling:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
What do you hope to get out of counseling?
________________________________________________________________________
________________________________________________________________________

Please describe any previous counseling/therapy you have received including dates, person seen, problems addressed, and level of helpfulness:
________________________________________________________________________
________________________________________________________________________

Describe any current or past significant issues with your immediate family, your intimate relationships, and/or your family of origin:
________________________________________________________________________
________________________________________________________________________

Current Marital/Partner Status: ______________   Number of Children: _____

Current Living Situation: ______________________

Current Employment Situation: ___________  Education Completed: __________

Physician: _________________________  Date Last Seen: ____________________
List any major health problems: ____________________________________________

List all medications you take: ____________________________________________

Please circle any of the following that are currently troubling you:

Inferiority  Child abuse  Bad memories
Nervousness  Loneliness  Drug use
Suicidal thoughts  Education  Phobias
Making decisions  Sexual problems  Extreme fatigue
Health problems  Bowl trouble  Panic attacks
Stomach trouble  Depression  Weight
Homicidal thoughts  Divorce  Sexual abuse
Family Violence  Relaxation  Friends
Confidence  Concentration  Compulsions
Unhappiness  Being a parent  Self-control
Unhappiness  Intimacy  Aggression
Self-esteem  Life satisfaction  Memory
Hyperactivity  Bingeing/purging  Self-harm
Activity level  Child neglect  Tiredness
Children  Headaches  Sadness
Shyness  Insomnia  Guilt
Separation  Agoraphobia  Fetishes
Substance use  Appetite  Conflict
Anger  Fears  Stress
Sleep  Finances  ACOA
Career Choices  Alcohol use  Temper
Work  Painful thoughts  Ambition
Impotence  Energy levels  No interests
Social isolation  Legal matters  Marriage/partner
Disorganization  Bereavement  Nightmares

Please describe any other issues or problems that would be important for us to know:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Thank you for taking the time to complete this form.
Appendix F. Release of Information to the PSC

Psychological Services Center
Department of Psychology
(916) 278-6887

____________________ is currently being seen at the Psychological Services Center in the Department of Psychology at California State University, Sacramento. As indicated below, this individual has provided a signed, written request for release of information from you. Would you please send, at your earliest convenience, copies of the following records:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please be assured that any material you send to us will be treated with the appropriate confidentiality and discretion. Thank you for your assistance in the treatment of this individual. If you have any questions regarding this request, please feel free to contact me at (916) 278-6887.

Sincerely,

________________________________
Counselor
Psychological Services Center
Department of Psychology
California State University, Sacramento
6000 J Street
Sacramento, California 95819

I hereby provide full permission for the release of copies of the above named documents to my counselor at the Psychological Services Center in the Department of Psychology at California State University, Sacramento.

Signature: ___________________________ Date: ___________________________
Appendix G. Release of Information from the PSC

Psychological Services Center  
Department of Psychology  
(916) 278-6887

Consent for Release of Information

I, ________________________________, who am currently or have been a client receiving counseling at the Psychological Services Center in the Department of Psychology at California State University, Sacramento, hereby request that the Psychological Services Center release, with my full permission, release to ______________________________________________________
the following information: ____________________________________________________
________________________________________
________________________________________

Client Signature: ___________________________

Date: ________________________________
Appendix H. Notification of Termination Due to Missed Sessions

Psychological Services Center
Department of Psychology
(916) 278-6887

Date: ______________________

Dear ______________________,

This is to notify you that, as you have missed the last ____ sessions (dates: _______________), it appears that you are not interested in or able to continue therapy at this time. This policy was discussed in person, and you have received telephone calls restating such.

In the future, if you feel that you are ready and wish to resume counseling, please feel free to call the CSUS Psychological Services Center at (916) 278-6887.

Sincerely,

MFT in Training
Appendix I. Termination Template

California State University, Sacramento
Psychological Services Center
Termination Form

Client’s name:
Age: Ethnic background:
Client’s first appointment date: Date terminated:
Total number of sessions:
Client seen alone or with other family members:

Presenting complaint/reason for coming:

Personal history of client:

Therapeutic strategy used:

Main changes in client’s life (including mental/emotional changes):

Reason for termination:

General appraisal/assessment of client:

In your opinion, did the client:

___ Greatly improve
___ Moderately improve
___ Slightly improve
___ Remain the same
___ Deteriorate

Signatures of therapist trainee and clinic supervisor:
References

American Psychological Association Committee on Training in Clinical Psychology (1950).  
*Standards for Practicum Training in Clinical Psychology: Tentative Recommendations.*


East Carolina University (2011). *ECU family therapy clinic policies and procedures manual.*


Nova Southeastern University (2012). *Family therapy clinic at the brief therapy institute policies and procedures.*

Regis University (2012). *Practicum/internship clinical manual.*

Southern Illinois University Carbondale (2011). Clinic center policies and procedures for student clinicians.


University of California, Santa Barbara (2006). Hosford counseling and psychological services center policies and procedures manual.


University of Hawaii (2006). Department of psychology clinical studies program practicum handbook.

University of Louisiana at Monroe (2011). Clinic policies and procedures handbook.

University of New Mexico (2012). UNM department of psychology clinic orientation manual.


University of Rhode Island (2009). *Psychological consultation center policy and procedures manual.*

University of Toledo (2010). *Psychology clinic policy and procedures handbook.*

Utah State University (2012). *Psychology community clinic policy and procedures manual.*