Policy and Procedures Manual

Psychological Services Center

University at Buffalo, The State University of New York

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Introduction

This *Policy and Procedures Manual* for the Psychological Services Center (PSC) outlines the standard operating procedures of the center, and is meant to be used as a resource that can be referred to as needed. Of course, no manual can cover every possible situation that may arise. If you are ever uncertain of how to proceed with a given situation, consult with the PSC director or assistant director, PSC office staff, advanced students, or faculty. Asking questions is **always** appropriate when unsure of the proper procedure to follow!

It should be noted that PSC policies and procedures are updated from time to time by the director and board of the PSC. New or revised policies are distributed promptly to the faculty, students, and PSC staff; are placed in notebooks in the PSC office and clinical staff workroom; and will be added into the *Manual* at the time of its next revision.

Mission and Scope of the PSC

The Psychological Services Center has a two-fold mission. The Department of Psychology of the University at Buffalo operates the PSC both as a service to the community and as a training clinic for the doctoral program in clinical psychology.

1. <u>*As a service to the community*</u>, PSC services are available to anyone in the Western New York and Southern Ontario region. Services are NOT limited to people associated with the University at Buffalo. The PSC strives to provide high quality services to all persons regardless of age, religion, creed, color, disability, national origin, race, ethnicity, sex, sexual orientation, marital or veteran status. In order to be broadly accessible to the community, services are provided on a sliding fee scale, and both day and evening appointments are available. Fees are due at the time of service, and insurance is not accepted.

2. <u>*As a training clinic*</u>, the PSC is the practicum and training site for doctoral students in the clinical psychology program, which is accredited by the American Psychological Association. In addition, some students from other graduate programs at UB gain experience through the PSC. Most of the clinicians, therefore, are graduate students, with additional services provided by the director and other faculty members.

The PSC offers a broad array of psychological services, with the most common being therapy/counseling and psychological assessment for individuals and couples. The PSC is also expanding its services in the areas of group therapy, workshops, consultation, and family therapy. Services are guided by current research literature on effective psychological interventions.

The PSC provides services for persons experiencing a broad array of concerns, including but not limited to the following list. Please note, however, that we are unable to serve people whose primary issues involve substance abuse, psychosis, or acute psychiatric crisis (e.g., suicidality). Persons who contact the PSC inquiring about these issues are referred to other, more appropriate, treatment facilities.

- Academic problems
- Gay / lesbian / bisexual /transgender issues

- Aggressiveness
- Anger
- Anxiety / panic
- Assertiveness
- Child behavioral and emotional problems
- Coping with pain and illness
- Depression
- Discrimination or harassment
- Divorce / separation
- Eating problems
- Family discord
- Grief / loss
- Identity problems
- Interpersonal conflict resolution
- Loneliness
- Life changes
- Marital / relationship concerns
- Obsessive-compulsive behavior
- Recovering from sexual abuse / assault
- Self-esteem
- Sexual problems
- Workplace and career concerns

The PSC cooperates closely with clinical research programs of several faculty members. Persons who contact the PSC for services and may be eligible to obtain free treatment through one of these research programs are referred to them, and the research programs often refer persons to the PSC who either are ineligible for their research protocol or would like additional therapy.

PSC Facilities, Equipment, and Resources

The PSC is located on the north side of the first floor of Park Hall, on the Amherst campus of UB. There are two entrances to the PSC: the public entrance (into room 168) is at the west end of Park Hall, and the locked personnel-only entrance leads into the PSC hallway at the east end of the building. The PSC contains the following rooms:

- Five individual therapy/consultation rooms: rooms 173, 175, 177, 178, and 180. Rooms 173 and 175 can be observed through a one-way mirror from a common observation room, 175A. Rooms 173 and 175 are equipped with mounted video recorders for taping of individual sessions.
- Three group therapy rooms: rooms 174, 179, and 182. Rooms 174 and 179 are equipped with mounted video recorders and can be observed live from individual observation rooms 174A and 179A.
- Client waiting area, room 168, provides seating for six people
- Clinical staff workroom, room 172 (see below for further information)
- PSC business office, room 169
- Assistant director's office, room 170
- Director's office, room 171
- Two storage rooms: 169A and 176. Only paid PSC staff are allowed access to these rooms.
- Two bathrooms off two of the large group rooms: 174B and 179B
- Four rooms devoted to the Depression Research and Treatment (DRT) Program: 181, 183, 184, and 185.
- One room devoted to the psychophysiology research laboratory, 182A.

Clinical Staff Workroom

The clinical staff workroom (room 172) was created for all clinicians seeing clients in the PSC. In order to provide our staff (and ultimately our clients) with the best services available, this workroom has been equipped with the following resources:

- All PSC forms needed for clients, samples of reports, a copy of this manual in a notebook with any additional new policies, and referral listings
- A wide variety of brochures and other information about common psychological problems
- A wide variety of questionnaire measures and monitoring forms (filed alphabetically; for a list see Appendix E)
- A mini-library of assorted text books, journals, treatment manuals, and copies of the DSM
- Tape recorders and two TV/VCR combos, which can be signed out for use in the PSC for recording and reviewing client tapes
- Six "white noise" sound generators, which can be signed out for use during sessions
- A phone which can be used for contacting clients (please be respectful of your peers when the phone is in use)
- A microwave, refrigerator, and coffee maker which all are welcome to use (but please, if you make coffee, clean out the pot when you're finished and more generally, just clean up after yourself when using these appliances)
- Three computers and a printer that can be used for writing up contact notes, intake reports, and other PSC-relevant information.

Security Policy

The PSC facilities are used for several purposes in addition to clinical work with PSC clients. Thus, a large number of people have authorization to enter and use the PSC, including:

- PSC clinicians, supervisors, and paid staff
- Faculty, graduate students, and undergraduate research assistants involved in the DRT, the MVA, and the psychophysiology research labs
- Other researchers who have obtained permission to conduct research in the PSC and their research assistants

Paid PSC staff cannot be present at all times that the PSC is used. Thus, it is crucial for everyone who uses the PSC to help promote the security of the facility by following these policies:

- The main office door (169) and file cabinet in 169 should always be locked. You may prop open the office door when someone is in the office, but when the office is empty the door should be shut and locked. You need to unlock the file cabinet to get into a drawer, but lock it back up as soon as you push the drawer(s) shut.
- Do not allow clients to enter the PSC main office (169), because this is where confidential client records are stored. The "Employees Only" sign on the office door means that only authorized personnel (not all of whom are actually paid employees) may enter the office.
- Clients may at times request to use a PSC telephone, and you may permit clients to make brief local calls from the PSC office phone. Again, however, the client may not enter the PSC office. Instead, have the client stand in the waiting room outside the office window,

open the window, and let the client use the phone through the window. Please dial the phone for the client.

- Whenever you leave the PSC, check the schedule. If there are no more appointments scheduled for the remainder of the day or evening, lock the door to the waiting room and turn out the lights unless one of the PSC staff (i.e. Director, Assistant Director, one of the receptionists) are still there, in which case they will take care of it.
- The rear (east) entrance to the PSC is only for the use of personnel, not clients or research participants. Do not invite clients or research participants to use that door. Instead, have them use the front entrance of the PSC. The only people to use the rear door should be personnel who have a key to it; thus, there should be no circumstances under which the door is left unlocked.
- The rear entrance to the PSC should be kept locked at all times. If you leave via that door, bring your key so that you can re-enter. If you forget your key, walk around to the front door of the PSC instead.

Keys for the PSC

Persons authorized to use the PSC need one or both of the following keys:

- Key 8002, which works for both entrances to the PSC (the public entrance into room 168 and the personnel-only entrance at the east end of the building)
- Key 2440, which works for the PSC office (room 169) and the Clinical Staff Workroom (room 172)

Clinicians, supervisors, and researchers who need access to the office and workroom should get both keys. Undergraduate research assistants should get only key 8002, because they are not authorized to access the PSC office. (Of course, researchers in the DRT or psychophysiology labs also need the key or keys specific to their lab room or rooms within the PSC.)

To obtain keys, see Sam Folby, the psychology department Instructional Support Specialist (Room B15, ext. 610), who will require a deposit of $5.00 per key. When your need for PSC access is over, please return your key(s) to Sam to get your deposit back.

Signage Policy

The PSC is well marked with colorful, visible signage, so it should be easy to find for clients and research participants. Thus, it is neither necessary nor permitted to display temporary signs.

- Taped signs on the public PSC doors are not permitted. This includes both the outside door (the door to the waiting room, 168), and the inside doors to the front office (both the window from the waiting room and the entrance from the hallway). Paper signs not only look tacky, they are also against fire code.
- All clinical and research programs that use the PSC facilities on an ongoing basis are prominently advertised in the display case outside the PSC door.

Parking Policy

Please familiarize yourself with the Parking Information Brochure (see Appendix E). **Note:** The parking spots marked "Clinic Parking Only" in the Park Hall parking lot are reserved for clients only. Please do not help yourself to parking permits and use them for yourself. If you need to make a brief stop in the PSC, you may park at a meter spot if you pay the meter.

Waste Disposal (Trash and Recycling) Policy

It is important to dispose of waste in the PSC properly, both to promote client confidentiality and to support the university's campus recycling policy. Each room in the PSC is supplied with waste receptacles for both trash and recycling. Trash baskets are small and black; recycling baskets are larger and blue. Use the recycling baskets for disposing of paper waste. Cans and glass can and should also be recycled, but need to be taken to the appropriate receptacles in the atrium of Park Hall—don't put them into the PSC recycling or trash baskets. If paper has anything confidential on it, it needs to be shredded before disposal. There is a shredder in the PSC main office (Room 169) that empties directly into one of the blue recycling baskets.

OK to put into blue recycling baskets:

- Paper
- Envelopes
- Post-it notes
- Phone books
- Three-ring binders
- Staples
- Paper clips

Not OK to put into blue recycling baskets:

- Food (e.g., pizza boxes)
- Chemicals (e.g., toner cartridges)
- Biological matter (e.g., used kleenex tissues)

Initiation of Services

Clients are seen at the PSC by appointment only—we do not offer walk-in services. People can enter treatment at the PSC either by self-referral (i.e., by phoning the PSC directly and requesting service) or by referral from one of the research clinics: the Depression Research and Treatment Clinic (DRT), the Motor Vehicle Accident Clinic (MVA), or the Center for Children and Families (CCF).

Self-Referral

1. *Initial contact*. Potential clients typically contact the PSC by phone or, less frequently, in person. Calls and walk-ins are received by paid PSC staff (a receptionist, the director, or the assistant director). If it is immediately apparent that the caller is seeking a service beyond the scope of the PSC (e.g., alcoholism treatment, learning disability assessment), the staff member will provide referral information to the caller. If the caller seems to be seeking a service that the PSC could provide, the staff member collects some basic information and records it on a **Confidential Request for Information/Services** form (commonly known as a "**Call Sheet**"). See Appendix A for a copy of this form.

2. *Scheduling the screening interview*. During the initial contact, the PSC staff member schedules the prospective client for a screening interview, which is an initial evaluation of the prospective client's concerns and appropriateness for treatment in the PSC. The staff member sends the prospective client a **Pre-Screening Packet** (see Appendix B) consisting of: (a) cover letter with appointment information, (b) map, parking pass, and parking information brochure, (c) consent form and fee determination schedule, and (d) intake information form. The staff member notifies the scheduled therapist that a screening has been scheduled, enters the information into the **Client Tracking Database**, and then files the call sheet in the "Screening pending" folder in the top drawer of the file cabinet in room 169.

3. *The screening interview*. Screening interviews are conducted by students taking the advanced practicum class. All clients are charged a $15 flat fee for the screening, which is a brief interview to ascertain a client's appropriateness for the PSC, not a comprehensive diagnostic assessment. The screening interviewer will review/obtain informed consent; gather basic assessment information about the client's presenting concerns, strengths, and treatment goals; provide information and answer client questions; and collaboratively with the client, decide on a course of action. If PSC therapy is not chosen, the interviewer will provide appropriate referrals to the client. If PSC therapy is chosen, the fee will be determined, the interviewer will explain the therapist assignment procedure, and the interviewer will obtain the client's availability. (See Appendix B for the **Fee Determination Schedule**, Appendix C for the **PSC Screening Interview Outline and Checklist**, and Appendix B for the **Client Availability Schedule Form**). Immediately after the screening interview, the interviewer should (a) obtain a PSC case number and empty client file from the receptionist, (b) file the call sheet in the "Screening completed" folder, and (c) file the new client file in the "Therapist assignment pending" folder. Within two days, the interviewer should complete a **Screening Summary Report** (see Appendix C for a template), insert the report and the call sheet into the client folder, and return the client folder to the "Therapist assignment pending" folder.

4. *Therapist assignment*. Once weekly (generally on Monday afternoons), the PSC director and the practicum instructors staff new cases. Clients appropriate for practicum students are assigned by practicum instructors. Clients who need to be seen by more advanced students or senior staff are assigned by the PSC director. Practicum instructors complete a **Practicum Update Form** (see Appendix D) each week to indicate new case assignments, terminations, intakes completed, and any changes in therapist or supervisor—this form is to be returned to the office staff, who update the Client Tracking Database with the information. A printout of the Client Tracking Database is kept in the blue "Client number directory" folder in the top drawer of the file cabinet in the main office (room 169). **Note that only office staff are to assign client numbers, write on the printout of the database, and enter data into the database on the computer.**

5. *Beginning the therapy*. It's the responsibility of the assigned therapist to phone the new client to schedule treatment as soon as possible after the case has been assigned. Clinicians are expected to be diligent and persistent in attempting to reach new clients, which may be challenging. For instance, if the client isn't reached upon the first telephone attempt, the clinician should try phoning several different times of day for several days in a row until the client is reached. The clinician should not think that just trying once every few days, at the

same time of day, is good enough. Once a case has been assigned to a therapist, it is considered an active case, and the file is stored in the second drawer of the file cabinet, labeled "Active cases." When a file is removed from the cabinet, an "OUT" card must be completed and placed where the file was.

Research Clinic Referral

1. *Initial contact*. When the DRT or MVA has a research participant to refer to the PSC for service, a research lab staffer will have the potential client fill out a **Release of Information Form**, a **Client Availability Schedule Form**, and an **Intake Information Form** (see Appendix B). The research lab staffer will also give the potential client a consent form and a fee determination schedule (see Appendix B) to take home and bring in to the PSC for the first appointment. The research staffer will fill out a PSC call sheet with the basic referral information, being sure to indicate whether a screening appointment is needed, and if not, what level of therapist would be appropriate for the client. The referral paperwork will be temporarily placed in the "Incomplete call sheets" folder in the top drawer of the file cabinet in room 169, and eventually added to the client's folder.

2. *Determination of whether a screening interview is needed*. In order to determine whether the potential client needs to be screened or can be assigned directly to a therapist, the PSC director will consult with research lab staff regarding the client's current stage of assessment and treatment. Depending on this determination, the process then continues with the remaining steps outlined above. Note that the case number is assigned when the client is seen in the PSC for the first time, whether for screening or therapy. For example, if a client is referred from a research clinic for a screening appointment, a client number is assigned at that time, even if the client decides not to continue at the PSC. In contrast, if a client is referred from a research clinic directly to therapy because no screening appointment is needed, the client number is assigned immediately following the first therapy appointment. If a person referred directly to therapy never follows through and never attends an appointment, no client number is ever assigned.

Waiting List

There may occasionally be more new clients than can be immediately assigned to clinicians. At such times a waiting list is created, and the files of these clients are stored in the top drawer of the file cabinet in room 169 in the section labeled "Client Waitlist" until they are assigned a therapist by the PSC director or a practicum supervisor. Advanced students are encouraged to browse these files and request a particular client. However, individual clinicians may not initiate therapy with any wait-listed client without formal case assignment by the PSC director or a practicum supervisor.

Continuation and Termination of Services

Case Conceptualization and Treatment Planning

The therapist assigned a case is responsible for performing a thorough assessment, lasting approximately one to three sessions. With help from his or her supervisor, the therapist will determine the parameters of the client's problem, administer tests if needed, contact previous therapists or schools if needed, and decide collaboratively with the client on the direction of treatment. In deciding on a plan of treatment, it is important to specify goals, objectives, and plans for reaching them, as well as objective criteria by which the therapist and client can evaluate progress toward the goals. As much as possible, the plan should include use of therapeutic methods for which there is research support of their effectiveness. The plan should also clearly specify the exact nature of the methods (e.g., use of the *Mastery of your Anxiety and Panic* protocol to reduce the frequency of panic attacks).

At the completion of the assessment, the therapist is expected to write up a **Case Conceptualization and Treatment Plan** (CCTP) report. (Note: this is similar to what used to be known here at the PSC as an "intake report.") The CCTP report must include as a minimum the items listed in the first two bullets below, and at the discretion of your supervisor, may also include additional items as listed in the third bullet:

- The contents of the **Initial Assessment and Treatment Plan** form found in Appendix C. Note that this form requires a DSM-IV diagnosis, an explicit assessment of critical variables (e.g., lethality, substance abuse, medications, etc.), and a detailed treatment plan.
- Case conceptualization (narrative formulation of the client's problems and what caused them).
- Additional sections such as behavioral observations, social history of the client, etc. at the discretion of the therapist's supervisor.

CCTP reports should be printed with the first page on PSC letterhead. CCTP reports must be signed by the therapist and counter-signed by the supervisor, and are due in the client's file within two weeks following the completion of the assessment sessions. The treatment plan should be reviewed at least every six months—see the "Periodic Case Re-evaluation" section in the "Supervision and Quality Control Issues" chapter of this manual. To facilitate the monitoring of progress, we have collected a pool of relevant standardized symptom measures (see the "Documenting Change" section in the "Supervision and Quality Control Issues" chapter).

Keeping records

Every contact with the client should be documented in the chart. Contacts include not only sessions, but also telephone contacts, letters, and email correspondence. Client contacts must be documented in two places in the client's chart: (a) very briefly on the **Contact Sheet** (see Appendix F) and (b) thoroughly in a progress note. Most clinicians choose to type their progress notes, but it is permissible to write them by hand on the **Progress Notes** form (see Appendix C). In either case, each progress note must be signed by the student and countersigned by the student's clinical supervisor. Progress notes must be made in a timely manner, which means the

same day as the contact, whenever possible, and never more than 48 hours after the contact. Doing progress notes several days or weeks after contact is unprofessional.

In addition to documenting contact with clients, progress notes are also used to document additional activities. For instance, if you have any contact with someone else regarding the client, such as a family member or another professional (which, of course, may only be done with the client's express permission via a signed Release of Information form), you should document the contact with a progress note. It is also permissible to add a progress note after a supervision session. You should document a supervision session in the file if the result of the supervision session is to change a policy, treatment plan, or clinical approach; or if you change supervisors.

Please check with your supervisor about what he/she considers to be appropriate material for the progress note. There are some things, however, that must be in your progress notes. Reference to a specific treatment plan should appear regularly in the progress notes. The progress note should relate to the treatment plan, and periodic reference to progress or lack of progress relative to the treatment plan should be a part of the note. If there is a crisis or potential crisis (such as suicidal ideation), the documentation must be especially thorough. It is also legitimate to add an addendum to progress notes, if upon reflection about a session you decide on a different interpretation of the data. Such an addendum should be added as a regular progress note, but should be clearly labeled as a conceptual addendum. A good way to maintain the kind of quality that should be a part of a progress note is to imagine something going wrong with the case and, as a result, your professional competence is being questioned in a courtroom. The quality of care provided to a client will be judged almost entirely on the basis of the progress notes and intake or termination summaries. From a legal perspective, "If you didn't document it, you didn't do it."

Closing a Case

When contacts with the client have been terminated, cases must be formally closed in a timely manner. A closing summary (final report about the therapy), typed and signed by both the therapist and supervisor, must be put in the client's file. The closing summary should be printed with the first page on PSC letterhead. **Closing summaries must be placed in the files within two (2) weeks after the termination.** A case is not closed until a closing summary and a **Final Checklist** (see Appendix C) have been turned in to the supervisor. The closing summary report should include: (1) the nature of the presenting problem; (2) the therapist's diagnostic formulation and evaluation; (3) a summary of the major problems dealt with in the course of therapy; (4) an evaluation of the client's progress during therapy; and (5) an explanation of how and why the case was terminated. If the client was seen for only 1-3 sessions, it is sufficient to simply complete the **Final Checklist** form and to omit preparation of a full closing summary report. When the final checklist and closing summaries are signed by the supervisor, the file should be given to PSC staff to close in our databases. PSC staff will then file the closed file.

Transferring a Case

Discussions should begin with the supervisor as soon as the clinician becomes aware of the need to transfer a client. It is the clinician's responsibility to inform both their client(s) and their supervisor about their plans well before the transfer will occur. Further, it is the clinician's

responsibility to affect the transfer of their client(s). The clinician is expected to work closely with their supervisor and their client(s) to manage any transitions. More specifically, a clinician should consult with their current supervisor and Dr. Sherry Thomas in order to generate potential clinicians for the transfer case(s). It is then the clinician's responsibility to approach those potential clinicians. Those clinicians who have been approached for the transfer will then need to consult with their own supervisors about the appropriateness of taking the case. In summary, clinicians are in charge of the transfer process in consultation with and approval by their supervisors.

Other Treatment Issues

Standardized Assessment Battery

All clients must be administered each assessment measure in the standardized assessment battery. The purpose of this battery is to provide baseline information for treatment planning and case conceptualization, to provide a standardized assessment of treatment progress and outcome, to target specific client types for recruitment into research studies, and as a means to obtain clinical validation data for measures developed by faculty or student clinicians. The assessment battery includes measures of personality (i.e., Schedule for Nonadaptive and Adaptive Personality-2), distress symptoms (i.e., Inventory of Depression & Anxiety Symptoms), psychosocial functioning (i.e., Behavior and Symptom Identification Scale-32), intellectual functioning (i.e., Wechsler Abbreviated Scale of Intelligence Vocabulary and Matrix Reasoning subtests), cigarette use (i.e., Cigarette Screening Inventory), and a structured diagnostic interview (i.e., MINI International Neuropsychiatric Interview). The information gleaned from these measures will then be included on a summary sheet within each client's folder and will subsequently be entered into a central database. Information in this database could then be subsequently used for recruitment into research studies, validation of measures, program assessment, and treatment effectiveness studies by faculty and student clinicians.

Organization of Client Charts

All clients being seen through the Psychological Services Center for assessment and/or treatment must have a Psychological Services Center file. The file is identified by a five-digit number, of which the first two digits indicate the year in which PSC services were begun. Old client files (prior to August 2000) were identified by a four-digit number. Client numbers are to be assigned by paid PSC staff only. Current files are stored in a locked filing cabinet in room 169, and closed files are stored in a locked filing cabinet in the office storage closet (room 169A).

It is important to keep your clients' charts well organized and up-to-date. There are sample client folders available in rooms 169 and 172; please file paperwork in the manner shown in these samples. Also refer to Appendix F for a detailed list of what items need to be in client files, and how these items are to be arranged. This appendix also includes copies of forms for client charts that have not already appeared in other appendices.

Client Fee Determination

Most PSC clients come into the PSC for a screening interview, and the therapy fee is determined at that time by the screening interviewer, using the procedure explained in the **PSC Screening Outline and Checklist** (see Appendix C). However, some clients begin services at the PSC without a screening interview, usually when they have been referred from one of the research clinics who have already conducted an assessment. In such cases, the assigned therapist is responsible for setting the fee with the client at the beginning of treatment. To do this, the therapist should do an initial fee determination with the client over the phone while scheduling the first appointment, and ask the client to bring a tax form or pay stub to the first appointment. During that session, the therapist can then finalize the fee determination and have the client sign the **Fee Determination Schedule** (see Appendix B). Regardless of whether it is the screening interviewer or the therapist who conducts the fee determination process, the fee schedule must be approved and signed by the PSC director. It is the clinician's responsibility to request and obtain the director's signature promptly. There are some times when clients request a fee reduction. When this happens, obtain an explanation from the client of the client's circumstances and explain that fee reductions must be approved by the PSC director. Then consult with the director as soon as possible so that the fee determination process can be completed in a timely manner.

Clinician/Client Schedule Matching

When we assign clients to clinicians, we want to avoid assigning people whose schedules are incompatible. Thus, we need to know the availability of both clients and clinicians. This information is gathered from clients during their screening interview, at which time they complete the **Client Availability Schedule Form** (see Appendix B). Clinicians are required to complete a similar form, the **Clinician Availability Schedule Form** (see Appendix E), at the beginning of each semester and the beginning of the summer.

Obtaining Informed Consent

Informed consent is typically obtained from the client by the screening interviewer, but will need to be done by the therapist for clients who start therapy without a screening interview. Clients receive a copy of the **Information and Consent Form** (see Appendix B) in their pre-screening packet. Despite the fact that most clients will have already signed the consent form prior to coming into the PSC, screening interviewers and therapists should take a few minutes to verbally explain the following important points regarding treatment at the PSC:

- Because this is a training clinic, the therapist will probably be a student, and the therapy will be video- or audiotaped.
- Limits of confidentiality and release of information
- PSC involvement in research

For clients who are minors, the standard consent form is replaced with two forms: **Information and Assent Form for Child Clients** and **Information and Consent Form for Parents of Child Clients** (see Appendix B). Children are not legally empowered to provide consent to treatment, but in order to establish a good therapeutic relationship, it is good practice to obtain a child's

informed "assent" to treatment. Formal consent to treatment for a child client must be granted by the child's parent or guardian.

There are three specific instances in which the therapist is under an ethical obligation to release information to certain people, even if the client objects to such a release of information. These exceptions should be explained to the client in the first session to avoid potential problems later on. For any of these situations, be sure to contact your supervisor and the PSC director as soon as possible.

1. If the therapist has reason to believe that child abuse has occurred, he or she is required by state law to report it to the appropriate authorities. There is a notebook on the black shelf in the Clinical Staff Workroom (172) that details how to report such instances and provides copies of all relevant paperwork.
2. If the therapist believes that there is a serious threat to another person, case law requires that we must not only warn the proper authorities of the risk, but must also warn the person(s) at risk.
3. Finally, if the client is suicidal, outside contacts may be made as necessary in order to protect the client.

In at least two states, courts have held that graduate students in a clinic such as ours have no right of confidentiality, and any records on a client are subject to subpoena. PSC staff would resist such a subpoena to avoid the routine release of information, but if the attorney or judge continued to push, records would have to be released. In light of this, if you have any questions about what to include in a progress note, discuss the issue with your supervisor.

Maintaining Confidentiality

All records are confidential. Should records be used for research or other training purposes, they are to be edited so that they disguise the identity of the client. **Client files may not leave the PSC.**

To protect confidentiality of clients, we do not even acknowledge that a client is being seen at the PSC, even if it is a family member making the inquiry. If someone calls and asks if a family member is being seen at the PSC, briefly explain to the person that it is PSC policy not to divulge such information to protect our clients' confidentiality. If a professional from another agency calls, explain that we cannot acknowledge whether a person is being seen at the PSC unless we receive a written **Release of Information Authorization** form (available in room 169 or 172; see also Appendix B).

Releasing Client Information

Client records are confidential. Information about a client is released to other persons or agencies only when authorized in writing by the client, using the **Release of Information Authorization** form (see Appendix B). Copies of this form are available in both rooms 169 and in 172. In order to obtain information from other agencies about your client, you must have a written release

signed by the client as well. Either the PSC form or the other agency's analogous form may be used for this purpose.

Be aware that confidentiality refers to the confidentiality of the client and not to your own. If the client requests that the entire file be released to an appropriate agency or professional, we are under obligation to release the file (actually, a copy of the file). Furthermore, clients may request to see their own files, and state law guarantees them this right. Therefore, when writing progress notes and reports, keep in mind that the client may at some point read his/her own file. In other words, minimize the use of jargon, avoid condescending or derogatory wording, and write clearly and respectfully.

Taping Sessions and the Protection of Client Confidentiality

Students are required to tape all therapy sessions unless live supervision is used. (See "Taping Sessions with Clients" in the "Administrative Issues" chapter of this manual for instructions.) Taping allows us to provide adequate supervision without the necessity of coordinating sessions around the schedule of the supervisor. Clients must give us permission to tape in order to be seen at the Center; this information is provided in our consent for treatment (Appendix B).

A tape is a PSC record and must be protected. The client has a right to expect that all client records are confidential, including tapes. Tapes should be locked up at all times and should be erased after viewing and/or supervision. Special care is needed with videotapes because the client's identity is more obvious on these tapes.

Referring a Case

The decision to refer a client should be arrived at in consultation with the PSC director or your case supervisor. An agency reference list is available that contains names and addresses of clinics and private therapists in the local and surrounding area. Various directories are also available. Names of private practitioners may be provided as requested but provision of names is not intended as an endorsement and this should be made clear to the client. It is good practice to give clients a minimum of two names when referring to private practitioners. Referrals should also be made to other agencies as appropriate.

Emergency Procedures

If one of your clients should contact you in an emergency, do not hesitate to consult with your supervisor or the PSC director. If none of these people are available, consult with any of the supervisory staff (i.e., clinical faculty). Inform your clinical supervisor as soon as possible. The psychiatric emergency room at ECMC (CPEP; 898-3462) and Crisis Services (834-3131) are available to clients 24 hours a day for emergency care and referral. You should carry these numbers with you at all times so that you are ready to respond in case of an emergency. You should also have phone numbers for each of your supervisors, as well as a list of your clients and their phone numbers with you at all times. When keeping such a client list, in order to preserve

confidentiality please use these common sense precautions: (a) do not label the list “clients”, and (b) keep the list in a secure place, such as a datebook or your wallet.

Weather Closings

When winter weather conditions become so severe that the university cannot operate effectively, an announcement to that effect will be made over local radio stations, including WBFO-FM 88.7, which may broadcast more detailed information. The initial announcement will be made by 6 a.m. and will be repeated frequently. A message also will be placed on UB's new mass calling line at 645-NEWS (645-6397). You need to become informed of any campus closings due to weather when you have a client scheduled, so that you can contact your client to inform him or her that your appointment is cancelled and to reschedule.

Supervision and Quality Control Issues

Regardless of the discipline, in a professional setting it is essential that procedures designed to monitor and maintain the highest level of performance and quality are implemented. At the Psychological Services Center, we have instituted several measures designed to provide the structure and procedures necessary for maintaining high quality, professional service to our clients as well as to provide an appropriate training experience for our students. The effectiveness of these procedures depends on the cooperation of each student therapist and their supervisor.

Location and Maintenance of Client Files

Files must be kept in the Psychological Services Center at all times. A file should never leave the file cabinet for more than several hours at a time. When a file is removed from the cabinet, an “OUT” card must be completed and placed where the file was. Be sure to check the folder back in by removing the “OUT” card, writing the return date and time on it, returning it to the supply of “OUT” cards, and replacing the case folder in its correct numerical placement in the file. Files should always be up-to-date and orderly, so that in the event of an emergency any qualified professional could use the file to guide them in an appropriate interaction. The files are periodically audited to assure quality care.

Supervision

All student clinicians seeing clients through the PSC must be supervised by their practicum instructor, the PSC director, or another faculty member (either regular or adjunct, as assigned by the PSC director). In some cases, supervision may be provided by an advanced graduate student who receives supervision for supervision from the director or faculty member designated by the director. Supervisors are fully responsible for each case that they are supervising. It is their responsibility to approve screening, assessment, and treatment by countersigning reports and progress notes from the case. The amount, type, and intensity of supervision will vary depending on the skill level of the therapist. Supervision sessions should be scheduled regularly for all active cases. In the event of illness, travel away from Buffalo, or incapacity of the supervisor,

alternative supervisory arrangements must be made. If a supervisor is unavailable for emergency supervision, contact the PSC director or a member of the clinical faculty.

Periodic Case Re-evaluation

The environment for the practice of psychology has changed dramatically in the last few years. The external management of psychological services (managed care) mandates specific treatment plans, as well as periodic evaluation of the progress and need for continued service. Few professionals providing psychological service enjoy the paperwork associated with such oversight, but some type of oversight is likely to continue for the foreseeable future. On the bright side, however, a formal treatment plan and periodic oversight does encourage a focus on the goals of therapy. Furthermore, it is good practice for a professional psychologist to specify a clear treatment plan grounded in empirical science whenever possible, and specific goals for treatment (with criteria for meeting those goals).

Most managed care firms reevaluate cases every 2 to 10 sessions (averaging about 3 or 4 sessions). We have elected to be a bit more generous, reevaluating cases after 12 sessions, and having the reevaluation conducted solely by the clinician's supervisor, rather than a managerial or external committee. We have a form for this purpose (**Periodic Reevaluation of Case Progress**; see Appendix C), which was modeled after forms used by several Managed Care firms. After 12 therapy sessions, the clinician should either fill out this form or type a report using the form as a template. The supervisor should sign the form both as supervisor and as approver, unless the supervisor is an advanced graduate student, in which case the supervisor needs to obtain approval from the supervisor of supervision (the PSC director). The top of the form should be completed as soon as sessions are approved. The second section monitors the use of the approved sessions (by recording the dates of the sessions). Once the 12th session is used, the rest of the form should be completed, signed by both the supervisor and the therapist. Unlike most managed care firms, additional sessions are routinely authorized, but your supervisor will provide constructive feedback on the effectiveness of the request and will require additional justification in writing when the request for additional sessions is inadequately argued.

The best argument for continued treatment includes the following: (1) a clear indication of the need for treatment; (2) a clear indication of accountability for progress or lack of progress; and (3) a treatment plan relying as much as is feasible on empirically validated protocols to address the specific symptoms. As clinical scientists, you need to appreciate these realities in your effort to provide the empirical base for the practice of psychology.

Periodic Audits of Files

Periodically, PSC staff review cases to verify that required documentation is completed and filed (treatment plan, periodic reevaluation of the case, reports, progress notes, etc.). Approximately once a year, the PSC Director directs a more thorough review of all active PSC cases. This audit goes beyond a documentation check to review, for example, how well progress notes relate to the treatment plan. This review is intended to be educational, and includes constructive feedback on how to improve the documentation of the case.

Documenting Change

In an effort to facilitate the documentation of clinical progress, we encourage the use of clinical measures to track client progress. The PSC has compiled a set of empirical symptom measures, most on convenient single-page sheets. We are constantly adding to this collection of measures. If you have suggestions for specific measures you'd like to add, please bring them to the attention of the PSC Director. The measures are located in the file cabinet in room 172 (the Clinical Staff Workroom). These are for PSC use only and should not be taken for your own research.

Administrative Issues

Room Use and Scheduling Protocols

Always put the "Do Not Disturb" sign on the outside of the door when you are in a session, and never lock the doors to the therapy rooms. Individual therapy appointments are typically 50-minute sessions. If you plan for your appointment to last longer, please indicate this when you sign out the room. Sessions must end on time because another therapist may be waiting to use the room. Be sure to remove the "Do Not Disturb" sign from the door after your session; if you leave the sign up, other therapists and/or PSC staff will think that the room is still in use. Coordinating the use of therapy rooms requires care and courtesy. Problems should be reported to PSC staff or the director.

You must reserve a room for therapy when you make an appointment with a client or research participant. Indicate the time, your name, and the client number or research program in the schedule book in room 169. Specific instructions for reserving a room are available at the top of each page in the schedule book (see copy of a **Room Reservation Calendar** page in Appendix E). As a general rule, please do not use the group rooms when seeing individual clients unless you are videotaping or seeing a family or group. If your client or research participant cancels, immediately cross out the reservation on the schedule sheet. Standing appointments can be written in several weeks in advance, but again, cancellations should be indicated immediately. Therapy rooms are not to be signed out for any purposes other than therapy or assessment (for PSC clients or research treatment program participants) unless you have received explicit permission to do so by the PSC director.

Taping Sessions with Clients

Videotaping is the norm, but audiotaping is acceptable. Video equipment is available with cameras mounted on wall brackets in two of the group rooms (174 and 179) and one of the individual therapy rooms (173). See Appendix E for instructions on using the video equipment.

Audio tape recorders for use in the individual therapy rooms (173, 175, 177, 178, and 180) are available to be signed out in the Clinical Staff Workroom (172). Next to the tape recorders is an audiotape erasing device; please do not remove that device from 172 but use it there only. Before beginning a session which you will be audiotaping, test to verify that both the microphone and tape recorder are working properly. If the microphone battery is dead, nothing will be recorded.

The microphones in the clinical staff workroom for use with audiotape recorders operate on one AA or another small battery. Replacement batteries can be obtained from the office staff. For most tape recorders, the microphone must be used with an adapter plug. The adapters eventually become worn and may fail to work properly. Replacement adapters can be obtained from the PSC secretary. Please report any microphone problems to the secretary or assistant director.

Client Parking Permits

Clients, with the exception of UB staff and students, are mailed a parking permit with their pre-screening packet, which also includes information about where to park and how to display the parking permit. It is important that you periodically check with your clients regarding the expiration date of their parking permit, as they typically are good for only 2-3 months, and they WILL receive a ticket as soon as the permit expires (those Park Hall lot police are on top of things!). PLEASE do everything you can to avoid your client getting a parking ticket. In the unfortunate event that this does occur, give the ticket to the PSC director who will request it be dropped without payment. It should be noted that while the Campus Parking office has dropped these tickets in the past, there is no guarantee that this will continue to happen in the future, especially if this privilege is abused.

Collecting Fees from Clients

Since the PSC does not have the capacity to handle billing, PSC policy is that all fees are due at the time of the service (i.e., directly following the appointment). All clients will be informed of this policy during the screening interview when their fee is set. Payment is accepted by check or cash only. Unfortunately, the PSC is not able to keep a cash box on hand for change. Thus, please encourage clients to come prepared with correct change.

It is the clinician’s responsibility to collect their clients’ fees. There is a receipt book in room 169 for all payments received from clients. For each payment, complete the receipt (note that it is a triplicate form) and give the client the white copy. Tear out the yellow copy only. It is critical that the pink copies remain in the receipt book. Place the payment and yellow receipt into one of the small envelopes located in the top right hand drawer of the desk in front of the half window in room 169. Write your name, the date, the amount, and the receipt number on the outside of the small envelope, and then deposit it into the black lock box attached to the black shelf unit in room 169. Please remember to note payments received in the client file on the Contact Sheet (see Appendix F) by completing the columns for session fee, fee collected, and balance. If a client is unable to pay the exact fee, indicate this as well. For example, a client whose fee is $15 may regularly get cash from a machine that doesn’t dispense $5 bills, so this client may pay $20 one week and $10 the next. The client’s balance, whether positive or negative, is easily indicated on the contact sheet.

Mileage Reimbursement

On rare occasions, PSC clinicians leave the PSC to do clinical work—in particular, when they're working with a client to overcome anxiety or panic problems, they may work off-site with the

client so that they can go to the place that the client needs to overcome the fear of. In these cases, the clinicians may have significant gasoline and automobile wear-and-tear expenses. Student clinicians may be reimbursed for their mileage at the standard UB rate of $0.345/mile. Clinicians should document the date(s), destination location(s), and miles traveled on each occasion. At the completion of the course of treatment involving travel, the clinician needs to fill out a **Travel Voucher** form and a **Statement of Automobile Travel** form (see Appendix E; forms are also available online at http://www.avpc.buffalo.edu/travel/Forms/forms.html). Give the filled-out forms to the PSC director, who will check and complete them, obtain approval from the department chair, and submit the request.

Evening Hours Policy

Safety of clinicians is an important consideration, and therefore, a clinician should never be in a situation where they are seeing a client alone in the clinic. All clinicians are expected to sign-up for coverage of clinic evening hours. Clinicians are only to see clients after 5 pm on designated evenings when support is available, such as when the Director, Assistant Director, or a clinician assigned to be on coverage are in the clinic specifically for this purpose. Therefore, clinicians should only be seeing clients between business hours on weekdays, except for those evenings when coverage is being provided. In the event of a clinical emergency, a supervisor, another available clinical faculty, or the Director should be contacted to provide consultation and guidance. In the case that a student clinician is on duty, this clinician can provide assistance and support while a supervisor or other clinical faculty is contacted.