Practice Manual & Syllabus for Psychology 691
The Community Counseling & Psychology Clinic
Texas A&M University – Commerce

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Clinic Policies and Procedures and Guide
For Practicum Students in Counseling, Social Work, Special Education, and Psychology

This document will serve, in conjunction with other documents and directives of Clinic staff, to guide the conduct of graduate students in counseling, psychology, social work, and special education who are working in (or, in a field site setting, managed through) the Community Counseling and Psychology Clinic. It will also assist employees of the Clinic in understanding the policies and procedures of the Clinic insofar as the practices of psychology and educational diagnostics are concerned. Finally, the document will provide guidance to faculty members wishing to use Clinic resources or involve themselves in the teaching, research, or service activities of the Clinic.

This semester will entail your working principally with several clinically trained professionals. Sean Lauderdale, PhD (Sean.Lauderdale@tamuc.edu) serves as the Clinic director, and your contact will probably be mostly with him, Steven E. Ball, PhD (steve.ball@tamuc.edu) and, less frequently, Karin Tochkov, PhD (Karin.Tochkov@tamuc.edu). These three faculty members also form the core faculty for the applied master's program

CHECK LIST OF STUFF YOU NEED TO HAVE BEFORE YOU START TO WORK OR ACCUMULATE HOURS IN THE CLINIC

Official Letter from A&M Commerce Confirming Full Admission
To the Mental Health Master's or Doctoral Program in Counseling
or
To the Master's Program in Social Work
or
To the Master's Program in Applied Psychology or the Specialist Program in School Psychology

Current (Official) Transcript
Curriculum Vitae (Professional Résumé)
Schedule of the Hours You Will Be Occupied at Work or in Other Classes This Term
Documentation of Professional or Student Liability Insurance in Force by Term's Beginning
Current Contact Information Sheet
(i.e. name, telephone number, email, graduate program, CWID)

Bring the following from this document to the first mandatory practicum meeting:
Student Agreement Form
Agreement to Maintain Confidentiality in Clinical Observation
Expanded Current Information Sheet
Documentation of HIPAA/HB 300 Training Taken and Passed

I. Mission statement for the Community Counseling and Psychology Clinic

To provide clinical and research experience for graduate students in counseling, psychology, special education, and social work that emphasizes quality service to the public and university community, as well as a deep respect for the humanity and circumstances of its clients, the developing strengths and abilities of its trainees, and the fundamental principles that can help people solve their problems and move toward more fulfilling lives.

II. Declaration of understanding and trust

All members of the supervisory professional staff are licensed to practice in one or more human service disciplines in the State of Texas. Several important inferences follow:

A. All counseling, psychological, or social work activities conducted in the Community Counseling and Psychology Clinic are *de facto* a part of one or more of our practices. Each thing you do for this clinic, no

matter how small it may seem, is thus our responsibility. This of course includes the activities while in the clinic (or enrolled in PSY 691 and working off-site) of educational diagnosticians in training.

B. Each action taken by anyone in the Clinic pertaining to Clinic activities is ultimately our responsibility.

C. We can lose our licenses or be otherwise sanctioned for any malfeasance of any practicum student, Clinic director, department head, graduate assistant, or any other person operating under the jurisdiction of the Community Counseling and Psychology Clinic in its capacity as a source of counseling, psychological, educational, or social work services.

D. It is reasonable for us to require that practicum students and others working in the Clinic conform to standards of clinical practice that will protect our professional status and licensure.

A few things that do not necessarily follow, but which most of us believe, and which we think that practicum and internship students, and Community Counseling and Psychology Clinic employees, should know:

E. We (all of us) have *no* assurance that Texas A&M University – Commerce, the Texas A&M University System, or the State of Texas can (or will) adequately protect us legally in the event the Clinic and one or all of us are sued. A&M system lawyers are of course employees of the system, and are principally charged with attending to the system's interests – not ours. The best guess is that they will let us, as individuals, hang out to dry, unless to do otherwise is in the best interests of the system. (People have objected to this paragraph's inclusion in this manual, but I prefer to tell you the truths I can – and this is one.)

F. You are legally liable and can be sued for your own actions in tort cases, even though we provide clinical supervision and responsibility (and of course will also be sued). This is especially true in cases of negligence, malfeasance, or failure to comply with explicit supervisory directives, some of which can lead to criminal prosecution.

G. Notwithstanding these things, we are committed to the process of helping you as a practicum student become more effective as professionals through your experience in the Community Counseling and Psychology Clinic. We do not believe that this will be an optimal experience for you unless you are treated as responsible professionals, with both privileges and concurrent obligations. All of this should be made as clear as possible to practicum and counseling internship students, as soon as is possible, beginning with the following **assumptions**:

1. By virtue of their qualifying for the experience, practicum students have already achieved the status of professionals. They are in the process of receiving training in order to become more effective professionals. **Part of that training is technical, and part is directly related to professional conduct, including a social philosophy or moral code.**
2. Practicum students want to practice professionally, in an atmosphere of trust and mutual respect.
3. If trusted and expected to conduct themselves in professionally appropriate ways, *most* practicum students generally will do so.
4. Practicum students (especially the young or inexperienced) will require more direct guidance in proper professional conduct than will more fully qualified and experienced professionals. This guidance ideally will be based on a supportive structure that operates fairly automatically, more than on managerial prompts and chiding. This manual is a part of that supportive structure. Sometimes, however, younger or less mature student clinicians will approach their work in the clinic much as some undergraduates do, and do not take it as seriously as they might. In these cases, we impose sanctions to protect the integrity of the clinic and the licensed supervisors who work in it.
   In general, though, **we choose to trust and respect you as Clinic professionals**, as well as to provide you the necessary and positive structure you require as learners of this craft.

III. Clinical policies and procedures in practice

A. *Admission to the Clinic*

1. **Permission for a student to work in the Clinic is a privilege afforded by the faculty supervisory staff who are working actively in the Clinic and by the individual training program for each semester that the student wishes to work in the Clinic. The Clinic faculty who are actively working and providing supervision in the Clinic will collectively make the**

decision to admit a student, and may decline or revoke the privilege at any time for cause. No one else can permit a student to work in the Clinic.

2. Admission to the Clinic as a practicum or internship student is also dependent on consent of the program coordinator for your major and in the course in which you are enrolling. You cannot be permitted into the Clinic until you have secured this consent in writing (usually by e-mail), and provide documentation of your eligibility to persons in your department who have the authority to permit you to apply to work in the Clinic.
3. Each program will determine the criteria for granting access to application to the Clinic for their students, as well as the procedures for communicating that information in writing to the faculty supervisory staff of the Clinic. Most of the time, final consent from the student's program is also necessary for the student to be admitted to work in the Clinic.
4. **The final decision for a student to work in the Clinic lies entirely with the Clinic supervisory staff**.
5. **In some instances, and for a multitude of reasons, we may suggest or require that you lay out of working in the Clinic for a semester or more**.
6. It is useless for students to enroll in practicum with the intention of working in the Clinic if they do not have the skills necessary to do the work of their disciplines.
    a. Students in applied or school psychology programs at a minimum must have passed with a grade of B or better PSY 503, 508, 537, 538 (or equivalent), 572, 573, and 575 (576 if you are in the SSP program, or other equivalent approved by the Clinic director) before admission.
    b. Master's students in Counseling must be approved for admission to the Clinic by the mental health counseling master's program coordinator. Master's level students in Counseling must have completed the pre-practicum experience (COUN 516) successfully (a grade of B or better), as well as COUN 510, COUN 528, COUN 611 or 539, and any other courses required by the Counseling Department. Doctoral level students in Counseling will be evaluated on a per case basis, but they must have the written approval of the program coordinator, and they must be demonstrably capable of contributing to the Clinic offerings. Doctoral students in Counseling must be enrolled in an appropriate course with a licensed professional counselor or licensed marriage and family therapist identified as the departmental supervisor and instructor of record, and provide the written consent of the doctoral program coordinator. Doctoral level students in Counseling must agree to be present in the Clinic for at least 6 mutually agreed upon hours per week, including availability to work with at least four in clients weekly 50-minute sessions, and attend all weekly staffings. Master's and doctoral level counseling students admitted to work in the Clinic as student clinicians acknowledge that they will not likely get all the direct hours required for their practicum or internship experiences per semester in this placement. This reality means that such students should consider Clinic placement a secondary site.
    c. Students in Social Work must have completed a set of clinically oriented courses specified by the Department of Social Work, and documented by the head of the department or a designated coordinator. They also must be demonstrably capable of making a relevant contribution to the Clinic's ability to serve its clientele.
7. Due to limited space in the Clinic for students in training, we will need to review your credentials before giving you permission to enroll. In this way, those who are admitted will be most ready to do what is required in the Clinic of a student clinician. In addition, since all of you who are interested may not get to enroll in the semester of your choice, we will evaluate your qualifications on a competitive basis with those others who have submitted requests to enroll that same semester. Most people document their credentials by submitting an official transcript and a copy of official university documents confirming admission to the relevant program. You must also be approved by your program ccordinator and complete an application form to be admitted to the practicum. Admission to work in the Clinic, or to enroll in 691 for a field-site placement, also requires a formal interview with Clinic/PSY 691 staff. Suitable documentation of field-site placements, including site supervision and the programmatic characteristics of the site, is also necessary. (Use the forms provided by the Clinic Manager for such documentation.)
8. Once admitted to work in the Clinic, you must, ***by law***, have received documented HIPAA/HB 300 training before you can work with clients. HIPAA/HB 300 requirements differ across professional

settings, and even if you have worked somewhere else where you have had HIPAA/HB 300 training (including elsewhere in Texas A&M University – Commerce) you must take ours and pass a related exam over its contents before working in the Clinic. The exam includes specific elements from this manual as well as HIPAA/HB 300-specific concerns. Documanted review of HIPAA/HB 300 matrials and this Manual are now necessary each semester a student clinician works in the Clinic.

9. In its biennual wisdom the Texas legislature has added even more layers to the obligations of those of us who work with protected health information (PHI). **With Texas HB 300, you must undergo job specific training in how we handle issues of confidentiality within 60 days of employment, and you cannot handle PHI at all until you have had the training, which you confirm (1) by passing the exam mentioned above, and (2) by signing a form confirming your training.**
10. Before beginning work in the Clinic, students must also demonstrate (typically by a written by examination) that they have read, understood, and recall the contents of this manual.

B. Dress

1. Using your best judgment, and consulting freely and comfortably with others, dress professionally while in the Clinic. Skirted suits, ties, etc., are not always necessary, but, if you consider with whom you will interact and the context, and if you view yourself as a professional social worker, counselor, diagnostician, specialist in school psychology, or psychologist, you should make good choices. Shorts are **always** a poor choice, but neat, clean jeans can work *occasionally* in the business casual atmosphere of the Clinic – if you are prudent. Any items of clothing that "hook" a strong transference in a client are problematic. (Neither men nor women, for example, should wear clothing that reveals any of their body cleavages – except those on the face.) Sometimes a clinician may have to make clothing choices that play down features that may be disruptive of the assessment or treatment process. Moreover, some people look controlled and appropriate, even in casual clothes, while others can transform an exquisitely tailored suit into a sartorial disaster. Know thyself and adjust accordingly. Any member of the supervisory staff may provide you feedback about these matters, we hope always in the spirit of collegiality and in order to facilitate professional growth in all of us. **Just dropping into the Clinic in professionally inappropriate attire can cause difficulties, if, as has happened, an unscheduled client of yours shows up unexpectedly and urgently seeks a conference. Whenever you are physically on the premises of the clinic and the waiting room door is unlocked, you should be dressed at a minimum as "professional casual, and ready to work."** Because of their obvious gravitas, faculty members working in the Clinic may choose to wear what in their judgment is most appropriate for the setting and the roles they play in it. Spoken, the word "gravitas" in this connection might suggest, through pragmatic communication, a degree of sarcasm or risibility. Notwithstanding, faculty members working in the Clinic (except for the director, or anyone else who regularly meets with clients) have considerable latitude in ther clothing choices.
2. When it is appropriate and true, tell your peers in the Clinic that you believe they are dressed professionally that day. Be prudent here, avoiding even a remote semblance of sexual harassment or other impropriety. Let the professional staff deal with problematic clothing choices – unless you have a friendship with the other person that you know can sustain your doing it yourself.
3. Choosing your wardrobe always represents a significant activity for professionals. You should think of whom you will be dealing, and make an effort to look good without calling undue attention to yourself. Avoid at all costs the HEYLAM choice (Hey! Look at me!) in choosing clothing, jewelry, and coifs.

B. Presence

1. If you are enrolled in PSY 691, for each three-hour practicum course for which you enroll, you *must* receive credit for a minimum of 200 hours of approved Clinic service time. (Different program requirements may make it necessary to earn more hours. The 200-hour requirement is necessary for you simply to work in the Clinic, regardless of your program – though it can be waived by the director for cause. Counselors using the Clinic as a secondary practicum or internship site, for example, will have real but quantitatively less demanding requirements.) These hours may be direct or indirect, but they must include service to the Clinic (or an approved field-site placement).

Testing, providing feedback/consultation, speaking to clients briefly on the telephone, and therapeutic intervention are all examples of direct contact. Writing reports, scoring protocols, writing in your Clinic log (if you are keeping one), practicing assessment and intervention procedures on each other, staffing cases with other professionals, and reading relevant books, articles, and manuals are all examples of indirect contact. We specifically exclude studying for other classes, writing term papers or documents associated with theses and dissertations, extensive idle chatter, communicating on social media, sleeping, etc. Work at home does not count, and you should be mindful that there are professional risks in making notes or working on assessment reports outside of the Clinic. **During the summer it is impossible to achieve the hourly requirements for practicum credit during the course of one normal summer semester.**

2. In scheduling your time in the Clinic in the fall or spring, you *must* arrange to be in the Clinic for a minimum of 14 full weeks (for at least 15 hours per week).
3. In scheduling your time in the Clinic in the summer, you *must* arrange to be in the Clinic for a minimum of 10 full weeks (for at least 20 hours per week – do the math). If you are receiving financial aid through the university, you must be proactive in ensuring that the Financial Aid Office people understand what you are doing so that you do not lose money (though if you are relying too heavily on student loans you are losing way more money than you may imagine). **All students, including public school employees, must commit to presence in the Clinic during the summer term, and continued work on Clinic matters through at least August 15 or the last day scheduled for the second summer term, whichever is later.**
4. For students enrolled in PSY 691, in each three-hour practicum course for which you enroll, you *must* receive credit for a minimum of 80 hours of direct contact. (Different departmental requirements may make it necessary to earn more than 80 direct hours, e.g., in Counseling or School Psychology programs. The 80-hour requirement is necessary simply for you to work in the Clinic.) This means that you should strive to get at least 6 hours of direct contact each week you are in the semester in a long term and 8 direct hours per week in the summer.
5. In special circumstances, e.g., when the student clinician is working in multiple sites in order to complete an adequate number of direct hours (a situation that is far more common in counseling students), the student may formally petition the Clinic to work a reduced weekly schedule. The student must complete this process, and receive written consent to work a shorter schedule, before being accepted to work in the Clinic. In all such instances the clinician must be in the Clinic a minimum of 10 hours per week, scheduled at times that serve the Clinic's needs in serving clients. This arrangement means that the student clinician in such a situation must be in the Clinic during the specified 10 hours weekly, and may see as many as eight clients per week during that time.
6. By the time you arrive on our first Clinic day (the first Tuesday of any new semester), **Ms. Triplett will assign you a Clinic working schedule, based on your class and work schedules**. As soon as you have access to this syllabus, download and print a copy. Then complete the last page and deliver it in person or by electronic means to CCPC@tamuc.edu at least a week before the first day of classes. Ms. Triplett will inform you of this requirement by an email to your university email address. She will schedule you to be in the Clinic for 14 (20 or more in the summer) hours each week, including supervision time and time spent in any *approved* field-site activities. **Clinic time will be scheduled in blocks of not fewer than 4 hours at a time, or 5.5 if it is to include scheduled staffing time.**
7. Be here when you are assigned to be, if at all possible. When you cannot, for cause, call and let the Clinic know as soon as you reasonably can. If there is no cause, be here when you are scheduled.
8. **Record your presence at the Clinic (or field site) daily**, using whatever procedure is current (e.g., a sign-in sheet, or simply reporting to the Clinic Administrator), and as otherwise defined by Ms. Triplett. You should check with Ms. Triplett for the procedure currently in use. Working with the several disciplines and teachers of record, the Clinic will provide a single time-keeping procedure for *all* students in the Clinic, regardless of their discipline. You *must* record all direct and indirect contact hours, either in the Clinic or at approved field sites, on a daily basis on a form the Clinic will provide. ***Failure to do so will result in your failing to get credit for these hours, and will, if it is chronic, yield a failing or unsatisfactory grade, or dismissal from the Clinic. Failure to submit the record of hours by the time specified each week will result in those hours not being counted toward the hourly requirements for PSY 691 or any other course relevant to the student's working***

in the Clinic. If you send your weekly record of hours to the Clinic Administrator as an email attachment, the attachment must be either a WORD (doc or docx) file or a legible PDF file. Do not send pictures of the form taken with your cell phone, or any other mobile device.

9. Different programs may require additional documentation procedures, and, if they do, you remain responsible for both sets of documentation requirements, copies of which should be placed in your Clinic folder.

10. **Enrollment in the Clinic (for any number of credit hours) requires that you be present on a prearranged schedule and ready to perform assigned professional tasks for 14 weeks during the fall or spring semester, and for 9-10 weeks in the summer. You must complete all report writing assigned to you (essentially, at the very least, a write-up for every test or therapeutic contact you have done – much more may be necessary), progress notes, case summaries, and case closings before your time in the Clinic is done.** ***You must be officially enrolled in an appropriate course in order to work in the Clinic, except that, if you are currently pre-enrolled and have successfully satisfactorily completed at least one prior semester of work in the Clinic in the last 6 months, you may work in the Clinic under the Clinic Director's immediate supervision (which may be delegated to another relevant professional supervisor) in the time between terms before the semester in which you are pre-enrolled begins. The Clinic Administrator determines the feasibility and form of any such arrangements.*** In certain cases, we may approve a student's ending his or her time in the Clinic a few days early if all other criteria for completing the semester with a passing grade are already met, and if the student clinician's presence is absolutely unneeded to complete the semester's Clinic contracts. A student having completed all requirements, and who has a job that begins in early August, *may*, for example, be granted such a leave *at our discretion*. In no instance, however, will we grant such a release for more than 4 Clinic work days.

11. **YOUR OBLIGATION TO WORK AND PERFORM ASSIGNED PROFESSIONAL DUTIES IN THE CLINIC (or an approved field site, if requested by your field site supervisor) CONTINUES THROUGHOUT THE ENTIRE SEMESTER IN WHICH YOU HAVE ENROLLED, REGARDLESS OF WHETHER YOU HAVE COMPLETED YOUR MINIMUM NUMBER OF DIRECT OR INDIRECT HOURS, WITHIN THE CONFINES OF THE SEMESTER(S) IN WHICH YOU ARE ENROLLED. THE CLINIC DIRECTOR WILL DECIDE WHEN YOU ARE DONE – NOT YOU.**

12. Provide the Clinic with a current copy of your curriculum vitae by the second day of the Clinic's being open each semester, or sooner if required by the Clinic Manager. This document is your academic résumé, and it should include information about your training, professional work history, relevant publications, professional presentations, and the like. Ask for examples if you need them. We need these in both electronic and hard copy forms.

13. **The best way to succeed in practicum is to assume that *de facto* for these 10-15 weeks you have a job working for the Community Counseling and Psychology Clinic (or some other professional organization if you have a field site placement). You are providing skilled, pre-professional labor in exchange for experience, supervision, and credit hours (not money – what you are getting can in fact be more valuable than gold). As with any job, you will be rewarded for good performance and negatively sanctioned for lesser work. At any job, if you are chronically late, sometimes don't show up, don't do your work adequately or on time, are insubordinate or disruptive of organizational functioning, are rude to customers (clients), do not complete your assignments within stated time limits, or fail to support the mission of the organization (and its underlying assumptions), you will get in trouble, and you *can* be suspended or fired. The choices are of course yours, except for the decision to suspend or "fire" you and other sanctions. The Clinic equivalent of suspending or firing you is simply not to give you any work to do, and to deny you future enrollments and current access to Clinic space. Ultimately, of course, we could drop you from the class and bar you from entering the Clinic space even before the semester is over. Inappropriate behavior by a student clinician will be ruled on by the Clinic director or Clinic Administrator, and they will mete out**

sanctions of their choice. This is a zero-tolerance policy, and rarely will we give you a warning. All you need to know to avoid such consequences is available to you in this and other Clinic sources, and as professionals in training we will expect you to behave accordingly.

14. **For your convenience here is a table of some of the most important requirements for success within the Clinic:**

TABLE 1
CRUCIAL REQUIREMENTS FOR STUDENT CLINICIANS
COMMUNITY COUNSELING & PSYCHOLOGY CLINIC

Clinic Activity	Requirements
Attendance & Participation in Staffing	Attend for the entire duration, and participate appropriately in, a minimum of fourteen (14) "staffings" (supervision/ training sessions). In the summer attendance at nine (9) such sessions is necessary.
Recording appropriately a future appointment in the Clinic scheduling book	Record each appointment in blue ink in the appropriate space with client name, number, and telephone number
Exiting clients in non-emergency sessions with no fewer than 30 minutes left to the scheduled closing	End sessions at a time so that the client can leave the Clinic at least 30 minutes before closing time
Charting: Contact Sheet	Daily for all in-clinic activities; ASAP for outside contact
Charting: Initial Interview & Progress Notes	Daily for all in-clinic activities; ASAP for outside contact
Scoring Protocols	Day administered or first activity on the Clinic's next opening
Making Observational Notes for Assessments	Day administered on form provided; signed with copy to the director same day
Creating Assessment Planning Form Completed & Signed	5 calendar days following completion of Life History Questionnaire & Neuropsychological Referral Form
Crafting High Quality Draft of Referral Question and Full Background with "Masthead"	1 calendar week from first interview with client/parent/guardian/other
Writing First Draft of Report	14 days after second session (or first session, if there is no second within first week)
Recording Video of Assessment Feedback Session	Record session, archived in Clinic
Revising Draft of Report	4 calendar days following receipt of feedback from supervisor
Completing Signed Treatment Planning Form	10 calendar dayss following first meeting with counseling/psychotherapy client
Making Video of Counseling/ Psychotherapy Session	Record session, archived in Clinic
Closing Case	On completion of clinical work

C. Appointments and client scheduling

1. **First, no person may be seen by a clinician in the Clinic as a client or representative of a client without our first getting a written and fully executed informed consent to receive services & a fully completed Life History Questionnaire & Neuropsychological Referral Form (LHQ). A phone intake is an initial gathering of information that allows the staff to determine whether to accept the person as a client, and obviously consent is not required for that. In the case of a walk-in, and even if the potential client just stands in the waiting room talking to a clinician in any but the most rudimentary detail about the clinical situation, executed informed consent is necessary. (As a rule, moreover, you should not talk about clinical issues with anyone in the waiting room.)**
2. All initial appointments with clients, for whatever purpose, will ordinarily be made by the Clinic Administrator (Ms. Triplett), the Clinic director, or a member of the Clinic staff under the direction of the Clinic director or Clinic Administrator. Most of the time, Ms. Triplett will assign initial appointments to a counselor, social worker, or psychologist in training, who will conduct an initial intake interview, which will not occur until the client has provided a completed informed consent and one or more Life History Questionnaire and Neuropsychological Referral Forms (LHQ). The interviewing student clinician must review the LHQ in advance, noting content of interest and omissions, in anticipation of the actual in-depth interview, which may take an hour or more. In the interests of efficiency, the student clinician *may* in fact begin the assessment process on the same day as the clinical interview, but only with the approval of the director or anther Clinic supervisor.

3. Notwithstanding, that interviewer will in turn present the case for consideration at staffing, and assignment of the cases will happen after that initial discussion.
4. All appointments must be written in a single appointment book (or other related mechanism) by client number and clinician name as the appointment is made. We typically write our appointments in blue ink, indicating in a similar fashion if they arrive, call-and-cancel, or simply no-show. In general, the scheduling book, since it contains information about *all* clients, is not subpoenaed. It remains an important tool, however, in the orderly conduct of clinical business. **Always write a client's name in the book with client CONTACT number (see below) and phone number, and attach it to the names of all clinicians scheduled to see the client that day. Print in manuscript or write *very* legibly in cursive (remember that, as time passes, fewer and fewer student clinicians will be able to write or read cursive). If the client comes for the appointment, mark a check beside the name in the schedule book, and if not, note the fact both in the book and in the client's chart. These procedures are subject to modification by the Clinic Administrator.** Appointments never should be penciled in. The client or the client's parent/guardian should be given the **client contact number or other code** at the outset for purposes of telephone communication. The contact number cannot be the same as the **client case number**, by which we deidentify and reidentify protected health information (PHI). The client contact number will be a random 6-digit number. The 9-digit numbers will be assigned non-sequentially and randomly, so that they will not be correlated with client case numbers. (Ms. Triplett has provided a schedule book that is individually tailored to the Clinic's practice.)
5. **IF YOU MAKE AN APPOINTMENT FOR ANY CLIENT, WRITE IT IN THE SCHEDULE BOOK IMMEDIATELY. Failure to do so will result in a one-week suspension from the Clinic (or more), and the permanent loss of all current case manager assignments.**
6. **When a parent or guardian brings a minor child for treatment of assessment, both the parent and the child should be interviewed, the child first. Older children and adolescents should complete the LHQ independently to the extent that their capabilities allow. Children under 8 should receive both a play-based interview (if appropriate personnel are available), and a more traditional, but child-focused, clinical interview (if possible).**
7. As noted above, whenever a first appointment is made for a new client (individual, family, or group), Ms. Triplett will schedule that meeting as a general intake interview with any one of the student clinicians, during the scheduled work hours for the clinician involved. In this meeting the student clinician, using fundamental interviewing skills and mindful of the presenting issue, will discuss the nature and ramifications of the presenting problem with the client, securing as clear a picture as possible of the issue at hand and its personal context, i.e., with a clarity suitable for a presentation to a "general staffing session," a process for which that clinician must prepare before the next general staffing.
8. At the next general staffing session following the intake interview, the student clinician who conducted the intake interview will present the case formally to the Community Counseling and Psychology Clinic staff. An outline for a formal case presentation is available in Appendix 1 below. The clinical work force as a whole will formulate a preliminary plan of possible goals, subsequent assessment (formal and informal), intervention, and (if appropriate) referral, but these will be articulated in writing by the student clinician assigned as case manager on a form provided by the Clinic. The professional supervisory staff will thus necessarily assign a case manager, who will be responsible for tracking the case from beginning to end, ensuring that time lines are met, chart notes are complete, reports or case summaries are written, etc. The student clinician who conducts the intake interview is responsible for charting the details of this preliminary plan, communicating its specifics to the Clinic director, and transferring the case to the case manager, all of which the student clinician must also chart.
9. Under some, perhaps most, circumstances (usually associated with scheduling and the pragmatics of formal psychometric evaluation), a formal assessment may begin in advance of the case's being discussed at a general staffing session. This decision will be made at the discretion of one of the professional supervisory staff, and the case will be staffed as usual at the next general staffing session. The student clinician beginning the case may or may not continue as case manager.
10. **When a member of the professional staff (usually Ms. Triplett) makes an appointment for any formal assessment, she will schedule two to four sessions at once so that (ideally) the work will be completed within 4 to 6 Clinic work days. Unless it is absolutely necessary, you should not reschedule these sessions.**

11. Sessions for activities other than formal psychological assessment (i.e., other than those involving tests and other assessment procedures with known psychometric properties, which must be administered according to a normative protocol, such as intelligence and academic skills tests, personality tests, neuropsychological tests, etc.) will initially be scheduled by the Clinic Administrator. These include activities involving intake interviews, counseling or psychotherapy, group therapy, play therapy, intervention, consultation, etc. Subsequent appointments will ordinarily be scheduled by the clinician, but other Clinic personnel may also schedule such appointments (e.g., when a client calls in to reschedule). Generally, however, only Ms. Triplett, the clinician with whom client will meet, or the Clinic director may write a scheduled appointment in the appointment book for a given client.
12. **Each clinician is responsible for checking the appointment book immediately on arriving at the Clinic each day.**
13. Any person working in the Clinic who makes an appointment for a clinician that is scheduled at the beginning of the next day on which the clinician will be at the Clinic must contact the clinician at least 4 business hours in advance by phone (voice mail or answering machine suffices – the clinician is responsible for checking messages), or in person, with pertinent details necessary for planning the scheduled activity. Chart the contact in order to cover (protect) yourself. And of course do no not leave client identifying information on a voice mail recording device (cf. HIPAA/HB 300 training module).
14. Under some (emergency) circumstances, a clinician may schedule an initial appointment without going through the Clinic Administrator or Clinic director, but, as always, all other Clinic procedures should be followed exactly, and the Clinic Administrator, and any other relevant Clinic supervisors should be informed immediately. Remember that written informed consent is necessary in every case.
15. **All clients should be out of the Clinic by 30 minutes before closing time, no exceptions (except in life-threatening or similarly serious emergencies). The Clinic Administrator or Clinic director may suspend you from the Clinic for up to 8 weeks if you habitually violate this rule**
16. **All extraneous paper work, i.e., stuff that is not going into a client's file, and which we no longer need, should be shredded (or given to the Clinic Administrator for shredding, but only if our shredder is not available to the student clinician) before you leave the Clinic each day.**

D. Charts

1. **All contact with or about active, pre-active, inactive or discharged clients *must* be charted, and it should be charted immediately after it is completed**. Late charting should be completed within 24 hours and should be used only when circumstances legitimately preclude timely charting. **Client contacts that should be charted include, but are not limited to, intake sessions, assessment sessions, intervention sessions, feedback sessions, consultation, telephone calls (initiated by the client or the clinician or other Clinic staff), staffing/supervision of a client's case (including discussions with other student clinicians, brief discussions with a supervisor outside of staffing), incidental contact in the community (e.g., at the grocery store – obviously a late chart here), and calls to and from other professionals regarding the client (e.g., physicians, law enforcement officers, etc. – even if we cannot legitimately discuss the case with the caller). Chart all no-shows, noting efforts made to contact the client, etc. Chart all cancellations, noting how and who made them. Include the complete date (month, day, and year) in each chart entry. Chart the closing of a case.**
2. **In some instances, a student's instructor of record for the activities the student is engaging in while working in the Clinic is not a part of the Clinic work force. The student in this case *must* chart all supervisory discussion with that non-Clinic instructor regarding those cases in detail, including recommendations made by the teacher of record and the full names of all present for that discussion. (Note that, with Clinic clients, your Clinic supervisor or the Clinic director may countermand the suggestions of an outside supervisor and you must comply with such a directive. You should discuss with the supervisor or director the basis for such an action.)**
3. Write **chart notes in *blue* ink only** and of course in the appropriate place in the client's chart. Chronically using ink that is not blue, or especially pencil, to write chart notes, will earn you a suspension or termination from Clinic placement, and (in PSY 691) a grade in the course of "unsatisfactory."

4. If you make an **error in a chart, use *blue* ink to draw a *single* ~~line~~ through the error, write "error" and your initials above it, and write in the correct entry. Do *not* mark out an error, either with ink or correction fluid ("white-out").**
5. Write chart notes ***legibly*** (cursive or manuscript, the latter only if your cursive writing is illegible or unavailable in your skill set), summarizing the contact clearly and concisely, but with enough detail to know on reading what kinds of activity took place. If you choose not to spell out a word, use only standard clinical abbreviations (e.g., pt, ct, dx, tx, hx, etc.).

   All counseling or psychotherapy notes should be typed (not written by hand) and of course signed.

   Your chart signature *must* be accompanied by a clearly legible, and printed-in-manuscript, non-signature version of your name. The contact sheet now in use has a space dedicated to this printed version of your name. Failing to produce a legible, printed version of you name in a chart note can result in suspension from Clinic activities from 1 to 16 weeks.

6. **Sign the chart note**, adding your credentials afterwards (e.g*., Mobina Gunch, M.A., LPCi, LSSPi*). At the beginning of each semester, during HIPAA/HB 300 training, you will be required to complete a form allowing us to identify your signature in the future.
7. Label a chart note that is entered late as "**LATE CHART**" providing the date the contact or work occurred, as well as the date you are writing the note (this in the regular place).
8. Clinic staff will periodically review chart notes for completeness and correctness of form. **Significant failures of any sort in adequate charting will be grounds for receiving a grade in Practicum of "F" (PSY 691; instructors of students enrolled in other practicum or internship courses will be encouraged to grade the student in a similar fashion), and the student will be dismissed from the Clinic.**
   A member of the Clinic workforce will check your charts on a weekly (or more frequent) basis. Failures to maintain adequate charting will result, first, in a one-week suspension from the clinic (i.e., you will not be able to come to the clinic and you will permanently lose your case manager status for any active cases). A second violation will result in a similar suspension for four weeks. Note that it will be impossible to get your direct and indirect hours if you are not working in the Clinic for four weeks during a semester, necessitating your enrolling/working in the Clinic for at least one additional semester.

9. You should include in the chart by way of additional documentation all paper records generated on or for the client. Such documents would include (but not be limited to) test protocols and questionnaires, telephone message pad notes, hand written notes from interview, telephone, or other conversations, typed interview transcriptions, subpoenas, letters from the client or other persons concerning the client, etc. Sometimes other items, such as audio or video recordings, are included in the chart as well, or a reference is made to their archival location. All inclusions and storage procedures must comply with HIPAA/HB 300 and other federal and state regulations for PHI (protected health information). The client's name and case number must be clearly placed on every separate document page in the file.

11. **ACCESS TO FILES & PROTECTION OF PRIVACY:** Federal Law, which became effective in April of 2003, applies to this Clinic, and it greatly influences our practices in records stewardship. This law is known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). All files are kept in a locked room, to which only our designated Records Officer (the Clinic Administrator) or a formally designated alternate; or a member of the professional supervisory staff has legitimate access. The practical consequence of this convention is that you may not retrieve charts from the file yourself, but must get them from a Clinic officer (in practice the format for this retrieval is determined by the Clinic Administrator, who, with the director, implements it). There will be a clear paper trail associated with the location and movement of all records.
12. **PRAGMATICS OF FILE RETRIEVAL AND MOVEMENT: You may retrieve only one client file at a time from the records room. You must comply with existing procedure as established by the Clinic Administrator in order to retrieve files. You may not retrieve another file until you return the first one, i.e., you can have no more than one file in your**

possession at any time. All files must stay in the designated Clinic space only. You should have the file in your possession at all times, except that you may leave it under very specific conditions for brief periods, e.g., restroom breaks. You may leave the file closed and face down in the staff room (Binnion 102) for short periods of time if other members of the Clinic staff who are clinicians (e.g., they are not clerical employees without clinical duties) remain in the room, whom you have told about the file, and who have orally agreed to manage the file for you while you are gone.

NOTE: STUDENT CLINICIANS TAKING FILES OUT OF THE CLINIC AREA FOR ANY REASON WILL BE SUSPENDED FROM WORKING IN THE CLINIC FOR THE REMAINDER OF THE LONG TERM OR SUMMER SESSION IN WHICH THE INFRACTION OCCURS + ONE-HALF OF THE NEXT SEMESTER IN WHICH THE STUDENT CLINICIAN ENROLLS TO EARN CLINIC HOURS. IN ADDITION, THE STUDENT CLINICIAN WILL RECEIVE A FAILING OR UNSATISFACTORY GRADE FOR THE SEMESTER IN WHICH THE INFRACTION OCCURS.

NOTE: STUDENT CLINICIANS PROVIDING COUNSELING OR PSYCHOTHERAPY SERVICES MUST MAKE VIDEO RECORDINGS OF EVERY SESSION FOR REVIEW BY CLINIC SUPERVISORS AND (AS IS THE CASE) EXTERNAL PRACTICUM OR INTERNSHIP SUPERVISORS WHO ARE NOT ATTACHED TO THE CLINIC. SUCH RECORDINGS MUST BE IMMEDIATELY PLACED ON AN EXTERNAL DRIVE WHICH REMAINS IN THE CLINIC EXCEPT ON SPECIFIC DAYS ON WHICH THE VIDEO RECORDING WILL BE SHARED WITH THE EXTERNAL SUPERVISOR. TRANSFER OF ALL VIDEO RECORDINGS OF SESSIONS PLACED ON AN EXTERNAL DRIVE OUTSIDE THE CLINIC MUST COMPLY WITH A PROTOCOL ESTABLISHED BY THE CLINIC ADMINISTRATOR. SUCH RECORDINGS OF INDIVIDUAL SESSIONS WILL BE DESTROYED ONCE THEY ARE REVIEWED (OR ON THE CASE'S BEING CLOSED, WHICHEVER COMES FIRST). NO STUDENT CLINICIAN OR EXTERNAL SUPERVISOR MAY MAKE OR KEEP A COPY OF ANY SUCH RECORDING, AND NO OTHER COPY OF THE VIDEO SHOULD EXIST ON ANY OTHER EXTERNAL DRIVE. THE CLINIC ADMINISTRATOR WILL BE RESPONSIBLE FOR MAINTENANCE AND TIMELY DESTRUCTION OF THESE RECORDINGS. FAILURE TO COMPLY WITH THESE REGULATIONS WILL RESULT IN PERMANENT SUSPENSION FROM THE CLINIC WORKFORCE.

E. Opening and Closing Cases

1. Opening and Closing Cases: Offical acts necessary to receive services or end a professional relationship.
   a. The Clinic Administrator or Clinic director will open all cases.
   b. The Clinic Administrator or Clinic director will open a case after a potential client has called and made an appointment. Opening a case entails creating a file containing basic client data. Once opened, a case may be continued as open or be closed. It cannot be simply eliminated, even if the client never shows up.
   c. The Clinic Administrator, a student clinician, the Clinic director, student clinician case manager, or a member of the professional supervisory staff involved in a case may initiate closing a case.
      1. When an assessment is completed, the chart is current, all reports are written, a hard copy of the final report is in the client's file, and an electronic copy of the final report is on a designated electronic storage device, named appropriately, and the client and third parties have received feedback concerning the assessment, the clinician should close the case by completing the appropriate form with signatures and placing it in the client's chart. The case is not closed until this happens, and until it is closed the Community Counseling and Psychology Clinic remains liable to a certain extent for things the client does or experiences. You should include the form, as fully completed as possible, with (what you believe to be) the final copy of the assessment report that you give your supervisor to read and sign. The Clinic Administrator must confirm that you have provided an appropriately named electronic copy of all assessment reports completed.
      2. When an intervention (counseling, play therapy, psychotherapy, group, family, or couples intervention, etc.) is completed by mutual agreement between the clinician and the client, and the chart is current, the clinician should close the case by completing the appropriate

form with signatures and placing it in the client's chart. The case is not closed until this happens, and until it is closed the Community Counseling and Psychology Clinic remains somewhat liable for things the client does or experiences.

d. The Clinic Administrator, student clinician (typically the case manager), or anyone else in the Clinic workforce involved with the case, may initiate the closing of the case, if the client has missed two times without notice or cause, or three times, even if s/he has called, or if the client has engaged in other documented misconduct that threatens the integrity of the assessment or intervention, or which makes continuation impossible, dangerous, difficult, or significantly wasteful of Community Counseling and Psychology Clinic resources. The Clinic Administrator will create a letter to the client to this effect, a Clinic supervisor will sign it (not the student clinician), and the Community Counseling and Psychology Clinic will mail it by certified mail, return receipt requested. When we receive the receipt (or if the letter is never claimed by the addressee), the Clinic director will close the case by completing the appropriate form with signatures and placing it in the client's chart.

2. Failure to close cases properly and in timely fashion is grounds for receiving a failing or unsatisfactory grade, or related report to an external supervisor not associated with the Clinic.

F. Assessments

1. **Note: The sequence of detailed steps necessary for a case manager to complete an assessment successfully is in Appendix 5, around page 42.**
2. Developing and implementing an assessment plan for a client and writing all complete early and final drafts of an assessment report will be the tasks of an assigned case manager. The case manager will also coordinate the activities of other student clinicians working on the assessment (including checking the other student clinicians' scoring of administered test protocols), prepare final paper copies with signatures of the final paper report, save the final report electronically on the Clinic shared drive through the Clinic Administrator, coordinate the final feedback session to the client/guardian and any guests, and close the case. A case manager for an assessment case must be a second- or third-semester student clinician enrolled in PSY 691. First semester students in applied psychology and the diagnostician's program will administer and score procedures, make chart notes, and write up specific procedures for inclusion in complete reports. They may participate in client and informant interviews, but only with a second-semester or later clinician's taking the lead.
3. A first-semester student clinician may work as a co-case manager, for purposes of determining the student's grade at the end of a semester in PSY 691.
4. The case manager in an assessment case is also responsible in one sense for the components of a report written by other student clinicians that eventually appear in the final report: The case manager must confirm that the tables in components written by others are accurate and that the prose narrative accompanying them is both accurate and consistent with the rest of the document.
5. The testing and other materials chosen for a given assessment will be dictated first by the referral question that brings the client to the Clinic. Individual preferences, skills (or lack thereof), and prejudices cannot dictate a particular battery, if to do so is to the detriment of the client. As a group, student clinicians generally have a broad range of effective assessment skills, and the Community Counseling and Psychology Clinic can generally ensure that clients are adequately served. Consultation with a member of the professional supervisory staff, or (sometimes, and then with extreme caution) other student clinicians should serve this end. (Such conferences must of course be charted.) At last resort, we will naturally refer the client rather than do a disservice. Core assessment procedures, in general and for various referral questions, are in Appendix 2, but do not approach these mindlessly.
6. **An initial assessment plan (Clincal Assessment Report Planning Form) must be in the chart for each assessment client, after consent is received and the LHQ has been completed and reviewed, and before the assessment begins. A clinic supervisor responsible for the case must review and sign the assessment plan, with some discussion of its elements.**
7. **Failing to meet deadlines for turning in written drafts to the supervisor of record will be grounds for suspension. If suspended, you may not come to the Clinic, you may not work with clients, and you cannot be a case manager for a period specified by the Clinic director. The Clinic Administrator will maintain an assessment tracking spreadsheet provided by the director which the assessment case managers must update in real time through the Clinic Administrator (no later**

than Thurday at 430 pm each week). The Clinic Administrator will provide both a hard and electronic copy of the updated spreadsheet copy of the of the spreadsheet to the director by Tuesday morning at 930 am, and a deidentified hard copy of the spreadsheet to all members of the Clinic workforce who work with clients or provide supervision, and to the department head, by the same time. The department head, the Clinic director, and all faculty working in the Clinic will as a group review progress and determine whether a case manager shall be allowed to coninue as such, be suspended, or receive some other sanction as needed. Some automatic sanctions are in place, effective in the fall semester of 2016, and these are specified in the table at the bottom of this section.

8. Assessments entailing consideration of possible learning disorders, in both children and adults, will be based in part or entirely on a cross-battery assessment algorithm. **If you are enrolled in PSY 691, you should buy and read the following:**

   Flanagan, D. P., Ortiz, S. O., & Alfonso, V. C. (2013). *Essentials of cross-battery assessment* (3rd ed.). Hoboken, NJ: John Wiley. ISBN-13: 9780470621950

   Note that the third edition of this book was released in April of 2013. As a rule we approach cross-battery assessment as clinicians, not actuaries, and we are disinclined to use the available computerized algorithm from Flanagan et al., because it is precludes the need to think about our data set in a larger and fully clinical context, but mostly because the program itself is based in part on assumptions and questionable judgments concerning the meaning and equatability of certain test procedures.
9. Each assessment prepared will ordinarily result in a final written report suitable for distribution to other approved professionals, as well as to the client.
10. **THE CLINICIAN SHOULD SCORE AND MAKE OBSERVATIONAL NOTES FOR ANY TEST ON THE SAME DAY THAT IT IS GIVEN OR WITHIN THE FIRST TWO HOURS THAT THE CLINIC IS NEXT OPEN**. Chronically failing to do this will result in your suspension of clinical privileges in the Clinic.
11. Reports should be written in clear, concise prose, using professional terms sparingly but as needed.
12. Merriam-Webster's Webster's Collegiate Dictionary, 10th edition, will be the arbiter of spelling. It serves that role for the *Publication Manual of the American Psychological Association* (6th edition), which will also be the general guide for matters of style, many abbreviations, etc., with a few exceptions. Your individual supervisor may also require other variations from APA format.

    American Psychological Association. (2009). *Publication manual* (6th ed., second printing or later). Washington, DC: Author.

13. A member of the professional supervisory staff with suitable expertise and licensure will read and sign all reports that are to be issued as part of the psychological practice of the Community Counseling and Psychology Clinic. In order to stay within time lines, report writers should follow the procedures specified by the professional supervisory staff for receiving feedback and making corrections.
14. If Steven Ball will review your report, you should submit it to the Clinic Administrator, who will ensure that Steve has direct access to it. Guidelines for doing this correctly are in Appendix 3.
15. The rules and guidelines for preparing a manuscript report for Steve Ball's review are in the universty's newly acquired program for online and hybrid courses, as it becomes available. In the meantime, you can find them in the very fine Manual that Ms. Triplett will have prpared for you. If he is reading a report that you have written, and it is clear that you are ignoring that protocol, he will return it to you without feedback and ask you to prepare it again, this time as specified by that protocol, and within 4 days. If you fail to comply a second time for the same report, he will write it himself. If he has to write two of your reports in a semester, he will recommend that you receive a grade of U for that semester.
16. **Regardless, assessments must be completed with a written first draft within 14 calendar days of the second assessment appointment. If only one appointment is necessary to complete the assessment, then the first draft is due 14 calendar days later.**
17. **Moreover, a polished draft of the material covering the referral question and all available and relevant background material must be prepared for review by the supervisng psychologist no more than one (1) calendar week after the initial interview(s) with the client and informants. You**

may complete this draft using the report writing templates provided, but please delete all the template's components after the "observations" section.

18. **A student will receive assessment clients more rapidly if meeting time lines in satisfactory ways. This is particularly true now, since failing to meet a timeline will result in immediate suspension and loss of case manager status in all active cases**.
19. Members of the professional supervisory staff may present a brief workshop on report writing for this Clinic each long term, and once at the beginning of the summer (assuming that the University administration does not by its action make it prohibitive to do so). Steve Ball's Powerpoint® presentation for writing reports *his* way is currently available in eCollege for students enrolled in his section of PSY 691, as are numerous documents on how to write particular sections of the report that he will sign. Other supervisors will provide their own models at their discretion, in eCollege or otherwise. Major exceptions to the standard format should be cleared with a supervising member of the professional supervisory staff in advance.
20. See "REPORT WRITING, RESTRICTIONS AND STEPS IN COMPLETING" in Appendix 1, and also Appendices 3, 4, and 5.
21. You should score and make observational notes for any test you give on the same day that you give it, or within 2 hours of the Clinic's next opening (not your next scheduled shift), without exception. If perusal of a chart reveals an administered but unscored test, then the supervising member of the professional supervisory staff will warn you once and once only, reminding you of the sanction for the next "offense" (see table below).
22. Details of the report writing algorithm are in Appendix 1, and guidelines for decent writing are currently in eCollege.

G. Feedback and consultation sessions regarding formal assessments

1. As a part of an assessment done by and through the Community Counseling and Psychology Clinic, a client and/or parents and/or guardians should receive, without additional charge, up to 55 minutes of feedback/consultation from the principal clinician who did the assessment work and wrote the final report (i.e., the case manager). This appointment is to be scheduled by the case manager *and/or* the Clinic Administrator, usually after the written report is completed and signed. The client or guardian usually receives two signed copies of the report at this meeting. This feedback/consultation session can occur only once at no additional charge, regardless of who fails to be present for this meeting (and even if the free one is a "no-show" for the client, family, etc.). The Community Counseling and Psychology Clinic will charge for additional feedback/consultation sessions if needed and requested at the current rate specified in the informed consent to receive services form.
2. Feedback sessions represent a semi-formal talking through of findings, the diagnostic formulation(s), and recommendations. Those present can ask questions, clarify, etc. In a word, these are clinical sessions and should be treated with that kind of respect and appropriate forethought. Under no circumstances should the clinician give the report to the client to read and then leave the room, or read the report to the client or family. It is sometimes possible (or necessary) for a supervisor to be present for these sessions. You should schedule a room in the therapy suite (upstairs) or Binnion 123, and the case manager must ensure that these sessions are recorded (video).
3. Telephone feedback is generally unacceptable, though exceptional circumstances may occasionally demand it. Such activity should be cleared in advance with one of the professional supervisory staff, and, of course, the subsequent conversation charted.
4. Feedback/consultation provided relevant to litigation (e.g., testimony, deposition, discussions with lawyers or judges, etc.) should always be arranged by a member of the professional supervisory staff (who almost certainly will wish to be present if "invoking the rule" makes it possible). It will also be necessary to record these sessions, again the case manager's responsibility.
5. Consultation with or for clients with whom the clinician has not done a formal psychological assessment is a common component of clinical activity. The form of this activity will vary according to the circumstances of the case and the discipline of the clinician, but will typically include information gathering and analysis, intervention/treatment planning, evaluation, and feedback. The Community Counseling and Psychology Clinic typically provides such services to Head Start programs, juvenile

probation offices, schools and colleges, municipalities, federal agencies, UNICEF, families, other clinics and agencies, etc.

6. Wherever appropriate, feedback sessions will be team-based and structured like some components of a treatment team or ARD committee meeting. This means that if you were involved in the assessment, you need to be there for the feedback session.

H. Interventions

1. Guidlines for student clinicians carrying out counseling or psychotherapy intervents are also in Appendix 6, around page 43.
2. Interventions conducted by student or other clinicians will be carried out under the direct supervision of a relevantly trained member of the professional supervisory staff assigned to do so by the Clinic director.
3. Every therapeutic session conducted in the Clinic must be video recorded, a procedure which is the responsibility of the student clinician performing the intervention.
4. Any intervention carried out in the Community Counseling and Psychology Clinic must be carried out by or supervised by a licensed clinician with documented training and skill in the technic used.
5. **A treatment plan must be in the chart for each client unit (individual, family, group, class, etc.) within 10 calendar days of the initial intake interview, and before a fourth session can be scheduled. Remember that you can (and should) modify it later if circumstances demand it.**
6. All interventions should be observed by a member of the professional supervisory staff (or in some instances by a doctoral student in training as a counselor supervisor) assigned to do so by the Clinic director (live or by video). Funding realities, however, sometimes make this impractical, and a student clinician should be available to observe (or participate in) every therapy or counseling session we have (half direct hours if the observer talks to the clinician afterwards and the two of them separately chart the observation and the talk). Intervention cases will be individually assigned, after extensive consideration in staffing of the clinician's particular clinical skills and availability, and the needs of the client. The member of the professional supervisory staff should provide supervisory feedback immediately on the conclusion of the session, or on review of the video recording of the session, if the supervisor does not observe it live.
7. Necessarily, the clinician will have received procedure-specific training in such interventions. This training would come from taking PSY 508 and 537, COUN 516 and 551, or an equivalent approved by a Clinic supervisor (Psychology or Counseling). Taking COUN 528, PSY 592, or an approved equivalent will prepare the student to work with groups, and PSY 535 or SPED 535 can provide training in individual behavioral interventions. In some cases, and for various reasons, we will refer the client to another treatment facility or a private practitioner. It is necessary to have completed one or more courses in play therapy and related techniques in order to work with children using play or sand tray treatments. You must have completed COUN 611 and one other course in marriage and family therapy or marriage and family counseling to work with couples or families.
8. General considerations and limitations. The Clinic will provide minimal training in specific intervention skills, but **students who provide interventions to the public should have received specific, documented training in the necessary techniques before reaching the Clinic setting**.
9. Schools and other corporate settings requiring or requesting system interventions will be considered by the case, fitting system needs with clinicians if they are available.
10. Routine behavior management, especially in educational, family, and similar settings, is generally within the available skill set of most (though not all) of our student clinicians, some requiring closer supervision than others.
11. Brief cognitive interventions and treatment plans for individuals will be developed by the case.
12. Group interventions will be planned by the case. Clinicians providing such interventions must have completed COUN 528, PSY 592, or an approved equivalent.
13. Priority in making decisions about a therapeutic intervention lies with the Clinic supervisor who is supervising the case. If you are enrolled in a practicum or internship class under an instructor who is not working in the Clinic and providing site supervision for the case, that instructor may provide recommendations, but final decisions about implementation of a strategy lie entirely with the Clinic supervisor.

I. Referrals

1. Many agencies and persons make referral to the Community Counseling and Psychology Clinic. In general, the Clinic Director or members of the professional supervisory staff handle such referrals. As a practicum student, however, you will likely have some contact with these resources. Treat them with respect and maintain good clinical boundaries, especially with respect to client confidentiality. In general, think of the referral source as you might were you an ethical retail proprietor dealing with a prospective customer.
2. Referrals from the Community Counseling and Psychology Clinic will also often be based on the judgment of the Clinic director or a member of the professional supervisory staff, but the student clinician's role will typically be much larger. On completing an assessment, for example, you will often provide referral suggestions during feedback/consultation sessions, and the give-and-take of these discussions will possibly lead you onto unexpected referral ground. You should:
    a. Familiarize yourself with the strengths, emphases, prejudices, procedures, waiting times, etc., of the principal referral resources in the area (Dallas to Texarkana, Durant and Hugo to Tyler and Ennis). The Student Counseling Center (Student Services) is the principal one of these at Texas A&M University – Commerce for its students. You will also often use the MHID/Outreach/CD clinics in Greenville, Sulphur Springs, Terrell, and Mount Pleasant. A list of other clinics and private practitioners who will take our clients has been in preparation for some time now. Waiting is.
    b. Secure written consent from the client using current forms to discuss (disclose) particulars of the case, provide copies of notes and reports, etc., to the prospective referral. You cannot even tell the resource that you have made the referral of a particular person without written consent. Oral consent is generally *not* enough, but, in an emergency, we have a protocol for securing witnessed oral consent. A supervisor will assist you with this protocol as needed.
    c. If there is clinical reason to do so, secure written consent to receive follow-up information from the referral clinician after the client has been in treatment.
    d. In ***all*** instances the Clinic will assign a client a code CONTACT number, and will discuss matters of scheduling, etc., only with individuals who possess the code. In urgent situation, the last 4 digits of the client's social security number can substitute for the code.
    e. In making referrals for chronic neurological conditions (e.g., ADHD, autism spectrum disorders, including Asperger's disorder, etc.) to a pediatric neurologist, please consult with a member of the professional supervisory staff.
    f. In referring an adult to a neurologist, please consult with a member of the professional supervisory staff.
    g. When referring to a psychiatrist, discuss alternatives with a member of the professional supervisory staff.

J. Transfer of records

1. Transfer (disclosure) of clinical, academic, or other records to and from the Community Counseling and Psychology Clinic must be done according to law, standard procedures of the profession, and the established policies of the Clinic. Written and specific consent for such disclosure must always be secured from the client, or, as appropriate, a parent or guardian. The actual procedures will usually be handled by the Clinic Administrator, or by a member of the professional supervisory staff, not by the practicum student working alone.
2. HIPAA/HB 300 (and occasionally also FERPA) requirements will set significant limits in the procedures the Clinic uses in transferring records. These are outlined in the mandatory HIPAA/HB 300 training you must receive in order to work in the Clinic.
3. Records received from other agencies must not be released to or discussed with anyone outside of the Clinic without additional and specific written consent for such disclosure, or, for that matter, to a member of the Clinic workforce without a need to know.
4. Be aware that not all requests for records are honored, for a variety of reasons. Sometimes only treatment summaries or other limited data are released. It is also conceivable that the Clinic may be forced to ignore certain elements of a subpoena if a client's legal and ethical rights are in danger of infringement (we will do this within the law, however). Moreover, a professional may choose not to

release materials to the Clinic if s/he has not developed a clear sense that they will be used in clinically appropriate ways. The client, of course, always has access to his or her records.

5. Generally, a *copy* of a formal assessment is released only to a professional qualified to understand and interpret it. Exceptions occur for a variety of reasons (and ultimately can be legally required in some instances), all of which must be approved by a member of the professional supervisory staff.
6. Currently, we use a form provided by the Texas Attorney General's office, which was developed by mandate of HB 300, in order to secure disclosure of records to or from our office. You can find a link to this form in the HIPAA/HB 300 PowerPoint™ presentation.

K. Ethical Conduct

Your conduct in the Community Counseling and Psychology Clinic should be governed ethically by the most recent codes of ethics from the National Association of Social Work, the American Counseling Association, and the American Psychological Association, with modifications and supplements from the several state licensing boards governing the actions of the professional supervisory staff. HIPAA/HB 300, FERPA, and all other relevant state and federal laws will guide us as well.

1. The three most salient ethical concerns in clinical practice are consent, confidentiality, and competence. Of the three, competence is absolute, while the other two have their exceptions (both in ethics and the law). Ethical standards and casebooks will provide you what you need if you haven't picked it up elsewhere in your training (though you should have). We will assume, however, that you know your profession's ethical standards, can recognize an ethical dilemma when you see one, and that you know what to do when you encounter one. Educational diagnosticians in training will adhere to the most recent Code of Ethics of the American Psychological Association, as well as their own professional ethical standards, while working in the Clinic. The greater the conflict and potential consequences in an ethical dilemma, the more we are obliged to work out the matter in a collegial framework. As a student, when you recognize an ethical dilemma, you should discuss it with a member of the professional supervisory staff at once.
2. In the matter of confidentiality, know all the rules, but always remember that **you cannot even acknowledge (or deny) that you have seen or have an appointment with a client to anyone who does not have either a defined and documented *a priori* legal right to have clinical information about the client (i.e., the client, or a parent or legal guardian), or an appropriately executed consent form for us to disclose clinical information about the client. Do not talk about cases, even without names, outside of the Clinic *punkt*.**
3. **Release no information without appropriate consent for disclosure executed in writing**.
4. If unsure about your own competence, discuss the case with a member of the professional supervisory staff. This is a training clinic, but some at least rudimentary skill is necessary, and prerequisites are designed to ensure that a measure of competence is present.
5. Avoid dual relationships wherever possible. No exceptions. When in doubt, discuss the matter with one of the supervisors.
6. Clients who come to the Community Counseling and Psychology Clinic represent a broad diversity of cultural and ethnic backgrounds. Indeed, one of the most important considerations in your training as a social worker, counselor, psychologist, or educational diagnostician entails your learning to discern the presence of behavioral, cognitive, or emotional characteristics in a client which are produced or modified by the person's cultural experiences and context. **Students and staff working in the Community Counseling and Psychology Clinic will respect the cultural diversity represented in our clients, and we will draw diagnostic inferences and make recommendations for interventions that consider the relevance of such diversity. At their discretion, student clinicians may complete a 4-hour training to become an Ally in order to facilitate working with diverse clients, especially those in the LGBTQ communities.**
7. **You must purchase approved student professional liability insurance at your own expense to do any direct contact work in the Clinic, or as a part of the PSY 691 field-site experience.** Check with the Clinic Administrator for the procedure and the forms (if we have them). In order to document that you have this insurance in place initially, you should give a copy of your application and the check you write for the insurance or a copy of the downloaded face sheet of your new policy to the Clinic Administrator, who will place it in your file. When you receive your policy, make a

copy for the file. If your check clears first, then make us a copy of it as well, or provide similar documentation of a credit or debit card transaction.

8. **In order to discuss anything about a case over the phone, or with someone in person whom you do not know to have legitimate access to the information, the person must give us a code number which we will have issue**d. Example: Jane calls to cancel, or just to confirm her appointment. You cannot say anything that might affirm or deny that Jane is our client unless she gives you the current code number for her case.

L. Fees

Though it is a training facility, **the Community Counseling and Psychology Clinic provides almost all services for a fee**. These are generally arranged initially through the Clinic Administrator, though the clinician will discuss the fee with the client at the first meeting, in some instances securing in the process the informed consent necessary to provide the contracted services. The practicum student should not, unwittingly or knowingly, lead clients to believe otherwise than that they will need to pay the specified fee according to the written terms in the informed consent form. Of course, some institutional referrals may be paid by the referring institution. We also provide a sliding scale for clients of less independent means, and very rarely we provide services *pro bono*. (Our *pro bono* clients are notorious for misbehaving in the role of client.) *Pro bono* clients must cooperate fully with Clinic scheduling and other aspects of the treatment or assessment protocol. Failure to do so will result in their having to pay fees or our closing the case.

Currently, the base fee for a comprehensive psychological assessment is $500, which may slide as low as $200, depending on client income. The base fee for counseling or psychotherapy is $75 per 50-minute hour, which may slide as low as $10 per 50-minute hour. All initial (first-time) intake interviews are $25, unless waived by the Clinic Administrator or Clinic director. This intake fee will be deducted from subsequent charges, both in counseling/ psychotherapy and in assessments, if the client continues with the process.

The Community Counseling and Psychology Clinic must work to maximize our income. This will be necessary in order to ensure future funding for tests, protocols, cameras, and other Clinic expenses. Accordingly, the Clinic director or a supervisor will evaluate the paying capability of *all* clients, and we will require virtually all of them to pay, at least something, according to a specified schedule. For the most part, this system will be implemented by the Clinic Administrator. The student clinician should avoid undermining this process (which is based on sound clinical practices designed to serve the client), as to do so might have a detrimental effect on the future of the Clinic (as well as the therapeutic progress of many clients). In no instance should the student clinician modify the fee that the client must pay, alter the schedule for payment, or assist the client in paying the fee. Whenever we choose to take a case on a *pro bono* basis, the client must agree to be fully cooperative with the clinical protocol, or the *pro bono* agreement will be nullified.

M. Protocol and professional roles/relationships

1. At its best, the Community Counseling and Psychology Clinic should run rather automatically over a long time, requiring little direct intervention from the professional supervisory staff. Occasionally, however, you may need to contact one of us quickly. The Clinic Administrator, Clinic director, and the will generally know how to reach us, but here are the numbers for us if you need them:

Sean Lauderdale, PhD:	**Clinic Director & Supervisor**
Office Phone:	**903-886-5660**
email Address:	**Sean.Lauderdale@@tamuc.edu**
Steve Ball:	**691 Instructor & Supervisor**
Laboratory Office Phone/Fax:	**903-886-5586**
Cell:	**903-###-#### (provided to student clinicians on admission to Clinic workforce)**
email Address:	**steve.ball@tamuc.edu**

Karin Tochkov, PhD	**Associate Professor & Supervisor**
email Address:	**Karin.Tochkov@tamuc.edu**

2. **Please treat your clients, your peers, and all Clinic employees with the utmost respect and professionalism**. Especially, do us all the favor of talking to us directly, either privately or in staffing, whenever you perceive a difficult situation that we are causing or involved in, or can help fix.
3. The Clinic director, another member of the professional staff, or, at the direction of the professional staff, graduate assistants will schedule new clients *without consulting the practicum student in advance*. You must check the scheduling book on your initial arrival at the Clinic each day to see if you have had clients added. *It is an ethical breach worthy of a failing grade simply not to show up for a scheduled client appointment without a valid reason (it's called "client abandonment").* You or other Clinic personnel may schedule reappointments anytime during regular Clinic hours where space is available.
4. Our goal is to return all calls within one business day, and to schedule new clients within ten days of their first call.
5. **When you remove a test, a protocol form, or a book from its place in the Clinic, check it out with the current procedure, use it only in the Clinic, and replace it the same day. Be especially mindful of returning all component parts to individual tests properly stored in their containers, paper-and-pencil keys and manuals to the files, etc. Any item that you wish to use, inside or outside of the Clinic, overnight or just for a few minutes, must be checked out through the Clinic Administrator or director, and permission may not be granted for such use for some materials or at some times. Failure to act as a good steward of Clinic property may be grounds for a course grade of "Unsatisfactory," or termination of all Clinic privileges.**

O. Borrowing Clinic Materials

1. Current students and faculty admitted to and enrolled in graduate training programs in the either the Department of Psychology, Counseling, and Special Education, or the Department of Social Work, may borrow both books and materials for educational use. These should be formally checked out through the Clinic Administrator, according to current procedures, and they will be due back at different, negotiated times, depending on Clinic needs. Occasionally, the Clinic may require that materials be returned earlier than agreed, in order to meet an exigent need. Borrowers may be required to leave a security deposit in order to borrow certain items, and some potential borrowers may not have sufficient training in order to borrow some materials. This service may be terminated without notice, and the Clinic reserves the right to decline to loan materials to anyone with or without cause.
2. Protocol forms (e.g., WISC-V, WIAT-III, or WJ-IV profiles, NEO-PI-R or 16-PF blanks, etc.) may be checked out, but they must be returned unused and unmodified or the borrower will be charged ($20.00 per form, an amount that may be required as a deposit in order to take the forms requested).

P. Staffing

We will meet each week in one or more "staffing sessions" on a day of the week determined the first week of the semester. We expect you to attend these sessions: **Do not schedule clients during these times. You should have in-room access to all open files for which you are the case manager at each meeting (retrieved through the Clinic Administrator), and expect them to be reviewed for accuracy and completeness.** The format of the session will generally be as follows:

1. Announcements
2. Opportunities to discuss plenary Clinic issues
3. Presentation of new intakes
4. Assignments by the professional supervisory staff
5. "Grand Rounds" case presentations by student clinicians/faculty
6. Student clinician/faculty presentations of procedures and procedural updates
7. Updates of open cases and brief case reviews as needed
8. File review

9. Specific skills training (occasionally – usually in a separately scheduled meeting)
10. Supervision

You may not sit in front of a computer screen, or use a smart phone or other computing device during staffing, except at the explicit direction of a clinic supervisor.

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The director or another supervisor will meet with practicum students on a scheduled basis, individually or in assigned pairs, to attend to general and specific supervision issues.

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We may meet in occasional extended sessions that will be scheduled in advance. We will determine the time of these sessions, and we expect you to attend them. Do not schedule clients during these times. Topics will be announced by e-mail.

Q. e-mail

You must communicate with the members of the professional supervisory staff through **your university email account**, which you should also check daily.

Internet access, an e-mail address, and access to courses on eCollege are available through University enrollment. **Do not use client names or other identifying material in any email correspondence you send us (or anyone else). Do not transfer identifiable client records (PHI) by email attachment.**

Grading Procedures

A. Psychology and Special Education (PSY 691)

1. This course (PSY 691) has historically been graded on a satisfactory-unsatisfactory (S/U) basis, but beginning in the fall of 2017, we switched to the traditional A-to-F scheme
2. To earn a passing grade in PSY 691 you must comply with all the requirements set forth in this manual and your HIPAA/HB 300 training, such that you receive minimal sanctions in the form of suspensions. You must also avoid absences as completely as possible. Specifically, such absences and suspensions will affect your grade as follows in this Suspension-Sanctions table:

Absences (Including Suspension Sanctions)	Maximum Grade
No more than two weeks absences (6 clinic workdays)	**A**
1 suspension, no more than 2 weeks or excessive absences (5-6 clinic workdays)	**B**
2-3 suspensions, totaling no more than 3 weeks; or excessive absences (7-8 clinic workdays)	**C**
More than 3 suspensions of any duration, totaling no more than 8 weeks or excessive absences (9-10 clinic workdays)	**D**
Any number of suspensions totaling more than 8 weeks or more than 10 absences	**F**

The criteria in the previous table set the upper limit on your grade in PSY 691, but to earn a grade at that limit you must also complete the following things during the semester, as delineated in this Success Points Table (it's a sort of a rubric):

Positive Activities to Earn Success Points	Maximum Success Points
Act as case manager or co-case manager in at least four cases that have progressed satisfactorily during the semester. (Defining satisfactory progress: In	

assessments you have submitted an acceptable second or final draft. In psychotherapy, you have had a minimum of six successful sessions and made behaviorally identifiable progress toward accomplishing the goals in your treatment plan,) Each case managership is worth a maximum of 2 points (with 0, 1, or 2 points being awarded).	**8**
Attend and actively participate in all scheduled staff meetings and all called meetings to which you are invited (for the full duration of each meeting). Proportion of meetings you are scheduled to attend that you actually attend will be multiplied by the maximum points.	**8**
Be visibly present in the Clinic for all the hours you are scheduled to be there. The proportion of those hours that you are visibly present will be multiplied by the maximum points. Note also, that, by definition, you remain visibly present if you take up to 45 minutes for lunch, so long as you return within that limit and have confirmed with the Clinic Manger (Ms. Triplett) a time to leave that is appropriate in the context of ongoing Clinic activities. All student clinicians will receive such a lunch break sometime during their scheduled time, so long as they are scheduled to be present that day for at least 6 hours.	**8**
Behave in a consistently ethical and professional way so long as you are working in the Clinic. Professionality entails appropriate dress, relationships with clients, peers, supervisors, clients, and other concerned parties (e.g., probation officers public school personnel, etc.). Legal and ethical issues derive from relevant federal and state law, and the current code of ethics of the American Psychological Association. The Clinic Manager (Ms. Triplett) and the Clinic director (S. Ball) will each award you 0 to 4 points on this dimension. Consistently high quality professional behavior with no legal or ethical breaches will get you 4 points. A few minor professional lapses with no legal or ethical breaches will earn 2-3 points, and serious or pervasive failures in these areas will earn you 0-1 points.	**8**

So, this rubric-like thing is the basis by which we will determine your letter grade in PSY 691 – in conjunction with the previous table of sanction-based upper limits. Note that the first table determines the maximum grade you can earn, but does not guarantee your grade. Now look at this table:

To Earn This Grade	You Must Earn at Least	And Make at Least This Grade Based on the Absences/Suspension Sanctions Table
A	**29 success points**	**A**
B	**27 success points**	**B**
C	**24 success points**	**B**

3. If you would otherwise have earned a grade of Satisfactory/A/B but have not completed sufficient hours (80/200), you will receive a grade of "incomplete."
4. If you receive an "incomplete," you must complete the remaining required total and direct contact hours by the final week of your next semester working in the Clinic. Regardless, the university will change your grade to "unsatisfactory," or to an F, one year after the assignment of the grade if the instructor has not changed the grade by then.
5. Students accumulating hours to remove an "incomplete" or "in progress" *must* be currently enrolled in an appropriate course at Texas A&M University – Commerce.
6. You must remove any grade of "incomplete" or "in progress" before you begin accumulating direct or indirect hours in your next enrollment in practicum. **It is your responsibility to document and initiate (in writing) the process of removing an "incomplete" or "in progress" and replacing it with a grade of "satisfactory" (whether at the end of a semester or any other time). Initiate the process through the Clinic Manager (Ms. Triplett).**
7. **You can*not* carry over indirect Clinic hours from one semester to the next**. In other words, if you document 205 approved total hours this semester and 84.33 direct contact hours, you may not

carry the extra 5 indirect hours over to apply to your next enrollment in practicum. You may, however, carry over up to 25 direct hours, subject to supervisory staff approval in writing, which approval you are solely responsible for securing. In this case, the direct hours you can carry over number 4.33.

8. To receive a final grade in the semester before you graduate, you must have finished the following assessment procedures with Clinic clients, including administration, correct scoring, and write-up:

Procedure	Recommended Enrollment Period (Semester 1, 2, or 3)	Date Completed (with case numbers)
Five broad intellectual measures (including WJ-IV, WISC-V, DAS-II, KABC-II)	1-2	
Five broad or narrow achievement measures (including at least one of these: WJ-IV, WIAT-III, KeyMath 3, FAM)	1-2	
Two complete D-KEFS	2-3	
Three MMPI-2-RF	1-2	
Two MMPI-A-RF	1-3	
Three MCMI-IV	1-3	
Five BASC-III sets (self-report and informant report)	1-3	
Five additional personality measures, not otherwise included in this table		
Ten narrow-band measures of personality and its pathology (including the BDI-2, BYS-2, MASC-2, CDI-2, RCDS-2)	2-3	
Five continuous performance tests (including at least one of each these: CPT 3, K-CPT and CATA)	1-2	
Twenty clinical interviews with mental status evaluations and full write-ups	1-3	

In addition, to receive a grade in the last semester of PSY 691 before graduation, you must have completed a satisfactory (as defined by the director) course of psychotherapy with at least two clients.

B. Grades in Counseling and Social Work

The evaluative criteria for students enrolled in courses in Counseling or Social Work that will be based on working in the Clinic are the same as those for students enrolled in PSY 691. Reports made to those students' teachers of record will be based on what grade the student would make as one enrolled in PSY 691. That information in hand, a student's teacher of record (in-course supervisor) will of course assign the student's actual grade based on the criteria for that counseling or social work course.

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BONUS MATERIAL REQUIRED BY THE UNIVERSITY

STUDENTS WITH DISABILITIES

The Americans with Disabilities Act (ADA) is a federal anti-discrimination statute that provides comprehensive civil rights protection for persons with disabilities. Among other things, this legislation requires that all students with disabilities be guaranteed a learning environment that provides for reasonable accommodation of their disabilities. If you have a disability requiring an accommodation, please contact:

Office of Student Disability Resources and Services
Texas A&M University-Commerce

Gee Library
Room 132
Phone (903) 886-5150 or (903) 886-5835
Fax (903) 468-8148
StudentDisabilityServices@tamuc.edu

Faculty are required to include in their course syllabi the following statement: "All students enrolled at the University shall follow the tenets of common decency and acceptable behavior conducive to a positive learning environment." (See Student's Guide Handbook, Policies and Procedures, Conduct)

NON-DISCRIMINATION POLICY

Faculty members teaching courses must also include in their syllabuses the following disavowal of discriminatory practices by the university (I have touched it up to name the university correctly, and to eliminate an unnecessarily ugly passive voice construction):

[Texas] A&M [University]-Commerce will comply in the classroom, and in online courses, with all federal and state laws prohibiting discrimination and related retaliation on the basis of race, color, religion, sex, national origin, disability, age, genetic information or veteran status. Further, [we will maintain] an environment free from discrimination on the basis of sexual orientation, gender identity, or gender expression ~~will be maintained~~.

CAMPUS CONCEALED CARRY

Texas Senate Bill - 11 (Government Code 411.2031, et al.) authorizes the carrying of a concealed handgun in Texas A&M University-Commerce buildings only by persons who have been issued and are in possession of a Texas License to Carry a Handgun. Qualified law enforcement officers or those who are otherwise authorized to carry a concealed handgun in the State of Texas are also permitted to do so. Pursuant to Penal Code (PC) 46.035 and A&M-Commerce Rule 34.06.02.R1, license holders may not carry a concealed handgun in restricted locations. For a list of locations, please refer to ((http://www.tamuc.edu/aboutUs/policiesProceduresStandardsStatements/rulesProcedures/34SafetyOfEmployeesAndStudents/34.06.02.R1.pdf) and/or consult your event organizer). Pursuant to PC 46.035, the open carrying of handguns is prohibited on all A&M-Commerce campuses. Report violations to the University Police Department at 903-886-5868 or 911.

NOTE: IN SPITE OF THE UNIVERSITY'S CONCEAL CARRY POLICY AS DEFINED ABOVE, NO ONE EXCEPT A LICENSED LAW ENFORCEMENT OFFICER MAY CARRY A CONCEALED WEAPON INTO ANY CLINIC SPACE, LICENSED OR NOT.

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The following pages are of equal importance to those above, as they include material instructors are required to include in their syllabuses. I have deleted content that I have already provided above.

COURSE REQUIREMENTS

Minimal Technical Skills Needed

Understanding and use of D2L and Microsoft Office, managing an appropriate internet browser.

TECHNOLOGY REQUIREMENTS

Browser support

D2L is committed to performing key application testing when new browser versions are released. New and updated functionality is also tested against the latest version of supported browsers. However, due to the frequency of some browser releases, D2L cannot guarantee that each browser version will perform as expected. If you encounter any issues with any of the browser versions listed in the tables below, contact D2L Support, who will determine the best course of action for resolution. Reported issues are prioritized by supported browsers and then maintenance browsers.

Supported browsers are the latest or most recent browser versions that are tested against new versions of D2L products. Customers can report problems and receive support for issues. For an optimal experience, D2L recommends using supported browsers with D2L products.

Maintenance browsers are older browser versions that are not tested extensively against new versions of D2L products. Customers can still report problems and receive support for critical issues; however, D2L does not guarantee all issues will be addressed. A maintenance browser becomes officially unsupported after one year.

Note the following:

- Ensure that your browser has JavaScript and Cookies enabled.
- For desktop systems, you must have Adobe Flash Player 10.1 or greater.
- The Brightspace Support features are now optimized for production environments when using the Google Chrome browser, Apple Safari browser, Microsoft Edge browser, Microsoft Internet Explorer browser, and Mozilla Firefox browsers.

Desktop Support

Browser	Supported Browser Version(s)	Maintenance Browser Version(s)
Microsoft® Edge	Latest	N/A
Microsoft® Internet Explorer®	N/A	11
Mozilla® Firefox®	Latest, ESR	N/A
Google® Chrome™	Latest	N/A
Apple® Safari®	Latest	N/A

Tablet and Mobile Support

Device	Operating System	Browser	Supported Browser Version(s)
Android™	Android 4.4+	Chrome	Latest
Apple	iOS®	Safari, Chrome	The current major version of iOS (the latest minor or **point** release of that major version) and the previous major version of iOS (the latest minor

Device	Operating System	Browser	Supported Browser Version(s)
			or **point** release of that major version). For example, as of June 7, 2017, D2Lsupports iOS 10.3.2 and iOS 9.3.5, but not iOS 10.2.1, 9.0.2, or any other version. Chrome: Latest version for the iOS browser.
Windows	Windows 10	Edge, Chrome, Firefox	Latest of all browsers, and Firefox ESR.

- You will need regular access to a computer with a broadband Internet connection. The minimum computer requirements are:
    - 512 MB of RAM, 1 GB or more preferred
    - Broadband connection required courses are heavily video intensive
    - Video display capable of high-color 16-bit display 1024 x 768 or higher resolution

- You must have a:
    - Sound card, which is usually integrated into your desktop or laptop computer
    - Speakers or headphones.
    - *For courses utilizing video-conferencing tools and/or an online proctoring solution, a webcam and microphone are required.

- Both versions of Java (32 bit and 64 bit) must be installed and up to date on your machine. At a minimum Java 7, update 51, is required to support the learning management system. The most current version of Java can be downloaded at: JAVA web site http://www.java.com/en/download/manual.jsp

- Current anti-virus software must be installed and kept up to date.

Running the browser check will ensure your internet browser is supported.
Pop-ups are allowed.
JavaScript is enabled.
Cookies are enabled.

- You will need some additional free software (plug-ins) for enhanced web browsing. Ensure that you download the free versions of the following software:
    - Adobe Reader https://get.adobe.com/reader/
    - Adobe Flash Player *(version 17 or later)* https://get.adobe.com/flashplayer/
    - Adobe Shockwave Player https://get.adobe.com/shockwave/
    - Apple Quick Time http://www.apple.com/quicktime/download/

- At a minimum, you must have Microsoft Office 2013, 2010, 2007 or Open Office. Microsoft Office is the standard office productivity software utilized by faculty, students, and staff**. Microsoft Word is the standard word processing software**, Microsoft Excel is the standard spreadsheet software, and Microsoft PowerPoint is the standard presentation software. Copying and pasting, along with attaching/uploading documents for assignment submission, will also be required. If you do not have Microsoft Office, you can check with the bookstore to see if they have any student copies.

ACCESS AND NAVIGATION

You will need your campus-wide ID (CWID) and password to log into the course. If you do not know your CWID or have forgotten your password, contact the Center for IT Excellence (CITE) at 903.468.6000 or helpdesk@tamuc.edu**.**

Note: Personal computer and internet connection problems do not excuse the requirement to complete all course work in a timely and satisfactory manner. Each student needs to have a backup method to deal with these inevitable problems. These methods might include the availability of a backup PC at home or work, the temporary use of a computer at a friend's home, the local library, office service companies, Starbucks, a TAMUC campus open computer lab, etc.

COMMUNICATION AND SUPPORT

Brightspace Support

Need Help?

Student Support

If you have any questions or are having difficulties with the course material, please contact your Instructor.

Technical Support

If you are having technical difficulty with any part of Brightspace, please contact Brightspace Technical Support at 1-877-325-7778 or click on the **Live Chat** or words "click here" to submit an issue via email.

click on the

System Maintenance

D2L runs monthly updates during the last week of the month, usually on Wednesday. The system should remain up during this time unless otherwise specified in an announcement. You may experience minimal impacts to performance and/or look and feel of the environment.

COURSE AND UNIVERSITY PROCEDURES/POLICIES

Syllabus Change Policy

The syllabus is a guide. Circumstances and events, such as student progress, may make it necessary for the instructor to modify the syllabus during the semester. Any changes made to the syllabus will be announced in advance.

University Specific Procedures

Student Conduct

All students enrolled at the University shall follow the tenets of common decency and acceptable behavior conducive to a positive learning environment. The Code of Student Conduct is described in detail in the Student Guidebook. http://www.tamuc.edu/Admissions/oneStopShop/undergraduateAdmissions/studentGuidebook.aspx

Students should also consult the Rules of Netiquette for more information regarding how to interact with students in an online forum: Netiquette http://www.albion.com/netiquette/corerules.html

TAMUC Attendance

For more information about the attendance policy please visit the Attendance webpage and Procedure 13.99.99.R0.01. http://www.tamuc.edu/admissions/registrar/generalInformation/attendance.aspx

http://www.tamuc.edu/aboutUs/policiesProceduresStandardsStatements/rulesProcedures/13students/academic/13.99.99.R0.01.pdf

Academic Integrity

Students at Texas A&M University-Commerce are expected to maintain high standards of integrity and honesty in all of their scholastic work. For more details and the definition of academic dishonesty see the following procedures:

Undergraduate Academic Dishonesty 13.99.99.R0.03

http://www.tamuc.edu/aboutUs/policiesProceduresStandardsStatements/rulesProcedures/13students/undergraduates/13.99.99.R0.03UndergraduateAcademicDishonesty.pdf

Graduate Student Academic Dishonesty 13.99.99.R0.10

http://www.tamuc.edu/aboutUs/policiesProceduresStandardsStatements/rulesProcedures/13students/graduate/13.99.99.R0.10GraduateStudentAcademicDishonesty.pdf

ADA Statement

Students with Disabilities

The Americans with Disabilities Act (ADA) is a federal anti-discrimination statute that provides comprehensive civil rights protection for persons with disabilities. Among other things, this legislation requires that all students with disabilities be guaranteed a learning environment that provides for reasonable accommodation of their disabilities. If you have a disability requiring an accommodation, please contact:

Office of Student Disability Resources and Services

Texas A&M University-Commerce
Gee Library- Room 162
Phone (903) 886-5150 or (903) 886-5835
Fax (903) 468-8148
Email: studentdisabilityservices@tamuc.edu

Website: Office of Student Disability Resources and Services

http://www.tamuc.edu/campusLife/campusServices/studentDisabilityResourcesAndServices/

Nondiscrimination Notice

Texas A&M University-Commerce will comply in the classroom, and in online courses, with all federal and state laws prohibiting discrimination and related retaliation on the basis of race, color, religion, sex, national origin, disability, age, genetic information or veteran status. Further, an environment free from discrimination on the basis of sexual orientation, gender identity, or gender expression will be maintained.

Campus Concealed Carry Statement

Texas Senate Bill - 11 (Government Code 411.2031, et al.) authorizes the carrying of a concealed handgun in Texas A&M University-Commerce buildings only by persons who have been issued and are in possession of a Texas License to Carry a Handgun. Qualified law enforcement officers or those who are otherwise authorized to carry a concealed handgun in the State of Texas are also permitted to do so. Pursuant to Penal Code (PC) 46.035 and A&M-Commerce Rule 34.06.02.R1, license holders may not carry a concealed handgun in restricted locations.

For a list of locations, please refer to the Carrying Concealed Handguns On Campus document and/or consult your event organizer.

Web url:
http://www.tamuc.edu/aboutUs/policiesProceduresStandardsStatements/rulesProcedures/34SafetyOfEmployeesAndStudents/34.06.02.R1.pdf

Pursuant to PC 46.035, the open carrying of handguns is prohibited on all A&M-Commerce campuses. Report violations to the University Police Department at 903-886-5868 or 9-1-1.

Appendix 1
Clinic Briefs

ACADEMIC REFERRALS, EMOTIONAL SCREENING WITH ALL

1. We will *always* do an emotional screen for persons referred for intellectual or academic testing. As we all (should) know, emotional problems may mask themselves as academic difficulties. Hence, to omit such screening would be to run the risk of an egregious misdiagnosis that could seriously impede our client's chances of improvement.

2. While we may use the TAT, HTP, or similar projective measure as a part of the screening, these are not sufficient to the task of an emotional screening. If done by themselves, without an objective measure, they may place us in legal jeopardy. In many instances the projective measures are contraindicated. The Rorschach, which traditionally has been viewed as a "projective" device, has good psychometric properties, and is considerably more than just a "projective." It meets Daubert standards, and it is useful in this screening process for younger clients and others for whom paper-and-pencil tests may not work as well.

3. Sometimes the tests must be read to the client. This procedure is necessary with the others if reading level is low (and occasionally for other reasons). Some procedures (e.g., the MMPI-2-RF) come with a CD recording of the items for those clients with significant reading problems. Chart *all* departures from or normative variations in standard procedure and mention them explicitly in written reports of your work.

COMPUTER-GENERATED REPORTS

1. We have had several different software programs that generate algorithm-driven clinical reports of varying quality, consistency, and accuracy. These include the BASC-3, the MCMI-IV, the NEPSY-2, etc. We may consult these in writing our reports, but we will write in our own prose the reports that we place in the client's file and which we give to them and to other professionals. Never cut and paste a table from such a printout into a report you are writing (at least not unless it is impossible to tell that you have done so – but even then you should acknowledge it).

2. If we rely on such a computer-generated report in producing our own, we should make note of the fact in the text (or a footnote) of our report.

3. If we generate a computer-created report, a copy of it must be included in the client file.

4. If we generate a computerized report, and it says stupid things, we still have to include the findings, albeit with appropriate qualifiers.

GENERAL STAFFING

1. General staffings will occur once a week, and you are required to attend. They usually last about 75 minutes, but block your time for 90 minutes to be safe. Most semesters they are scheduled for noon to 130 pm on Tuesday. We try to be done in an hour, an we have a new structure which increases the likelihood that we will be.

2. Clients should never be scheduled during staffing.

3. Clients should never be scheduled during staffing.

4. During staffing you should attend to the case and procedural discussions, making appropriately supportive and insightful comments from time to time. Sit around the big tables in the staff work room and do not work on your computers, score protocols, play with your smart phones, or do anything else not pertaining to the business at

hand. You will learn by participation and through others' articulated contributions. Give the rest of the group opportunity to learn from you as well.

5. Always have the folders for all active cases with you in staffing. This is the only time that you can have more than one folder at a time with you; so, make good use of it. The Clinic Administrator will, however, hold all but one of your files at a time. Return them all (except the one you are going to work on after staffing, if any) to the Clinic Administrator immediately after staffing for immediate refiling.

6. Occasionally, additional general staffings will be scheduled, typically for special pedagogical reasons, e.g., training on a new test or procedure, report writing, etc.

GLOSSARY OF ORGANIZATIONAL CLINIC TERMS

Case Manager – the clinican (usually a student clinician) who has the responsibility for ensuring that a case is opened properly, that appropriate services are delivered, that treatment and assessment plans are developed and implemented, that all records are generated and in place, that the case is staffed and supervised effectively, that the case is closed when it should be, and, if relevant, that any report is completed adequately and on time.

Client – A person receiving Clinic services, whether they are private or public clients in the traditional sense, or public school students or employees. A client may also be a corporate body, such as a school district, incorporated municipality, the U.S. Department of State, the United Nations, or a private business.

Clinic Administrator – the administrative assistant assigned by the Department of Psychology and Special Education to work part- or full-time in the Clinic

Clinic Director, CCPC – One or more members of the faculty in Social Work, or Psychology, Counseling, and Special Education, assigned to work in the Clinic in a given semester, and either designated as the Clinic director by the Clinic's Policy Council, or having such duties fall to him or her *de facto*.

Clinic Director, HMMC – One or more members of the faculty in Social Work, or Psychology, Counseling, and Special Education, assigned to direct the activities of the Harold Murphy Memorial Clinic in McKinney, Texas. This entity is becoming progressively irrelevant to the practice of the CCPC (approaching an asymptote of 0).

Clinic Staff – Includes all employees of Texas A&M University – Commerce who are formally assigned to work in the Clinic as part of their duties. These include the Clinic Administrator, Clinic director, Clinic supervisors, and other Clinical faculty assigned by the Counseling, Psychology and Special Edcuation, and Social Work departments to work in the Clinic, adjunct clinical faculty, the Clinical Services Coordinator, and other designated graduate assistants. With all enrolled student clinicians, this group constitutes the Clinic "work force" for implementation of HIPAA/HB 300 guidelines.

Clinic(al) Supervisor – A member of the faculty assigned to Clinic duty, who is licensed to provide clinical services in the State of Texas, and who has the training and (if necessary) the legal license to provide clinical supervison in his or her field.

Clinic, the – The Community Counseling and Psychology Clinic, Texas A&M University – Commerce, Commerce, Texas.

Clinical Services Coordinator – the advanced graduate student assigned to the clinic to coordinate clinical activities, incluiding providing general oversight of Clinic practice. In some semesters this position is not filled.

Clinician – A student clinican or clinically licensed member of the faculty carrying out direct or supervisory clinical services in reference to Clinic clients.

GAR (Graduate Assistant Research) – A graduate student employed by the university to conduct and to facilitate the conduct of scholarly research. The principal administrative graduate assistant research (Clinical Services Coordinator) is typically also a GAR.

HB 300 – The Texas legislature's generally unnecessary attempt (2011) to tighten up HIPAA regulations, and enhance the opportunity to increase state revenues in the process.

HIPAA – Health Insurance Portability and Accountability Act, passed by the U.S. Congress in 1996 and implemented in 2003; Title II of HIPAA, with state law and various ethical codes, governs the actions of clinicians in order to protect the privacy and other rights of clients.

Policy Council – The governing body of the Clinic, comprised of the department heads of Social Work and Psychology, Counseling, and Special Education, as well as clinically licensed members of the faculty from each of those departments (one each from social work, counseling, and psychology faculties). Currently, the Policy Council rarely meets (and its current membership probably does not know it exists, and may in fact be mythical).

Staffing, General – Mandatory meetings held weekly, or more often, in order to review cases and make appropriate treatment and assessment plans.

Student Clinician – A graduate student in Counseling, Psychology, Special Education, or Social Work who is working under supervision of a clinically licensed member of the faculty assigned to the Clinic. The student clinician must be enrolled in an appropriate departmental course, have been approved by the respective department, and be accepted by the active supervisory staff working in the Clinic.

Supervisory Graduate Assistant – A graduate assistant with sufficient training, experience, and documented expertise to provide supervision to student clinicians providing counseling and psychotherapy. Supervision may be clinical or administrative. The is also a supervisory graduate assistant. A supervisory graduate assistant may or may not be licensed by the state to provide clinical services.

Work Force – See Clinic Staff

INTAKE INTERVIEW, GOALS OF & STRUCTURE

The purpose of the intake interview is multifold. In it, we want to introduce the client (and family) to the Clinic as much as the other way around. Throughout, and for clinical, human, and marketing reasons, our aim is to help the client to feel comfortable in the Clinic, to understand what the Clinic can and cannot do for them, to grasp the procedures we are planning to use with them, and to see what their behavioral and other obligations are in order to receive our services:

The specific objectives of the initial intake interview follow. These need not be introduced in this order, or in a format that a Clinic supervisor might use, but they all should be completed by the end of the first meeting with the client.

1. Introduce yourself, clarifying your status (as *student* clinician *in training*), and learn (and write down for reference) the names of everyone present. Get verbal assent from client/guardian for all who are present to be there and to hear what might be said.
2. Complete any consent forms not yet filled out and signed (this must be done before any data are gathered, formally or informally, e.g., the actual interview). At this point, clarify with the client/guardian the nature of his or her financial obligations, getting these in writing and signed as well. DO NOT PROCEED UNTIL ALL OF THESE MATTERS ARE CLARIFIED, IN WRITING, AND SIGNED. In many instances the client/guardian will already have discussed financial obligations with the Clinic Administrator, Clinic director, or another staff person, but it is here (in the intake) that these arrangements are finalized and confirmed, and they must be discussed openly.

3. Conduct whatever clinical interviews are appropriate for the case. These may be individual or conjoint, and you may find yourself interviewing several individuals separately or in different combinations. Carry out an *appropriate* mental status examination with every *client*.
4. While interviewing, have other persons in the client's entourage complete behavioral checklists, life history forms, etc., if these are necessary and not already done.
5. For those persons who will have already completed the Life History Questionnaire & Neuropsychological Referral Form (this should include almost everyone), you must review it before the interview, qualifying what you learn there and helping the client (or other informant) to fill in the parts that were left blank in the otherwise completed form.
6. Make or confirm the next appointment.
7. Begin or complete the development of an assessment or treatment plan for inclusion in the client's chart.
8. Chart the encounter.
9. During the interview explore all of the following issues as fully as possible (taking 1.5-2 hours, or more if necessary – with each person interviewed):
    a. The referral question and initial expressed concerns
    b. Prior reports pertinent to the referral question, and related data
    c. The client's version (interview data regarding the referral question) – this will include parents' and child's versions, taken independently, in the case of minors
    d. Other current informants' views of the referral question
    e. Medical/developmental, psychological, and other relevant history that may or may not bear on our answering the referral question, but which helps paint a complete picture of the client in his or her world – includes prenatal, perinatal, and immediately postnatal data; biological mother's pregnancy history (gravida/para/abortus); developmental milestones; client's chronic conditions; significant diseases and injuries; urogenital issues; current and past medications
    f. Family history
    g. Families of origin
    h. Families of procreation
    i. All relevant living arrangements, current and past
    j. Other significant relationships
    k. Any special conditions in the person's educational history, e.g., special education services, interruptions for illness or injury, dropping out, etc.
    l. Work, military, legal history
10. You must prepare a typed summary of all extensive or formal interviews you conduct with a claient or other relevant individual.

IPAT (CATTELL'S) TESTS

1. When administering Cattell's IPAT personality tests (e.g., 16PF, CAQ, CPQ, ESPQ), always compute second order factors.

2. Discuss both first and second-order factors in your write-ups.

3. Provide data from all scored scales in the folder that you hand a member of the professional supervisory staff with your write-up.

MEASUREMENT IN SOUND AND LITIGABLE CLINICAL PRACTICE

1. Psychologists can no longer justify inferences based principally on "projective" measures. Tests without scientifically defined reliability and validity will not sustain the test of litigation (or science for that matter). This legal requirement is based on the Supreme Court decision settling the Daubert v Dow Chemical suit. Details of this ruling, which bears on evidentiary standards with regard to experts, are available in eCollege (PSY 691).

2. "Projective" tests include the TAT, HTP, Kinetic Family Drawings, incomplete sentence blanks, etc. Notwithstanding their clear psychometric weaknesses, such procedures often add immeasurably to a

qualitative understanding of the client's situation. The TAT, for example, permits the clinician to see what kinds of situations, environmental presses, and motives are meaningful in the client's life, and thus how they might fit into the more psychometrically sound but therefore more mathematical data which we always gather in an assessment. Likewise, the HTP can also add to an understanding of the client's circumstances and qualitative self-representation. Work with a supervisor to add these pieces to your repertoire and to a battery as needed. Use them only following a discussion with your supervisor and with that supervisor's consent.

3. Though (like the Wechsler scales and most other procedures) the Rorschach contains projective elements, John Exner's Comprehensive System has rendered the procedure one with acceptable psychometric characteristics for our work, i.e., it meets Daubert criteria. Exner argues forcibly that the Rorschach is not a projective procedure, but rather a measure of cognitive-perceptual processing.

4. If at all possible, always use a paper-and-pencil measure of personality/pathology with projective tests. Draw inferences from the former and modulate and qualify with the latter. The Rorschach is usually an adequate substitute for an individual paper-and-pencil test, and it should be used with children under 12 for these purposes (assuming student clinicians are adequately trained in its use).

5. Always use a paper-and-pencil measure of personality/pathology with the Rorschach. With very young clients, this requirement may entail using behavior rating scales completed by others (e.g., BASC-3, Achenbach scales).

6. Report scale names (or abbreviations) and numbers for paper-and-pencil tests in the body of your technical report (include validity scales).

MILLON SCALES

1. Use Millon's scales (i.e., MCMI-IV, MACI) ***only*** if you have in hand some other indication of psychopathology. Usually this will mean other test data (e.g., Rorschach, MMPI-2-RF, CAQ, etc.) but it could also imply a rather unequivocal history, or a problematic interview. The MCMI is normed on clinical groups and can be misleading with "normals."

2. Include all BR scores for all scales by name in the folder you hand your clinical supervisor with your write-up.

3. You may use the MACI more generally, but only with the approval of a member of the professional supervisory staff.

MMPI SCORING

1. When you administer the MMPI-2, MMPI-2-RF, or MMPI-A, score it using every scoring template we have. In general, this will mean all validity scales, basic clinical scales, supplementary scales, etc., for each test.

2. When you write up the results of these tests, include in tabular form all the validity and basic clinical scales, as well as the supplemental and content scales you have scored.

3. Include all *T* scores for all scales scored in the folder you hand to the member of the professional supervisory staff supervising the case with your write-up.

NEUROPSYCHOLOGICAL SCREENING

1. Regardless of the referral question, we will do at least a brief neuropsychological screening on each client we assess.

4. Generally, we have use the Bender Visual-Motor Gestalt Test – II (apparently stolen), or the Beery-Buktenica VMI, for this purpose. It is increasingly clear that other procedures are preferable. Conners CPT-III and its companion auditory test (CATA) are necessary with all clients of a suitable age. It is increasingly obvious that executive functioning should also be screened for. Selected tests from the D-KEFS typically are sufficient in this role. Reitan's Aphasia Screening Test is also very useful.

3. Other measures may also be required by a member of the professional supervisory staff.

4. More complex screening procedures are available (e.g., the full D-KEFS), and we will use them if it seems prudent. Moreover, a complete neuropsychological evaluation may also be necessary in select cases.

MINIMUM COMPONENTS OF A BASIC PSYCHOLOGICAL ASSESSMENT

1. Clinical interview (and/or play assessment) with the client.

2. Interviews with other relevant parties.

3. Mental status examination.

4. Academic skills measure(s).

5. Cognitive measures (usually, but not always, guided by cross-battery assessment models; it depends on the referral question).

6. Situation-specific academic and cognitive measures as indicated (e.g., GORT-5, CTOPP-2, KeyMath 3).

7. Neuropsychological screening measures.

8. The Conners Continuous Performance Test (CPT-III) and the Conners Continuous Auditory Test of Attention.

9. Two or more broad-spectrum and age-appropriate measures of personality, emotion, or psychopathology.

10. Situation-specific specialized measures given to the client (e.g., Conners 3 Self-Report, BASC-3 Self-Report, BRIEF-A Self-Report, BRIEF-2 Self-Report, CBRT, etc.)

11. Behavior rating scales completed by informants (e.g., BRIEF-A, BRIEF-2, BASC-3, Achenbach, Conners 3, CBRT, etc.).

12. Life History Questionnaire & Neuropsychological Referral Form.

13. Review of available records (which you do, that is, you review them carefully, if they are available, including your assessment of them in any report that you write for the client).

REPORT WRITING, RESTRICTIONS AND STEPS IN COMPLETING; NAMING THE FILE

1. Write and save all reports and other materials for your work in the clinic on a single "jump" or "flash" drive which the Clinic Administrator issues you.

2. Under no circumstances should you ever save a report or other written material identifying a client in any way whatsoever (i.e., not necessarily by name) to a hard disk on any of the computers in the clinic, or any other computer, or to a remote drive which you remove from the Clinic offices. Never remove a report file (in whatever storage format, e.g., flash drive, the Cloud, whatever) from the Clinic, an act that will lead to a grade of Unsatisfactory, likely permanent removal from the Clinic work force, and initiation of due process to have you removed from the program.

3. Writers of assessment reports should follow the procedures required by the member of the professional supervisory staff who is supervising the case (and who will sign the report).

4. Working report documents *per se* should never leave the Clinic.

5. Name working report documents (not the final report) this way: CLIENTCODE#.CLIENTSEX.REFERRALISSUE.YOURLASTNAME.DATESUBMITTED.DRAFT#.REPORT (components of this naming convention are defined in Appendix 3)

6. Working with the , save the FINAL ASSESSMENT REPORT to a ZIP or other external drive provided for that purpose by the Clinic director. Use this format to name the file: CLIENTLASTNAME.CLIENTFIRSTNAME.CLIENT#.DATECLOSED An example would be BALL.STEVEN 022.10-11-2018. Use this file naming convention ONLY for THE FINAL VERSION OF AN ASSESSMENT REPORT, which the case manager and the Clinic Administrator will save to the external hard drive in the office.

7. After completing the final version of a report, delete all other electronic copies of the report, including those on your Clinic jump drive or other external or internal storage devices. Shred all hard copies except those of the final assessment report (i.e., shred all drafts).

8. Fill out and sign (while also having a supervisor sign) the "Case Closing Form," and place it in the client's chart.

9. At the end of each term the Clinic Administrator will review your Clinic-issued jump drives. You will not be able to remove them from the Clinic – ever.

STAFFING A CASE

Periodically we will ask you to staff a case during a staff meeting, as what we refer to casually as "Grand Rounds." Present the case in an orderly fashion, without assuming that anyone in the room remembers anything about the case. Include the following elements:

1. Client age, sex, marital status, ethnic affiliation, other relevant demographics.

2. Presenting problem or referral question.

3. What procedures you have used with the client so far.

4. A summary of prior, relevant assessments and diagnoses.

5. What you have observed that is relevant to the presenting problem/referral question and your DSM-5 diagnostic inferences about the client.

6. Your (probably provisional) diagnostic inferences about the client and the family/organizational context in which the client is functioning.

7. What you plan to do next (which should include details of the treatment or assessment plan that you are formulating or (later) implementing.

8. Invitation to others around the table to comment on the case.

When you are at a staffing and someone is presenting a case, listen and add to the conversation. We are all blind people exploring different parts of an elephant with our hands (which is probably safer if you happen to be sitting on the elephant's back).

ALWAYS have access to all your active files in staffing, as staffing a case may be an *ad hoc* process, or we may review your files for completeness.

In "grand rounds" the student clinician will present the case in a more formal way, using a slide presentation, etc., but the content will be substantially the same as described above.

SUICIDAL IDEATION AND THE INTERVIEW: OVERVIEW

1. Ask about suicidal ideation at a discreet time in the intake interview, and later times in the work (counseling or assessment) when it appears to be prudent to do so. During the intake, work up to the issue with matter-of-fact questions about things like sadness and depression, asking it like this, "Have you ever felt so bad about things that you thought it might be better not to go on living?" In an ongoing therapy case in which you are working intentionally, the theme should emerge if it is there. If your questioning suggests the plausibility, you should pursue it further.

2. If you establish the presence of suicidal thinking, find out when in the person's life this has happened and what was going on in the person's life. Be sure to find out if it is current, and what is happening currently that is related to it (and a lot more – see also the next section in this appendix, "Suicide Protocol").

3. If suicidal thoughts have ever occurred, find out if the person has acted on them. If so, how did they try to carry out their intention? Who was present, how was the plan foiled, or otherwise how did they survive, how did people react after the deed, what followed medically/psychiatrically or in other treatment? Can you comfortably determine the degree of seriousness of the effort?

4. If suicidal thoughts are current, determine the degree of "lethality." Does the person have a plan? How detailed is it? What is the plan? How does the person react emotionally to these discussions? How detailed is the person's view of the future? Do they have access to a means to suicide? How ambivalent are they about living or dying? How frequent and pervasive are the thoughts in the person's current daily life? Has anything changed in the person's life that prior interviews have suggested might be a trigger for thoughts and behaviors? Etc.

5. Most of the time this material will be only a small fragment in the interview. If so, don't make a big deal of it – but make sure that you are right.

6. If the person is actively suicidal, staff the situation with your supervisor at once, or at least before the person leaves the Clinic.

7. Consult your teacher of record and the member of the professional supervisory staff who is supervising the case for additions, deletions, or modifications of this plan.

SUICIDE PROTOCOL

Some clients will present in such a way as to suggest to you that they might be actively suicidal, i.e., that they could engage in an intentional act designed to end their own life, or an act designed to make others think they are attempting to end their own life, which, though unintended, could actually result in death to the client. Note also that intention itself may not be entirely conscious, and "unconsciously suicidal" clients might engage in reckless behavior or criminal acts that have a reasonable likelihood of leading to death or injury to themselves and sometimes others.

Some clients will present with "suicidal talk" that is sometimes no more than verbal manipulation. The person talks this way in some contexts because of the reaction it gets from the other people involved. While this is one of the few clinical phenomena that can be understood in the abstract using simple models of social reinforcement and object relations, it is by no means a simple clinical problem. Discriminating such patter from "real" suicidal talk is never easy in specific cases and is always uncertain, requiring the clinician to err frequently on the conservative side, resulting in more reinforcement of the behavior. Moreover, failure to respond to the behavior in an anticipated way may result in its escalation and the emergence of other, more dangerous behavior (an extinction burst, if you will).

You should approach this discussion with your client directly and honestly, making a significant and caring effort to get into the thoughts that are suicidal. Do not be anxious to fix the problem or get the conversation behind you. Use all your clinical skills (including basic microskills) to gain a complete and detailed picture of the thinking that comprises the client's thoughts.

An excellent source that you all should review is the following article by Batya Swift Yasgur, MA, LSW, entitled "Is This Patient Suicidal: Tips for Effective Assessment":

An outline of our procedures for dealing with clients who appear as if they might be actively suicidal follows:

1. If by word or gesture a client indicates to you that s/he is actively suicidal, move in a calm way to discuss specific details, including the circumstances which have led them to this point, details of any specific plan they might have, the nature of any suicidal thoughts or fantasies, frequency of the thoughts, the circumstances in which the thoughts occur, past suicidal attempts or thinking (including the medical and social consequences of whatever they might have done). In general, ask questions related to a "lethality scale." Here is one from the Yasgur article:

Stratifying Suicidal Risk

Level of Risk	Description
Imminent/Severe	• Specific suicide plan • Access to lethal means • Impaired judgment • Psychosis and/or chemical dependency • Poor social support network
Moderate	• No access to lethal means • No clear plan • Exhibits fair/good judgment • Has supportive family/significant other • Willing to comply with treatment recommendations • High degree of ambivalence
Low	• No suicide plan • No "clear intent" • Willing to talk about stressors or depression • Has supportive family/significant other • Willing to comply with treatment recommendations • High degree of ambivalence

Adapted by Yasgur from Roberts A. R., Monferrari, I., & Yeager, K. R. (2008) Avoiding malpractice lawsuits by following risk assessment and suicide prevention guidelines. *Brief Treatment and Crisis Intervention*, *8*(1), 5-14.

It is imperative that you not overreact and inadvertently and unnecessarily reinforce the suicidal communication, or communicate to the client that your needs (based on anxiety about this topic in the interview) are more important than the client's pain (which may be "intolerable pain"), Be matter-of-fact and unemotional, and at the same time empathic and caring. Do not show your own feelings, especially in reaction to the client's descriptions of intentions, plans, fantasies, and the like that make you uncomfortable. *Act* in the client's best interests in order to send the clearest message of genuine concern, including a caring interest in the fullness of the client's thought processes in this area.

Many manipulative clients will putter along until their time is up and then drop their suicidal bombshell on you. The first time this happens, abbreviate step 2 below. If it occurs again, confront the client (appropriately) about his or her behavior, abbreviate step 2 even more, and move rapidly to step 6.

2. As you pursue step 1, evaluate what you are getting:

   Is the client engaging in behavior that suggests to you that your initial concerns are valid? Is s/he high on the lethality scale? Does s/he show signs of instability, agitation, and deterioration from a prior level of functioning, or decompensation?

   Does the client resist discussing the issue? Is the evasiveness due more to insincerity and feeling afraid of being unmasked in a deception, or resistance to opening up to you with a very real issue involving considerable pain? If you believe that suicidal thoughts are present, you will eventually have to ask the question, "Are you thinking about killing yourself?"

3. Err on the conservative side of course. A human life may hang in the balance.

4. If you are convinced that the threat is real and active (i.e., that the client may die through his or her own action before you see him or her again), negotiate a written and signed agreement with the client to engage in more appropriate behavior should suicidal ideation or impulses begin to emerge. Make sure a supervisor knows what is happening by this point, and before the client leaves the Clinic.

5. If the client is a minor, contact a parent or guardian as soon as is practicable, and in an appropriate way.

6. If you remain uncomfortable in allowing the client to leave, take a specific preventive action:

   If the client is a current TAMU-C student, contact the counseling center, which will carry out a prearranged protocol.

   If the client is not a TAMU-C student, or if you cannot rouse the counseling center (for whatever reason), call the local hot line (Hunt County MHID, 903-455-3987 or other available number). HCMHID will also carry out a prearranged protocol.

   If it is necessary to begin the process of ensuring that the client is safe, e.g., hospitalized, before s/he leaves your office, voluntary or involuntary commitment proceedings may be necessary.

   If the client is attempting to manipulate you, s/he will generally find that your relentless (but caring) movement to this step results in punitive outcomes. Involuntary hospitalization or incarceration, stomach pumping, etc., are generally uncomfortable enough to neutralize any necessary reinforcement (through attention) of manipulative behavior. The matter is essentially out of our hands at this point. Remember that we are not an emergency clinic, and we are not staffed adequately to function as one.

8. Chart the encounter in detail immediately.

9. Consult your teacher of record and the member of the professional supervisory staff who is supervising the case for additions, deletions, or modifications of this plan.

Appendix 2
Assessment Batteries

You should review these lists in setting up an assessment plan, but ***nothing*** is written in stone in the most specific sense. Ask your supervisor if in doubt.

All assessment clients get the situationally relevant and age-appropriate core battery, plus other procedures as indicated below. If in doubt, ask a Clinic supervisor (not another student clinician). Individual cases may be fine-tuned during the course of the assessment.

1. Core battery (every case; specific components of the core and additional elements for specific referral questions are detailed after this list)
    a. Clinical interview
    b. Mental status exam
    c. Interviews with any available informants
    d. Review of school, hospital, other medical records, etc.
    e. Academic achievement measure (WRAT4 if academic skills are not at issue; or none with very young children for whom academic achievement is not germane)
    f. Cognitive ability measure(s)
    g. Neuropsychological screening procedure(s)
    h. Continuous performance tests (CPT3 and perhaps theCATA)
    i. Personality and pathology measure(s) (broad spectrum)
    j. Selected self-reports as needed (Beck Youth Scales, BASC-3, Achenbach, various of Conners' scales, BRIEF-A/BRIEF-2, CDI-II, RADS-2, RCDS-2, etc.)
    k. Relevant narrow spectrum personality or pathology measure as needed
    l. Selected informant reports (BASC-3, Achenbach, CAARS, various ones of Conners' procedures, BRIEF-A/2/P, BRIEF-2, CDI-II)
    m. Life History Questionnaire & Neuropsychological Referral Form (completely filled out)

The supplements listed below are specific to particular referral questions. (1) They indicate the specific procedures that might be necessary for a given referral question, and (2) they specify procedures necessary or sufficient to answer the referral question adequately in most cases.

2. ADHD battery supplement to core battery
    a. BRIEF (all appropriate versions: BRIEF-2, BRIEF-A, BRIEF-P)
    b. D-KEFS
    c. WMS or WRAML
    d. Selected neuropsychological assessment procedures (confirmed by supervisor)
    e. Selected self-reports (BASC-3, Achenbach, CAARS, Conners 3)
    f. Selected informant reports (BASC-3, Achenbach, CAARS, Conners 3)
    g. Observation in context (e.g., classroom)

3. Specific learning disability supplement (CA = 8+) to core battery
    a. Woodcock-Johnson Psycho-Educational Test Battery, Tests of Academic Achievement (all tests)
    b. GORT and CTOPP (if reading or writing is at issue)
    c. KeyMath 3 (if mathematics is at issue)
    d. Woodcock-Johnson Psycho-Educational Test Battery, Tests of Cognitive Ability (all tests) – others are possible substitutes, e.g., the KTEA, WIAT-III)
    e. Based on deliberate and well-informed cross-battery considerations, selected subtests/tests from the KABC-II, DAS-II, SB-V, WISC-V, WAIS-IV, CTOPP-2, NEPSY-II, etc. (confirmed by supervisor)

4. Intellectual disability supplement to core battery
    a. Carefully selected academic (if relevant) and cognitive measures that fit the client's apparent functional level (confirmed by supervisor)
    b. Vineland (forms selected with supervisory consultation) or other adaptive functioning measure

5. Autism spectrum supplement to core battery
    a. Carefully selected cognitive measures that fit the client's apparent functional level (confirmed by supervisor)
    b. Vineland (forms selected with supervisory consultation) or other adaptive functioning measure
    c. ADOS-2 or PEP-3
    d. MIGDAS (if high functioning)
    e. GARS-3
    f. CARS-2 (parent and teacher forms)
    g. CARS-2 (ST or HF form, completed by multiple observers)
    h. Observation in at least two distinct group settings
    i. SSRS

6. Law enforcement evaluation core battery (substitute or add these as parts of the core)
    a. WRAT-4 (for achievement measure)
    b. WASI-II (replacing longer cognitive measures on the core battery)
    c. Reitan-Indiana Aphasia Screening Test (added)
    d. MMPI-2-RF
    e. MCMI-IV
    f. NEO-PI-R or 16 PF (5th edition)

7. Mental health evaluation core battery (substitute or add these as parts of the core)
    a. WRAT4 (unless a more complex measure is called for, which will often be the case)
    b. WAIS-IV/WISC-V/KABC-II or III/DAS-II
    c. MMPI-2-RF/MMPI-A
    d. Rorschach
    e. MCMI-IV/MACI
    f. NEO-PI-R (or 16PF or other IPAT test if needed and available
    g. BRIEF-A or BRIEF-2 Self-Report
    h. Narrow-spectrum measures as needed
    i. Selected other self-reports (BASC-3/Achenbach/Beck Youth Scales, etc.)
    j. Appropriate BRIEF informant-reports
    k. Other selected informant-reports (BASC-3/Achenbach/Conners, etc.)

8. Gifted & talented assessment to core battery
    a. WIAT-III (or other, if circumstances suggest it)
    b. Woodcock-Johnson Psycho-Educational Test Battery, Tests of Cognitive Ability (first 17 tests)
    c. Fluid reasoning measures from WISC-V, DAS-II, KABC-II
    d. Torrance Tests of Creative Thinking

Appendix 3
Submitting a Draft Assessment Report

1. The report should be absolutely finished as far as you understand it, including proof-reading by a fellow clinician not involved in the case (your assigned peer reviewer), and strict adherence to the guidelines provided for writing reports in eCollege.

2. The report should be completely deidentified based on University of Miami guidelines (Appendix 4). Completely deidentify your report: Remove all names, dates of birth, addresses, ages, addresses, etc. from the report, as well as its header and footer. Use the client number to identify the client in the body of the paper and the header. eCollege is no more secure than a regular e-mail that is not encrypted.
3.

4. You must provide an electronic copy of the draft report as a Word doc or docx to the Clinic Administrator

5. Be sure to format your report according to models provided by your supervisor. Otherwise, you may get it back unread.

6. Use the following format to name your file:

   CLIENTCODE#.CLIENTSEX.REFERRALISSUE.YOURLASTNAME.DATESUBMITTED.DRAFT#.REPORT

   CLIENTSEX = F *or* M
   REFERRALISSUE = one or two words identifying the referral issue (e.g., “ADHD” or “DEPRESSION”)

   For example, if, on April 14, 2025, I (Steve Ball) am turning in the first draft of a report on Mobina Gunch, a 35-year-old nontraditional college student, who is concerned that she might have a learning disorder or ADHD, and who is client #23456:

   23456.F.LD-ADHD.ball.4.14.2025.1.REPORT

7. This is a bit of a pain, but it allows the supervisor to know the purpose of what she is reading, what file to look at to confirm your inferences, etc.

8. If one of the student clinicians or a faculty member on the assessment team administered the Rorschach, you must also attach to the dropbox a PDF copy of the client’s responses (the originally handwritten and legible response and inquiry conversation between clinician and client, retyped if you like), the locator sheet, the coding page, and (if it is scored) the structural summary page. These materials should be a single PDF file that is deidentified and labeled according to the following model:

   CLIENTCODE#.CLIENTAGE.CLIENTSEX.REFERRALISSUE.YOURLASTNAME.DATESUBMITTED.DRAFT#.RORSCHACH

9. Submit the files to the Clinic Administrator, who will provide them to the supervisor who is managing the case.

10. Your supervisor will return your edited and commented-upon document to you, through the Clinic Administrator.

11. When your final copy is ready to print, name the reidentified copy according to the model specified in appendix 1 of the manual/syllabus, and facilitate the Clinic Administrator’s saving it to a permanent external drive in the office.

12. When all steps are completed initiate closing the file.

Appendix 4
Deidentifying Protected Health Information
From the University of Miami, Miller School of Medicine

Under HIPAA's Privacy Rule, there are two approaches to de-identify health information so that it is no longer protected health information (PHI).

Protected health information under HIPAA is *individually identifiable* health information. *Identifiable* refers not only to data that is explicitly linked to a particular individual (that's *identified* information). It also includes health information with data items which reasonably could be expected to allow individual identification.

Potential identifiers include obvious ones like name and social security number, and also:

- all geographic subdivisions smaller than a state, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census: the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and [t]he initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

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

- voice and fax telephone numbers;

- electronic mail addresses;

- medical record numbers, health plan beneficiary numbers, or other health plan account numbers;

- certificate/license numbers;

- vehicle identifiers and serial numbers, including license plate numbers;

- device identifiers and serial numbers;

- Internet Protocol (IP) address numbers and Universal Resource Locators (URLs);

- biometric identifiers, including finger and voice prints;

- full face photographic images and any comparable images; and

- any other unique identifying number, characteristic, or code.

Under HIPAA's "safe harbor" standard, information is considered de-indentified if all of the above have been removed, *and* there is no reasonable basis to believe that the remaining information could be used to identify a person.

The covered entity may assign a code or other means of record identification to allow de-identified information to be re-identified, if the code is not derived from, or related to, the removed identifiers. (Only the covered entity will have the re-linking information.)

Alternatively, under the “statistical” standard, a covered entity may determine that health information is not individually identifiable (and thus protected) health information if:

A person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods for rendering information not individually identifiable, applying such principles and methods, determines that the risk is very small that the information could be used, alone or in combination with other reasonably available information, by an anticipated recipient to identify an individual who is a subject of the information; and [that person] documents the methods and results of the analysis that justify such determination.

As an alternative to using fully-deidentified information, HIPAA makes provisions for a limited data set from which direct identifiers (like name and address) have been removed, but not indirect ones (such as age). Limited data sets require a data use agreement with the party to which/whom it is provided.

Appendix 5

Summary of Steps in Completing a Psychological Assessment for Case Managers

Activity	Case Manager Active?	Timeline	Who Else Is Involved?
Telephone intake	No	N/A	Clinic Administrator or designee (who could be the eventual case manager)
LHQ completion & informed consent	No	ASAP after telephone intake	
Initial Assessment Planning Form Completed & Signed	Yes	5 days after LHQ obtained	Supervisor, who reviews and signs it
High Quality Draft of Referral Question and Full Background with "Masthead"	Yes	1 calendar week from first interview with client/parent	Clinic Administrator; otherwise no one unless secondary interviewers
First Draft of Report that has been proofed by a Peer in the Clinic	Yes	14 days after second session (or first if there is no second within one week of the first)	Peer reviewer; secondary assessment personnel
Revision of report (repeated as often as required by supervising faculty to produce final copy)	Yes	Four calendar days following receipt of feedback from supervisor	Secondary assessment personnel
Print three or more final copies; get supervisor to sign them	Yes	Same day as final copy is available	Supervisor
Schedule final feedback session	Yes	Same day as final copy is available	None
Carry out final feedback session	Yes	ASAP	Secondary assessment personnel; possibly supervisor
Make any necessary revisions following feedback, securing signatures anew, and placing in file	Yes	Same day as feedback session	Supervisor
Place final electronic copy on external drive	Yes	Same day final, final copies placed in the file	Confirm with
Close case	Yes	Same day final, final copies placed in the file	Confirm with ; get signature from supervisor or Clinic director

Appendix 6
Conventions for Counseling and Psychotherapy

1. Always use a room in which you can be observed by a supervisor or another student clinician, directly or electronically.

2. Always have a supervisor or another student clinician observe you while you are in session if at all possible, again directly or electronically.

3. Make a video recording of every session, storing them in the Clinic office, but *not* in the client's file. You may remove them from the Clinic with Clinic supervisor approval, and only to review with a supervisor in a course you are taking for which this Clinic experience has been approved (by the instructor of record and a Clinic supervisor).

4. Report anything that concerns you about a session at once to a Clinic supervisor and then to your instructor of record (if not a member of the Clinic workforce).

5. Use the standard charting procedure (SOAP) modulated by enjoinders in the HIPAA/HB 300 training module. **Always chart immediately after a session, and before any subsequent sessions**.

6. Maintain good boundaries with clients, including the ***strict* observance of the 50-minute hour limitation, and ensuring that the client pays for additional time, if it is necessary**.

7. **Begin sessions at the scheduled time and end them 50 minutes later**. If, for example, the client is 40 minutes late s/he pays for the full 50-minute session notwithstanding, and is seen for 10 minutes. If you are late (which is usually avoidable), end the session at the scheduled time and prorate the client's fee accordingly.

8. We do not schedule sessions with clients who are in arrears, unless specific arrangements are made through the Clinic Administrator.

9. Escort the client to a session on the wing of the upstairs therapy suite in Binnion by way of the first floor of that building, ascending the stairs in the area of the radio station offices (KETR). Return to the waiting room by the same route. Secure the passkey card by checking it out from the office, returning it as soon as you are finished for the day.

10. Have a completed treatment plan signed by you, your clinic supervisor, and the client (or client's guardian) in the client's file before scheduling the fourth session with the client.

11. If you are taking a course in which your teacher of record reviews video recordings of your sessions, we will consult with your outside supervisor, normally with you present as well, and arrive at some mutually satisfactory compromise if a conflict in supervisory strategies arises.

12. Be sure to chart in very broad terms the meetings you have with your outside supervisor. ("Very broad terms" might look like this: "Met with course supervisor, discussing current issues and counseling/therapeutic strategies."

Community Counseling and Psychology Clinic
(Counselors, Psychologists, and Diagnosticians in Training)
Daily Checklist for Clinicians

1. Sign or Check In with the Office on Your Arrival
2. Record and Turn In Direct Contact Hours for Today
3. Record and turn in Field-Site Hours for "Yesterday"
4. Score and Return Tests, Keys, and Manuals to Their Proper Storage Spaces Daily
5. Work Hard
6. Chart and Shred as You Go
7. Ask If You Don't Know
8. Maintain Confidentiality
9. Maintain Boundaries
10. Sign or Check Out with the Clinic Administrator or the Director (Record Your Daily Hours)

Community Counseling and Psychology Clinic

Texas A&M University-Commerce

Student Agreement Form

I have read and agree to abide by the terms of the document entitled "Practice Manual" (revised January 2019, for the spring semester of 2019), and hereinafter referred to as "the document." I understand and agree that my opportunity to receive practicum experiences in the Community Counseling and Psychology Clinic is contingent on my abiding by the terms of the document, as well as in my compliance with any and all specific directives consistent with the document and given me by a member of the professional supervisory staff of the Community Counseling and Psychology Clinic. I further understand and agree that my failure to comply with the terms of the document or such directives is grounds for immediate termination of my access to Clinic space and other resources of the Community Counseling and Psychology Clinic. I also understand and agree that my failure to comply with the terms of the document or such directives is a sufficient basis for my receiving a grade of "Unsatisfactory" or "F" in the practicum, internship, or other course for which I am enrolled, and on the basis of which I work in the Clinic.

Student Name Printed	Student Identification Number (CWID)
Student Signature	Date
Witness Signature	Date
Witness Signature	Date

Agreement to Maintain Confidentiality in Clinical Observation

As a part of my training in psychology, special education, counseling, or social work at Texas A&M University – Commerce, I herewith acknowledge that I have chosen to observe clinical exchanges between professionals, or other professionals in training, and other persons who are actual clients (or public school students), or who are offering their own content (expressed thoughts and feelings, and behavior) in an effort to play the role of a client for pedagogical purposes. I understand that all such exchanges are to be kept in strictest confidence and otherwise treated in accordance with the codes of ethics of the American Psychological Association, the American Counseling Association, the National Association of School Psychologists, and the National Association of Social Workers, and all relevant state and federal laws. I agree that my ethical and legal obligations include (without being limited to) discussing what I have observed in no place but the observation area from which I have seen and heard it, or in an appropriate supervision session with my clinical supervisor or teacher as designated by the university. I agree to comply with this restriction, and I further agree that I will never discuss the observations I make, or the identities of the persons observed, with any outside party, including other students in training who were not privy to the observations themselves or legitimately a part of the supervision sessions mentioned above.

_____ _____

Printed Name of Student in Training Date

_____

Signature of Student in Training

_____

Signature of Witness