Practice Manual
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 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 or service activities of the Clinic.

This semester will entail your working principally with Steven E. Ball, PhD (@madelowe), as the faculty member serving as the department's professional supervisory psychologist for the Clinic during the spring of 2013. The director of both clinics (in Commerce and McKinney, Texas) is Dean Aslinia, PhD, a licensed professional counselor who will be on site some of the time as well. The local director for the Commerce clinic presumably will also be named soon, while Dr. Aslinia will provide regular direction on site in McKinney. A number of members of the counseling and psychology faculty *may* also be on site for those times when these others must be in class or attending to other obligations. Ms. Morgan Saxon will be the principal Administrative Graduate Assistant from the Department of Counseling, Psychology, and Special Education, and she will work approximately 20 hours a week in the Clinic. Ms. Saxon is also in the applied/clinical master's program, and she has research and therapeutic obligations in the Clinic separate from managing the office.

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 Master's or Doctoral Program in Counseling
or
To The Master's Program in Social Work
or
To the Master's Program in Psychology in the Applied or School Program
or
To the Master's Program in Special Education (Diagnostician's Track)
or
Confirming Admission To a Certification Program To Become an Educational Diagnostician

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
Current Contact Information Sheet
(i.e. name, telephone number, email, graduate program, CWID)

We will get the following from you at the first mandatory practicum meeting:
Student Agreement Form
Agreement to Maintain Confidentiality in Clinical Observation
Expanded Current Information Sheet

HIPAA Training and Passed Exam

I. Mission statement for the Community Counseling and Psychology Clinic

To provide applied 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, 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:

. 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 interest – 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.

E. 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.

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 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.**
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, 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.

Hence, **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 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 instructor (or program director) for 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 in.
3. Each program will determine the criteria for granting access 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 program the student in 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. 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, 535, 572, 573, and 575/576 (or equivalents approved by the faculty supervisory staff) before admission. Students in training to become educational diagnosticians must have completed SPED 520, 524, 526, 535, 553, 572, 573, 574, 580, and at least one approved methods class (approved by the current coordinator of special education graduate studies, along with any substitutions).
   b. Students in Counseling must be approved for admission to the Clinic by the community/mental health master's prgram coordinator. Master's level students in Counseling must have completed the pre-practicum experience (COUN 516) successfully, as well as COUN 510 and COUN 528, and any other courses required by the Counseling Department. Doctoral level students in Counseling will be evaluated on a per case basis.
   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.
6. 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 ready to do what is required in the Clinic. 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 admission to the relevant program. You must also be approved by your program advisor and complete an application form in order 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 for such documentation).

7. Once admitted to the Clinic, you must, ***by law***, receive documented HIPAA training by the second week before you can work with clients. HIPAA requirements differ across professional settings, and even if you have worked somewhere else where you have had HIPAA training 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.
8. Before beginning work in the Clinic students must also demonstrate that they have read, understood, and recall the contents of this manual.

B. Dress

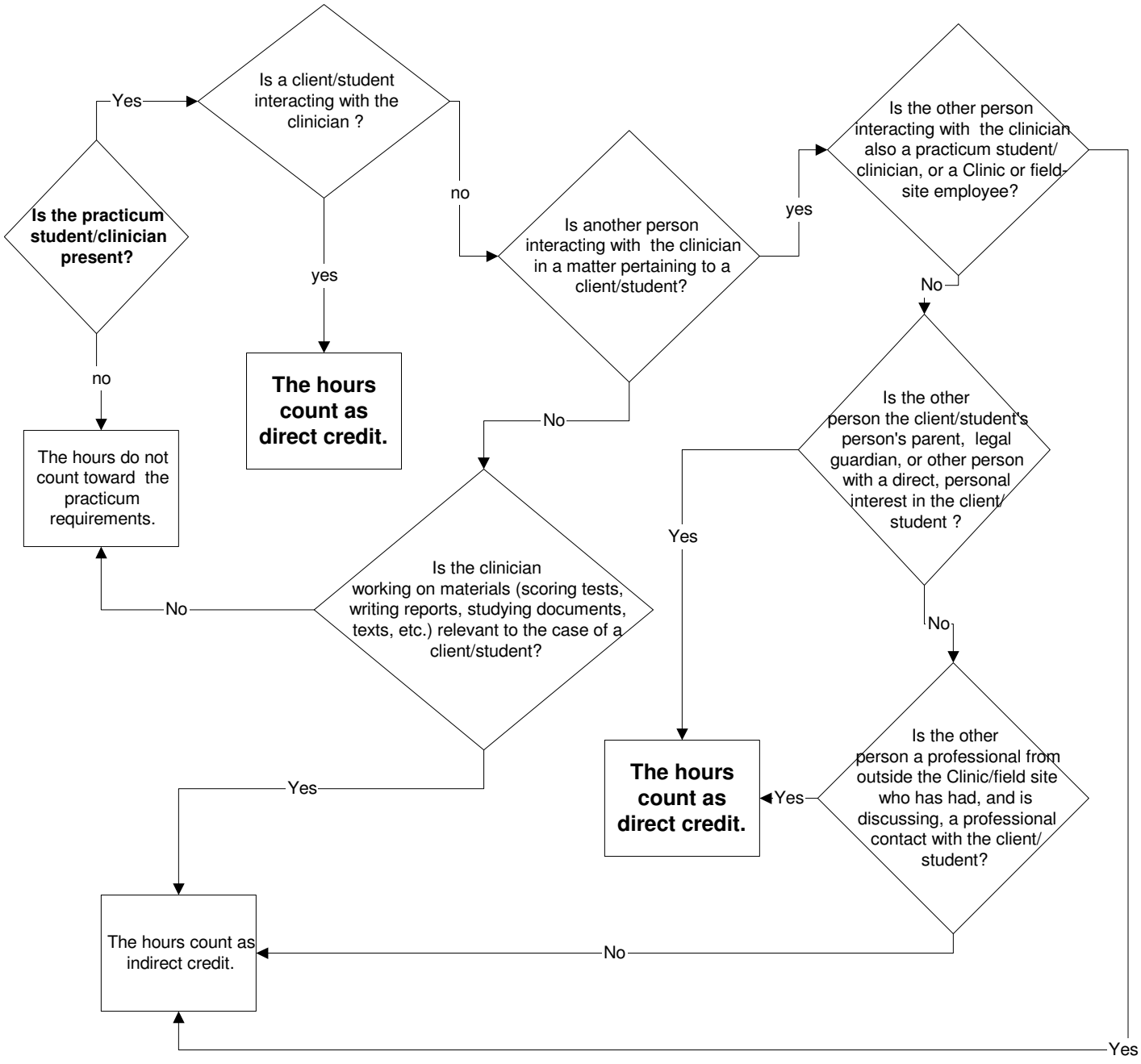
1. Using your best judgment, and consulting freely and comfortably with others, dress professionally while in the Clinic. Skirted suits, ties, etc., are not always necessary, but, if you consider with whom you will interact and the context, and if you view yourself as a professional social worker, counselor, diagnostician, or psychologist, you should make good choices. Jeans and shorts are usually poor choices, as are any items of clothing that "hook" a strong transference in a client. (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.**
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. Let the professional staff deal with problematic clothing choices – unless you have a friendship with the other person that can sustain your doing it yourself.

B. Presence

1. For each three-hour practicum course for which you enroll, you *must* receive credit for a minimum of 160 hours of approved Clinic service time. (Different program requirements may make it necessary to earn more hours. The 160-hour requirement is necessary for you simply to work in the Clinic.) These hours may be direct or indirect, but they must include service to the Clinic (or 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, 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 Facebook, 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 12 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 8 full weeks (for at least 20 hours per week). 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. **All students, including educational diagnosticians in training (and other 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.**
4. **Because of budgeting and personnel constraints, the Clinic's summer hours <u>may</u> be structured in such a way as to shorten dramatically the time available for student clinicians to work. The**

result is that it may be impossible to get all your hours during the summer, depending on what the administration is willing to fund.

5. For each three-hour practicum course for which you enroll, you *must* receive credit for a minimum of 54 hours of direct contact. (Different departmental requirements may make it necessary to earn more than 54 direct hours, e.g., in Counseling or School Psychology programs. The 54-hour requirement is necessary simply for you to work in the Clinic.)
6. By Wednesday of the first week of classes each semester, you will be assigned your Clinic working schedule by the Clinic staff working (probably) with available professional supervisors. The Clinic staff will schedule you for 12 (16-22 in the summer) or more hours each week to be in the Clinic, including supervision time and time spent in *approved* field-site activities. **Clinic time will be scheduled in blocks of not fewer than 3 hours at a time, or 4.5 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. You should check with the principal graduate assistant 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. 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.***
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 8-10 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 a relevant professional supervisor) in the time between terms before the semester in which you are pre-enrolled begins.*** 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. 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 then 4 Clinic work days.
11. **YOUR OBLIGATION TO WORK AND PERFORM ASSIGNED PROFESSIONAL DUTIES IN THE CLINIC 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 vita by the second day of the Clinic's being open each semester. 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.



Is It Direct Hours?

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 is in fact 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, are rude to customers (clients), 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. The practicum equivalent of suspending or firing you is simply not to give you any work to do, and to deny you future enrollments. Ultimately, of course, we could drop you from the class and bar you from entering the Clinic space even before the semester is over.**

C. Appointments and client scheduling

1. All initial appointments with clients, for whatever purpose, will ordinarily be made by the Clinic Director, or a member of the Clinic Staff under the direction of the Clinic Directors (e.g., the principal administrative graduate assistant). These appointments must be written in a single appointment book by client number and clinician name as the appointment is made. We 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 number, and attach it to the name of the clinician scheduled to see the client. Print in manuscript or write *very* legibly in cursive.**
2. Whenever a first appointment is made for a new client (individual, family, or group), the Clinic director (usually in consultation with, or delegated to, one of the professional supervisory staff) 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, 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.
3. 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 staff as a whole will formulate a preliminary plan of possible goals, subsequent assessment (formal and informal), intervention, and (if appropriate) referral. The professional supervisory staff will also 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 conducted 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.
4. 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, and the student clinician beginning the case may or may not continue as case manager.
5. A permanent record of appointments will be written in blue ink in a formal appointment book dedicated to that purpose. Use both the client's name and client number, adding the names of any and all clinicians assigned to the client for that day. Appointments never should be penciled in. The client or the client's parent/guardian should be given the client number at the outset for purposes of telephone communication.

6. **When a member of the professional staff makes an appointment for any formal assessment, he or she will schedule two or three sessions at once so that (ideally) the work will be completed within 4 to 6 Clinic work days.**
7. Sessions for activities other than formal psychological assessment (i.e., 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 Director. These include activities involving intake, counseling or psychotherapy, 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 the principal administrative graduate assistant, the clinician being scheduled, or the Clinic directors may write a scheduled appointment in the appointment book (or on a schedule marker board) for a given client.
8. **Each clinician is responsible for checking the appointment book immediately on arriving at the Clinic each day.**
9. 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 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 training module).
10. Under some (emergency) circumstances, a clinician may schedule an initial appointment without going through one of the Clinic Directors, but, as always, all other Clinic procedures should be followed exactly, and the Clinic Directors and any other relevant Clinic supervisors should be informed immediately.
11. **All clients should be out of the Clinic by 30 minutes before closing time, no exceptions.**
12. **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 Administrative Graduate Assistant for shredding if our shredder is not available) 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, and brief discussions with a supervisor outside of class), 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 a 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.**
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.**
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 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), 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, hx, etc.).
6. **Sign the chart note**, legibly (or, if legibility is not part of your signature, print your name in manuscript form above or before your signature), adding your credentials afterwards (e.g., *Mobina Gunch, M.A., LPCi, LSSPi*). At the beginning of each semester, during HIPAA 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 "unsatisfactory" (PSY 691; instructors of students enrolled in other practicum or internship courses will be encouraged to grade the student in a similar fashion), and they will be dismissed from the Clinic.**
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 telephone or other conversations, 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 must comply with HIPAA and other federal and state regulations.
9. **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 Director) or the Designated Alternate (the Psychology, Counseling, Social Work, or Special Education Graduate Assistant; 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 this retrieval is delegated to the principal administrative graduate assistant). There will be a clear paper trail associated with the location and movement of all records.
10. **PRAGMATICS OF FILE RETRIEVAL AND MOVEMENT: You may retrieve only one client file at a time from the records room. You must ask the Records Officer or Designated Alternate for the file, and only that person may retrieve it for you. When the Records Officer or Designated Alternate retrieves a file for you, he or she will place a large card with your name printed on it in the hanging file which holds the manila folder containing the file. You may not retrieve another file until you return the first one, i.e., you can have only one file in your possession at a 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 with the Records Officer or Designated Alternate for brief periods, e.g., restroom breaks. You may also 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 and whom you have told about the file.** Multiple files can be taken to general staffings. Indeed, this one exception requires you to bring all your active files (those for which you are the case manager) to each general staffing, except special meetings with another designated purpose (e.g., pedagogical sessions).

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.

E. Opening and Closing Cases

1. Opening and Closing Cases: Offical acts necessary to receive services or end a professional relationship.
    a. A Clinic Director or faculty supervisor or the principal administrative graduate assistant will open all cases.
    b. A Clinic Director or faculty supervisor will open a case whenever 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. The professional supervisory staff will decide collectively whether the Clinic Director should create a separate file for each appointed client who never shows up, or a composite file for all of these "pre-clients."
    c. The student clinician, a Clinic Director, 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.
        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 student clinician, or anyone in the Clinic 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 Director will create a letter to the client to this effect, a Clinic supervisor will sign it, 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.

F. Assessments

1. 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, 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) 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.
2. **An assessment plan must be in the chart for each assessment clientwithin 5 days of the initial intake interview.**
3. 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. You can buy a new third edition from Barnes & Noble's online site for about what your local bookstore sells a used version of the second, and now outdated, edition of the book.

4. Each assessment prepared will ordinarily result in a final written report suitable for distribution to other approved professionals.
5. **The clinician should score and make observational notes for any test on the same day that it is given**.
6. Reports should be written in clear, concise prose, using professional terms sparingly but as needed. Writers should avoid pompous or pretentious writing, and never say anything unnecessarily ugly.
7. 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 variations from APA format.

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

8. 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.
9. If Steven Ball will review your report, you should submit it electronically in the eCollege dropbox for PSY 691 and the week in which you submit it. Guidelines for doing this correctly are in Appendix 2.
10. The rules for preparing a manuscript report for Steve Ball's review are contained in eCollege. 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. 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.
11. **Assessments must be completed with a written first draft within 15 calendar days of the initial assessment appointment.**
12. A student will receive assessment clients more rapidly meeting time lines in a satisfactory ways.
13. 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 available in eCollege, as are numerous documents on how to write particular sections of the report. Other, so far invisible 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.
14. See "REPORT WRITING, RESTRICTIONS AND STEPS IN COMPLETING" in Appendix 1.
15. You should score and make observational notes for any test you give on the same day that you give it. 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": You will receive a grade of "unsatisfactory" or "F," depending on the course you are in.
16. Details of the report writing algorithm are in Appendix 1, and guidelines for decent writing are on 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 report.

This time is to be scheduled by the clinician, usually after the written report is completed and signed, and the client or guardian usually receives a copy 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. They should be scheduled for a room in the therapy suite (upstairs).

3. Telephone feedback is generally unacceptable, though exceptional circumstances may occasionally demand it. Such activity should be cleared in advance with one of members of the professional supervisory staff, and that 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 wish to be present if "invoking the rule" makes it possible).

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 and 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, 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.

H. Interventions

1. Interventions conducted by student or other clinicians will be carried out under the direct supervision of a member of the professional supervisory staff assigned to do so by a Clinic Director.
2. 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.
3. **A treatment plan must be in the chart for each client unit (individual, family, group, class, etc.) within 20 days of the initial intake interview.**
4. All interventions should be observed by a member of the professional supervisory staff assigned to do so by the Clinic Director. Funding realities, however, make this impractical, and a student clinician should be available to observe (or participate in) every therapy or counseling session we have. Intervention cases will be individually assigned, after extensive consideration in staffing of the clinician's particular clinical skills 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.
5. Preferably, the clinician will have received specific training in such interventions. This training would come from taking PSY 508, COUN 516 or 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 and behavioral interventions. In some cases, and for different 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 counseling to work with couples or families.
6. 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.
7. 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.

8. Routine behavior management, especially in educational, family, and similar settings, is generally within the available skill set of most of our clinicians.
9. Brief cognitive interventions and treatment plans for individuals will be developed by the case.
10. Group interventions will be planned by the case. Clinicians providing such interventions must have completed COUN 528, PSY 592, or an approved equivalent.
11. 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, a graduate assistant assigned to the Clinic, 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 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. You will also often use the MHMR/ Outreach/CD clinics in Greenville, Sulphur Springs, and Mount Pleasant. A list of other clinics and private practitioners who will take our clients has been in preparation for some time now. We also have a valuable referral source document from Glen Oaks Hospital in Greenville, Texas.
    b. Secure written consent from the client 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 *not* enough.
    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 number, and will discuss matters of scheduling, etc., only with individuals who possess 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 a member of the professional supervisory staff, not by the practicum student working alone.

2. HIPAA (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 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.
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.

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, 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.
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 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.**
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.**
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 a Clinic supervisor 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 to the principal administrative graduate assistant, 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 issued. 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 principal administrative graduate assistant, though the clinician will discuss the fee with the client at the first meeting, in most instances securing in the process the informed consent necessary. 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*.

Currently, the base fee for a comprehensive psychological assessment is $500.00, 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.

As you may know, many changes are emerging quickly at Texas A&M University – Commerce, and many of these are associated with funding and revenue shortfalls. 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 all of them to pay, at least something, according to a specified schedule. 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.

M. Field-site work (see below for general field-site guidelines for diagnosticians)

1. **Until you have completed three semester hours of Practicum, all of your work *must* be done on site at the Community Counseling and Psychology Clinic at Texas A&M University – Commerce in Commerce. If you are in the school psychology program, and you complete your first semester of practicum at a school under the supervision of school psychology faculty (but have never worked in the Clinic before), then all you hours for your second semester of practicum must be completed on site at the Clinic.** Very rarely, exceptions may occur for special projects that the Clinic director or supervisor designates and approves *in advance* in writing. Observation in a school, daycare facility, or other field-site setting might be one such situation. Another important exception occurs for educational diagnosticians in training (only) who arrange to do components of their work on site at a school district or within a shared services arrangement. This situation must be arranged in advance, specified in writing, and agreed to, also in writing, by all parties, including the coordinator of the special education program for educational diagnosticians at Texas A&M University – Commerce. In most instances, the practicum student or the coordinator of special education training must secure a field-site supervisor for work that involves activity away from the Community Counseling and Psychology Clinic. A member of the professional supervisory staff may make field-site visits, call the field-site supervisor, meet with the student at the field site, etc. We must have access to relevant components of a field-site client's records, though generally without breaching confidentiality at the field site. The details governing the conduct of

diagnosticians at field sites are provided in the next section. As a rule, the practicum student may not be compensated directly for field-site activities used for practicum credit.

2. When you have successfully completed three semester hours of Practicum, a maximum of 25-75% of your work may be routinely off-campus at approved field sites. These assignments may involve brief or long-term placements, and the teacher of record for the student must designate and approve them *in advance* in writing, with the written approval of the Clinic director. The practicum student generally may not be compensated directly for these activities, and the teacher of record will be the university supervisor of record. A dated letter of understanding and other signed documents from the field-site supervisor and program director must be in the student's file before she or he receives credit for any such work. The practicum student or coordinator of special education training for educational diagnosticians must secure a field-site supervisor for work that involves activity away from the Community Counseling and Psychology Clinic. The teacher of record will remain the principal university supervisor and may make field-site visits, call the field-site supervisor, etc. The teacher of record must have access to relevant components of a field-site client's records. A dated letter of understanding and other signed documents from the field-site supervisor (including a signed description of the field site and the work the student clinician will be doing) must be in the student's file before she or he receives credit for any such work.
3. Except for those students who have qualified for an Extended Field-Site Practicum semester (working, for example, at Rusk State Hospital), when you have completed six semester hours of Practicum (or three hours if the student is in the School Psychology program), a maximum of 75-95% of this work may be off-campus at approved field sites. These assignments may involve brief or long-term placements, and the teacher of record must designate and approve them *in advance* in writing, with the written approval of the Clinic director. In most instances, the practicum student may not be compensated directly for these activities, and the teacher of record will be the university supervisor of record. Generally, the practicum student must secure a field-site supervisor for work that involves activity away from the Community Counseling and Psychology Clinic. The teacher of record will remain the principal university supervisor and may make field-site visits, call the field-site supervisor, etc. The teacher of record must have access to relevant components of a field-site client's records. A dated letter of understanding and other signed documents from the field-site supervisor (including a signed description of the field site and the work the student clinician will be doing) must be in the student's file before she or he receives credit for any such work.
4. Psychology students approaching their final semester of practicum may apply for an appointment to an **Extended Field-Site Practicum**, if such an appointment is currently available. These generally will last for approximately one semester, involve full-time work at an approved site (e.g., Rusk State Hospital), and the detailed requirements of which will be specified for each site placement. Most of the work will be done at the field site and will be under the exclusive direct supervision of its psychologists or other appropriately licensed clinical professionals. The student-clinician will be required to document the experience by preparing a detailed daily log of experiences, and other activities to be specified in the extended field-site practicum agreement. Meetings with Community Counseling and Psychology Clinic staff will also be required at appropriate times as a part of the requirements necessary to receive course credit. Since the work is similar to that of a formal internship (i.e., full-time and professional), the student may receive compensation if the field site so chooses.
5. Written reports for field-site students who are not in an Extended Field-Site Practicum should in general conform to the standards established for the Community Counseling and Psychology Clinic. Variations should be worked out in advance with the field-site supervisor, the teacher of record, and the Clinic Director. In some instances, two different versions of the report may be necessary in order to comply with both Clinic and field-site requirements.
6. In any field site work, detailed charting should be done only at the site and according to its standard format. The only exception to this rule occurs whenever a field site does not require on-site chart notes (e.g., juvenile probation in Greenville).
7. If field-site students who are not in an Extended Field-Site Practicum desire to receive Clinic credit for this work, they should **prepare a *daily* summary record of field-site contacts and activities** to be placed in the student's file at the Community Counseling and Psychology Clinic in order to

receive credit for field-site activities. Failure to file these records on a weekly basis will result in your not being credited for the hours.

8. All field site approval will eventually fall into the province of a departmental committee, which will develop a protocol for the consideration and approval of both permanent and temporary field sites.

9. **Note: If you are taking Psychology 691 to fulfill practicum requirements in applied psychology, school psychology, or the diagnostician's program, with primary placement in the Community Counseling and Psychology Clinic, any field site must also be identified, developed, and approved according to the procedures identified above. Moreover, any work done on the campus of Texas A&M University – Commerce, or elsewhere as a function of the University (or otherwise), cannot be used for direct or indirect credit in the Clinic (Psychology 691), unless the site is approved and all procedures are carried out in accordance with the guidelines outlined in this manual.**

N. Field Placement for Educational Diagnosticians in Training

The following guidelines will govern the activities of educational diagnosticians in training who are enrolled in Psychology 691 and who are receiving credit for clinical work done at field-site placements (usually, but not always, in a Texas public school setting). This Manual/ Syllabus governs additional aspects of the practicum training not addressed in this section.

1. Educational diagnosticians in training must stay in contact with their instructor of recorrd and the principal administrative graduate assistant assigned to the Clinic during the semester that they enroll in practicum (PSY 691). For the most part, such contact can be accomplished through eCollege, the fax, and the phones. Sometimes the instructor of record may set a meeting to facilitate communication, but this rarely occurs. The purpose of meetings and other contacts is to monitor the progress, experiences, and supervision of the diagnosticians in training enrolled in 691 and doing field work at approved sites away from the main campus (viz., outside the Community Counseling and Psychology Clinic). The member of the professional supervisory staff (who will usually be the teacher of record) will document attendance, as well as record the materials discussed (while maintaining confidentiality of any public school students mentioned), and these records will be placed in each student's file in Commerce in the Community Counseling and Psychology Clinic.

2. Students in training to become educational diagnosticians and their field-site supervisors will **complete and have notarized a supervision agreement** form to be signed by the practicum student, the field-site supervisor (who must be a fully certified educational diagnostician in the State of Texas with a minimum of 3 years full-time post-certification experience, as well as an employee of the district or shared services arrangement in which the practicum student is doing field-site work), the director of special education in the district (or shared services arrangement) in which the field placement is to take place, and the student's building principal or other immediate supervisor of additional activities in the student's work setting.

3. The special education director or, in larger districts, a special education coordinator of the district for the field-site placement will complete a "Field Site Agreement" form, acknowledging the director's acceptance of the field-site placement and the supervision arrangements.

4. The special education director of the district (or shared services arrangement) for the field-site placement will complete a "Field Site Description Form." This form will include the following elements:

   A. The number of weekly hours the student will be working in activities relevant to the practicum, and a description of those activities (e.g., intellectual assessment, academic achievement assessment, cross-battery assessment, other assessment, meeting with staff, meeting with students or parents, report writing, ARD committee meetings, etc.).
   B. The nature and extent of the contact, regular or otherwise, between the student, on the one hand, and the school psychologist and the supervising diagnostician on the other.

C. Descriptive data for the special education department (or shared services arrangement) in question, sufficient to evaluate the future suitability of the field placement site. This information would include the number and nature of public school students served, number and nature of staff, accessibility of the practicum student to organizational resources, status with TEA (e.g., failed and as yet uncorrected audits; mediations won and lost by the district), etc.

5. Students in field-site placements must fax or otherwise transmit to the principal administrative graduate assistant working in the Clinic a record of hours worked on a weekly basis (due by Thursday at 2:00 pm of each week, and to include the hours worked since the last such record was due. The record will be on a form designated by the Clinic, and must be signed by the student's supervisor. **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.**

6. Before receiving practicum credit for hours completed at a field site, all practicum students seeking to become educational diagnosticians must submit a sample of their work in the form of one or more deidentified writeups based in part on at least two different achievement measures (from the WIAT-III, Woodcock-Johnson III NU – achievement, and KTEA-II), and at least two cognitive measures (from the Woodcock-Johnson III NU – cognitive, KABC-II, DAS-2, and WAIS-IV/WISC-IV/WPPSI-IV), which you have administered and scored. Deidentification guidelines are available on the eCollege site for PSY 691. (The tests must have been given to persons of the age with which the student will be working at the field site, and preferably they are anonymous students with whom the diagnostician in training has worked during the semester of the practicum.) **Note that you cannot legally provide copies of copyrighted test protocols. What you should do is to provide a deidentified writeup of your findings for each child included. All the data should be included in tabular form, with an accompanying description of the findings, diagnostic inferences (and formulation), and appropriate and detailed recommendations.** The writeup must be typed and ***NOT*** computer generated, and it should include appropriate cross-battery analysis (i.e., considerations of SLD or another disorder for which CHC models and cross-battery conceptualizations are appropriate must be relevant for at least one student for which work samples are provided). The reports may be modeled after those submitted successfully to instructors in previous classes, but you can also refer to the materials guiding the process of writing a diagnostic report on eCollege. These documents must be accompanied by a signed "Pre-practicum Work Review" form that has been signed by both the supervising diagnostician for the field site and the director of special education for the field site. **The signed documents and work samples, fully deidentified, are due as a single PDF file on Wednesday of the final week of class by 10 pm in the dropbox for week 15 of the semester in eCollege.**

7. The student, the field-site supervisor, and the director of special education for the field site will document (on a form provided by the Community Counseling and Psychology Clinic) all work performed by the student in order to receive credit for work performed. The forms must be completed on the last working day of the month, or on the last day of the semester, whichever comes earlier, and faxed to the Clinic.

8. The educational diagnostician in training may be compensated for work done in a field-site setting at the discretion of the school district or shared services arrangement for which the student will be working. As a rule, such compensation is reasonable and appropriate, given the typical historical relationship of the student with the district or SSA, and the amount of work normally entailed in such placements.

9. All field-site practicum enrollment requires that the student clinician earn at least 160 hours of practicum time each semester, with 54 hours being direct.

O. 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 Directors and the graduate assistants will generally know how to reach us, but here are the numbers for us if you need them:

Morgan Saxon:	**Principal Administrative Graduate Assistant (PAGA)**
Office Phone:	**903-886-5660**
email Address:	**msaxon@leomail.tamuc.edu**
Steve Ball:	**Clinic Supervisor**
Laboratory Office Phone/Fax:	**903-886-5586**
Cell:	**903-366-3263**
email Addresses:	**academicstevie@yahoo.com**
	steve.ball@tamuc.edu
email address for reports (only):	**steve@hawkinsandball.com**
Dean Aslinia, PhD:	**Clinic Director**
email Address:	**dean.aslinia@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, 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 principal administrative graduate assistant, a Clinic supervisor, or the Clinic 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.**

P. 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 a Clinic staff member or the principal administrative graduate assistant, 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-IV or WIAT-III profiles, 16-PF blanks, etc.) may be checked out, but they must be returned unused or the borrower will be charged ($10.00 per form, an amount that may be required as a deposit in order to take the forms requested).

Q. 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. Bring all open files for which you are the case manager with you to each meeting, 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. "Grand Rounds" case presentations
4. Discussion of new intakes
5. Assignments by the professional supervisory staff
6. Updates of open cases and brief case reviews as needed
7. File review
8. Specific skills training
9. Supervision

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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.

R. e-mail

You must communicate with the members of the professional supervisory staff through eCollege e-mail, which you should also check daily.

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

IV. Grading Procedures

A. Psychology and Special Education (PSY 691)

1. This course (PSY 691) is graded on a satisfactory-unsatisfactory basis
2. In order to earn a grade of "satisfactory" in the course you must accomplish the following:
   a. Spend a minimum of twelve (12) hours per calendar week in the Clinic engaged in Clinic activities for 14 weeks during a regular semester. [In the summer: Spend a necessary number of hours (16-22) per calendar week in the Clinic engaged in Clinic activities.
   b. Attend for the entire duration, and participate appropriately in, a minimum of twelve (12) "staffings" (supervision/training sessions). [In the summer attendance at seven to nine (7-9) such sessions is necessary.] These are scheduled at the convenience of the Clinic supervisory staff and will be announced anew each semester. We have discussed the content of these sessions elsewhere in this document.
   c. Complete scheduled assessments and reports, interventions, consultations, and other assigned Clinic duties, at an acceptable level of competence and in a timely fashion throughout the entire semester in which you are enrolled, even when you have passed the minimum hourly requirements.
   d. Chart progress and other contact notes in a timely fashion – generally on the day on which contact with the client occurs.
   e. Avoid ethical or gross professional impropriety.
   f. Provide suitable and *accurate* documentation on a daily basis of total and direct Clinic hours. In a word, if you do not document total hours on a daily basis and direct contact on a weekly basis, you do not get credit for them. Students in the Extended Field-Site Practicum

will document their experience in a variety of ways and based on both site requirements and criteria to be described, in a separate document, generally weekly.

g. Accumulate a total of 160 approved Clinic hours.

h. Accumulate a total of 54 approved direct contact Clinic hours.

Note: If you are taking Psychology 691 to fulfill practicum requirements in applied psychology, school psychology, or the diagnostician's program, with primary placement in the Community Counseling and Psychology Clinic, any field site must be identified, developed, and approved according to the procedures identified in this manual. Moreover, any work done on the campus of Texas A&M University – Commerce, or elsewhere as a function of the University (or otherwise), cannot be used for direct or indirect credit in the Clinic (Psychology 691) unless the site is approved in advance and all procedures are carried out in accordance with the guidelines outlined in this manual.

If you are in a field site prearranged and approved by the Coordinator of the School Psychology Program, and at the same time your teacher of record for PSY 691 is based in the Community Counseling and Psychology Clinic, you must provide the Clinic with suitable documentation concerning the field site, your field-site supervisor, and your supervision arrangement.

2. If you fail to accomplish any one of criteria a-f under IV.A.2 above, you will receive a grade of "unsatisfactory."
3. If you fail to accomplish either one of criteria g-h under IV.A.2 above by the end of the semester, you will receive a grade of "incomplete" or "in progress."
4.. If you receive an "incomplete," you must complete the remaining required total and direct contact hours by the final week of the next long semester at Texas A&M University – Commerce (i.e., by the end of the next fall or spring semester, whichever comes first). Otherwise, the university will change your grade to "unsatisfactory." Students accumulating hours to remove an "incomplete" or "in progress" *must* be currently enrolled in Practicum at Texas A&M University – Commerce.
5. 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).**
6. **You can*not* carry over indirect Clinic hours from one semester to the next**. In other words, if you document 165 approved total hours this semester and 54.34 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 15 direct hours subject to supervisory staff approval in writing.

B. Counseling and Social Work

Grading criteria for students enrolled in courses in Counseling or Social Work that will be based on working in the Clinic will be distributed by the student's teacher of record (in-course supervisor) in a separate document.

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BONUS MATERIAL REQUIRED BY THE UNIVERSITY

Section 10 - Faculty are encouraged to include in their course syllabi the following statement: Students requesting accommodations for disabilities must go through the Academic Support Committee. For more information, please contact the Director of Disability Resources and Services, Halladay Student Services Building, Room 303D, (903) 886-5835. [Note that our Clinic is often involved in documenting such disabilities for students in the areas of learning disability, attention-deficit/hyperactivity disorder, and mental disorders.]

Section 11 - 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)

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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 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 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 standard for the ESPQ and necessary with the others if reading level is low (and occasionally for other reasons). Some procedures (e.g., the MMPI-2) 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 in written reports of your work.

COMPUTER-GENERATED REPORTS

1. We have several different software programs that generate algorithm-driven clinical reports of varying quality, consistency, and accuracy. These include the BASC-2, 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).

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.

2. Clients should never be scheduled during staffing.

3. During staffing you should attend to the case discussions, making appropriately supportive and insightful comments from time to time. Sit around big table in the staff work room and do not work on your computers, score protocols, or anything else. You will learn by participation.

4. Always bring the folders for all active cases to staffing. This is the only time that you can have pulled more than one folder at a time; so, make good use of it. Return them all (except the one you are going to work on after staffing, if any) to the filing cabinets immediately after staffing.

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

GLOSSARY OF ORGANIZATIONAL CLINIC TERMS

Administrative Graduate Assistant/Principal Administrative Graduate Assistant – The graduate assistant having principal responsibility for manging the office and daily operations of the Clinic.

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, 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 or private business.

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, General – One or more members of the faculty in Social Work, or Psychology, Counseling, and Special Education, assigned to coordiate the Community Counseling and Pschology Clinic and the Harold Murphy Memorial Clinic in McKinney, Texas.

Clinic Staff – Includes all employees of Texas A&M University who are formally assigned to work in the Clinic as part of their duties. These include the Clinic Directors, 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, and Designated Graduate Assistants. With enrolled student clinicians, this group constitutes the Clinic "work force" for implementation of HIPAA guidelines.

Clinical 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.

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 is typically also a GAR.

HIPAA – Health Insurance Portability and Accountability Act, passed by the U.S. Congress in 1996; 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 ofSocial Work and Psychology, Counseling, and Special Education, as well as one clinically licensed member of the faculty from each of those departments. Currently, the Policy Council rarely meets (and its current membership probably does not know it exists).

Principal Administrative Graduate Assistant – See Administrative Graduate Assistant

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.

Work Force – See Clinic Staff

INTAKE INTERVIEW, GOALS OF

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 I 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 necessary (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 Director or another staff person, but it is here (in the intake) that these arrangements are finalized, 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 clients entourage complete behavioral checklists, life history forms, etc. These should be completed in the Clinic and not taken home or otherwise worked on outside of the Clinic.
5. Make or confirm the next appointment.
6. Chart the encounter.

IPAT (CATTELL'S) TESTS

1. When administering Cattell's 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.

3. Though (like the Wechsler scales and most other procedures) the Rorschach contains projective elements, Exner's Comprehensive System has rendered the procedure one which has acceptable psychometric characteristics for our work, i.e., it meets Daubert criteria.

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 (e.g., BASC-2, 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 (e.g., MCMI-III, MACI) ***only*** if you have in hand some other indication of psychopathology. Usually this will mean other test data (e.g., Rorschach, MMPI-2, CAQ, etc.) but it could 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 for each test.

2. When you write up the results of these tests, include in tabular form 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.

2. Generally, we use the Bender Visual-Motor Gestalt Test – II (apparently stolen), or the Beery-Buktenica VMI, for this purpose. Others may be used with charted consent of a Clinic supervisor.

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

4. The Reitan-Indiana Aphasia Screening Test is an alternative to the Bender, one that offers a little wider range.

4. The Bender is not really of much value as a personality measure, in spite of what you may have heard.

5. More complex screening procedures are available (e.g., the VMI), 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.

5. Cognitive measures (usually guided by cross-battery assessment models).

6. Situation-specific academic and cognitive measures (e.g., GORT-5, CTOPP).

7. Neuropsychological screening measures.

8. The Conners Continuous Performance Test (CPT).

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

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

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

12. Life History Questionnaire.

13. Neuropsychological Referral Form.

14. Review of available records

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 you supply, and the Clinic Director or Administrative Graduate Assistant labels for such purpose.

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 unless you have *exclusive* access to it and it is not ever connected to the internet, or 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 and likely permanent removal from the Clinic work force.

3. Writers of assessment reports should follow the procedures required by the member of the professional supervisory staff who is supervising the case.

4. Working report documents *per se* should never leave the Clinic. Name working report documents (not the final report) this way:
CLIENT#.CLIENTAGE.CLIENTSEX.REFERRALISSUE.YOURLASTNAME.DATESUBMITTED.DRAFT#

5. Working with the principal administrative graduate assistant, 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.

6. 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.

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

8. At the end of each term give your jump drives to the Principal Administrative Graduate Assistant for review. 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. 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. What you have observed that is relevant to the presenting problem/referral question and your DSM-5 diagnostic inferences about the client.

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

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

7. 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 an elephant with our hands.

ALWAYS bring all of your active files to staffing, as staffing a case may be an *ad hoc* process, or we may review your files for completeness

SUICIDAL IDEATION AND THE INTERVIEW

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.

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.

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, 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? Etc.

6. 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.

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

8. 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).

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, past suicidal attempts or thinking (including the medical and social consequences of whatever they might have done). In general, ask questions related to the "lethality scale" (to be distributed separately).

It is imperative that you not overreact and inadvertently reinforce the suicidal communication. 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 send the clearest message of genuine concern.

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, 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?

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 "suicide contract" with the client. 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.

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 MHMR, 903-455-3987 or other available number). HCMHMR 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, <u>voluntary or involuntary commitment proceedings may be necessary.</u>

   If the client is attempting to manipulate you, s/he will generally find that your relentless movement to this step results in punitive circumstances. 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.

9. Chart the encounter in detail immediately.

10. 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

All assessment clients get the situationally and age- appropriate core battery, plus other procedures as indicated below. If in doubt, ask a Clinic supervisor. 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. Academic achievement measure (WRAT4 if academic skills are not at issue)
    e. Cognitive ability measure(s)
    f. Neuropsychological screening procedure
    g. Continuous performance test
    h. Personality and pathology measure(s) (broad spectrum)
    i. Relevant narrow spectrum personality or pathology measure
    j. Life History Questionnaire (completely filled out)
    k. Neuropsychological Referral Form (completely filled out)

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

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

3. Specific learning disability supplement (CA = 8+) to core battery
    a. Woodcock-Johnson Psycho-Educational Test Battery, Tests of Academic Achievement (core battery + selected 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 (entire core battery & supplemental battery)
    e. Based on deliberate and well-informed cross-battery considerations, selected subtests/tests from the KABC-II, DAS-II, SB-V, WISC-IV, WAIS-IV, CTOPP, NEPSY, 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-2
f. GADS (if high functioning)
g. CARS-2 (parent and teacher forms)
h. CARS-2 (ST or HF form, completed by multiple observers)
i. Observation in group setting
j. SRS

6. Law enforcement evaluation to core battery (use these as parts of the core)
    a. WRAT-4
    b. WASI-2
    c. Reitan-Indiana Aphasia Screening Test
    d. MMPI-2-RF
    e. MCMI-III
    f. 16 PF (5th edition)

7. Mental health evaluation to core battery
    a. WRAT4 (unless a more complex measure is called for)
    b. WAIS-IV/WISC-IV/KABC-II/DAS-II
    c. MMPI-2-RF/MMPI-A
    d. Rorschach
    e. MCMI-III/MACI
    f. 16PF or other IPAT test if needed
    g. BRIEF-A Self-Report
    h. Narrow-spectrum measures as needed
    i. Selected other self-reports (BASC-2/Achenbach/Beck Youth Scales)
    j. Appropriate BRIEF informant-reports
    k. Selected informant-reports (BASC-2/Achenbach

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-IV, DAS-II, KABC-II
    d. Torrance Tests of Creative Thinking

Appendix 3
Submitting a Draft Assessment Report through eCollege

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, 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 provided in eCollege.

3. You must *attach* a Word doc to the dropbox document. Do *not* cut and paste into the eCollege dropbox.

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

5. 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.

6. Use the following format to name your file:

   CLIENT#.CLIENTAGE.CLIENTSEX.REFERRALISSUE.YOURLASTNAME.DATESUBMITTED.DRAFT#.REPORT

7. 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 whom we have assigned the client number of #2289, then the file name would be:

8. 2289.35.F.LD-ADHD.ball.4-14-2025.1.REPORT

9. 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.

10. If one of the team administered the Rorschach, you must also attach to the dropbox a PDF copy of the client's responses (the originally handwritten 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:

11. CLIENT#.CLIENTAGE.CLIENTSEX.REFERRALISSUE.YOURLASTNAME.DATESUBMITTED.RORSCHACH

12. Attach the files to the dropbox for the week of the semester in which you are submitting the report.

13. Your supervisor will return your edited and commented-upon document to you, either as an e-mail attachment, a dropbox attachment, or as a hard copy.

14. 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 principal administrative graduate assistant's saving it to a permanent external drive in the office.

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

Appendix 4
Submitting a Draft Assessment Report through email

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, 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 (link provided at http://hawkinsandball.com/?page_id=519).

3. You must *attach* your deidentified Word doc (or docx) to an email directed to steve@hawkinsandball.com or other address provided by your supervisor.

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

5. 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.

6. Use the following format to name your file:

   CLIENT#.CLIENTAGE.CLIENTSEX.REFERRALISSUE.YOURLASTNAME.DATESUBMITTED.DRAFT#.REPORT

7. 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 whom we have assigned the client number of #2289, then the file name would be:

8. 2289.35.F.LD-ADHD.ball.4-14-2025.1.REPORT

9. 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.

10. If one of the team administered the Rorschach, you must also attach to the same email a PDF copy of the client's responses (the originally handwritten 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:

11. CLIENT#.CLIENTAGE.CLIENTSEX.REFERRALISSUE.YOURLASTNAME.DATESUBMITTED.RORSCHACH

12. Your supervisor will return your edited and commented-upon document to you, either as an e-mail attachment or as a hard copy.

13. 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 principal administrative graduate assistant's saving it to a permanent external drive in the office.

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

Appendix 5
Conventions for Counseling and Psychotherapy

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

2. Always have supervisor or another student clinician observe you while you are in session.

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 supervisor approval, and 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 or course supervisor.

5. Use a standard charting procedure (e.g., SOAP) modulated by enjoinders in the HIPAA training module. Chart immediately after a session.

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.

7. Begin sessions at the scheduled time and end them 50 minutes later. If the client is 40 minutes late s/he pays for the 50-minute session notwithstanding. If you are late (which is usually avoidable)

8. We do not schedule sessions with clients who are in arrears, unless specific arrangements are made with the administrative graduate assistant.

9. Escort the client to a session on the wing of the 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.

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

1. Sign In
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 Out (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 " Practicum Manual (PSY 691)" (Revised May 2014, for the summer of 2014), 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 further 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 actually 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, and the National Association of Social Workers. 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

Clinic Information Form – Psychology & Special Education
Community Counseling and Psychology Clinic
Texas A&M University-Commerce

This form must be completed anew each semester you are enrolled in Practicum 691, or another course permitting you to work in the clinic. Print in clear manuscript form. You must complete all items marked with an asterisk (*).

*Name _____ *Home Phone _____

*Address _____ Work Phone _____

_____ FAX Line _____

*e-mail address(es) _____ *Cell Phone _____

*Another way to reach you in emergencies _____

*The most permanent address at which you can be reached in the next 5-10 years _____

_____

*Your Signature as You Will Sign Reports, Chart Notes, etc. (e.g., *Steven E. Ball, PhD*):

_____

HOURS YOU ARE WORKING (WRITE "WORK") OR IN CLASS (WRITE "CLASS" AND ADD THE LOCATION) FOR EACH WEEKOF THE CURRENT SEMESTER:

CIRCLE ONE: FALL SPRING **SUMMER** **YEAR 2014**

1-Hour Blocks **Beginning** at:	**Tuesday**	**Wednesday**	**Thursday**	SPECIAL MONDAY WORKDAYS (if available - no clients seen)
9 am	No Clients until 9:45	No Clients until 9:45	No Clients until 9:45	
10 am				
11 am				
Noon	**Staffing noon – 1:10 pm**			
1 pm				
2 pm				
3 pm				
4 pm				
Special Considerations:	Beginning at 330 pm during the first summer term Steve Ball will travel to Mesquite to teach a course. Other supervision may not be available during this time, and if not no clients can be seen.		Beginning at 330 pm during the first summer term Steve Ball will travel to Mesquite to teach a course. Other supervision may not be available during this time, and if not no clients can be seen.	Monday workdays must be scheduled individually and in advance. They are not guaranteed.

Special Consideration for Summer Scheduling Using the *Faux* Business Model

In an unusual and remarkably morale-crushing move, administrators at this institution will prorate faculty summer salaries downward for a professor whose class has low enrollment (i.e., not high enough for its tuition revenue to pay his or her salary for that course). It is perhaps not surprising that they are not willing to prorate upward for those faculty members whose enrollments exceed what they are making. Revenues in the College of Education and Human Services are consistently high enough in the summers to pay everyone's teaching salary (which is 90% of the long term monthly salary for 3 months, assuming a 4-course load), with some left over for administative discretionary use.

Moreover, clinic directors in the department have traditionally received release time for the tasks entailed in managing such a complex enterprise. Since it is clear that one scheduled section of 691 will not make, I (Steve Ball) will only be teaching two courses (PSY 691 and PSY 503) during the summer. With the standard release for clinic management, I will *de facto* have a 3-course load, for which I should receive 75% of my summer salary. Should I receive only 50% of my summer salary, we will not see assessment clients during the second summer semester, and instead will concentrate our efforts on completing reports adequately, mostly online. We will open one day a week to serve our therapy/counseling clients, and for face-to-face consultation. Unfortunately, this arrangement will make it difficult for most students to complete their required number of hours in the summer. As the administration continues to remind us, however, "Summers are not guaranteed."