**Doctoral Programme in Clinical Psychology**

**Department of Psychology**

**University of British Columbia**

**Clinic Policies and**

**Procedures Manual**

**(Students)**

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# PREAMBLE

Individuals working within the Clinic are Psychology Service Providers, and as such, represent the profession of psychology. It is expected that all procedures and services conducted in the Clinic will reflect high professional standards. The Clinic allows students to engage in clinical work appropriate to their level of training, and thereby facilitates development of clinical knowledge, judgment, professional identity and responsibility. The Clinic also provides a setting for research that contributes to the development of clinical knowledge and techniques, and to strengthening the scientific basis of clinical practice.

All authorized psychological services offered through the Clinic must conform to the ethical and procedural guidelines stipulated by the College of Psychologists of British Columbia (CPBC). It is incumbent upon clinic personnel to practice in accordance with these guidelines, as well as all relevant measures adopted by the CPBC. This Policy and Procedures Manual addresses matters that are of particular significance to Psychological Service Providers in the Clinic.

Listed below are documents that provide the ethical, legal, and procedural framework for the present manual. Most of these materials are reviewed as part of students’ training in Professional Ethics.

* CPBC Code of Conduct (September 1, 2014)
* CPBC Practice Advisories
* Health Professions Act: Psychologists Regulation
* Canadian Psychological Association (2002) Companion Manual to the Canadian Code of Ethics for Psychologists
* Freedom of Information & Protection of Privacy Act (FIPPA)
* Mental Health Act
* Infants Act
* Motor Vehicle Act
* Child, Family, and Community Service Act
* Adult Guardianship Act

The contents of this handbook also serve to acquaint all students completing their practica at the UBC Psychology Clinic (“in-house practica”) with the administrative policies and procedures applicable throughout the duration of their training. It is important to note that all client files stored in the UBC Psychology Clinic (“Clinic”) may be subject to random audit and review by the College of Psychologists of British Columbia. This handbook is meant to supplement the information provided in the Practicum and Internship Handbook (<http://psych.ubc.ca/graduate/handbooks/>).

Please ensure to visit the Practicum Support Website ([www.practiumsupport.psych.ubc.ca](http://www.practiumsupport.psych.ubc.ca)) for a current list of available practicums, the timeline for practicum applications, details about the upcoming annual practicum night, links for downloading Clinic forms, and other student resources.

Students in the clinical psychology program at UBC are often first exposed to direct client contact for the purposes of providing treatment in their second year of training. This training is provided under the supervision of a clinical faculty member through PSYC 534. Throughout the duration of their doctoral training, students are also able to apply for in-house practicums. A registered psychologist supervises each practicum.

# POLICY 1: CLINIC PURPOSE AND FORMAT

The Clinic emphasizes clinical training through the provision of psychological services to the public. The highest priority is placed on service delivery and client welfare. Consistent with the research/training role of the Clinic, fees are assessed to clients on a sliding scale.

1.1 Clients are seen at the Clinic within the context of practica, courses, and research programs. In all cases, the nature and extent of services offered through the Clinic is reviewed with clients.

1.2 The resources of the Clinic may assist in clinical research that is supervised by Faculty members, including participant recruitment and the use of consulting rooms, equipment, etc. Proposals for research are submitted to the Clinic Director for consideration. The Clinic Director can choose to accept proposals or, if warranted, bring certain proposals to the Clinic Supervisory Committee or Clinical Area for review.

1.3 Faculty may develop advanced assessment or therapy courses for upper level students. Such courses may require a cross-section of clients to be recruited to the Clinic for this specific purpose.

The Clinic endeavors to play a visible role in the Continuing Education of practitioners in Clinical Psychology.

The UBC Department of Psychology and Clinic support Faculty in the private practice of psychology.

The purposes of this policy are:

To better organize the professional practice of psychology by department faculty in a single location;

To enhance the quality of professional practice and the clinical experience of department faculty members;

To provide faculty with an opportunity to maintain and improve their therapeutic and applied skills;

To allow faculty to serve as role models for students; and

To enhance the delivery of psychological services to citizens of the Lower Mainland Area of British Columbia.

Faculty who wish to participate in private practice on Department premises, are required to agree as follows:

To be registered with the College of Psychologists of British Columbia;

To render professional psychological services in accordance with those standards of professional ethics and practice as may be applicable;

To clarify, with each client, in writing, that they are not acting as a Faculty Member or other employee of the University of British Columbia during the delivery of professional services and that the University is not responsible for nor is it liable for the delivery of said services;

 To maintain professional liability insurance;

To remit 10% of billed services to the UBC Clinic as payment for use of Department space and resources; and

To not interfere with the Clinic’s primary mission of providing clinical training opportunities for students.

## Mission Statement

Activities of the Psychology Clinic advance the mission of the University as well as the Department of Psychology through a commitment to learning, research, and public service. The Clinic serves the public by presenting opportunities to benefit directly from psychological research and expertise. The Clinic is dedicated to the dissemination of evidence-based practices through learning among graduate students and professionals, and to furthering clinical knowledge by supporting on-site research.

# POLICY 2: CLINIC PERSONNEL & PHYSICAL LAYOUT

## Clinic Personnel

**2.1 Clinic Personnel**

A minimum of two full-time staff members are required to operate the Clinic. These are:

(i) Clinic Director

The Clinic Director oversees the administration of the Clinic, teaches courses, including Introduction to Psychotherapy (PSYC 541) and Ethics and Professional Issues (PSYC 537), and contributes substantially to the provision of supervision to graduate students and coordination of external practica.

The Clinic Director assists students and clinical supervisors in ensuring that client care meets acceptable professional and legal standards. The Clinic Director provides consultation to students and staff, and acts as a liaison with the professional community.

(ii) Clinic Assistant

The Clinic Assistant receives telephone inquiries, walk-in clients, and the types of emergencies that arise in psychology clinics. This person also maintains a comprehensive database of clinical information, keeps records of telephone calls, and is responsible for tests and other materials that belong to the Clinic.

The Clinic Assistant's time is not to be used for clinical research purposes unless the department is compensated for such use of his/her time. The Clinic Assistant provides support services to the Clinic Director and the Clinical Faculty. The Clinic Assistant keeps regular hours, which are posted.

**2.2 Clinical Supervisors**

Clinical Supervisors are Psychologists who supervise students in their work with clients. Clinical Supervisors working with graduate students comprise Practicum Teams, often addressing a particular subset of presenting problems or emphasizing the application of particular intervention strategies. Through their participation in each Practicum Team, students develop depth of training, while their involvement with several Practica over time ensures breadth of training.

**2.3 Clinic Teaching Assistants (TAs)**

Clinic Teaching Assistants are Clinical Psychology graduate students (usually doctoral level) who assist the Clinic Director in screening potential clients and managing a list of potential clients waiting to be picked up for treatment. The Clinic TAs receive initial referral information from the Clinic Assistant and follow up with a scheduled, comprehensive, structured, telephone intake. This information is then used to determine whether referred individuals are appropriate for the clinic. The Clinic TAs work closely with the Clinic Director to make certain that potential clients are appropriately screened and a good fit for our clinic. Additionally, TAs provide information regarding alternative treatment options for all treatment seekers placed on the waitlist and make certain that these individuals are appropriately managed in the event that they are not picked up for treatment within a year. TAs keep several, regular, posted office hours and are on hand during these times to assist student therapists with selecting cases for treatment.

## Physical Layout

All room bookings and appointments are made online via the Zimbra calendar. Students and faculty may book rooms by accessing the calendar tab of their departmental email account. Clients are received in the reception area (1505). Computer resources, telephone, and support materials are available in the TA Office (1601). There are presently four therapy rooms used during in-house therapy sessions. Specifically, these include Kenny Rooms 1615, 1621, 1623, and 1625. Rooms 1615, 1623, and 1625 are best suited for individual counselling, while Room 1621 is often used as the Clinic classroom or for group therapy sessions held during the summer. Therapists can view and make bookings for a therapy room through Zimbra. Please contact the Clinic Assistant if you do not have access to any of the said calendars.

The office of the Clinic Director (1619) is also in the Clinic area. Priority for the Clinic space is determined in the following order: 1) clinical practica, 2) classes, and 3) research. Rooms 1606, 1703, 1003 are designated as shared research space and can be booked by faculty and students in the Clinical area. Room 1703 functions as a flex space: being available for both research and practica. Though it is prioritized for research, it can be booked for use with Clinic clients in the event that 1615, 1623, and 1625 are fully booked.

A broad range of psychological tests and assessment materials are available in the Clinic, and are introduced in the required Psychological Assessment courses. Rooms 1615, 1623, 1625, 1703 (flex space) and 1621 (classroom) are fully equipped for digital recording (OwnCloud); audio monitoring for ‘live’ supervision is also possible in each of these rooms. Computers and a printer are available in the Clinic for the generation of reports, and the management of client information.

The Clinic TAs and Clinic Assistant provide an introduction to the Clinic area and resources each year at the outset of students’ Clinical Practica.

# POLICY 3: CLIENT REFERRALS TO THE CLINIC

3.1 Avenues for client referral or recruitment to the Clinic include the following:

* Referrals from community agencies, schools, hospitals, and mental health clinics
* Referrals from within the university community
* Advertisements in the media, including social media
* Referrals from individual physicians and mental health practitioners
* Self-initiated referral by prospective clients

Referrals are made through contacting the Clinic Assistant, who maintains a database of inquiries and referrals to the Clinic. The Clinic TAs screen potential clients through a telephone screen intake. Those treatment seekers who appear to present an appropriate match for services available through the Clinic are placed on a waiting list and are categorized in folders according to their presenting problem(s). As services become available, Practicum Teams go to the folders and select potential clients.

Student therapists select clients during the academic year for individual treatment and assessment at various points from September. Some students are also involved as therapists for the summer group treatment programs. Student therapists are expected to contact prospective clients from the waitlist to set-up an initial assessment. The Clinic Assistant must be notified of the initial in-person assessment date in order to prepare the client’s chart and the necessary agreement forms in advance of the first session. Students can notify the Clinic Assistant by leaving the client’s phone screen with the Clinic Assistant with a note or email indicating the scheduled assessment date.

# POLICY 4: CLIENT CHARACTERISTICS

4.1 Preference is given to clients who present a good match for available Practicum Teams, assessment and therapy courses, or clinical research. Clients not appropriate for the available Clinic resources are directed to alternative services.

4.2 As a precaution against potential conflicts of interest, the clinic does not accept as faculty or staff from the UBC Psychology Department, their family members, and graduate or undergraduate students presently majoring in the psychology program at UBC as clients. These exclusions do not necessarily apply to research projects approved by the Clinic Ethics Committee.

# POLICY 5: INTAKE PROCEDURE

## Initial Referrals and Client-Initiated Contacts

Procedures for screening initial referrals and handling walk-in contacts are as follows:

5.1 The Clinic Assistant receives initial referral information regarding prospective clients. Typically, referrals are patient initiated and received by phone. In rare cases, treatment seekers will present in person and speak to the Clinic Assistant directly. In some cases referrals are made directly to the Clinic Director, an identified team, or a supervising Psychologist. In the event that a client emails the Clinic, the Clinic Assistant will respond with an email indicating that to protect client confidentiality we conduct Clinic business by phone or in person and invite the person to call the Clinic.

5.2 A Clinic TA (usually an advanced graduate student in the Clinical Area) responds to initial referrals with a telephone screen. We do not do initial intakes in person. The results of this assessment are reviewed with the Clinic Director and are used to identify potential resources within the Clinic (i.e., a specific team). In cases where there are no appropriate clinic resources then alternative referral information is provided.

5.3 In cases of crisis where a faculty member or the Clinic Director are not available, the Clinic Assistant will refer to the Campus Police (604-224-1322) or Emergency Services -Fire/Rescue (local 4567), or Ambulance (911).

5.4 Treatment seekers accepted for assessment or treatment in the Clinic are indicated as such in records maintained by the Clinic TAs. The Clinic Assistant maintains a separate listing of clients’ appointments and financial information.

5.5 Because there is sometimes a lengthy delay between initial referral and pick up for treatment, Clinic TAs provide information regarding alternative treatment options to all treatment seekers placed on the waitlist and make certain that these individuals are appropriately managed in the event that they are not picked up for treatment within a year.

## Medical Back-Up

5.5 Clinical faculty and student therapists will refer clients for medical services as required, or as indicated by client characteristics.

## Psychological Assessment

5.6 During the initial assessment, it is expected that students complete an Assessment Form to obtain a detailed history from the patients and make applicable diagnoses (see Appendix A). Following the initial assessment appointment, it is expected that the student therapist who conducted the assessment prepare an Assessment Report (see Appendix B). The Assessment Report must be written by the therapist and signed by both the therapist and their Practicum Supervisor. The final version of the Assessment Report must be completed and submitted to the Clinic **within three weeks from the date of assessment**. The Assessment Report illustrates the patient’s referral route, presenting symptoms, a history of presenting complaints or other mental health complaints, current and past adjustment, medical history, and any diagnoses. This report utilizes a client-centered approach for conceptualizing each patient and allows the therapist to plan an appropriate intervention.

5.7 Commonly employed measures belonging to the Clinic are stored in the large filing cabinet in 1601. These materials are for the use of clinical graduate students and clinical faculty and can be checked out from the Clinic Assistant. The sign out period for most assessment materials is one day (24-hours). Extensions may be possible depending upon demand, but require an in-person renewal. **If materials are lost, damaged, or not signed back in, the borrower will be responsible for replacing the relevant materials.**

5.8 Computer resources are available to students for clinic-related work in 1601. A Clinic laptop and portable projector are also available for student and Faculty use.

## Consent Forms

5.9 Consent forms are available from the Clinic Assistant and should be used where appropriate. These forms include:

* Informed Consent and Service Agreement:

## Student therapists are expected to go over the Informed Consent and Service Agreement with each client in the initial portion of the first session (see Appendix C). It is absolutely critical for both the client and the therapist (as a witness) to sign this form. The signed form should be appropriately filed in the client’s file. The completion of this form is critical to communicating the limitations and details around the provision of treatment at the Clinic and helps safeguard the Clinic from any potential future legal matters.

* Consent to Release and Receive Information (see Appendix D):

The Consent to Release and Receive Information form must be completed and signed by any client requesting or consenting to the release of their health information to a third party. A witness signature, such as the therapist’s signature, is required and each form must specify the name of the third party.

* Consent Form for Observation and Intervention in School Setting (see Appendix E)

Other consent forms, such as those specific to a research project, are the responsibility of individual faculty members.

## Fees

5.10 Fees are set on a sliding scale based on each client’s total, yearly household income and apply to all services (e.g., initial assessments, individual treatment, group therapy)

**ASSESSMENTS & TREATMENT**

***(Individual, Family, and Group Therapy)***

Yearly Household Income Fee

 Before taxes

<$20,000 $15/session

$20,000 – $40,999 $20/session

$41,000 – $61,000 $35/session

>$61,000 $50/session

***Psycho-educational Assessment (SUBSIDIES ARE AVAILABLE)***

 Yearly Household Income Fee

 Before taxes

<$20,000 Total fee: $360

 $20,000 – $40,999 Total fee: $600

 $41,000 – $61,000 Total fee: $840

 >$61,000 Total fee: $1000

***Group Therapy***

Yearly Household Income Fee

Before taxes

<$20,000 $10/session

 $20,000 – $40,999 $20/session

 $41,000 – $61,000 $30/session

 >$61,000 $50/session

5.11 At the time of the initial phone screen, the intake TA determines what fee the client will pay, marks the appropriate box on the intake form and communicates this to the client. When the client begins treatment, the Secretary will review the fee scale once more, as financial situations sometimes change from the time of phone screen.

5.12 It is the Clinic Assistant’s responsibility to discuss the determined fee with the client at the initial visit, discuss payment policies and opportunities for waivers and have the client sign the Fee Agreement.

5.13 Clients who wish to use extended health benefits with coverage for psychological services may do so, but must recognize that their insurer may not cover services delivered by supervised student therapists. The Clinic Assistant will explain this to clients mentioning that they plan to submit receipts for reimbursement.

# POLICY 6: CASE MONITORING AND SUPERVISION

6.1 The Clinic Director is responsible for providing students with training in professional and legal record keeping standards. This training is offered through the Introduction to Psychotherapy course (PSYC 541) and individual consultation. Students are responsible for following the Clinic record keeping guidelines (see Policy 13 on Record Keeping).

6.2 Students are responsible for ensuring that clients are registered with the Clinic, which must be arranged with the Clinic Assistant.

6.3 Students and their supervisors are responsible for the content of their files. The student carries the primary responsibility for generating reports, notes, etc., while supervisors are responsible for ensuring the completeness of records.

6.4 The Clinic Assistant will work under the direction of the Clinic Director to ensure that all files registered with the Clinic are properly managed and stored in the Clinic. (e.g., overseeing that files are signed out/in appropriately).

6.5 Client appointments and accounts are recorded and maintained by each student therapist in the online calendar. Students must ensure that clients check in with the Clinic Assistant prior to each appointment, and must also reserve space for their sessions.

6.6 It is the responsibility of each individual Supervisor to ensure that supervision is provided according to the terms outlined in the In House Practicum Contract (see practicum support website for prototype: <http://www.practicumsupport.psych.ubc.ca>). If Supervisors are out of town, in town but plan to be unreachable, or have the need to cancel regularly scheduled supervision, they must personally obtain supervisory backup from another faculty Supervisor for their cases. For extended absences or periods of time that would require skipping regular supervision sessions, backup Supervisors are strongly encouraged to read and co-sign therapy notes and/or touch base with students so that treatment can be appropriately monitored.

Ultimately, it is the responsibility of each Supervisor to determine what type and amount of supervision is needed to ensure the safety and best therapeutic/teaching outcome for their clients/students.

# POLICY 7: CLIENT FOLLOW-UP

7.1 Individual Practicum Teams are responsible for deciding if follow-up is necessary, and for determining procedures for the follow-up of individual cases. Supervisors are aware that practica may terminate before follow-up has been completed, and make arrangements accordingly. The responsibility for follow-up rests with the supervisor for the case. The Clinic does not generally provide individual therapy throughout the summer (May 1st till August 31st) each year, however, group therapy services have been provided throughout parts of the summer since 2015 and are expected to continue.

# POLICY 8: CLINICAL RESEARCH ISSUES

8.1 All research projects conducted in the Clinic, with Clinic clients, or with information regarding these clients, must be approved by the UBC Ethical Review Board and the Clinic Director.

8.2 Research conducted with Clinic clients requires both the Clinic consent form and an additional consent form specific to the research project being conducted. The responsibility rests with the supervising faculty member for ensuring that such forms are available and used when appropriate.

8.3 Barring legal and ethical exceptions to confidentiality, access to Clinic files is restricted to Psychologists who are responsible for a particular client, and persons under their supervision.

If other researchers wish to access Clinic information they must contact the faculty person responsible for the clients in question. If the faculty person agrees to co-operate with the research, it is his/her responsibility to access the file and to ensure that identifying information (name, address, and telephone number) and information that may provide clues to the client's identity (e.g. profession, personal references) is either deleted or disguised to prevent client identification.

If information is stored in a computer system, there must be no identifying information included in the files. Research access to computer-stored information must receive approval from the UBC Behavioral Research Ethics Board.

8.4 Information on computer systems containing no identifying client information may be used for research purposes provided the conditions of 8.2 have been met.

8.5 Faculty using the Clinic Assistant for research purposes are expected to contribute research funds to compensate the department for secretarial time.

8.6 Reserving space for Research:

All persons wishing to use Clinic space for research must submit an application to the Clinic Director.

All space must be booked off in advance of the time it is used via the online calendar.

Space may only be booked for pre-scheduled research activity. It is unacceptable to block off room time ‘just in case’ or in anticipation of something that has yet to be scheduled.

Clinic space is used primarily for practica and other clinical course related activity. This type of activity takes priority over research activity. While space conflict is expected to be very rare, if it occurs, the research group will be asked to re-schedule their work for a different time.

8.7 Confidentiality and Professionalism:

The Clinic is a professional place. All persons using the space are expected to conduct themselves accordingly. It will be the responsibility of the Graduate Student or Faculty Advisor to make this clear to other research personnel (e.g., RAs, Undergraduate Volunteers, etc).

Because, clients are seen in this space, RAs and Volunteers should know that they are not to discuss or share information about things or people they’ve seen/heard while using this space. It will be the responsibility of the Graduate Student or Faculty Advisor to make this clear to other research personnel.

8.8 Other:

Rooms must be left the way they are found. Moving furniture or bringing items into the room is acceptable, as long as the room is returned to its original state. Equipment or other research related items may not be left in the Clinic rooms.

Exceptions to these policies and procedures will be considered on a case-by-case basis. Please contact the Clinic Director if you have any questions or concerns.

# POLICY 9: LEGAL AND ETHICAL ISSUES

## Ethical Conduct

9.1 The Clinic has adopted the CPA Code of Ethics and the CPBC Code of Conduct (2014).

## Liability Insurance

9.2 According to the most recent correspondence with the University concerning liability insurance coverage for students working at the Clinic, students enrolled in UBC courses, and faculty and employees carrying out their usual work requirements, are covered under the Master Insurance Policy for the university. This insurance will likely cover the damages awarded to any persons injured or damaged as a result of attending the Clinic and/or engaging in approved research.

9.3 It should not be expected that the University Master Policy will provide insurance coverage where individual malpractice can be demonstrated (e.g. if faculty and/or students are providing unauthorized services) or where criminal charges are pending (e.g., assault). Further, the University Master Policy may not cover the legal costs involved in defense of such cases.

9.4 Students and faculty using the Clinic might wish to obtain individual Professional Liability Insurance for the purposes of covering the costs of legal defense in the case of a malpractice suit. This can be obtained through the B.C. Psychological Association or the Canadian Psychological Association. Further details are available from the Clinic Director.

## Legal Consultation

9.5 Legal consultation on matters related to the Clinic is available through the UBC lawyer associated with the Office of the University Counsel.

## Accreditation Issues

9.6 As part of a CPA/APA accredited clinical psychology program, the Clinic maintains standards consistent with those established for internship and practicum agencies in the relevant CPA and APA documents. Starting in 2016, APA accreditation will no longer be required for the UBC Doctoral Programme in Clinical Psychology.

# POLICY 10: USE OF CLINIC ROOMS

10.1 Clients are to be seen during normal department hours (8.30 am to 4.30 p.m., Monday to Friday) or outside of these hours with the permission of their Clinical Supervisor.

10.2 Only Clinic clients should be seen for evaluation and treatment in the Clinic rooms. Faculty may use Clinic space for private clinical work (see Policy 1) as long as it does not interfere with primary Clinic business of training.

10.3 Clinic rooms are reserved using the online Zimbra calendar. For all sessions with clients, students must reserve a room beforehand by placing their name with the patient initials in parentheses in the appropriate calendar. This procedure ensures the availability of space, and facilitates the complete accounting of client appointments. The Clinic Assistant arranges his/her schedule to be available to take payments when clients attend the Clinic. Typically, clients telephone the Clinic to cancel appointments. Any appointments or cancellations made directly between a therapist and client should be changed in the online calendar as soon as possible and/or brought to the attention of the Clinic Assistant in order to facilitate her schedule and maintain the accurate billing of clients.

10.4 Therapists should arrive in advance of sessions in order to prepare recording equipment, arrange furniture, etc.. Therapy sessions are typically 50 minutes in length. Therapists are expected to stop their sessions 10 minutes before the hour. Additional time may be reserved if it is indicated or required.

10.5 Clients should be directed to check in with the Clinic Assistant prior to each appointment and to arrive 15 minutes early for their first appointment. If the Clinic Assistant is away from the reception area, or if clients are seen after hours, payment envelopes are available on the Secretary’s office door. Clients should place their payment in one of these envelopes and deposit it through the slot on the door of the Clinic office. A receipt will be issued at a later date. Cheques are payable to the UBC Psychology Clinic.

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# POLICY 11: INFORMED CONSENT

A broad goal of informed consent is to provide clients with enough information about psychological assessment and therapy that they can make a reasoned decision. Accordingly, information must be presented in a manner that the client understands, and opportunities to seek clarification or receive further information must be offered. To the extent that clients do not know what psychological services entail, they may not be able to make choices in their own best interest. As well, clients may assume that confidentiality is absolute and, hence, need to be informed of its limits.

11.1 It is incumbent upon a student therapist to inform potential clients about the nature of any proposed assessment or therapy, the nature and limits of confidentiality, the fact that they are being supervised, the name of their supervisor, as well as any details related to recording or observation of the session by others. Recording devices should not be turned on until the client has been informed of and consented to their use. Any questions that a client may have should be answered in as much detail as is possible and reasonable. Therapists must ensure that clients completely understand what they are agreeing to. If the client refuses or does not wish to participate further with assessment and/or therapy, an appropriate note should be made in his/her file.

11.2 Student therapists must obtain a signed Informed Consent and Service Agreement from clients if consent to assessment and/or therapy is given. This must be witnessed and dated. An unsigned copy of this agreement should be given to each client for his or her own reference.

# POLICY 12: CONFIDENTIALITY OF CLIENT FILES

Psychologists are generally held liable for breaches of confidentiality if they are clearly preventable. Two types of breaches can occur: (1) active disclosure whereby the psychologist actively reveals information about the client through speech, writing, or some other medium, without the client's expressed consent; and (2) unintentional disclosure whereby the psychologist leaves confidential records in unsecured locations. To maintain confidentiality and prevent breaches from occurring, the Clinic has the following policy:

12.1 Client information is strictly confidential and is not to be discussed outside of the Clinic unless it directly pertains to a teaching situation (e.g. meeting with supervisor, case conferences), or other exceptions to confidentiality explicitly reviewed in the informed consent procedure.

12.2 Client files (including waitlist/phone intakes) and/or material identifying clients must be kept in the locked file cabinet in the Clinic office (or in the TA room, as is the case with the waitlist files). Files must be signed out if they are removed from the Clinic offices and must be returned by the end of the day they are signed out. If the Clinic Assistant is ill or on holiday, access to Clinic files can be obtained by through borrowing a key from the main Psychology Office or the Clinic Director.

12.3 Client files are not to be taken out of the office overnight. An exception to this policy may be made if specifically requested by the clinical supervisor, but arrangements must also be made to ensure that the file is kept in a secure location.

12.4 Client files should not be removed from the Psychology Department and must always be securely kept.

12.5 The information contained in a client's file can only be released after the client has consented and signed Consent to Release and Receive Information form, except in cases where demanded by law (e.g. by court order). Information that is to be used for research purposes is subject to Policy 8 concerning Clinical Research Issues.

12.6 When responding to requests for confidential information from sources outside of the Clinic, students must ensure that they: (1) inform the client of the request, (2) obtain client consent before responding to the request, and (3) communicate only information that is directly relevant to that request.

12.7 Correspondence requesting access to a client record (e.g., court order, request from a law office) should be immediately shared with the Clinic Director, if received by a student therapist or supervisor. The clinical supervisor and student therapist will be informed of any such requests, should they be received by the Clinic. The Clinic Director and/or UBC legal counsel will process any such requests.

12.8 Whenever information to be released pertains to assessment results, it is incumbent upon the student to acknowledge any reservations he/she may have concerning the validity and/or reliability of those results.

# POLICY 13: GUIDELINES FOR RECORD KEEPING AND CORRESPONDENCE

## General Record Keeping Guidelines

The guidelines that follow are based on the CPBC Code of Conduct. Students within the UBC Clinical Psychology Program receive detailed instruction in the content and implementation of the core documents that inform this brief overview. The purpose of this summary is to provide an introductory characterization of the record keeping practices of Psychologists. Naturally, in the event of any conflict between this outline and the relevant laws, codes, and guidelines on which it is based, the latter documents should be primarily considered.

## Underlying Principles and Purpose

Psychologists maintain records for a variety of reasons, the most important of which is the benefit of the client. Records allow a psychologist to document and review the delivery of psychological services. The nature and extent of the record will vary depending upon the type and purpose of psychological services. Records can provide a history and current status in the event that a client seeks psychological services from another psychologist or mental health professional.

Conscientious record keeping may also benefit psychologists themselves, by guiding them to plan and implement an appropriate course of psychological services, to review work as a whole, and to self-monitor more precisely.

Maintenance of records may also be relevant for a variety of other institutional, financial, and legal purposes. Provincial and federal laws in many cases require maintenance of appropriate records of certain kinds of psychological services. Adequate records may be a requirement for receipt of third party payment for psychological services.

In addition, well-documented records may help protect psychologists from professional liability, if they become the subject of legal or ethical proceedings. In these circumstances, the principal issue will be the professional action of the psychologists, as reflected in part by the records.

Psychologists are justifiably concerned that, at times, record-keeping information will be required to be disclosed against the wishes of the psychologist or client, and may be released to persons unqualified to interpret such records. These guidelines assume that no record is free from disclosure all of the time, regardless of the wishes of the client or the psychologist.

## Description of Record Keeping Systems

There are five categories of records maintained in the Clinic:

1. Treatment records

2. Accounting and statistical records

3. Research records

4. Shadow notes

5. Recordings

***Treatment Records***

Written records of the client's background information, treatment, and correspondence are kept in a Client folder, alphabetically filed in a locked file cabinet in the Clinic Assistant's office. The Psychologist or Psychology Service Provider uses these records in planning and reporting on the treatment provided to the client. These records may also be used to provide future clinicians with information on the client. To ensure the confidentiality of these records, they are not allowed to leave the Psychology Department. Clinicians and supervisors (and the client if he/she wishes) may review information in this folder.

Computer files that contain any assessment or treatment related materials should be encrypted to insure that unauthorized individuals cannot access the information. (Please see instructions for installing and using TrueCrypt on the Practicum Support website: www.practicumsupport.psych.ubc.ca).

It is common for students to keep a copy of written work (e.g., assessment reports, termination summary) for future use. If a student does keep a copy of such work it is imperative that he or she take the following precautions to protect the confidentiality of the material:

1. **Encrypt** the document

2. **Remove or alter ALL identifying information** (e.g., client name, age, gender, place/type of work, place of birth, date of birth, names of family members, medical conditions, names of other care providers) to prevent the possibility that the client could be identified if another person accessed the document.

Work of this nature should never be composed on public computers (e.g., the library) or in a public place (e.g., research labs) where others are liable to perceive identifying information found within the document. Using Clinic computers will greatly reduce this type of liability.

The following information and materials are stored in the Client Folders:

a) Name of the client and other identifying information

b) The presenting problem(s) or the purpose of the consultation

c) Telephone Intake

d) Informed Consent and Service Agreement and other consent forms if applicable (e.g., observation and intervention in school setting, participation in research).

e) Fee Agreement

f) File Audit Sheet

g) Consent to Release and Receive Information forms

h) Information obtained from other clinicians or agencies

i) Formal Psychological Evaluation Report (aka Assessment/Intake Report)

j) Copies of all correspondence pertaining to client (e.g., letters to client or letters from other agencies).

k) Progress Notes

i. Including session notes and non-session contacts (e.g., phone calls from client, emergency situations, case consultations with other professionals or family members).

ii. Session notes contain the date and substance of each meeting, including relevant information on interventions, progress, issues of informed consent, or issues related to termination.

l) Test reports and any test data or test forms

m) Termination Report

n) Termination Summary Form – For Archive

o) Emergency Contact Form

## Record keeping is an essential part of Clinic work, and must be completed in a timely fashion as outlined in the In-House Practicum Contract. A Progress Note form must be completed for each therapy session within a maximum of forty-eight hours following the session (see Appendix F). This helps ensure that the information detailed in the report accurately reflects the content covered with the client and serves as a memory aid for the therapist when preparing for future sessions. Progress Notes contain information regarding the client’s clinical presentation on a specified date, the session’s synopsis, recommended interventions, and a plan for the remaining course of treatment. Both the student therapist and their practicum supervisor must sign each Progress Note.

Any emergency situations should be immediately and comprehensively documented in the chart.

Records allow a psychologist to document and review the delivery of psychological services. The most important reason for keeping records is to benefit the client. Additionally, records may help to protect clinicians, supervisors and the Clinic in the event that records are subject to ethical or legal proceedings.

***Accounting and Statistical Records***

For audit purposes, the Clinic Assistant keeps a set of accounting records on all clients. Besides an electronic file containing the client's account information, supporting information documenting and further explaining the financial records are kept on file.

***Research Records***

Questionnaires and other research information collected on clients/subjects are ordinarily maintained in the Clinic and are available only to authorized persons. Alternative record storage arrangements for research data may also be made, as approved by University and Clinic ethics review committees.

***Shadow Notes***

These are typically handwritten personal notes of clinicians that are related to ongoing clinical care. They are usually notes that the clinician takes in session or in supervision and wishes to save in addition to the official progress note. If these notes contain identifying information, their security must be managed in ways similar to other official records. All students have a personal folder in the clinical files cabinet (in Clinic Assistant’s office). Shadow notes should be kept in this folder only. **Since these types of notes may also be court ordered along with official chart notes, it is strongly encouraged that students discuss with their supervisor whether or not to keep these types of notes.** In any case, a conservative policy would be that they are kept to a minimum and shredded after the client has terminated treatment.

***Audio/Video Recordings***

These recordings may be used for supervision or for other purposes, relevant to client care. The Clinic has a separate computer, TV, and wall-mounted camera and microphone for each of 4 therapy rooms (1615, 1623, 1625, and 1703). The Apple computers were installed in Fall 2013. This equipment allows students and supervisors to record therapy/assessment sessions. The protocol is 1) to record sessions onto the computer hard drive, 2) to upload the file to the secure departmental server, and 3) to then use Secure Empty trash to wipe the file from the computer hard drive.

* Students and Faculty must submit a Linux Virtual Machine Account application form (<http://www.psych.ubc.ca/services/pit/email/linuxvmapp.pdf>) to the Departmental IT staff to access the server (cloud). Login IDs and passwords will be provided to each applicant individually by the IT staff.
* Instructions for operating the equipment are printed directly on the desktop display of the monitors for each computer.
* The computers are encrypted to protect any data that is stored on the hard drive.
* To login to the computers use the password “Cl!n!crecording”
* If difficulties arise with the recording equipment, contact Matt Smith, Helpdesk Manager.
* In addition to the recording equipment, the Clinic also has a laptop computer and portable projector that can be signed out by students or faculty in the Clinical Area. Most commonly, this equipment is used for teaching purposes.

As with other portions of the client record, clients have a right to access information stored in a digital form or in audio or videotapes. However, when clients consent to receiving services they are aware that any recordings of their sessions do not become part of their permanent record. Moreover, keeping copies of multiple client sessions creates additional risk for confidentiality. Students are only permitted to retain recordings of 1-2 client sessions at a time (to provide sufficient time for supervision review). Students do not have permission to delete recorded sessions on the OwnCloud, but their supervisors do. Supervisors are responsible for destroying sessions after supervision has taken place.

## Guidelines for Clinical Records

**General Content of Records**

1. According to the CPBC Code of Conduct (2009), records include notes, reports, invoices, completed or partially completed test forms and protocol sheets, test results, interview notes, correspondence, and other documents in whatever forms, including information stored in digital form or on audio or videotapes, in the primary control of the psychologist and in any way related to the provision of psychological services to the client. Under the Freedom of Information and Protection of Privacy Act, records can be reviewed and duplicated.
2. Records of psychological services minimally include (a) identifying data, (b) dates of services, (c) types of services, (d) fees, (e) any assessment, plan for intervention, consultation, summary reports, and/or testing reports and supporting data as may be appropriate, and (f) any release of information obtained.
3. As may be required by their jurisdiction and circumstances, psychologists maintain to a reasonable degree accurate, current, and pertinent records of psychological services. The detail is sufficient to permit planning for continuity in the event that another psychologist takes over delivery of services, including, in the event of death, disability, and retirement. In addition, psychologists maintain records in sufficient detail for regulatory and administrative review of psychological service delivery.
4. Psychologists make reasonable efforts to protect against the misuse of records. They take into account the anticipated use by the intended or anticipated recipients when preparing records. Psychologists adequately identify impressions and tentative conclusions as such.

**Construction and Control of Records**

Psychologists maintain a system that protects the confidentiality of records. They must take reasonable steps to establish and maintain the confidentiality of information arising from their own delivery of psychological services, or the services provided by others working under their supervision.

1. Psychologists have ultimate responsibility for the content of their records and the records of those under their supervision. Where appropriate, this requires that the psychologist oversees the design and implementation of record keeping procedures, and monitor their observance.
2. Psychologists maintain control over their clients' records, taking into account the policies of the institutions in which they practice. In the event that circumstances change such that it is no longer feasible to maintain control over such records, Psychologists make appropriate arrangements for transfer.
3. The psychologist and other authorized persons organize records in a manner that facilitates their use. Psychologists strive to assure that record entries are legible. Records are to be completed in a timely manner.
4. Records may be maintained in a variety of media, so long as their utility, confidentiality and durability are assured.

**Retention of Records**

1. Clinic files are retained for at least seven years after the last contact with the client or seven years beyond the age of majority, in the case of a minor client. Retention of records in excess of this period may be indicated if in the best interests of the client, as determined by the Supervising Psychologist. A one page Termination Summary is completed at the time of termination, and survives the file as a permanent record of client services (see Appendix G).
2. Waitlist files of treatment seekers who were either a) unsuitable for the Clinic or b) not picked up for treatment are kept for one year after the date of last contact (per FIPPA). The files are destroyed, in their entirety, after one year.
3. All records, active and inactive, are maintained securely with properly limited access, and from which timely retrieval is possible.

**Outdated Records**

1. Psychologists are attentive to situations in which recorded information has become outdated, and may therefore be invalid, particularly in circumstances where disclosure might cause adverse affects. Psychologists ensure that, when disclosing such information, that its outdated nature and limited utility are noted using professional judgment and complying with applicable law.
2. When records are to be disposed of, this is done in an appropriate manner that preserves confidentiality. The Psychology Clinic has access to confidential shredding services on campus.

**Disclosure of Record Keeping Procedures**

1. Psychologists inform their client of the nature and extent of their record keeping procedure. This information includes a statement on the limitations of the confidentiality of the records.
2. Psychologists may typically charge a reasonable fee for review and reproduction of records (see schedule below). Psychologists do not withhold records that are needed for valid health care purposes solely because the client has not paid for prior services.

 Photocopying per page (up to 10 pages)…………………. No Cost

 -subsequent pages – per page ……………………………. $0.30

Creation of letters, reports, etc……………………………… $15 – 50/hr, capped at 3 hrs.

 [same fee as is used for assessment and therapy services]

Clients will also be responsible for any costs incurred in shipping, faxing, mailing the requested materials.

## Clinic Procedures

## Templates of each form indicated below are available on the Practicum Support Website ([www.practiumsupport.psych.ubc.ca](http://www.practiumsupport.psych.ubc.ca)) under the ‘Resources’ heading.

**Intake**

Upon accepting a referral, it is incumbent upon the student therapist to complete an Assessment Report **within three weeks from the date of assessment** (see Policy 5.6 for further details). One purpose of the Assessment Report is to formulate treatment goals and outline the psychological intervention(s) to be employed in order to accomplish those goals. It is the student's responsibility to ensure that the Assessment Report contains a clearly articulated statement of the client's reason(s) for referral, relevant personal history, the goals of therapy, and the criteria by which progress will be measured.

13.1 Once a client has consented to assessment and/or therapy, students shall complete an assessment report. It is recommended that the report contain at least the information on the sample report (see practicum support website: www.practicumsupport.psych.ubc.ca). However, the precise content and form of the report is at the discretion of the faculty member who is supervising the case.

**Progress Notes**

13.2 Progress Notes are to be kept in the client's file. A Progress Note form must be completed for each therapy session **within a maximum of forty-eight hours following the session** (see Appendix F). These notes, although brief, should contain enough information to document the progress of each case. The following are recommended guidelines to the content of these notes (\*denotes elements are required for billing):

* \*Client name
* \*Date of session or contact
* \*Length of session
* \*Type of service (e.g., group, individual or conjoint session, phone note, cancellation)
* \*Individuals present in the room
* Name of supervisor
* Name of therapist
* Progress monitoring scale scores
* Main issue discussed
* Nature of therapeutic intervention
* Status of presenting problem
* Important new information about the client
* Changes in goals or strategies
* Next appointment

The Clinic uses a structured Progress Note that prompts students to include the above elements.

**Termination**

13.3 Client termination dates are recorded on the database maintained by the Clinic Assistant. After the termination of treatment, the student therapist must fill out a Termination Summary form **within four weeks of the final treatment session** (see Appendix G). This form serves as a quick reference of the client’s contact information, presenting complaint(s), dates of contact, and the Supervising Psychologist or attending therapist’s recommendation at termination. It is archived with the client’s file.

13.4 Upon termination of therapy, students must complete a formal Termination Report to be kept in the client's file (see Appendix H). The Termination Report must be completed **within three weeks of the last session** with a particular client.

Guidelines for this report are as follows:

* Basic personal history and presenting problem
* Initial goals and methods planned
* Number of sessions and time span
* Any changes that occurred in the goals
* Outcome regarding each goal
* Reasons for termination
* Post therapy recommendations and statement of case disposition

A sample completed Termination Report is available on the Practicum Support website ([www.practiumsupport.psych.ubc.ca](http://www.practiumsupport.psych.ubc.ca)) under the ‘Resources’ heading. This sample has been prepared for you for illustrative purposes and may be adapted as your supervisor or you deem appropriate.

13.5 If a follow-up is deemed necessary, client consent to subsequent contact should be secured and attached to their file. The responsibility for devising any follow-up rests with the Supervising Psychologist for the client.

13.6 Subsequent to the time of termination, the Supervising Psychologist must sign the File Audit Form (attached to each file), indicating that the case documentation meets their approval (see Appendix I). This form contains a brief checklist around the items stored inside each client file, lists tests and measures administered during treatment, and lists all session dates for speedy future reference. Both the therapist and their supervisor must sign the completed form before it can be stored away. It must be completed and signed **within four weeks of the final treatment session**.

**Closing the Client File**

13.7 Student therapists will ensure that the file is prepared to be archived by completing the following tasks:

1. Securely delete any remaining digital files left on the server or the student’s personal computer
2. Shred any shadow notes that have been stored in the student’s personal file
3. Remove any draft reports or notes from the client file
4. Remove any monitoring forms or homework sheets that are not necessary for continuity of care. Most such forms can be removed, but they may be retained at the discretion of the supervisor.
5. Ensure that the File Audit form, reports, and progress notes have been signed by both the supervisor and student therapist.
6. Retain the following in the client file:
	* Telephone Intake
	* Consent form
	* Consent to Release and Receive Information (if applicable)
	* Fee Agreement
	* Reduced Fee Form (if applicable)
	* Completed or partially completed test forms and raw test data
	* Computer generated test reports
	* Progress monitoring forms
	* Intake/Assessment report
	* Progress notes (in chronological order). Include copies of any email communication with the client.
	* File Audit Form
	* Information obtained from other clinicians or agencies
	* Copies of all correspondence pertaining to client (e.g., letters to client or letters from other agencies).
	* Termination Report
	* Termination Summary Form
	* Any other information on which decisions about the client’s care were based

13.8 The student will give the client file to the Clinic Assistant to be archived

# POLICY 14: SUICIDE

## Suicide Threats

14.1 Students must be sensitive to the potential for self-injury or suicide among clients seen in therapy, and must exercise skill in diagnosing and responding to such threats. When the student suspects that a significant risk may be present, it is incumbent upon him/her to document this and inform his/her supervisor. It is also necessary to assess, at minimum, the degree of planning and its lethality, the emotional state of the client and his/her intent, the means available to the client to carry out his/her plans, and the client's previous history of suicide attempts.

14.2 Instruction concerning risk factors for suicide and intervention strategies takes place within the Clinical Practica as well as the Introduction to Psychotherapy (PSYC 541) and Ethics and Professional Issues (PSYC 537) seminars.

## Suicide Completion

14.3 In the event of a suicide or unexpected death of a client currently being seen by a student therapist in the Clinic, the following procedures will be followed:

Following an unexpected death of a client, the therapist should talk about this as soon as possible with their practicum supervisor and other relevant faculty (e.g., research supervisor) as per the following:

When a student therapist learns about the client death, she/he should inform their practicum supervisor as soon as possible.

When Clinic staff or faculty learn about an unexpected death before the practicum therapist, the practicum therapist will be informed as soon as possible by an appropriate faculty member, preferably their practicum supervisor, about the client’s death. This will be done in person (not via e mail, phone, etc.) so that the student and supervisor can best process what has occurred and make plans for what courses of action should be taken.

The student's research supervisor(s) should be informed, in general terms, that this has occurred, so that additional assistance can be provided to the student during this time. Additionally, the Director of Clinical Training and Clinic Director should also be informed and possibly consulted regarding appropriate responses to take.

The student therapist and their practicum supervisor should consider whether accommodations should be made to the students’ workload, including work with clients, in order for the student to better cope with this loss.

It is recommended that the student therapist, and possibly the practicum supervisor, obtain whatever assistance is needed in order to respond to this loss effectively. For example, it can be very helpful during this very stressful time for the therapist and/or supervisor to obtain therapy services.

While relevant assistance should be actively sought by the student therapist and his/her supervisor during this time, maintaining both client confidentiality and appropriate record-keeping in the official client file continues to be very important. Psychologists are required to maintain client confidentiality even after the death of the client.

Specific procedures for dealing with the untimely death of a client may differ based on the particular situation, the particular client, the particular therapist, etc. A task force of the American Association of Suicidology maintains a webpage at http://mypage.iusb.edu/~jmcintos/therapists\_mainpg.htm that provides helpful information to assist therapists dealing with the loss of a client by suicide.

# POLICY 15: CONFIDENTIALITY AND RELEASE OF INFORMATION

## General Statement

Clinicians, staff members, and supervisors respect the confidentiality of information obtained from clients of the Clinic. All information from or about clients is confidential, when obtained during professional activities such as psychotherapy, assessment, counselling or consultation. Such information will be released to others only with the consent of the client or the client's legal representative (e.g., parent or guardian), except in those unusual situations when limitations to confidentiality may apply. When receiving services at the Clinic, clients will be informed of possible exceptions or limitations to confidentiality. Clinicians, staff members and supervisors are responsible for understanding and carrying out this policy, as well as sections of the CPA Code of Ethics for Psychologists, the CPBC Code of Conduct and Provincial and Federal laws which apply to the issue of confidentiality.

## Possible Limitations of Confidentiality

Provincial and federal laws stipulate that information about clients be released to third parties under specific circumstances. The fact that the Clinic is a training facility also necessitates proscribed limitations to confidentiality. Clinic Teams will discuss with new clients the possible situations in which confidentiality may be limited. However, the student therapist is ultimately responsible for ensuring that his/her clients understand the limitations of confidentiality.

Before violating confidentiality, a student therapist should discuss the circumstances with his or her supervisor and/or with the Clinic Director. Whenever possible, the student therapist should attempt to secure the client's consent before divulging information to others. The student therapist (under the guidance of their supervisor) is responsible for understanding and following legislation and ethical principles pertaining to confidentiality. The following list describes some circumstances under which it may be appropriate to release confidential information:

1. If the clinician believes that the client can reasonably be expected to harm an identifiable party or class of individuals, the clinician may have a duty to protect that person by informing the person and/or the police or by taking some other action.
2. If the client is 16 years of age or older and the clinician believes that the client has a medical condition that makes it dangerous to the client or to the public for the client to drive a motor vehicle, and he/she continues to drive a motor vehicle after being warned of the danger by the clinician, then the clinician must report to the superintendent of Motor Vehicles the name, address and medical condition of a client. (see Motor Vehicle Act)
3. If the clinician has reasonable cause to suspect that a child has been, or is likely to be, harmed or neglected, the clinician may be required by law to report the suspected abuse or neglect to the Ministry of Children and Family Development. (see Child, Family, and Community Service Act)
4. If the clinician has reasonable cause to suspect that abuse, exploitation or neglect of a person over the age of 19, who is vulnerable because of physical or mental impairment or advanced age, has occurred, the clinician may report the suspected abuse or neglect to the appropriate agency. (see Adult Guardianship Act)
5. If a judge orders release of information about a client, the Clinic may be required to release this information. Clinicians and supervisors may also be required to testify in court cases.
6. Information about clients may be shared with the student therapist's supervisor or Practicum Team. Principles of confidentiality still apply, and information about clients is not to go beyond the supervision setting (so-called “bubble of confidentiality”).
7. Therapy sessions at the Clinic may be recorded as part of the student therapist's training. Recordings are intended for professional or training use only by the student therapist and his/her supervisor or Practicum Team. Clinicians are responsible for the security of recordings.

## Release of Information by the Clinic to Other Parties

Clients may request that the clinic release confidential information to third parties. Before information can be sent to another person or agency, the client must provide written authorization by signing a copy of the Consent to Release and Receive Information form (see Appendix D). In the case of a minor child or adult with guardian, the parent or legal guardian must authorize the release of information.

The Consent to Release and Receive Information form should include the following information: 1) the time period covered by the release, 2) specific reasons for sharing information, 3) the specific records or information to be shared, 3) the name of the person or agency to whom information is to be released, 4) any limitations on data to be sent, 5) the signature of the client or person authorizing the release, and 6) the signer's relationship to the client if it is not the client her/himself.

Confidential materials released to other parties should be marked “Confidential”. A cover letter should accompany the materials. The purpose of this letter is to inform the recipient that the information is confidential and is not to be released to other parties or agencies.

The student therapist and Practicum Team should assess the ability of the person receiving information to understand the nature of the data. Non-professionals or members of other professions may misunderstand psychological terms and concepts, possibly to the detriment of the client. Where such risks appear possible, the student therapist should review appropriate measures with the Supervising Psychologist.

As the Clinic is part of the university and, thereby, a public body, access to client information is governed by the Freedom of Information and Protection of Privacy Act. Under this legislation, all requests to access client information should be made in writing to the Office of University Counsel (Freedom of Information Specialist and/or Access and Privacy Manager). This is always the case when information is requested by a third party either without the client’s knowledge or without his/her consent (e.g., court order). In such situations, the written request should be sent to the Office of University Counsel and the Clinic Director informed immediately.

In practice, when a client requests access to his/her own record or asks that it be sent to a third party the Clinic is permitted to grant access provided the client has signed the Consent to Release and Receive Information form and there is no reason to suspect that disclosure of such information to the client would be likely to cause a) substantial adverse effect to the client’s physical, emotional, or mental health, or b) harm to a third party. The clinician and supervisor must respond to the client’s request **within 30 days**.

# POLICY 16: OTHER IN-HOUSE PRACTICA PROCEDURES

Please note that the instructions below may only pertain to practicums held at the UBC Psychology Clinic with the exception of any procedures applicable to Practicum Contracts and Evaluations.

## Practicum and Internship Approvals

16.1 It is expected that students complete and sign a Practicum Approval form (see Appendix **J)**. A student’s Faculty Supervisor must approve each practicum and this approval is verified by obtaining their signature on the form. It is the student’s responsibility to fill out this form and obtain this signature before the commencement of each applicable practicum. The completed form must be dropped off at the Clinic in a timely fashion.

16.2 Policy 16.1 also applies to Internship Approval forms (see Appendix **K**).

16.3 Upon accepting a practicum offer, students are expected to notify the Clinic Assistant and continue to promptly notify the Clinic Assistant if any changes are made to their scheduled start and end dates or primary supervisor(s). This helps ensure that the Clinic Assistant is able to send out reminders to the practicum supervisor regarding important administrative matters when appropriate.

## Practicum Contract

16.4 Students are expected to provide the Clinic Assistant with a copy of their practicum contract within approximately two weeks of starting their practicum. The practicum contract should be collaboratively written with your practicum supervisor. It may also be adapted as necessary to reflect the training experience that will be provided. Please see Appendix **L** for the Practicum Contract template. Sample Practicum Contracts are also available on the Practicum Support website ([www.practiumsupport.psych.ubc.ca](http://www.practiumsupport.psych.ubc.ca)) under the ‘Resources’ heading.

## Practicum Evaluations

## 16.5 The Clinic Assistant usually sends out a reminder to each practicum supervisor requesting an evaluation of his or her practicum student(s). This reminder is sent out approximately two weeks before the scheduled end date for each practicum. It is important for students to notify the Clinic Assistant about practicum extensions, so that unnecessary reminders can be avoided. The student therapist and their practicum supervisor must both sign the completed Student Evaluation report (see Appendix M).

## The Student Evaluation provides an assessment of the student’s progress in meeting the evidence-based practice, ethics and professionalism, interpersonal skills, and communication competencies expected for successful completion of the UBC Clinical Psychology program. It also enables the Director of Clinical Training and the Clinic Director to determine each student’s progress towards preparing for their internship.

## 16.6 Completed evaluation forms can be sent to the Clinic Assistant by e-mail, mail (2136 West Mall, Vancouver, BC V6T 1Z4), or personally delivered by the students. These evaluations are stored in each student’s file in the Clinic.

## Supervisor Evaluations

## 16.7 As the Directors of the Clinical Psychology Program are not present at all practicums, it is extremely helpful for students to provide the Directors with confidential and anonymous feedback on each of their supervisors. Any feedback provided by the students also enables the Clinic Assistant to synthesize anonymous and transparent reports for the supervisors. Each supervisor will only receive aggregated anonymous feedback provided by at least four students over at least two years. Please complete the Supervisor Evaluation form within two weeks of your practicum’s end date and return the completed form to the Clinic Assistant (see Appendix N).

## Please note that the Supervisor Evaluations do not need to contain your name, but it is helpful for the Clinic Assistant to know that you have submitted the form as they can then avoid sending you future reminders. This identifying information, however, is not shared with the reviewer or practicum supervisor. The Clinic Director is the sole reviewer of the Supervisor Evaluation forms for all evaluations that are not evaluating his or her supervision. In the latter case, the Supervisor Evaluation form is only reviewed by the Director of Clinical Training.

# POLICY 17: CLINIC COMPUTER

17.1 Computer resources supporting word processing and printing are available in the Clinic. These resources are expressly intended to assist students in their clinical work (e.g., report writing, test scoring) and the use of these systems should be limited to these purposes. No software may be added to the Clinic computers without prior approval from the Clinic Director and the Department of Psychology’s IT team, and no student files are to be saved on hard drives.

# POLICY 18: ADMINISTRATIVE TIMELINES

18.1 All students are expected to follow the timelines set forth in the aforementioned policies and there may be academic disciplinary measures taken against any student failing to adhere to any of the said policies.

## REVIEW OF TIMELINES

|  |  |
| --- | --- |
| FORM | COMPLETION DEADLINE |
| Practicum Approval | Before Starting Each Practicum |
| Practicum Contract | Within 2 Weeks After Practicum Starts |
| Informed Consent &Service Agreement | First In-Person Contact(Date of Assessment) |
| Assessment Form | Date of Assessment |
| Assessment Report | Within 3 weeks of Assessment Date |
| Progress Notes | Within 48 hours of Each Therapy Session |
| Termination Report | Within 3 weeks of Last Session |
| Termination Summary | Within 4 weeks of Final Treatment Session |
| File Audit Form | Within 4 weeks of Final Treatment Session |
| Student Evaluations | Depends on Supervisor’s Availability (Preferred Within 3 weeks of End Date) |
| Supervisor Evaluations | Within 3 weeks of Practicum End Date (Completion Strongly Encouraged) |

##

**Appendix A**

 **(NOTE: The following assessment form is used for assessments conducted at the**

 **UBC Psychology Clinic and may not be used in other practicum placements.)**

**Assessment Form**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Assessment Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Duration:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **GP:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIMITS TO CONFIDENTIALITY**

1. Immediate risk of harm to self or others
2. Child is being harmed or is at risk of being harmed
3. Records requested by court order or WCB
4. Unsafe to operate a motor vehicle

**Referral Route**

How did you come to be here? Given that this has been a longstanding problem, what brought you to treatment now?

**Purpose of Assessment**

## PRESENTING PROBLEM

Tell me about the problem that brought you here. [Assess specific symptoms (incl. anxiety, depression, mania, and any other relevant sxs as well as differential dx)]

**History of Problem**

When did this problem start? Have you had any prior episodes? How has this difficulty changed over time?

How does this affect your life right now?

## CRITICAL ITEMS

Sometimes when a person feels down or is really unhappy they might think about dying or hurting themselves. Have you been having any thoughts like that? (plan, intent, access to means, prior hx, resources)

Have you ever heard things or seen things that others don’t see or hear?

Do you smoke? (freq., amount)

Do you drink coffee? Caffeinated tea? Coke/Pepsi? (freq, amount)

How much alcohol do you drink in a typical week? (what type, with whom, how often, how much)

Do you use any drugs? (what, how often, how much)

Was there ever a time in your life when you used drugs or alcohol heavily or when you had problems because of your alcohol or substance use? (when, how much, how long, what problems)

Have you ever had any traumatic experiences? (what, when, current effects)

Overall, how would you rate your sleep? *Always good Mostly good Fair Mostly poor Always poor*

What time do you go to sleep / get up? \_\_\_\_\_\_\_\_\_\_\_ am/pm / \_\_\_\_\_\_\_\_\_\_\_ am/pm

Total # hours sleep: \_\_\_\_\_\_\_\_\_\_\_\_

No Yes Difficulties going to sleep

No Yes Frequent awakenings

No Yes Difficulties going back to sleep

No Yes Early morning wakening

No Yes Nightmares

No Yes Sleep walking

Difficulty sleeping due to?

## CURRENT ADJUSTMENT

## Love

Tell me a bit about your family—do you have any brothers or sisters? (how many, ages) Are your parents still living? Are they still together? Who do you live with?

How do you get along with your siblings?

What about your parents? What is your relationship like with your parents? Do you live with them? Do you argue? How often? What about? How often do you talk/see them?

How about friends? Do you have anyone that you feel close to and can confide in? Tell me about that person(s). Freq. of contact with friends? In general, how happy are you with support from family and friends?

Are you married or dating anyone? (Partner’s name, age, occupation). How would you describe your relationship? Do you argue? How often? What about? Sexual relationship (desire, arousal, orgasm, freq)?

## Play

What do you do for fun? Do you have any hobbies? What did you do for fun this past week?

Work

Do you work or take any classes? What kind of work/school do you do? Have you had any problems at work/school? Have you missed any time from work/school? How satisfied are you with your work (stress level, work relationships, meaningfulness)?

PAST ADJUSTMENT

Where were you born and raised? Who did you live with when you were growing up? Who did you feel closest to? Who made the rules and enforced discipline in your house?

Did you ever see any violence in the family? Has anyone at any time ever forced you to participate in sexual activity *of any kind*?

How was school for you? How were your grades? What was the highest grade that you completed?

Did you have any trouble making friends (bullying, teasing)? Were you more of a leader or a follower? Did you ever get into trouble at school?

## MEDICAL & PSYCHIATRIC HISTORY

Any major medical conditions? (e.g., **chronic pain**, heart condition, hypo/hyperthyroidism, asthma, head injury, seizures)

Have you ever been on medication for psychological problems? (what, for how long, how much, and is it helping)

Have you ever seen a psychiatrist, a psychologist, or a school counselor before? (If so, who, when, what for, and for how long.)

Ever been hospitalized before for psychological difficulties? If so, when, what for, and for how long.

Anyone in your family ever see a psychiatrist or psychologist? Anyone who *should* have seen someone?

Any suicides in your family? Anyone have a problem with alcohol or drugs?

**FOLLOW-UP**

**Anything that I haven’t asked you that you think it would be important for me to know?**

**Other strengths not mentioned (what is going well for you right now? What do you feel good about?)**

**What are your biggest stressors right now?**

What are your top 3 goals that we could initially work on?

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Mental Status Exam

**Appearance:** neat, meticulous, unkempt, seductive dress

**Countenance:** impassive, perplexed, sad, angry, sullen, tearful, woeful, bored, silly, laughing, grimacing, vigilant, poor/good eye contact, stares into space

**Posture:** stooped, stiff, relaxed (appropriate, inappropriate), calm, tense, fixed, rigid, upright, slumped

**Psychomotor Activity:** slowed movement, catatonic, waxy flexibility, overactivity, tremor, tics, posturing, pacing, picking at skin/clothes, pulling hair, agitated, involuntary movement, drooling, cogwheel rigidity (robotic movements)

**General Attitude:** positive-cooperative, responsible, pleasant, friendly, trusting, suicidal threats, ideation, attempts, self-harm, uncooperative, hostile, angry, sarcastic, sullen, irritable, withdrawn, distrustful, argumentative, threatening, antisocial, suspicious, guarded impulsive, passive, dependent, demanding, arrogant, complaining, despondent, apathetic, fearful, dramatic, ingratiating, grandiose, manipulative

**Speech:** Normal rate and rhythm, pressure, tangential, circumstantial, mute, loud voice, screaming, monotonous, soft, retarded, slow response, incoherent, evasive, obscure, concrete, excessive profanity, organized, disorganized, loosened associations, flight of ideas, neologisms, clang associations, echolalia, perseveration

**Mood and Affect:** appropriate/inappropriate to thought content, stable, labile, flat, constricted, anxious, depressed, euphoric, grandiose

**Content of Speech and Thought:** (cite examples) appropriate, grandiosity, ideas of reference, bizarre thoughts, phobias, compulsions, obsessions, guilt, self-pity, inadequacy, self-derogatory, indecisiveness, isolation, helplessness, failure, loss, resentful of others, death, loss of control, being harmed by others, fear of abandonment, sexual problems, somatic

**Perceptual Distortions:** Hallucinations – auditory voices/noises, visual formed/unformed, tactile, olfactory, gustatory, visceral, illusions, depersonalization, derealization, déjà vu

**Summary/Impressions**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Biological** | **Psychological** | **Social** |
| **Predisposing** |  |  |  |
| **Precipitating** |  |  |  |
| **Perpetuating** |  |  |  |
| **Protective** |  |  |  |

**Axis I:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Axis II:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Axis III:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Axis IV:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Axis V:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recommendations and Treatment Plan (referral, reading/resource material)**

**Tests Given:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix B**

**(NOTE: The following Assessment Report is only a template and may be adapted as necessary for your practicum. Please note that non-internal practica may require you to use a different template)**

**UBC Psychology Clinic**

2136 West Mall, Vancouver, BC, V6T 1Z4

Phone: 604-822-3005⏐Fax: 604-822-6923

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**Assessment Report**

**Referral Route and Identifying Information:**

Ms. X is a 38 year old single woman who was referred to the Clinic by her general practitioner, Dr. Y, for recurring depression and distressing thoughts about needing to be thin.

**Purpose of Assessment**

**Presenting Complaints and History of Presenting Complaints**

Ms. X reported an 11 year history of discrete depressive episodes characterized by feelings of sadness and hopelessness, tearfulness, hypersomnia, irritability, fatigue, decreased interest in activities, and poor concentration. She reported that she has had thoughts of suicide once in the past year and has no plan or history of past attempts. She noted that a given episode will last from 2 weeks to 2 months, the most recent being in July-August 2006. She said that she believes that this episode was precipitated by weight gain in March, which left her feeling “fat and ugly”. In between episodes, Ms. X reported that she does have periods of good mood. She reported her current mood to be 5 out of 10 (0= no sadness, 10=most sadness ever felt), though she said that she has been very fatigued over the past year and is experiencing a great deal of anger over the past 3-4 months. For example, if she makes a wrong turn while driving she said that she will experience a rush of anger, will clench or pound the steering wheel, and will shout in the car. Ms. X reported that she quite often becomes depressed in January and again in March. However, this does not appear to reflect a seasonal pattern, as Ms. X has also been depressed in the summer and said she typically feels better in the fall. Further, she attributes her typically low mood in January to having just spent time with family over Christmas and feeling very lonely upon returning home. She became tearful in the interview when talking about her feelings of loneliness. Ms. X noted that her depressive episodes have generally followed a break-up of a romantic relationship or an upswing in concerns about her weight or appearance.

Ms. X also described recurring self-critical thoughts such as “I’m dumb and ugly”. She said that she is very critical of her appearance and feels guilty about eating particular foods. Further, her self-evaluation is closely linked to her appraisal of her appearance. However, she is not currently dieting or underweight and she denied current bingeing or inappropriate compensatory behaviors. She did note that in 1990 she struggled with overeating and, possibly, occasional binge behavior. Since stopping her antidepressant medication approximately 3 weeks ago, she has noticed an increase in her preoccupation with food and is concerned that she is eating more of the foods that she previously did not permit herself to eat.

Ms. X denied symptoms of mania, social anxiety, generalized worries, obsessions or compulsions, or any history of traumatic experiences. She drinks approximately 2 glasses of wine 2-3 times per week, and she does not use any recreational drugs.

**Current Adjustment**

Ms. X is currently living alone in Edmonton. Her younger sister, Mia, lives with her husband and children in Ontario, and her parents live in Ottawa. Ms. X reported that she gets along fairly well with her sister, but that they do have disagreements and she sometimes feels that her sister does not appreciate her good fortune (i.e., having a husband and children). Ms. X said that she has a close and supportive relationship with her parents and talks to them daily. She reported good social support from her friends and noted that she has a close childhood friend in Edmonton as well and 2 or 3 friends that she met working at her current job.

Ms. X is not currently involved in a romantic relationship, though she expressed a strong desire to get married and have children. Approximately 2-3 years ago, Ms. X broke up with her boyfriend of 5 years, Gary. At that point, Ms. X moved back to Ottawa and lived with her parents before accepting a job in Edmonton and moving there in June 2005. She remains friends with her former boyfriend, who is now living in Ottawa and they talk every week. He has been diagnosed with Crohn’s disease and Ms. X noted that she tries to take care of him, although she no longer has any romantic feelings for him. Ms. X also described an “on again, off again” relationship with Chris, a former co-worker. She said that she began dating Chris while she was still with Gary, and feels that Chris is her soul mate. However, she reported that Cameron gives her mixed messages about his willingness to be in a relationship with her. For example, when Ms. X recently offered to visit Cameron in Ontario, he rebuffed her, only to call back a few days later and ask her to come.

Ms. X is an avid scrapbooker and she enjoys going to the gym and watching sporting events. She is currently working full time in an administrative position for Chuck E. Cheese. She said that she is not very happy in her job, noting that she feels quite bored and believes that the job is not a good fit for her because she is a people person and this job involves more paperwork than interpersonal interaction. As well, she has reportedly had conflict with two of her co-workers, which has added to her workplace stress. In addition to her job at Chuck E. Cheese, Ms. X also works 1-2 shifts per week waitressing at a bar for extra money.

**Past Adjustment**

Ms. X was born and raised in St. Catherine’s, Ontario, except for a 1 year period at the age of 6, when she moved with her family to Ireland. Ms. X reported that she was closest to her mother growing up, noting that both she and her sister were afraid of their father whom she described as a stern disciplinarian. She said there was no violence in her family home and she denied sexual assault or sexual abuse. She described herself as a “good kid” and said that she did not have trouble making friends in school.

**Medical and Psychiatric History**

Ms. X reported that she underwent a breast reduction 2 years ago due to back pain. She reported no other medical conditions. She is not currently taking any medications, but had been taking antidepressants consistently for the past 10 years and only finished tapering off those medications approximately 2-3 weeks ago. Most recently, she was taking Wellbutrin (150 mg) and fluoxetine (40 mg). She discontinued the medication because she didn’t feel that it was helping. Ms. X is currently seeing a psychologist in the community, whom she has been seeing on an irregular basis since July 2006. She reported that she has also had psychotherapy on a number of occasions in the past, beginning in 1995 (for 2 years), again after she broke up with Gary and moved back to Ottawa (for 1.5 years), and most recently in the past two years through Employee Assistance (for 1 year). She said that she has found psychotherapy helpful in the past. She denied previous hospitalizations.

Ms. X noted that, to her knowledge, no one in her family has ever seen a psychologist or psychiatrist and she could not think of anyone that she felt needed those services. She denied a family history of suicide, but she reported that her paternal grandfather “drank himself into the ground” after his wife died.

**Diagnoses (DSM-5, 2013)**

Axis I Major Depressive Disorder, Recurrent, in Partial Remission (296.3x)

Axis II Deferred

**Formulation**

Ms. X has a longstanding pattern of major depressive episodes that follow a relationship break-up or self-critical thoughts about her weight and appearance. Although Ms. X is dissatisfied with her work life and her romantic relationships, she presents a very bubbly, positive façade and has difficulty sharing her negative feelings with others in a direct and honest manner (e.g., using sarcastic comments to convey anger). It may be that this is perceived as disingenuous by others and that they respond by distancing themselves from her or rejecting her. Ms. X is currently eager to find a partner with whom she can start a family. As a result of her desire to avoid feeling lonely, she has been willing to accept poor treatment within her romantic relationships and her passively unassertive behavior with her boyfriends may be reinforcing their poor treatment of her.

**Treatment Plan**

It is recommended that Ms. X attend weekly sessions at the Clinic for psychotherapy, specifically Cognitive Behavioural Therapy. CBT is indicated to help her gain insight into the way her self-critical thinking may contribute to a pattern by which she becomes passive in her communication and withdraws from other people. CBT may help her gain more insight into her interpersonal style, and help her begin to challenge her self-critical thoughts and engage in more assertive behaviours. Treatment will be shorter term, i.e. 12-16 weekly sessions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name Supervisor Name, Ph.D., R. Psych.

Therapist Supervising Psychologist

**Appendix C**

**UBC PSYCHOLOGY CLINIC**

2136 West Mall, Vancouver, BC, V6T 1Z4

Phone: 604-822-3005⏐Fax: 604-822-6923

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**Informed Consent and Service Agreement**

Thank you for choosing the University of British Columbia (UBC) Psychology Clinic to assist you with your personal concerns. Please take the time to read and understand this document, and discuss any concerns or questions you may have with your therapist.

**Services Provided**

The UBC Psychology Clinic is dedicated to advancing the highest standards of assessment, treatment, research and training in clinical psychology. Our assessment and treatment services are provided by clinical psychology graduate students who work as therapists under the supervision of experienced Registered Psychologists. All further references to the “therapist” in this document should be understood as the therapist and supervising psychologist. The goal of supervision is to train the therapist and to ensure that the client receives the best possible care. We provide both assessment and treatment services. The length of treatment is generally a matter for mutual agreement between the client and the therapist, but clients are free to end treatment at any time. The UBC Psychology Clinic may bring treatment to an end a) if the therapist and client have agreed to meet for a specified number of sessions and these come to an end without a discussed extension; b) if the therapist judges that the approach does not appear to be beneficial (in which case a referral to another provider may be made); c) if the client threatens or harasses the therapist or staff of the UBC Psychology Clinic (in which case the therapist may terminate the therapeutic relationship immediately); and d) in the event of the unavailability, illness, or departure of the therapist. The UBC Psychology Clinic is unable to guarantee that services to which a client is referred will be able to accept the client for treatment. The Clinic is normally closed for the months of May-August and no services are provided during that time.

**Therapeutic Approach**

The UBC Psychology Clinic offers an array of different approaches to therapy. The two most common are Cognitive Behavior Therapy (CBT) and Interpersonal Therapy (IPT). Cognitive approaches emphasize the way that we think about the events of our lives, and have the aim of helping us to see things accurately and completely, neither unrealistically positively nor negatively, and to cope with our reactions to these perceptions. Behavioral approaches emphasize building skills for use in dealing with situations, breaking down large projects into manageable steps, and overcoming troublesome or habitual reactions to events. Interpersonal approaches focus on how previous relationship experiences affect how we feel about and behave in new relationships. The specific therapeutic approach used will depend on the particular difficulties that the client is struggling with and the services offered by the therapist and will be discussed at the outset of therapy.

### **Likely Benefits of Services**

Therapy can help a person gain new understanding about his or her problems and learn new ways of coping with and solving those problems, such as problems involving emotions (like anxiety, depression, or anger) or behaviours (like avoidance or aggression). Therapy can help a person to develop new skills and change behaviour patterns. Therapy can contribute to improved ability to cope with stress and difficult situations and can increase understanding of self and others. Therapy can also help a person to understand and improve the way they relate to others.

**Possible Risks of Services**

While most clients do experience improvement during psychotherapy, some do not. Some clients may not improve at all, or may not improve as quickly as they would like. Furthermore, a client should be aware that treatment is intended to induce change in his or her life, which can disrupt his or her accustomed manner of living and way of relating to others. Treatment may also be emotionally painful at times, stimulating emotions and memories that can alter one’s self-perceptions. In the long run, therapy is usually worth the effort, as these changes and emotional pain are steps along the road to growth and realizing one’s goals, but the process of personal change can be quite varied and individual. It is important to mention promptly any concerns or questions that one may have during the course of assessment or treatment.

**Your Rights**

All information that clients disclose to the therapist within sessions is confidential and will not be revealed to anyone without the client’s written permission (or his or her parent’s permission if the client is under 19 years old). The law, however, places certain limits on the confidential nature of psychological services. The therapist might need to share information about the client without his or her consent in the following situations:

1. If the client is at serious risk of doing harm to him or herself or to someone else
2. If the client shares information that suggests that a child is being harmed or is at risk of being harmed
3. If the client is unsafe to drive and persist in doing so
4. If the records are ordered by a court of law

Clients should be aware that if they choose to seek reimbursement under an extended health plan they may be asked to sign a waiver of confidential information, in which case the therapist would be required by the insurance company to supply them with any information about the client that they demand.

In the case of group therapy, all members of the group share responsibility for maintaining privacy of the personal information discussed in the group. Although therapists are bound by legal and professional standards to holding clients’ information confidentially, members of the group are bound simply by moral values. We will discuss privacy at the outset of group therapy and ask all group members to commit to not discussing the content of sessions outside of the group.

The College of Psychologists of British Columbia regulates the profession of psychology in the public interest in accordance with the Health Professions Act of British Columbia by setting the standards for competent and ethical practice, promoting excellence and taking action when standards are not met. Information about the College and relevant laws, Code of Conduct, and guidelines pertaining to provision of psychological services in BC can be obtained from their website at [www.collegeofpsychologists.bc.ca](http://www.collegeofpsychologists.bc.ca). If clients have a complaint about services that they have received, they have the right to make a formal complaint (signed and in writing) to the College. Their address is #404 – 1755 West Broadway, Vancouver, BC V6J 4S5.

**Teaching Clinic**

The UBC Psychology Clinic is a specialized training clinic within the Department of Psychology. Graduate student therapists are supervised by Registered Psychologists and typically work on a team with 1 to 3 other graduate student therapists. Details of a client’s care may be discussed during team supervision meetings with those other therapists. All members of the treatment team are bound by the same ethical guidelines and a client’s information will not be shared beyond the treatment team.

In some cases, details of a client’s care may be shared in a graduate course for the purposes of teaching students how to communicate effectively about clinical work. In such situations, all identifying information (e.g., name, age, type of job) would be changed to ensure client confidentiality before information is presented. Members of this class are bound by the same ethical guidelines noted above and a client’s information will not be shared outside the context of the class.

For the purposes of teaching, assessment and treatment sessions may be observed by the treatment team through a one-way window, the supervisor may sit in on the session, or sessions may be video- or audiotaped. If sessions are recorded, the recordings are treated as confidential information and stored in a locked cabinet. Recordings are destroyed once they are no longer needed for supervision. No recordings are kept after services have ended.

**Policies Regarding Appointments**

Appointments for individual psychotherapy are generally 50 minutes in length. We ask that clients provide at least 24 hours notice of any cancellation by calling the Clinic office (604-822-3005). If a client is late for an appointment the session will end at the scheduled time.

**In Case of Emergency**

The UBC Psychology Clinic is unable to provide 24-hour emergency services. Messages left on the office voicemail are generally retrieved each weekday and calls will be returned as soon as possible. In the event of an emergency, clients are advised to contact their family physician, to attend the nearest hospital emergency room, or to call the crisis line at 604-872-3311.

**Acknowledgement and Consent for Adult Clients**

I, the undersigned, acknowledge that I have had the opportunity to read this document carefully, and have had the opportunity to ask any questions or concerns I have about it or arising from it. I am aware that I will be provided with a copy of this document (without signatures). My signature below indicates that I have read and understood the information in this document and agree to abide by its terms.

In knowledge and appreciation of the benefits and risks as made known to me by the UBC Psychology Clinic, and as reflected in this form, I hereby give my consent to participate in assessment and/or treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name Witness Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Witness Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Date

**Acknowledgement and Consent for Child Clients**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, acknowledge that I have had the opportunity to read this document carefully, and have had the opportunity to ask any questions or concerns I have about it or arising from it. I am aware that I will be provided with a copy of this document (without signatures). My signature below indicates that I have read and understood the information in this document and agree to abide by its terms.

I am the Parent or Legal Guardian of the above named person. In knowledge and appreciation of the benefits and risks as made known to me by the UBC Psychology Clinic, and as reflected in this form, I hereby give my consent to participate in assessment and/or treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Name Witness Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Signature Witness Signature

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Date Date

**Appendix D**

**UBC Psychology Clinic**

2136 West Mall, Vancouver, BC, V6T 1Z4

Phone: 604-822-3005⏐Fax: 604-822-6923

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**Consent to Release and Receive Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

initial

I hereby authorize the UBC Psychology Clinic to **release** information concerning my case, with the noted limitations, to the person or agency listed below.

initial

I hereby authorize the UBC Psychology Clinic to **request and receive** information concerning my case, with the noted limitations, from the person or agency listed below.

I understand that I may revoke or amend this consent in writing at any time.

Agency or Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This request is confined by the following limitations:

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Date Client Signature

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness

**APPENDIX E**

**UBC Psychology Clinic**

2136 West Mall, Vancouver, BC, V6T 1Z4

Phone: 604-822-3005⏐Fax: 604-822-6923

**Consent Form for Observation and Intervention in School Settings**

I, the undersigned, agree to allow my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to be observed in his/her school. I also agree to allow \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to discuss my child with school officials. The purpose of these observations and school contact will be to aid in developing an intervention for my child. I understand that all information concerning my child will be kept in strict confidence. I understand that the details of this intervention will be shared with me prior to the initiation of that intervention. I also understand that I will be billed for school observations and contacts as per the fee agreement I have signed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Name Witness Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian Signature Witness Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Date

**Appendix F**

**UBC Psychology Clinic**

2136 West Mall, Vancouver, BC, V6T 1Z4

Phone: 604-822-3005⏐Fax: 604-822-6923

**PROGRESS NOTE**

**Client Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Supervisor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Contact:** ☐ Office ☐ Phone Duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Session Type:** ☐ Individual ☐ Couple ☐ Family ☐ Group

**Individuals in Session:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self-Report Measures Score(s) if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Clinical Presentation:** (Client’s subjective report of symptoms since last session; in-session observations of client affect, behavior, appearance, speech, thought attitude; any risk assessment (suicide/violence); and any changes to diagnosis or medications)

**Session Synopsis & Interventions:** (Brief narrative of session, including content, process, and new issues; description of specific interventions/techniques/strategies used & client response, including progress toward goals.

**UBC Psychology Clinic**

2136 West Mall, Vancouver, BC, V6T 1Z4

Phone: 604-822-3005⏐Fax: 604-822-6923

**Plan:** (Homework assigned; treatment plan for the following session; date of next session)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist’s Signature Supervisor’s Signature**

**Appendix G**

**UBC PSYCHOLOGY CLINIC**

2136 West Mall, Vancouver, BC, V6T 1Z4 Phone: 604-822-3005⏐Fax: 604-822-6923

**TERMINATION SUMMARY**

***~For Archive~***

Client #:

Date:

Student Therapist:

Supervisor:

Client’s Name:

Age: Gender:

Address:

Home Telephone #: Alternate Telephone #:

Presenting Complaint:

Dates of Contact (inclusive):

Referral Source:

Recommendation at Termination (if relevant):

Subsequent Referral:

Notes:

**Date Record Destroyed**:

**APPENDIX H**

**UBC PSYCHOLOGY CLINIC**

2136 West Mall, Vancouver, BC, V6T 1Z4

Phone: 604-822-3005****Fax: 604-822-6923

**TERMINATION REPORT**

Client Name: XXXXX YYYYY

Client Number: XXXX-XXX

Date of Birth: XXXX XX, 19XX Date of Report: XXXX XX, 20XX

Ms. XXX presented to the UBC Psychology Clinic with difficulties with anger in interpersonal situations, present since childhood. She was seen for an initial intake assessment, as well as 17 sessions of individual therapy involving a mixture of CBT and DBT techniques that included examining and challenging automatic thoughts as well as in session role-play and in vivo exercises of alternative ways of asserting herself. Over the course of therapy, Ms. XXX became aware of the painful thoughts and emotions underlying her anger, and both the passive and aggressive behaviors that result from these. Further, she was able to challenge many of her automatic thoughts and was able to successfully implement new ways of asserting herself to others. However, Ms. XXX recognized that she needed to continue to actively work on these skills in order to maintain her gains and generalize them to other situations. Further, she recognized the need to monitor herself for passive or aggressive (rather than assertive) ways of communicating.

Therapy ended after 17 sessions as Ms. XXX expressed that she was satisfied with how far she had come in therapy, and due to plans to move away for a year that required time and preparation to implement, she did not want to expend further energy in therapy.

Student’s Name Supervisor’s Name, Ph.D., R. Psych.

Therapist Supervising Psychologist

APPENDIX I

THE UNIVERSITY OF BRITISH COLUMBIA

**UBC Psychology Clinic**

2136 West Mall

Vancouver, B.C. Canada V6T 1Z4

Tel: (604) 822-3005

Fax: (604) 822-6923

 

FILE AUDIT

To be completed by student therapist & signed by supervisor upon termination.

|  |
| --- |
| **CLIENT #** |

|  |  |  |
| --- | --- | --- |
| **DOCUMENT** | **√** | **COMMENTS** |
| Referral Sheet |  |  |
| **Telephone Intake Form** |  |  |
| **Fee Agreement** |  |  |
| **Consent/Assessment & Therapy Form** |  |  |
| **Authorization for Release/Receipt of Information Form** |  |  |
| **Assessment Report** |  |  |
| **Termination Report** |  |  |
| **Termination Summary For Archive** |  |  |

|  |  |
| --- | --- |
| **TESTS & MEASURES (LIST)**  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| SESSION NOTES IN FILE – LIST SESSION DATES |
| #1 | #12 | #23 |
| #2 | #13 | #24 |
| #3 | #14 | #25 |
| #4 | #15 | #26 |
| #5 | #16 | #27 |
| #6 | #17 | #28 |
| #7 | #18 | #29 |
| #8 | #19 | #30 |
| #9 | #20 | #31 |
| #10 | #21 | #32 |
| #11 | #22 | **TOTAL:** |

FOR ADDITIONAL ENTRIES SEE REVERSE PAGE

**Signature of Student Therapist Signature of Supervisor**

## Print Name Print Name

|  |
| --- |
| SESSION NOTES IN FILE – LIST SESSION DATES (CONT’D) |
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**APPENDIX J**

(NOTE: This form is printed on **BLUE** paper)

OFFICE USE ONLY

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Approved

□ Declined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



UBC Department of Psychology

Practicum Approval

To be completed and returned to the Practicum/Internship coordinator well in advance of the start of the practicum. Note that practica/internships will not be credited unless approved in advance by the clinical area. You will be notified in writing of this approval.

### Date:

Student:

Faculty Supervisor:

Practicum will begin: End:

Practicum is: Full time Part time (Expected hours/wk: )

(If you are planning to combine placements you must present the entire plan for approval.)

Agency (give complete address):

Site Supervisor:

Phone Number: /E -mail:

Is this a paid position? Y / N

Approval may be sought for applications to more than one practicum placement. Please list additional agency names on this form so long as they are all found on the Practicum Support Website. Use a separate Approval Form for any agency not listed on the website.

### Student’s signature Faculty Supervisor’s signature

**Appendix K**

(NOTE: This form is printed on **YELLOW** paper)



OFFICE USE ONLY

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Approved

□ Declined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UBC Department of Psychology

Internship Approval

To be completed and returned to Dr. Ingrid Söchting well in advance of submitting your internship applications. Note that practica/internships will not be credited unless approved in advance by the clinical area. You will be notified in writing of this approval.

Date:

Student:

Faculty Supervisor:

Internship will begin:

Internship is: Full time

Half time

Agency (give complete address):

Site Supervisor:

Phone Number:

e-mail:

Is the internship CPA accredited? Yes\_\_\_\_\_\_

Is the internship APA accredited? Yes \_\_\_\_\_\_ D

No \_\_\_\_\_\_

No \_\_\_\_\_\_

Approval may be sought for applications to more than one internship placement. Append additional addresses and indication of CPA/APA accreditation.

Student’s signature Faculty Supervisor’s signature

**Appendix L**

## (NOTE: The following is sample or template; supervisors and students should collaboratively modify the language to suit their particular needs).

**STUDENT:**

**YEAR IN PROGRAM:**

**DATES OF PRACTICUM:**

**PRACTICUM LOCATION:**

**SUPERVISOR:**

The following contract delineates the guidelines agreed upon by the student and the supervisor listed above.

***Goals:***

***Knowledge*** *(e.g.,* knowledge of diagnostic issues related to the population served, theoretical underpinnings of case formulation, understanding of ethical principles)

* Develop knowledge of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, including diagnostic criteria.
* Develop knowledge of ethical and clinical issues particular to working with\_\_\_\_\_\_\_\_\_\_\_
* Develop knowledge of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Develop knowledge of evidence-based practice of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Assessment***(e.g., familiarity with a clinical assessment interview, ability to administer, score and interpret relevant psychometric tests)

* Develop skill in administering unstructured interviews, standardized and unstandardized rating scales, and observational measures as pertaining to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Develop skill in integrating information from multiple informants and sources
* Develop skill in case formulations and treatment planning based on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Develop skill in writing assessment and other reports

***Treatment***(e.g., ability to create and implement a treatment plan, ability to conduct a therapy session alone, ability to evaluate client progress as therapy proceeds, ability to develop a therapeutic alliance and an appropriate professional stance for that form of therapy)

* Develop skill in presenting treatment plans to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Develop skills in implementing and monitoring \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ treatments
* Develop skills in recognizing the limitations to manualized treatments, and in modifying these as appropriate for particular clients
* Develop skills in building rapport with clients, and in self-reflecting on your behavior as a therapist

***Administrative***(e.g., integrate interview and test material in an assessment report, summarize weekly progress in a summary note, ability to effectively terminate a therapy case [i.e., determining need for other referrals, making new referrals, closing a file])

* Develop skills in case documentation (e.g., writing progress notes)
* Develop skills in inter-professional communication (e.g., consulting with other treatment providers or agencies)
* Develop skills in case management (e.g., arranging referrals)

***Supervision***(e.g., ability to conceptualize and summarize weekly sessions for supervision, openness to discussing difficult therapy experiences, willingness to try new approaches, openness to feedback)

* Develop skills in summarizing sessions, identifying areas for development (e.g., what do you which you had done differently in session), and in planning next steps of treatment, including strategies for overcoming barriers or obstacles to treatment
* Develop skills for integrating empirical literature with clinical planning

***Clinical Activities:***

1. To complete a minimum of \_\_\_\_ assessments including clinical interview and relevant psychometric tests. Draft reports will be written within \_\_\_\_\_\_\_\_\_\_\_\_ of completion of the assessment and presented for review and, after revision, countersigning.
2. Cognitive Behavioural or \_\_\_\_\_\_\_\_\_\_treatment of a minimum of \_\_\_\_ clients over the course of the year.
3. Completion of weekly summary notes within one week of each session, and presentation of these notes at supervision for countersigning.
4. Completion of draft termination reports within 1 week of completion of treatment and presented for review and, after revision, countersigning.
5. Completion of termination process sheet (referral, termination note, file closure) within 1 week of therapy termination.
6. Participation in weekly group supervision sessions, and individual supervision as required.

***Supervision:***

1. Supervision will be provided by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Supervision sessions will be for \_\_\_\_\_\_\_\_\_\_\_\_, with additional individual item as needed.
3. During these sessions, the student will provide:
* a summary of the previous session
* a description of any difficulties or successes during the session
* suggestions of future directions

4. Supervisor will review sessions by videotape for all assessment and treatment sessions, and up to 1 hour per week of additional client sessions. The 1hour chosen is at the student’s discretion.

5. Feedback will be provided by supervisor in the form of notes and in person supervision.

SIGNATURES:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practicum Student Practicum Supervisor Clinic Director

**Appendix M**

**UNIVERSITY OF BRITISH COLUMBIA**

**CLINICAL PSYCHOLOGY PROGRAMME**

**PRACTICUM STUDENT EVALUATION FORM**

Instructions to supervisors:

The evaluation process is an important part of clinical training and we appreciate your time and effort in providing us with your observations. The information that your provide will be used to help guide the student’s traiing trajectory. Thank you again for your time.

### **SECTION A**

Date:

Student’s name:

Supervisor’s name:

Location of practicum:

Full-time Practicum

Part-time Practicum

Summary of Activities

Total number of practicum hours completed

* Sum of A+B+C below
1. Number of hours in service-related activities
	* + Sum of i+ii
	1. *Number of hours in face-to-face client contact*
		* Treatment/intervention, assessment interviews, testing
	2. *Number of hours in other service-related activities*
		* Report-writing, case presentations, and consultations
2. Number of hours in supervision
3. Number of indirect hours
* Prep time, background reading, observing other students

### **SECTION B**

Please rate the student’s performance by placing a check mark on the rating scale indicated in the table.

**Not Applicable:** Given to students who did not have the opportunity to obtain experience or demonstrate skill in the defined area.

**Below Expectations:** Given to students whose knowledge or skill performance was below the level expected based in his/her level of education, training, and experience. Suggests that a remediation plan needs to be developed.

**Emerging:** Given to students whose knowledge or skill is nascent in the defined area.

Suggests that this is an area in which the student should focus attention in the coming year.

**Demonstrating Good Progress:** Given to students whose knowledge or skill in the defined area is developing well given his/her level of education, training, and experience.

Suggests that the student should continue to acquire experience and hone skills, but that this area need not be a major focus of attention.

**Ready for Internship:** Given to students whose knowledge or skill in the defined area well-developed. Suggests that the student is ready for internship.

**Evidence-Based Practice**

Progress

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not Applicable** | **Below Expectations** | **Emerging** | **Demonstrating Good Progress** | **Ready for Internship** |
| Articulate a rationale for decisions and psychological services that relies on supporting data (e.g., research results, base rates, epidemiological data) |  |  |  |  |  |
| Apply evidence-based criteria in selection and adaptation of assessment methods (e.g., psychometric properties, cost effectiveness, relevance, norms) |  |  |  |  |  |
| Administer and score assessment instruments for children or adults |  |  |  |  |  |
| Interpret and synthesize results from multiple sources (e.g., multiple methods of assessment, multiple informants) |  |  |  |  |  |
| Formulate a diagnosis, recommendation, and/or professional opinion using multi-axial diagnostic criteria using multiple methods |  |  |  |  |  |
| Communicate assessment results in an integrative manner (e.g., psychological evaluation reports, feedback to clients) |  |  |  |  |  |
| Select, apply, and modify interventions to treat specific disorders or functional concerns based on available research evidence and contextual factors |  |  |  |  |  |
| Engage in collaborative intervention planning with client(s) and stakeholders |  |  |  |  |  |
| Evaluate effectiveness of psychological services (e.g., individual therapy outcomes, program evaluation) |  |  |  |  |  |
| Engage in consultation and collaboration across professions. |  |  |  |  |  |
| Other (please specify): |  |  |  |  |  |

**Ethics and Professionalism**

Progress

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not Applicable** | **Below Expectations** | **Emerging** | **Demonstrating Good Progress** | **Ready for Internship** |
| Perform ethically in all areas of clinical practice (e.g., informed consent, confidentiality, relationships, maintenance of records, assessment procedures, limits on practice) |  |  |  |  |  |
| Identify and observe boundaries of competence in all areas of professional practice |  |  |  |  |  |
| Demonstrate respect for others in all areas of professional functioning |  |  |  |  |  |
| Accurately represent and document work performed in scholarship and professional practice |  |  |  |  |  |
| Use specific skills related to ethical issues that commonly arise in the practicum setting |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not Applicable** | **Below Expectations** | **Emerging** | **Demonstrating Good Progress** | **Ready for Internship** |
| Other (please specify): |  |  |  |  |  |

**Supervision**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not Applicable** | **Below Expectations** | **Emerging** | **Demonstrating Good progress** | **Ready for Internship** |
| ***Student as Supervisee*** |
| Collaboratively develop a training plan with supervisor |  |  |  |  |  |
| Communicate openly about concerns/preferences for supervision format |  |  |  |  |  |
| Prepare for supervision meetings (e.g., questions, session summary, written work, assigned readings) |  |  |  |  |  |
| Admit errors and respond to supervisor feedback |  |  |  |  |  |
| Participate actively in group/team meetings |  |  |  |  |  |
| Critically evaluate own competence through self- assessment and feedback from others |  |  |  |  |  |
| Identify the impact of aspects of self in therapy and supervision |  |  |  |  |  |
| ***Student as Supervisor*** |
| Develop a basic training plan for trainees |  |  |  |  |  |
| Develop and communicate formative and summative evaluations of supervisees’ work |  |  |  |  |  |
| Provide specific feedback regarding therapeutic technique |  |  |  |  |  |
| Match supervision style and content to the individual needs of supervisee and context |  |  |  |  |  |
| Other (please specify): |  |  |  |  |  |

**Interpersonal Competence and Communication**

Progress

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not Applicable** | **Below Expectations** | **Emerging** | **Demonstrating Good Progress** | **Ready for Internship** |
| ntegrate and apply theory, research, and professional guidelines to work effectively with individuals, families, and groups with diverse social and cultural contexts |  |  |  |  |  |
| Communicate effectively in oral and written format in scholarly and practice settings |  |  |  |  |  |
| Identify and manage interpersonal conflict |  |  |  |  |  |
| Develop warm and constructive working alliance with clients and relevant stakeholders |  |  |  |  |  |
| Other (please specify): |  |  |  |  |  |

**Descriptive Evaluation and Recommendations**

Please take a moment to briefly describe the student’s specific strengths and areas for development:

Strengths:

Areas for Development:

If you have any recommendations as to the specific types of activities that you think would be useful for this student in helping him/her to progress in his/her training trajectory, please list them here:

**Achievement of Supervisor/Supervisee Goals**

Please rate the degree to which the goals outlined in the Practicum Training Contract were achieved, using the following scale:

1. **Strongly Disagree**
2. **Disagree**
3. **Neither Agree or Disagree**
4. **Agree**
5. **Strongly Agree**

|  |  |
| --- | --- |
| Goal | Rating 1-5) |
| The clinical activity goals outlined in the contract were met by the end of the practicum |  |
| The supervision plan outlined in the contract (e.g., format, frequency, etc.) was upheld throughout the practicum |  |
| The contract’s assessment and therapy training goals were met by the end of the practicum |  |

Signature of Supervisor Signature of Student

Date: Date:

**Appendix N**

**Supervisor Evaluation Form**

**Supervisor(s): \_\_\_**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practicum Site:**

Supervision is an interactive process in which the supervisor also learns and improves. Learning and improving result from validation as well as from highlighting areas needing attention. This evaluation tool is designed to allow constructive feedback along that spectrum.

In completing this evaluation, you may find it useful to review the contract you signed with the practicum supervisor prior to beginning the practicum.

Your feedback will be kept confidential in the following ways. First, if there was more than one supervisor, you can rate either the overall quality of supervision at that site, or you can complete ratings for each supervisor individually. Second, your evaluation will initially be available only to the Director of Clinical Training (or to the Clinic Director in the case of the evaluations made for the DCT). However, in order to provide constructive feedback to supervisors and external practicum sites, the DCT (or Clinic Director, as appropriate) will aggregate the feedback offered by multiple students over multiple years (at least 4 students over at least 2 years) and provide this to the supervisors/sites. Again, you are of course free to share your comments directly with supervisors at any time. You also are encouraged to speak with the Director of Clinical Training if you have concerns about being identified by this evaluation, as alternate ways to keep the information confidential may be possible.

Please rate your agreement with each of the following statements. If you had multiple supervisors you may choose to evaluate them collectively or complete separate evaluations for each of your primary supervisors. Your narrative commentary is also welcomed and can be included on the final page. Such comments are very useful, as item-based lists do not adequately cover all facets of supervision.

1. The supervisor assisted me in meeting the goals we agreed upon in the practicum contract (e.g., regarding assessment, therapy, administration, supervision).

1 2 3 4 5 6 7

Strongly Disagree

 Neutral Strongly

 Agree

1. The supervisor was dependable and accessible (e.g., kept appointments and adhered to schedule, could be reached if needed).

1 2 3 4 5 6 7

Strongly Disagree

 Neutral Strongly

 Agree

1. The supervisor read and commented on my reports and progress notes in a timely and useful fashion.

1 2 3 4 5 6 7

Strongly Disagree

 Neutral Strongly

 Agree

1. The supervisor gave useful pointers about techniques – helped me with what to say/do in assessments/therapy.

1 2 3 4 5 6 7

Strongly Disagree

 Neutral Strongly

 Agree

1. The supervisor suggested resources or readings appropriate for my cases, or provided additional learning experiences when possible (e.g., opportunities to observe therapy).

1 2 3 4 5 6 7

Strongly Disagree

 Neutral Strongly

 Agree

1. The supervisor related clinical work to research and/or theory and was knowledgeable about treatments and/or assessment, and for which presenting problems the treatments are most effective.

1 2 3 4 5 6 7

Strongly Disagree

 Neutral Strongly

 Agree

1. The supervisor assisted with my understanding of ethical and legal issues.

1 2 3 4 5 6 7

Strongly Disagree

 Neutral Strongly

 Agree

1. The supervisor assisted with my understanding of issues related to diversity.

1 2 3 4 5 6 7

Strongly Disagree

 Neutral Strongly

 Agree

1. The supervisor supported my voicing of differences of opinion regarding his/her suggestions.

1 2 3 4 5 6 7

Strongly Disagree

 Neutral Strongly

 Agree

1. The supervisor was open and non-judgmental. We could discuss both the strengths and weaknesses of my skills.

1 2 3 4 5 6 7

Strongly Disagree

 Neutral Strongly

 Agree

1. The supervisor increased my awareness of my therapeutic style and the impact on the client/therapy while at the same time allowing for difference in style of therapist.

1 2 3 4 5 6 7

Strongly Disagree

 Neutral Strongly

 Agree

1. The supervisor offered criticism and suggestions in a constructive, supportive way, and feedback was appropriate to my level of training.

1 2 3 4 5 6 7

Strongly Disagree

 Strongly

 Neutral Strongly

 Agree

1. In group supervision settings, the supervisor encouraged participation from all students and treated students equally.

1 2 3 4 5 6 7

Strongly Disagree

Neutral Strongly Agree

My overall evaluation of the supervisor:

1-------------2-------------3-------------4-------------5-------------6-------------7 -------------N/A

Negative Neutral Positive

The best thing about my supervisor/supervision was:

The thing most needing improvement in my supervisor/supervision was:

Any recommendations regarding what level or type of student this practicum experience would be most useful for?

Other comments?