**Arizona State University**

# Clinical Psychology Program Handbook

A Guide to Policies and Procedures for Students and Faculty

**2020-2021**

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# I.    Mission Statement

Our program is based on a clinical science model of training. Our mission is to prepare students (a) for professional careers in a variety of settings where they engage in research, teaching, or clinical supervision, and (b) who make contributions to clinical science by disseminating research findings and scholarship. Within this general mission of providing high-quality, science-based training, we strive to prepare a significant number of graduates who establish careers in academia and research institutes where they have primary responsibilities for conducting research that advances clinical science and for teaching new generations of clinical scientists.

The program operates on the principle that scientific training is critically important—not only for preparing students for academic and research careers but also for preparing students for professional practice that is grounded in clinical science research foundations. In turn, sound clinical and prevention research must be based on experience in practice. Because of this inherent reciprocal relation between clinical science and practice, we maintain a commitment to integrated training in both the scientific and professional aspects of clinical psychology. This is a core value in our clinical science training model. With the program's accreditation by the Psychological Clinical Science Accreditation System (PCSAS) in December 2011, we affirmed our commitment to clinical science training that emphasizes the conduct of clinical research, the dissemination of research findings, and the application of evidence-based interventions. A critical aspect of our training philosophy is that science-centered training in clinical psychology involves the sequenced coordination of faculty mentorship, coursework, supervised research, and supervised clinical experience. In addition to coursework, milestone research projects, and clinical training experiences, we strongly believe in the importance of active engagement with the program, department, university, and broader community. Active engagement includes efforts to directly contribute to the department and university (e.g. committee involvement) and the broader community (e.g. volunteer clinical services to community agencies). We hope that these experiences will instill values that will continue to engender commitment to and engagement with the community among our graduates.

Our graduates establish successful careers in academia, professional practice and other research settings where they use the clinical science training they pursued as graduate students. Outcomes of a recent alumni survey (students at least five years post-graduation) in 2020 provide support for our success in achieving Clinical Science outcomes, with 37 of 38 (97.4%) making scholarly/research contributions since graduation. Our data on graduates from the past 10 years also shows diversity in professional activities that is consistent with our clinical science training model. Among those beyond postdoctoral training (n = 54), 40.7% are in academic settings, 33.3% are in clinical or combined research and clinical positions in medical schools/centers, VA hospitals, or other hospital settings, 22.2% are in other practice environments such as mental health centers or private practices, and 3.7% are in government settings (e.g., public health, DoD). These data suggest that our training leads to career trajectories that are consistent with the program's philosophy and goals. Our graduates also report a diverse range of activities including psychotherapy (64%), research (57%), supervision (48%), consultation (46%), teaching (43%), administration (39%), assessment (36%), and preventive interventions (14%).  Over half (55%) of our graduates work with children, 68% work with health care recipients, and 80% serve ethnic minorities. These numbers reveal the rich professional lives of our graduates.

# II. Areas of Emphasis

The Clinical Training Program has three areas of emphases in which students may elect to participate: health psychology, child clinical psychology, and community/prevention.

It has been our experience that most of our students will choose one of the 3 emphasis areas which represent domains of faculty interest as well as clinical or preventive specialties for which an employment demand now exists. However, specialized training in one of these emphasis areas is *not a* program requirement. Some students might begin a particular emphasis but later decide to move in a different direction. Thus, the descriptions that follow are designed to give you an idea of the curricular choices available.

## The Health Psychology Area of Emphasis

Clinical students with interests centering on the interface of psychology and medicine may select Health Psychology as an area of emphasis. In our program, health psychology is broadly interpreted to encompass the theoretical, methodological, and/or procedural (treatment and prevention) contributions from contemporary psychology that bear upon the existing and emerging problems of modern medicine.

Such areas of study include (but are not limited to): patient noncompliance, chronic illness management, analysis and modification of lifestyle and thinking patterns that place individuals at risk for serious illness, physiological correlates of maladaptive behavior patterns, psychosocial assessment and/or screening of medical patients, assessment and treatment of acute and chronic pain, the analysis of life stress in disease, psychosocial factors in immunologic functioning, and the role of psychosocial moderators/ mediators in stress-illness relations (including such factors as social support, temperament, goal systems, etc.). These topics and others represent the current interests of full- time and adjunct faculty in clinical psychology as well as those in graduate programs in social psychology and behavioral neurosciences.

Some features of the health psychology area include:
> (1) training students to develop skills and knowledge in dealing with life-span biopsychosocial issues. Active research on health-relevant topics currently exists with children, adults, and aging populations as target groups;
> (2) a strong commitment to a <u>preventive focus</u>. Early identification of groups at risk constitutes an important domain of research for a number of our faculty;
> (3) excellent support from the local Phoenix community in terms of the availability of hospitals, clinics, and private medical practitioners willing to assist ASU faculty and students in their research pursuits.

Students electing to emphasize health psychology are advised to take the graduate course offering Introduction to Health Psychology and to select from a number of topical seminars (e.g., Emotions, Stress & Health) or advanced treatment method courses (e.g., Mindfulness) as dictated by their own interests and course availability. It is advisable to pursue both MA and Ph.D. research in the domain of health psychology, as well as to complete the one-year, APA-approved internship at a site permitting further development of intervention/diagnostic skills

with medical populations. Over the years, graduates of our program who have emphasized health psychology have found employment both in academic and in health-care settings.

**The Child Clinical Area of Emphasis**

The child clinical area of emphasis provides training in the etiology, assessment, treatment and prevention of childhood disorders. A major focus is on the prevention of child mental health problems among children and families under stress. Thus, most of our child clinical faculty also participate in our community-prevention area of emphasis.

Training is provided through formal courses, faculty- supervised research projects, in-house clinical practica, placements at mental health agencies in the community, and outreach efforts with local schools.  Students have an opportunity to work with faculty who are studying topics such as: the influence of stress and coping on children's mental health, children of divorce, effects of bereavement, minority mental health, family and contextual influences on risk and resilience, longitudinal studies linking child risk and resilience to later life outcomes, the development and intergenerational transmission of substance use disorders, outcomes for serious juvenile offenders, and the development and evaluation of prevention programs for children and their families. We emphasize the importance of a developmental perspective and students have opportunities to work with faculty in Developmental Psychology.

In addition to clinical core courses, several additional courses and experiences are recommended for students with child clinical interests. Students are encouraged to take Developmental Psychopathology and Child and Family Therapy. For their two ATM courses, students are encouraged to select those that focus on children and families. For the cognitive, affective and social bases requirements, students are encouraged to take courses in social, emotional and cognitive development.  Also, students are encouraged to select child clinical topics for their Masters and Dissertation projects. It is recommended that students complete a clinical placement and internship at child clinical sites.

*Relevant Course Offerings in the Psychology Department.* Over and above our core clinical curriculum, graduate courses in the Psychology Department that are focused on child clinical psychology include:  Developmental Psychopathology, Child and Family Therapy, Social Emotional Development, Child Language and Drawing, Cognitive Development, Seminar in Prevention Research, Child Assessment, Developing Preventive Interventions, Prevention Programs for Children of Divorce, Peer Relations and Social Competence, Growth Modeling, and Statistics in Prevention Research.

*Other Relevant Resources.*  Child clinical training at ASU benefits from the presence of the ASU Research and Education Advancing Children's Health (REACH) Institute, which provides research assistantships in a variety of large-scale field projects and intervention trials focused on the prevention of mental health problems for children and families under stress. In addition, students are eligible for pre-doctoral fellowships in our NIDA-funded prevention training grant. All clinical students are invited to attend the weekly seminar meetings of this training program to discuss topics in child mental health and primary prevention. In addition,

our in-house training clinic provides opportunities for practicum classes in child assessment and treatment, and work with local schools. The Psychology Department also houses a Child Study Laboratory with programs for preschool children and research opportunities. The Quantitative program within the Psychology Department provides training in the methodologies necessary for longitudinal studies of developmental trajectories and for evaluating the effects of intervention on those trajectories.

Outside of the Psychology Department, faculty from ASU's School of Social and Family Dynamics teach a variety of relevant courses and offer research opportunities for our students.

*Child clinical placements in the community*. Interested students can complete their required clinical placements in community settings that deliver services to children and families such as Phoenix Children's Hospital and Southwest Human Development. In addition, placements are available within the child and family team of our in-house training clinic, including work with child assessment and treatment, and outreach work with local schools.

## The Community/Prevention Area of Emphasis

We define the Community/Preventive area of emphasis to include theory, research methods, and interventions that are designed to prevent the occurrence of mental health, substance use or other problems, and to promote healthy adaptation in a range of social environments. Students study theoretical issues such as the influence of stress and coping, family processes, acculturation and cross-cultural issues, neighborhood influences, and economic hardship on the development of mental health or substance abuse problems. Students also become involved in the development, implementation, and evaluation of preventive interventions to promote healthy adaptation for children in a range of high-risk situations. Foci of preventive interventions include children of divorce, inner-city ethnic minority children, bereaved children, and school-based programs.

Some features of particular strength of the Community/Prevention area at ASU include the opportunity for students to be involved in the development, implementation, and evaluation of preventive interventions in close collaboration with the faculty. Our prevention program emphasizes a close integration between theory, intervention development and evaluation, and methodology.  Students also have the opportunity to be involved with research projects that have focused on the study of child and family adaptation to high-stress situations such as divorce, bereavement, and acculturation; and the development, implementation, and evaluation of preventive interventions.

Students with an emphasis on Community/Prevention are strongly encouraged to attend the weekly informal seminar in Prevention Research. Students are also advised to take Advanced Treatment Methods courses in which they get hands-on experience in the development and implementation of preventive intervention programs and to take methodology courses such as Prevention Research Methodology, which provide skills in the analysis of community-based studies. It is also recommended that students become involved in field placements in community-based agencies, and conduct their MA and Ph.D. research in prevention or community research.

# III.  Timeline for Satisfactory Progress

To maintain satisfactory standing, students should maintain a B average in courses, complete milestones in a timely fashion, and show good progress in the development of professional competencies.

The timeline for students entering without a master's degree or significant prior graduate work:

Master's thesis prospectus:  fall semester, second year
Master's thesis data meeting: spring semester, second year
Master's thesis defense: fall semester, third year
Comprehensive exam submission: first day of classes, fall semester, fourth year
Dissertation prospectus: October 1, fifth year
Internship readiness: early October, fifth year

Students who are admitted with a master's degree or significant prior graduate work should see the full description of comprehensive examination policies.

Satisfactory progress in clinical training is evaluated in all practicum courses, clinical placements, and internships.  Work as a teaching assistant or research assistant is evaluated annually by supervisors.

Students' annual reviews by the clinical faculty coincide with the timeline shown above. Coursework, research, and professional training (clinical work and teaching) are evaluated during annual reviews.   Students receive letters from the Director of Clinical Training that describe the results of annual evaluations.

# IV.  Doctoral Program Requirements

The basic training activities within the clinical program include:

I.      <u>Required Core Courses</u>: Courses covering the scientific and technical foundations of clinical psychology, as well as clinical practica are required:

Analysis of Variance (Intermediate Statistics), Multiple Regression, Mechanisms of Psychopathology, Clinical Research Methods, Psychotherapy or Child and Family Therapy, Psychological Assessment or Assessment ATM, Clinical Interviewing and Ethics, and Clinical Practicum.

II.     <u>Electives</u>: Various courses, seminars, and practica of the students' choosing are included in this category and are used to satisfy additional program requirements as outlined below.

III.    <u>Other Course Requirements</u>:

   A. Two (2) **Advanced Treatment Methods** (ATM) courses are required which involve integrated science-professional training and are taught by departmental faculty in timely and specific clinical and community modalities.

   B. In order to satisfy requirements for program accreditation, students are also required to demonstrate foundational knowledge in Biological Bases of Behavior, Social Bases of Behavior, Cognitive Bases of Behavior, Affective Bases of Behavior, Human Development, and History and Systems, and to demonstrate advanced integrative knowledge of these areas at the graduate level.

IV.     <u>Masters Thesis</u>: The Master's Thesis must be an empirical investigation. A three-person thesis committee is required, including one person from outside the clinical training area or outside the topic area. An oral defense is required.

V.      <u>Supervised clinical placements</u>: Beginning in the third year, students may engage in supervised clinical work with a community clinical service agency. Two years of quarter-time (10 hours per week) or one year of half-time (20 hours per week) of placement training are required. A faculty committee coordinates these.

VI.     <u>Comprehensive Examination</u>. Students are required to successfully pass a comprehensive examination prior to initiating dissertation research. To qualify for the comprehensive examination, students must complete a master's thesis, maintain a minimum of a B average in all required coursework, and have overall "satisfactory" ratings in their clinical/professional activities. Students write either a literature review of a substantive area of clinical psychology or a grant application similar to those that seek funding for dissertation research. The comprehensive exam includes an oral defense. For students who are admitted without a master's degree, comprehensive examination papers are submitted on the first day of the fall semester of the fourth year.

VII.     Full-time Internship: An APA-approved internship is required for graduation in Clinical Psychology. Students must have an approved dissertation prospectus by October 1 of the fall semester in which they apply for an internship. It is expected that the student will have completed analysis of dissertation data prior to leaving on internship.

VIII.    Dissertation Research: The dissertation must be an empirical investigation, and includes an oral defense. A four-person thesis committee is required. One person must be from outside the clinical training area or outside the topic area.

VII.     Curricular coverage of diversity issues is another important aspect of graduate training that is achieved in our core courses and other required courses. Students are exposed to diversity issues, through the infusion of this material throughout our core curriculum. In addition, students can participate in numerous research projects that are concerned with diversity in age, ethnicity, and gender. Specific course requirements are outlined on the following pages.

VIII.    In addition to required coursework, research milestones, and clinical practica, students are expected to actively engage with the departmental, university, and broader communities. This includes regular attendance at the Clinical Area Seminar or Prevention Seminar, involvement in departmental committee work, and engagement in service to the community (e.g. volunteer clinical work outside of formal clinical practicum placements).

Required Courses for Students who enter with a Masters Degree
For students who enter our program with prior graduate training, our policy is to evaluate their prior training to determine if it is equivalent to what we offer in our required courses. The student's advisor coordinates this process with the assistance of the Director of Clinical Training. The student is asked to submit a request for the class requirement(s) that he/she wishes to have waived, and to submit the syllabi for his/her previous equivalent classes. Our instructors review these syllabi to judge whether they are equivalent. If so, that course requirement is waived. If any of the student's previous coursework is accepted, the student will transfer in 30 credit hours from their Master's degree. However, only the specific courses that are waived will count toward requirements of the clinical area and toward APA requirements and licensure.

Graduate Student Mentoring
Entering students are each assigned to a clinical faculty member who, on the basis of the initial match of interests, serves as a temporary academic/research advisor. During the student's first year, there are ample opportunities to get to know other faculty and their respective interests. By year two, a student will have selected his or her master's thesis committee and major advisor. The advisor serves as the student's primary consultant in matters such as course selection, placement and internship choices, and general career development.

# V. Required Clinical and Broad and General Coursework

I.  Required Core Courses: Specific courses covering the scientific and technical foundations of clinical psychology and clinical practica are required and include:

    PSY 530      Analysis of Variance (Intermediate Statistics)
    PSY 531      Multiple Regression
    PSY 573      Mechanisms of Psychopathology
    PSY 578      Developmental Psychopathology (required for child emphasis only)
    PSY 600      Research Methods
    PSY 574/591 Psychotherapy or Child and Family Therapy
    PSY 780      Assessment ATM
    PSY 591      Clinical Interviewing and Ethics
    PSY 680      Clinical Practicum I and II

II. Various courses, seminars, and practica of the students' choosing are used to fulfill remaining program requirements as outlined below.

Other Course Requirements:

Two (2) **Advanced Treatment Methods** (ATM) courses are required which involve integrated science-professional training and are taught by departmental faculty in timely and specific clinical and community modalities.

        PSY 780               All topics listed as ATMs in Psychology
                                   The Assessment ATM also meets the requirement for Psychological Assessment
        PSY 501               Supervised Teaching (can count for 1 of 2 ATMs)

*ATMs taken in other departments require prior approval of clinical faculty for use to satisfy requirements.*

In order to meet requirements for training in discipline specific knowledge (DSK) based on the Commission on Accreditation's Standards on Accreditation (SoA), students must demonstrate foundational knowledge of the History and Systems of Psychology, and graduate level knowledge of the Affective, Biological, Cognitive, and Social bases of behavior and Human Development. Students must also take at least one graduate course that integrates two or more of the DSK areas. With the implementation of the SoA in 2017, students can demonstrate knowledge of DSK in one of two ways.

## Option 1

DSK may be demonstrated through separate courses that demonstrate graduate (or undergraduate in the case of History and Systems) knowledge in each area. For students using this option, the following courses satisfy the requirements for each content area. In order to satisfy requirements for program accreditation based on this option, students are required to take at least <u>one</u> course *each* in:

### Biological Bases of Behavior
PSY 591  Psychobiological Methods *or*
PSY 591  Psychopharmacology

### Social Bases of Behavior
PSY 550  Advanced Social Psychology: Interpersonal Processes *or*
PSY 551  Advanced Social Psychology: Intrapersonal Processes

### Cognitive Bases of Behavior
PSY 535  Cognitive Processes *or*
PSY 591  Embodied Cognition *or*
PSY 591  Cognitive Affective Neuroscience*

### Affective Bases of Behavior
PSY 591  Emotion *or*
PSY 542  Social Emotional Development* *or*
PSY 598  Socioemotional Development

### Human Development
PSY 542  Social Emotional Development* *or*
PSY 591  Children's Peer Relationships *or*
PSY 598  Socioemotional Development
PSY 598  Developmental Transitions
PSY 591  Theories of Development

*PSY 542 can only be used to either fulfill the Affective Bases of behavior requirement OR to fulfill the Human Development requirement. PSY 542 and PSY 591 can be used to fulfill either the foundational knowledge requirement for human development or cognitive bases, respectively or the advanced integrative requirement, but not both.

### History and Systems
PSY 591  History of Psychology *or*
      Undergraduate course on History and Systems from a regionally accredited university

### Integrative Coursework in 2 or more DSK Areas

Social Emotional Development*
Cognitive Affective Neuroscience*
Socioemotional Development

Other courses that are integrative and approved by the clinical faculty

## Option 2

This option involves a combination of undergraduate work or the Subject GRE, and graduate level work. For students who have demonstrated a foundational understanding of DSK areas at the undergraduate level (e.g., coursework on history and systems, cognitive psychology, developmental psychology, and social psychology) or through the Subject GRE (Scores of 70 or better within each area), individual courses on each of these topics is not necessary at the graduate level. Rather, students can take a smaller number of integrative courses that collectively allow for demonstration of graduate level knowledge in these areas.

For example, a student with undergraduate coursework or sufficient Subject GRE Scores in each of these areas could demonstrate integrative graduate level knowledge of the DSK areas by taking Cognitive Affective Neuroscience and Social Emotional Development.*

Note, it is also possible for students who have not demonstrated foundational knowledge in each area at the undergraduate level to do so at the graduate level through completion of additional undergraduate or graduate level coursework. For example, a student who has demonstrated foundational knowledge of all areas other than Cognitive Psychology could take an additional course to meet this requirement while using their other undergraduate coursework to meet the requirement for the other areas.

**Students using Option 2 need approval from the DCT regarding demonstration of foundational knowledge at the undergraduate level and the specific sequence of graduate level courses that will be used to demonstrate advanced integrative knowledge.**

*The combination of Cognitive Affective Neuroscience and Social Emotional Development fulfill integrative training requirements and touch on all DSK areas at the graduate level. Because both courses contain affective content, they can collectively be used to meet both foundational and advanced integrative content for affective bases.

## VI.        Sample General and Child Focused Schedules for Option 1

### SAMPLE SCHEDULE:  GENERAL

Listed below is a sample schedule. Note that, although we outline a five-year sequence in which the degree can be completed, most students finish the degree in six years including internship.

**YEAR ONE**

Fall (12 credits)

Spring (12 credits)

+ Analysis of Variance
+ Psychotherapy (if offered)
+ History and Systems (if no Psychotherapy)
+ Mechanisms of Psychopathology
+ Research (3)

+ Multiple Regression
+ Clinical Interviewing and Ethics
+ Clinical Research Methods
+ Research (3)

**YEAR TWO**

Fall (12 credits)

Spring (12 credits)

+ MA Thesis (3)
+ Clinical Practicum I
+ Multivariate Statistics
+ Assessment ATM or Psychological Assessment

+ MA Thesis (3)
+ Clinical Practicum II
+ Psychotherapy (if not offered in Year 1)
+ History & Systems (if Psychotherapy in Year 1)
+ Elective (Biological Bases of Behavior)

**YEAR THREE**

Fall (12 credits)

Spring (12 credits)

+ Elective (Cognitive Bases of Behavior)
+ Elective (Affective Bases of Behavior)
+ Research (3)
+ Dissertation Research (3)
(1/4 time clinical placement)

+ Elective (Human Development)
+ ATM
+ Research (3)
+ Dissertation Research (3)
(1/4 time clinical placement)

**YEAR FOUR**

Fall (9 credits)

Spring (9 credits)

+ Elective (Social Bases of Behavior)
+ Dissertation Research (3)
+ Elective
(1/4 time clinical placement)

+ ATM
+ Dissertation Research (3)
+ Elective
(1/4 time clinical placement)

**YEAR FIVE**

Fall (1 credit)                                    Spring (1 credit)

+ Internship                                       + Internship

## SAMPLE SCHEDULE:  CHILD CLINICAL EMPHASIS

Listed below is a sample schedule for students who chose a child clinical emphasis. Note that, although we outline a five-year sequence in which the degree can be completed, most students finish the degree in six years including internship.

### YEAR ONE

Fall (12 credits)

Spring (12 credits)

+ Multiple Regression
+ Analysis of Variance                             + Clinical Interviewing and Ethics
+ Developmental Psychopathology                    + Clinical Research Methods
+ Mechanisms of Psychopathology                    + Child and Family Therapy (if offered)
+ Research (3)                                      + Research (3) if C&F Therapy not offered

### YEAR TWO

Fall (12 credits)                                  Spring (12 credits)

+ MA Thesis (3)                                    + MA Thesis (3)
+ Clinical Practicum I                             + Clinical Practicum II
+ Multivariate Statistics                          + Child and Family Therapy (if not offered Year 1)
+ Assessment ATM or Psychological Assessment       + Research (3) (if C&F Therapy in Year 1)
                                                   + Elective (History and Systems)

### YEAR THREE

Fall (12 credits)                                  Spring (12 credits)

+ Elective (Biological Bases of Behavior)          + Elective (Human Development)
+ Elective (Affective Bases of Behavior)           + ATM
+ Research (3)                                      + Research (3)
+ Dissertation Research (3)                         + Dissertation Research (3)
(1/4 time clinical placement)                      (1/4 time clinical placement)

### YEAR FOUR

Fall (9 credits)                                   Spring (9 credits)

+ Elective (Social Bases of Behavior)              + ATM
+ Elective (Cognitive Bases of Behavior)           + Dissertation Research (3)
+ Dissertation Research (3)                         + Elective
(1/4 time clinical placement)                      (1/4 time clinical placement)

### YEAR FIVE

Fall (1 credit)                              Spring (1 credit)

+ Internship                                 + Internship

# Section 2: Program Policies and Procedures

# I.    Financial Support

## Tuition and Fees

ASU posts current and past tuition rates on the [Tuition and Fees Schedule](). Rates for graduate students are broken into three categories: resident, non-resident, and international. Students who wish to change their status to resident (for tuition purposes) must work with the Registrar's Office, which has a webpage dedicated to [Residency for Tuition Purposes](). Updating the status may be a lengthy and complex process.

## Financial Support

We strive to fund all students throughout their course of study but resources are finite. To be fair to all students, we use a system of prioritization to make best use of funds to benefit both students and the department. The following priorities govern use of TA lines only (not RAs):

1. Students in years 1-5 will have priority. Students in years 6 and above will drop in priority. Sometimes, exceptions may be made. Some exceptions might be:

    a. Students in good academic standing who have written successful fellowship/grant proposals will not be "penalized" for those years. Similarly, requests from students in good standing can be considered past the 5th year when they have previously supported themselves through mechanisms not associated with the Psychology Department.

    b. In rare circumstances, a particular specialized skill might be required (e.g., Quant TA). If no student in years 1-5 can be identified to fill that need, then a more advanced student may be given higher priority.

    c. In some circumstances, area heads might propose different timetables for students (e.g., those who enter with a master's degree).

2. Students who have satisfactory or better ratings in their TA or RA performance will have higher priority. Students who receive unsatisfactory ratings in either TA or RA performance will have lower priority.

3. Students in good standing in their programs will have priority. Students who have received ratings of "not making satisfactory progress" in their annual evaluations will have lower priority.

4. These department priorities override area allocation. That is, an area will not use a TA line to fund a "low priority" student if another area has an unfunded "high priority" student.

## Whom to Consult Concerning Financial Support

Funding may come from various sources. It is the student's responsibility to work closely with their mentor to inform them of continued needed support, especially for summer. The mentors work with their program's area head to convey this information. The area head is primarily responsible for the pattern of student support for their area. The area head works closely with the Director of Graduate Studies and the Department Chair with respect to long-range planning of stipend support.

Questions concerning appointments inside or outside of the university should be directed to the area head or Department Chair. Questions about applying for grants should be directed to both Research Advancement and the Director of Graduate Studies before pursuing the opportunity.

### Departmental Graduate Assistantships (TAs and RAs)

Graduate assistantships are technically categorized as one of the following:

| Position Title | Brief Explanation |
| --- | --- |
| Teaching Assistant | Works in a classroom setting with an assigned instructor. Funded by the department. Salary is <u>lower</u> than the *associate rate* due to not having a master's |
| Research Assistant | Works in a research setting with a faculty member. Funded by the faculty member's grant. Salary is <u>lower</u> than the *associate rate* due to not having a master's |
| Teaching Associate | Works with faculty in a classroom setting. Funded by the department. Salary is <u>higher</u> than the *assistant rate* due to having a master's |
| Research Associate | Works in a research setting with a faculty member. Funded by the faculty member's grant. Salary is <u>higher</u> than the *assistant rate* due to having a master's |

The Director of Graduate Studies assigns the duties of graduate assistants in consultation with the department Business Manager and the area directors. Graduate assistants are:

1. Assigned to work under the direct supervision of one faculty member (but it may be more) who will determine the details of the student's responsibility.

2. Considered to be on half-time (20 hours per week) or one quarter time (10 hours per week) appointments for the academic year.

3. Expected to begin their assistantship responsibilities before classes begin by attending the appropriate TA orientations and meeting with their supervising faculty member (see the TA Expectations and Required TA Orientation sections below). Exact dates change annually.

4. Expected to adhere to the policies and procedures within the ASU TA/RA Handbook.

### TA and RA Tuition and Health Benefits

TA and RA positions are usually 20 hour a week jobs, which come with a stipend, 100% tuition

waiver for the semester, and 100% health insurance coverage (for the individual student only; requires the student to enroll in a health insurance plan unless the student is international, in which case they are automatically enrolled in a health insurance plan). Some TA and RA positions are only 10 hour a week jobs, which come with a stipend, 50% tuition waiver for the semester, and 50% health insurance coverage (for the individual student only). Tuition waivers do not cover miscellaneous fees, which are the responsibility of the student to pay. Students who do not see the tuition waiver applied to their bill should make sure they're enrolled in at least 6 credits for the semester. If so, then they should contact the PSY graduate advising office to ensure the waiver has been entered in the system. See the Resources section for contact information.

## Teaching or Research Salary Increase

A salary increase from assistant to associate is awarded when a graduate student has advanced to a post-master's level in their program. Evidence of the earned master's degree, through degree conferral, is required before the salary increase will be awarded. The conferral date for each semester is listed in the Academic Calendar. Students must adhere to graduation deadlines to have their degree conferred in the same semester in which they defend. Missing the deadlines will result in a conferral date in a future semester.

| MA Degree Conferral Semester | Semester Salary Increase Begins |
|---|---|
| Spring or Summer | The following Fall semester |
| Fall | The following Spring semester |

## Pay Schedule

Teaching assistants and research assistants receive 20 equal paychecks over the academic year. Payroll is run bi-weekly and the pay date is every other Friday.

Arrangements for direct deposit to a bank may be done online but HR paperwork must be completed and submitted at least week before direct deposit can be set up. Employees can also do the W4 paperwork online. Paper paychecks can be picked up in the PSY Main Office. Paychecks will **not** be released to anyone other than the designated payee unless prior arrangements have been made. A signature is required for paper check pick-up.

## Extra Work/ Outside Work

**Summary: Students are encouraged to discuss with their advisor and/or training area head before choosing to work an outside job or engage in another opportunity that requires a substantial time commitment. This is in no way intended to prohibit or discourage graduate students from outside work.**

The Psychology Department, the College, and the Graduate College strive to ensure that students are financially supported throughout their time in the program. Students are typically

supported through teaching assistantships, research assistantships, grant funds, or fellowships. In assistantship positions, students are limited to a maximum of 20 hours per week of assistantship work during the academic year in order to have sufficient time to focus on their academic progress. This is consistent with ASU policy as stated in the ASU TA/RA Handbook (available on the Graduate College website). For students with 20-hour assignments, it is expected that they will not need to seek additional outside work to support themselves. If students need additional financial assistance, they are encouraged to consult with their advisor and/or area head to explore possibilities for seeking additional support within or outside of the department. Knowledge of outside work (including positions, hours, or compensation) will not be included in annual student evaluations and will not affect eligibility to receive TA/RA positions in the department during the academic year.

Students are encouraged to discuss with their advisor and/or training area head before choosing to work an outside job or engage in another opportunity that requires a substantial time commitment. Advance consultation with the faculty mentor and/or the area head can protect the student from possible negative consequences of outside employment such as over-commitment or potential ethical violations such as a possible conflict with the constraints of existing student fellowships. Such consultation can also provide students with ideas for obtaining additional support through the university or outside funding mechanisms. Finally, faculty advisors or area heads may be able to help coordinate outside work responsibilities with TA/RA responsibilities.

**The situation in which students absolutely must disclose outside employment to their mentor and/or area head is when a student chooses work within psychological practice** (i.e., clinical counseling work). In this case, the student must obtain written permission from the clinical training area director. This policy is to protect both the student and University from liability stemming from the level of training a student has achieved. The program is responsible for overseeing all practice-related activities of clinical psychology students, as they are not licensed to practice independently in the state of Arizona. **International students also need to consult the International Student and Scholars Center (ISSC) to make sure that they are in compliance with federal government regulations on work policies for international students.** Students on F-1 or J-1 visas must be limited to 20 hours of work per week while school is in session (summer sessions are voluntary and international students can work up to 40 hours a week).

When students are not supported by the Department (i.e., they do not have either RA or TA support or Fellowship support), we expect that in most cases the student will seek outside work. In these cases, we also encourage the work to be limited to about 20 hours per week so that students may continue to pursue full-time doctoral studies.

## Summer Employment

Students are supported in the summer in several ways. The Department has a small number of hourly worker positions to support the educational mission. Announcement of (and applications for) these positions usually occur in mid to late spring (around March).

Students are also employed during the summer as RAs on faculty grants. Those students must be

enrolled for at least one semester hour during the summer work period. The work period needs to align with the session dates of the course enrollment. A summer RA position at 20 hours a week comes with a 100% tuition waiver; 10 hour a week positions come with a 50% waiver.

Many students also use block grant funds distributed during the spring semester to save for summer support.

### Fellowships, Scholarships, and Student Loans

The Graduate College offers a number of fellowships and scholarships. Students interested in these awards, should see the Director of Graduate Studies, since the department sends nominations to the Graduate College; the student does not apply directly. Details on the various opportunities are on the Graduate College's Fellowships and Awards webpage. Self-nominations are welcome and should be sent to the Director of Graduate Studies.

The Financial Aid Office offers a series of brochures regarding scholarships, fellowships, grants, loans, etc. Students applying for need-based awards must have a Free Application for Federal Student Aid (FAFSA) on file for the academic year to be eligible. Any need-based aid awarded to students can be impacted, such as taken away, if the student's need changes due to receiving an additional source of funding. Taking out student loans may impact the eligibility to receive or continue receiving a need-based award. Additionally, students must meet qualifications to continue receiving student loans or work with the PSY graduate advising office to fill out a Satisfactory Academic Progress plan (SAP plan) for consideration of future loan awards. Students can contact the Financial Aid Office for questions and information on various opportunities. Contact information is listed in the Resources section of the Psychology Graduate Resources page. If a student wishes to apply for a grant or a fellowship outside of ASU, they should consult with the Director of Graduate Studies and the Research Advancement Office.

### Graduate Student Travel Funding

Graduate students are able to request funds to help support travel to present a poster or talk at a professional conference. Funds may come from one or more sources, all of which may have their own application, eligibility requirements, deadlines, etc. An overview of the most common funding sources for graduate students, and other pertinent details, are on the Psychology Graduate Resources webpage. Questions should be directed to the PSY graduate advising office.

## II.     Student Responsibilities

It is the responsibility of each student to understand and observe all procedures and requirements specified by the ASU Graduate College, The College, the Department of Psychology, and the Clinical Program. It is a requirement for all students to read and understand the Graduate Handbook and the ASU [Academic Catalog](#) and to adhere to the [Student Code of Conduct](#). Faculty and staff provide academic advice and assistance, but the ultimate responsibility for meeting degree and other requirements remains with the student. Students should frequently check their MyASU account.

### ASU Email

All ASU students are required to have an active ASU email address. Students may forward their ASU email to another preferred account. It is important that students check their ASU email frequently, so they do not miss important notices. Arizona State University, The College, and the Department of Psychology conduct their business and official communications via ASU email only.

### Registration/ Continuous Enrollment

Students are expected to register prior to the start of each semester and adhere to the Continuous Enrollment policy. See the Policy in the Graduate Handbook for additional details on the [Registration Enrollment](#) and the [Continuous Enrollment](#) policies.

### Culture of Respect

ASU is a community and a professional work environment. Graduate students are expected to treat peers, teachers, students, staff, and members of the ASU community with respect and to work with them in a professional manner, both in person and online. Psychology graduate students are representatives of the Department of Psychology and the university. The department expects its students to be good representatives who recognize that poor behavior by one student impacts others by creating a negative perception of the department.

### Relations with the Public

The department has relations with the lay public, members of allied professions, governmental officials, and psychologists outside the department. Each of these is a large and varied group. The

lay public, for instance, includes our undergraduate students, clients of the [Clinical Psychology Center](#) and Child Study Laboratory, research subjects, visitors to the department, and citizens of regions who may know of us only very intermittently through the publicity given to one or another of the department's programs. As members of a state university we quite properly have a direct responsibility to, and accountability to, the citizens and government of Arizona. We also clearly have responsibilities to the national organizations and professional associations with which we are affiliated, and our concept of public relations extends to these bodies also.

All graduate students involved in professional activities with undergraduate students or clients are requested to carry out their duties just as if they were the official representatives of the department to the public, which is, of course, very often exactly how you will be perceived. The department views entry into graduate training as in many ways quite disjunctive with the patterns of the undergraduate life which immediately preceded it. Modes of social interaction, dress, and oral expression which were appropriate to social relationships prior to graduate training will in many instances not transfer readily to the professional roles which accompany graduate training. While in many respects the professional roles of graduate students must evolve slowly over the course of the PhD program, it is nevertheless true that individuals outside the department will view you essentially as professionals from the moment you join the department. Furthermore, they are not apt to make fine distinctions as to when you are in or out of a professional role, regardless of the context of the interaction.

For these several reasons, all graduate students are requested at all times to consider the possible impact of their behavior upon the perceptions and attitudes of the non-psychologists with whom they interact, not only in explicitly professional interactions, but also in other places and situations in which non-psychologists are likely to perceive you as professionals. While the latter consideration applies to all areas of specialization, it is perhaps most obvious in the Clinical area, where the undergraduate student who observes you at a distance in the library on one day may turn out to be your client the next day.

Similarly, in any area of human research, it is clear that the participant's view of you as a scientific investigator may be facilitated or impaired according to his/her observations of you in other situations. As a general guideline, it is requested that graduate students consider the professional role implications of their style of interaction, speech, and dress when acting in any assigned professional capacity or in any situation likely to be perceived by a non-psychologist.

It should be noted that the issues discussed above do not bear upon the civil rights of graduate students but upon their professional obligations. Further, the faculty will usually assume that good judgment regarding professional conduct is not something they should have to teach explicitly, and therefore prefer usually to leave such matters to the student's discretion.

There is, however, a particular category of professional interaction in which the department will take a very specific interest—those situations in which stipend support or training appointments are provided by non-university agencies which set explicit, advance requirements concerning the behavior of graduate students when working with the agency or its clients or wards. Agencies are quite free under the Constitution to set requirements, during working hours, regarding styles of interaction, speech, or dress (including grooming). When graduate students accept non-university appointments with advance knowledge of such requirements, it is essential that the requirements

be complied with. If they do not appear to be appropriate requirements in the graduate student's view, the question should be raised with the DCT or the Department Chair before accepting the appointment.

## Sexual Harassment and Discrimination

The university prohibits sexual harassment by employees and students and will not tolerate sexual harassment that interferes with an individual's work or educational performance or creates an intimidating, hostile, or offensive working, learning, or residential environment. Please visit ASU's Sexual Violence Awareness and Response site to learn more about rights and responsibilities, how to report an incident and how to get immediate assistance and confidential support.

The Chair of the Department is available to hear any complaint of alleged discrimination in employment, educational programs or activities because of race, color, national origin, religion, sex, sexual orientation, age, disability or Vietnam era veteran status. If a person feels discomfort talking to the Department Chair, DCT, faculty mentor, or anyone else in the department, then a complaint may be filed with the Office of Equal Opportunity/ Affirmative Action for investigation and resolution.

## Student Code of Conduct

The Arizona Board of Regents (ABOR) Student Code of Conduct sets forth the standards of conduct expected of students who join the university community. Students who violate such standards will be subject to disciplinary sanctions in order to promote personal development, protect the university community, and maintain order and stability on campus and in associated learning environments.

In addition to the university's Academic Integrity and Student Code of Conduct policies, the department also expects graduate students to abide by the APA ethical code of conduct.

## Academic Integrity

Academic integrity is a fundamental value because violations of it cause harm to students and their peers, the university, and future employers, clients, or patients. Psychology students are expected to be ethical in their multiple roles as students, researchers, and representatives of the university. When in doubt about appropriate conduct, students should review ASU Academic Integrity Policies and Resources, review The College's Academic Integrity webpage, and consult an instructor or advisor to seek clarification as needed.

Newly admitted graduate students will receive a "priority task" in MyASU directing them to complete an online module on academic integrity. The module consists of a PowerPoint that outlines academic integrity and students must take a quiz and pass with an 80% or higher.

As outlined by ASU policy, a student may be found to have engaged in academic dishonesty if, in connection with any Academic Evaluation or academic or research assignment (including a paid research position), he or she:

1.      Engages in any form of academic deceit, such as fabricating data or information;

2.      Refers to materials or sources or uses devices (e.g., memory cards or drives, audio recorders, camera phones, text messages, crib sheets, calculators, solution manuals, materials from previous classes, or commercial research services) not authorized by the instructor for use during the Academic Evaluation or assignment;

3.      Possesses, reviews, buys, sells, obtains, or uses, without appropriate authorization, any materials intended to be used for an Academic Evaluation or assignment in advance of its administration;

4.      Acts as a substitute for another person in any Academic Evaluation or assignment;

5.      Uses a substitute in any Academic Evaluation or assignment;

6.      Depends on the aid of others, including other students or tutors, in connection with any Academic Evaluation or assignment to the extent that the work is not representative of the student's abilities;

7.      Provides inappropriate aid to another person in connection with any Academic Evaluation or assignment, including the unauthorized use of camera phones, text messages, photocopies, notes or other means to copy or photograph materials used or intended for Academic Evaluation;

8.      Engages in any form of plagiarism, including self-plagiarism (the act of taking work or ideas, passing them off as one's own and/or not giving credit to the source);

9.      Uses materials from the Internet or any other source without full and appropriate attribution;

10.     Permits his or her work to be submitted by another person in connection with any Academic Evaluation or assignment, without authorization;

11.     Claims credit for or submits work done by another;

12.     Signs an attendance sheet for another student, allows another student to sign on the student's behalf, or otherwise participates in gaining credit for attendance for oneself or another without actually attending;

13.     Falsifying or misrepresenting hours or activities in relationship to an internship, externship, field experience, clinical activity or similar activity; or

14.     Attempts to influence or change any Academic Evaluation, assignment or academic record for reasons having no relevance to academic achievement.

Academic honesty is expected of all students in all examinations, papers, academic transactions and records. Possible sanctions for academic dishonesty include, but are not limited to the following: appropriate grade penalties, loss of registration privileges, disqualification, and dismissal.

Students have the responsibility to understand and uphold the highest standards of academic integrity. The department has a zero-tolerance policy for any form of academic dishonesty and

follows the university's policies and procedures when responding to an academic integrity complaint and determining sanctions.

## Research Projects and Activities

Much of graduate training is essentially a research apprenticeship, and students should plan their programs with great care. At certain points in the graduate program, the student may feel some conflict over the time to be devoted to the several activities he is engaged in. In resolving these scheduling conflicts, it is essential that the schedule which is worked out does not interfere with the student's ongoing research activities. While the doctoral dissertation is typically the most important single piece of research the student accomplishes; its success is dependent upon the cumulative research apprentice training received from the beginning of graduate study.

Although the research training usually involves intensive work with one faculty supervisor at a time, departmental regulations allow working with two or more faculty supervisors simultaneously as well as students' working independently or with other students. If no faculty member is providing administrative supervision or space, the DCT or Director of Graduate Studies or Department Chair should be consulted to ensure that all university regulations concerning research are followed.

All research with human subjects, whether of an experimental character or not, must be approved in advance by the ASU IRB. If, at any stage of the research, a legal, ethical, or public relations issue becomes apparent, it is the responsibility of the investigator immediately to inform the Department Chair, and, in the case of graduate students, the faculty supervisor.

The department also takes very seriously the adherence to ethical guidelines in the treatment of animals. Statements concerning the care and research use of animals are posted in the animal laboratories, and graduate students are expected to be fully informed about them. The Chair of the Animal Care Committee is administratively responsible for ensuring the appropriateness of research use of animals, and any questions on this topic should be addressed to them.

# III.  Non-Discrimination Policy

Arizona State University is committed to providing an environment free of discrimination, harassment, or retaliation for the entire university community, including all students, faculty members, staff employees, and guests. ASU expressly prohibits discrimination, harassment, and retaliation by employees, students, contractors, or agents of the university based on any protected status: race, color, religion, sex, national origin, age, disability, veteran status, sexual orientation, gender identity, genetic information and Title IX sexual harassment.

Inappropriate conduct need not rise to the level of a violation of federal or state law to constitute a violation of this policy and to warrant disciplinary action/sanctions.

All individuals identified in the Applicability section of this policy are responsible for participating in and assisting with creating and maintaining an environment at ASU free from all forms of prohibited discrimination, including harassment and retaliation. All individuals identified in the Applicability section of this policy are required to cooperate with any investigation of allegations of violations of this policy.

Providing false or misleading information or failure to cooperate may result in disciplinary action.

# IV.  Values and Expectations for Graduate Student Mentoring

## Mutual Expectations

The fundamental goal of a mentoring relationship is to benefit the student and a good faculty mentor is important to a student's success. Good mentors act as role models and provide advice, resources and opportunities, support, and feedback. The mentor-student relationship is bidirectional. The student is responsible for meeting milestones and for being active in seeking advice, information, and feedback. If desired, the student can receive mentoring from multiple faculty members and should not feel constrained by the limits of a single faculty advisor/chair. Students and mentors, if they wish, can create a mentoring contract to outline expectations and goals. A sample mentoring contract is provided below.

## Respect for Students

Whether providing academic support or related services, a mentor should create a respectful learning environment that helps the student achieve professional and career goals. The faculty mentor strives to be supportive, equitable, accessible, encouraging, and respectful.  The mentor fosters the graduate student's professional confidence and encourages critical thinking and creativity, providing an environment that is intellectually stimulating, emotionally supportive, safe, and free of harassment. The mentor adheres to the following:

- APA ethical principles and code of conduct (http://www.apa.org/ethics/code/index.aspx);
- ASU policies Title IX: https://www.asu.edu/titleIX/ policies; and
- ASU Academic Affairs Manual: https://www.asu.edu/aad/manuals/acd/).

The mentor recognizes that the student's interests and goals can change and supports the student in changing mentors as needed.

## Diversity

The faculty mentor nurtures and builds community for students from historically underrepresented groups and for international students. The faculty mentor welcomes students' perspectives on diversity issues, while understanding that their viewpoints are their own. The mentor recognizes each student's unique strengths and scholarly promise, and this helps eliminate stereotypes.

## Meeting on a Regular Basis

The faculty mentor asks the graduate student to develop and share a work plan that includes short-term and long-term goals, as well as a timeframe for achieving those goals. They make sure the student's plan is feasible and meets the program's requirements. The mentor and student discuss the plan to help the student balance the competing demands of multiple roles. The mentor communicates with the student regarding how frequently they can meet, with an understanding that it is the student's responsibility to arrange and take the lead in these meetings. Faculty mentors let students know if they have a busy travel schedule, are about to take a sabbatical, or will be assuming an administrative position. The mentor is explicit about the components of successful meetings. The mentor lets the student know whether the student may contact the mentor at home, and under what circumstances, and asks for the student's preferences as well. The mentor and student discuss how often assessments of student progress will occur and what type of feedback will be given. The student is informed of the mentor's typical response time to student work and how the student can best prompt the mentor if a response has not been received within that specified time.

## Program Milestones

The mentor guides the student through the requirements and deadlines of the graduate program. This includes course selection and strategies for successful completion, selection of thesis/comps/dissertation committee members, and facilitation of timely committee meetings as articulated in the graduate handbook (or more frequent committee meetings if needed).

## Intellectual Contributions

Intellectual policy issues are discussed in the initial phase of each project. The mentor discusses authorship policies regarding papers with the student. The mentor explains upfront the approach to handling authorship, before any work is done. The faculty mentor is explicit about the amount of work the student is expected to complete. The mentor acknowledges the student's contributions to projects and works with the student to publish their joint work in a timely manner.

## Career Goals

The mentor facilitates the training of the student in skills needed to be a successful professional. The mentor provides career advice and assists in finding a position for the student after graduation, in accordance with the student's career goals. The mentor provides honest letters of recommendation and is available to give advice and feedback on the student's goals. If additional expertise is needed, the mentor helps the student identify relevant sources of information and advice about achieving these goals.

## Graduate Students as Members of Faculty Research Teams

The graduate student is expected to share common research responsibilities in the research group/lab and to utilize resources carefully and frugally. The mentor is committed to the

student's research projects in that the mentor helps plan and direct those projects, sets reasonable and attainable goals, and establishes a timeline for completion. There is great variability across types of laboratories and projects in terms of the time required; the mentor discusses expectations for student workload and work schedule (e.g., expectations for holidays/vacations). The mentor recognizes the possibility of conflicts between the interests of the mentor's own larger research program and the particular research goals of the student. Although it may not always be possible to accommodate the student's research goals within a particular lab (for example due to financial constraints), the mentor always attempts to support the student's pursuit of their own research.

## Graduate Students as TAs/RAs

Graduate students have a responsibility to fulfill their contractual obligations as TAs or RAs. The student informs the mentor of the number of hours dedicated to teaching and/or research obligations; the mentor encourages the student not to exceed the number of hours stipulated in the contract. The student is responsible for informing the TA/RA supervisor(s) and mentor of any changes or circumstances that would interfere with carrying out these obligations. The student always attempts to ensure stability and continuity for faculty, programs, and departments. The student has a responsibility to seek accurate information about the conditions of TA/RA employment (e.g., asking faculty supervisors about how to handle sick leave, vacation, and professional development opportunities). If the student has a concern, the student should discuss it with the mentor, DCT, or other appropriate faculty member (e.g., Director of Graduate Studies, Chair of the Department). Students in these roles also need to follow policies in the TA/RA Handbook (see the Resources section). Additionally, TAs need to follow expectations listed in the Departmental Graduate Assistantships (TAs and RAs) section.

## Graduate Students as Future Members of the Scholarly Community

The mentor leads by example, modeling best practices in the following areas: oral and written communication, grant writing, lab management, participant research policies, ethical conduct in research, and scientific professionalism. The mentor participates in and encourages the student to attend area, departmental, and professional meetings and help the student network with others during such activities.

## Addressing Problems in the Mentoring Relationship

As in any relationship, problems or conflicts may arise. When this occurs, the goal is to address the problem openly in a context of mutual respect. The student can reach out to the mentor, and the mentor should be open and receptive to such discussion. If a student feels the need for additional support for such a discussion, the student should consult with other faculty members, including the DCT, Director of Graduate Studies, or Department Chair. These individuals can provide advice and/or offer to meet with the student and the mentor to resolve the problem. Other graduate students can also be valuable resources, including the Graduate Student Council, who are student representatives to the Graduate Studies Committee. We encourage students to have these difficult conversations when necessary even though we recognize that students may be apprehensive and that they may have concerns about potential negative impacts on them. We want students to know that the Psychology Department faculty are committed to ensuring that

there will be no negative repercussions for students who express concerns.

# V.     Sample Mentor and Graduate Student Contract

Below is a draft of a contract for those who wish to use one. It has been adapted from the Interdisciplinary Research Colloquium at ASU. The mentor-student relationship in graduate school can be described as a personal relationship in which a faculty member acts as a guide, role model, teacher, and sponsor of a graduate student. Investment in this relationship is voluntary and based on the belief that if the relationship is no longer beneficial, both faculty member and student agree to significantly redefine or terminate the relationship. The following are relevant components of this mentor-student relationship:

### Frequency of Face-to-Face Contact to Discuss the Student's Progress and/or Goals

We agree to meet at this frequency:
- _____
- _____

### Specific Expectations for Workload in the Lab

What work will be done? Scheduling issues? How to handle vacations/ holidays/ illness? Are the expectations reasonable given course load, additional RA/TA responsibilities?

These are expectations concerning workload in the lab:
- _____
- _____

### Short-Term Goals

What type of guidance does the student need in order to learn and contribute most effectively (e.g., independent vs. one-on-one work)? What type of guidance does the faculty member typically provide?

These are our agreed-upon, short-term goals:
- _____
- _____

## Long-Term Goals

Faculty need to evaluate what they can provide and what the student needs. Students need to be realistic about what is possible and proactively get information about their mentor's expectations, developing a balance between seeking help and taking on more responsibility as the relationship progresses.

These are our agreed-upon, long-term goals:
- _____
- _____

## Expectations Regarding Communication and Confidentiality

Discuss preferred means of communication (email, cell phone) and response times. Be clear about the level of confidentiality that you will have.

This is our agreement regarding levels of communication:
- _____
- _____

## Frequency of Evaluation of the Relationship, Goals, and Objectives

We agree to this frequency of evaluations:
- _____
- _____

## Any Other Specific Roles and Expectations of the Faculty Mentor

These are other specific roles and expectations the student has for the mentor:
- _____
- _____

## Any Other Specific Roles and Expectations of the Student

These are other specific roles and expectations the mentor has for the student:
- _____
- _____

By signing this agreement, both the faculty mentor and graduate student are affirming they have reviewed the above and are willing to support this mentoring relationship.

_____
_____

Faculty Mentor                                                    Graduate Student

_____
_____

Date                                                                    Date

References: Johnson, W.B., & Huwe, J.M. (2003).  Getting Mentored in Graduate School, 111, 163
Mentoring: A Guide for Students: http://grad.washington.edu/mentoring/students/getting-started.shtml

# VI.  Clinical Policy on Students Living Away from the Program

The clinical faculty believes strongly that students should remain geographically in residence until they leave for internship. Indeed, students are required to remain full time in the program and have an approved dissertation proposal by October 1 of the fall semester in the year that they apply for internship. We hold this as a strong value believing that it is in the best interests of both the student and the program. When students are in residence it facilitates their training, their interactions with faculty mentors, and thus their progress through program "milestones," It also facilitates a strong training environment for the program, ensuring that there is a critical mass of students and faculty engaged in intellectual exchange and in research and clinical training. Thus, as policy, we assume that all students will remain in residence until their internship year.

In rare cases, however, we recognize that it may be in the student's best interest to relocate before the internship year. In these rare cases, the clinical faculty will entertain a student's written petition to relocate. However, given our strong values for students to remain in residence, these petitions will face a "high bar" and **students must be in residence for a minimum of two years before they may apply to live away from the program**. In addition, **petitions will only be accepted for consideration after the student has successfully passed his/her Comprehensive Examination**. Before that time, students wishing to leave the area, should apply for a leave of absence until they are able to return.

Each case will be evaluated on its own merits. To help maximize the likelihood that the student can continue to make timely progress even at a geographically distant site, the following factors will be considered:

1. A petition is likely to be viewed favorably only if the student has an approved Dissertation proposal at the time that he/she leaves, and has completed all required coursework.

2. A petition is likely to be viewed favorably if there is clear training benefit to the student. For example, the student may be doing a Dissertation using data gathered at another site or in collaboration with researchers at a geographically distant laboratory; or the student may have access to his/her study population only at another site.

3. The student must present a clear, specific, and detailed plan and time table for how the Dissertation will be completed at long distance, particularly with regard to methodological and statistical consultation.

4. The student's record of and potential for timely completion of program requirements will be considered as a predictor of future timely progress.

5. Individual factors about the Dissertation project will also be considered (e.g., Will the data be collected in Arizona? Is the Chair supportive of a long distance mentoring arrangement?) Each case will be approved for one year and time past that period requires a new petition.

# VII. Grievance Procedures & Due Process

## I. Grievances

In the event that a problem arises, whether it is personal, academic, or professional, the recommended procedure is:

1. Talk to your advisor

2. If your advisor is part of the problem, talk to your area director

3. If that doesn't create resolution, talk to the Director of Graduate Studies.

4. If the problem is still unresolved, make an appointment to talk to the Chair of the Department.

5. If necessary, the issue would be directed to the Dean's Office in the College of Liberal Arts and Sciences.

You may enter this procedure at any one of the steps (e.g., #4 first, #2 First).

There are two additional sources of help:

1. Student Life Office

2. Division of Graduate Studies: see the Division of Graduate Studies website for detailed instructions on submitting an appeal for an unresolved grievance.

https://graduate.asu.edu/sites/default/files/satisfactory-academic-progress-guidelines-and-dismissal-processes_1.pdf

## II. Due Process

Due process procedures at the University level no longer exist in paper form. This website https://www.asu.edu/aad/manuals contains the link to Academic Affairs Manual, the first of two manuals that describe due process procedures. The second is the University Student Initiatives (USI) manual, which can be found at https://www.asu.edu/aad/manuals/ssm/index.html

# VIII.  Clinical Psychology Student Liaisons

Conflicts between students and faculty often do not reach the formal grievance process as they are issues that can be addressed before they rise to this level. Student liaisons play an important role in helping resolve such issues by facilitating communication between students and faculty, particularly surrounding concerns around mentoring or other issues related to faculty/student relations. Student liaisons are graduate students in the clinical program elected by their peers. Students are asked to identify potential liaisons who they feel they can go to with concerns about the program and/or difficulties they are encountering with faculty members.

Responsibilities

-Serving as a student liaison will fulfill the requirement of serving on a committee

-Student liaisons will meet monthly with the DCT

-Student liaisons will be responsible for being a supportive resource for students facing issues with faculty and will be expected to advocate for the best interests of the students

-Student liaisons will have knowledge of processes for students to navigate issues they may experience while in the program, and the proper channel through which to address these issues, either through the psychology department or outside the department if necessary

-Student liaisons will be expected to reach out to incoming students and inform them of their roles

-Student liaisons will be responsible for coordinating the selection of the next year's student liaisons

Process for Selecting Student Liaisons

-There will be 2-3 student liaisons every year

- At the end of the spring semester students will be asked to volunteer for the role of student liaison

- If more than three students volunteer as student liaisons, an anonymous survey will be sent out and the clinical area students will vote

If students are not comfortable with any of the student liaisons elected, they can still go directly

to the DCT. The student liaisons are not the only way for students to advocate for themselves. At most, they are intended to be a source of support, protection, and a student-led source of accountability for faculty and at the very least they are another resource for students in the program.

## IX.    DCT Office Hours

The DCT, currently Dr. Corbin, will hold regular office hours during the fall and spring semesters for at least one hour each week. Given the size of the student body, it will rarely be possible to find office hours that accommodate all students. However, office hours will always be set to accommodate the schedules of the 3 student Liaisons. This will ensure that any student concerns make it to the DCT quickly so that issues can be addressed expeditiously. In addition, the DCT is always available to schedule meetings with students outside of these office hours. Office hours are simply meant to be a low barrier means to facilitate communication between the students and the DCT. At least once per semester, the office hours will be held in a larger venue to allow for all interested students to attend. This will provide an opportunity for the DCT to provide information to the students about any changes within the program, as well as a means for the DCT to assess the general climate of the program.

# X.    Participation in May Commencement Prior to Completion of Internship

<u>Memorandum of Understanding</u>

To:    Keith Crnic, Chair, Department of Psychology

From:  Maria T. Allison, Dean, Graduate College

Re:    Commencement Participation for Clinical Psychology PhD Students
       Preliminary Policy

Date:  April 28, 2009

Clinical Psychology doctoral students may only participate in Commencement ceremonies if they have applied for graduation and completed all degree requirements by the posted deadlines for the semester they plan to participate. This agreement outlines an exception to the standard commencement participation requirements for Clinical Psychology students completing an internship during the summer.

<u>Requirements</u>
Students who will graduate in a summer term (August) may submit a petition to participate in the spring semester Commencement ceremony immediately preceding the summer term they expect to graduate if the following conditions are met:

- The student has applied for graduation for the summer term.
- The student has completed <u>all</u> requirements for graduation by the end of the Spring semester with the exception of completion of an internship.
- The student will complete the internship prior to the bookstore deadlines to graduate for the summer term.
- Consistent with university guidelines, the student must register for a minimum of one credit hour of appropriate graduate level credit during one of the summer sessions (effective Summer 2010).

The only graduation requirements that may be completed after Commencement are the completion of the internship, grading for the internship, dean's signature on the pass/fail form, and presentation of the dissertation at the bookstore for binding (in accordance with the graduation deadlines for the summer term).

Procedure
The student must submit a petition through his/her academic unit to The Graduate College requesting participation in the commencement ceremony. The petition must include the beginning and ending dates of the internship, and confirm that the student is in satisfactory standing at the present time.

Following the successful completion of the internship, the department must submit a memo identifying each student (and ID number) who has completed the internship requirements and is eligible for summer graduation. (The department is responsible for all communication between the internship training directors regarding a student's performance). The department should submit separate memos for each student completing student so that documents may be scanned into the respective student electronic file.

This MOU replaces any previous arrangements developed to address the internship/commencement relationship for the Clinical Psychology program.

# XI.    Graduate Student Resources

There is a wide array of campus resources that are available to graduate students.  Links to many of them are provided on the Graduate College web page.

https://students.asu.edu/graduate/resources

Campus Health Service
Career Services
Child and Family Services (e.g., child care)
Counseling and Consultation Center
Credit union
Disability Resource Center
Financial Aid Office
Housing Office
International Student Office
Multicultural Student Center
Preparing Future Faculty
Student Legal Assistance
Writing Center

Online descriptions of these resources can be found easily by using the ASU search engine on the ASU homepage.

**XII.   State licensure laws can be found at this website.**

www.psychboard.az.gov

# Section 3: Evaluation of Student Progress

I.      Schedule of Student Evaluations of Progress

II.     Clinical Student Progress Report

III.    Dissertation Evaluation Form

IV.     Evaluation of Profession-wide Competencies

# I.    Schedule of Student Evaluations of Progress

The clinical faculty reviews students near the time that important milestone events should occur:

1.    First-year curriculum completion: first-year class, end of spring semester

2.    Master's thesis prospectus defense: second-year class, end of fall semester

3.    Master's thesis completion: third-year class, end of fall semester

4.    Comprehensive exam completion: fourth-year class, middle of fall semester.

5.    Dissertation prospectus/internship readiness: fifth-year class, after Oct. 1.

Students update their Clinical Student Progress Report and Supplementary Discipline Specific Knowledge form (for students entering in Fall 2017 or later) prior to these evaluations to provide  a complete picture of the student's activities. Following evaluations, the Director of Clinical Training will write each student a letter that summarizes the faculty's discussion. Any areas of concern will be identified in the letter. If major concerns are identified, a formal remediation plan will be developed with specific actions and

outcomes that must be met in order to remain in good standing within the program.

We want students and advisors to be aware of this timetable and the expectations that are associated with them. Students and advisors should talk about any issues concerned with student progress.

Research competencies are evaluated upon completion of the dissertation using the Dissertation Rubric Form.

Clinically relevant profession-wide competencies are evaluated in second year practicum and all community clinical placements. A full evaluation of profession-wide competencies (research, clinical, professional values and communication skills) is conducted upon completion of internship.

## II. Clinical Student Progress Report

Date of Report: _____

Student's name: _____

Year admitted to program: _____     Undergraduate school:

_____

Designated area of emphasis: _____     (if none, state

none)

Current academic advisor: _____

Source of support/placement:

1st year   __ _____ Fall _____ Spring _____

2nd year  _____ Fall _____ Spring _____

3rd year  _____ Fall _____ Spring _____

4th year  _____ Fall _____ Spring _____

5th year  _____ Fall _____ Spring _____

| I | Core Coursework Record | Not taken | In progress | Completed/grade |
|---|---|---|---|---|
| | 530 ANOVA | _____ | _____ | _____ |
| | 531 Multiple Regression | _____ | _____ | _____ |
| | 572 Psychological Assessment OR 780 Assessment ATM | _____ | _____ | _____ |
| | 573 Psychopathology | _____ | _____ | _____ |
| | 574 Psychotherapy OR 591 Child & Family Therapy | _____ | _____ | _____ |
| | 591 Clinical Interviewing & Ethics | _____ | _____ | _____ |
| | 600 Clinical Research Methods | _____ | _____ | _____ |
| | 580 Clinical Practicum I | _____ | _____ | _____ |
| | 680 Clinical Practicum II | _____ | _____ | _____ |

| II | Advanced Treatment Methods (name) | Not taken | In progress | Comp/grade | Instructor |
|---|---|---|---|---|---|
| | 1. _____ | _____ | _____ | _____ | _____ |

2. _____   _____   _____   _____   _____
3. _____   _____   _____   _____   _____
4. _____   _____   _____   _____   _____

**List any others on back of this sheet**

III    <u>List of electives or specialty courses:</u>    <u>When taken</u>    <u>Grade</u>

    1. _____   _____   _____
    2. _____   _____   _____
    3. _____   _____   _____
    4. _____   _____   _____
    5. _____   _____   _____
    6. _____   _____   _____
    7. _____   _____   _____
    8. _____   _____   _____
    9. _____   _____   _____

(AB) Course that satisfies <u>Affective Bases</u> of Behavior Requirement?    Yes ___ No ___
   (Affix AB to course listed above)

(BB)   Course that satisfies <u>Biological Bases</u> of Behavior Requirement?    Yes ___ No ___
   (Affix BB to course listed above)

(CB) Course that satisfies <u>Cognitive Bases</u> of Behavior Requirement?    Yes ___ No ___
   (Affix CB to course listed above)

(SB)   Course satisfies <u>Social Bases</u> of Behavior Requirement?    Yes ___ No ___
   (Affix SB to course listed above)

(DEV) Course that satisfies Human Development Requirement?    Yes ___ No ___
   (Affix DEV to course listed above)

(HIS) Course that satisfies History & Systems Requirement?    Yes ___ No ___
   (Affix HIS to course listed above)

(INT) Course that satisfies the Advanced Integrative Requirement?    Yes___ No ___

IV    <u>Master's Degree:</u>                 <u>Date</u>

     Committee:   Chair _____
     Member 1 _____ Member 2 _____
   _____   Committee filed   _____   _____
         Title: _____

         _____

   _____   Prospectus written and approved             _____
_____
   _____   Data meeting _____   _____
   _____   Final draft submitted                  _____

_____
_____ Orals passed/failed  (circle one)                                    _____
         Number of Master's Credit Hours received

_____
         Master's Program of Study filed                                   _____

_____

V      Comprehensive Examination

       _____ Prerequisites confirmed:   Core courses completed
       _____

                                MA Orals  _____
                                3.0 GPA    _____
                                Clinical ratings satisfactory  _____
                                Program of Study filed  _____
       _____ Committee formed (See "Dissertation requirement")
       _____ Paper submitted _____  _____
       Comprehensive Oral Examines    Passed    Failed  (Circle one)      _____

VI.    Dissertation Requirements   (Committee of at least 4 members. Must have outside member)

Committee:  Chair _____

                   _____

                   _____

                   _____

                   _____

Dissertation Title    _____

_____

_____ Committee selected and filed officially _____ (Date)

_____ Prospectus Meeting _____ (Date)

_____ Prospectus Approved _____ (Date)

_____ Data Meeting _____ (Date)

_____ Final Draft Submitted _____ (Date)

_____ Orals Passed _____ (Date)

                   Number of Dissertation Credits Received _____

VII. Clinical Experience

Psychology Clinic - 2nd year

        Supervisor: _____
        Supervisor: _____

Placement - 2nd year
  (if applicable)   _____
        Supervisor: _____
        Feedback forms completed: Yes ___ No ___; Funded Yes ___ No ___

Placement - 3rd year_____
        Supervisor: _____
        Feedback forms completed: Yes ___ No ___; Funded Yes ___ No ____

Placement - 4th year _____
        Supervisor: _____
        Feedback forms completed: Yes ___ No ___; Funded Yes ___ No ___

Placement - 5th year _____
        Supervisor: _____
        Feedback forms completed: Yes ___ No ___; Funded Yes ___ No ___


Other Volunteer Clinical Experience (e.g. Groups in Hospitals, Schools)

        _____
        _____
        Supervisor: _____
        Supervisor: _____
        Feedback forms completed: Yes ___ No ___; Funded Yes ___ No ___

        Internship application submitted _____ (Date)

        Internship accepted _____ (Date)

        _____ Prerequisite confirmed

        _____ Ph.D. Prospectus meeting _____ (Date)

        Internship site: _____

        (full address)   _____

        _____

_____

(    ) _____

OTHER DATA

Please list memberships in professional societies (e.g., APA) since you entered graduate school:

_____


Honors or Commendations

_____

Awards and Scholarships

_____

Grants

_____

Publications

_____

Conference Presentations

_____

Service to the Department, University, or Broader Field (e.g. committee work)

_____

Please indicate the date of any formal leave(s) of absence from the program:

_____      _____

_____      _____

_____      _____

**Keeping track of Clinical Practicum Hours for Internships**

You should begin tracking your clinical hours as soon as you begin clinical work. You can track your hours using an Excel Spreadsheet or a software program like Time2Track https://time2track.com (note that the cost is about $40 per year for this software).

Foundational and Advanced Integrative Discipline Specific Knowledge

| | Foundational | Advanced (Graduate) |
|---|---|---|
| History and Systems | Undergraduate: | |
| | Graduate: | |
| Affective Bases | GRE: | |
| | Undergraduate: | |
| | Graduate: | |
| Biological Bases | GRE: | |
| | Undergraduate: | |
| | Graduate: | |
| Cognitive Bases | GRE: | |
| | Undergraduate: | |
| | Graduate | |
| Human Development | GRE: | |
| | Undergraduate: | |
| | Graduate: | |
| Social Bases | GRE: | |
| | Undergraduate: | |
| | Graduate: | |
| Advanced Integrative | | |

<u>Please include the following information in the table above</u>

If meeting a requirement with the GRE subject test, provide the score for each domain. You should also have a copy of your GRE subject test in your student file.

If meeting a requirement with an undergraduate course, please provide the course number, course title, and your grade in the course. You should also have a copy of the syllabus for each undergraduate course in your student file.

If meeting a requirement with a graduate course, please provide the course number, course title, and grade. Note, you can fulfill multiple advanced knowledge requirements with a single course or combination of courses. For example, Social Emotional Development and Cognitive Affective Neuroscience can collectively meet requirements for all advanced DSK knowledge as well as advanced integrative knowledge.

## III. Evaluation of Student Mastery of Research Methodology Using Doctoral Dissertation:

A. Please use the following rubric to describe the student's ability to critically and comprehensively evaluate existing research literature as evidenced in the **Literature Review Section** of their doctoral dissertation.

Please circle the choice that best describes the student's literature review.

1=does not appropriately characterize psychological research literature; substantial inaccuracy or incomplete

2=weak and inconsistent use of psychological theory or research

3=generally appropriate characterization of psychological research literature; only minor inaccuracies or omissions

4=strong analysis; no inaccuracies or omissions, comparable to publications in a solid journal in the field

5=outstanding analysis; no inaccuracies and an exceptionally sophisticated and comprehensive analysis, comparable to publications in a top-tier journal in the field

B, Please use the following rubric to describe the student's ability to produce methodologically strong research as evidenced in the **Methods Section** of their doctoral dissertation (including data analytic methods).

Please circle the choice that best describes the student's methods section (including data analytic methods).
.
1=study design is not methodologically strong; major weaknesses that prevent conclusions from being drawn

2=moderate methodological weaknesses

3=generally well-designed, but has minor methodological weaknesses

4=strong methodology, comparable to publications in a solid journal in the field

5=outstanding methodology; exceeds expectations, exceptionally sophisticated or innovative methodology; comparable to publications in a top-tier journal in the field

# IV. PROFESSION-WIDE COMPETENCIES IN PROFESSIONAL HEALTH SERVICE PSYCHOLOGY
## Doctoral Level Rating Form

Trainee Name: _____

Name of Placement: _____

Dates of Training Experience this Review Covers: _____

Date Evaluation Completed:
_____

Name of Person Completing Form (please include          Licensed Psychologist:   Yes   No
highest degree earned):
_____

Was this trainee supervised by individuals also under
your supervision?   Yes   No

Type of Review:
Initial Review     Mid-term review     Final Review     Other (please describe):
                                                        _____

_____          _____          _____

Each practicum evaluation must be based in part on direct observation of the practicum student and her/his developing skills (either live or electronically). Was this trainee directly observed during this evaluation period?   Yes   No

Training Level of Person Being Assessed:  Year in Doctoral Program:
_____

**Based on specific expectations for competency at this level of training, rate each item by responding to the following question using the scale below:**

**How characteristic of the trainee's behavior is this competency description?**

| Not at All/Slightly | Somewhat | Moderately | Mostly | Very |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

**If you have not had the opportunity to observe a behavior in question, please indicate this by circling** "No Opportunity to Observe" [N/O].

**Near the end of the rating form, you will have the opportunity to provide a narrative evaluation of the trainee's current level of competence.**

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**This rating scale has been adapted from the American Psychological Association Commission on Accreditation, Implementing Regulations – Section C: IRs Related to the *Standards of Accreditation*, 2017.**

Not at All/Slightly = 0    Somewhat = 1    Moderately = 2    Mostly= 3    Very = 4    No Opp. = [N/O]

# PROFESSION-WIDE COMPETENCIES

## I. RESEARCH

| Demonstrate knowledge, skills, and competence sufficient to produce new knowledge, to critically evaluate and use existing knowledge to solve problems, and to disseminate research. This area of competence requires substantial knowledge of scientific methods, procedures, and practices. |

| | 0 | 1 | 2 [N/O] | 3 | 4 |
|---|---|---|---|---|---|
| Demonstrates the substantially independent ability to formulate research or other scholarly activities (e.g., critical literature reviews, dissertation, efficacy studies, clinical case studies, theoretical papers, program evaluation projects, program development projects) that are of sufficient quality and rigor to have the potential to contribute to scientific, psychological, or professional knowledge base. | 0 | 1 | 2 [N/O] | 3 | 4 |
| Conduct research or other scholarly activities. | 0 | 1 | 2 [N/O] | 3 | 4 |
| Critically evaluate and disseminate research or other scholarly activity via professional publication and presentation at the local (including the host institution), regional, or national level. | 0 | 1 | 2 [N/O] | 3 | 4 |

## II. ETHICAL AND LEGAL STANDARDS

| Respond professionally in increasingly complex situations with a greater degree of independence across levels of training. |

| | 0 | 1 | 2 [N/O] | 3 | 4 |
|---|---|---|---|---|---|
| Be knowledgeable of and act in accordance with each of the following: | | | | | |
| The current version of the APA Ethical Principles of Psychologists and Code of Conduct | 0 | 1 | 2 [N/O] | 3 | 4 |
| Relevant laws, regulations, rules, and policies governing health services psychology at the organizational, local, state, regional, and federal levels | 0 | 1 | 2 [N/O] | 3 | 4 |
| Relevant professional standards and guidelines | 0 | 1 | 2 [N/O] | 3 | 4 |
| Recognize ethical dilemmas as they arise, and apply ethical decision-making processes in order to resolve the dilemmas. | 0 | 1 | 2 [N/O] | 3 | 4 |
| Conduct self in an ethical manner in all professional activities. | 0 | 1 | 2 [N/O] | 3 | 4 |

## III. INDIVIDUAL AND CULTURAL DIVERSITY

Develop the ability to conduct all professional activities with sensitivity to human diversity, including the ability to deliver high quality services to an increasingly diverse population. Demonstrate knowledge, awareness, sensitivity, and skills when working with diverse individuals and communities who embody a variety of cultural and personal background and characteristics.

| | | | | | |
|---|---|---|---|---|---|
| Demonstrate an understanding of how one's own personal/cultural history, attitudes, and biases may affect how they understand and interact with people different from themselves | 0 | 1 | 2 [N/O] | 3 | 4 |
| Demonstrate knowledge of the current theoretical and empirical knowledge base as it relates to addressing diversity in all professional activities including research, training, supervision/consultation, and service | 0 | 1 | 2 [N/O] | 3 | 4 |
| Demonstrate the ability to integrate awareness and knowledge of individual and cultural differences in the conduct of professional roles (e.g., research, services, and other professional activities). This includes the ability to apply a framework for working effectively with areas of individual and cultural diversity not previously encountered over the course of their careers. Also included is the ability to work effectively with individuals whose group membership, demographic characteristics, or worldviews conflict with their own. | 0 | 1 | 2 [N/O] | 3 | 4 |
| Demonstrate the requisite knowledge base, ability to articulate an approach to working effectively with diverse individuals and groups, and apply this approach effectively in their professional work. | 0 | 1 | 2 [N/O] | 3 | 4 |

## IV. PROFESSIONAL VALUES AND ATTITUDES

Trainees are expected to respond professionally in increasingly complex situations with a greater degree of independence across levels of training.

| | | | | | |
|---|---|---|---|---|---|
| Behave in ways that reflect the values and attitudes of psychology, including integrity, deportment, professional identity, accountability, lifelong learning, and concern for the welfare of others. | 0 | 1 | 2 [N/O] | 3 | 4 |
| Engage in self-reflection regarding one's personal and professional functioning; engage in activities to maintain and | 0 | 1 | 2 | 3 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| improve performance, well-being, and professional effectiveness. | | | [N/O] | | |
| | | | | | |
| Actively seek and demonstrate openness and responsiveness to feedback and supervision. | 0 | 1 | 2 [N/O] | 3 | 4 |
| | | | | | |
| Respond professionally in increasingly complex situations with a greater degree of independence as they progress across levels of training. | 0 | 1 | 2 [N/O] | 3 | 4 |

## V. COMMUNICATION AND INTERPERSONAL SKILLS

| | | | | | |
|---|---|---|---|---|---|
| Communication and interpersonal skills are foundational to education, training, and practice in health services psychology. These skills are essential for any service delivery/activity/interaction, and are evident across the program's expected competencies. Trainees are expected to respond professionally in increasingly complex situations with a greater degree of independence across levels of training. | | | | | |
| | | | | | |
| Develop and maintain effective relationships with a wide range of individuals, including colleagues, communities, organizations, supervisors, supervisees, and those receiving professional services. | 0 | 1 | 2 [N/O] | 3 | 4 |
| | | | | | |
| Produce and comprehend oral, nonverbal, and written communications that are informative and well-integrated; demonstrate a thorough grasp of professional language and concepts. | 0 | 1 | 2 [N/O] | 3 | 4 |
| | | | | | |
| Demonstrate effective interpersonal skills and the ability to manage difficult communication well. | 0 | 1 | 2 [N/O] | 3 | 4 |

## VI. ASSESSMENT

| | | | | | |
|---|---|---|---|---|---|
| Demonstrate competence in conducting evidence-based assessment consistent with the scope of health service psychology. | | | | | |
| | | | | | |
| Demonstrate current knowledge of diagnostic classification systems, functional and dysfunctional behaviors, including consideration of client strengths and psychopathology. | 0 | 1 | 2 [N/O] | 3 | 4 |
| | | | | | |
| Demonstrate understanding of human behavior within its context (e.g., family, social, societal, and cultural). | 0 | 1 | 2 [N/O] | 3 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| Demonstrate the ability to apply the knowledge of functional and dysfunctional behaviors including context to the assessment and/or diagnostic process. | 0 | 1 | 2 [N/O] | 3 | 4 |
| Select and apply assessment methods that draw from the best available empirical literature and that reflect the science of measurement and psychometrics; collect relevant data using multiple sources and methods appropriate to the identified goals and questions of the assessment as well as relevant diversity characteristics of the service recipient. | 0 | 1 | 2 [N/O] | 3 | 4 |
| Interpret assessment results, following current research and professional standards and guidelines, to inform case conceptualization, classification, and recommendations, while guarding against decision-making biases, distinguishing the aspects of assessment that are subjective from those that are objective. | 0 | 1 | 2 [N/O] | 3 | 4 |
| Communicate orally and in written documents the findings and implications of the assessment in an accurate and effective manner sensitive to a range of audiences. | 0 | 1 | 2 [N/O] | 3 | 4 |

## VII. INTERVENTION

| | | | | | |
|---|---|---|---|---|---|
| Trainees demonstrate competence in evidence-based interventions consistent with the scope of Health Service Psychology. Intervention is being defined broadly to include but not be limited to psychotherapy. Interventions may be derived from a variety of theoretical orientations or approaches. The level of intervention includes those directed at an individual, a family, a group, an organization, a community, a population or other systems. | | | | | |
| Establish And maintain effective relationships with the recipients of psychological services. | 0 | 1 | 2 [N/O] | 3 | 4 |
| Develop evidence-based intervention plans specific to the service delivery goals. | 0 | 1 | 2 [N/O] | 3 | 4 |
| Implement interventions informed by the current scientific literature, assessment findings, diversity characteristics, and contextual variables. | 0 | 1 | 2 [N/O] | 3 | 4 |
| Demonstrate the ability to apply the relevant research literature to clinical decision making. | 0 | 1 | 2 [N/O] | 3 | 4 |

| | | | | | |
|---|---|---|---|---|---|
| Modify and adapt evidence-based approaches effectively when a clear evidence-base is lacking. | 0 | 1 | 2 [N/O] | 3 | 4 |
| | | | | | |
| Evaluate intervention effectiveness, and adapt intervention goals and methods consistent with ongoing evaluation. | 0 | 1 | 2 [N/O] | 3 | 4 |

## VIII. SUPERVISION

Supervision is grounded in science and integral to the activities of health service psychology. Supervision involves the mentoring and monitoring of trainees and others in the development of competence and skill in professional practice and the effective evaluation of those skills. Supervisors act as role models and maintain responsibility for the activities they oversee.

| | | | | | |
|---|---|---|---|---|---|
| Demonstrate knowledge of supervision models. | 0 | 1 | 2 [N/O] | 3 | 4 |
| | | | | | |
| Demonstrate knowledge of supervision practices. | 0 | 1 | 2 [N/O] | 3 | 4 |

## IX. CONSULTATION AND INTERPROFESSIONAL/INTERDISCIPLINARY SKILLS

Consultation and interprofessional/interdisciplinary skills are reflected in the intentional collaboration of professionals in health service psychology with other individuals or groups to address a problem, seek or share knowledge, or promote effectiveness in professional activities.

| | | | | | |
|---|---|---|---|---|---|
| Demonstrate knowledge and respect for the roles and perspectives of other professions. | 0 | 1 | 2 [N/O] | 3 | 4 |
| | | | | | |
| Demonstrate knowledge of consultation models and practices. | 0 | 1 | 2 [N/O] | 3 | 4 |

## Overall Assessment of Trainee's Current Level of Competence

Please provide a brief narrative summary of your overall impression of this trainee's current level of competence. In your narrative, please be sure to address the following questions:

- What are the trainee's particular strengths and weaknesses?
- Do you believe that the trainee has reached the level of competence expected by the program at this point in training?
- If applicable, is the trainee ready to move to the next level of training?

## SIGNATURES

_____          _____

(Supervisor signature)                                    Date


_____          _____

(Trainee signature)                                       Date

# Section 4:  Master's Thesis and Dissertation

## I.     Nature, Scope, and Timing of the Masters Thesis:
## A Guide for Students and Advisors

These suggestions are offered as a way to facilitate timely and positive progress through the Masters process.

I.     **Keep the timing and deadlines salient. Break the process down into the schedule of each step. Here is a suggested schedule.**

    A.     **Have a proposal meeting by May or August of First Year.**

        1.     Use the Clinical Research Methods course structure to help. The paper for Clinical Research Methods should be a draft of a proposal and efficiently combines a course requirement with a Masters requirement.

        2.     Note that there are important reasons why the prospectus should be defended before second year starts. The demands of clinical work in second year practicum and/or advanced stat classes make second year a hard time to come up with a masters project. The first year Clinical Research Methods course is designed to set aside time for the proposal.

    B.     **Do a one meeting a semester schedule for second year  data meeting by February, orals by May or data meeting by May and orals by August.**

        1.     Note that there are important advantages to finishing the masters before third year starts. It allows time in the third year for clinical placement, which is particularly important for students who wish to do an unpaid placement (adding 10 hours per week to their workloads). It allows plenty of time in the third year for choosing a comps topic and writing comps.

II.     **Keep the scope and ambition at a reasonable level.**
    A.     Work with your thesis chair and committee to help you determine the size and scope of the project.  At times, thesis projects have been too ambitious.

    B.     There is agreement among faculty that the project should be viewed as research skill development. It is a process to learn and sharpen skills to conceptualize a problem, design a study, analyze and interpret data. The Masters should NOT be viewed as some final career commitment or major research breakthrough.

C. There are some mistaken beliefs that seem to have slowed people down in terms of the study design and requirement.

    1. Community or clinical samples are NOT necessary. Secondary data analysis and/or PGS 100 subjects are just fine.

    2. The Masters should be designed to fit within the set of skills that students will reasonably have by the end of second year. Both qualitative and quantitative projects are fine but neither type of project should require advanced coursework or data collection that cannot be accomplished during the second year. Advanced statistical methods are NOT necessary.

III. **Students must prioritize Masters Activities in choosing among competing activities in the first two years.**

A. The Masters process fits best within the program curriculum if it is completed during the timeline outlined above (i.e., the Proposal completed before clinical demands of practicum are required; project completed before clinical demands of placement are required).

B. When students are thinking about taking on extra clinical/community involvement/coursework demands, these should be thought of as post-Masters activities. If the Masters is completed by the end of the second year, then the third and fourth and fifth years should have adequate room for additional commitments to research/lab commitments, coursework, clinical and community activities.

C. Students should meet regularly with their research advisors to discuss their Masters projects. That person may or may not be the advisor that we initially assigned. The goal is for the student to meet regularly with the faculty member who seems like the best fit to chair their masters project idea. If the initial advisor assignment was not a good fit for a Masters project, then the student should actively seek another faculty member to serve as chair of the Masters.

## II.    Advice about Committee Composition

Regulations concerning committee composition are provided in the Department Graduate Handbook (see "Resources" link).

Masters Thesis Committees.  A Masters Thesis committee consists of 3 faculty members-two inside members and an outside member.  An inside member is defined as a faculty member from either within the student's training area or within the topic area of the project.  Faculty members from other Departments may serve on the committee.  Non-tenure track faculty (e.g., adjunct faculty etc.) require special permission.

Can I have a thesis chair who is outside of the clinical area?  Students may have a non-clinical faculty member chair their Masters Thesis committee.  However, in these cases, students must have a clinical co-chair who can assure that clinical policies and standards are maintained.

Comprehensive Examination and Dissertation Committees.  For Comprehensive Examinations and Dissertations, the committee consists of 4 faculty members-three inside members and an outside member.  An inside member is defined as a faculty member from either within the student's training area or within the topic area of the project.  Faculty members from other Departments may serve on the committee.  Non-tenure track faculty (e.g., adjunct faculty etc.) require special permission.

Can I have a comps or dissertation chair who is outside the clinical area?  Students may have a non-clinical faculty member chair their Comprehensive Examination or Dissertation committee.  However, in these cases, students must have a clinical co-chair who can assure that clinical policies and standards are maintained.

Note on secondary data analyses:  Note that for Dissertations using secondary data, the supervisory committee should maintain independence from the research project (see policy on use of secondary data).

Note:  Students are always free to have more than the required number of committee members.

# III. Master's Thesis Step-by-Step

For up-to-date procedures on navigating the Department's and the Graduate College's required steps, please see the Department's Graduate Handbook:

https://psychology.asu.edu/sites/default/files/psych-phd_hnbk_2020-21.pdf

Also visit the Graduate College website for deadlines and procedures:

https://graduate.asu.edu

## IV.    Applying for Doctoral Candidacy

The dean of the Division of Graduate Studies admits students to candidacy. Ph.D. students must pass the comprehensive examination and defend the dissertation prospectus before admission to candidacy.  Letters are sent when the Division of Graduate Studies receives the forms indicating when students have completed these degree requirements.

There are separate forms to document that you passed the comprehensive exam and that you successfully defended the dissertation prospectus. These documents are titled "Report of Doctoral Comprehensive Examinations" and "Results of the Doctoral Dissertation Proposal/Prospectus" respectively and they are available for download in the Graduate Student section of the departmental web page:

https://psychology.clas.asu.edu/student-life/the-graduate-experience/graduate-resources

Each form has a place for faculty to sign verifying that the degree requirement has been met.  The Department Chair must also sign.  Katie Ulmer will see that they are sent to the Division of Graduate Studies.

# V.    The Use of Secondary Data Sets for Dissertations

The committee discussed four sets of issues that guide evaluations of dissertations in general, that seem especially important to considering the appropriateness of secondary data sets for dissertation projects within our program. The issues so raised actually are not unique to secondary data sets. Rather, they are applicable to all dissertation projects to some degree and may simply become particularly salient in the context of secondary data sets.  Regarding each issue, the committee has formulated a suggestion of policy, procedure, or general guiding principle.

1)    <u>Data collection as an essential skill</u>. The issue that the committee saw as most directly applicable to secondary data sets, was whether the collection of new empirical data is a necessary part of a Ph.D. project. This point of view has been expressed in terms of a view of the dissertation project as one that encompasses the entire research endeavor "from soup to nuts."

The committee felt that students should have experience (and hopefully competence) with five broad domains of research activity as part of their Ph.D. training:

1.    Conceptualizing research questions.
2.    Research design and operationalization of constructs.
3.    Implementation of data collection.
4.    Data reduction and analysis.
5.    Interpretation of results and dissemination of it.

In reviewing these domains, it would not be necessary that each were part of the dissertation. However, if a secondary data set were to be used in a dissertation, then at some other point in the student's training, they should have experience with the conduct of data collection.

It would be useful for some measure of progress within these domains be established <u>prior </u>to the formation of a dissertation committee, to provide the basic information for the student (and subsequently the committee) to know about the appropriateness of a secondary data set for a dissertation project.

To serve this function, we recommend that, at the comps committee review of the general progress of the student in our program, the committee establish the demonstrated research strengths (and weaknesses) of the student vis-à-vis the five domains of research competence listed above. While NOT establishing a fixed decision for the dissertation (as to the appropriateness of a secondary data set), this would provide a specific statement as to the student's experiences to date (more like a review than an editorial decision). Obviously, further activity or information might be brought to bear to influence the chair and the student to go ahead with a dissertation project using a secondary data set, even if that was not accomplished by the time of the comps review.

The implementation of such a review of strengths (see items 1 and 5) would need to be worked out by the faculty. In theory, this would be in parallel with the evaluation of students in terms of professional training.

2) <u>Ownership/independence of student work.</u> The committee saw no difference, in principle, between projects involving primary data sets and secondary data sets in this regard. In all dissertation projects, the student is expected to make an independent contribution to psychological science, and is expected to "own" a rather complex project in the sense of being responsible for the conceptual and methodological decisions involved in the research endeavor as well as the conceptual implications of the findings. If those decisions pre-dated the specific project (as in a secondary data set), the student is responsible for knowing the decisions that were made as to particular methodologies, and why (e.g., how missing data was handled, what was done for an interrupted interview, were family interviews in same or different rooms). If that information is not available, then they should know the potential alternatives and the cost/benefit trade-offs for the alternatives.

The faculty may also wish to discuss whether there are general expectations of dissertation projects in terms of authorship (e.g., the level of contribution for a dissertation is that usually associated with being first author).

3) <u>Existing data sets as constraints on the project.</u> A potential concern with secondary data sets is that the operationalizations are limited to the existing data. This pre-existing constraint may compromise the quality of the project, which would lead to a data-driven rather than an idea-driven or question-driven endeavor that would be less than ideal.

The committee felt that the standards for the acceptability of operationalization are general for all dissertations. Although with secondary data sets the committee has somewhat fewer degrees of freedom, we should expect that the finished project would result in a publishable contribution to the literature. Further, additional data collection to supplement analysis of secondary data may be a realistic option for some proposals. Thus, we can apply the standard of an editor recognizing that there will always be a trade-off between the uniqueness of the data set or importance of the question and the expense of alternatives and quality of operationalization.

4) <u>Heterogeneity of dissertation committees.</u> The committee felt it is important for all dissertations to separate the training function of a supervisory committee from the "research group" function of collaborators in a joint project. As a training committee, the dissertation committee should be independent enough of the project so that the training function would never be compromised (or appear to be compromised) The committee felt that all dissertation committees should have at least two members who are not directly connected to the data set itself.

# Section 5:  Comprehensive Examination

I.      Guidelines for Comprehensive Examinations in Clinical Psychology

# I.    Guidelines for Comprehensive Examinations in Clinical Psychology

Approved by Clinical Faculty, May 4, 2001
Additions/Revisions, November 2001, March 2007, April 2010

General Policies

The comprehensive exam requires the student to demonstrate a thorough understanding of research and theoretical issues in clinical psychology through written work and in an oral defense with members of the student's supervisory committee. Comprehensives are taken after a student has completed his/her Master's thesis and before submission of the dissertation prospectus.

To fulfill the comprehensive examination requirement in clinical psychology, eligible students will elect to write either a critical review paper or a grant application.  Papers and grant proposals can address any topic related to clinical psychology.  As a general guide, comprehensive examination projects can be concerned with any topic that would be suitable for a dissertation in our program.

A student who chooses to write a literature review should identify a topic in the empirical literature that has not been the topic of a recent review.  Papers should conform to APA style.  The text of the student's paper should be 40-50 pages.

Grant proposals should conform to one of the existing formats that are used to fund dissertation research in psychology (e.g., National Research Service Award). If yours deviates from this format, consult the faculty about its appropriateness (Brief fellowship applications that focus on the credentials of the applicant and the mentoring environment are not appropriate for comps). If you are unsure whether or not your format would be appropriate, please check with your chair and/or with the Director of Clinical Training. Grant proposals should include all required components except for letters of recommendation and actual IRB approval (the human subjects section is required). Students whose grants draw from a faculty mentor's parent grant should not use "canned" sections from the parent grant. Students must write all sections. **For grant applications (such as NRSAs) that are less than 10 single-spaced pages, a 10-15 page supplement (double-spaced, 11 pt Arial font) is required.  The supplement will contain a selective review and analysis of prior research that provided the context for the significance of the proposed research and its innovativeness. Students will submit the supplement with the grant application at the appropriate deadline.**

Comprehensive Examination Committee

Students will have a 4-person supervisory committee that will evaluate the written product

and conduct an oral examination. Orals can be conducted if 3 committee members are physically present, and the 4ᵗʰ member sends in questions.

## Collaboration

Students can consult with committee members about their comprehensive examination projects at any time, but committee members are not allowed to read drafts or provide written comments prior to the student's submission of the exam. This is true for both grant proposals and literature reviews. Successful grant submissions will require faculty collaboration and input, but this must occur **after** the comprehensive examination is complete (i.e., after the student has passed orals). If there is difficulty about the funding agency's submission dates, the student may submit his/her comp early and have an early orals and then work with the faculty member to submit it.

Eligibility for Taking Comprehensive Examinations

Students must have a successfully defended master's thesis, at least a B average in coursework, and an overall satisfactory rating in clinical practica and placements.

Timing

Comprehensive examination projects must be submitted by the first day of classes in the fall semester of the student's fourth year of the doctoral program.

Students will distribute copies of the completed exam to all committee members and to the Administrative Secretary for the Clinical Psychology Graduate Program.

In the rare event that an examination is not submitted on the due date, it will receive a failing grade. The Graduate College allows students to re-take comprehensive examinations once, but no earlier than three months after the first examination. Students who fail to meet the fall deadline will submit their examinations on the first day of classes in the spring semester of the fourth year.

Students who want to complete comprehensive examinations before their fourth year of graduate study should meet with their advisors to select a fall (first day of classes) or spring (first day of classes) submission date.

Students who are admitted with a master's degree, will submit comprehensive exams on the first day of the fall semester of their third year in residence. Students who are admitted with the equivalent of at least one-year's worth of prior graduate work will submit comprehensive examinations on the first day of the fall semester of their third year in residence.

Oral Evaluation

Oral examinations should be scheduled as soon as possible after the submission deadlines, but definitely before October 1 for fall submission and before March 1 for spring submissions. If at least three of the four-committee members determine that the written product and oral examination were satisfactory, the student will have passed the exam.

Students should begin trying to schedule their orals as early as possible. If possible, students should hand in to the Graduate Secretary along with their comps paper, the names of the committee members and the date of the oral. If scheduling is still unknown at the time of the paper submission, please inform the Doctoral Program Coordinator of the orals date as soon as possible.

NOTE: An oral can be conducted with only 3 committee members physically present, and the 4th member sending in questions. Orals should not require any more than 1 ½ hours.

If students do not pass, supervisory committees can allow them to apply to the Division of Graduate Studies for a second examination at the next available deadline.

In rare circumstances, students may pass with minor revisions. These revisions must be submitted by November 1 for fall submissions and by April 1 for spring submission and will be evaluated by the committee chair.

Petitions for Timeline Adjustments

The faculty recognizes that there might be rare and unpredictable circumstances (e.g., a serious illness) that might prevent a student from adhering to the regular timeline. Students may petition the faculty to request an adjustment to the timeline. The petition should be submitted to the DCT as soon as it is apparent that progress on the comprehensive exam is so seriously compromised that it is unrealistic to adhere to the regular timeline. The clinical faculty as a whole will consider each petition and render a judgment.

These guidelines affect students who were admitted in the fall, 2001 and thereafter.

# Section 6:  The Clinical Psychology Center

**POLICIES AND PROCEDURES**

**OF THE**

**CLINICAL PSYCHOLOGY CENTER**

**ARIZONA STATE UNIVERSITY**

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**Revised August 2020**

## Table of Contents

# I.    Mission Statement and Overview

## MISSION STATEMENT

It is the mission of the Clinical Psychology Center to provide excellence in training for our students and outstanding service to our clients and the community.

## OVERVIEW

The Clinical Psychology Center (CPC) was established in 1959 as The Psychology Clinic and renamed in 1969.  In 2014, the CPC moved to its current location at 1100 E. University Drive in the University Center, Building A, Suite 116.  This east of University and Rural, north of University on Athlete's Place, about 15 minutes' walk from the ASU Campus.

The CPC offers a variety of psychological services to the greater Phoenix community.  Services provided include individual, couples, family therapy, and group programs.  We provide traditional psychological assessment in addition to the evaluation of those seeking services through the Division of Developmental Disabilities or the Rehabilitation Services Administration.  We also provide Brief Alcohol Screening and Intervention for College Students (BASICS), an evidence-based, educational approach used to address problematic alcohol use.  In addition to these traditional clinical services, therapists from the CPC take part in a speakers' bureau and work with community agencies and local schools.   More than 400 psychologists have been trained at the CPC.

The most common problems of those seen at the CPC are depression, relationship problems, anxiety, anger, stress, adjustment to chronic illness, and poor academic performance.  The CPC has provided service for over 11,000 people.

Most of the therapists at the CPC are graduate students in the doctoral program in clinical psychology. Faculty members, who are licensed psychologists, provide supervision.   The CPC operates on a sliding fee scale for therapy, has evening appointments, and is open all year.

## II. Clients: Who are they and who may see them?

**CLIENTS - WHO ARE THEY?**

The CPC is open to the general public. About two-thirds of our clients come from the community-at-large and the remaining third from campus.  ASU students may be seen here but will be charged; services are also available to them at reduced rates at various places on campus (see Referral List, under "ASU Referrals"). All potential clients who are ASU students should be informed of the different services and fee arrangements available on campus before scheduling an intake session with them. About 20% of our clientele come from diverse cultural and ethnic backgrounds.

**CLIENTS - WHO MAY SEE THEM?**

Any clinical student beyond the first year can see clients in the CPC. If a student is not in 2nd Year Practicum or an ATM, she/he must arrange to be supervised by a clinical faculty member.

All individuals seeing clients must adhere to CPC policies and procedures, although faculty members are free to set their own fees. Students at all year-levels are welcome to observe cases in the CPC, with the knowledge and permission of the client, therapist, and supervisor.

No one who is not a faculty member or student may provide services in the CPC.

# III. Client Contact Procedures, Scheduling, and Automatic Termination

**CLIENT CONTACT PROCEDURES**

Once the Resident Therapist has verified appropriateness for the CPC, the Resident Therapist will determine the appropriate assignment of the case (second year practicum, ATM, Resident Therapist). The Contact Sheet will be placed in the Clients Awaiting Assignment notebooks (there are books for those awaiting assessment and those awaiting therapy) located in the locked file cabinet in the student room, 190B.

For practicum students, the practicum supervisor will review the information of clients appropriate for second year students and assign cases in the first few weeks of class. Second and third clients will subsequently be assigned after the intake for the first (second) client is completed so that a caseload of three clients is maintained throughout the year.

Evaluators/Therapists above second year can review the Contact Sheets in this notebook to select new cases. If clients are not taken in a timely manner and caseloads are not full, assignments will be made by the supervisor of the ATM or the Center Director.

If there are no therapists available, the client is informed of the anticipated wait time and given appropriate referrals. Our waitlist can be very lengthy.

When looking for a new client, advanced therapists should have a "first come, first served" approach and take those potential clients that have been waiting the longest. An advanced student therapist can briefly sign out a Contact Sheet, by filling in the necessary information on the sign-out sheet in the notebook kept in the second drawer to the right of the mail boxes. This information should include the date taken and the student's name. The Contact Sheet should be signed out only briefly, and should be maintained with proper precautions for confidentiality. It should never leave the CPC.

Advanced students must then confer with their supervisor if they are considering taking on the client. The supervisor must be competent to supervise that particular client. If the student decides not to schedule an appointment with the client, she/he should return the Contact Sheet to its book and cross-out her/his entry on the sign-out sheet.

If the advanced student therapist/evaluator decides to work with the client or wishes to gather more information, she/he should contact the prospective client by telephone. All contacts and attempts to contact the prospective client prior to intake should be noted by the student therapist on the Contact Sheet. Date of contact and therapist's initials should appear with relevant comments (e.g., "left message", "no one answered", "scheduled" etc.).

If the prospective client is no longer interested in available services, the therapist should note the reason that the person is no longer interested (e.g. problem resolved, in therapy elsewhere etc.) and indicate that the client has "Terminated Before Intake (TBI)" on the Contact Sheet and place it in the Terminated Before Intake notebook, also kept in that drawer. The student/therapist should not terminate a prospective client prior to intake unless she/he receives clear instructions to do so from the person who requested services. If three consecutive messages are not returned or at least five calls on different days

and times are not answered, the case may be TBI.

If the student schedules an initial interview, it should be explained to the client beforehand that there is a $25.00 fee for the intake interview, and that a permanent fee, based on a sliding scale, will be established at the intake. (It is sometimes helpful to keep a copy of the fee schedules with you when phoning, so that you can provide a fee estimate in advance if the client is very anxious to know.)   The client should also be asked to come 20-25 minutes early, just this once, to fill out some paperwork before the intake.  It is also a good idea to inform the client of supervision, observation, and video-recording policies at this time.

If the client will be driving to the CPC, the therapist should also explain the CPC policy for client parking. The client will park in the three spaces reserved for the CPC opposite the clinic.  If those spaces are filled, the client may have to pay for parking at one of the kiosks.

In the case of a divorced parent bringing a minor child in for treatment, it should be made clear that proof of their authority to give consent to treatment (i.e., divorce decree, parenting plan, or custody agreement) should be brought to the intake OR that co-authorization from the joint custodial parent will be required. (A photocopy of that documentation must be placed in their treatment file.)

Once the intake is scheduled, the telephone Contact Sheet should be given to the CPC Secretary. The appointment must be noted, and marked as an intake, in the Appointment Book kept at the CPC Secretary's desk. When the client arrives for the intake interview, the CPC Secretary will administer the intake data forms (there are different forms depending on whether the client is an individual, couple, family or child case) and the OQ-45 to the client.

The client will also be given a fee contract, which will be filled out with the therapist during the intake.

The therapist will determine the client's fee, using the CPC fee schedule. There are separate fee schedules for individuals, couple/family cases, and groups. If the client agrees to the determined fee, she/he signs the fee contract. If the client requests a fee adjustment, the student therapist must discuss this with his or her supervisor and/or the CPC Director, who will make the final decision on any change in fee. There is fee flexibility when warranted, however, some fee will always be charged.

Some clients might question the CPC's policies concerning observation and supervision. If the client refuses to sign the consent form, she/he cannot be treated at the CPC by a student therapist (however, faculty seeing clients may make observation arrangements with clients on a case-by-case basis). The student therapist may hold a brief interview to discuss the observation policy and, if necessary, arrange a referral to another agency or therapy resource. No intake interview or therapeutic contact may occur without a signed consent form. Again, note that in cases of divorced parents bringing in a minor child for treatment, proof must be supplied as to their authority to grant consent to treatment (i.e., sole custody) or consent of both parents must be obtained. In the either case, a copy of the appropriate documentation should be placed in their file.

If the client (or prospective client) is a minor (under 18), the parent or guardian must sign the necessary forms, including a consent for release of information from the minor's school.  If the minor turns 18 in the course of therapy, the now-adult must then sign new forms and changes to confidentiality regarding communication with parents must be discussed and a release of information signed, if relevant.

Authorization for the release of information to or from other agencies, when necessary, is requested using the release form.

Before the intake interview, the CPC Secretary will open a file for the client. All intake paperwork should be given to the secretary after the intake session.

**APPOINTMENTS**
Appointments should be made well in advance, and ideally, after checking in the appointment book, to ensure that space is available. The CPC hours are from 8 a.m.-8 p.m. Monday through Thursday; and 8 a.m. – 4:00 p.m. Friday.  Appointments during other times are not allowed (except in very special circumstances with appropriate personnel backup).  All students need another person present in the CPC when providing service.  Second year practicum students must schedule appointments when a senior clinician (RT, Director, supervisor, etc.) is on-site.

The best time to make each successive appointment is when the receipt for that session's payment is written at the secretary's desk at the end of the therapy session. Future appointments are recorded on the client's receipt to serve as a reminder to them. It is the therapist's responsibility to write each appointment in the appointment book.

Appointments for sessions outside the CPC (e.g., in the client's house or in community settings) are exceedingly rare, and permissible only if there is a clear rationale in the treatment plan and the visits have been approved by the supervisor and CPC Director. The secretary should be notified of such appointments so that appropriate records can be kept and billing can occur.

**AUTOMATIC TERMINATION**

Sometimes a client misses an appointment or "no shows" without contacting the Center beforehand which results in a charge to the client for the missed session. If a client misses 3 consecutive appointments or misses three out of six scheduled appointments without adequate notice or excuse, then the client will be automatically terminated from therapy. This policy should be explained to clients during the intake session, and the importance of keeping appointments should be stressed.  A letter should be sent to the client, reviewing the policy, detailing their absences, including a copy of their signed agreement, informing him/her of the termination, and listing alternative resources.

# IV. Receipts, Fees, and Insurance Claims

**SERVICE RECEIPTS**

The CPC Secretary will generate receipts for services at the end of each therapy session when fees are collected. Receipts given to the client indicate the date, type of service, fee, balance due and therapist's name. It is vital that the CPC keep accurate fee records on each client. When a client fails to keep a scheduled appointment, the secretary should be notified. In cases of "no-shows" or inadequate notice of cancellation, the client will be charged for the missed session (see FEES below).

In the secretary's absence, Resident Therapists are responsible for completing the service receipt, giving the client a receipt, and placing the client's fee in the cash box kept in the secretary's desk.

**FEES**

Because the CPC is partially self-supporting, it is dependent upon the fees paid by clients. These fees are charged on a sliding scale determined by income and the number of dependents. Other allowable expenses which may be deducted from gross monthly income include outstanding medical bills, child support, child care payments and tuition, if paid by the client. Fees are significantly lower than most other mental health facilities. Copies of the fee schedules for individuals, couples/families, and groups, are available in the Center office. As noted earlier, fees can be adjusted at the discretion of the faculty supervisor and/or CPC Director. Please use the form to request a fee adjustment.

A copy of the fee contract is included in the client's folder. Clients should be made familiar with all the terms of the contract. Clients who fail to cancel appointments 24 hours in advance (except in emergencies) will be charged for the missed appointment. This is stated on the fee contract. Therapists should be alert to changes in the client's financial situation that could affect the fee. A statement to that effect is in the fee contract.

Fees should be paid at the time of each session. ASU students have the option of charging their fees to their student accounts. If other arrangements are made, they must first be approved by a faculty supervisor. Arrangements that depart significantly from our established procedures (e.g., if the client is running up a substantial bill) should be approved by the CPC Director. Therapists are expected to monitor payments in accordance with established guidelines and remind clients if they fall behind in payments. If a client misses payment for three consecutive sessions despite reminders, the CPC Director is to be informed and a solution reached jointly by the therapist, his/her supervisor and the Director.

Many group therapy programs will have criteria for determining who is appropriate for inclusion. A prospective group member's appropriateness for a group is not always apparent prior to the first session. To avoid charging a client who ultimately will be excluded from participation, clients are not charged for screening sessions (but are responsible for paying for their own parking).

**INSURANCE CLAIM FORMS**

In the very rare case that a client is trying to use insurance benefits to pay for services, the CPC policy is

to request that clients pay for services and be reimbursed by their insurance carrier, if any. In filling out the CPC portion of a claim form for a client, <u>both</u> the student therapist and the faculty supervisor should sign the form, and attach to it (on CPC letterhead) a brief cover letter identifying the direct provider, the nature of the supervisory relationship, and the Ph.D. licensed status of the supervisor. (A sample insurance cover letter can be obtained from the CPC Secretary). Copies of the form and the cover letter should be placed in the client's file. In some extremely rare cases, the CPC <u>will</u> bill the insurance company directly, but such arrangements should be made only with the approval of the CPC Director and the CPC Secretary. The client will want to verify in advance that their insurance company will cover services by student-therapists, a prospect which is highly unlikely.

# V. Supervision

Second year practicum students should have one hour of individual supervision per week. Group supervision will occur in practicum class. Resident therapists should have one hour of individual supervision per 10 hours of pre-internship professional experience. Group supervision will occur in the resident therapist meeting (twice per month). Students in the ATM class will receive group supervision in class as well as individual supervision as arranged with the instructor. Early on, students and supervisors review expectations that are formalized in a supervision contract (See appendix L). As a part of that contract, the pair collaborate to establish a training plan for the duration of the supervision (see Appendix L). Students prepare for supervision by reviewing video of their most recent session and forwarding segments of note to the supervisor. Notes are written and submitted to the supervisor for editing and eventual signature.

Supervisors include clinical faculty as well as adjunct clinical faculty. These adjunct supervisors are licensed to practice psychology in the state of Arizona and have been approved by the Placement and Clinic Policy Committee. Supervisors keep notes regarding on-going supervision. Notes list critical clinical issues, directives for the supervisee is to follow, changes in diagnosis or treatment plan, details of any risk and its resolution. The student's problems in professional competence, if any, should also be documented in these notes. These notes serve as a basis for formative evaluation throughout supervision. Supervisors regularly review video of therapy sessions. The review of session video and documentation of supervision sessions allows supervisors to provide summative evaluations according to the profession- wide competencies at the conclusion of supervision. (see page 52)

During the COVID-19 pandemic, the program has followed APA's advice in the March 12, 2020 e-mail correspondence that advised programs to follow the guidance offered by their institutional administration, as well as that from the U.S. Center for Disease Control and our state and local health department, in regard to maintaining operations in a manner that reduces risk of exposure to the virus. In the e-mail, the COA recognized that a temporary transition to telesupervision may be necessary Thus; following this guidance, telesupervision has been used extensively to enhance the safety of supervisors and students. In addition to the procedures above, the supervisory pair conduct a supervision risk-analysis (see Appendix H). When risks have been addressed, the supervisory pair complete a telesupervision addendum to the previous contract (see Appendix M).

In non-pandemic conditions, telesupervision may not account for more than 50% of the total supervision at a given practicum site, and may not be utilized until a student has completed his/her first intervention practicum experience. Telesupervision will not be used until the student has had sufficient experience and in-person supervision in intervention at the doctoral level and possesses a level of competence to justify this modality of supervision in his/her sequence of training. Prior to the use of telesupervision, generally accepted best practices will be addressed.

Programs utilizing ANY amount of telesupervision need to have a formal policy addressing their utilization of this supervision modality, including but not limited to:

• An explicit rationale for using telesupervision.  Telesupervision can help with clinical placements in a cost- and time-efficient manner. It can eliminate barriers such as distance or bad weather conditions that supervisors might face in providing weekly supervision. Telesupervision can decrease travel time from facility to facility, allowing supervisors to focus on supervision itself. It can also help with training more students, who may live in remote areas or attend distance graduate programs. Telesupervision allows universities to hire more qualified candidates to supervise students during a clinical practicum, as they can reach more geographic locations. Telesupervision can help students with their clinical placements, especially if they live in remote areas. It can also provide a more consistent learning experience if other barriers prevent students from consistently attending brick and mortar clinics or university clinics. Telesupervision has been found to increase communication between students and supervisors, as they can instantly connect via video conferencing platforms to discuss their clinical observations, needs, and objectives in more detail, without emailing back and forth. Students may also benefit financially from telesupervision, as it eliminates costs associated with traveling

• How telesupervision is consistent with their overall aims and training outcomes;  Part of our mission is to prepare students for professional careers in a variety of settings where they engage in research, teaching, or clinical supervision.  Our graduates report a diverse range of activities in their current positions including psychotherapy (64%), research (57%), supervision (48%), consultation (46%), teaching (43%), administration (39%), assessment (36%), and preventive interventions (14%).  As was stated at the Council on Clinical Health Psychology Training Programs mid-winter meeting from 2021 regarding teletherapy and telesupervision, "the Genie is out of the bottle" and will continue to some degree after the COVID-19 pandemic. Demonstrating competence in the ethics, efficacy, provision, and technological aspects of telesupervision will facilitate the achievement of the desired outcomes for our students.

• How and when telesupervision is utilized in clinical training; telesupervision is only used when face-to-face supervision is impractical and/or a specific training competence area is identified (e.g., the provision of telepsychology services in the future).  The supervisory dyad would submit a petition to the director of the clinical psychology Center describing the need for telesupervision and specifying the steps taken to ensure adequate Education in the use of a tele supervision, sufficient technology and facility in its use, quality of training, confidentiality of client and trainee, and adequate emergency procedures.  The director of the clinical psychology Center would review and decide on the sufficiency of the petition.

• How it is determined which trainees can participate in telesupervision; trainees who participate in tele supervision will have demonstrated competence at their level of training in establishing relationships with clients and providing psychotherapeutic intervention.  The student's practicum supervisor, using the program's form for evaluating profession-wide competency (see page 52) can make this determination.  Based on their face-to- face meetings, the supervisor will judge the strength of the supervisory Alliance (see appendix G) and determine if it is sufficient for tele supervision.

• How the program ensures that relationships between supervisors and trainees are established at the onset of the supervisory experience; the program can ensure that relationships in the supervisory dyad are established at the onset of the supervisory experience by using the

supervisory Alliance rating form.  This supervisory dyad can use these forms to examine their relationship and, if necessary, consult with the director of the clinical psychology Center to mediate ruptures in the supervisory Alliance.

• How an off-site supervisor maintains full professional responsibility for clinical cases; as is the case with all supervision, supervisors maintain full professional responsibility for all clinical cases.  At the outset of clinical services, the student discloses to the client his/her trainee status and provides the name of the supervisor.  The supervisor hears descriptions of clinical material, reviews notes, and views video to maintain up-to-date information and obtain an independent perspective in order to provide oversight for all cases.

• How non-scheduled consultation and crisis coverage are managed; the means to obtain non-scheduled consultation and crisis coverage are specified in the supervision contract.  Preferred methods of contact and alternative supervisors (e.g., vacation coverage, etc.) are described in the contract.

• How privacy and confidentiality of the client and trainees are assured; tele supervision is conducted over a secure zoom network provided by the University. HIPAA compliant video conferencing platform should include unique user identification; verification that a person or entity seeking access is the one claimed; encryptions at the database, video conferencing and server's levels; and have systems in place for breach notifications and audit controls.  The tele supervision risk analysis examines issues of privacy and confidentiality, insuring that adequate private space is available for tele supervision.

• The technology and quality requirement and any education in the use of this technology that is required by either trainee or supervisor.  Again, the tele the supervision risk analysis examines the adequacy of technology to be used.  Students in supervisors are required to complete the APA training on tele psychology prior to the use of tele supervision.

# VI.  Evaluations

**EVALUATIONS**

Many people call the CPC to obtain assessments.  Generally, these are ASU students who have been to Disability Resources Center (480-965-1234) and need additional documentation to substantiate their request for academic accommodations.  Other requests are received from counselors at Arizona Rehabilitation Services Administration/Vocational Rehabilitation for their clients with visual impairment or other disabilities, or from those seeking evaluation to support applications to the Arizona Division of Developmental Disability. At other times, students from other colleges or parents of younger children may want an evaluation.  The fees for assessment are established at an all-inclusive, flat rate. The fees vary according to the referral question and the evaluation procedures conducted.  The fee schedule is available from the Center secretary.  There are no discounts.

Forms and questionnaires can be mailed to the client before the initial appointment.

Most of the testing materials are kept in the four-drawer file and the two door cabinet in the Grand Canyon Room 199A.  Test kits, or manuals should be checked out using the clipboard near the door and reserved by noting their use in the appointment book in the space allocated for the testing appointment. Computer administered tests, such as the MMPI-2 and the CVLT-II, are installed in 199A, as are the computer scoring programs.  Detailed instructions about how to use these programs are in a three-ring binder on the credenza.

After testing is complete, the results, conclusions, and recommendations are documented in a report.  A psychometric summary, containing all relevant scores, is also prepared.  Generally, the report is given to the client at the feedback session, along with the summary.  Copies are kept in the chart.  With written consent, the report and summary can be sent to the Disability Resource Center or other professionals.

# VII. Client Records and Chart Review

**CENTER RECORDS**

The recommended intake format is available in the appendix (*Intake Summary, Appendix A*). Therapists should use client initials, rather than names, on *drafts* in order to protect confidentiality. Full names and other identifying information would be included in final drafts of intakes, termination summaries, and reports. There is also a Developmental History and a Health History form available. All final documents must be signed by both the therapist <u>and</u> the supervisor. Therapists may want to bring a Therapist Intake Outline or Child Intake into the intake session, to help them organize their information-gathering. Supervisors are likely to recommend changes to be made in initial drafts of the Intake Summary, before signing off on a final version. The Intake Summary should be placed in the client's folder within two weeks after the last intake session (it is expected that 1 to 3 sessions would be the usual range for obtaining client history)

Subsequent records, i.e., progress notes (Appendix E), usually will be kept according to the Problem Oriented Record system. A sample file is available in the CPC office with a brief description of the system and additional information is available in the 2<sup>nd</sup> Year Practicum Orientation Manual. Special systems of record-keeping for members of therapy groups should be worked out with the appropriate supervisor. It is expected that supervisors will read all progress notes on a regular basis, and supervisors must co-sign all notes. While we do not conduct "telephone sessions" in the CPC, telephone contacts with clients regarding sensitive issues (i.e., therapeutically relevant material is discussed or the client makes an emergency call where suicidality is assessed) should also be charted.

Termination Summaries should be presented in draft form to the supervisor within two weeks after termination, or within one month after the last session if no formal termination occurred (e.g., if they "no show" three times in a row, etc.). The Termination Summary should follow the standard format shown in Appendix B. Outcome, as suggested by the serial BSI administrations, should be discussed. When a client is being transferred directly from one therapist to another, a Transfer Summary (Appendix D) by the terminating therapist is written. It takes the place of the Termination Summary and obviates the need for a new Intake Summary.

**ELECTRONIC HEALTH RECORD SYSTEM**

The CPC is in the process of implementing an electronic health record (EHR). Once live, all records for new clients will be maintained electronically. Paper charts will be maintained for existing clients. New documentation procedures will be established prior to implementation of the EHR, and all students will receive training prior to activation of the EHR. Electronic progress notes must be entered within 24 hours of the session.

**CHART REVIEW**

At least once each semester (in November and April), the CPC Clinic Coordinator will review all active charts, to ensure that client files are kept in proper format and that all paperwork is up-to-date. Students should give completed documents to the Clinic Coordinator so that they can be audited and filed. Maintaining accurate and up-to-date records is an ethical obligation and a demonstration of professional competence (both of which are referenced in letters of recommendation for placement and internship). Delinquent individuals and their supervisors will be notified and instructed to remedy the situation; this includes faculty. The CPC Director will also be notified of all delinquent paperwork. If documentation is not completed in a timely manner, the student's advisor will be contacted and the Director of Clinical Training may be notified. Clinical activities may be curtailed until documentation is completed.

# VIII.  Referring Clients to Psychiatrists

**REFERRING CLIENTS TO PSYCHIATRISTS**

In certain cases, a student-therapist and his/her supervisor may agree that a client could benefit from a psychiatric consultation. If the client is <u>not</u> an ASU student, the therapist may check with the supervisor or with a Resident Therapist to decide on an appropriate community referral. If the client <u>is</u> an ASU student, there are three different procedures.  If the ASU student needs a refill of previously prescribed medication, they can go directly to Student Health Services.  If the ASU student has the ASU student health insurance, s/he must get an initial evaluation through ASU Counseling Services (<u>480-965-6147</u>). Finally, if the ASU student has another insurance plan, then check with supervisors to make a direct referral to a community psychiatrist.

When referring clients to Student Health, the psychiatrists may prefer the CPC therapist contact them ahead of time, regarding the referral. They may want either verbal or written information about the client and the reason for wanting a psychiatric consultation. Remember to get signed informed consent for release-of-information (using the forms described above under '"Client Contact Procedures"), prior to communicating any client information to a psychiatrist.

# IX. Clinic Facilities and Resources

**THERAPY ROOMS**

Furniture should not be moved from rooms. When a session is in progress, a DO NOT DISTURB sign should always be placed on the door. Don't forget to remove it after the session. Therapists should adhere to the scheduled end-time for a session whenever possible. If a session is going to run overtime, the therapist should leave the room briefly and notify the secretary so that she/he can make appropriate arrangements for other clients. A stereo system is on the counter in the therapy room hallway with CDs of soft music or nature sounds that can be used to mask sound in the therapy rooms. Each room also contains a folder containing material that will help the therapist assess and intervene with a client's suicidal ideation.

**MAILBOXES**

Mailboxes are provided for all students, faculty, and supervisors involved in second-year practicum or advanced practicum courses. These mailboxes are only for information that is not confidential. Anything with information that could identify clients should be placed in the locked files below the mailboxes.

**TELEPHONES**

Each faculty office, the Resident Therapists' offices, and the therapist workroom (l90 B) have phones.

**EQUIPMENT**

A Guide to the CPC recording and playback systems of cameras, computers, and monitors is contained in the Second Year Practicum Orientation Manual. These procedures are also discussed in the Practicum Orientation just prior to starting the second year. This should be reviewed carefully before attempting to use any equipment, and it is highly recommended that a training session be arranged with a Resident Therapist. Stopwatches, testing materials, books, CD players, etc. are available for clinical use within the CPC. Materials should be checked out on the sign-out sheet located in 199A. If you are using testing equipment, it is a good idea to make a note in the appointment book of the tests you will be using. That way, others can plan accordingly if they will be testing at the same time. If equipment is signed out by either students or faculty, an estimated time of return should be given. In all cases, the individual signing out the equipment is responsible for returning the equipment in good condition.

# X. Guidelines Regarding Non-Practicum Related Use of Clinic Space

1.      The priority of the CPC is the delivery of psychotherapy and assessment services and training.

2.      Any non-clinical use of the space cannot interfere with the functioning of the CPC in terms of the number of people involved, space demands, conduct, and noise level.  The CPC is a professional treatment center, and professional standards must be maintained at all times.

3.      <u>Research</u>:  Priority will be given to research setting and/or the type of facilities available in the CPC.  Projects involving a very large number of subjects or time will ordinarily not be approved.

4.      <u>Small Classes</u>:  These requests will be handled as the need arises.

5.      All requests for use of CPC space must be submitted to the PCPC in writing well in advance of the date of the proposed use.

# XI.  Recording and Confidentiality Policies

**CENTER THERAPY RECORDING POLICY**

It is mandatory for second year students and common for advanced therapists to record their therapy sessions and to review the recordings with their faculty supervisors. Recordings are stored on the dedicated server in 199F.  Recordings should be reviewed only in clinic rooms or in the offices of supervising faculty who are using the secure portal provided by the REACH Institute.  On occasion, an RT may want an external supervisor to review a recorded session.  This can be accomplished by saving the session to an encrypted flash-drive with password protection before viewing at the supervisor's office.  Beyond these circumstances, IT IS FORBIDDEN TO REMOVE RECORDINGS FROM THE CENTER OR TO REVIEW THEM OUTSIDE THE CPC. We cannot protect the confidentiality of recordings when they are reviewed on home computers or in other settings where non-Center personnel might be present or might have access to the recordings.

Video recordings should be deleted after supervision has been obtained. Exceptions to keep a recording (i.e. for a case presentation) need to be approved by the clinic director. Otherwise, all videos should be deleted within 3 weeks of the recording date.

**CONFIDENTIALITY**

Confidentiality is one of the core values of psychotherapy and fundamental in our Ethics Code.  The importance of confidentiality is cannot be over-emphasized. As a therapy relationship is built on trust, breaking confidentiality not only will have an impact on the current therapy relationship, but may hinder the client's possibility of trusting any other therapist enough to form any future therapeutic alliances. A breach of confidentiality also represents an infraction of APA ethical guidelines, and may hinder a therapist's chances of ever getting licensed as a psychologist (or may result in loss of license for a professional). There can also be legal liability for breaking confidentiality; thus, a therapist's unprofessional actions can result in the supervisor being held legally responsible, in addition to the therapist and training center.

The CPC policy on confidentiality necessarily allows for discussion of cases (including showing video-recording) with other CPC staff, including other therapists, supervisors, or the CPC Director. The client has given her/his permission for this policy when she/he signs the consent form, before the Intake. Secretarial staff (including answering service) will necessarily know a client's identity, and possibly diagnosis, status with regard to suicidality, and other limited information. Otherwise, however, it is forbidden to share any case material in any way with anyone else.

Any other discussion of cases, without authorization by the client, represents a breach of confidentiality.  Consent to release information to other health-care agencies (e.g., a psychiatrist working on the case, or the client's general physician, etc.) must be authorized by the client (see very bottom of "Contact

Procedures").

The following are ways that a therapist unintentionally could break confidentiality:

1.      Discussing a case with another CPC staff member in a hall of the Psychology Building, where someone not affiliated with the CPC could overhear the conversation.

2.      Calling the client from your home, if other people could hear your end of the phone conversation or listen in.
3.      Calling clients at their work-place, and leaving a message with the client's co-worker that you are calling from the CPC, without the client having given you permission to leave such a message. (The client's preference for how to identify yourself in a message is clearly marked on the Contact Sheet.)

4.      Taking or writing client notes outside of the CPC; or leaving progress notes on a desk, visible on a computer screen, or accessible in computer files, or even in the CPC where clients or others might walk by.

5.      Failing to adequately protect electronic files

To avoid the necessity of removing video recordings, progress notes, or other confidential materials from the CPC, Room 190 B has been made into a private work room. It contains several computers, three of which are encrypted and able to store client information, a telephone, and a locking file cabinet for storing confidential materials (such as personal notes, supervisory notes, etc.) needed after the main CPC office is closed. Again, confidential materials are not to leave the confines of the CPC at any time, and are to be locked up when not being used.  Client files are to be kept in the locked file cabinet in the front office.

A particularly awkward situation with respect to confidentiality is when a person whom one knows from a different context becomes a client in the CPC. If the therapist were to be present at a team meeting during which that client's case were discussed, the appropriate action would be to leave the team meeting; another option is to transfer the client to another team.

A related type of situation is when a therapist runs into a client in public. There is a natural tendency to say "hi" to any person whom you know, and therapists must break this tendency when running into a present or former client. However, a therapist also does not want to give the impression of ignoring a client. The therapist should let the client lead the course of such a chance meeting; if the client says "hi" first, the therapist can return the greeting. If the client does not say anything, use your discretion to decide whether the client would expect a smile or a nod, or no acknowledgment. It is helpful to mention this interaction at the next session with the client, if you are still seeing this client in therapy.  If it is likely that such an encounter will occur (e.g., the client is taking classes in the Psychology Building; the client is a member of an organization that the therapist belongs to, etc.), a pre-emptive discussion can be held at the earliest appropriate occasion.

There are clear times when confidentiality <u>must </u>be broken; these are very specific, and should be followed exactly. These include: (1) when the therapist feels the client is a danger to himself or to another person, and (2) when the therapist suspects child or elder abuse. (A copy of the law regarding suspicion of child abuse can be found in the back of the CPC Policies and Procedures Manual notebook.)

Also, there are limits on confidentiality for minors. Parents have the right to access the files of their minor children. While they will often agree to allow the minor child substantial privacy, they can

(almost) never be forced to do so. These limits should be explicitly discussed with parents and their children.

In the case of keeping separate files when couple or family cases fragment into individual cases, the information in joint files is joint property, while the information in separate files is <u>not</u>, and must be treated as confidential (except for limits on confidentiality; see above). It is tricky and important to <u>not</u> leak information from one to another. When seeing a couple or a family, discuss issues of confidentiality with your supervisor, and then with the clients.

# XII. APPROPRIATE DRESS

Graduate school is a time of transition from the role of a student to that of a professional. In addition to all of the other skills one needs to learn to successfully make that transition, students must understand how their appearance can impact the range of professional roles graduate students fill both during and after graduate school. Regardless of whether you believe it is correct or not, a student clinician's appearance sends a message about their level of competence, trustworthiness, dependability, and other desirable professional attributes. It can influence the degree of respect others will have for him/her. Because of others' reactions to a person's appearance, it can impact an individual's effectiveness and ability to adequately represent him/herself or the program, and as a result can potentially impact outcomes. While some people portray this as personal rights issue, the concern here is not whether or not you have the "right" to look as you choose. Rather the issue is what the impact is of the choices you make. Note that there will be places where you do practicum, internship, or even eventually work where there will be a strict dress code that may limit your overall appearance, often for many of the same reasons we talk about here.

Proper attire and grooming is expected of all student clinicians when they onsite at the CPC. The following are guidelines to assist student clinicians in selecting proper attire for their professional roles. As a general rule, if one is uncertain if something is appropriate, it is best to find something else to wear that day, and then to ask clinic staff. When dressing "professional," you should be selecting articles of clothing that fit well, are in good condition, are well-structured, ironed (if needed), and, for the most part, more on the conservative side.

These include:
- o Dresses and skirts that are of sufficient length to not be too revealing when either standing or sitting
- o Dress slacks, khakis, Capri pants, casual pants and colored jeans. NO BLUE JEANs
- o Sweaters, cotton tops, polo shirts, button-up shirts and blouses
- o Dress scarves or ties
- o Dress shoes, dress boots, loafers, oxfords, dress sandals,

People tend to make a poorer, less professional impression when wearing articles of clothing that do not fit well or are overly casual, revealing, or are in bad shape. Examples of unacceptable attire include:
- o Blue jeans
- o Shorts, skorts, or skirts that are either more than 3 inches above the knee or are overly revealing when sitting or standing

- o   Leggings (unless under a skirt or <u>long</u> blouse), spandex tops or bottoms, stirrup pants, sweatpants
- o   Spaghetti-strap tops or dresses, unless worn under an appropriate top or jacket
- o   Loungewear

.
A good rule of thumb:  if you're wondering if it is appropriate, it probably isn't.

## XIII.      ELECTRONIC COMMUNICATION & SOCIAL MEDIA

Email is not a secure medium for communication of confidential information, and is, therefore, strongly discouraged as a means of conversing with your clients.  It may also give a false impression of immediate and constant access to you.  Your clients should be aware of these issues.  However, given the nature of current communication styles and preferences, the CPC does have a generic email address that can be used for scheduling and other, brief, non-urgent, business details.  The address is [clinic@asu.edu](mailto:clinic@asu.edu).  The Clinic Coordinator will receive and forward any messages.

We specifically prohibit emailing and texting between students and clients. We have this stated in our intake procedures and explain to clients that due to our inability to guarantee privacy via email and text, that we do not allow this type of communication. Additionally, we do not want to imply that students are in the position where they feel as if they are always "on call," with clients being able to access them at any time. We are not a 24/7 clinic and do not provide emergency services.

Be very wary of using your cell phone to communicate with your clients.  Your conversation is less secure than over land-lines and you probably don't want your client to have your personal number.  In emergencies, you can dial *67 to block your number.

Drop Box is not a secure location to store any client data.  Documentation should not be stored on flash-drives that are not encrypted.  Encrypted flash-drives must themselves be kept in locked storage.

You are strongly encouraged to carefully scrutinize any on-line presence you have for both content and access.  You are now representing our department, University, and profession and should do so with dignity and integrity.  You must not discuss on-line anything about your sessions, should not interact with clients (present or past) on-line, or search for information regarding clients (except in extremely unusual circumstances that have been discussed with your supervisor beforehand).   You can assume and it is appropriate that clients may google you for personal information. Some sites (i.e., LinkedIn) are specifically for sharing professional information about yourself as you develop a career path. You must accurately represent your qualifications.  Beware of inadvertently connecting personal opinions with the university or program.    Practice concerns in this area are evolving and are a good topic for discussion in class.

# XIV.  Emergencies

The CPC has a 24-hour answering service (866-210-7696). Clients may contact the CPC at any time. The voicemail message will direct the caller to the answering service in cases of emergency.  If there is an emergency situation with a client, the answering service will attempt to contact the therapist requested. In the event that the therapist cannot be reached, the answering service will contact the CPC Director. All CPC staff (therapists, supervisors, CPC Director, etc.) are responsible for informing the CPC Secretary of changes in their emergency telephone numbers. Therapists who will be out of town for any length of time must inform the Secretary, arrange for coverage for their clients, and leave numbers of where they may be reached.  Therapists and supervisors should be aware of each other's most current emergency numbers.  To facilitate this process, the CPC Secretary will distribute a phone list at the beginning of each semester and at the beginning of summer.

Any client or therapist wishing to leave a message for the CPC at other than working hours, may dial the CPC number, 480-965-7296, and their call will be automatically forwarded to the campus voicemail system.  The voicemail message then refers emergencies to the answering service number.   Therapists may use the account number listed on the phone roster in order to check messages.  Procedures for handling suicide threats may be found in Appendices. These procedures should be strictly followed, and actions painstakingly documented.

# XV. Student Training Plans and Student and Faculty Evaluations

**TRAINING PLANS**

Part of the law which governs psychology licensure in Arizona (and at least 14 other states) provides a path to licensure without first completing post-doctoral hours.  To obtain licensure by this path, each applicant must document pre-internship clinical training experiences through the use of a training plan.  Therefore, a written training plan will be developed for each professional training experience (eg., practicum, ATMs, and placements).  A sample training plan for practicum is in Appendix M.  These plans will be developed in collaboration between the student and the program (and the placement site, if appropriate).  The training plan for each supervised pre-internship training site must designate an allotment of time for each training activity and must assure the quality, breadth, and depth of training experience through specification of goals and objectives of the supervised experience, the methods of evaluation of the student and supervisory experiences.

**STUDENT EVALUATIONS**

While students should receive ongoing feedback from their faculty supervisors, they are formally evaluated at the end of each semester by their supervisors (see page 52). Students meet individually with each supervisor to review these evaluations. These evaluations go into the student's permanent file in the program office that contains transcripts and other academic records.

**FACULTY EVALUATIONS**

While ideally students will be engaged in ongoing, open communication with their supervisors, each practicum student is also requested to formally evaluate the quality of his/her supervision at the end of each semester. The student will fill out evaluation forms (Appendix I) for each of their supervisors, and give the forms to the CPC Secretary. The secretary will type a copy to be given to the faculty supervisor. Evaluations are anonymous.

# XVI.  Resident Therapists

Every year, two to four advanced graduate students in the clinical program will serve as Resident Therapists. These are 10 or 20-hour-per-week positions and will serve as the students' clinical placement for the year. The Resident Therapists will carry a case load that results in at least 7 contact (as opposed to scheduled) client-hours per week (where 90-120 minute groups count for 3 contact hours, and families/couples for 1 hour).  Expectations are adjusted for 10 hour/week placements.  Resident Therapists will also conduct one or two Learning Disorders or ADHD evaluations per month.  RTs might also conduct psycho-educational/vocational evaluations of visually impaired consumers of Vocational Rehabilitation services.  Resident Therapists also help in generating clientele by visiting campus and community agencies, giving presentations on clinical topics, and other recruitment activities.  RTs make referrals for clients who they designate as inappropriate for the CPC. It is expected that the Resident Therapists will be available as co-therapists for practicum students when appropriate, and will be available to answer practicum students' questions regarding CPC policy, video equipment, etc.  RTs are often asked to provide demonstrations for the Interviewing class, Second Year Practicum, and the Assessment ATM.

# XVII. Setting Center Policy

Questions regarding policy or suggestions for changes should be addressed to the Resident Therapists, CPC Secretary, or CPC Director. They can then be discussed at one of the regularly scheduled Placement and Clinic Policy Committee (PCPC) meetings, or if necessary, a special meeting may be called. Requests for special policy exceptions or nonclinical use of the CPC should be made in this fashion as well. The PCPC will be comprised of the Director of Clinical Training, CPC Director, a supervisor from second-year practicum, a Resident Therapist, a student member of the second-year practicum team, and the Center secretary.

Arizona State University
Clinical Psychology Center

## INTAKE SUMMARY

NAME:_____Date_____

CASE#: _____Age:_____ _____Sex:_____

DATE (S) OF INTERVIEWS:_____

THERAPIST:_____

SUPERVISOR:_____

1.      INITIAL PRESENTATION
A.      Individual/(Couple/family)

2.      PRESENTING PROBLEM(S)
A.      Why now?
B.      Nature of problem
C.      Past attempts at solution
D.      Suicidal/homicidal ideation, past or current

3.      HISTORICAL SETTING EVENTS
A.      Current
B.      Historical

4.      OBSTACLES TO TREATMENT
A.      External obstacles
B.      Internal obstacles

5.      PERSONAL ASSETS

6.      ASSESSMENT
A.      Conceptualization, including motivation for treatment and prognosis
a.      incorporating BSI and other psychometric data
b.      motivation for treatment
c.      prognosis
B.      Diagnostic impressions (DSM-5)

7.      TREATMENT PLAN
A.      Specific goals for treatment
B.      Specific Interventions

Reviewed and approved by:

Clinical Psychology Trainee          Supervising Psychologist, Ph.D.

**Appendix B**
Arizona State University
Clinical Psychology Center

TERMINATION SUMMARY

CLIENT'S NAME:_____DATE_____

CASE#:_____

AGE:_____

SEX:_____

NUMBER OF TIMES SEEN:_____

THERAPIST:_____

SUPERVISOR:_____

1.      PRESENTING PROBLEMS(S):

2.      TREATMENT PLAN:

3.      COURSE OF THERAPY: (including discussion of BSI outcome)

4.      TERMINATION (including reason for termination, post-test data and other measures of outcome, and a description of termination session(s).

5.      DISPOSITION:  (Describe arrangements following the termination – self-help group, another therapist, etc.)


_____          _____
Clinical Psychology Trainee                             Supervising Psychologist, Ph.D.

Arizona State University
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# INTAKE/TERMINATION SUMMARY

NAME:_____DATE_____

CASE #: _____

AGE: _____

SEX: _____

DATE OF INTERVIEWS: _____

THERAPIST: _____

SUPERVISOR: _____

  1.    PRESENTING PROBLEM(S):

  2.    TERMINATION:


_____        _____
Clinical Psychology Trainee              Supervising Psychologist, Ph.D.

**Appendix D**
Arizona State University
Clinical Psychology Center

## TRANSFER SUMMARY

NAME:_____DATE_____

CASE#: _____

AGE:_____

SEX: _____

NUMBER OF TIMES SEEN: _____

ORIGINAL THERAPIST: _____

NEW THERAPIST: _____

SUPERVISOR: _____

    1.     PRESENTING PROBLEM(S)

    2.     TREATMENT PLAN:

    3.     COURSE OF THERAPY:

    4.     RECOMMENDATIONS FOR FUTURE TREATMENT:

    5.     DISPOSITION:  (Describe arrangements surrounding the transfer.)


_____         _____
Clinical Psychology Trainee         Supervising Psychologist, Ph.D.

Arizona State University
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## PROGRESS NOTES (Continuous Progress Record)

The method for keeping a continuous progress record (chart) is to write a brief note for each session as soon as possible following the session.  Supervisors should review and co-sign each note.

Each note should include the following:  date, number and duration of the session; **D.A.H.P.** sections (see below); therapist's name, degree and signature; and supervisor's name, degree, and signature.  (Please leave enough room for <u>both</u> signatures.)

The format used in the Center is the D.A.H.P. system:

**(D):**     Notes begin with a description of key "Data" from the session.  In this section you give a summary of the "action" of the session.  Include direct quotes, your observations, the client's reports, etc.  Be specific but concise.

**(A):**     An "Assessment" of the client's status and/or dynamics and/or interpretation of the data follow.  Here is the opportunity to incorporate the new information from "D", into your overall conceptualization of the client.  Why did "D" happen?  How would you explain what happened in theoretical terms?  What do you <u>think?</u>  Now that you have new insights, how will your treatment plan change (see below)?

       "A" is also the section to discuss your conclusions about any formal assessment data you have collected (e.g., BDI-2, self-monitoring, etc.)

**(H):**     "Homework" is assigned; describe what the client is to do between sessions.  Since you have stated your understanding of how the client is making the problem better/worse, your homework assignments ought to be a logical extension of that understanding.  Homework should be directly connected to and flow from "A".

**(P):**     A "Plan" is outlined for the next steps toward achieving the treatment goal, which has been defined in the intake.  This is your chance to do some treatment planning.  You can speculate about various outcomes from the homework and generate possible interventions to implement in the next session.

**A sample progress note appears below:**

• • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • • •

## Progress Note

D:     Mr. X reported significant difficulty sleeping this week due to anxiety over ……..

A:     Mr. X appears to be over-reacting to current stressors based on a few specific cognitive distortions (list…….).  He has few effective methods for coping with stress.

H:     Mr. X develops his repertoire of refutations.  If it takes him longer than 30 minutes to fall asleep, he will get out of bed and work on his list.

P:     Next appointment 9/26/20 @ 2 p.m.
   1.     teach progressive relaxation
   2.     check degree of acceptance of genitive model
   3.     check on meds, caffeine, alcohol intake

                                    Reviewed and approved by:


_____          _____
Name, degree                               Name, degree
Clinical Psychology Trainee                Supervisor and Psychologist

**Appendix F**

Arizona State University
Clinical Psychology Center

ASPPB Supervision Guidelines for Education and Training leading to Licensure as a Healthcare Provider

I. **Goals of Supervision**

A. Monitor and ensure welfare and protection of clients of the Supervisee.

B. Gatekeep for the profession to ensure competent professionals enter.

C. Promote development of Supervisee's professional identity and competence.

D. Provide evaluative feedback to the Supervisee.

II. **Structure of Supervision**

A. The primary supervisor during this training period will be John L. Barton, Ph.D., ABPP, who will provide 1 hour of supervision for each 10 hours of student professional experience. The delegated supervisor(s) during this training period will be _____, who will provide _1_hour of supervision for each 10 hours of student professional experience per week.

B. Structure of the supervision session: supervisor and supervisee preparation for supervision, in-session structure and processes, utilizing live or video observation for some therapy sessions.
       1. notes and reports will be completed and reviewed in a timely manner
       2. cases will be reviewed for conceptualization, treatment planning, progress and problems
       3. the therapy process will be examined to assess quality and therapist responsiveness (vs. reactivity).
       4. readings and other learning activities will be assigned and skills practiced as needed
       5. formative feedback will be provided regarding development of professional competence
       6. summative feedback will be provided at 6 and 12 months of placement

C. Limits of confidentiality exist for supervisee disclosures in supervision. (e.g., supervisor normative reporting to graduate programs, licensing boards, training teams, program directors, upholding legal and ethical standards).

D. Supervision records are available for licensing boards, training programs, and other

organizations/individuals mutually agreed upon in writing by the supervisor and supervisee.

III. **Duties and Responsibilities of Supervisor**

A. Assumes legal responsibility for services offered by the supervisee.

B. Oversees and monitors all aspects of patient case conceptualization and treatment planning, assessment, and intervention including but not limited to emergent circumstances, duty to warn and protect, legal, ethical, and regulatory standards, diversity factors, management of supervisee reactivity or countertransference to patient, strains to the supervisory relationship.

C. Ensures availability when the supervisee is providing client services.

D. Reviews and signs off on all reports, case notes, and communications.

E. Develops and maintains a respectful and collaborative supervisory relationship within the power differential.

F. Practices effective supervision that includes describing supervisor's theoretical orientations for supervision and therapy, and maintaining a distinction between supervision and psychotherapy.

G. Assists the supervisee in setting and attaining goals.

H. Provides feedback anchored in supervisee training goals, objectives and competencies

I. Provides ongoing formative and end of supervisory relationship summative evaluation on forms using the competency benchmarks consistent with the APA Standards of Accreditation, available in the Student Handbook.

J. Informs supervisee when the supervisee is not meeting competence criteria for successful completion of the training experience, and implements remedial steps to assist the supervisee's development. Guidelines for processes that may be implemented should competencies not be achieved are available at (website or training manual).

K. Discloses training, licensure including number and state(s), areas of specialty and special expertise, previous supervision training and experience, and areas in which he/she has previously supervised.

L. Reschedules sessions to adhere to the legal standard and the requirements of this contract if the supervisor must cancel or miss a supervision session.

M. Maintains documentation of the clinical supervision and services provided.

N. If the supervisor determines that a case is beyond the supervisee's competence, the supervisor may join the supervisee as co-therapist or may transfer a case to another therapist, as determined by the supervisor to be in the best interest of the patient.

IV. **Duties and Responsibilities of the Supervisee**

A. Understands the responsibility of the supervisor for all supervisee professional practice and behavior.

B. Implements supervisor directives, and discloses clinical issues, concerns, and errors as they arise.

C. Identifies to clients his/her status as supervisee, the name of the clinical supervisor, and describes the supervisory structure (including supervisor access to all aspects of case documentation and records) obtaining patient's informed consent to discuss all aspects of the clinical work with the supervisor.

D. Attends supervision prepared to discuss patient cases with completed case notes and case conceptualization, patient progress, clinical and ethics questions, time-marked video recordings as requested, and literature on relevant evidence-based practices.

E. Informs supervisor of clinically relevant information from patient including patient progress, risk situations, self-exploration, supervisee emotional reactivity or countertransference to patient(s).

F. Integrates supervisor feedback into practice and provides feedback weekly to supervisor on patient and supervision process.

G. Seeks out and receives immediate supervision on emergent situations. Supervisor contact information: _480-967-4566 (home) 602-663-0874 (cell).

H. If the supervisee must cancel or miss a supervision session, the supervisee will reschedule the session to ensure adherence to the legal standard and this contract.

A formal review of this contract will be conducted during the last supervision session of the semester when a review of the specific goals (described in the Training Plan, attached) will be made.

Specific duties of the supervisee (given appropriate conditions):

Complete 10/20 hours per week as a resident therapist

Average 4/10 hours per week of direct client contact

Conduct 6/12 psychological evaluations (roughly ½ ADHD/psychological evaluations and ½ LD/combo/VR evaluations) per year

Complete 12 months of placement

Complete BASICS training

Complete training in the use of Titanium, the electronic health record

Supervise a junior student through one case

Participate in at least 3/6 BASICS interventions per year (for 10/20)

Provide 1 presentation to ASU Employee Wellness Program on a mutually agreed upon topic.

Conduct 1 psychoeducational group program (not including BASICS)

Provide at least 1 formal case presentation and 1 formal ethics presentation over the course of the year

Provide coverage of the CPC as needed (in proportion to hours of placement; 10 or 20)

Conduct screenings (i.e., contact sheets) (in proportion to hours of placement; 10 or 20)

Participate in recruitment efforts as needed


We, _____ (supervisee) and _____ (supervisor) agree to follow the parameters described in this supervision contract and to conduct ourselves in keeping with the American Psychological Association Ethical Principles


_____
Supervisor /Date


_____
Supervisee/ Date

Dates Contract is in effect: Start date: _____End date: _____

Mutually determined goals and tasks by Supervisor and Supervisee to accomplish are contained in the Training Plan (see attached)

**Appendix G**

**Assessing Supervisory Alliance/ Supervisee**

Supervisor/Resident Therapist _____

Practicum Student_____

Feedback is a valuable learning tool.  Please assist your fellow students' training by providing honest feedback.  This feedback is NOT shared directly with your supervisor.

1.  I'm feeling comfortable about supervision

Never ___        Occasionally ___        Sometimes ___        Often ___        Always ___

2.   We agree about things needing to be done

Never ___        Occasionally ___        Sometimes ___        Often ___        Always ___

3.  I'm worried about supervision outcomes

Never ___     Occasionally ___     Sometimes ___     Often ___     Always ___

4.  Supervision provides a new way of looking at myself

Never ___     Occasionally ___     Sometimes ___     Often ___     Always ___

5.  We understand each other

Never ___     Occasionally ___     Sometimes ___     Often ___     Always ___

6.  I'm finding what we do in supervision confusing

Never ___     Occasionally ___     Sometimes ___     Often ___     Always ___

7.  We disagree about what I should get out of supervision

Never ___     Occasionally ___     Sometimes ___     Often ___     Always ___

8.  I believe time is not spent efficiently

Never ___     Occasionally ___     Sometimes ___     Often ___     Always ___

9.  I'm clear about what responsibilities are in supervision

Never ___     Occasionally ___     Sometimes ___     Often ___     Always ___

10.  We collaborate on setting goals for supervisory sessions

Never ___     Occasionally ___     Sometimes ___     Often ___     Always ___

11.  Feedback is helpful

Never ___     Occasionally ___     Sometimes ___     Often ___     Always ___


_____     _____

    (Program representative)

## Appendix H

## Telepsychology Supervision Risk Analysis

Supervisee: _____

<u>Evaluation of supervisee appropriateness for telepsychology supervision:</u>

☐      Is telepsychology supervision appropriate for the supervisee's clients?

☐      Does the supervisee have the knowledge and skill necessary to provide telepsychology under supervision?

☐      Does the supervisee have the requisite knowledge and skill regarding the use of the technology involved to receive and benefit from telepsychology supervision?

☐      Is it in the best interest of both the supervisee and the supervisee's clients to receive telepsychology

supervision?


Comments:


<div align="center">

**Appendix I**
Arizona State University
Clinical Psychology Center

</div>

<div align="center">

**STUDENT EVALUATION OF PRACTICUM/CLINICAL/ATM SUPERVISORS**

</div>

Name of Supervisor:_____

This form is designed to allow students to give feedback to practicum and external supervisors on a variety of dimensions relevant to training.  The form should be filled out anonymously. Please use the following scale for appropriate questions:

  1- Excellent in this regard
  2- Positive in this regard
  3- Average in this regard
  4- Needs improvement in this regard
  5- Very poor in this regard
    N/A No basis for judgment or not applicable

1.      Mechanics of supervision**:**

Is the supervisor responsible with regard to keeping scheduled appointments?

____a. Is the supervisor responsive to requests for extra supervision or consultation with the student?

____b. Are written reports and files read and constructive criticisms made?

____c. Does the supervisor keep informed about the cases he/she is supervising?

Comments:

2.      Conceptualization of problems:

____a.      Does the supervisor appear to have an adequate and accurate understanding of the problem presented by the client?

____b. Is the supervisor willing to consider possible alternate conceptualizations?

____c. Does the supervisor generate alternate conceptualizations or supplement the current one?

Comments:

3.      Implementation of treatment:

____a. Is the supervisor able to suggest procedures for dealing with the target problem?

____b. Is the supervisor able to recognize potential problems with the implementation?

____c. Is he/she able to offer suggestions for dealing with these problems?

____d. Is the supervisor able to accurately assess problems and strengths in the relationship established between the therapist and client?

____e. Are appropriate suggestions made?

Comments:

4.      Professional Relationship:

____a.  Is the supervisor an adequate model for the role of professional psychologist in regard to

the various dimensions of professional manner, ethics, confidentiality, punctuality, concern, and continuing educations?

_____b. Is the supervisor open to student input and suggestions?

_____c. Is the supervisor aware of his/her own limitations and willing to seek consultation with other professionals should his/her expertise be exhausted?

_____d. How well does the supervisor convey positive and negative feedback?

Comments:

_____5. (Practicum supervisors only)    Were the team meetings conducted in such a way as to be a useful training experience?

Comments:

6.      Please delineate any important strengths and weaknesses you see this supervisor having.

_____

          Stengths:                          Weaknesses:

**Appendix J**

Client's Risk
of Suicide

Action: Steps (1) through (8)

| Low Risk |

(1) Non-immediate treatment issue. Consult with supervisor after session.

Reassess, monitor, and document as needed.

| Moderate Risk |

(2) Provide suicide prevention resources (e.g., EMPACT 480-784-1500).

(3) Administer brief psychotherapy aimed at reducing the risk of suicide. For example, ask the client for a commitment to treatment, create a crisis response plan, and create ambivalence by bolstering the client's reasons for living.

(4) Refer client to alternative treatment sources. In particular, discuss consulting a medical doctor for psychoactive medication.

(5) Consult with an on-duty resident therapist, clinical supervisor, clinic director, and/or an available clinical faculty member.

Reassess, monitor, and document as needed. Take step (1) as called for.

| High Risk |

(6) Ask client to contact a trusted family member or friend. Determine whether that person is willing and capable of monitoring the client and preventing a suicide attempt without the immediate assistance of a mental health professional.

(7) Ask the client to commit to voluntary hospitalization. Contact C&C psychiatrist and/or EMPACT and inform them of the situation.

(8) Arrange for involuntary commitment of the client only if client refuse voluntary hospitalization. Call 911 and ask for a suicide hold if the client intends to leave the clinic without accessing treatment.

Reassess, monitor, and document as needed. Always take step (5). Steps (6) through (8) should be implemented in ascending order dependent upon the client's level of risk and compliance with treatment. Take steps (2), (3), and (4) if possible. Take step (1) as called for.

# Suicide Assessment

First, collect information to help you determine the client's current level of suicidality. Consult with a supervisor or clinical peer while the client is at the clinic if you need help or advice on any part of the assessment. Second, determine the client's risk of suicide.

1) Demographics: assess age (>65 = ↑ risk), ethnicity (Caucasian= ↑ risk), sexual orientation (homosexual= ↑ risk), gender (male= ↑ risk), etc.

2) Ideation: assess hopelessness, desire to live, desire to die, suicidal impulses, ability to resist impulses, frequency of thoughts, etc.

3) Plan: assess specificity of plan, preparation, timeframe, precaution against being discovered, etc.

4) Means: assess access to suicidal means, lethality of means, knowledge of means, etc.

5) Intent: assess intent to carry through with the act, what the client expects to happen, etc.

6) Context: assess social support, drug use, loss, external and internal obstacles, etc.

7) History: assess for past attempts, family history of attempts, friends history of attempts, etc.

8) Treatment Context: assess whether the client has access to and desire for psychotherapy, psychoactive medication, hospitalization, etc. Also assess for depression, personality disorders, anxiety, insomnia, rapid mood shifts, etc.

| Low Risk | Moderate Risk | High Risk |
|---|---|---|
| *E.g., Client presents with some ideation or with a vague plan but with no intent to carry through on the act. The client's demographics and social context suggest that he/she is unlikely to commit suicide. Treatment options are readily available and the client seems prepared to access those options if necessary. | *E.g., Client has made past suicide attempts and is currently ideating. S/he admits to having a plan and posses the means to carry through on the act. However, s/he does not intend to carry through with the action. The client has a mental disorder known to exacerbate the situation or is prone to impulsivity. Treatment is accessible and the client seems willing to access those options if necessary. The client has been psychiatrically hospitalized in the past. | *E.g., Client reports having a specific plan and intends to commit suicide. Drugs, violence, and/or lack of social support are exacerbating the situation. The client seems resigned and passive when discussing treatment or refuses treatment altogether. Past attempts and current ideation suggest that the client will likely make another attempt. |

*Examples are sufficient but not necessary for each category of risk.

Arizona State University
Clinical Psychology Center

## PROCEDURES FOR SUICIDAL THREATS/BEHAVIORS IN CHILDREN AND ADOLESCENTS

Purpose:  To ensure that suicidal threats/behaviors made by children or adolescents are properly assessed, and appropriate interventions are made that will ensure the safety and well-being of the client, meet ethical and legal standards of professional practice and protect the Center from legal liability.

Policy:  In the event that a client under 18 years of age makes suicidal threats, has engaged in suicidal behavior or in extremely hazardous high risk-taking behavior, the clinical staff will make maximum effort to ensure the safety and well-being of the client by following the procedures outlined below.

I.      Therapist should assess the suicidal risk by careful inquiry into the following areas:

   A.  Lethality (seriousness) of suicidal threat or behavior.  (See Appendix H)

   B.  Motivation for suicide ranging from lowest risk (e.g., attempting to influence Someone else's behaviors and still survive) to highest risk (e.g., a wish to escape an intolerable situation by death).  **Younger children often do not have a concept of death as irreversible; hence, suicidal risk may be high even though death is not perceived as final nor intended as eventual outcome.**

   C.  Degree of effective preparation or planning.

   D.  Access to lethal resources to carry out plan.

   E.  Prior suicidal attempts or seriously hazardous, high risk-taking behaviors.

   F.  Suicidal behavior that has occurred in immediate family or environment.

   G.  Extent to which the suicidal threat represents an impulsive act or is the outcome of irrational (disturbed, psychotic, depressed) thought processes.

   H.  Presence of clinical depression should always lead to an inquiry about suicidal ideas and past suicidal behavior.  In children and adolescents, depression may be manifested by the usual clinical signs as well as the behaviors described below:

      1.  Withdrawal from family and friends.
      2.  Drop in school achievement or refusing to go to school.

3. Excessive sleeping (or reversal of normal sleep-wake pattern).

4. Withdrawal from sports or other school activities in which the child/youth has been engaged.
5. Running away from home.
6. Other noticeable changes in behaviors, I.E., increased irritability, decreased responsiveness.
7. Giving away possessions or behavior eared at "putting things in order."
8. Symptoms of conduct disorder and substance abuse.  Look for risk factors like impulsivity and risk-taking.
9. Chronic and debilitating illness.
10. Chronic preoccupation with death and related themes.
11. Significant loss
12. Feelings of hopelessness and helplessness
13. Anxiety
14. Substance abuse
15. Eating Disorder

I. If a client is described as having been depressed, but shows abrupt lifting of depression or "improved attitude," this may represent a critical and high-risk period. Ask about having decided to commit suicide.

J. Presence of acute family conflict that may be contributing significantly to suicidal ideation or behaviors.

K. Among adolescents, conflicts revolving around relationships, sexual identity, etc. may be critical and should be considered.

II. The assessment for suicide risk should be thoroughly documented in the chart, including consultations with clinical supervisors.

A. If the primary therapist judges the suicide risk to be serious, then the therapist should consult his/her clinical supervisor and Director and arrange for (a) psychiatric consultation and/or (b) assistance from the **Suicide Prevention Center (EMPACT) hotline:  (480)784-1500** for the East Valley (See Appendix H).

B. If the primary therapist's judgment of high risk is supported by consideration of the above factors, the primary therapist should protect the client by following the most appropriate of the following methods:
1. If the child has available parents, guardians, or concerned adults who can carry out intensive monitoring until the crisis passes, the therapist will outline with them procedures for monitoring behavior, and options for hospitalization of called for.

2.  In addition, the therapist will immediately begin helping the child and family to improve communication and make him or herself available to the child during the crisis.

C.  If there are not concerned adults available, or none willing or able to to assume responsibility, the primary therapist will seek an emergency hospitalization by calling **EMPACT, 480-784-1500.**  (See Appendix H)**.**

III.  If the suicidal risk is not deemed imminent, after thorough assessment, the therapist will:

A.  Formulate a safety plan that provides for:
1.  24 hour monitoring
2.  Reduced access to weapons, etc.
3.  Actions to reduce the distress associated with events leading to suicidal ideation
    a.  Set next appointment
    b.  Arrange for telephone check-ins
    c.  Offer psychiatric referral
    d.  While listening, reflection, empathy are always important, a crisis puts a higher premium on a "take-charge" attitude and specific, time-sensitive recommendations.  Recommend specific actions for distress tolerance and enlisting social support.
4.  Enhanced barriers to suicide.

IV.  In the event a suicide call is received on the telephone and the client will not come to the center, the therapist should:

A.  Assess availability of suicidal means.

B.  Ascertain location of client

C.  Contact a Crisis Center for assistance with home visit if called for.

D.  If person is calling and suicidal act is underway, (i.e., ingested pills) an ambulance and police should be dispatched.

**In all the above, it is recommended that the primary therapist obtain the maximum amount of consultation available form his/her clinical supervisor(s) or the Center Director.  All efforts and justification should be documented in the clinical record, and countersigned by clinical supervisor(s).  The notes should include data from a detailed assessment and your thought process as to what you recommended and why.  Also, include what you <u>didn't</u> do and why you didn't do it.**

## ASU Clinical Psychology Program
## Practicum Training Plan

Clinical Trainee: Sparky Sundevil

Training Year: 2018-2019

Date Training began: 7/1/2018          Date Training ended: 6/30/19

**Training experience #1: Resident Therapist, ASU Clinical Psychology Center**

*Time allotment* for each training activity (with a clear indication of face-to-face client contact).

Average Hours of training per week: 20 hours

      Therapy:  30 hrs/mo, 37.5%

      Assessment (including interviews):  16 hrs/mo, 20%

      Documentation:  20 hrs/mo, 25%

      Training (case presentations, seminars, group supervision, etc.):  8 hrs/mo, 10%

      Other:  6 hrs/mo, 7.5%

*Training Goals*

Competencies:

Research:

Critically evaluate and use existing knowledge to solve problems

Ethics:

Recognize ethical dilemmas as they arise, and apply ethical decision-making processes in order to resolve the dilemmas.

Conduct self in an ethical manner in all professional activities.

Diversity:

Demonstrate the ability to integrate awareness and knowledge of individual and cultural differences in the conduct of professional roles.   Also included is the ability to work effectively with individuals whose group membership, demographic characteristics, or worldviews conflict with their own.

Professional values and attitudes:

Behave in ways that reflect the values and attitudes of psychology, including integrity, deportment, professional identity, accountability, lifelong learning, and concern for the welfare of others.

Engage in self-reflection regarding one's personal and professional functioning; engage in activities to maintain and improve performance, well-being, and professional effectiveness

Communications and interpersonal skills

Demonstrate effective interpersonal skills and the ability to manage difficult communication well.

Assessment

Demonstrate current knowledge of diagnostic classification systems, functional and dysfunctional behaviors, including consideration of client strengths and psychopathology.

Select and apply assessment methods that draw from the best available empirical literature and that reflect the science of measurement and psychometrics; collect relevant data using multiple sources and methods appropriate to the identified goals and questions of the assessment as well as relevant diversity characteristics of the service recipient.

Interpret assessment results, following current research and professional standards and guidelines, to inform case conceptualization, classification, and recommendations, while guarding against decision-making biases, distinguishing the aspects of assessment that are subjective from those that are objective.

Communicate orally and in written documents the findings and implications of the assessment in an accurate and effective manner sensitive to a range of audiences.

Build proficiency in learning disability/ ADHD/ visual impairment and/ or vocational assessments.  Enhance cultural sensitivity, especially the visually impaired.   Enhance competence in writing integrated reports

Objective 1: Write at least 12 integrated reports that will demonstrate an understanding test results and include recommendations that address assessed needs.  The referral questions may

pertain to learning disabilities, ADHD or their interaction with visual impairment

Objective 2: Develop cultural sensitivity skills through orientation to blindness program and administration of at least 3 evaluations to visually impaired or blind individuals

Intervention:

Develop evidence-based intervention plans specific to the service delivery goals.

Become more familiar with in-house therapy manuals.

Objective 1: With supervisor, and when appropriate for a client, identify appropriate therapy from in-house manual selection for implementation to treat a client. Therapies from these manuals should be considered with supervisor for a minimum of six clients, with comfort and facility with the material evaluated in supervision and client progress measured across treatment.

Implement interventions informed by the current scientific literature, assessment findings, diversity characteristics, and contextual variables.

Objective 1: Assist the clients in achieving decreases in intrusiveness of pain in daily living, as well as improving feelings of self-compassion, and sense of mindfulness during daily activities as measured by a short battery of assessments at baseline and at end of group (e.g., PAGE, self-compassion, mindfulness scales)

Modify and adapt evidence-based approaches effectively when a clear evidence-base is lacking.

Evaluate intervention effectiveness, and adapt intervention goals and methods consistent with ongoing evaluation.

Supervision

Actively seek and demonstrate openness and responsiveness to feedback and supervision.

Consultation/interprofessional skills:

Demonstrate knowledge and respect for the roles and perspectives of other professions

**Average Hours of training/ week**: 20        **hours of supervision/year**: 72-100

**Methods of Evaluation**:

1. Trainee will receive feedback during weekly supervision with a licensed psychologist

2. Written evaluations completed by supervisors twice/year

3. Evaluation of Pre- and Post- questionnaires on participant improvements in:

6. Direct observation (live or video recording) of practice with clients

**Supervision**

At least two hours of regularly scheduled contemporaneous supervision per twenty hours of supervised preinternship professional experience that addresses the direct psychological services provided by the student. At least fifty per cent of the supervision during the total supervised preinternship professional experience shall be provided through contemporaneous in-person individual supervision. Not more than fifty per cent shall be through in-person group supervision. At least seventy-five per cent of the supervision shall be by a psychologist who is licensed or certified to practice psychology at the independent level by a licensing jurisdiction of the United States or Canada and who is designated by the academic program.

Names and credentials of supervisors:

1. John Barton, Ph.D., ABPP

2. , Ph.D

3.

4. _____

Total hours of supervision per week: 2+

Total hours of supervision per year: 100+

Amount of time spent in supervision provided by a licensed allied mental health professional (*cannot exceed 25% of time spent in supervision*) 0

Supervisor(s) is/are licensed in AZ: **Yes**  No

Supervisor(s) is/are on staff at site where experience takes place:

Yes   No

Barton – Yes

**Ethics Training and Protection of the Public**:

Competencies:

   Ethics training provided:  Application of ethics to each specific case as discussed in individual supervision. Resident therapist is required to make a one-hour presentation on an ethics topic using Pope & Vasquez (or similar) as a model for ethical decision-making. Group supervision includes a variety of ethics topics and the option of attending meetings of the AzPA Ethics committee,  AZ Board of Psychologist Examiners, or didactics at PCH pertaining to ethics topics.

_____  _____

   (Student signature)          date

**Appendix M**

**Supervision Contract – Telepsychology Addendum**

This Telepsychology Supervision Addendum, in conjunction with the supervisee's Supervision Contract, Practicum Training Plan, and the Clinical Psychology Program Handbook, will provide specific parameters for telepsychology supervision, while maintaining a focus on the protection of the client. The Supervision Contract – Telepsychology Addendum is an informed consent document, describing the expectations, requirements, and parameters of telepsychology supervision.

Supervisee:

_____

Supervisor: __John L. Barton, Ph.D.,
ABPP_____

Training Site: __ASU Clinical Psychology Center_____

Supervisee Phone: _____

Supervisor Phone: _602-663-0874_____

Supervisee email: _____

Supervisor email: _john.barton@asu.edu_____

Format of Telepsychology Supervision

- No more than 50% of supervision may be provided through telepsychology (expect in public health emergencies).

- Telepsychology supervision must be conducted using secure, confidential, real-time telecommunication technology

- Based on a risk analysis, telepsychology supervision may not be appropriate for all clients
  or all presenting issues. In these cases, in-person supervision is required.

- If a telepsychology supervision session does not involve video, the licensee will be identified by providing a predetermined pass phrase.

- Telepsychology is an innovative method for providing supervision. There is limited evidence that supervision provided by telepsychology is as effective as in-person supervision. However, as there is limited evidence on the effectiveness of in-person supervision, telepsychology supervision is not expected to be significantly different from in-person supervision.

- Technical problems can occur when using telepsychology, which could disrupt the supervision session. In the case of interruption, your supervisor will call you at your preferred phone number. If your supervisor cannot re-establish contact during the scheduled supervision time, you will be emailed to reschedule supervision.

- Both supervisor and supervisee are expected to respond to phone calls, texts, and emails
regarding supervision within 24 hours.

- Whenever possible, telepsychology supervision will be conducted through Zoom for Healthcare. When this is not possible, Zoom or phone supervision will be used.

Supervisee Signature: _____ Date: _____

Supervisor Signature: _____

## Appendix N
### Tele-mental health Procedures

(with thanks to the University of North Texas Clinic: Randall Cox, Jennifer Callahan)


### HOW TO SET UP YOUR SPACE FOR TELEMENTAL HEALTH SESSIONS[1]


#### Environment Requirements

Background
With telemental health sessions, your clients are only seeing a limited part of your space, which will be the background behind you during the telehealth sessions. It is important to set up a background that is coherent and not too distracting. In general, be thoughtful about your décor selection and arrangement, then consider how that background looks on-screen, before the first session. **For our clinic specifically, you must either create a "virtual background" in the settings of your zoom account or have a completely neutral background**.

Lighting
You will need to be thoughtful about having enough light behind yourself so that the background is not too dim. You will also need light *in front of you* **to brighten your face**. You might find putting a desk lamp behind your monitor works for that purpose. If you will be in a space with natural lighting, also pay attention to how different times of the day may look on screen to your clients. As much as possible, you want your clients to be able to see you clearly throughout the session. **IF YOU WEAR GLASSES**, you will need to adjust your light position to find the spot where you do not have glare. Typically, this is addressed by moving the bright light that is facing you higher up (e.g., put books under your lamp to raise it).

Noise/Sound
While a quiet space is important for most therapy sessions, it becomes even more important during telemental health sessions. Without the total visual context, ambient sounds or noise can be quite distracting and potentially even distressing for clients. Make sure the space you will be using is quiet. Utilize a white noise sound machine outside your office door to help block outside

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1 Much of this information is from: https://www.theraplatform.com/blog/255/how-to-set-up-your-office-for-teletherapy-sessions

sounds. You can download white noise apps on any smartphone. Be sure you plug your phone in so the battery doesn't die while you are in session and end your white noise app protection.

Comfort
During your teletherapy sessions, you will likely be sitting at a desk, which may feel a little different from your typical style during traditional therapy. Maximize your comfort for prolonged sitting with a desk that is the right height and a comfortable, perhaps even an ergonomic desk chair.

Isolation
Just as with other services, you are expected to be alone or with a qualified peer/supervisor when providing telepsychology services. During the COVID-19 crisis, this may be challenging. You may need to get creative (e.g., restroom, closet) in finding alone space. The virtual background and white noise app will go a good distance to creating visual and sound screening but they are not foolproof. Avoid verbalizing personal identifiers as much as possible (e.g., not using the client's name unless you have to while in session).

Technical Requirements and Access for Telemental Health

To provide telehealth, clinicians must verify that they have access to, and can competently use necessary resources. This includes a computer, web camera, stable internet connection, complete privacy, and neutral surroundings in the visual field captured by the web camera. Before offering telehealth services or beginning a telehealth psychotherapy session, ensure that the above mentioned criteria are met. Should a technical issue arise, contact your client immediately to indicate a delay in services or to reschedule.

First Contact to Discuss Telemental Health Services
Please review the below questions and information to discuss with clients in addition to using the phone script.

1. Inquire if the client has the capability to make the decided method of contact happen

    a. Do they have a data plan that allows for this communication to happen weekly?

    b. Do they have capabilities to download apps?

    c. Do they have a private space to have these meetings?

    d. Do they have access to a stable internet connection?

    e. Do they have a device that will work for Zoom?

2. Prepare the client for what communication from you might look like (e.g., calling from an unknown number; sending them emails via clinic@asu.edu.).

3. Explain to the client how the clinician will communicate with the client. The clinician should explain that they will only be able to contact/communicate with the client during regular Clinic hours when an on-call supervisor is available.

4. Insure/verify client's phone number and email address are up-to-date so they may receive telecommunication (i.e., phone calls and emails) from the clinic and/or their clinician.

5. Discuss how sessions may feel different from in-person meetings. Importantly, ask clients to treat these sessions similarly to an in-person office session (i.e., they should attend in a similar state as they would an in-person appointment; they should be dressed appropriately and groomed as they typically would be for an appointment).

6. Anticipate that there will be questions and concerns about the pandemic. Please review trusted sources and/or direct your clients to them in addition to making space for what they are experiencing.

7. Prepare them for the possibility of technical issues (especially in the beginning). Everything should be explained in simple, clear language.

8. Discuss the potential limitations and/or reservations your client may have about the use of videoconferencing software. There is a breadth of research that indicates that telemental health treatment can be effective and that clients are typically satisfied with this method of delivery. Nonetheless, it is important to invite clients to share their thoughts, feelings, and potential reservations about working with you remotely especially given the unique circumstances of the current situation.

9. Discuss and emphasize the importance of privacy. Affirm your efforts to conduct sessions from a private space on your end, engage in conversation about how they can ensure privacy on their end, and set boundaries that require ongoing commitment to privacy.

    a. For example, it may be important to discuss a "safe-word" to be used in some cases where privacy has been interrupted on the client's end. Although very rare, it may be the case that another individual (e.g., abuser) may have entered the room and the client might fear discussing it directly. It would be important for the client to be able to safely inform the clinician of the break in privacy.

10. Explain that using the telemental health platform may be awkward at first. It is okay to discuss this with your client.

11. Discuss how fees/payments will be handled by Christy to minimize the potential for misunderstandings.

In your intake document, include this language:

*Informed Consent Document was comprehensively reviewed with the client prior to beginning telemental health services. Client provided their verbal consent that they understood the contents of the consent document and consented to begin telehealth services. The informed consent document is attached to this note. Written consent will be obtained as soon as is safely and physically possible. Additionally, client contact information was obtained, an emergency contact* [insert contact name, phone number,

and relationship to client] *was identified, and a call back number for the client was obtained* [insert call back number]. *The informed consent document was provided to the client via email for their records.*

Intake Process for **New** Telehealth Clients

Clinicians should follow typical clinic practices and processes for intakes conducted via telehealth for both assessment and therapy clients. This means that both the traditional ASU Clinic Informed Consent should be verbally explained to all clients in addition to the Telehealth Informed Consent. Consent for both forms should be verbally gathered from clients and documented.  Both consent forms should also be emailed to clients for their records via Christy. Clinicians should document that they have emailed these forms to clients. Further, a Fee Agreement Form should be verbally consented to with all clients.  Following intake, clinicians must complete an **Intake Report** for therapy clients in a Word document and send a de-identified copy to John for editing.  The final draft is uploaded to Titanium for signatures Additionally, **Treatment Plans** must be completed for all psychotherapy clients.

Before Each Telehealth Session, Review and Complete this Checklist:
1. Ensure Zoom is the only application open on your computer before beginning sessions and encourage clients to do the same to increase security.

2. Turn off all notifications on your computer to reduce distractions and ask the client to do the same.

3. Clinicians should *ensure the session is set to record* before beginning.

4. For new clients, be sure to confirm the client's identity. Ask to see a photo ID.

5. Ensure clients are **physically located in Arizona (we cannot provide services if they are in another state)**. Obtain the client's physical address where they are participating in the telehealth session and record this in case it is needed during the session (e.g., a crisis emerges and a welfare check is needed).

6. Know crisis/emergency resources in the client's area before beginning the session (e.g., nearest hospital).

7. Verify that emergency contact information is on file (part of Telehealth Emergency Plan Form) and accessible to you should you need that information during the session.

8. Verify with the client that payment was made before the session begins.

9. Ensure you are in a quiet, private space free of distractions and other people. Verify similar sufficient privacy on the client's end. If needed, clients may relocate to their restroom for greater privacy.

   a. Please note that a virtual background will NOT eliminate other people from view. If their child, or someone else, walks into view of the client's webcam, they will be visible to you as the clinician. Also, the client should be informed of the

importance of reducing light from windows or light emanating from behind them. Share tips for lighting from above if they wear glasses, so you can see their eyes and nonverbal facial expressions more fully.

10. Encourage the client to use a secure internet connection, rather than free/public WiFi, when possible. Reassure them that data via Zoom is encrypted if that is not possible.

11. Verify client's call back phone number should videoconferencing encounter technical difficulties and the remainder of the session needs to be completed via phone. Do not share your personal phone number with clients under any circumstances.

12. Remind the client of the plan for contact should technical difficulties arise during a telehealth session. See "Contact Plan for Technical Difficulties" section below.

Contact Plan for Technical Difficulties
If technical difficulties or disruptions occur during a video session, clients should be instructed that the clinician will call them back using the phone number provided by them earlier in the session.

**Please comprehensively review this plan with all clients at the outset of services***

Managing a Crisis with a Telehealth Client
Should a mental health emergency arise during a telehealth appointment with a client the following steps should be taken.

1. Collect information from the client in the format of a risk assessment.

2. Safety plan with the client if appropriate. The clinician should initiate a phone consultation with the on-call supervisor, disabling their video feed and muting their sound. This will allow the clinician to watch and listen to the client while consulting with the on-call supervisor. Additionally, the case supervisor can be brought into the call via the meeting invitation. Clinicians should upload a copy of the safety plan (if completed) into the client's **Progress Note** in Titanium. A template safety plan form can be located within the Clinic Resources Dropbox. If a safety plan is created, please email a copy to the client via Christy.

3. Furthermore, the clinician will have obtained an emergency contact from the client during informed consent. This individual can be contacted in the event of an emergency.

4. Lastly, the clinician can utilize emergency services such as 911 and/or instruct the client to contact emergency services while on the telehealth platform.

**Client contact**
- All email contact is done through encrypted email by Christy through clinic@asu.edu

    o Secure email will be sent for OQ link and Zoom link

- The clinician will need to provide Christy with the unique Zoom link

- Or, the client can download the Zoom app, select "Join Meeting," and by phone the therapist will give the 9-digit meeting code and 6-digit password

  o We must send all emails securely to protect confidentiality; once logged in to view the secure email, clients can then respond in a secure manner

  o Clients can send whatever information they want by email, though we need to explain that it is not a secure form of communication

- Phone calls from therapist phones need to use *67 to block number

  o Many people do not answer calls from blocked numbers, so you need to inform your clients you will be blocking your number

  o Call beforehand and leave a message to explain this procedure

  o To block your number, enter *67, followed immediately by the phone number


**Supervision**
- Document Supervision Risk Analysis

- Complete Supervision Contract – Telepsychology Addendum

- Second year students will record each session on Zoom, save to their computer, upload to the secure storage space.  RTs will record sessions on a limited basis.

- Provided telepsychology to supervisees

  o Take advantage of the free online trainings

  o Review the research on telepsychology in general, about your client's presenting problems, and about evidence-based treatments

**Clinic Access**
- 2nd year prac students, RTs, post-docs, administrative support, and supervisors are considered essential personnel and may access the clinic.

- Christy will maintain an Outlook Calendar to facilitate scheduling of clients, as well as to reserve a time if you need to be physically present at the clinic.

  o The primary reasons to be at the clinic are:

    - To access client records

    - To score psychological test

<p style="text-align:center">Appendix O</p>

<p style="text-align:center">**Titanium Access & Use**</p>

Training videos on Ti's site.  They are useful.
http://www.titaniumschedule.com/Main/Videos/Users/Menu.html

**How to access Titanium:**
1.      Go to https://adminapps.asu.edu
2.      Login to Citrix with ASURITE and password
3.      Click on Titanium
4.      Clink on Run in the "Open File – Security Warning" pop-up
5.      Login to Titanium with ASURITE and password

**How to find all clients:**
1.      Click "Open" on the top menu bar
2.      Select Advanced Client Search
3.      Change "Filters" to Client Fields
4.      Click Search (at the top)
5.      Double click on the client's name to open
6.      Click on Client File to open the client's record

**To enter a new appointment**
1.      On the therapist's schedule, right click on the start time
2.      Add Individual Appointment
3.      Enter client's name and click Find
4.      Select the client's name and click OK
5.      Under Code, select Therapy Session (in-person or telepsychology)
6.      Click Save and then click Exit

**How to enter a progress note:**
1.      Click on the scheduled session on your schedule
2.      Under Attendance, change to Attended
3.      Click on Client Note
4.      Select Progress within Type of note
5.      Select your name within Counselor
6.      Enter your note
7.      Under Sign:, click on the "1:"

8.      Under Forward to:, select your supervisor
9.      Click Save and then click Exit

**Supervisor sign-off**
1.      In the Open menu, select Task List
2.      Double-click on the note
3.      Under Sign:, click on the "3:"
4.      Click Yes to sign and lock
5.      Once a note is locked, it cannot be edited. An addendum can be added.
6.      Click Save and then click Exit

**To enter a new client (done by Christy)**
1.      In the Open menu, select Clients
2.      Enter last and first name
3.      Click New Client
4.      Fill in available information
5.      Click Save and then click Exit

OQ Scores and Data Collection with Telepsychology Therapy Clients

1.      Clinicians should continue to collect **weekly OQ data** for all telehealth psychotherapy clients.

**Appendix P**

**DIGITAL RESOURCE TOOLKIT FOR STUDENT CLINICIANS & SUPERVISORS**

**Psychoeducation**

Tips for Social Distancing, Quarantine, and Isolation During an Infectious Disease Outbreak
https://store.samhsa.gov/system/files/sma14-4894.pdf

About PTSD in Kids & Other Disorders
https://kidshealth.org/en/parents/ptsd.html?WT.ac=ctg#catfeelings

Age-Related Reactions to a Traumatic Event
https://www.nctsn.org/resources/age-related-reactions-traumatic-event

Anxiety and COVID-19 Information Sheet
https://www.heretohelp.bc.ca/infosheet/covid-19-and-anxiety

Adjustment Disorders in Children
https://www.massgeneral.org/condition/adjustment-disorders

**Treatment Resources[2]**

Disaster Distress Helpline
  This is a 24/7, 365-day-a-year, national hotline dedicated to providing immediate crisis counseling for people who are experiencing emotional distress related to any natural or human-caused disaster, including infectious disease outbreaks. This toll-free, multilingual, and confidential crisis support service is available to all residents in the United States and its territories. Stress, anxiety, and other depression-like symptoms are common reactions after a disaster. Call 1-800-985-5990 (tel:1-800-985-5990) or text the phrase "TalkWithUs" to 66746 to connect with a trained crisis counselor.

Parent/Caregiver Guide to Helping Families Cope With the Coronavirus (2019)

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2 You may need to copy/paste addresses. Some are quite long and may suffer from line breaks.

https://www.nctsn.org/resources/parent-caregiver-guide-to-helping-families-cope-with-the-coronavirus-disease-2019

Talking to Children About COVID-19 (Coronavirus): A Parent Resource
https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-climate-safety-and-crisis/health-crisis-resources/talking-to-children-about-covid-19-(coronavirus)-a-parent-resource

Helping Children Cope After a Traumatic Event
https://childmind.org/guide/helping-children-cope-traumatic-event/

12 Ways to Effectively Parent During a Crisis
https://www.psychologytoday.com/us/blog/here-there-and-everywhere/202003/12-ways-effectively-parent-during-crisis

Healthcare Toolbox
https://www.healthcaretoolbox.org/patient-education-materials/download-print-patient-handouts.html

Apps (Deep Breathing, Guided Meditation, Mindfulness, Yoga)
　　Meditation Apps for Kids
　　https://www.commonsensemedia.org/lists/meditation-apps-for-kids

　　Smiling Mind
　　https://www.smilingmind.com.au/

　　2019 Top Rated Mental Health Apps
　　https://www.psycom.net/25-best-mental-health-apps

Help for Teens and Young Adults with Anxiety
https://www.anxietycanada.com/resources/mindshift-cbt/

Guided Imagery Tracks from Children's Hospital of Orange County
https://www.choc.org/programs-services/integrative-health/guided-imagery/

Triple P Online Parenting Program (Not COVID-19 Specific)
https://www.triplep-parenting.com/us/triple-p/

Creating Ways to Support Mental Health
https://mindyourmind.ca/wellness/creative-ways-support-your-mental-health

Coping with Stress During Infectious Disease Outbreaks (for Adults)
https://store.samhsa.gov/system/files/sma14-4885.pdf

**Guidance for Families**

National Child Traumatic Stress Network: Parent/Caregiver Guide to Helping Families Copes with the COVID-19 (English + Spanish)
https://www.nctsn.org/resources/parent-caregiver-guide-to-helping-families-cope-with-the-coronavirus-disease-2019

What to Say to Your Child About the Coronavirus – and How to Cope as a Parent
https://www.ahaparenting.com/blog/talking-with-children-about-the-corona-virus

Explaining the Coronavirus to a Child with Anxiety or ADHD
https://www.additudemag.com/explain-coronavirus-covid-19-anxiety-adhd-child/

Talking to Kids with OCD About COVID-19
https://iocdf.org/covid19/talking-to-kids-about-covid-19/

Talking to Children About COVID-19: A Parent Resource
https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school climate-safety-and-crisis/health-crisis-resources/talking-to-children-about-covid-19-(coronavirus)-a-parent-resource

Talking with Children – Tips for Caregivers, Parents, and Teachers During Infectious Disease Outbreaks
https://store.samhsa.gov/system/files/pep20-01-01-006_508_0.pdf

Parent Tips for Helping Infants and Toddlers After Disasters
https://www.nctsn.org/resources/pfa-parent-tips-helping-infants-and-toddlers-after-disasters

Parent Tips for Helping Adolescents After Disasters
https://www.nctsn.org/resources/pfa-parent-tips-helping-adolescents

Disaster Media Intervention: Helping Students Cope with Disaster Media Coverage
https://rems.ed.gov/docs/resources/NCTSN_Students_Coping_Media_Coverage.pdf

[For Teens/Older Adolescents] What to Do if You're Anxious About Coronavirus
https://youngminds.org.uk/blog/what-to-do-if-you-re-anxious-about-coronavirus/

Teaching Story: Talking to Children with Autism About Coronavirus
https://m.youtube.com/watch?feature=youtu.be&v=xkZ23tDzN4c

**Transition from Home to School**

Online Learning Resources

https://swingeducation.com/resources/20-online-learning-resources-to-help-you-get-through-coronavirus-school-closures/

Family De-Stressing During Coronavirus
https://www.pbs.org/parents/thrive/how-you-and-your-kids-can-de-stress-during-coronavirus

Museums/Virtual Tours
https://www.travelandleisure.com/attractions/museums-galleries/museums-with-virtual-tours

Scholastic Learn at Home – Day by Day
https://classroommagazines.scholastic.com/support/learnathome.html

Sample At-Home Schedule
https://docs.google.com/document/d/e/2PACX-1vSZhOdEPAWjUQpqDkVAlJrFwxxZ9Sa6zGOq0CNRms6Z7DZNq-tQWS3OhuVCUbh_-P-WmksHAzbsrk9d/pub

Coronavirus Crash Course for Parents: Keeping Kids with ADHD in 'Study Mode' While Home from School
https://www.additudemag.com/webinar/coronavirus-homeschooling-parent-strategies/?utm_source=eletter&utm_medium=email&utm_campaign=webinar_march_2020&utm_content=031620&goal=0_d9446392d6-049aae7e7a-297270053

Extensive Compendium of Educational Resources
http://www.amazingeducationalresources.com/

**Practitioner Specific Resources**

Seven research findings that can help people cope with COVID-19 outbreak
https://www.apa.org/news/apa/2020/03/covid-19-research-findings

Self-care for psychologists: A podcast via APA
https://www.apaservices.org/practice/business/podcasts/self-care

Coronavirus Anxiety: A Podcast via APA
https://www.apa.org/research/action/speaking-of-psychology/coronavirus-anxiety

Mental Health Coping Advice via the CDC
https://www.cdc.gov/coronavirus/2019-ncov/prepare/managing-stress-anxiety.html

[Avoiding Burnout] Headspace for Healthcare Professionals
https://www.theverge.com/2020/3/16/21181773/headspace-free-health-care-provider-public-health

Headspace (Offering Headspace Plus for Free for Healthcare Providers, as well as Free Access to School Staff: likely a temporary price reduction due to covid-19)
https://www.headspace.com/covid-19

Guide to Practicing Telepsychology with Minimal Risk
https://www.nationalpracticeconference.org/images/Slides/Session_1_-_A_Practical_Guide_to_Providing_Telepsychology_with_Minimal_Risk.pdf

Review of Telehealth Platforms
https://www.apaservices.org/practice/business/technology/tech-column/telehealth-solutions

APA's Office & Technology Checklist for Telepsychology Services
https://www.apa.org/practice/programs/dmhi/research-information/telepsychological-services-checklist

E-Mental Health Implementation Toolkit
https://www.mentalhealthcommission.ca/sites/default/files/2018-09/E_Mental_Health_Implementation_Toolkit_2018_eng.pdf

APA Recommendations for COVID-19 and Psychology Services: How to Protect Your Patients and Your Practice
https://www.apaservices.org/practice/news/covid19-psychology-services-protection

Support Healthcare Provider Well-Being
https://www1.ucdenver.edu/docs/librariesprovider45/covid-19-support/health-care-provider-well-being.pdf

OPA-COVID-19 Guidance
https://drive.google.com/file/d/1pQ6IV6b9hQloGURxkto854hAws9vvTvT/view

## Appendix Q

Psychology Lab Safety Plan

**'Return to Work'**

As we plan to reengage research on campus, we are tasked with developing a plan to ensure the safety of all faculty, staff and students. Each lab will need to develop its own detailed safety plan for adhering to the COVID-19 Research Facilities Guidelines. These plans will require, for example, that you specify the number of people in your labs, their daily shifts, their understanding of guidelines for disinfection and PPE, confirmation that they have reviewed the safety training materials developed by our colleagues at EHS, etc.

Your plan will be initially reviewed by Sharon Kenyon, who will help to work through any challenges that you may have. The plans will then be reviewed and approved by me and the dean. The building and labs will not be able to be occupied until university facilities team has ensured the building and common areas are ready for occupancy based on cleaning protocols, signage, and other required facilities modifications.

**<u>Process</u>**

Step 1. Carefully review the relevant information provided by the university:

https://research.asu.edu/research-intensification-plan-2020
https://research.asu.edu/sites/default/files/2020-05/ResearchFacilitiesGuidelines.pdf
https://www.asu.edu/ehs/documents/asu-laboratory-ramp-up-checklist.pdf

Step 2. On the basis of these guidelines, please complete the form below and the laboratory ramp up checklist. Submit both forms to Sharon Kenyon (sharon.kenyon@asu.edu). Sharon will

review, follow up with any questions she may have, and help you work through challenges you may have.

Step 3.  After receiving approval from Sharon to proceed, use the university portal to create and submit a lab safety plan consistent with the information you've had approved by Sharon:

Sharon will send me the department's approved plan, and the plan you submit through the portal will be routed to me as well.  After I approve, your plan will be forwarded to the College for approvals.  Once approved there, and once our buildings are prepared by the university for (initially limited) occupation, you'll receive approval to return to your labs and re-engage aspects of your research programs.  (As of today, we still don't have guidance regarding human subjects contact.)

<div align="center">CPC Safety Plan</div>

1.  Name: John Barton

2.  Email address: john.barton@asu.edu

3.  Cell number: 602-663-0874

4.   Lab location, room numbers:  UCENTA  #116  (1100 E. University)

    190 A   Front Desk / Reception
    190 B   student work room
    190 C   John's office
    190 D   2-person RT office
    190 E   3-person RT office
    190 F   Therapy room "Agave"
    190 G   Therapy room "Bell Rock"
    190 H   Therapy room "Cholla"
    199 F   Large Therapy room "Diamondback"
    199 G  Family Therapy room "Echo Canyon"
    199 E   Records/Server room
    199 D   Break room / Copy Room
    199 C   Conference room
    199 UI  Telecom room
    199 B   Group therapy room "Four Peaks"
    199 A   Assessment room "Grand Canyon"
    191      Waiting room

5.   Please specify your planned PPE use and disinfection routines in your lab:
    - All wear masks

- Shift scheduling
- Wash hands 20" before and after sessions
- Wipe all surfaces in room maintaining wet surfaces according to guidelines > 1 minute, with approved disinfectant
- Personnel who perform cleaning and disinfection must use the following personal protective equipment: Gloves
- Clean and disinfect high use clinic surfaces after each use.
- Clean the surfaces of dust, smudges and debris using regular housekeeping protocols with water and detergents, then use disinfectants. Disposable wipes may be placed into the regular trash. (Do not use spray bottles to apply disinfectant when cleaning surfaces. Spraying surfaces may cause aerosols. If wipes are not available, apply 70% isopropanol to a cloth while avoiding saturation or dripping.)
- Equipment that is shared by multiple people should be cleaned and disinfected before and after each use.
- Hand sanitizer of at least 60% alcohol can be used for glove changes but is not a substitute for proper handwashing. Always completely cover hands with hand sanitizer and allow to air dry.
- A log will be kept of locations and surfaces that are cleaned. Included: the date, time and cleaner's initials. • More frequent cleaning of highly-touched surfaces is recommended. These surfaces include countertops, desks, doorknobs, handles, keyboards, light switches, phones, sinks and tables. Wash hands and forearms thoroughly for at least 20 seconds with soap and warm water after removing PPE.

6.  Separately for each room, please provide the names of people who will be working in that space:

190 A   Front desk space: Christy Roberts
190 B   Student work room 2nd year students
190 C   John's office:  John Barton
190 D   2-person RT office: Emma Lecarie (10 or 20 hrs/wk), Jessica Borders (4 hrs/wk)
190 E   3-person RT office:  Saul Castro (10 hrs/wk), Steven Marsiglia, (10 hrs/wk)
190 F   Therapy room: Therapist and client
190 G   Therapy room: Therapist and client
190 H   Therapy room: Therapist and client
199 F   Large Therapy room: Therapist and client(s)
199 G   Family Therapy room: Therapist and family
199 E   Records/Server room: none
199 C   Conference room:  instructor and class (6)?
199 U   1 telecom room: None
199 B   Group therapy room:  Therapist and client(s)
199 A   Assessment room: Therapist and client
191     Waiting room 1-2 clients

7.   If more than one person is assigned to a space, physical and/or temporal distancing will be required.

- Separately for each room, please specify your plan for maintaining safe distance (e.g., physical distance, barriers, shift scheduling) and performing appropriate disinfection:
- If there are multiple stations to complete work, as in a wet lab, please specify the tasks performed there and if multiple people will need to work at the same space even if at different times.  Please identify the tasks occurring there and the disinfecting procedures:
- Please identify any spaces shared between multiple labs such as -80 freezer rooms, surgery suite, please specify the protocols and coordination with the other labs sharing the space:
- 

190 A Front desk space
- Clear barrier installed at desk
- wear masks
- physical distance, no more than 2 at one time;
- Clean and disinfect all surfaces after each use

190 B student work room
- wear masks
- physical distance, no more than 2 at one time;
- Clean and disinfect all surfaces after each use
- Keep a log of locations and surfaces that are cleaned. It is a best practice to include the date, time and cleaner's initials. • More frequent cleaning of highly-touched surfaces is recommended.

190 C John's office:  John Barton N/A
- Clean and disinfect all surfaces after each use

190 D   2-person RT office:  Emma Lecarie (10 or 20 hrs/wk), Jessica Borders (4 hrs/wk)
- Shift scheduling
- Clean and disinfect after every use

190 E 3-person RT office: Saul Castro (10 hrs/wk), Steven Marsiglia (10 hrs/wk)

190 F   Therapy room "Agave":  Therapist and client
- wear masks
- physical distance
- clean and disinfect after each use with cleaning supplies in room

190 G   Therapy room "Bell Rock":  Therapist and client

- wear masks
- physical distance
- clean and disinfect after each use with cleaning supplies in room

190 H   Therapy room "Cholla": Therapist and client
- wear masks
- physical distance
- clean and disinfect after each use with cleaning supplies in room

199 G Family Therapy Room "Echo Canyon:
- wear masks
- physical distance
- clean and disinfect after each use with cleaning supplies in room
- remove all toys.  Provide disposable coloring materials.

199 F   Large Therapy room "Diamondback": Therapist and client(s)
- wear masks
- physical distance
- clean and disinfect after each use with cleaning supplies in room

199 E   Records/Server room: Clean and disinfect surfaces after each use

199 C   Conference room:  instructor and class (n/a Fall 2020) use as needed
- wear masks
- physical distance
- clean and disinfect after each use with cleaning supplies in room

199 UI  Telecom room: None (no access)

199 B Group Therapy room "Four Peaks": Therapist and client
- wear masks
- physical distance
- clean and disinfect after each use with cleaning supplies in room

199 A   Assessment room "Grand Canyon": Evaluator and client
- wear masks
- physical distance
- use iPads for test administration
- clean and disinfect after each use with cleaning supplies in room

191 Waiting room 1-2 client (and significant other / parent)
- wear masks
- physical distance
- clean and disinfect after each use with cleaning supplies at front desk

- shift scheduling

8. If you are requesting approval for the return of undergraduate student(s), please explain the specific nature of their work and role(s) in your lab, and a justification for why they must return now.

We are asking that graduate students be allowed to provide a limited amount of testing for clients from the community and/or the university at the clinic. While safety concerns are primary, with the precautions above, students can continue to develop competencies necessary for graduation, internship, and licensure. There would be no more than one client at a time.

# Section 7: Clinical Placements

I. Policies Regarding Placements for Clinical Students

II. Procedures for Applying for Clinical Placements

*CLINICAL TRAINING PROGRAM*
*DEPARTMENT OF PSYCHOLOGY - ARIZONA STATE UNIVERSITY*

## POLICIES REGARDING PLACEMENTS FOR CLINICAL STUDENTS

### I.    Clinical Placement Policies

*(Updated  8-10-2015)*

ClinPo13.doc

This document describes the policies and procedures on clinical placements. The policies and procedures are influenced by a number of factors such as American Psychological Association (APA) guidelines, licensure laws, the realities and constraints of our particular university and city, and the policies of our own department.

It is a policy of the clinical training program that every student must complete a 20-hour per week clinical placement for one year, or 10-hour per week placements for two years. Clinical placements occur in settings where the primary focus is on the provision of <u>direct services</u> to a client population.

**<u>Primary Supervisor</u>**

Important aspects of doctoral training in clinical psychology are based on an apprenticeship model in which faculty members and other psychologists serve as models for students in their acquisition of knowledge and skills in research and practice. Thus, a primary component of any placement should be the active presence of a licensed psychologist who possesses the knowledge and models the skills that we want students to acquire. Ideally, a clinical placement should have one or more full-time psychologists who provide clinical training to students. The presence of a psychologist on a part-time basis, or a psychologist whose training and background is different from what we would prefer are examples of variations that we might

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consider on a case-by-case basis because of a setting's unique training opportunities. However, it is essential that we should make every effort to afford our students the opportunity to form their primary identification with the work of the discipline of psychology, and not a different discipline. Moreover, in order for placement training to count toward licensure in Arizona (and several other states), no more than 25% of the supervision a student receives can be provided by an allied mental health professional.   In accordance with program standards, there shall be at least 1 hour per week of regularly scheduled contemporaneous face-to-face individual supervision provided to the graduate student per 10 hours of supervised pre-internship professional experience that addresses direct psychological services provided by the student (e.g., therapy, assessment, interviews, documentation, case-presentations, seminars on applied issues, group supervision, consultation, etc.).

## Placement Activities

The primary purpose of a clinical placement is graduate student training. It is also recognized that for many placement sites, one of the facts of life in accepting one of our graduate students is that this must be economically feasible from the agency's viewpoint. In fact, a significant aspect of training for the student can be the exposure to the "real world" with its necessity for being accountable for specific tasks. Thus, the following guidelines attempt to strike a balance between a direct training function and service requirements.

The placement agency should understand that a graduate student position within that agency must emphasize training, and the agency should abide by the requirements for adequate training as outlined in this document.

The graduate student's clinical activities within the agency should be consistent with the nature and level of the student's training. Thus, students should participate in an organized, sequential series of supervised experiences of increasing complexity and should not be expected to engage in activities that psychologists ordinarily do not do. Similarly, graduate students should not be asked to engage in tasks that are beyond their current level of competence.  By contrast, a graduate student should serve as an apprentice to the supervisor in completing clinical tasks that constitute an integral part of the clinical services offered by that agency.

In addition, none of the above is intended to preclude the student from serving as a resource to the placement agency such as in generating new knowledge, or in developing a new clinical or treatment program.  Indeed, the availability of the student as a resource and a liaison with the university is often seen as one of the benefits that an agency gains by making training opportunities available.

Seminars, workshops, case conferences, and in-service training sessions are other modalities available within placements to develop the skills student trainees need to function adequately in the clinical setting, although these do not replace the value of clinical training activities that involve direct contact with clients.

## Stipends

Some clinical placements are able to offer student training stipends.  Those financial

arrangements should be discussed with the Director of the Clinical Psychology Center before the availability of the placement is advertised and prospective trainees are interviewed.

## **Schedules**

In many placement agencies, graduate students will become an integral part of the service team; this experience is a useful aspect of the student's training. However, the primary agency commitment to the graduate student is expected to be to training. Thus, students should be permitted to negotiate their schedules so that it is possible for them to meet the requirements of their university work. It is also expected that students will not be pressured in any way to work more than the quarter-time/half-time agreement (10/20 hours in an ordinary working week).

The total number of field placement hours is limited to no more than 20 hours per week if the student has no TA or RA support, or to no more than 10-12 hours per week if the student has a 20-hour per week TA or RA position.

# II.  Clinical Placement Procedures

Our goal is to develop stable, long-term relationships with training agencies. We will be flexible in collaborating with sites to develop training opportunities that meet students' needs and that are feasible from the site's perspective. For example, a field placement might be accepted at an agency that does not fulfill all the policy requirements, but has the potential for doing so in the future.

## <u>Development of Potential Placements</u>

In early January of each year, the Placement and Clinical Policy Committee (PCPC) of the Clinical Psychology Program checks with current placement sites regarding the potential availability of placements for the following year (Placement years run from July 1 through June 30). Information regarding Placements is then included in a comprehensive listing (i.e., "The Grid") that informs graduate students of available field placements for the coming year.  The PCPC also considers possible new sites and ascertains their suitability. As part of this process, potential supervisors are advised of our general policies and of the process of student selection, as described below.

Each <u>proposed new placement</u> opportunity must be submitted to the Director of the Clinical Psychology Center or the Chair of the PCPC. The PCPC will then determine the appropriateness and viability of that proposed placement.  As a first step in establishing a new field placement, the representative of the prospective placement should submit to the PCPC the Placement Information Form and the vitae of potential supervisors. The Director of the Clinical Psychology Center, or the Chair of the PCPC will review the site information and supervisors' credentials, and will offer a recommendation regarding the placement. Pending this initial review, the proposal will be submitted to the whole PCPC for approval.  Additional information will be gathered, if necessary, and the placement reconsidered.

## Student Selection

In early February, a list is circulated to all clinical students that describes the placements that are available for the coming year. One or more members of the PCPC then meet with students to discuss this list and to answer questions. In addition, students are asked to become familiar with any existing placements in which they might be interested by talking with students who trained in those settings. Students then may call the supervisors of those placements in which they are interested to arrange for an interview. A deadline is set on interviews.

Students and site supervisors rank order their preferences and submit them to the CPC secretary.  Similar to the APPIC procedure, students and sites are then notified of their match. There is the possibility that all available placement slots will not be filled, just as it is possible that students will not find a placement.  In either case, supervisors and students should contact the Director of the CPC to determine what alternate arrangements can be made.

We have established a policy that limits students to one and only one year in a particular clinical placement.  Here we recognize that there exist only a limited number of clinical field placements within the Phoenix metropolitan area, each with unique features that have special

training value. For example, only one or two local sites might offer clinical training in forensic evaluation, assessment and therapy with children, inpatient treatment, or clinical work with ethnic minority clientele. If certain students remained in a training site for multiple years, it would deprive other students of experiencing that setting and its unique training opportunities.

## Training Plans

On June 30, 2009 the Arizona legislature passed House Bill 2206, revising the manner in which psychologists can become licensed in Arizona. Part of the new law calls for each applicant to document pre-internship clinical training experiences through the use of a training plan. Therefore, each trainee should develop a written training plan with the professional training site and the clinical program. The training plan for each supervised pre-internship training site must designate an allotment of time for each training activity and must assure the quality, breadth, and depth of training experience through specification of goals and objectives of the supervised experience, the methods of evaluation of the student, and supervisory experiences. Model training plans will be provided to assist placements in developing plans for each trainee.

## Evaluation of Student Performance and Placement Experiences

Midway through the placement, the Director of the Clinic will conduct a brief evaluation with that student's clinical placement supervisor. A brief evaluation checklist will be provided to the supervisor to indicate the quality of the student's performance. It will be the responsibility of the CPC Secretary to monitor the completion of these brief evaluation checklists.

Towards the end of the placement, the Director of the CPC and the PCP Committee request from the field placement supervisor, a written end-of-year evaluation of the graduate student's progress. This evaluation uses the Clinical Training Program's standard evaluation form. It is the responsibility of the CPC Secretary, under the guidance of the Director of the CPC, to coordinate the distribution, collection, and processing of these end-of-year evaluation forms. As part of this process of evaluation, each graduate student is also asked to follow-up with their placement supervisor to ensure that the supervisor's evaluation is completed and submitted in a timely manner.

Our current evaluation form provides for ratings over a number of different categories, for comments, and for the signature of both the supervisor and the student to indicate that the form has been utilized for feedback purposes to the student. These forms are returned to the Director of the Clinical Psychology Center who places the evaluations in the students' permanent files. The Director provides information to the faculty regarding student evaluations in clinical placements during annual reviews that are conducted by the full clinical faculty for each student.

All field placements are evaluated by the student each year using a standard form distributed by the CPC Secretary. Especially for new field placements, graduate students are encouraged to provide early feedback regarding the strengths and limitations of their new field placement experience. The CPC Director and the Director of Clinical Training review the evaluation forms and alert the full clinical faculty when evaluations raise concerns about any of the community placements

# Section 8: Internship

I.  Dissertation Prospectus and Internship Readiness

II. Registering for Course Credit During Internship

III.    Petitioning for a non-APA Accredited Internship

## I. Dissertation Prospectus and Internship Readiness

Students must submit the dissertation prospectus by October 1 and hold the prospectus defense by October 15 of the fall that they wish to apply for internships.  This policy will apply to the class admitted in 2004 and those that follow.

Other information for the APPI:
- required for participation in the AAPIC match—master's thesis, comps, dissertation prospectus
- required to attend an internship--complete all academic coursework, comps, master's thesis, dissertation prospectus
- completion of dissertation data analyses and dissertation defense are not required before attending an internship, but highly recommended.

## II. Registering for Course Credit during Internship

The clinical psychology program requires that students enroll for one hour of internship credit during the fall and spring semesters of the internship year. Those credits must appear on the program of study. Because you will not be receiving a stipend from the department while on internship, the cost of tuition will be your responsibility. **For this reason, we strongly encourage all students to apply for in-state residency well in advance of the internship year. Further, although any existing loans will deferred since you will be continuously enrolled for course credit, you will not be able to take out new loans during the internship year as you will not be enrolled full time (at least 5 hours). So, if paying the one hour of tuition during the fall and spring semesters of internship will create financial difficulties, you should plan in advance (and consult the financial aid office) about how you might save funds to cover the tuition costs during internship.**

Under some circumstances, the fall and spring internship credit tuition costs can be reduced. Students are eligible for this benefit if, **before** their fall tuition bill is due they have completed all of their coursework, successfully defended their dissertation (i.e., passed their orals and completed all needed revisions), and completed a petition for GRD 595 that is signed by the Department chair and approved by the Graduate College. With approval of that petition, students can register for their internship credits at reduced cost.

Students must also register for at least one credit during the term in which they graduate. For example, if a student has defended the dissertation, completes the internship by June 30th and is eligible to graduate in the second summer session, that student should enroll in one credit (e.g., continuing enrollment PSY 795) during the second summer session. If a student's internship ends after the August graduation deadline, that student would apply for fall semester graduation and would enroll in one credit for that fall semester. Students may receive only two semesters of reduced credit. So, if a student registers for GRD 595 in the fall and spring semesters of their internship year, they will be responsible for the cost of one full credit hour during the semester they graduate (summer or fall).

The Graduate College requires that you formally apply for graduation. The necessary

materials should be obtained from them.

# III.  Petitioning For an Internship That Is Not APA Accredited

Students are required to complete a one-year clinical internship at an APA-approved facility. The faculty recognizes that on very rare occasions, a student might have reasons to consider a non-APA accredited internship. Students who want to apply for non-accredited internships may petition the clinical faculty. The petition must show that the proposed internship site is a member of APPIC or meets APPIC guidelines (see internship checklist).

The petition should include the following elements:

1. The reasons for considering a non-APA internship.
2. A description of the proposed internship including training activities and supervisors.
3. Vita of supervisors who are licensed psychologists.
4. A letter from the internship director that indicates that the facility is an APPIC member, the start and stop dates of the internship, and the stipend and benefits the intern will receive.  If the facility is not a member of APPIC, the letter must be accompanied by the internship checklist (that is modeled after APPIC requirements).

In addition, the student must provide evidence that the internship training program meets the standards outlined by APPIC including the following:

1. The psychology internship is an organized training program, with a defined curriculum, that provides interns with a planned sequence of training experiences. The primary focus and purpose is assuring breadth and quality of training. The internship has a written statement that provides a clear description of the nature of the training program and is made available to prospective interns.

2. The internship program has a clearly designated doctoral level staff psychologist who is responsible for the integrity and quality of the training program. This person is actively licensed, certified, or registered by the Board of Examiners in the jurisdiction where the program exists, and is present at the training facility for a minimum of 20 hours per week.

3. Regularly scheduled individual supervision is provided by one or more doctoral level licensed psychologists, at a ratio of no less than one hour of supervision for every 20 internship hours.

4. The internship provides training in a range of psychological assessment and intervention activities conducted directly with recipients of psychological services.

5. The internship must provide at least two hours per week in didactic activities such as case conferences, seminars, in-service training, or grand rounds.

6. Internship training is at the post-clerkship, post-practicum, and post-externship level, and precedes the granting of the doctoral degree.

7. The internship agency has a minimum of two internship positions at the doctoral level of training. These interns must be at least half-time (i.e., 20 hours per week).

8. The internship experience (minimum 1500 hours) must be completed in no less than 9 months and no more than 24 months. Only school psychology programs will be allowed to participate in the Match with 1500 hours or 9-10 month internships.

9. The internship program provides training that meets the requirements for licensure eligibility in the state, province, territory, or jurisdiction in which it is located.

10. At least twice a year the internship program conducts formal written evaluations of each trainee's performance.

11. A stipend is paid that is reasonable for the institutional and regional context and stated clearly in advance.