The OISE Psychology Clinic

at the

Ontario Institute for Studies in Education
of the University of Toronto

Clinic Handbook

SCCP Edition

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Last updated: November 2013

A Note to the Student…

The contents of this booklet will give you a basic understanding of the policies and procedures of our Clinic. Please read it carefully. If concerns develop either with clients or with Clinic procedures, please feel free to discuss them with either one of the Clinic Co-Directors.

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GETTING STARTED

As part of the initial orientation to the Clinic, student clinicians will be given the special access codes to the main clinic door and to the Photocopy/'Key' Room (7-281). These codes may be changed from time to time for security reasons. Students are asked to fill out a Clinic User Qualification Form, co-signed by their supervisor. In case of client appointment cancellation or an emergency situation regarding the client, the Clinic staff will attempt to notify you directly through the phone number on this form. This form enables the student to use the test library and book rooms within the Clinic.

Noise

Remember that the Clinic walls are very thin. As a courtesy to others when possible, please avoid making loud noise in the Clinic rooms and hallway.

The Photocopy Room/ "Key" Room

Room 7-281 is the place where the photocopier and Clinic room keys are located. Each student using the facilities of the Clinic should have the access code to this room (obtainable from Clinic staff during regular office hours). Room keys are kept on hooks along the wall and need to be returned after clinicians have finished using their respective rooms or when a session is over.

The SCCP and Counselling Student Rooms

Room 7-290 is used by the AECP students and room 7-283 is used by the SCCP students. Each room has a telephone, filing cabinet, desk(s) and computer. Files that the student is currently working on should be stored in the filing cabinets located in the respective student rooms. For file security reasons, these rooms should be kept locked when unoccupied.

Client files will be left in the SCCP Student Room no later than the morning of your scheduled appointment. Case files are to remain in the Clinic. Files can be "borrowed" to take to supervisors for supervision feedback, but must not under any circumstances leave OISE/UT.

Room Booking

When making appointments for sessions with clients, clinicians will schedule time in one of the Clinic interview rooms. Rooms are set up with table and chairs for assessment purposes, and also have more comfortable furniture for counselling, psychotherapy or interviews. The group room is a larger room with table and chairs. We have set up a web-based system for room bookings; you will be updated on how this works at our orientation in September.

When scheduling, please limit your use of Clinic interview rooms to the time when you are actually meeting with the client(s). You may need to allow an extra half-hour for set up of video equipment. It is expected that you will not use Clinic interview rooms for scoring of tests or writing up process notes. Because of the shortage of Clinic space, priority is given to students or interns meeting with clients of the Clinic. Following this, and on the basis of availability, rooms may be booked for course-related training purposes, faculty research, thesis data collection, interviews and similar OISE-related work. In cases of regular, ongoing counselling, therapy and remediation, "block booking" in advance can be made. If your client cancels an appointment, please ensure that your booking is deleted from the schedule.

Audio and Video Equipment

AV Room 1 is equipped with two video recording systems, one for Room D and Group Room, and another one for Room E. However, the video recording system cannot tape Room D and the Group Room simultaneously. To avoid confusion, if you are booking with Room D or the Group Room and plan to use the video capacity, please put a "V" beside your name when you book the room. The program to video record on the computers in the AV Room 1 is called "Media Cruise". Instructions for use are posted on the wall. Room F also has a video recording system set up on the computer in the Clinic Training Room. To access the program, simply look for "Media Recorder 2" on the computer desktop.

Student clinicians are expected to provide their own storage devices (e.g., USB key, preferably with password protection) to save the video files recorded with the computer video recording systems. Video files stored on the video recording systems are erased regularly. All audio and video files should be treated as confidential material. Students should ensure that clients have given informed consent in signing the release allowing the taping of sessions. No equipment should be turned on until this form has been signed.

Students can also book equipment through Media Services in Education Commons (3rd floor, OISE/UT). Media Services has digital voice recorders that can be signed out for one week at a time. Students are expected to provide their own AA or AAA batteries. Digital camcorders are also available for borrowing. They must be returned on the same day before closing time. Tripods are also available. Be sure to bring your student card with you when you sign out equipment. Standard Media Services sign out procedures apply. Remember to delete all client files on the voice recorder and/or camcorder after you have securely saved the files.

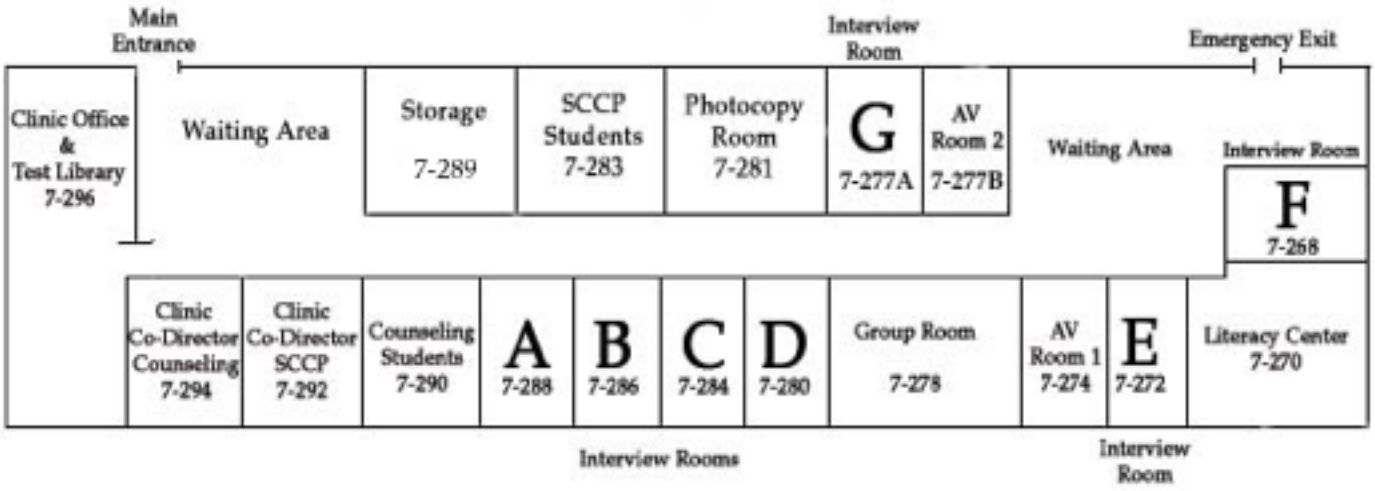
Taping and Observation of Assessment Sessions

As part of the observation of students, assessment sessions may be audiotaped or videotaped, and/or observed through a "one-way" mirror. Video files may be viewed individually by the clinician and supervisor, or by students in class as part of group training and supervision. It

is Clinic policy that all video files are deleted when supervision is complete, and no later than the termination of the assessment. Tapes do not become a permanent part of the clinic record. The release form that the client signs at the first meeting, Consent for Use of Client Records and/or Video Tape Recordings authorizes their destruction. It is the student's responsibility to ensure it is destroyed.

Clinic Floor Plan

(Not to scale)



Test Collection

The Clinic has a collection of test instruments for training in assessment. These tests are primarily for the use of SCCP and CP students who are being supervised by faculty psychologists as part of their coursework. All users of the test collection must fill out a Clinic User Qualification Form on an annual basis. The tests are taken out of the Clinic on a library lending system. Lenders are financially responsible for lost or damaged tests. The standard lending period is one week, although some tests in short supply have a shorter lending period. It is the responsibility of the student clinician to renew any tests they have borrowed should they not have finished using it by the due date. Late fees are charged at a rate of $5 per date overdue.

Students should note that there is a test return box outside of the Clinic so that tests can be returned at any time.

Borrowed tests can be stored in the Clinician's room (in a file drawer, labeled with the student's name.) This is useful if the student is conducting an assessment on the weekend when the test library is closed.

Clinic Security

Many student clinicians see clients in the evenings and on weekends, when there are fewer people present in the building. With fewer people around, security risk factors increase. Therefore, students should be aware of the following:

- In case of an emergency in the Clinic, the University of Toronto police should be phoned at 416-978-2222. This number is posted on the Clinic phones. OISE/UT security should not be the first call because if the security guard is not at the front desk, there will be no response. The University of Toronto police have the OISE/UT security cell phone number so that they can immediately alert the OISE/UT security guard. As well University of Toronto police have more authority than security. For example, they can cite people for trespassing.

- The telephone number for OISE/UT Security is 8-3636. During the day, the number is answered by switchboard and after hours by the security guard.

- The emergency assistance push button on the Clinic wall next to the SCCP Student Room works. If it is pushed, it rings in two locations: switchboard and security. Security will respond through the intercom and ask what the problem is. If no one answers, security will come up.

- There are two exits from the Clinic. If you leave from the second exit, an alarm will sound.

- When possible, students should work in pairs rather than alone in the Clinic.

- The Clinic door should be kept closed after hours and opened only when the student is expecting a client.

- The main Clinic door is equipped with a peephole. The main Clinic door is also equipped with a doorbell, so that a client needing entrance after hours can ring the bell.

Accessing Clinic Forms Online

To access clinic forms online, visit the following link:

http://www.oise.utoronto.ca/aphd/Students/Forms_and_Resources/Student_Forms/index.html#Clinic

The following forms can be found online and/or downloaded to your computer:

- Assessment Consent Form – Client
- Assessment Consent Form – Parent
- Assessment Contact Note
- Child History Form
- Clinic Letterhead
- Clinic Privacy Policy
- Clinic User Qualification Form
- Closing Assessment File
- Closing Counselling File
- Consent for Disclosure of Personal Health Information
- Consent for Use of Client Records and/or Video Tape Recordings
- Contact Record Sheet
- Counselling Consent Form - Client
- Counselling Consent Form - Parent
- Intake Information Form
- Pre-Treatment Assessment for Counselling/Psychotherapy
- Psychological Assessment Form
- Psychotherapy Process Note
- SCCP Counselling Fee Agreement
- SCCP Fee Agreement Form

CLINIC VOICEMAIL SYSTEM

The number for the Clinic office is 416-978-0620.
The Clinic fax number is 416-926-4763.

Parents and others who wish to refer to the Clinic Child and Adolescent Services can do so by calling our intake line at 416-978-0678. Intake coordinators (Clinic GAs) respond to these inquiries and collect basic intake information.

Once clients have been assigned student clinicians working in the Clinic, clients may leave a message for their clinician at 416-978-0677. This voice mailbox is NOT CONFIDENTIAL and is shared with all other SCCP student clinicians. Therefore, clients should limit their message to the name of the clinician, name of client, phone number and a short message (e.g., "cancelling appointment, please call to re-book").

All student clinicians/interns should check their voice mailbox on a regular basis, preferably daily whenever they have an active case load. Once a message has been collected, please erase it. Messages can be picked up either from an OISE/UT phone or from outside the building. If there are messages for other clinicians/interns, please contact them, if possible, to let them know there is a message for them. If you find that other clinicians/interns' messages are not being collected, please report the matter to the Clinic Secretary or one of the Clinic Directors.

The SCCP clinician's phone is located in the SCCP room (room 7-283). To access messages from this phone, dial 8-1700. You will be prompted for your password (see the Clinic secretary to obtain this information; the security code is usually changed January 1st of each year).

If calling from an external phone, dial 416-978-0677:

- Upon hearing the message, press the '*' key twice.
- It will ask you for the mailbox number. Enter 978-0677 (no area code).
- You will be prompted for your password (see the Clinic secretary to obtain this information; the security code is usually changed January 1 of each year).
- It will ask you to retain your extended absence greeting." Press '1'.
- The system will tell you there are X number of new messages and X number of saved messages. To access new messages, press '11' and the first message will be heard (more detailed instructions about voicemail will follow this summary). This is a general mailbox which will be used by several people. After the first message is heard, if it is not for you, you must save it by pressing '9'. This system saves messages for only one week. To delete a message, press '7'. If you want to know the date, time and number of the message, press '5'. For further options, press '0'. To exit the system, press the '*' key.

INFORMED CONSENT

A client must give informed oral and written consent before beginning a psychological assessment or treatment. For the consent to be informed, a range of topics must be covered with the client including: fees, nature and purpose of the procedures, length and frequency of visits, potential risks and benefits of procedures, limits to confidentiality, clinicians' training and qualifications, and the nature of supervision provided.

Informed Consent: Fees

Before service can begin, there must be a written understanding between the client and the Clinic of the fees involved and the schedule of payment. Clients must complete the SCCP Fee Agreement Form . This agreement provides the client with the option of applying for fee subsidization. Usually the subsidy issue is covered during the initial intake. If the client wishes to apply for a subsidy, the intake coordinator or the student clinician responsible for the case arranges the SCCP Fee Agreement Form to be sent to the client. The client forwards the completed forms to the Clinic office, along with a photocopy of the previous year's income tax to verify income. When one of the Clinic Co-Directors has determined the fee, the income tax information is destroyed.

If the situation regarding payment is not clearly stated in the file, the student should ask the Clinic Administrator or the Intake Coordinator about the understanding of fee payment between the client and the Clinic. Consult with the Intake Coordinator for further information if this situation arises.

Informed Consent: Nature of the Service Provided

In addition to providing information about the specifics of the assessment and/or counselling procedures, clients should be routinely informed that the case material they provide will be used for educational and, possibly, research purposes, and that their case material will be discussed with the student's supervisor. Clients should also be provided with the supervisor's name and phone number. Space for the number is provided on the consent forms.

Notably, the requirements for informed consent are met by the Assessment Consent Form - Parent, the Assessment Consent Form - Client, the Counselling Consent Form - Client and the Counselling Consent Form - Parent (first two are specific to assessments and the latter are specific to counselling).

In cases where the student wants to audio- or videotape, the student must obtain written permission and an understanding of the use of that material. The form required to obtain this specific consent is Consent for Use of Client Records and/or Video Tape Recordings.

Informed Consent: Procedures

Before treatment/assessment begins, the student clinician must obtain informed consent. At the first face-to-face meeting, all assessment clients should be given a copy of the document entitled Psychological Assessment Form and the relevant consent forms for the parent/client to read and sign. This is often most easily accomplished if the client is given these documents to read in the waiting area and then the discussion and signing can take place at the beginning of the first interview. Student clinicians should be prepared to discuss client's questions regarding informed consent. Once signed, the clinician should give the parent/client a photocopy of the consent form.

On rare occasions, when the client refuses to grant consent to have the session taped, the clinician should inquire about the client's concern, and attempt to reassure him/her that the recordings will not be

used beyond the stated purpose. If the concern persists, the student clinician will need to discuss this with their supervisor and let the client know if the assessment can continue or not.

CONFIDENTIALITY

Clients must be able to trust that the information they give their psychologist will be handled in a manner that takes into account their needs and interests. The standards of confidentiality are based on this understanding.

Unlike the concept of privilege which is a legal concept pertaining to providing testimony in court, confidentiality is an ethical principle. In order to safeguard the confidentiality of clients, psychologists have standards of conduct. These standards ensure that the psychologist treats, with great care, the information gained in a clinical relationship.

The following are highlights of some of the ethical principles that apply most directly to the work that takes place within the Clinic.

Issues Regarding the Confidentiality of Clients

Psychologists, psychological associates, and those in training to be psychologists or psychological associates are required to keep a client's name and clinical material confidential. For example, a hospital administrator calls you and asks if you are Sally Jones' therapist. The answer to the question is confidential even if you are not Sally Jones' therapist. Psychologists must be extremely careful with all information that they obtain in the course of their professional work. Psychologists must not share information about clients, colleagues, colleagues' clients, students and members of organizations, that they have gained in the process of their clinical activities and that they have reason to believe is considered confidential. This often involves sensitive judgments on the part of the psychologist. These judgments can become very difficult if the psychologist knows the client in more than one way. For example, the Psychologist tests the child of a colleague. The client/colleague may give the Psychologist information about the child that is confidential to the professional relationship and is not part of the collegial relationship (e.g., child is adopted). It is task of the Psychologist to know what information is confidential and to maintain that confidentiality. This is one of many reasons why dual relationships are to be avoided whenever possible.

A psychologist is responsible for informing clients early in the professional relationship of the limits of confidentiality. (See section entitled “Duty to Report”.)

In the clinic, the Assessment Consent Form-Parent/Client contains information about the limits of confidentiality. The clinician should give the parent/client this form, answer any questions and make sure that it is read and signed prior to beginning assessment or treatment.

Clients should routinely be informed that the case material they provide will be used for educational and possibly research purposes and that their case material will be discussed with the student's supervisor. Clients should also be provided with the supervisor's name and phone number.

The problems of confidentiality are particularly important for students because, in order to learn, they must discuss their clinical cases with others. Discussions usually include conversations with supervisors and fellow students. The following guidelines should be followed:

- Any cases discussed in class are confidential. Students should not discuss any case material

outside of class.

- Avoid using names when talking about a case. It is better to refer to the client as a "12 year old boy" than to give him a pseudonym. If you use a pseudonym, sooner or later you may forget and use the real name.

- Avoid using identifying information. For example, it is better to say that the person holds a "high position in a bank" than to say that he is the "Vice President of the Royal Bank".

- Avoid discussing cases in public places. Even if the student does not use names and identifying information, it appears as unprofessional to discuss cases in a manner that could be overheard.

Issues Regarding the Protection of Clinical Material (File Safety)

Privacy laws, as well as professional practice and ethical standards, dictate that it is very important that personal information is carefully safeguarded. Client files, themselves, must stay in the Clinic at all times. Tests and other clinical material may be taken from the file during the course of an assessment and/or treatment. When this occurs, extra care should be taken with this material. Clinical records/material (including session notes, test protocols, and draft reports) should be maintained without names, addresses, or other clearly identifying information until drafts have been approved and finalized for placement into the clinic chart. Client clinical material should be stored in a secured place, and not left out in the open. When leaving client clinical material in a car, leave it locked in the trunk. When discarding clinical material (e.g. draft copies of reports) the material should be shredded, not be placed in the garbage. There are shredder bins in the photocopy rooms on the 9th floor and in the Clinic.

Safeguarding Electronic Information

The risk for the inappropriate disclosure of confidential health information increases when information is stored and transmitted electronically. To reduce this risk, students must adhere to the following rules:

- When writing and revising your report on your computer, save it without identifying information (e.g., you may use either an X or initials but do not use the first and last name, birth date or address).

- At the time when you print out your final report, insert the identifying information and then once printed, delete that information.

- Never store an identified report on an OISE or home computer.

In addition, students should use an encrypted USB key when transporting confidential electronic information. Note that passwords are more secure when they are not common names and include characters and symbols (e.g., a&k@82nt).

Email Communication with Clients

It is acceptable to communicate with clients around minor issues (such as setting up appointment times and cancellations) using the email system in lieu of the Clinic phone system. Students are advised to use their University of Toronto email address and not their personal email address. Email contacts should be recorded on the contact sheet in the same way that telephone contacts are recorded. Substantive email contacts should be printed out and placed in the client's file. Emails should be deleted from the system once they have been dealt with. If a client emails with important clinical questions, students should

consult with their supervisors prior to responding.

Keeping Copies of Reports for Personal Use

Students may keep an electronic copy of their reports for personal reference, as long as the identifying information has been removed. Prospective supervisors and employers sometimes ask students to submit copies of their reports. If the report will be read by others, students must be additionally careful to ensure that all possible identifying information is removed. This includes not only the names of clients and families, but birth dates, names of schools, hospitals and other institutions, and community (e.g., city, town) names. Students should ask for the return of these reports once they have been evaluated.

DUTY TO REPORT

Although psychologists have an obligation to ensure the confidentiality of their clients, there are some circumstances when they are obligated to share information about the client with others. In the circumstance of child abuse and/or therapist-client sexual abuse, the obligation to report is legally mandated. In cases where the client represents a danger to self or others, the psychologist must decide whether or not to report based on an ethical decision-making process.

Child Abuse -- Mandated Report

The following outlines the public's duty to report as required by the Child and Family Services Act (CFSA). The paramount purpose of the CFSA is to promote the best interests, protection and well being of children.

Responsibility to report a child in need of protection

If a person has reasonable grounds to suspect that a child is or may be in need of protection, the person must promptly report the suspicion and the information upon which it is based to a Children's Aid Society.

The situations that must be reported are listed in detail below:

Child and Family Services Act CFSA s.72 (1)

Despite the provisions of any other Act, if a person, including a person who performs professional or official duties with respect to children, has reasonable grounds to suspect one of the following, the person shall forthwith report the suspicion and the information on which it is based to a society:

1. The child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,

i. failure to adequately care for, provide for, supervise or protect the child, or
ii. pattern of neglect in caring for, providing for, supervising or protecting the child.

2. There is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,

i. failure to adequately care for, provide for, supervise or protect the child, or
ii. pattern of neglect in caring for, providing for, supervising or protecting the

child.

3. The child has been sexually molested or sexually exploited, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual molestation or sexual exploitation and fails to protect the child.

4. There is a risk that the child is likely to be sexually molested or sexually exploited as described in paragraph 3.

5. The child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment.

6. The child has suffered emotional harm, demonstrated by serious,

i. anxiety,
ii. depression,
iii. withdrawal,
iv. self-destructive or aggressive behaviour, or
v. delayed development,

and there are reasonable grounds to believe that the emotional harm suffered by the child results from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.

7. The child has suffered emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to remedy or alleviate the harm.

8. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 resulting from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child.

9. There is a risk that the child is likely to suffer emotional harm of the kind described in subparagraph i, ii, iii, iv or v of paragraph 6 and that the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to prevent the harm.

10. The child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, treatment to remedy or alleviate the condition.

11. The child has been abandoned, the child's parent has died or is unavailable to exercise his or her custodial rights over the child and has not made adequate provision for the child's care and custody, or the child is in a residential placement

and the parent refuses or is unable or unwilling to resume the child's care and custody.

12. The child is less than 12 years old and has killed or seriously injured another person or caused serious damage to another person's property, services or treatment are necessary to prevent a recurrence and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, those services or treatment.

13. The child is less than 12 years old and has on more than one occasion injured another person or caused loss or damage to another person's property, with the encouragement of the person having charge of the child or because of that person's failure or inability to supervise the child adequately.

Who has to report?
The Act recognizes that each of us has a responsibility for the welfare of children. It states clearly that members of the public, including professionals who work with children, have an obligation to report promptly to a Children's Aid Society if they suspect that a child is or may be in need of protection.

The Act defines the term "child in need of protection" and sets out what must be reported to a Children's Aid Society. The definition, indicated in CFSA s.72(1), includes physical, sexual and emotional abuse, neglect and risk of harm.

What are "reasonable grounds to suspect?"
You do not need to be sure that a child is or may be in need of protection to make a report to a Children's Aid Society. "Reasonable grounds" are what an average person, given his or her training, background and experience, exercising normal and honest judgment, would suspect.

Special responsibilities of professionals/officials and penalty for failure to report
Professional persons and officials have the same duty as any member of the public to report a suspicion that a child is in need of protection. The Act recognizes, however, that persons working closely with children have a special awareness of the signs of child abuse and neglect, and a particular responsibility to report their suspicions. As such, a failure to report is considered an offence.

Any professional or official who fails to report a suspicion that a child is or may be in need of protection, where the information on which that suspicion is based was obtained in the course of his or her professional or official duties, is liable on conviction to a fine of up to $1,000.

Persons who perform professional or official duties with respect to children include the following:

- Health care professionals, including physicians, nurses, dentists, pharmacists and psychologists
- Teachers, and school principals
- Social workers and family counselors
- Priests, rabbis and other members of the clergy
- Operators or employees of day nurseries
- Youth and recreation workers (not volunteers)
- Peace officers and coroners

- Solicitors
- Service providers and employees of service providers
- Any other person who performs professional or official duties with respect to a child

This list sets out examples only. If your work involves children but is not listed above, you may still be considered to be a professional for purposes of the duty to report. If you are not sure whether you may be considered a professional for purposes of the duty to report, you should contact your local Children's Aid Society, professional association or regulatory body.

Professional confidentiality
The professional's duty to report overrides the provisions of any other provincial statute, specifically, those provisions that would otherwise prohibit disclosure by the professional or official. That is, the professional must report that a child is or may be in need of protection even when the information is confidential or privileged. Only lawyers have the right not to divulge "privileged" information about their clients. If a civil action is brought against a person who made a report, that person will be protected unless he or she acted maliciously or without reasonable grounds for his or her suspicion.

Ongoing duty to report
The duty to report is an ongoing obligation. If a person has made a previous report about a child, and has additional reasonable grounds to suspect that a child is or may be in need of protection, that person must make another report to a Children's Aid Society.

Persons must report directly
The person who has the reasonable grounds to suspect that a child is or may be in need of protection must directly make the report to a Children's Aid Society. The person must not rely on anyone else to report on his or her behalf.

Which agency to call
The telephone numbers are:

Children's Aid Society of Metropolitan Toronto:	(416) 924-4646
Catholic Children's Aid Society of Metropolitan Toronto:	(416) 925-6641
Jewish Family and Child Service of Metropolitan Toronto:	(416) 638-7800

It is advised that you record the name and extension of any children's aid workers you speak with. Also, you should keep through documentation of time, date and details of all conversations.

Time frame
The law in Ontario does not specify how soon the report should be made after the therapist becomes aware of it. A good rule of thumb is that the report should be made within 24 hours.

Documentation
All events surrounding the reporting of child abuse should be fully documented in the file. The report should contain quotes about what the client said pertaining to the abuse. It should describe the actions taken by the student, as well as the name of the person spoken to at the Society and the information that was provided by that person. It should also contain information about the plan for follow up.

Procedures for Reporting Child Abuse

1. When a child/adolescent or another person discloses to a student clinician that a child may have been abused, it is the duty of the student to report to a Children's Aid Society.

2. The person to whom the disclosure is made must report it to the Children's Aid Society. This duty CANNOT be delegated. However in the case of a student, the report should be made in consultation with the supervising psychologist.

3. The student who heard the allegation should seek support from his/her supervisor before making the call to the Children's Aid Society. However, he/she must first record the information about the alleged abuse before discussing it. This is to avoid the possibility of facts becoming altered in the course of discussion.

4. Do not inform the parents or guardians of the child before calling the Children's Aid Society. After making the report, consult with your supervisor concerning whether you should inform the parents or guardians.

5. Within 24 hours of the disclosure, complete a detailed contact note describing the nature of reporting and the events that occurred.

6. Sometimes, it is not clear whether an incident needs to be reported. It is possible to consult with a Children's Aid Society worker without disclosing the name of the client. The Children's Aid Society worker may advise that the incident need not be reported. If not reported, the student must still complete a contact form describing details of the incident and the outcome of the consultation with the Children's Aid Society. The form is then placed in the child's file.

Therapist-Client Sexual Abuse -- Mandated Report

In the same way that the clinician is obligated to report abuse in children, a psychologist is also obligated to report sexual abuse of a client by a regulated health professional.

For example, if a client reports to a psychologist that another health professional has sexually abused[1] him/her, then the psychologist is obligated to make a written report to the Registrar of that health professional's College.

The report must contain:

- The name of the person filing the report
- The name of the member who is the subject of the report
- An explanation of the sexual abuse

The report may contain:

- The name of the client who was sexually abused (the client must consent in writing to have their name included)
- A statement made by the member filing the report of their opinion as to whether or not the subject of the report is likely to sexually abuse patients in the future

[1] Sexual abuse is defined as intercourse or physical sexual relations, inappropriate touching, or inappropriate remarks of a sexual nature.

This legal reporting obligation applies only to licensed psychologists. If students encounter this situation, they are advised to consult with their supervisor and/or appropriate Clinic staff prior to taking any action.

Client Represents a Danger to Self (Suicide) - Permitted Report

Many clients in therapy talk about suicidal feelings. It is important that clients feel comfortable being able to discuss all of their feelings in therapy including the most negative ones. When the situation warrants it, the therapist may ask the client directly if they have considered suicide. Suicide is difficult to predict; however, the act of suicide is more likely to occur when clients can describe a detailed suicide plan, or if they seem to be "tidying up their affairs." If the therapist determines that confidentiality needs to be breached to prevent a client's suicide, the most appropriate first step is often to warn a relative to be on alert and to make sure the client does not have access to things that would facilitate the suicide (e.g., pills or a gun). In a more extreme situation, the therapist may decide to call the police and have the client hospitalized. Below is a useful resource on how to approach suicide in a clinical context:

Sommers-Flanagan, J., & Sommers-Flanagan, R. (1995). Intake interviewing with suicidal patients: A systematic approach. *Professional Psychology: Research and Practice*, *26*, 41-47.

Client is Dangerous to Others -- Permitted Report

In many U.S. states, if the client makes a threat against an identifiable person, the therapist is mandated to report that information to the person who is at risk. This is referred to as 'duty to warn.' In Ontario, psychologists are not required to breach confidentiality and warn; however, they are *permitted* to breach confidentiality in situations where they have reasonable cause to believe that a third party is at risk of physical harm. Depending on the situation, the clinician might also decide to call the police and have the client hospitalized.

FILE MAINTENANCE AND RECORD KEEPING

Opening the File

As soon as the initial telephone contact is made and the first appointment is set up, the student should give a copy of the intake form to the clinic secretary, who will open a file. The student should tell the clinic secretary the date and time of the first appointment. Before the first appointment, the clinic secretary will place the file in the filing cabinet of the SCCP Student Room in the letter slot of the client's last name.

The Regulations of the College of Psychologists of Ontario require the following information to be maintained on each client:

- Name and date of birth of client
- Address and phone numbers of client
- Person to contact in case of emergency, and the referring agent
- Diagnosis or statement of condition being assessed or treated (i.e., reason for referral)
- Dates of each contact with a brief statement of the nature of the contact and the advice or suggestions made by the clinician
- In the Clinic, the first four bullets are met when the Intake Information Form is filled out.

Dates and details of each contact will be recorded using the Contact Record Sheet (stapled to the left inside cover of the file). On this sheet, students and others should record each contact with the client by phone, visit, e-mail, etc. Also, relevant telephone contacts or meetings with people other than the client should be recorded. Missed appointments are to be recorded on the sheet as well. After every contact with the client, the student should also complete an Assessment Contact Note. See section entitled: "Guidelines for Completing Assessment Contact Notes".

Procedure for Consent for Request of Information

A Consent for Disclosure of Personal Health Information form should be signed by the client in any situation when the clinician wishes to contact a third party to obtain information about the client. Most often this occurs when, in the course of early discussions with the parent/client, the clinician is told that other information has been collected in the past that may be of relevance to the present assessment. Another time when the form should be used is when student clinicians are interested to contact the child's school in order to speak with the teacher, observe the child in the classroom or review the OSR. The student clinician should send the signed original to the party from whom the information is being requested. A photocopy of the signed release and a copy of the cover letter should be retained in the Clinic file.

Sometimes the client will provide the student clinician with a written copy of a previous assessment. If the clinician wishes to use this as background information, then the report will become part of the clinic file. In this situation, the clinician should write on the top of the document: "Provided by (name of the parent, date)".

Procedure for Consent for Release of Information

Before the clinician can talk to or provide written information about the client to an outside source, the clinician must first obtain written permission from the client. This situation often occurs at the end of the assessment when it becomes apparent that it is in the best interests of the child to share the assessment information with another party such as the school or the referring physician. If the client/parent indicates a desire to have the information transmitted to a third party, then the clinician should obtain a signed Consent for Disclosure of Personal Health Information form. The original of this form should be kept in the clinic file, along with a copy of the cover letter accompanying the assessment report.

If the parent plans to provide the third party with a photocopy of the report, the clinician should still obtain a signed Consent for Disclosure of Personal Health Information form and note on the form that the parent planned to give the report directly to the third party. The clinician should explain to the parent that the written consent allows us to keep track of the copies of our report. It also allows us to talk directly to the third party, should they have any follow-up questions.

Minimum Standards for Clinic Assessment Files

The clinic file must stay in the Clinic (either in the Clinicians' Room or the clinic office) at all times, except when the student is working with a client or reviewing the file with the supervisor. Students will, in all likelihood, work on their assessment reports outside of the clinic (see guidelines for maintaining confidentiality of clinic material). The Clinic file must at all times contain information that allows the clinic personnel to respond appropriately to questions about the current status of the client. The student should keep the clinic file current by updating the client contact sheet regularly. The following are guidelines about what must be kept in the clinic file at all times and what must be in the file at the time of closing.

The clinic file must contain:

- The completed Intake Information Form.

- The Contact Record Sheet, stapled on the left inside file cover. The student must record all contacts with or about the client, made directly, by phone or by mail on this sheet.

- In addition to the Contact Record Sheet, significant contacts should also be recorded on an Assessment Contact Note. An Assessment Contact Note should contain: name of client(s) and family members seen, the names of others present (psychology interns, faculty, etc.), clinical interventions used, and any advice given or decisions made. Significant telephone conversations should also be summarized on an Assessment Contact Note.

- An Assessment Consent Form – Parent, signed by the parent or the guardian of the child (if under 16), or an Assessment Consent Form – Client, signed by the client (if 16 years of age or older). In cases when the parent has requested the assessment and the client is between the ages of 16 and 18 it is usually good practice to have both the parent and the client sign a form.

- Consent for Use of Client Records and/or Video Tape Recordings if audio or video recording will take place.

- An SCCP Fee Agreement Form is to be filled out and signed by the parent or guardian at the first session or preferably ahead of time.

Upon closing, the clinic file must contain:

All documents from other agencies or practitioners that were obtained and used in the course of the assessment. Documents must be accompanied by a permission form: Consent for Disclosure of Personal Health Information.

- All test protocols and record forms. For assessment cases, a signed copy of the assessment report must be kept in the file. This is prepared on Clinic letterhead and signed by the student clinician or intern and by the supervising faculty. The original is given (or sent) to the parent/guardian and a copy is maintained in the file.

- Copies of all correspondence.

- If the parent provided a copy of a confidential report that is to remain in the file, a copy of the letter sent to that service provider, informing them that we were given a copy of the report.

- A destruction date. With adults the destruction date is 10 years after the date when the case was closed. With children, the destruction date is 10 years after the child reaches his/her 18th birthday, except when the child has been a victim of physical or sexual abuse. In the latter situation, no destruction date is given. The destruction date should be written across the front outside cover of the file.

- A closing note (for assessment clients). At the termination of contact with the client, a closing

note must be written. It can be in the form of an Assessment Contact Note with the term "Closing Note" written across the top or, if the assessment is sent to the parent after the last meeting, the covering letter may serve as a closing note. The basic function of the closing note is to inform the next clinician that the contact with the client has ended. If the file is ever opened again, the next clinician should, from the closing note, be able to quickly find out how things were left at the point of last contact.

- A termination summary (for counselling/therapy clients). At the termination of contact with a counselling/therapy client, a one to two page summary must be written, outlining the client's present concerns, client's relevant history, interventions used and referral status at termination. This should be prepared on Clinic letterhead and signed by both the intern and the supervising faculty.

- Upon closing an assessment case, the Closing Assessment File or the Closing Counselling File must be completed for assessment and counseling cases, respectively.

Guidelines for Completing Assessment Contact Notes

Failure to keep records as prescribed is grounds for a charge of professional misconduct [Reg 801/93 of the College of Psychologists of Ontario (CPO)]. Aside from basic demographic information that must be kept in a client's record, practitioners must maintain a record of the dates of relevant and material contacts with the client, as well as dates of all consultations given or received related to services provided to a client (Evans, 1997, p. 138). In addition, the case file must contain a description of the presenting problem, an account of any history relevant to the problem, and reasonable information about every relevant and material service activity related to the client that is carried out. This includes:

- Assessment procedures
- Resulting assessment findings
- Diagnoses
- Goals or plans of service developed
- Reviews of progress on goals
- Activities related to crises or critical incidents
- Interventions carried out and advice given

The completion of contact notes is designed to assist you in fulfilling the above requirements related to record keeping. The Assessment Contact Note provides a template for doing this. In accordance with the information above, a contact note should be completed for every "material" contact with or about a client. Details about that contact should be included on the sheet so that the nature of the contact can be reconstructed. A fairly brief description is all that is necessary.

For example, for a contact relating to a testing session, you should indicate the date, start and finish time of the session, who was present, tests administered (in the order in which they were administered) and any other noteworthy details. Behavioural observations of the client would not likely be recorded on this sheet. Behavioural observations should be recorded on a separate piece of paper or on the protocols themselves, and are to be integrated into a more final description in the psychological report.

Students are encouraged to condense, polish, and integrate rough notes (e.g., of a clinical interview) before closing a file. This can be done on the contact note itself or on a sheet attached to the contact note. Once this is done, the original rough notes can be destroyed. The idea is not to keep information

that is not relevant to the assessment.

It is wise to document telephone calls made and messages left (e.g., setting up appointments) so that you have a complete record of all of your activities. However, it is not necessary to complete a contact note to record leaving a message or simply arranging an appointment time. For these types of activities, use the Contact Record Sheet (e.g., "left voicemail with X re: appointment time"). If you end up having a conversation with the client/parent in which information is exchanged, this should be documented in a contact note.

Remember that supervision sessions and consultations with others about your client should also be documented in contact notes. This includes individual face-to-face supervision with your course instructor.

Closing Note

The closing note is the final note that goes in the file. It should be at the top of all paperwork when the file is opened. The closing note includes a statement about how things were left at the time of last contact. In some cases, the covering letter accompanying the sent report will serve as the closing note. In other cases, the Assessment Contact Note for the final feedback session will serve as the closing note. Whichever document records the last contact, it is important that you write "Closing Note" at the top of the form.

REPORTS

Report Preparation

Reports should be formatted allowing space for Clinic letterhead on the first page (1.5 inches on the left margin). Letterhead for final copy, as well as additional formatting instructions can be obtained from the Clinic secretary. The final report, unless given directly to the client in the feedback session, is sent out through the Clinic office.

Protection of Privacy

All material related to a client must be kept in a secure place and care must be taken to prevent it from being misplaced or inadvertently viewed by others. Within the Clinic office, all client records are stored in locked files and in order of case number. The record cards of clients seen, as well as their case numbers, are kept in a locked file in alphabetical order. All discs holding case records are also stored in locked files. Students should be vigilant to ensure that client information is protected. If they believe that client information might be at risk, they should report this to one of the Clinic Co-Directors.

The Clinic has a privacy policy which can be found on the Clinic web site. Clients should be provided with a copy of this policy.

Clinical Material Security (General)

While working on an assessment or therapy report, students may find it necessary to work on tests and other clinical material outside the Clinic. In this circumstance the student must take precautions to protect that material. The following guidelines should be observed:

- Never work on Clinic files in the clinic waiting room.

- When working on a computer, information should be stored on an encrypted USB key, not on the hard drive. Once the case is closed, the student should delete the confidential files from their

disc.

- If students keep a copy of the assessment for their personal use, they must follow the policy regarding the "Copying of Assessment Material for the Student's Personal Use" (next section).

- Clinical material should be stored in a safe place, not left out in the open. When leaving clinical material in a car, leave it locked in the trunk.

- Pages of draft reports and other clinical material should be treated with care. A shredder is available in the clinicians' room for the destruction of confidential material. In the absence of a shredder, each page should be torn into 16 pieces before placing it in the garbage or recycling bin.

Copying of Assessment Material for the Student's Personal Use

It is anticipated that students may wish to keep copies of their assessment reports and of the test protocols for their personal use. If students wish to make copies of this information for their records, they may do so under the following conditions:

- Information retained for personal use has identifying information deleted. This includes all client(s) names, the address, the name of the Client's school or business, and other salient background information.

- Students should submit this modified material to their supervisors for approval at the time when the assessment report is completed.

- Students are cautioned that these modified reports are for their personal use only. It is the student's responsibility to keep these modified reports in a safe, locked place and to destroy them when they are no longer needed.

- Sometimes applicants are asked to submit, with their placement application, examples of their assessment work. When this occurs, the student must take additional care to ensure that no identifying information remains in the report. As well, the student should request the return of the report once it has been reviewed.

FILE ORGANIZATION

Files should be ordered so that, when the file is opened, the most recent information is at the top and the oldest information is at the bottom. For assessment files, the Intake Information Sheet should be at the bottom, stapled to the right side of the file. Following this are all the forms and documents, and then test protocols and all other test materials (test protocols and materials should be paper clipped or stapled together). Next is the assessment report. Finally, the closing note is placed on the top.

For counselling/therapy files, the Intake Information Sheet should be at the bottom, followed by all forms and documents, process notes and the termination summary.

On the left side of the file, stapled to the inside cover, is the Contact Record Sheet which should include dated entries for each client contact (this also includes documentation of when draft reports were submitted, sent for approval, mailed out, etc.). This section must be accurate since reports to insurance

companies and bills will be based on it.

All rough notes and scratch work should be removed from the file.

Procedures for Closing an Assessment File

After the last contact with the client, the file may be closed. At closing, the Closing Assessment File or the Closing Counselling File must be completed by the student and signed by the supervisor.

The date when the file should be destroyed must be written on the front of the file ("Destruction date: day, month, year"). For adults, this date is ten years after the case was closed. For children or adolescents, the date is ten years after the day they reach their 18th birthday (or 28 years after their birth date).