Frances Smith Center for Individual & Family Therapy

CLINIC HANDBOOK

POLICIES & PROCEDURES

2026-2027

Crean College of Health and Behavioral Sciences

Chapman University

One University Drive

Orange, CA 92866

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WELCOME TO THE CENTER

You are now ready to embark on the final phase of the Master of Arts in Marriage & Family Therapy program at Chapman University. The fact that you are here in the Center signifies that you have been reviewed by the faculty and deemed ready to see clients in a real clinic setting.

Although you are still a graduate student, officially you are a Marriage and Family Therapist Trainee, as defined by the Board of Behavioral Sciences (BBS).

This is an important fact to know: As an MFT Trainee, you are bound by the same legal and ethical guidelines as a licensed MFT.

The Frances Smith Center for Individual and Family Therapy is a real outpatient mental health clinic that offers services to members of the community. While you are here to develop your skills as a clinician and learn the many facets of the field, you have entered the professional world and are expected to conduct yourself according to BBS standards, as well as AAMFT and CAMFT ethical guidelines.

This manual is to provide you with a resource to consult on the multitude of issues that you will encounter as an MFT Trainee. While it is not an exhaustive and complete resource, it has been written as an introduction and should be helpful to you in providing a place to start.

One of the most important things you need to remember:
We do not expect you to know all the answers,
but we do expect you to ask questions!

UNIVERSITY POLICIES

Students should familiarize themselves with the CURRENT INSTITUTIONAL POLICIES. The list below is not exhaustive. See the Institutional Policies at Chapman webpage for the full list of university policies.

- Graduate Catalogs
- Non-Discrimination Policy
- Discrimination, Harassment, and Retaliation Prevention Policy
- Sexual Misconduct, Sex-Based/Gender Discrimination and Title IX
- Gender-Inclusive Policies
- Religious Accommodations Policy
- Student Conduct Code
- Integrity in Research Policy
- Student Privacy Policies (FERPA)
- Website and Other Electronic Records Accessibility Policy
- Inventions and Patents Policy
- Guidelines for Administering On-line Surveys Involving Students, Faculty and Staff
- Computer and Network Acceptable Use Policy
- Copyrighted Works Policy
- Record Retention Policy and Matrix
- Reporting Misconduct Policy
- Smoking Policy
- Privacy Policy

CONDITIONS OF ACCURACY

The information within this handbook is accurate as of the time of publication. Students are responsible for informing themselves of and satisfactorily meeting all requirements pertinent to their relationship with the University. Students and others who use this handbook should be aware that the information changes from time to time at the sole discretion of Chapman University and that these changes may alter information contained in this handbook. More current and complete information may be obtained in the appropriate department, school, or administrative offices. The University reserves the right, at any time and without notice, to make any changes to all rules, policies, procedures, and any other information that pertains to students or to the institution including, but not limited to, admission, registration, tuition and fees, attendance, curriculum requirements, conduct, academic standing, candidacy, and graduation. This handbook does not constitute a contract or terms or conditions of a contract between the student and Chapman University.

IN CASES OF CONFLICT BETWEEN THE HANDBOOK AND GRADUATE CATALOG

The Graduate Catalog is considered the official representation of program requirements for all graduate programs at Chapman University. If a conflict between the information in this handbook and the Graduate Catalog arises, the information in the Graduate Catalog prevails.

CONCERNS, COMPLAINTS & GRIEVANCES

The Marriage and Family Therapy Program at Chapman University strives to create a safe environment in the classroom, clinic, and amongst students, faculty, and staff. **Chapman University expects that students read and adhere to the Student Conduct Code.**

The Student Code of Conduct reviews Chapman University's stance and policy on how to address issues such as discrimination or harassment. If these incidents have occurred, information on filing a grievance can be found on the Chapman University website under Sexual Misconduct, Sex- Based/Gender Discrimination, and Title IX.

A concern is defined as informal and relates to minor issues that can be solved between individuals such as student/instructor or student/Department Chair and are usually communicated to the Department Chair or faculty verbally or through informal written communication (i.e., email). Examples may include concerns about course scheduling, timeliness of faculty feedback, etc. When a concern is brought to the attention of the MFT program, the MFT Department Chair, the MFT Program Specialist , the Frances Smith Center Clinic Director, or any other MFT faculty member or staff, whoever is most appropriate to respond, will give a response within ten business days. The program does not generally keep formal records of student concerns.

A student complaint is outlined as being communicated to the program in writing regarding issues that have a significantly negative impact on students' learning experiences. Examples may include a grade appeal. Complaints generally require completion of the Graduate Petition form to bring about resolution, and records regarding their resolution are kept on file in the MFT program for ten years. Further information regarding Chapman University's complaint, petition, and appeal process can be found in the Current Graduate Catalog under Academic Policies and Procedures.

According to COAMFTE, a student grievance refers to formal complaints filed with the program and/or the university through a formal grievance channel. They refer to issues that may violate students' rights. Examples include sexual harassment and discrimination. Information regarding filing a formal grievance can be found on the Chapman University Sexual Misconduct, Sex-Based/Gender Discrimination, and Title IX webpage. Records regarding the resolution of grievances are generally kept on file for a period of ten years.

If a student is dissatisfied with any aspect of a class (e.g., content, lectures, presentations, assignments, exams, grades), students are encouraged to discuss the issue openly and constructively with the instructor. If a student is unable to resolve the issue with the instructor, the student should contact the Department Chair Dr. Naveen Jonathan. If the issue is still unresolved, students will be referred to the Crean College Dean.

If a student has a concern regarding advising and Plan of Study, the contact person would be Joleen Martin, the Program Specialist. If the concern is about the Frances

Smith Center, the Clinic Director, is the point of contact. For any other concerns that are related to an external traineeship contact Dr. Beth Patrick, Director of Clinical Training. For any other concerns/feedback on the program, accreditation, or a grievance, please follow up with Department Chair, Dr. Naveen Jonathan.

BACKGROUND SCREENING FOR MFT LICENSURE AND PRACTICUM PLACEMENT

Any student with a felony or misdemeanor conviction (including DUIs or nolo contendre pleas) may find that their application for licensure or other similar organizations may be negatively impacted. Typically, this becomes evident while undergoing the Live Scan fingerprinting process. Therefore, it is each student's responsibility to become informed as to how such previous convictions may affect the license they are pursuing or even placement in a practicum site. (See the BBS website on Criminal Convictions for specific information).

For full descriptions of MFT Program Policies, see the Graduate Catalog.

OVERVIEW OF CENTER PROCESSES

The Frances Smith Center was established in 1968 as a training clinic for the MFT program, as well as a community service. Our Center is one of a few low-cost/sliding scale clinics in Orange County. It is staffed by MFT trainees supervised by licensed faculty and Program Clinical Supervisors in compliance with State and BBS requirements.

The Frances Smith Center is located in:
Crean Hall
501 W. Palm Ave.
Orange, CA 92868
(714) 997-6746

Note, however, that the mailing address remains at the University's address: Chapman University, One University Dr. Frances Smith Center for Individual & Family Therapy, Orange, CA 92866.

TELEPHONES AND VOICEMAIL

The primary numbers you should know for the Center are as follows:

(714) 997-6746	Main Clinic #
(714) 744-7698	Voicemail # to be given to clients
(714) 516-5545	Voicemail # to call to retrieve messages

General Information: The Center's main number is 714-997-6746. Please keep the main lines open for incoming calls. Please do not place personal long-distance calls from a Center phone. Utilize your cell phone instead.

When using the Clinic telephones, you must dial “9” to get an outside line.

VERY IMPORTANT

If your home, work, or cell number changes, you must notify Ana Santacruz, the MFT Administrative Assistant, immediately. The reason for this is that the Center must always have current numbers in case of a client emergency. Failure to notify the Center of a telephone number change may result in not being able to locate you when there is a client emergency.

VOICEMAIL

Once a client has been assigned to you, you should advise the client to use the voicemail number to leave messages. The number is (714) 744-7698, plus your two-digit extension.

You will be assigned a two-digit extension number that will then access your own personal voicemail box. This extension number may change each semester as the voicemail is organized in alphabetical order by the trainee’s last name. You will be notified of any changes in your extension number in advance so that you can notify your clients.

You are expected to check your voicemail at least two times daily Monday through Friday, and once a day on Saturday and Sunday and all holidays. It is suggested that you also check it before coming to the Center for a session, as you may have a late cancellation.

All messages from clients or client-related messages are to be documented in the client’s ClinicNote by using the Client Communication tab. See the section on “Documentation” regarding the protocol.

You will be given a form entitled **“Voice Mail Instructions”** (in FSC SharePoint Shared Document > How to Guides and Client Scripts) that outlines how to access your voicemail, pick up messages, delete messages, and record your voicemail greeting. Should you have any problems with your voicemail box, please report this immediately to the Clinic Director or the MFT Administrative Assistant.

When using your cell phone to call a client, you must dial ***67** first to block your number from showing up on the client’s screen. **NOTE: YOU MAY NOT GIVE YOUR CELL NUMBER TO CLIENTS – EVER.**

PARKING

Clients can park in the Palm parking lot across the street from Crean Hall or in the West Palm Industrial parking lot located behind Crean Hall. Handicapped parking is available in the lot located behind Crean Hall. Clients will need to display a Parking Permit on their Dashboard. A temporary parking permit has been issued by Public Safety for Clinic

clients. See MFT Administrative Assistant, Ana Santacruz Cardenas for access to the document.

HOURS

The Center hours are generally Monday through Friday from 9:00 am to 9:00 pm, and Saturday from 9:00 am to 5:00 pm.

OPENING THE CENTER

1. Turn on the lights in the lobby, the hallway, and all counseling rooms.
2. Turn on the video monitors in the Observation Room (Room 112-A) and adjust lights to the appropriate setting to ensure one-way windows are operating correctly.

CLOSING THE CENTER

If you are the last person to leave at night or on a Saturday, please turn off the lights and make sure that the waiting room window is shut and locked and that the Center has been secured.

STAFF LOUNGE

Room 131 is available to you for food and breaks. You are welcome to use the appliances (refrigerator, microwave, coffee maker, etc.). Along with that privilege, goes your responsibility to keep the room clean. Specifically, this means:

1. No dirty dishes in the sink area. Wash your dishes and place them on the drain rack.
2. Do not collect leftovers in the refrigerator.
3. Only eat or drink what belongs to you!

TRAINEE REQUIREMENTS

HOURS, EVALUATION & GRADING

To meet the requirements of the 12-month practicum in the Frances Smith Center for Individual and Family Therapy, you must complete the following:

1. **Hours:** You will obtain a minimum of 300 “direct service” hours in the Center of which 100 hours must be relational. Overall, to complete within one year the required 300 hours, you will need to complete a minimum of 25 hours per month of therapy, of which 8-9 hours must be relational. In addition, you must complete 50 hours of “live” supervision.

2. **Collaborations:** You must participate in a minimum of 2 collaborations during your year of practicum.
3. **File Documentation:** Complete all file documentation per Center guidelines.

4. **Monthly Activity Reports and BBS log sheets** are to be completed and signed by your Program Clinical Supervisors monthly (in FSC SharePoint Student Folder).

5. At the end of each semester, the **BBS Experience Verification Forms** and Weekly Logs are to be completed and signed by your Program Clinical Supervisor.

6. **Trainee Evaluation:** Each trainee will be evaluated using the Basic Skills Evaluation Device (BSED) (blank form in FSC SharePoint>Shared Documents folder) by their Program Clinical Supervisor at the end of each semester. Your evaluations will remain part of your Center file. You may keep a copy of your evaluations for your records as well.

    a. The trainee will be evaluated in a series of categories on a scale of 0 to 3 as follows:
        0 = Inadequate Information
        1 = Deficient
        2 = Below Expectation
        3 = Meet Expectation
        3 = Exceeds Expectation
        3 = Exceptional Skills

7. **Grading:** Each trainee will be graded by their Program Clinical Supervisor at the end of each semester. Grading criteria are carefully outlined on the MFT 694 syllabus distributed by the Program Clinical Supervisor at the beginning of each semester.

STUDENT TECHNOLOGY REQUIREMENTS

Students are required to have the following technology during practicum in the Frances Smith Center:

1. Laptop (if a student does not have a laptop/desktop computer, the University and Clinic have laptops that can be checked out for use)
2. Wi-Fi
3. Chapman email account
4. Microsoft Teams
5. Zoom
6. Canvas
7. OneDrive
8. SharePoint
9. Software:
    a. Word
    b. Excel
    c. PowerPoint
    d. Adobe Acrobat

NON-NEGOTIABLES

While in the Clinic, all client documentation is saved in ClinicNote electronic health record. All session recordings are to be saved to the Frances Smith Center OneDrive only. NO client files or individual documents pertaining to a client, testing, or session recordings may be photographed, copied, or taken out of the Center in any format at any time or saved in any other location due to security and confidentiality requirements. Violation of this rule may cause dismissal from the program. When in the Clinic, you may work on paperwork in the main office (Room 123), an open counseling room, or the Observation Room (Room 112-A) by using unoccupied counter space. Note, however, that live supervision has precedence.

NO eating or liquids in the Observation Room (Room 112-A).

NO ONE other than members of the Center staff, Center trainees, Program Clinical Supervisors, and MFT 689 students are permitted in the Center office (Room 123) or Observation Room (Room 112-A). Use courteous assertion with anyone who is not authorized to be in these areas.

CENTER POLICIES

TRAINEE INFORMATION AND FORMS

The following forms are reviewed and signed by all Center Trainees before or during orientation to the Center: These forms will be sent to students and are in the Frances Smith Center Student Files SharePoint (FSC SharePoint)> Shared Documents > New Trainee Documents Folder. Once signed, these forms should be saved in each student's FSC SharePoint Trainee Documents Folder.

MFT Trainee Information: This form provides not only basic information on the trainee (e.g., address, telephone numbers), but also bilingual skills, previous counseling experience, special training, and other information that is utilized when assigning clients.

Oath of Confidentiality: Required for any student that is permitted to be in the Center.

Child Abuse and Neglect Reporting Law: Information pertinent to all mandated reporters.

Statement Acknowledging Requirement to Report Suspected Abuse of Dependent Adults and Elders: Information pertinent to all mandated reporters.

Dress Code: The form outlines the Center's dress code and rationale.

Practicum Requirements for MFT Trainees: This form provides a comprehensive list of requirements for Center trainees.

Social media: Information related to social media and legal/ethical considerations and Center policy.

Protecting Children from Sexual Misconduct Training: Online training module through Chapman Risk Management regarding protecting minors from sexual misconduct. Module and certificate to be done and submitted to the Department Assistant before starting in the clinic as a trainee. See Chapman University Risk Management for additional information: https://www.chapman.edu/faculty-staff/risk-management/index.aspx

PROFESSIONAL CONDUCT

Professional conduct is an essential skill for Marriage and Family Therapists. Students are expected to be courteous and professional at all times and adhere to professional standards in both their appearance and actions, as described in the AAMFT Code of Ethics, the CAMFT Code of Ethics, and Chapman University's Student Conduct Code. Whether on campus (in the classroom, the Frances Smith Center, other university, or program sponsored event), or when representing the program in the community (practicum collaborations, external traineeship placements, program sponsored community presentations), student conduct reflects on the quality of Chapman University and its Department of Marriage and Family Therapy.

Although the standards for appearance and actions may differ between the academic and clinical settings, students are expected to adhere to the policies set forth within each setting. In general, codes for appearance and actions are established to convey one's dedication to excellence, commitment to meeting obligations, and respect for peers, colleagues, professors, guest speakers, staff, clinical Program Clinical Supervisors, community partners, and clients.

First and foremost, students must adhere to the Academic Integrity Policy outlined in the Graduate Catalog. The Academic Integrity Policy is printed in every syllabus and course outline. Faculty also have rights and procedures regarding student classroom behavior and expect students to show respect to peers and faculty at all times, as stated in the Graduate Catalog. Students are expected to approach faculty, staff, Program Clinical Supervisors with courtesy and respect for their position. Professional courtesies may include but are not limited to:

1. Punctually attend all classes and program trainings as outlined in the Tardy Policy in program handbook.
2. Adhering to all instructor classroom technology guidelines
3. Turning off cell phones during meetings with faculty, staff, and peers.
4. Remaining seated and attentive in class except during scheduled breaks or emergencies.
5. Following instructions for all classroom activities including in-class student role-plays, small and large group discussions and class lectures.

6. Maintaining confidentiality of instructor and peer disclosures during in-class discussions and role-play activities.
7. Upholding the University and the MFT profession's dedication to non-discrimination, equity, and inclusion.
8. Setting up advance appointments and use of office hours to discuss issues with faculty.
9. Following the MFT Department's Student Concerns, Complaints, and Grievance Policies outlined in this Handbook.
10. Adhering to the University's Grade Review Policy when questions arise regarding grades.

DRESS CODE

All trainees will be required to follow the Center's dress code as part of their professional training. Understanding the clinical significance of one's appearance and the non-verbal messages it conveys is extremely important. Trainees are expected to make the transition from "student" to "professional."

All trainees will be required to review and sign the Dress Code (in FSC SharePoint New Trainee Documents folder) form during orientation.

SOCIAL MEDIA

The presence and use of social media invite us to evaluate our professional and ethical use including but not limited to the following expectations:

1.You may **NEVER "friend" a client – EVER.** Even after you graduate from Chapman, you may not ever "friend" a client that you had here at the Center.

2.Review all Social Media privacy controls to implement the highest level of privacy on your site. You will soon see that this is a small world, and the "six degrees of separation" concept applies.

3.You may not use Social Media to write or comment on anything related to your caseload, supervision, or anything that might be seen and misconstrued by a client, either current or former. Examples of this include:

- "Had the worst clients today! All they did was argue!"
- "Mary the therapist at the Clinic is horrible."
- "I can't believe my Program Clinical Supervisor even has a job!"
- "Hope my 6 pm client no-shows!"

There are many other examples, but the above gives an idea of the type of inappropriate comments.

4.In addition to comments, you may not take pictures that may include any client-related items or that convey any sense of casualness or lack of professionalism. For example, a picture of another trainee joking around with a stack of client files next to

them; or someone sitting at a computer with the computer screen showing an intake summary.
5.All trainees will be required to review and sign the Social Media form during orientation (in FSC SharePoint >Shared Documents> New Trainee Documents)

AI GENERATIVE TOOLS STATEMENT (NO USE PERMITTED):

It is essential that confidentiality is maintained at all times. For this reason, the use of generative models of artificial intelligence such as ChatGPT, Haptic, and Microsoft Copilot (among others) is not permitted. Additionally, translation tools such as Google Translate, paraphrasing tools such as Spinbot and Wordtune, writing tools such as Google Docs and tools to check spelling and grammar errors, such as Grammarly are also prohibited. If you have any questions, please consult with your clinical Program Clinical Supervisor and the Clinic Director prior to using any tools in your clinical work.

SECURITY POLICIES AND PRACTICES

The Marriage & Family Therapy program has transitioned to secure cloud-based technologies.

In partnership with Chapman University's Information Security team, the program has adopted the use of Microsoft 365 technologies to store and securely collaborate on student and client data. Shared data is stored in a secured SharePoint repository, and access is reviewed via an automated process by program leadership each semester. Video conferencing is conducted over Microsoft Teams, and any session recordings are automatically secured to only the participants in the session. All students, staff, program clinical Program Clinical Supervisors, and faculty with access to information are protected via a 2-factor authentication process.

The University employs many layers of safeguards to guard against unauthorized access to Microsoft cloud information including automated alerts around unusual behaviors and data loss prevention. Data stored within the cloud environment is automatically backed up and is restorable for up to 3 months. The University maintains a Computer and Network Acceptable Use Policy governing appropriate uses of technology systems on the University website.

VACATION POLICY/CENTER HOLIDAYS

VACATION POLICY/CENTER HOLIDAYS

Management of vacations and other time off from Clinic affects client hours. It is understood that no trainee will take more than two consecutive weeks off during the regular semester or when clients are normally seen. All requests for vacation or time off for any reason must be in writing a minimum of two weeks in advance with a copy to the Clinical Supervisor and to the Clinic Director.

VACATION NOTIFICATION FORM

If the trainee plans to take vacation time during practicum, they must complete the "Vacation Notification Form" (in FSC SharePoint > Shared Documents > Trainee Forms) and have it signed by their Clinical Program Clinical Supervisor then submit it to the Clinic Director before the first day of vacation. NOTE: There are 2 forms: travel within state and out-of-state.

HOLIDAYS

The Center is open year-round but closed for certain holidays. You will be notified of the holidays in advance to remind your clients. The current Chapman holidays are https://www.chapman.edu/faculty-staff/human-resources/employee-relations-and-services/services/holiday-schedule.aspx

- Martin Luther King holiday
- Spring Break (one week)
- Farmworkers Day
- Week between Spring and Summer semester
- Memorial Day (Monday)
- Juneteenth
- July 4th holiday
- Week between Summer and Fall semester (when applicable)
- Labor Day (Monday)
- Thanksgiving week
- Christmas/New Year (approx. last 2 weeks of December)

BUDDY SYSTEM

Any time an MFT trainee is out of town and not picking up messages, the MFT trainee must designate a colleague who will be on call for their clients.

The name and extension of the "buddy" must be given to all clients as the person on call in case of an emergency.

Please follow the instructions listed on the **"Vacation Notification Form"** (in FSC SharePoint>Shared Documents>Trainee Forms)

For any absence that is more than a weekend, the MFT trainee must change their voicemail to advise clients of their absence, who is on call, and how to reach the on-call therapist.

PRACTICUM SUPERVISION INFORMATION

BOARD OF BEHAVIORAL SCIENCES (BBS)

According to current BBS regulations, you become a Marriage and Family Therapist Trainee (MFT Trainee) when you have completed 12 units in a qualified Master's program.

BBS regulations change periodically. While we will make every effort to keep you informed of current regulations, you are responsible for keeping current on changes in the law. To ensure accurate information, contact the BBS directly – do not rely on information provided by other trainees.

The BBS address, telephone number, and website are:

Board of Behavioral Sciences
1625 North Market Blvd., Suite S200 Sacramento, CA 95834
(916) 574-7830
http://www.bbs.ca.gov/

SUPERVISION

Supervision is one of the most valuable components of your experience here in the Center. Your supervision requirements for the Center are:

Group:	2 hours per week
Individual:	1 hour per week

BBS requirements for supervision of MFT trainees are 1 hour of individual/triadic OR 2 hours of group for every 5 client hours.

Center requirements for supervision are that you are to attend all scheduled supervision weekly, regardless of client hours. Simply speaking, you are expected to attend both supervisions, even if you did not see any clients during the week. **See MFT 694 syllabus for more detailed information.**

Group supervision meets weekly for 2 hours. It is considered a practicum class, and you will receive a grade for this 3-unit class.

Supervision (both individual and group) is generally held in person, but it can be conducted virtually using the HIPAA-compliant platform of Microsoft Teams. To ensure confidentiality, the same standards are used as in telehealth sessions. Both Program Clinical Supervisors and students are to be in a room with a closed door, and no other person present. Headsets or sound machines are encouraged to be used to increase privacy. (See Business & Professions Code Sections 4980.43.2(d), 4996.23.1(f), and 4999.46.2(d))

SUPERVISION CONTRACT

During the first individual supervision, you will review and collaborate on the **Supervision Contract** (in FSC SharePoint > Supervisor Documents folder) with your Program Clinical Supervisor who will sign off on all BBS forms, file documentation, etc. You will then be provided with a copy of this form after it has been completed and signed by both you and your Program Clinical Supervisor. This contract outlines specific information regarding supervision.

In addition to the information outlined in the **Supervision Contract**, please note the following:

Supervision begins the first week of the semester. For new trainees, you are expected to attend supervision, even though you may not have any client assignments.

If you must miss supervision (individual or group) due to illness or emergency, you are expected to notify your Program Clinical Supervisor accordingly. You will be given a staff telephone list which will list your Program Clinical Supervisor's telephone numbers.
If your supervision time is pre-empted by a holiday (e.g., Labor Day is on a Monday and your group supervision is on Monday), your Program Clinical Supervisor will advise you when the supervision has been rescheduled.

Your Program Clinical Supervisor will sign the BBS form, Supervision Agreement Between Program Clinical Supervisor and Supervisee found on the BBS Website here: https://www.bbs.ca.gov/licensees/supervisor.html within the first week of the semester. Please retain a signed electronic copy of this form in your BBS Folder in the Frances Smith Center Student Files SharePoint.

PROGRAM CLINICAL SUPERVISOR EVALUATION FOR MFT TRAINEE EXPERIENCE

You will be evaluated by your individual Program Clinical Supervisor at the end of each semester. The Basic Skills Evaluation Device (BSED) is composed of the following areas:

Conceptual Skills	Professional Skills	Executive Skills
Perceptual Skills	Evaluation Skills	Theory

The BSED is on a scale of 0 to 3, with narrative comments.

0 = Inadequate information
1 = Deficient information
2 = Below Expectation
3 = Meets Expectation
3 = Exceeds Expectation
3 = Exceptional Skills
Your evaluations will remain part of your Center file and a copy saved in the Student SharePoint Folder, subfile "BSED." You may keep a copy of your evaluations for your records as well.

GRADING

Grades will be assigned based on the timeliness and quality of each assignment. Points for practicum semesters 1 and 2, and Interterm differ from your final semester. The point distribution for the different methods of evaluation will be as follows:

Semesters 1, 2 and Interterm

Method of Evaluation	Fall/Spring	Summer	Interterm
Attendance/Participation*	130 pts.	100 pts.	30 pts.
Documentation	70 pts.	50 pts.	15 pts.
Professionalism	20 pts.	20 pts.	10 pts.
Formal Case Presentation	45 pts.	45 pts.	-------
Theory of Change	15 pts.	15 pts.	-------
Live Observation	10 pts.	10 pts.	10pts. *Select a live obs **or** case report*
Informal Case Presentation	10 pts.	-------	
Total Maximum Points	**300 pts.**	**240 pts.**	**65 pts.**

Final Semester (either Fall or Spring)

Method of Evaluation	Fall/Spring
Attendance/Participation*	130 pts.
Documentation*	65 pts.
Professionalism	20 pts.
Final Theory of Change†	30 pts.
Comprehensive Written Case Report†	45 pts.
Oral Case Presentation (PPT)†	45 pts.
Live Observation	10 pts.
Informal Case Presentation	10 pts.
Total Maximum Points	**355 pts.**

Individual and Group Supervision

You will meet with your Program Clinical Supervisor every week. Your BBS log sheet will be signed by your Program Clinical Supervisor as well.

CAPSTONE PROJECT

As part of the graduation requirements, MFT students are required to complete a Capstone Project in their final semester of the MFT Program.

The Capstone Project will include three parts, A). a theory of change paper (completed in MFT 556) B). a comprehensive written case report and C). an oral case presentation, which includes a videotape demonstrating specific interventions (completed by final semester in MFT 694).

A. Theory of Change Paper (to be completed in MFT 556)
B. Comprehensive Written Case Report

During their training at the Frances Smith Center, the students will select a relational case (couple/family) based on which they will write a Comprehensive Written Case Report as part of the Capstone Project. Cases in which individuals are the unit of treatment can only be selected in rare occasions. During your first semester in MFT 694, if you do not have a relational case, work with your Program Clinical Supervisor to identify an individual case that has clear relational or systemic elements to use for your case report. The Comprehensive Written Case Report will be submitted to the Program Clinical Supervisor during the final semester at the Frances Smith Center along with the final version of the Theory of Change Paper. The student will be expected to prepare a three-generation genogram of the individual/couple/family they are writing the case report on. The case report will be based on the following format:

1. **Identifying information and clinical data** (age, gender, ethnicity, family composition, occupation and/or school status, relationship status, SES, treatment history, clinical symptoms, presenting problems, medications, history of mental illness or family dysfunction, significant medical problems, why the client is seeking treatment).

2. **Systemic assessment and clinical assessment**, utilizing the genogram (include significant family patterns and events, chemical dependency, others living in the home, medical problems, intergenerational issues). If treating a couple, include information about their relationship history.

3. **DSM-5-TR Diagnosis**, listed by number and providing the rationale for client's diagnosis, including symptoms and client's report of symptoms. If appropriate, provide a differential process. Do not forget to diagnose each client you are treating in the treatment unit.
4. **Theoretical model of treatment**, used to conceptualize the case, develop the treatment plan, and intervene.

5. **Case Conceptualization**, which is a tentative explanation of how relational patterns operate to keep a family from, and move a family toward, optimum functioning. Case conceptualizations are dynamic and should evolve as the case progresses. Your case conceptualization should be derived from ongoing assessment that is informed by systems theory in general and MFT clinical theories and models.

6. **Treatment objectives/goals**, develop a complete treatment plan, and prioritize treatment goals based on assessment, diagnosis, and chosen theoretical model. The treatment plan should be consistent with a theoretical model and should be broken down into beginning, middle, and closing phases.

7. **Brief summary of how change could be anticipated** to occur for this individual/couple/family (within the theoretical model)

8. **Description of the role of the therapist** within the theoretical model

9. **Specific interventions** and techniques that have been used and will be used. Therapeutic interventions should be presented consistent with the chosen theory. This section should include a discussion of the client's motivation for treatment; specific interventions implemented, including rationale, expected outcome, and potential barriers to treatment. The interventions should be informed by research, and the case report should demonstrate that through citations. If relevant, describe how crisis issues were managed. Also, discuss the implementation and management of safety plans if applicable.
10. An assessment of possible **transference and countertransference considerations**

11. A discussion of possible **ethical/legal** considerations and how they would be addressed. Include a discussion of the identification and management of any legal/ethical obligations and mandates that apply specifically to the case.

12. Discuss any **diversity** considerations and how they may impact treatment, including:

    - **Cultural identity** (ethnic/cultural reference). For immigrants and ethnic minorities, note the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use and preference (including multilingualism)

    - **Cultural factors related to psychosocial environment and levels of functioning:** Note any culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

    - **Cultural elements of the relationship between the individual and the clinician:** Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological.

    - **Overall cultural assessment for diagnosis and care:** The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

13. Case management considerations (consents and initial structuring of treatment, who attends sessions, managing family secrets, missed appointments, crisis management, referrals, termination, etc.)

14. Client-centered advocacy (CCA) (any adjunctive services that would be important to meeting treatment goals including referrals, telephone conversations, and other CCA-related activities)

15. Evaluation of the therapeutic process to date, including an assessment of the therapeutic relationship

Oral Case Presentation

During the time allocated for group supervision, all students will make an Oral Case Presentation as part of their preparation for the Capstone Project. The Oral Case Presentation will be based on the case that is selected for the Comprehensive Written Case Report and will follow the same format as the Comprehensive Written Case Report.

The presentation should not take more than 60 minutes following which 20 minutes will be for questions from the Program Clinical Supervisor and 20 minutes for discussion which will make a total of 1 hour 40 minutes.

The Oral Case Presentation must be accompanied by a Power Point which should be submitted to the Program Clinical Supervisor 1 week prior to the Oral Case Presentation. The Oral Case Presentation will include detailed descriptions from sessions with the client(s). The descriptions of interventions used should be from four sessions. Each clip should be approximately three to five minutes in length and must demonstrate the therapist facilitating the intervention and the client's response. In your final case presentation, it is best practice to include videos from different stages of therapy (early, middle and current) in order to tell the story of change, you may also include a brief introduction clip that highlights the couple or family's negative cycle that you are working to intervene in. Students can also choose video clips from their clinical work that showcase theory-specific assessment strategies, which helped them conceptualize the case. Just remember that the main purpose of the clips is for you to showcase the skills you have, and the client's response to those skills and to demonstrate your unique application of your theory of change.

In Semester 1 and 2 the Oral Case Presentation will not be graded individually. The same grading guidelines will be used for both the Comprehensive Written Case Report and the Oral Case Presentation.

Grading for the Capstone Project

To pass the Capstone Project the student must pass all three components of the Capstone Project which includes the:

A. Theory of Change Paper
B. Comprehensive Written Case Report and
C. Oral Case Presentation

Passing the Capstone Project
To pass the Capstone Project during the third and final semester in the Center, the student should get a “meets” or “exceeds expectations” on all the sections of the Theory of Change Paper. The student should also get a “meets” or “exceeds expectations” on all sections of the Comprehensive Written Case Report as well as the Oral Case Presentation.

Passing the Capstone Project with Recommendations
If the student gets a “below expectations” on any section of the Theory of Change Paper, Comprehensive Written Case Report, or the Oral Case Presentation, the student will pass with recommendations. The recommendation will be provided by the Program Clinical Supervisor, and the student will have to show proof of completion before graduation.

Failing the Capstone Project
If the student gets a “deficient” on any section of the Theory of Change Paper, Comprehensive Written Case Report, or the Oral Case Presentation, the student will fail the Capstone Project. The Program Clinical Supervisor will provide the student with stipulations in consultation with the Clinic Director and the Director of Clinical Training. The student will have to show proof of completion of the stipulations to graduate.

SAFETY PROCEDURES

Center Safety

In case of a potentially life-threatening emergency, dial 9-1-1 from any Center telephone and contact the nearest Program Clinical Supervisor. Dialing 9-1-1 from a campus telephone will automatically connect you with Campus Safety. Such emergencies include a client who is in imminent danger of self-harm, a client who has made an imminent threat to others, a burglary or break-in to the Center, etc.

The following procedures are outlined to address specific types of safety concerns and/or emergencies that may occur during your practicum. Please read carefully and ask questions.

Client Related Safety Procedures

To ensure safety for both our trainees and clients, each of the counseling rooms has a telephone installed capable of dialing out. Posted on the telephone is a list of numbers in case of emergency. These numbers include Public Safety, the County of Orange

Crisis Assessment Team (C.A.T.) as well as extensions for the Clinic Director and the Clinic Administrative Assistant.

Protocol for Emergencies and CAT Team

1. Notify your Program Clinical Supervisor ASAP

2. For any CAT team Calls:
    a. Contact your Program Clinical Supervisor AND contact Clinic Director as soon as possible (yes, even during session if necessary)
3. For other Emergencies:
    a. Contact your Program Clinical Supervisor
    b. If your Program Clinical Supervisor is not available or able to respond: contact Clinic Director
    c. If Clinic Director isn't available: contact Program Chair
4. Depending on the situation, it can be appropriate to ask peers for help if in clinic if needed if they are willing and able
5. Notify Public Safety and/or 911 if applicable
    a. With CAT TEAM-let Public Safety know that:
        i. CAT Team is coming to the Frances Smith Center in Crean Hall
        ii. Tell public safety you must maintain client confidentiality (unless otherwise warranted); therefore, they must wait outside of the clinic or in the waiting room.

Crisis Assessment Team (CAT)-714-517-6353
Public Safety-714-997-6763

During your Center orientation, emergency procedures for contacting the C.A.T. team will be reviewed for a client who may be suicidal or a danger to self or others. In addition, there are two telephones in the back observation room (Room 112A) with the same dialing-out capabilities. Please review policies regarding specific guidelines to assess suicidal clients and potentially violent clients.

Public Safety: (714) 997-6763

Public Safety is located at 418 N. Glassell. They are available 24 hours a day, 7 days a week. If you are leaving Crean Hall and would like an escort to your car, call Public Safety and they will send an officer to accompany you. Note: The Public Safety phone number is printed on your ID/Keycard. Students are also encouraged to download the Panther Guardian App on their phone.

In addition, if your card key malfunctions and does not allow entrance to Crean Hall, contact Public Safety and they will send an officer to provide access.

On-Site Program Clinical Supervisors

Posted each semester is a chart that identifies the location of any Center Program Clinical Supervisors during normal Center hours. Should you have a client emergency that requires consultation with a Program Clinical Supervisor, please refer to the chart to locate a Program Clinical Supervisor on-site. In addition, the Clinic Director is the on-site supervisor and is available for emergencies. If the Clinic Director or any other

Program Clinical Supervisor is on-site, the telephone numbers of all Center clinical staff are posted in the Center, and you have been given a complete telephone list as well.
Class Schedule AY 2026-2027

Summer 2026

MFT 533 - Psychopharmacology	Vitoria Cottiss	Mon/Wed 4pm-6:30pm	CB112
MFT 565 - Dx & Tx of Child/Adol	Julie Payne	Tues/Thru 4pm-6:30pm	CB117
MFT 620 - Public Mental Health	Victoria Brown	Tues/Thru 7pm-9:30pm	CB117

Fall 2026

MFT 541 - Theories I	Brennan Peterson	Monday 4pm-6:50pm	CB112
MFT 570 - Adv Psychopathology	Julie Payne	Thursday 4pm-6:50pm	CB149
MFT 573 - Crisis Management	Julie Payne	Thursday 7pm-9:50pm	CB149
MFT 578 - Ethical/Profes Issues	Naveen Jonathan	Tuesday 4pm-6:50pm	CB149
MFT 584 - Trauma	Brennan Peterson	Monday 7pm-9:50pm	CB112
MFT 588 - Ax & Tx of Substance	Julie Payne	Wednesday 7pm-9:50pm	CB149
MFT 605 - Group Therapy	TBD	Tuesday 7pm-9:50pm	CB117
MFT 618 - Diversity Issues	Beth Patrick	Wednesday 4pm-6:50pm	CB112

Other Emergencies

In case of a power outage, please help to safely escort all individuals out of the Center and out through the front door of Crean Hall.

REPORTING CHILD AND DEPENDENT ADULT/ELDER ABUSE

Due to the complexity and range of this issue, you are to refer to current laws and regulations regarding the reporting of abuse.

During therapy, if the issue of abuse is raised, you are to contact your Program Clinical Supervisor as soon as possible to consult. There are many issues to address, including legal, ethical, client safety and welfare, clinical, documentation, and many more, not the least of which may also be managing your own anxiety.

Local reporting agencies are:

Child Protective Services:
800 N. Eckhoff
Orange, CA 92863

714-940-1000 (hotline)
714-938-0289 (fax number)

When reporting abuse, a call to CPS is to be made as soon as possible after becoming aware of possible abuse. If a report is taken, the written report is required to be mailed within 36 hours; however, the report may be faxed or submitted electronically, in which case it is not necessary to send a written report as well. **Always get the name of the individual you spoke with at CPS. If told that a report is not necessary, get the person's name and the reason given for no report and document this in the file.**

Adult Protective Services:
P.O. Box 22006
Santa Ana, CA 92702

714-825-3030
714-825-3001 (fax number)

When reporting abuse, a call to APS is to be made as soon as possible after becoming aware of possible abuse. If a report is taken, the written report is required to be mailed within 2 business days; however, the report may be faxed or submitted electronically, in which it is not necessary to send a written report as well. **Always get the name of the individual you spoke with at APS. If told that a report is not necessary, get the person's name and the reason given for no report and document this in the file.**

Suspected Child Abuse Report and Report of Suspected Dependent Adult/Elder Abuse forms can be done on-line here: https://www.cdss.ca.gov/reporting/report-abuse

You must also familiarize yourself with the University's Policy on Mandated Reporters and Required Reporting of Abuse and Neglect which is available at: Mandated Reporter Policy

The University Policy on Protecting Minors which is available at: Protecting Minors Policy

NOTE: Whenever making a report or a consultation call, you must notify your Program Clinical Supervisor at that time. DO NOT wait until supervision to do so.

GUIDELINES FOR DEALING WITH SUICIDAL CLIENTS

As an MFT Trainee, you have an ethical and legal responsibility to follow these procedures when you become aware of potentially suicidal behavior on the part of a client.

Doing therapy with a suicidal client can be an unnerving experience, particularly the first time. There are many issues to cover: legal, ethical, client safety and welfare, clinical,

documentation, and many more, not the least of which can be managing your own anxiety.

The information outlined in this section is merely a guide to some of the more critical areas to cover. It is expected that you will be consulting with your Program Clinical Supervisor frequently should a client become suicidal.

EVALUATION:

As part of the assessment of potentially suicidal behavior, you should immediately advise and consult with your Program Clinical Supervisor or the Clinic Director.

As part of the assessment, you should assess the level of suicidal ideation. While there is no definitive measure to make such an assessment, attached is a suicide risk assessment worksheet that will aid in making such an evaluation.

After consulting with your Program Clinical Supervisor or the Clinic Director, a decision will be made as to the level of risk, and appropriate steps you should take to manage the case. These steps are outlined in the following pages.

NOTE: The process of evaluation should be continuous to add all relevant information and changes in the circumstances in the case. You should maintain frequent contact with your Program Clinical Supervisor and/or the Clinic Director until the client is deemed to be “safe.”

CLIENTS AT LOW RISK (e.g., ideation only without an intent, plan, or past attempts):

Continue to monitor suicidal ideation weekly in session. Make a written safety plan with the client.

Work with the client to reduce risk factors:

- Increase social contacts
- Increase physical activity
- Decrease (or eliminate) any alcohol/substance use

Discuss with your Program Clinical Supervisor if a medication referral is appropriate. If the client is on medication and under the care of a psychiatrist or physician, get a release signed and consult immediately.

ALL steps are taken, and any consultations with your Program Clinical Supervisor, Clinic Director, or other professionals must be documented promptly and thoroughly.

CLIENTS AT “MEDIUM” RISK (ideation with a plan, no intent, no past attempts):

Continue to monitor suicidal ideation weekly in session. Make a written safety plan with the client.

If the client has a plan, have the client remove access to the means.

Consider increasing the number of sessions per week until the crisis symptoms stabilize.

Discuss with your Program Clinical Supervisor whether family members or friends should be enlisted to increase the client's safety. This will involve the issue of confidentiality and whether it can be breached due to safety and welfare issues.

Work with the client to reduce risk factors:

- Increase social contacts
- Increase physical activity
- Decrease (or eliminate) any alcohol/substance use

Refer to a psychiatrist for an evaluation immediately.

If the client is on medication and under the care of a psychiatrist or physician, get a release signed and consult immediately. NOTE: You may not need a release, depending upon the client's level of suicidality. Consult with your Program Clinical Supervisor and/or the Clinic Director.

ALL steps are taken, and any consultations with your Program Clinical Supervisor, Clinic Director, or other professionals must be documented promptly and thoroughly.

CLIENTS AT "HIGH" RISK (e.g., ideation with intent or past attempts):

If a client is considered at a "high" risk for suicide, a thorough plan is mandatory and should try to include family members or other support systems (if available). You should be consulting closely with your Program Clinical Supervisor to ensure that all steps are taken to minimize any risk to the client.

Please review the following steps as guidelines for a client assessed to be at "high" risk:

If under the care of a psychiatrist, call him/her immediately and notify the psychiatrist of the emergency. Consult with the psychiatrist regarding where the client should go (where the psychiatrist can arrange to meet the client or have the client evaluated).

You should attempt to get the client to go to the nearest hospital for evaluation and voluntary hospitalization. Part of the assessment may be to determine whether the client is "safe" to drive. If not, you should see if there is a family member or friend that can transport the client. **Due to liability – you may not transport a client to the hospital.**

If the client refuses to go voluntarily or the client is not safe to drive themselves and there is no one who can transport them, then call the County's C.A.T. team or 9-1-1 and request emergency assistance. Only a designated county employee or police officer can initiate the "51/50" process (involuntary hospitalization). Please see protocol for emergencies and the CAT Team.

Protocol for Emergencies and CAT Team

1. Notify your Program Clinical Supervisor ASAP
2. For any CAT team Calls:
    a. Contact your Program Clinical Supervisor AND contract Clinic Director as soon as possible (yes, even during session if necessary)
3. For other Emergencies:
    a. Contact your Program Clinical Supervisor
    b. If your Program Clinical Supervisor is not available or able to respond: contact Clinic Director
    c. If Clinic Director isn't available: contract Department Chair
4. Depending on the situation, it can be appropriate to ask peers for help if in clinic if needed if they are willing and able
5. Notify Public Safety and/or 911 if applicable
    a. With CAT TEAM-let Public Safety know that:
        i. CAT Team is coming to the Frances Smith Center in Crean Hall
        ii. Tell public safety you must maintain client confidentiality (unless otherwise warranted); therefore, they must wait outside of the clinic or in the waiting room.

Crisis Assessment Team (CAT)-714-517-6353
Public Safety-714-997-6763

GUIDELINES FOR WORKING WITH POTENTIALLY VIOLENT CLIENTS

As an MFT Trainee, you have an ethical and legal responsibility to follow these procedures when you become aware of potentially violent behavior on the part of a client.

Doing therapy with a potentially violent client can be an unnerving experience, particularly the first time. There are many issues to cover: legal, ethical, client safety and welfare, duty to warn, clinical, documentation, and many more, not the least of which can be managing your own anxiety.

The information outlined in this section is merely a guide to some of the more critical areas to cover. It is expected that you will be consulting with your Program Clinical Supervisor frequently should a client express violent intention.

EVALUATION:

As part of the assessment of potentially violent behavior, you should immediately advise and consult with your Program Clinical Supervisor or the Clinic Director.

As part of the assessment, you should assess the level of threat. After consulting with your Program Clinical Supervisor or the Clinic Director, a decision will be made as to the level of risk, and appropriate steps you should take to manage the case.

NOTE: The evaluation process should be continuous to add all relevant information and changes in the case's circumstances. You should maintain frequent contact with your Program Clinical Supervisor and/or the Clinic Director until the client is deemed to be "safe."

In addition, you should utilize the "No Violence Safety Agreement" as a therapeutic instrument. This form is in the FSC SharePoint>Shared Documents>Blank Client Forms.

GENERAL PROCEDURES

TELEPHONE INTAKE PROCEDURES

While in the Clinic trainees are expected to complete a **Telephone Intakes**, as assigned. The following procedures have been put in place.

1. The Clinic Director or Administrative Assistant will check the voicemails; all potential new clients will be added to an excel document labeled Intake Call Assignment Log (located in FSC SharePoint>Telephone Intakes folder).
2. Each MFT Trainee will be assigned telephone intakes as needed. This information will be tracked on the Call Log by typing the MFT trainee's name under the 'Trainee' column.
3. MFT Trainees will receive an email from the MFT Administrative Assistant with information regarding the intake and full instructions regarding how to complete the intake.
4. When you reach the client and can complete the phone intake, please complete the following steps.
    a. In the Client's Profile in ClinicNote, use the appropriate Forms Telephone Intake templates (e.g., individual, couple, child)
    b. Once the intake has been completed, submit the form to the Clinic Director for Review.
    c. Open the "Call Back Log" in SharePoint and enter the date Intake was completed and any notes.
    d. Make any needed corrections to spelling of name or other details on the Telephone Intake Log and edit the Client Info in ClinicNote.
    e. In ClinicNote, add "Completed Telephone Intake" to the client's last name to help track the client until they are assigned or referred out.

    f. In ClinicNote, edit client info to include the correct spelling of their name, address, phone, DOB, email address, emergency contact, fee, modality etc.
5. If you reach the client's voicemail at any time during the process, complete the following steps.
    a. Leave your Clinic VM number and extension and ask the client to call and let you know a good day and time to reach them. Also let them know that when you call your number will show up as "blocked" or "Restricted."
    b. Log the date you left the VM on the Call Back Log under the column 'call attempts.'
    c. If this is the first call attempt and you have not heard back from the client within 2-3 business days, try calling the client again (document this on the Call Back Log)
    d. If the client has not responded 3 business days after the second call attempt, ensure you have documented all dates of VMs on the Contact Log, then document on the "Call Back Log."

INTAKE PAPERWORK PROCEDURE FOR BRAND NEW CLIENTS

1. Once you have been assigned a new client, the MFT Administrative Assistant will create a new client profile in ClinicNote and a folder for the client in your CLIENTS folder in the Frances Smith Center SharePoint.
2. All Supervision Notes and Recordings will be kept in the Frances Smith SharePoint Client folder. All other client-related Forms and Reports are in ClinicNote.
3. In the first session with the new client, the MFT Trainee will obtain verbal consent from the client and document this by signing the Informed Consent form in ClinicNote Forms templates.
4. Over sessions 1 and 2 the MFT Trainee will complete the Initial Intake Assessment (ClinicNote Forms template). Once completed, Trainee will sign and submit to their Program Clinical Supervisor for Signature.
5. The Program Clinical Supervisor will then review the Initial Intake Assessment and sign off.
6. By Session 4-6, the MFT Trainee will have completed the Intake Summary.
7. The Program Clinical Supervisor will then review the Intake Summary and sign off.
8. The Trainee will continue to complete and sign Session Notes, maintain the Session and Fee Record, and document any client contact via email or voicemail in Contact Notes/Messages in ClinicNote.
9. The MFT Trainee will discuss the case with their Program Clinical Supervisor at minimum once a month. The Program Clinical Supervisor will then document the discussion in the Supervision Notes (in FSC SharePoint Clients Folder).
10. If a client decides to Terminate/stop showing up for sessions, see the procedures below on how to proceed.

INTAKE PAPERWORK PROCEDURE FOR TRANSFER CLIENTS

1. Once a client has been transferred, the MFT Administrative Assistant will transfer the client to you in ClinicNote and transfer any SharePoint documents from the prior Therapist to you in your CLIENTS Folder in the FSC SharePoint.
2. In the first session with the transfer client, the Trainee will obtain verbal consent from the client and document this by signing the Informed Consent. (Forms template in ClinicNote)
3. By Session 4-6, the Trainee will have completed the Intake Summary. (Forms template in ClinicNote).
4. The Program Clinical Supervisor will then review the Intake Summary and sign off.
5. The Trainee will continue to complete and sign Session Notes, maintain the Session & Fee Record and document all client contact by voicemail or email on the Contact Notes/Messages in ClinicNote.
6. Trainees will discuss the case with their Program Clinical Supervisor at a minimum once a month. The Program Clinical Supervisor will then document the discussion in the Supervision Notes. (in FSC SharePoint)
7. If a client decides to Terminate/stop showing up for sessions, see the termination procedures below on how to proceed.

SIGNING UP FOR A COUNSELING ROOM

The Clinic Rooms are scheduled through the ClinicNote Scheduling System. Please refer to ClinicNote "help." Additionally, there are instructions in the FSC SharePoint > ClinicNote Info folder.

Clinic rooms can be used for in-person and telehealth sessions; however, in-person sessions will take precedence.

If a client cancels their appointment for that week or does not show up for their appointment, **please update the schedule for that date in the recurring schedule in ClinicNote to reflect the cancellation so that others will be aware that the room is available.**

If a client terminates or transfers to another day and time, please **delete/move the appointment in ClinicNote**. This signifies that the room is now available, going forward to others for ongoing scheduling.

REMEMBER:

YELLOW Border = IN-PERSON SESSION
BLUE Border = TELEHEALTH SESSION

THE FIRST SESSION – TELEHEALTH

Please read the following information carefully before your first session.

When scheduling the initial appointment, you will confirm the day and time of the appointment and then send an email to the client confirming the appointment. If the client is being seen via telehealth, you will include a Microsoft Teams invite.

When scheduling the initial appointment for a client being seen in-person, you will confirm the day and time of the appointment and then send an email to the client confirming the appointment, a parking permit, and location of the Frances Smith Center. At the onset of a telehealth session, you will confirm the client's name and current location (address) of the client during the session. You will then review the **AGREEMENT FOR SERVICE/INFORMED CONSENT** (in ClinicNote Documents templates) with the client and answer any questions the client may have. You should document any client questions and your response on the Session Note (located in ClinicNote Documents tab). After obtaining the client's verbal consent, you will date and sign the form, then email a copy to the client immediately after the session.

If this is the client's first session, you will complete the Initial Intake Assessment form to gather pertinent background information on the client. (NOTE: There is a separate form for an adult individual, couple, and child). See ClinicNote Documents templates.

A sample script immediately follows which details information that should be included during your discussion of informed consent.

After the session has ended, you will complete a **Session Note** (in ClinicNote Documents and document the session and fee payment on the **Session and Fee Record** (in ClinicNote Documents).

General information about the session:

A. Watch the clock! The session is 50 minutes (or 90 minutes for a relational case) – not 60 minutes.
B. Schedule sessions on the hour only (e.g., clients cannot be seen at 4:30, 5:15)
C. If you are using a Clinic room to conduct a telehealth session, use the **"In Session"** sign when you are in a room and be sure to slide it over to **"Available"** when you are finished.

Documentation to be completed after the initial session:

1. **Session Note**, including that informed consent was reviewed and obtained, and any questions or concerns the client may have expressed about it. (Appendix B)
2. **Initial Intake Assessment form:** There is a separate assessment form for an adult individual, couple, and child. (ClinicNote Forms)
3. **Log onto the Session and Fee Record** form, enter the date, CPT code, and client payment. (ClinicNote Reports)

SCRIPT TO REVIEW INFORMED CONSENT

Before getting started, I want to review the “Agreement for Service/Informed Consent” form as it outlines many issues that you, the client, need to be aware of concerning your therapy here at the Center. I’ll have you give verbal consent, and I will email you a signed copy after our session today.

As you have already been told, I am a Marriage and Family Therapist Trainee. I will be Training in the Center until_____, 20___ , seeing clients under the supervision of licensed faculty. My current Program Clinical Supervisor is and is listed here on this form.

I also want you to know the limits of confidentiality. Under the therapist-client privilege, what we talk about is confidential, but there are 3 limits to confidentiality that I want to make sure you are aware of. By law, I must break confidentiality if I feel that you are at risk of harming yourself and I need to take steps to keep you safe. I also must break confidentiality if you are at risk of harming someone else. Third, as I am a mandated reporter, I am required to report child abuse and neglect and dependent adult/elder abuse or neglect.

Because this is a training clinic, at times we do record sessions and live observations as part of the training here at the Center. The recording is for the purposes of my training as an MFT trainee. Recording and live observation of my sessions are for supervision, and it is an important part of my experience in the MFT program.

When I record our sessions, the recording and any observation are considered confidential and held to the same standards as any other communication in therapy. They are stored on a HIPAA-compliant platform that ensures a level of security as required by law. After being reviewed by my Program Clinical Supervisor, all recordings are destroyed in a confidential manner consistent with mental health standards.

If you have any questions, please ask me as we go along.

There are several categories:
Information on our staff and services Information regarding confidentiality Records and recordkeeping
Risks and benefits of therapy
The assessment period of therapy
Information regarding sessions and appointments, along with the 24-hour cancellation policy
Payment and fees
The counseling agreement

Again, please take your time and ask any questions that you may have.

FEES / SESSION AND FEE RECORD

Client fees are collected electronically using the University's secure debit/credit card system that is encrypted. Center policy is that payment is due at the time of the session, and each student will ensure that the client can access the program and make the payment directly (students will have no access to card information, for security reasons).

Clients are advised of their fee at the time of the telephone intake. If they have requested a fee reduction, this will be noted on the form as well. See instructions regarding a fee reduction.

Our Center policy is that the client must give at least 24-hour notice, or they will be charged for the session. This policy is to be enforced with clients. If you do not, you are almost guaranteed many no-shows and last-minute cancellations, for which you cannot count the hours.

For telehealth sessions, payment must be made by debit or credit card. For in-person sessions, payment by debit or credit card is also encouraged but can be made via cash or check if necessary. If payment is made in cash, the Center cannot give change. Therefore, if a client pays in cash, they must have the exact amount or credit any overage for the next session. Clinicians will put payment into an envelope and note the client number and amount due and amount paid on the outside of the envelope and leave per Clinic Director and Administrative Assistant for instruction.

SESSION AND FEE RECORD FORM

The Session and Fee Record form includes not only what the client has paid, but also the record of client sessions, including cancellations, no-shows, and re-scheduling. At the bottom of the form are codes to be used for recording this information:

C	=	Client canceled with at least 24-hour notice
L/C	=	Client canceled with less than 24-hour notice
N/S	=	Client did not show up for the session and gave no notice
P	=	Payment only (client not seen – merely made payment)

These codes are to be recorded on the **Session and Fee Record** (in ClinicNote Documents templates) in the section entitled "CPT Code." If the client had a late cancellation or no show, the session fee should be recorded as a balance to be collected at the next session.
The **Session and Fee Record** form must be kept current and accurately reflect the client's activity and balance. Random file checks will be made, and this information must be current.

IMPORTANT: PLEASE NOTE THE FOLLOWING:
Your client must pay for each session – they cannot accrue a balance when their fee has been reduced. The late cancellation policy applies to a fee reduction.

Remember that the fee reduction has an expiration date – you are responsible for monitoring it and re-evaluating the fee with the client before its expiration.

Complete and accurate documentation includes the payment of fees. **The Session and Fee Record** was developed to not only keep an account of fees collected and a running balance but also to provide a quick visual of the client's consistency in attending therapy. By recording not only the dates of sessions, but also the dates of cancellations, late cancellations, and no-shows, in addition to keeping track of client's attendance of sessions.

As the file is a legal document, the **Session and Fee Record** (see ClinicNote Reports) must be accurate! The dates listed must coincide with the date of the session notes regarding sessions, cancellations, and no-shows.

Remember to log onto this form for any cancellations, late cancellations (less than 24 hours' notice), and no-shows. Please note; cancelled sessions should not be numbered please see example below. If you have received a transfer case, please continue with session numbering from the last session of the prior therapist.

SESSION #	DATE OF SVC	PREV BALANCE	CPT CODE	PAYMENT	BALANCE	COMMENT
1	9/19/21	0	90791	$15.00	0	
2	9/26/21	0	90834	$10.00	$5.00	
X	10/2/21	$5.00	L/C	0	$20.00	
3	10/9/21	$20.00	90834	$35.00	0	

If your client begins to accrue a balance, please speak with your Program Clinical Supervisor or the Clinic Director regarding how to handle the issue.

CLIENT FEE INFORMATION
The client's fee information will be listed on the Telephone Intake. This information was given to the client at the time of completion of the telephone intake by the intake trainee.

REQUEST FOR FEE REDUCTION
Occasionally one of your clients will indicate that due to special circumstances, they are unable to pay the assessed fee and request a fee reduction. Or, during the Initial Intake, the caller will request a fee reduction. A **Request for Fee Reduction** form will be included with the telephone intake. If this occurs during the course of therapy, you will fill out the **Request for Fee Reduction** form and forward it to the Clinic Director for review and approval. (See ClinicNote Documents)

After the form has been approved and signed by the Clinic Director, it will be saved in the client's file in ClinicNote.

IMPORTANT: PLEASE NOTE THE FOLLOWING:
Your client must pay for each session – they are not to accrue a balance. If they have received a fee reduction, the fee reduction becomes void if they do not keep their balance current.

The late cancellation policy applies also to a fee reduction.

Remember that the fee reduction has an expiration date – you are responsible for monitoring it and re-evaluating the fee with the client before its expiration.

TELEHEALTH POLICIES AND PROCEDURES

All telehealth policies and procedures are in compliance with the following statutes and regulations:

- California Code of Regulations (CCR) Title 16, Division 18 § 1815.5. STANDARDS OF PRACTICE FOR TELEHEALTH
  https://www.law.cornell.edu/regulations/california/16-CCR-Sec-1815-5

- Business and Professions Code (BPC)
  § 2290.5. TELEHEALTH; CONSENT REQUIREMENTS; EFFECT OF NONCOMPLIANCE ON HEALTH PRACTITIONER
  https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=BPC&sectionNum=2290.5

Implementation of these telehealth policies and procedures in the Frances Smith Center required training the students in telehealth procedures consistent with the above. This included:

- Use of a HIPAA-compliant platform for all sessions and supervision (Microsoft Teams only)
- Telehealth Informed Consent
- Obtaining client's (clients') full name and address at the time of the telehealth session and its documentation
- How to assure privacy and confidentiality for both MFT trainee and client during a telehealth session, and Program Clinical Supervisor and supervisee during supervision via videoconferencing
- Procedures in the event video connection is lost during session and communication to the client.

TELEHEALTH GENERAL POLICIES
The following numbers should be provided and confirmed with the client:
- Therapist voicemail extension for a client to reach you (714) 744-7698 ext: XX
- Emergency numbers: 911

VIDEO SESSION PROCEDURES

Download Microsoft Teams on your selected device. The software is compatible with Windows, Mac, iOS, and Android devices. Download Teams FIRST before asking your client to do so. Having the app compared to access via a web browser is much more convenient. Website: https://teams.microsoft.com

You can use this link, or share with your client, for a tutorial on Microsoft Teams Help and Learning: https://support.microsoft.com/en-us/teams?ui=en-US&rs=en-US&ad=US

TEST starting a Teams meeting with a peer, family member, or friend. It is highly recommended that you test starting a Teams meeting through email links. You can ask MFT Administrative Assistant, Ana Santacruz, to be your test subject

Have the client download Teams *(otherwise they will need to use either Google Chrome or Microsoft Edge for the audio/video to work)*. If possible, walk them through the process and test it out with them.

In preparation for a Telehealth session, you must make sure of the following:

You have identified where you will conduct the session. **For ANY telehealth session** you will need a private place to do the session. This means that you will need to be in a closed room without interruptions. If you live with a roommate or significant other, this is particularly true. **YOU MAY NOT CONDUCT A SESSION AT ANY PUBLIC PLACE.**

NOTE: Please make sure that all security updates have been completed on your device.

If the client is interested in a video session, they will need to download Teams *(unless they have Google Chrome or Microsoft Edge).* To provide them with access to the Teams Meeting, they will receive an email from you with a link. Students need to use their Chapman email to send this link. You must notify the client that the email is to be used for providing a link for the meeting and nothing else.

Starting Video Sessions with an Adult Individual Client

1. Once you have established with your client that they would like to start video conferencing, please have them download the Microsoft Teams application (Teams is compatible with Windows, Mac, iOS, and Android devices).
2. Obtain the client's email address and schedule a day and time for the session (Document this on the Client Communication form in ClinicNote.
3. Log on to Teams and click the Calendar tab within the app. On the top right-hand side click "New Meeting." Enter the date and time for your session. Under "Required Attendees" enter your client's email address that they provided.
4. On the day and time of the session, log onto the Teams application and click the scheduled meeting on the calendar. On the top right-hand side, click join. Your client will click the link provided to them within the email.

5. Once your client has joined the video session, you must identify yourself to them. Then ask your client to give you their full name (document this on the Session Note). Next, you are required to remind your client of the need for the conversation to remain confidential and ask if they feel like their location will provide confidentiality. You will do this at the beginning of every video session.
6. Next, ask your client to give you the location and address of where they are at that moment in time (document the full address on the Session Note). You will do this at the beginning of every video session.
7. Before beginning the first video session, you must review the **Agreement for Service/Informed Consent** and obtain verbal consent (in ClinicNote Forms template)
8. You will then begin the 50-minute session (or 90-minutes for a relational case). The 50/90 minutes include the time you used to review the Informed Consent.
9. At the conclusion of the session, confirm the day and time of the next video session. Also, tell the client that you will be checking your voice mail regularly for messages. Remind them that voice mail is not for emergency services.
10. Schedule the next session in the Teams Calendar tab and email all participants (including co-therapist for relational cases). Complete the **Session Note** (in ClinicNote Reports templates).

All Subsequent Video Sessions with an Adult Individual Client

1. On the day and time of the session, log onto the Teams application and click the scheduled meeting on the calendar. On the top right-hand side, click join. Your client will click the link provided to them within the email.
2. Once your client has joined the video session, you must identify yourself to your client. Then ask your client to give you their full name (document this on the Session Note).
3. Next, ask your client to give you the location and address of where they are at that moment in time (document the full address on the Session Note). You will do this at the beginning of every video session.
4. You will then begin the session.
5. At the conclusion of the session, confirm the day and time of the next video session. Also, tell the client that you will be checking your voice mail regularly for messages. Verify that they have your voice mail phone number. Remind them that voice mail is not for emergency services.
6. Schedule the next session in the Teams Calendar tab and email all participants. Complete the **Session Note** (in ClinicNote Reports templates)

Starting Video Sessions with a Couple

1. In the case of co-therapy, the student therapists will first confer about the appointment time and who will schedule the video session.
2. Once you have established with your clients that they would like to do telehealth, have them download the Microsoft Teams application (Teams is compatible with Windows, Mac, iOS, and Android devices).

3. Obtain the clients' email address(es) and schedule a day and time for the session and document this on the **Client Communication** tab in ClinicNote.
4. For the therapist who will schedule the sessions: Log on to Teams and click the Calendar tab within the app. On the top right-hand side click "New Meeting." Enter the date and time for your session. Under "Required Attendees" enter your client's or clients' email address(es) that they provided. *If you are providing co-therapy, please include the Chapman email address of your co-therapist; only one of you will be scheduling the session.*
5. On the day and time of the session, log onto the Teams application and click the scheduled meeting on the calendar. On the top right-hand side click "join." Your clients and co-therapist will click the link provided to them within the email.
6. Once your clients have joined the video session, ask your clients to give you their full names *(document this on the Session Note)*. You will do this at the beginning of every telehealth session.
7. Next, ask your clients to give you the location and address of where they are at that moment in time *(document the full address on the Session Note)*. You will do this at the beginning of every telehealth session.
8. Before beginning the first telehealth session, you must review the **Informed Consent** (in ClinicNote Forms templates) and obtain verbal consent from both clients.
9. You will then begin the 90-minute session (the 90 minutes includes the time you used to review the Informed Consent).
10. At the conclusion of the session, confirm the day and time of the next video session. Also, tell the clients that you will be checking your voice mail regularly for messages. Verify that they have your voice mail phone number. Remind them voice mail is not for emergency services.
11. The primary scheduler will schedule the next session in the Teams Calendar tab and email all participants. One of you will complete the Session Note.

DOCUMENTATION

NOTE: The Frances Smith Center utilizes ClinicNote, an electronic health record. The information currently listed below covers current documentation requirements.

> "3.3 Marriage and family therapists maintain patient records, whether written, taped, computerized, or stored in any other medium, consistent with sound clinical practice."
>
> *Part I: Ethical Standards for Marriage and Family Therapists (1997) California Association of Marriage and Family Therapists* *CAMFT Patient Records Under California Law The Basics*

Documentation is a vital component of this profession. Thorough and accurate record keeping is vital, not only to providing effective therapy, but also to ensure that legal and ethical guidelines are maintained to minimize legal liability.

The following description of documentation requirements has been developed to ensure that you as an MFT trainee follow sound legal and ethical principles of the Marriage and Family Therapist profession.

Some of the forms you will be required to complete may be unique to the Center; however, all paperwork and forms have been designed to help you develop the skills you will need as a competent and ethical therapist.

Please review the following sections carefully. It is impossible to cover every possible situation that may occur; therefore, consult with your Program Clinical Supervisor or the Clinic Director if you have **any** questions.

WHAT IS DOCUMENTED IN THE CLIENT'S FILE?

All contact between the MFT trainee, the Program Clinical Supervisor, and the client must be documented in the client's file. This includes the following:

- Every time you call or email your client.
- Every time your client calls or emails you.
- Any calls made to or received from other professionals (psychiatrist, teacher, physician, etc.)
- Session notes for every session.
- All supervision, either directly in supervision or outside of supervision.
- Every "no show" or rescheduled session.
- Every payment made (or not made).
- All correspondence made to a client or received from a client. (this includes if you receive a Christmas card, thank you card, etc.)
- Every action taken outside of a session in response to a legal and ethical issue (e.g., call to a Program Clinical Supervisor regarding concerns you have about a suicidal client).
- Any calls made to comply with legal and ethical mandates (e.g., Child Protective Services, Adult Protective Services, police department, or the target of a Tarasoff warning).
- Any research for outside services you performed as Client Centered Advocacy (CAC).

NOTE: This list is not complete – consult with your Program Clinical Supervisor or Clinic Director if there is a question regarding documentation.
Your session notes are considered medical documents and must be written in such a manner that would stand up in a court proceeding (e.g., in liability cases or ethics complaints). A general rule of thumb to keep in mind regarding documentation is: If it isn't written down, it didn't happen." There is no substitute for a timely, thoughtful, and complete chart record that demonstrates clear and well-written assessment and treatment notes.

Documentation Timeline

Clinical documentation is an essential responsibility for all clinicians in the field. Students are expected to complete all documentation as follows:

- Session Notes (Within 24hours of the session.)
- Initial Intake Assessment (Between the first and second sessions).
- Initial Intake Summary (Between the third and fourth sessions).
- Termination Summary (Within one week after the session).

TERMINATION PROCEDURES

TERMINATION PAPERWORK PROCEDURE FOR CLIENTS WITH NO TELEHEALTH SESSIONS

1. If a client is not responding to calls, or fails to show up for any scheduled sessions, the Trainee will leave a voicemail requesting a call back by the provided deadline (5 business days) to start services.
2. The MFT Trainee will ensure that ALL calls made to the client are documented on the Contact Notes/Messages in ClinicNote.
3. The MFT Trainee will notify their Program Clinical Supervisor and Clinic Director and update the caseload on the Client Caseload & Availability.
4. The MFT Trainee will email the MFT Administrative Assistant to move the file out of their client folder.

TERMINATION PAPERWORK PROCEDURE FOR CLIENTS WITH 1 – 2 TELEHEALTH SESSIONS

1. If a client is not responding to calls, or fails to show up for scheduled sessions, the Trainee will leave a voicemail requesting a call back by the provided deadline *(5 business days)* to resume services. *If a client requests Termination, skip this step.*
2. The MFT Trainee will ensure that ALL calls made to the client are documented on the Contact Notes/Message in ClinicNote that Session Notes are signed, and the Session & Fee Record is up to date.
3. The Program Clinical Supervisor will then review the Termination Summary 1-2 and sign off.
4. The MFT Trainee and Program Clinical Supervisor will sign off on the Telehealth File Checklist under the “Clients with 1+ telehealth sessions” portion indicating all required documents have been completed and signed.
5. The MFT Trainee will notify their Program Clinical Supervisor and Clinic Director and update the caseload on the Client Caseload & Availability.
6. The MFT Trainee will email the MFT Administrative Assistant to move the file out of their client folder.

TERMINATION PAPERWORK PROCEDURE FOR CLIENTS WITH 4+ SESSIONS

1. If a client is not responding to calls, or fails to show up for scheduled sessions, the Trainee will leave a voicemail requesting a call back by the provided deadline *(5 business days)* to resume services. *If a client requests Termination, skip this step.*
2. The MFT Trainee will ensure that ALL calls made to the client are documented on the Contact Notes/Messages in ClinicNote that Session Notes are signed, and the Session & Fee Record is up to date.
3. The MFT Trainee will complete the Termination Summary no later than 1 week after the last session date *(as outlined on the Practicum Requirements document signed during Orientation)* and will sign it.
4. The Program Clinical Supervisor will then review the Termination Summary and sign off.
5. The MFT Trainee will notify their Program Clinical Supervisor and Clinic Director and update the caseload on the Client Caseload & Availability.
6. The MFT Trainee will email the MFT Administrative Assistant to move the file out of their client folder.

TRANSFER PROCEDURES

1. If a client requests a Transfer, and receives approval from the Program Clinical Supervisor, the MFT Trainee will complete the following documentation.
2. The MFT Trainee will ensure that ALL calls and emails made to the client are documented on the Contact Notes/Messages in ClinicNote, that Session Notes are signed, and the Session & Fee Record is up to date.
3. The MFT Trainee will complete and sign the Transfer Summary (in ClinicNote Reports Template) before client transfer.
4. The Program Clinical Supervisor will then review the Transfer Summary and sign off on the Signature Page PDF.
5. The MFT Trainee will notify their Program Clinical Supervisor and Clinic Director and update the caseload on the Caseload and Availability.
6. The MFT Trainee will email the MFT Administrative Assistant to move the file out of their client folder to the new Trainee.

**If you have not had any Telehealth sessions before transferring a client, complete steps 1, 2, 5 and 6*

CLIENT FORMS

Telephone Intake (Individual, Couple, Child)
This Center is not a walk-in clinic, nor a crisis clinic. While occasionally an individual will walk in to seek counseling, typically a telephone intake is completed before the person is assigned to an MFT Trainee. This allows the Clinic Director to review the presenting issues and determine whether an individual is appropriate for the Center.

Acknowledgement of Center Policy re: Outside Evaluations (located in FSC SharePoint Shared Documents)

At times, a client will present with issues that suggest they may request documentation to support a court case, claim for services, etc. The Clinic Director reviews all telephone intakes before the assignment and will contact a potential client if the information presented suggests that this may become an issue. The client is then advised that because the Center is a training clinic, we are unable to provide documentation in the role of either an expert or suggesting that the therapist possesses a level of expertise in a particular area. In cases where documentation is required, the Clinic Director will provide appropriate referrals so that the client can obtain the level of services needed. Common examples of this include:

1. Child custody evaluation,
2. Any court evaluation,
3. Social services evaluation,
4. Probation or parole evaluation,
5. Workers compensation/disability evaluation, or
6. Any other type of evaluation that may require testifying in court.

The purpose of the form is to confirm that this information has been provided to the client (or to the parent and/or guardian). The signed form then becomes part of the client's file.

Agreement for Services/Informed Consent

You will provide informed consent and obtain consent with all clients before the commencement of therapy by having all clients aged 12 and above, and/or the parent/guardian of a minor sign the **Agreement for Service/Informed Consent** form (in ClinicNote Documents templates). For parents who are married or divorced, with joint custody, you must obtain written consent from both parents. If one parent denies his or her consent for treatment, then you cannot treat the minor child.

Informed consent includes the following: you are an unlicensed MFT trainee, the name of your Program Clinical Supervisor, and that you will be discussing his/her/their case with your Program Clinical Supervisor as part of supervision, and limits of confidentiality You must first review with the client the **Agreement for Service/Informed Consent** form. Allow the client to ask any questions they may have, then obtain their verbal consent. You will then date and sign the form and email a copy of the form to the client, as well as keep a signed copy in the client's file. Please make a note of any questions or concerns that your client expresses about the informed consent – this should be noted in the session note when you document that informed consent was obtained.

NOTE: As you will typically have a change in Program Clinical Supervisor each semester. MFT trainee must inform client of change of Program Clinical Supervisor and document notification on session note or client communication.

Child Custody Consent

When treating a minor child/adolescent, it is the Center's policy to obtain the consent of both parents in cases where the parents are separated, divorced, or never married, whenever possible and appropriate. While custody documents may allow one parent to obtain therapy without the consent of the other parent, generally it is in the child's best interest to have the consent and agreement of both parents before the commencement of therapy. This can reduce the possibility of one parent interfering or rendering the child's therapy ineffective.

This form is to be completed and signed by the parent who has initiated therapy. Appropriate documents (e.g., custody documents) are to be provided when indicated. By completing and signing this form, the parent is doing so under penalty of perjury, which then absolves the Center of any potential legal issues if the parent is not truthful or fails to disclose pertinent information.

Depending on the circumstances, one parent may sign, or both parents may need to sign a separate consent form. The Clinic Director will advise you as to what signatures are needed based on the circumstances and the related laws. This form is located in ClinicNote Documents tab.

Authorization to Release Information or Records

The issues of confidentiality and how and when information may be released or disclosed are covered in detail in the Ethics course of the MFT program and are too extensive to be covered in detail in this manual.

Whenever a client requests that information be released by the MFT Trainee to another party, whether verbally or in writing, or a trainee is contacted by another party regarding a client, the Trainee must consult with their Program Clinical Supervisor regarding the request and legal and ethical guidelines to ensure that all appropriate steps have been followed and releases have been obtained.

It is a general Center policy that releases will be obtained from clients for all prior psychotherapy, psychiatric hospitalizations, and psychiatrists/physicians who have prescribed psychotropic medications.

Release of Information:

If a client requests that information from his file be forwarded to another professional (i.e., therapist, psychiatrist, attorney), you must discuss the request with your Program Clinical Supervisor before any action being taken.

If you receive a telephone call from another professional regarding a client, you may not return the telephone call until consulting with your Program Clinical Supervisor regarding confidentiality and legal and ethical issues. **NEVER RETURN A CALL TO AN ATTORNEY WITHOUT FIRST CONSULTING WITH YOUR PROGRAM CLINICAL SUPERVISOR AND THE CLINIC DIRECTOR.**

After discussion with your Program Clinical Supervisor and/or Clinic Director, it is deemed appropriate, have your client complete and sign an **Authorization for Release of Records or Information form (in ClinicNote forms templates).** Even if your client has provided you with a signed release from the other party, it is recommended that you have them sign the **Authorization for Release of Records or Information** form as well.

The **Authorization for Release of Information** form should be completely filled out, dated, and signed.

The signed **Authorization for Release of Information** form and information to be released should be given to the Clinic Director for final review and photocopying.

Your session notes should reflect that the **Authorization for Release of Information** form was signed, and a copy maintained for the file.

Request for Information:

When requesting information from other professionals (i.e., previous therapist, psychiatrist, hospital records, medical doctor), you must complete the **Authorization for Release of Records or Information form** (in ClinicNote Documents) in its entirety and obtain verbal consent that is dated.

If the client does not know the full address of the other party, you may need to do an internet search for it.

DO NOT ALLOW YOUR CLIENT TO TAKE THE FORM HOME TO COMPLETE AS THE CLIENT WILL PROBABLY NOT BRING IT BACK. Instead, fill in the known information, have the form signed, then tell your client you will call them and get the missing information over the telephone.
After the **Authorization for Release of Information** form is complete, attach it to a letter request so that the MFT Administrative Assistant can prepare the appropriate cover letter. After obtaining all signatures, a copy of the release and the cover letter will be mailed to the provider. A copy of the letter and the original Authorization for **Release of Information** form will be saved in the client's file.

Release of Verbal Information:

At times, you may want to consult verbally with another professional rather than obtain (or release) written material. Examples of this include talking to a schoolteacher regarding a child client or speaking with a psychiatrist who is currently treating one of your clients.

Complete the **Authorization for Release of Information** in its entirety and have the client sign it. Then attach it to a letter request form and the MFT Administrative Assistant

will prepare the appropriate cover letter. After obtaining all signatures, a copy of the release and the cover letter will be mailed to the provider. A copy of the letter and the original **Authorization for Release of Information** form will be saved in the client's file.

Your session notes should reflect that the **Authorization for Release of Information** form was signed and mailed. You will then document your conversation with the other professional in your session notes or the Client Contact Log.

CCA Note

According to Business and Professions Code (BPC) 4980.03(h), client-centered advocacy is defined as including, but is not limited to "researching, identifying, and accessing resources, or other activities, related to obtaining or providing services and support for clients or groups of clients receiving psychotherapy or counseling services." The purpose of this form is to ensure that such activities are documented in the file, as they are generally done outside of the session. In addition, the form serves as a reminder to the Trainee to keep track of these hours for purposes of recording. This form is in FSC SharePoint Shared Documents >Clinic Forms Masters>Blank Client Forms

Examples of CCA activities include, but are not limited to:

Identify/research support groups
Identify/research psychiatric evaluation Identify/research low-cost medical services
Identify/research low-cost legal services Identify/research psychoeducational class
Identify/research substance abuse treatment program Identify/research other adjunctive services
A telephone call to advocate for the client with another professional (with a signed release)

Client Contact Notes/Messages (in ClinicNote)

From the moment you make the initial call to a new client to set up an appointment, you must document all telephone conversations with a client. The ClinicNote Communication tab should include the date and time of the call and a brief description of the purpose and content of the call.

Example: *9/27/21* *Called client at home to schedule initial appt.*
Appt. for Monday, 10/7/21, at 5:00 pm.
Gave client directions and where to park.

If you place a call to a client but do not reach them, you must document the attempt. Follow the same instructions as above.

Example: *9/27/21* *Called client at home to schedule initial appt. Left*

message on VM including my VM number/extension, with available times: 10/4/21 at 10:00 am or 10/6/21 at 1:00 pm.

If you receive an emergency call or a lengthy message on your voicemail, you must document the call. The note should include the date and time of the call, the content of the call, and your response.

Example: 10/2/21 *Called at home by answering service – ER call from Client. Returned call immediately to client at home. Client crying and upset, reports she and husband just had a fight and he told her he wants a divorce and walked out. Client made several statements that marriage seems hopeless, and she feels overwhelmed. Assessed suicidality – client denies any suicidal thoughts. "I wouldn't do anything because of the children." Scheduled appt. for tomorrow at 3pm. In addition, she agreed to call sister and have her stay overnight.*

If you place a call to another professional (WITH APPROPRIATE RELEASE), you must document the date and time of the call and a brief description of the purpose of the call and any conversation.

Example: 10/1/21 *Placed call to Dr. Redman (psychiatrist) to discuss client's medication, as she reported feeling Prozac is not alleviating depressive symptoms. He advised client has only been on Prozac for 1 week and may not detect any changes for another 2-3 weeks. His diagnostic impression is persistent depressive disorder vs. major depression. He suggested the client call him if she has any questions.*

Initial Intake Assessment form (Individual, Couple, Child)
This form (in ClinicNote Documents templates) is to be completed in the first 1-2 sessions with a new client. The purpose of this form is to gather sufficient information to ensure that the Center can provide the level of care that the client needs. There are separate forms for an adult individual, a couple, and child/family.

Intake Summary: Between Session 4-6, the Intake Summary is to be completed that summarizes information on the client including psychosocial history, mental health history, psychological testing, diagnosis, treatment plan, and referrals. The form is then signed off by you and your Program Clinical Supervisor.

Transfer Summary: When a client is being transferred to another therapist (typically when the current therapist is graduating), the Transfer Summary is completed. The

Intake Summary is copied and relabeled Transfer Summary, and any new information since the Intake Summary was done is added. The last page then reports the reason for transfer, and progress to date and prognosis. The form is then signed off by you and your Program Clinical Supervisor.

Termination Summary: When a client completes therapy or drops out of therapy, a Termination Summary is completed. The Intake Summary is copied and relabeled Termination Summary, and any new information since the Intake Summary was done is added. The last page then reports the reason for termination, and progress to date and prognosis. The form is then signed off by you and your Program Clinical Supervisor.

Session Notes: Session notes are important in the conscientious effort to record the therapeutic process of the MFT trainee-client interaction. They are also important in the event of an emergency where another trainee must handle a crisis, or in the transfer of the client to another trainee. They also qualify as medical and legal documents, and so must provide an accurate and objective record of events that have occurred during the course of treatment. Records must be accurate in terms of logging all sessions or contacts with the client, including correspondence and telephone calls, to protect the trainee in the event of possible litigation. Each session note must be signed (located in ClinicNote Documents templates).

NAME: Client's name

DATE: Date of the session

SESSION NUMBER: Keep track of the session number and write it in the space. Only a session is numbered – if a client cancels or no-shows, that is not numbered.

FOR TELEHEALTH SESSION ONLY: BEFORE THE BEGINNING OF SESSION,

Ask the full name of the client, and current address of the client while in session and document. If you are doing a telehealth session with a couple who are in separate locations, get the full name of each, and the address for each, and document in the box. **IS CLIENT APPROPRIATE FOR TELEHEALTH SESSION:** If yes, check the box for "There are no crisis issues or other factors that make telehealth session not appropriate."

OR

Potential factors that may make telehealth session not appropriate (describe in detail):

GOAL: Document the treatment goal(s) from the treatment plan, or goals that are the focus of this particular session.

INTERVENTION: Document the interventions used to help the client reach the goals stated above. Intervention means, what did you do? What service did you provide to help the client attain their goal(s)? Interventions are active, meaning "listening" is not enough. You need to demonstrate that the client's impairments and/or symptoms are

being addressed through the use of clinical intervention. Indicate the purpose of the intervention(s) and how they relate back to the goals.

RESPONSE: Document the client's response (verbal and non-verbal) to the intervention provided. Did the client actively participate? Was the client compliant or non-compliant? A positive response indicates that something is working, while a negative response indicates resistance, or the need to re-evaluate either the goal or intervention. When completing the response section, always back the client's responses with "as evidence by."

PLAN: The plan should address what the trainee and client plan to do between sessions and/or for the next session. This should be more than just "continuing treatment" or "continue next session." The plan section may include the goals in which the trainee and client agree to work on for the next session, may include the date for the next planned session, or may document a week that will be missed due to upcoming vacations. It is important to remember that the trainee must follow up with documented plan(s) in future sessions with the client ("Continue with the assessment to identify triggers for anger."

ASSIGNMENTS/HOMEWORK: If none, put "none." Otherwise note any homework given to the client, request for information, referral made, etc.

REFERRALS: If none, check "none."

A. **None:** If you didn't make any referrals, check "none."
B. **Psychiatric:** Any referral for evaluation for psychotropic medication, whether it be to their general practitioner or a psychiatrist.
C. **Medical:** Any referral for physical evaluation, including to rule out a medical condition that may be contributing to a psychiatric disorder (e.g., rule out thyroid problems that might be causing depressive symptoms).
D. **Other:** Any referral to a group, 12-step group, employment counseling, yoga class, etc. Anything you suggest to your client based on your treatment plan.

Date and sign the note. Make sure the date of the session is correct and matches with the date on the Session and Fee Record.

Supervision Notes

It is the Center's policy that every client's treatment be reviewed and signed off a minimum of once per month. You will consult more frequently on clients that require additional attention.

The Program Clinical Supervisor's Notes are essential to document that you, as a trainee, are receiving adequate supervision and review of your cases. Supervision

Notes are written by Program Clinical Supervisors and not a part of the Frances Smith Center SharePoint Client File or ClinicNote.

All client files must have at least one Program Clinical Supervisor's signature, even if only seen once.

If you receive supervision on a case between the regularly scheduled supervision time, it is your responsibility to see that the Program Clinical Supervisor documents the consultation.

It is your responsibility to ensure that your cases are reviewed regularly by your Program Clinical Supervisor and obtain signatures as outlined above. Failure to do so may negatively impact your evaluation and may result in more serious repercussions.

Termination/Transfer Summary 1-2 Sessions

At times, a client will only be seen for a few sessions and then discontinues therapy. This form is similar to the Termination/Transfer Summary but does not require a diagnosis or treatment plan, as the client was not seen for sufficient sessions. This form must be signed by you and your Program Clinical Supervisor (the form is in ClinicNote Documents templates).

MISCELLANEOUS FORMS

Attendance Contract
This form is to be used when a client cancels, late cancels, or no shows for three or more sessions. The purpose is to notify the client of the importance of attending therapy weekly, and the possibility that if the client continues sporadic attendance, they may be terminated and given referrals to other counseling services. This form is located in ClinicNote Documents tab.

Guest Session Consent
As part of treatment, you may ask your client to bring in a parent, partner, adult child, or other individual. This consent is to clarify that the guest is not a "client" and therefore has no therapist-client privilege. This form is in ClinicNote Documents tab

No Violence Contract
When a client discloses the current use of violence, a No Violence Agreement is completed and signed by the client. The purpose is to notify the client of the Center's no violence policy, as well as suggest other coping mechanisms that are not physical in nature. This form is in ClinicNote Documents tab

Safety Plan
When a client discloses to you suicidal ideation, self-harm, or other behavior that may be considered as unsafe, a safety plan is developed by you and your client. This plan outlines the client's support system, places to go that are considered safe, hotlines, and

other behaviors that can be utilized to decrease thoughts and feelings of harm to self. A copy of the Safety Plan should be given to the client, and one retained in the file. This form is in ClinicNote Documents tab.

CORRESPONDENCE

The Center may be requested to provide correspondence regarding a client's therapy. These requests come from a variety of sources, including the Social Security Administration, attorneys, probation officers, and courts.

No correspondence may occur without approval of Clinic Director and Program Clinical Supervisor. The term "correspondence" is defined as letters, notes, copy of anything from the client's file (e.g., copies of testing, notes). This also includes telephone conversations with anyone other than the client (or parent/guardian of a minor) whether the MFT Trainee places the call or is asked to return a call.

The reason for this is to ensure that you, the MFT Trainee, do not violate any legal or ethical guidelines that could result in liability against you, your Program Clinical Supervisor, or the Center.

The issue of the scope of practice/competence is also a factor. For example, a parent may request that you send a letter to their attorney documenting that he/she is the better parent (parent is in a custody battle); a letter to a probation officer that a client dealing with anger issues is "cured" and the anger no longer an issue. **THE CENTER DOES NOT PROVIDE ANY TYPE OF EVALUATION. AS AN MFT TRAINEE, YOU DO NOT HAVE THE EXPERIENCE OR TRAINING TO PROVIDE ANY TYPE OF EVALUATION.**

The purpose of this section is to review some of the more typical requests and how to follow safe guidelines.

STANDARD CORRESPONDENCE

In addition to the above, there are a variety of standard letters and email templates that have been created to send to clients about routine issues such as:

- Client has not responded to telephone calls to schedule an appointment
- Client scheduled appointment but did not show up
- Client has not been seen in quite awhile, and you are not sure if they are still interested in therapy
- Client terminated therapy over the telephone
- Client has stopped therapy and has a balance

Letter templates are in the "Shared Clinic Files" folder (FS SharePoint>Shared Documents>Letter Templates) with a shortcut located on the desktop of the computers

in the clinic. All letters are to be prepared and signed by the MFT Trainee and then given to the Clinic Director to sign. The MFT Administrative Assistant will then copy the letter for the file and mail the original. If the letter is to include a signed release, the original signed release should be paper clipped to the back of the letter. For a specialized letter please consult with your Program Clinical Supervisor or the Clinic Director. The MFT Administrative Assistant can help draft a specialized letter.

ATYPICAL CORRESPONDENCE

If you are requested by a client to provide a letter or report regarding the client's therapy to another professional, or you receive a request for information through the mail, follow the steps outlined below:

Gather a full description of what is being requested. This will include:

Who is the letter to be sent to? **Full name and mailing address. "To Whom It May Concern" is not acceptable.** If the client does not have an individual's name, get the full name of the agency. If the request is going to an agency without a name to send to the attention of, you should try to get a client number, case number, or some other identifying information.

What information is being requested? For example, a summary of treatment, recommendations, etc. Ask the client what the purpose of the request is. This will help to understand what is being requested and whether you can follow through with the request.

Have the client complete (in its entirety) and sign the **Authorization for Release of Records or Information** form at the time the request is made. Then advise the client that you will review the request with your Program Clinical Supervisor and that the Clinic Director must sign off on all correspondence. The Release of Information is in ClinicNote Documents tab.

If the client states that the document is needed immediately (today or tomorrow), **TELL THE CLIENT YOU ARE UNABLE TO DO IT.** Do not get pressured into doing something that may result in you doing something that is (unknowingly) unethical or illegal.

Review the client's request with your Program Clinical Supervisor. The review should include:

1. Is it appropriate?
2. Has proper consent been obtained?
3. Review a draft of the correspondence.

If the request is deemed appropriate and the draft is approved by your Program Clinical Supervisor, submit the draft to the Administrative Assistant for typing, along with a copy of the signed **Authorization for Release of Information** form. The letter will not be prepared unless a copy of the Authorization for Release of Information form is attached. The Clinic Director will then co-sign the letter and upload it into their client file. If a

document is to be mailed, a copy will be uploaded into the client file and the original mailed to the client. See ClinicNote Forms templates.

If your Program Clinical Supervisor believes the request to be inappropriate (e.g., outside your scope or there are clinical reasons), discuss how to inform the client that you are not able to provide the document and why.
Document all information in the client's file: The client's request, the signed **Authorization for Release of Information** form, discussion with your Program Clinical Supervisor, a copy of the letter, and any conversations with the client.

If you receive a request for a copy of records, forward the request and the client's file to the Clinic Director. **YOU ARE NEVER TO COPY A FILE OR ITS CONTENTS AND SEND THEM TO ANOTHER PARTY.**

RECORDING SESSIONS

As the Frances Smith Center is a training clinic, recording a session is an integral part of the training you will receive. In addition, you will use clips of various sessions in your Capstone Project. In general, sessions that are recorded are only kept until your Program Clinical Supervisor has reviewed them. Once reviewed, the recording is to be erased. It is important that you do not accrue multiple recordings. They should be erased as soon as your Program Clinical Supervisor has viewed them.

There are two methods of recording, based on whether your client is being seen in person or via telehealth.

Recording an In-Person or Telehealth Session

All telehealth sessions are conducted via Microsoft Teams, a HIPAA-compliant platform. To record a session being done via Microsoft Teams, you will need to let your client know that the session is being recorded (as Teams will post a note that "Recording has started"). Go to the three dots (…) in the upper screen. You will see "Start Recording" and click on this. Once recorded, the recording will be stored in the SharePoint file where your documents are kept, within the individual client's subfile under the subfile "Recordings."

Once the recording has been discussed and viewed in supervision, you will delete the recording to keep any stored recordings at a minimum.

Steps for Recording with TEAMS in a Clinic Room

1. 15 minutes before your session begins.
2. **Log in on the clinic laptop** specified and labeled for the room you are using and located in the Supervisor Space. Use your Chapman Credentials.
3. **Go to TEAMS.** (you may need to use the Search Bar to look up the TEAMS App to select it).

4. **Schedule a TEAMS meeting with yourself, click on "Join" (you can do this in teams by selecting the calendar icon and selecting start a meeting located along the top of the page)**
5. In the TEAMS Meeting do these steps to set up **Microphone Settings etc.**:
    a. **Turn on the Camera** (you will see the clinic room showing on the laptop)
    b. **Computer Audio Settings** (choose the following settings to get the microphone in the clinic room to activate for the recording).
        i. **Custom Set-Up**
        ii. **Microphone**
        iii. **"Digital Audio Interface"**
        iv. Close Device Settings ("x" out)
    c. **"Join Now"** to join the "Meeting" (may say you are using Custom Device Settings)
    d. Click on the three dots on the top bar: ***
    e. Click **Start Recording**
6. Session: Bring your Client back and do your session.
7. Complete your session: Take the Client back to the lobby.
8. **Stop Recording:** Click on the *** select "stop recording" and confirm this.
9. Go into the Chat Section and it will show your recording and transcription.
10. **Click on Recording to open it** (will open in a browser). Make sure under the recording it says "no expiration" on the recording (or change the setting to this).
11. Can **Share the Access as appropriate** (Program Clinical Supervisor, co-therapist)
12. **SIGN OUT of the laptop**. You will be able to access the recording from your own device when you sign-in to the TEAMS App.

The Frances Smith Clinic has installed Webcams inside the Clinic Rooms, apart from the two Telehealth rooms. Directions for recording a session will remain the same, but users will access Teams from within the room from either their own device or a clinic laptop or iPad.

MAKING REFERRALS

MAKING A PSYCHIATRIC REFERRAL

Making a psychiatric referral is heavily related to a client's insurance (if any). If the client has an insurance card, look for "Mental Health or Behavioral Health" telephone number. For Medi-Cal or CalOptima, call the referral line to obtain the names of psychiatrists who accept these insurances. For Medicare and Medi-Cal, you can also go to the website for the O.C. Psychiatric Society (http://www.ocps.org/) and search for a psychiatrist that accepts Medicare and/or Medi-Cal.

PSYCHIATRIC MEDICATIONS

For clients that are having trouble paying for their psychiatric medication(s), refer them to Patient Assistance Programs (PAPs) such as RX Hope, Good Rx, NeedyMeds, etc. These are Patient Assistance programs funded by the pharmaceutical companies for

clients that cannot afford their medications. Their doctor's office will fill out the application, and they may receive their medications for free or at a reduced cost. Another resource is Good Rx, and the app can be downloaded.

SUBSTANCE ABUSE SERVICES

If a client presents with a significant substance abuse problem, the client will be referred out for services due to scope of practice issues. The accurate assessment of a client's use of substances (including but not limited to: alcohol, prescription drugs, and illegal drugs) is extremely important.

At times we may allow a client to be seen at the Center if they are concurrently enrolled in a specific substance abuse treatment program. Depending on a client's financial ability to pay, some may utilize insurance benefits. For many of our clients, this is not an option.

OC DRUG AND ALCOHOL SERVICES

The County of Orange has substance abuse treatment programs and can provide referrals for substance abuse related treatment, housing, etc. Go to https://www.ochealthinfo.com/services-programs/mental-health-crisis-recovery/alcohol-substance-use-services or call 855- OC-LINKS for county programs and referrals.

SUBSTANCE USE SURVEY

In addition to the listing of locations is a form entitled **"Substance Use Survey"** which will assist you in the assessment of abuse/dependence for your clients. Ongoing consultation with your Program Clinical Supervisor is required. (located in FSC SharePoint>Shared Documents>Blank Client Forms)

MISCELLANEOUS REFERRALS

"Client Advocacy" is defined in Business and Professions Code (BPC) Section 4980.03(h) as including, but not limited to "researching, identifying, and accessing resources, or other activities, related to obtaining or providing services and supports for clients or groups of clients receiving psychotherapy or counseling services."

During your practicum, you will find adjunctive services for your clients in a variety of areas. For example, your client may need a depression support group, a low-cost psychiatric referral, or the location of a food bank. These types of services often change due to funding and other factors.

2-1-1 OC or 211oc.org

In 2008, the state of California devised a referral service throughout California entitled "2-1-1." Any California resident can dial 2-1-1 from their telephone and reach this

service. This agency is staffed by bilingual operators who can provide referrals for anything related to human services in the local county. This includes low-cost housing, food banks, low-cost medical services, shelters, support groups, low-cost therapy, etc. This is an excellent source for locating these types of services for your clients.

COUNTY OF ORANGE SOCIAL SERVICES

Call 855-OC-LINKS and an intake worker will help to identify county resources and referrals.

Share Our Selves (SOS) The SOS Medical Clinic serves all of Orange County. In particular, the safety net population who are uninsured or underinsured and have little to no options for affordable health care. The clinic provides full-scope primary care including preventive health care, urgent medical care, chronic disease management, mental health services, and same-day appointments. SOS treats patients at all stages of life – pediatrics to geriatrics.

Main Campus
SOS COMMUNITY HEALTH CENTER
1550 Superior Avenue
Costa Mesa, CA 92627
Main Number: 949.270.2100
https://www.shareourselves.org/

Comprehensive services include:
- lab tests
- medications
- patient education

Screenings include:
- cancer
- communicable diseases
- hypertension
- cholesterol
- pediatric development
- diabetes

Specialty services include:
- cardiology
- nephrology
- neurology
- physical therapy
- recuperative care
- environmental health
- TB therapy

Referrals:

- behavioral health
- substance abuse
- diagnostic x-ray
- podiatry
- specialty services
- substance services for the homeless

Additional services available to our patients:

- outreach
- transportation
- translation
- WIC
- housing assistance
- employment and education counseling
- food pantry
- case management

STUDENT RESOURCES

As a graduate student in the Chapman University Marriage and Family Therapy program, you have access to a variety of student resources. These include the following:

1. **LIBRARY SERVICES**
    i. Leatherby Library
    ii. Frances Smith Center student library
2. **Chapman University Student Disability Services**
    i. Phone-714-516-4520
    ii. Location: Argyros Forum 203
3. **Student Psychological Counseling Services**
    i. Phone-714-997-6778
    ii. 401 N Glassell St, Orange, CA 92866
4. **Student Health Center**
    i. Phone-714-744-7077
    ii. 402 N Glassell, Orange, CA 92866
5. **Public Safety**
    i. Phone-714-997-6763 (24-hour dispatch)
    ii. 418 N Glassell St., Orange, CA, 92866

CENTER LIBRARY

The Center has developed an in-house library including books, manuals, and DVDs, on many topics. These include but are not limited to:

- Abuse and Trauma
- Acceptance and Commitment Therapy (ACT)
- Addictions
- Aging
- Anger
- Anxiety Disorders
- Behavior Modification
- Child/Adolescent Treatment
- Child Books on a variety of issues (anger, jealousy, fear, etc.)
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Diversity
- Domestic Violence
- Emotionally Focused Therapy (EFT)
- Eating Disorders
- Family Therapy
- Genograms
- Interpersonal Theory
- Marital Therapy
- MFT Practice
- Mood Disorders
- Multicultural Therapy
- Multigenerational Therapy
- Pain Management
- Parenting
- Personality Disorders
- Psychopharmacology
- Self Esteem
- Sexual Abuse

CLIENT FORMS INDEX FOR SHAREPOINT AND CLINICNOTE

Acknowledgment Re Outside Evaluations (ClinicNote Forms) Use when a client presents with issues that suggest the possibility of some type of evaluation document needed.

Attendance Contract (ClinicNote Forms)
Use when a client is continuously late, late cancels, or no-shows to sessions.

Authorization to Release Info (ClinicNote Forms): This allows the MFT Trainee to exchange information about the client(s) with another party.

Child Custody Consent (ClinicNote Forms): Use for any minor client whose parents are not married or no longer married to confirm custody status.

Client-Centered Advocacy (CCA) Note (ClinicNote Reports) To be filled out when CCA is completed for a client.

Contact Notes/Messages (ClinicNote) - All phone calls and emails MUST be documented on the Contact Notes/Messages in ClinicNote.
Initial Intake Assessment (ClinicNoteForms) (Child, Couple, Individual, and Family): To be completed by the Trainee during sessions 1 – 2 for new clients to the Clinic. For couples, one Intake is completed per partner.

Intake Summary (ClinicNote Forms) (Child, Couple, Individual, Family, and Transfer, 1-2): Must be completed for ALL clients receiving telehealth sessions. The forms for the Intake and Tx Summary are the same with a few additions and alterations for the Tx portion. Intake Summaries must be completed by session 4, Tx Summaries no later than 2 weeks after the last session, while Transfer Summaries must be completed before the first session with the new Trainee.

No Violence Agreement (ClinicNote Forms) To be used with clients when violence is present. Clients will have to verbally consent, and a copy of the form can be sent via Teams or email.

Overall Initial Intake Assessment (ClinicNote Forms): On the last page of the Initial Intake Assessment – questions must be completed (top portion for adult clients, both individuals and couples, while the bottom portion is for child clients). Trainee and Program Clinical Supervisor must both agree and sign off on the document. Please hold for the Clinic Director's signature – she will notify you when ready.

Release of Information (ClinicNote Forms): To be used to obtain consent from clients to gather or share information with other health professionals. For clients with more than one Tx Modality in the clinic, an ROI must be obtained with the other therapists; verbal consent from the clients is acceptable. For outside professionals, please work with your Program Clinical Supervisor to determine if verbal consent, electronic signatures, and electronic delivery are sufficient. Some may still require wet signatures and to be sent via mail or fax.

Safety Plan (ClinicNote Forms): To be used with clients when SI has been expressed. Clients will have to verbally consent, and a copy of the form can be sent via Teams or email.

Session and Fee Record (ClinicNote Reports): All completed sessions, no shows, cancellations, and late cancellations are to be documented on the Session & Fee Record.

Supervision Notes (FSC SharePoint>Shared Documents>Supervisor Documents): Program Clinical Supervisors are to document after reviewing a client's case. Must review each case at a minimum once per month. For relational cases, clinicians usually

alternate who writes the notes for each session. One clinician writes the notes, and their Program Clinical Supervisor signs the notes for that session.

Agreement for Services/Informed Consent (ClinicNote Forms): Must go over with the client in the first session (both new and transfer clients). Clients will have to verbally consent, and a copy of the form can be sent via Teams or email.
Session Note (ClinicNote Reports): Each session should be completed AND signed within 24 hours.

Telephone Intakes (ClinicNote Forms) (Child, Couple, Family, Individual): All new clients will complete a Telephone Intake before receiving services.