University of Manitoba

Psychological Service Centre

Student Handbook and Operations Manual
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About the Psychological Service Centre

The Psychological Service Centre (PSC) is the Clinical Psychology program’s primary centre for clinical training. Located on the Fort Garry campus of the University of Manitoba, the PSC was opened in 1968 as a training clinic for the then newly-established Clinical Psychology Program. The UM Clinical program was one of the first in Canada, and the first in Western Canada, to achieve full accreditation by the American Psychological Association. Following its APA accreditation in 1972, the program expanded gradually over the years and received full accreditation by the Canadian Psychological Association in 1988/89 after CPA developed its own accreditation standards and procedures. Since that time, activities at the PSC have varied in concert with the needs of students and their clients, the expertise of faculty associated with the Clinical program, and contemporary and emerging areas of professional practice.

Today’s PSC is an active, dynamic clinic serving a wide range of clients from Winnipeg and the surrounding area. PSC clients include children, adults, couples, and families. Our clients are referred to the PSC for a wide variety of psychological service needs by community and social service agencies, physicians, members of the campus community, and former clients. At times, active recruitment of specific client types occurs to meet student training needs. Services offered through the PSC include individual psychotherapy for adults and children, couple and family therapy, cognitive, psychoeducational, and psychodiagnostic assessments, and group therapy.

Currently, the clinical work of students at the PSC is supervised by a complement of 11 Clinical faculty members with clinical appointments at the PSC. Partnerships are currently being explored between the PSC and allied professional programs and services at UM to further enrich the PSC and provide more training opportunities for students. Other community partnerships and research possibilities are also being explored. In addition to the clinical training facilities, the PSC also has computer work stations for clinical graduate students and an on-duty room for student clinicians.
PSC Mission Statement

To provide high quality clinical training opportunities for graduate students in Clinical Psychology and allied professional programs through (a) delivery of a range of supervised psychological and related services to the public, (b) partnerships with community service agencies, (c) continuing professional education, and (d) research. (Approved by Clinical Faculty, September 6, 2011)

PSC Vision Statement

We would like the PSC to be a recognized centre for excellence in clinical training and supervision, sought out by students in Clinical Psychology and allied professional programs who are interested in broad-based and specialized practicum experiences.

We would like the PSC to be an active, vital, and dynamic setting in which students feel both challenged and supported in pursuing their clinical and academic goals.

We would like the PSC to serve as the ‘hub’ for the Clinical Psychology program, creating a welcoming space where all students training at the PSC feel at home and are able to interact freely with peers and access supervisors and other clinical resources as needed.

We would like the PSC to be recognized by the university, other service agencies, and the general public as a valuable resource for diverse client issues and populations. (Approved by Clinical Faculty, September 6, 2011)
PSC Staff and Faculty

PSC Director
Dr. Hal Wallbridge, PSC Director
Contact: Room 171 Dafoe Building (PSC), ph: 474-9069, e: Harold.Wallbridge@umanitoba.ca

PSC Associate Director
Dr. Diane Hiebert-Murphy, Professor and Associate Director, PSC.
Contact: Room 419A Tier Building, ph: 474-8283, e: Diane.Hiebert-Murphy@umanitoba.ca

PSC Administrative Assistant/Coordinator
Ms. Kelly Kennedy
Contact: Room 164 Dafoe Building (PSC), ph: 474-6392, e: Kelly.Kennedy@umanitoba.ca

PSC Office Assistant
Andrea Labossiere
Contact: 162 Dafoe Building (PSC), ph: 474-9222, e: Andrea.Labossiere@umanitoba.ca

Director of Clinical Training
Dr. Corey Mackenzie, Associate Professor, Director of Clinical Training.
Contact: P516 Duff Roblin Building, ph: 474-8260, e: Corey.Mackenzie@umanitoba.ca

Clinical Psychology Faculty
Dr. George Bednarczyk, Instructor, Clinical/School Psychology programs
Contact: Room: P517B Duff Roblin, ph: 474-9276, e: George.Bednarczyk@umanitoba.ca
Contact: 110 Fletcher Argue Building, ph: 474-8041

Dr. Rayleen De Luca, Professor, Clinical Psychology program
Contact: Room P438 Duff Roblin Building, ph: 474-7255, e: Rayleen.Deluca@umanitoba.ca

Dr. Lorna Jakobson, Associate Professor, Brain & Cognitive Sciences/Clinical Psychology program
Contact: Room P413 Duff Roblin Building, ph: 474-6980 e: Lorna.Jakobson@umanitoba.ca

Dr. Ed Johnson, Associate Professor, Clinical Psychology program
Contact: Room P416 Duff Roblin Building ph: 474:9006 e: Ed.Johnson@umanitoba.ca

Dr. Michael LeBow, Professor, Clinical Psychology program
Contact: Room 105 Fletcher Argue Building, ph: 474-8719, e: Michael.Lebow@umanitoba.ca

Dr. David Martin, Senior Scholar, Clinical Psychology program
Contact: 106 Fletcher Argue Building, ph: 474-8194, e: Jen.Theule@umanitoba.ca

Dr. Maria Medved, Associate Professor, Clinical Psychology program
Contact: Room P414 Duff Roblin Building, ph: 480-1465, e: Maria.Medved@umanitoba.ca

Dr. Bruce Tefft, Associate Professor, Clinical Psychology program
Contact: Room P439 Duff Roblin Building, ph: 474-8259, e: Bruce.Tefft@umanitoba.ca

Dr. Jen Theule, Assistant Professor, Clinical/School Psychology programs
Contact: Room P255 Duff Roblin Building, ph: 474-7417, e:

**Ethics, Standards, and Professionalism**

It is both a privilege and a responsibility to have clients place their trust and confidence in you as a clinical professional. To facilitate your learning process with regard to professional ethics, responsibilities, and obligations, you will find up-to-date copies of the Canadian Psychological Association Code of Ethics, the Psychological Association of Manitoba’s standards and guidelines, and the provincial child abuse reporting guidelines available on the PSC website under ‘Student Resources’, with printed copies at the front desk and in the Clinical Practicum Students room 165.

All faculty, staff, and students have a responsibility to know and understand these rules, and to comply with all their obligations therein. Any breach must be reported to the PSC Director immediately. **Ignorance of these rules is not an acceptable excuse.** Those in breach of these requirements may face disciplinary action, up to and including suspension, dismissal, or termination, in accordance with applicable policies.

**Ethics and Standards**

As a psychological service unit, all activities at the PSC must be conducted in compliance with the Canadian Psychological Association Canadian Code of Ethics for Psychologists (third edition), which applies equally to students and to their supervisors. CPA has also developed Guidelines for Ethical Supervision in Psychology to assist both supervisors and supervisees to fulfill their ethical obligations within the supervisory context. In addition, as members of a self-regulating profession, students and their supervisors must also abide by the relevant standards of the provincial regulatory body for psychology, The Psychological Association of Manitoba.

Along with these national and provincial psychology standards, as a unit at the University of Manitoba that is engaging in health service delivery, the PSC is legally responsible to operate the clinic and all of its teaching and service functions in accordance with applicable privacy legislation (including the Freedom of Information and Protection of Privacy Act and the Personal Health Information Act, collectively known as FIPPA/PHIA).
More detailed information may be found on the following websites:

- CPA Canadian Code of Ethics
- CPA Guidelines for Ethical Supervision
- Psychological Association of Manitoba
- U of M Governing Documents
- FIPPA/PHIA

To facilitate compliance with the relevant provisions of FIPPA/PHIA, all students, staff, and faculty members at the PSC are required to attend a Personal Health Information Act seminar provided by the UM Access and Privacy Office and sign a University of Manitoba pledge of confidentiality. For students, this pledge must be signed prior to commencement of their clinical training as assurance that they understand and agree to comply with all legal obligations. The onus is on the student to come forward if clarification is required. Students who plan to undertake any clinical training at Winnipeg Regional Health Authority sites (e.g., Health Sciences Centre, St. Boniface Hospital, Victoria General Hospital) must also attend a PHIA seminar sanctioned by the WRHA and sign the WRHA pledge of confidentiality. These seminars are arranged in September each year as part of the PSC Orientation process to ensure students have access to this information in a timely manner.

**Informed Consent and Release of Information**

There will be situations where clients request that you provide information to others about their contact at the PSC, or you wish to gain access to information about your client from another service provider or agency. You may also receive a request from a client to access her or his PSC file. To preserve confidentiality and enhance informed consent regarding all such requests, we have developed specific forms that pertain to requests from clients to access their personal health information or to obtain permission from them to exchange/release information from/to the PSC and other service providers. No release of information can occur without proper informed consent and signed/witnessed copies of these forms (subject to ‘Limits to Confidentiality’ on p. 11). Supervisors and office staff can provide assistance regarding these forms, which are located in the document baskets in the General Office. All requests and are to go to the records administrator.

**Professionalism**

Professionalism is a concept that encompasses many essential aspects of your role at the PSC and in the Clinical Psychology program.

‘Professionalism’ has been described by Dr. Samia Barakat as the skills, attitudes, and behaviours which are expected from individuals during the practice of their profession. Professionalism, thereby

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1 Cited material in this paragraph used with permission of Dr. Samia Barakat, Associate Dean Professionalism, Faculty of Medicine, University of Manitoba
includes such concepts as: maintenance of competence; ethical behaviour; integrity; honesty; altruism; service to others; adherence to professional codes; justice; respect for others; and self-regulation. Dr. Barakat goes on to state that professionalism is the keystone of the social contract between a profession and the public at large, and also notes that studies have demonstrated that lapses in professional behaviour observed in training are associated with subsequent unprofessional conduct in practice.

Within psychology, efforts have been made to describe the core elements of professionalism among practicing psychologists as well as trainees.

For professional psychologists, the essential elements of professionalism encompass both character and fitness-to-practice aspects, including: personality adjustment; psychological health; responsible use of substances; integrity; prudence; and caring (Johnson & Campbell, 2002)

For beginning Clinical students, the Council of Chairs of Training Councils (CCTC) and the Association of Directors of Psychology Training Clinics (ADPTC) agreed on the following baseline personality characteristics, intellectual and personal skills, attitudes, and knowledge that all students should possess prior to their practicum training experience: interpersonal skills (e.g., empathy, respect, openness to feedback); cognitive skills (e.g., critical thinking, intellectual curiosity and flexibility); affective skills (e.g., affect tolerance, tolerance of ambiguity and uncertainty); personality/attitudes (e.g., desire to help others, honesty/integrity); expressive skills (e.g., ability to communicate ideas and feelings in verbal and nonverbal forms); reflective skills (e.g., ability to consider own motives and effect on others); and personal skills (e.g., organization, personal hygiene).

Our intention at the PSC is to provide an environment consistent with and supportive of the highest levels of professionalism, as an ideal and as a daily practice, among both students and staff in all of their undertakings here.

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3 See appic.org
Guide to Professional Behaviour/Confidentiality

The following points are designed to promote an atmosphere of professionalism consistent with contemporary professional standards and expectations while fulfilling our obligations regarding confidentiality. This list is intended to be illustrative of professional behaviour and is neither comprehensive nor exhaustive:

- **ALL POLICIES AND PROCEDURES RELATED TO CONFIDENTIALITY MUST BE FOLLOWED.**

- **CLIENT FILES, RECORDINGS, ASSESSMENT DATA, OR ANY OTHER FORM OF CLIENT INFORMATION MAY NOT BE REMOVED FROM THE PSC AT ANY TIME.** THE USE OF CLOUD-BASED FILE STORAGE AND FILE SHARING SYSTEMS, SUCH AS DROPBOX, FOR ANY CLIENT INFORMATION IS STRICTLY PROHIBITED. ANY CLIENT INFORMATION TRANSMITTED ELECTRONICALLY IS SUBJECT TO **APPENDIX 1: PSC GUIDELINES FOR DE-IDENTIFYING PERSONAL HEALTH INFORMATION FOR ELECTRONIC TRANSMISSION**.

- Students are encouraged to consult with faculty regarding clinical issues; however, consultation must be done in a confidential and appropriate manner (For example, meetings should be held behind closed doors and not in the hallway or at the front desk).

- Due diligence must be observed with regard to the confidentiality and ethical considerations of all clinical actions. This includes client files, client contact, and supervision issues. Please treat all client information with the respect it deserves.

- All documents with the names of clients and/or descriptive information about clients are to be treated as confidential records, including electronic communications and post-it notes.

- Client records will **not** be left in public view.

- Clients will **not** be discussed, even without names, with individuals other than those who have a professionally legitimate reason for knowing.

- Information about a client will not be released beyond supervisory sessions without the client’s specific written permission.

- Observation or recording of testing or therapy will only take place after written permission has been obtained from the client.

- Telephone messages with the name and/or phone number of a client must be confidentially shredded, even if there is no context for the message.

- Client files should record only that information necessary for the goals of treatment.

- Respect the right of clients, staff, students and faculty to reasonable personal privacy.

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4 See **APPENDIX 1**, Revised by D. Stewart in consultation with the UM Access and Privacy Office, 21 June 2012.
• Collect, store, handle, and transfer all private information whether written or unwritten (e.g., conversations, faxes, client files, digital data, video/audio tapes) in a manner that safeguards privacy and security in accordance of ethical guidelines and legislation.

• Conduct all professional activities in a manner that reflects a commitment to our ethical principles of respect for the dignity of persons, responsible caring, integrity in relationships, and responsibility to society.

Social Media Guidelines

The following guidelines for social media interactions with current and past clients are recommended:

• Do not “friend” clients or accept requests to be “friended” from current or previous clients.
• Do not use messaging websites such as Twitter or Facebook to contact clients or to respond to clients.
• If you have a social media account, it is wise to use a pseudo name so clients cannot search or friend you online.
• Some clients prefer to communicate electronically, which is permissible, but only after the client has specifically requested this.
• Electronic communication should be generally restricted to scheduling appointments and should not be used to receive sensitive personal information from the client.
• Use your professional email address to communicate with clients, not your personal email address. If you are registered for practicum at the Psychological Service Centre, please correspond through the PSC email account.
• Assume that your clients and students will search for information about you on the internet, so be mindful of what you put online.

Limits to Confidentiality

1. Child Abuse/Neglect. Under The Child and Family Services Act of Manitoba, a psychologist who has information that leads him/her to believe that a child is or might be in need of protection must report the information to an agency or to a parent or guardian of the child. An agency rather than the parent/guardian should be contacted if it appears that the child is or might be suffering abuse and/or neglect by a parent or guardian.

See Reporting of Child Protection & Child Abuse Handbook and Protocols for Manitoba Service Providers

See Child Abuse Reporting Guidelines (PDF)

2. Abuse/Neglect of a Vulnerable Person. Under The Vulnerable Persons Living with a Mental Disability Act, a psychologist who believes, on reasonable grounds, that a vulnerable person to whom he/she is providing service is likely to be abused or neglected must immediately
report this belief and the information on which it is based to the executive director specified under the Act. This obligation extends to students, who are expected to consult immediately with a supervisor if any concerns arise in this area.

See Vulnerable Persons Act

3. Prevention of Harm/Duty to Warn. Under The Personal Health Information Act (PHIA), disclosure of personal health information is permitted without the consent of the individual if the psychologist believes that the disclosure is necessary to prevent or lessen a serious and immediate threat to:

   a) The health and/or safety of the individual the information is about or another individual or;

   b) Public health or public safety

Disclosure without consent is also permitted if it is:

   c) Required to comply with a subpoena, warrant or order issued or made by a court, person or body with jurisdiction to compel the production of the personal health information

Students who are dealing with a situation involving a serious and immediate threat or court order are expected to consult immediately with a supervisor about this situation.

See Personal Health Information Act

4. Missing Persons Act. The Missing Persons Act (MPA) allows the police to obtain specific information about a missing person when criminal activity is not suspected at the time a person is reported missing. Also, in emergency situations police may be granted immediate access to client records under the control of the PSC. The following examples are some types of information under a record access order:

   - Contact or identification information
   - Personal Health Information
   - School Attendance
   - Video Records
   - Employment Information

See Missing Persons Fact Sheet (PDF)

See Missing Persons Act

Clinical Practicum Training

Practicum training, or clerkship, is the core clinical training activity for students in the Clinical Psychology program and the raison d’être for the PSC. Practica occur in a developmental sequence
of graded complexity throughout the program, beginning with early practica at the PSC and continuing throughout the doctoral program, where students participate in more advanced practica designed to prepare them for their clinical internship near the end of the PhD program. Practica are integrated with didactic instruction via coursework and are intended to complement the academic and research components of the clinical program by giving students the opportunity to apply their knowledge in clinical practice. The Canadian Psychological Association, which accredits Canadian doctoral programs and internships, has set out specific requirements for the amount and content of practicum training, which informs our practicum training sequence.⁵

**Practicum Overview**

Students will complete a minimum of 900 hours of practicum training over the course of a minimum of six required practica, each of which involves a minimum of 150 hours of total experience. Consistent with CPA’s current accreditation standards, each practicum must include at least 50 hours of direct client contact and 25 hours of supervision. The remaining hours could include additional clinical contact and supervision, along with a range of indirect activities in support of the practicum, such as case notes, video review, preparations for supervision, report-writing, readings, etc. Depending on circumstances, the total hours of experience for a given practicum may approach 200 hours. Beyond the six required practica, students may take up to two additional practica at the doctoral level to increase and/or broaden their clinical skill set.

With respect to the amount of practicum training a student should acquire, the CPA Accreditation Panel has stated that it believes no more than 1000 hours of practicum training are necessary prior to internship. Moreover, the Panel has also stated that it strongly encourages students to focus on quality (e.g., expanding variety of issues and populations) over quantity, and advises against amassing a large number of hours solely in an effort to enhance competitiveness for internship matching. In line with this advice, any students seeking to do more than eight practica must have compelling justification for their request, as simply accruing more hours may not enhance their competitiveness for internship and could unnecessarily slow their program time to completion.

According to the CPA (2011) *Accreditation Standards and Procedures*, practicum training incorporates and covers the following activities:

- An understanding of, and a commitment to, professional and social responsibility as defined by the statutes of the CPA *Code of Ethics*,
- The ability to conceptualize human problems,
- Awareness of, and sensitivity to, the full range of human diversity,

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⁵ See CPA 2011 *Accreditation Standards and Procedures (5th rev.)*:
• An understanding of one’s own characteristics, strengths, and biases and the impact these have upon professional functioning,

• Skill in psychological assessment, intervention, and consultation, which includes more than one type of assessment (e.g., intelligence testing, behavioural assessment, personality testing, neuropsychological assessment) as well as more than one type (e.g., cognitive-behavioural, interpersonal) and mode (e.g., individual, group, family) of intervention,

• Skill in writing reports and progress/session notes, and

• The use of research to inform practice and the ability to use practice experiences to inform and direct research. (p. 27)

General Practicum Requirements

To facilitate the fulfillment of the CPA requirements, by the end of their third general practicum at the PSC, and prior to beginning external specialty practica, clinical students will normally be required to complete a minimum of:

• Two couples and/or families

• Three formal assessments (at least one cognitive and one personality/diagnostic)

• Individual psychotherapy with a minimum of nine clients. Six of those nine clients must be seen for at least six sessions each. At least one of those clients must be a child (i.e., 14 years and under)

• One group

• Participation as a supervisee in one supervision sub-practicum

When developing their practicum contracts with supervisors, students must be mindful of these requirements and negotiate whatever specific experiences are necessary to fulfill these requirements. Possibilities exist for secondary supervision within general practica, where such input is necessary to meet specific goals (e.g., child assessment case, couple/family therapy). Students should consult with the PSC Director regarding their needs in these cases. If necessary, students may also fulfill any unfulfilled general practicum requirements in senior practica with the approval of the Director of Clinical Training and/or the PSC Director.

General Practicum Experiences

6 See Appendix 12 for the general practicum syllabus
The Clinical program requires clinical students to complete two general practica and one in-house specialty practicum (PSYC 7910, 7920, and 7930) at the Psychological Service Centre. Two of these practica will be at the Master’s level; the third is normally at the Doctoral level.

The first two practica, denoted as general practica, usually occur in the first and second terms of the second MA year. These early training experiences are intended to provide students with basic clinical skills related to interviewing, assessment, conceptualization, and intervention. These practica serve as the foundation upon which later advanced and specialty practica can build. The third practicum is denoted as an in-house specialty practicum and allows for refinement of clinical skills in a particular area (e.g., cognitive assessment; dialectical behaviour therapy; child therapy) or with a supervisor having a specific therapeutic orientation or approach (e.g., CBT; DBT; psychodynamic) prior to undertaking any external specialty practica.

**Specialty Practicum Experiences**

Specialty practica are considered to be more advanced, specialized training experiences that occur later in the clinical training program and provide students with clinical experiences that are more tailored to their individual needs and emerging interests. These practica may be provided at the PSC but are commonly provided at clinical facilities in the community, such as hospital or agency settings. Specialty practica may be initially conceived and organized by psychologists in the community, students themselves, clinical faculty members, or the PSC Director and, in many instances, by some combination of all the above. In order for a psychologist who is not a clinical faculty member to supervise a specialty practicum, he or she must be designated as a Clinical Associate by the Clinical Psychology faculty members. This usually involves submission of a curriculum vita by the external supervisor, along with a detailed proposal for the specialty practicum experience and evidence of training and/or experience as a supervisor. Specialty practicum proposals (if a new placement) must be reviewed and approved by the PSC Director in consultation with the clinical faculty.

**Practicum Registration, Guidelines and Evaluation**

**Practicum Registration Requirements:**

Practica are courses, graded on a pass/fail basis, and students normally register for them each year after meeting with the Director of Clinical Training for their annual program registration. However, as these are clinical courses, additional steps are necessary to gain approval of practicum requests once registered for them.

All practica require contracts between the student and the supervisor(s), which must be reviewed and approved by the PSC Director. In addition, specialty practicum approval is contingent upon

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7 See Appendix 13 for the specialty practicum syllabus

8 See the document, *Eligibility Guidelines for PSC Clinical Associates*
submission of a proposed contract for a specialty practicum outlining the details of the experience. These proposals should be submitted to the Administrative Assistant well in advance of the anticipated start date in order to allow sufficient time to review the details and determine the suitability of the experience for the student. In the case of a new placement, the qualifications of the proposed supervisor and details of the practicum experience must be approved by the clinical faculty prior to commencing the practicum. This may require up to eight weeks advance notice. In addition, no grades for a practicum will be submitted until supervisors’ Practicum Evaluation Rating Forms (PERFs) and students’ evaluations of supervisors have been satisfactorily completed.

The practicum contract and evaluations are available in the general office and on the PSC website.

**Practicum Planning Guidelines:**

As courses, practica are atypical in that they do not fit into a particular “time slot” like other courses. Along with the practicum contract and program expectations regarding the clinical work to be done, students also need to be aware of some additional considerations and commitments related to practica.

In-service presentations are scheduled for the second Tuesday of the month from 3:00 – 5:00 p.m., September through April each year. Topics for in-service training are posted on the PSC website and in the general office. All clinical students and faculty are welcome and encouraged to attend these events as a form of professional development and continuing education. **In-service training is mandatory for all clinical graduate students doing their PSYC 7910 and PSYC 7920 practica.** PSC in-service training is considered part of the practicum for which students have registered.

The fourth Tuesday afternoon of each month is reserved for a Clinical Student Meeting. These meetings are optional but students are **strongly encouraged** to attend, as this is when the Clinical Student Representatives (CSR) will share information about the program and listen to your concerns so that they may advocate on your behalf with clinical faculty. CSR’s are elected by clinical students and serve alternate two year terms.

The second (or third) Tuesday afternoon of each month is set aside for a Clinical Faculty Meeting, chaired by the PSC Director. These meetings are also attended by the Clinical Student Representatives; however, for reasons of confidentiality, CSRs are excused from any meetings at which individual students are discussed. Examples would be end-of-term practicum review meetings and annual student evaluation meetings.

In addition to the specific time commitments listed above, students must be aware of the scheduling aspects of their clinical work. Client appointments are scheduled during hours the PSC is open to the public. Often appointments are scheduled in the late afternoons and evenings to accommodate client availability. Clients may also experience crises or other urgent situations that require
immediate attention from you and your supervisor outside of regularly scheduled appointments. Flexibility is key to a successful practicum and that is facilitated through advance planning wherever possible (advance room/equipment bookings at the PSC). In general, assume that your practicum will require a large time commitment (e.g., 150 hours per term), and make any necessary adjustments in other areas of your academic and personal life to accommodate your commitment to your clinical training.

**Practicum Approval and Supervision Procedures**

All practica must be proposed to the PSC Director prior to the start of term, by filling out and submitting the Practicum Contract. In particular, specialty practicum contracts should ideally be submitted at least four weeks prior to the start of term. The practicum contract form requires the signatures of the student, supervisor, and PSC Director, who is the instructor of record for all practica -- internal or external. All practa utilize the same contract, but some practica require additional levels of approval. For example, a practicum with WRHA will also require approval from the WRHA Clinical Health Psychology Practicum Coordinator in addition to the supervisor and PSC Director. See Appendix 2 for details regarding WRHA practicum procedures.

**Practicum Evaluations:**

At the conclusion of each practicum, supervisors must complete a competency-based Practicum Evaluation Rating Form (PERF) based on the performance of their supervisee(s). Each supervisee is likewise required to complete an Evaluation of Practicum Supervisor Form regarding their experience with the practicum supervisor. Both forms must be submitted to the PSC Director, who is the instructor of record for all practica. It is important for students to note that no grades for practica will be submitted without satisfactory completion of all requirements, including paperwork. Forms are available in the general office and on the PSC website.

**Summary of Practicum Requirements**

The fundamental practicum requirements are the same for both General and Specialty Practicum experiences:

1. A minimum of 150 hours of direct experience spread out over either 13 weeks (1 term) or 26 weeks (2 terms), as negotiated with the supervisor and approved by the PSC Director. A single practicum should not normally exceed 200 hours. Consistent with CPA accreditation guidelines, the required hours of practicum experience must include the following:
   a. A minimum of 50 hours of direct face-to-face client contact;
   b. A minimum of 25 hours of direct face to face supervision provided by a registered psychologist (up to 25% of supervision may be group supervision);
   c. The additional hours include indirect service activity (e.g. test scoring, report preparation, client related information gathering, etc.);
d. Regular occurring clinical activity throughout the practicum with an average of 10-12 hours per week committed to direct and indirect clinical work.

2. A written contract between the clinical supervisor and the student must be prepared and submitted to the PSC Administrative Assistant.

3. All clinical supervisors are obliged to provide a competency based assessment of student performance (PERF) promptly upon completion of the practicum.

4. All practicum students are obliged to provide an evaluation of the practicum and supervision experience promptly upon completion of the practicum.

5. Both supervisor and student agree to notify the PSC Director of any problems or concerns related to the training experience as soon as possible.

6. Students are required to log hours of clinical activity during each practicum using Time2Track and these logs will be verified by the PSC Director prior to grade submission. This log of clinical activity will also be an integral part of the application for internship\(^9\). Ideally, data should be entered on a continual, consistent basis throughout each practicum as it will also be used as part of the annual clinical faculty review of student progress.

In addition to the above general practicum requirements, additional requirements apply to specialty practicum experiences, particularly those provided off campus:

1. Specialty practicum submissions will only be considered after the student has successfully completed three practica at the PSC. Students are encouraged to meet with the PSC Director and the Administrative Assistant near the end of their third practicum to plan specialty practica.

2. External specialty practicum submissions will only be considered only after the student has completed the Master’s Degree (i.e., is not dually-registered).

3. The specialty practicum contract between the supervisor and the student should be prepared and submitted to the Administrative Assistant at least four weeks prior to the planned beginning of the practicum. This provides the time necessary for the submission to be reviewed by clinical faculty and approved by the PSC Director.

4. The training experience must be one in which education and training is prioritized over service delivery. In addition, although some practicum experiences could include remuneration, students may not claim or seek credit for any form of paid employment as practicum experience.

\(^9\) See the APPIC Application for Psychology Internship form: [http://www.appic.org/AAPI-APPA](http://www.appic.org/AAPI-APPA)
Guidelines for Clinical Supervision

Professional Liability and Student Responsibilities

The University of Manitoba, through its Office of Risk Management, ensures that registered clinical students are provided with professional liability insurance under the provisions of the institution’s membership in the Canadian Universities Reciprocal Insurance Exchange (CURIE). Under this insurance program, students who undertake clinical work as part of their academic program are automatically provided with professional liability coverage so long as this work is done with the knowledge and consent of an approved supervisor.

No coverage through CURIE is provided for clinical activities that are done outside the registered academic program (e.g., acting as a psychological associate in a private psychological practice; working as a counsellor in a community agency), or without the knowledge and consent of an approved supervisor for activities that occur as part of the academic program. For this reason, the onus is on the students to keep their supervisors apprised of the progress of therapy and of any potential problems or risks to the client or others. Your supervisor cannot help you if she or he does not know what is going on! In addition, supervisors may be absolved of responsibility if you act without their knowledge or consent, or act in a manner inconsistent with what they advised regarding a particular situation (e.g., failing to properly negotiate a safety contract when advised to do so). For this reason, close contact with supervisors is necessary when dealing with client safety issues.

Despite the university-provided group liability insurance coverage, students are urged to consider purchasing their own individual professional liability insurance, available at a reduced rate for students through CPA’s insurance broker. Information is available in the Clinical Practicum Student room 165 Dafoe Building, and from PSC staff.¹⁰

Designation of Supervisors

All general practicum students (PSYC 7910, PSYC 7920, PSYC 7930), in conjunction with their practicum supervisor, must complete and submit a PSC Practicum Contract. Contracts are to be submitted to the Administrative Assistant by the end of the third week of their practicum. Please note that a student must always have a designated supervisor for every client being seen, even if the client is continuing from a previous practicum and the original supervisor is not available. For example, if a supervisor is on sabbatical, arrangements must be made for a new supervisor, and a new contract should be drafted to ensure there is a record of supervisory responsibility for the continuing clients. Similar provisions apply when a student is continuing with some clients from a

¹⁰ See link for more information: www.cpa.ca
previous practicum, transferring supervisory responsibility from the former to the current clinical supervisor and documenting this on the appropriate form.

**Supervision Loads**

Practicum supervision is assigned as part of a faculty member's teaching load, under the Teaching Responsibility Policy of the Faculty of Arts. Clinical faculty earn a certain number of teaching credits by supervising practicum students and fulfilling associated PSC duties as described below. Teaching/supervision loads are discussed with the Clinical Area Director, negotiated with the Head, Department of Psychology, and approved by the Dean, Faculty of Arts.

In general, a normal assignment includes having two practicum students each term, participating in PSC meetings, covering specified on-duty time (being available for emergencies) during the regular session, and being on-duty for approximately three weeks in the summer. Each supervisor is expected to carry at least one PSC client, either as an individual client or in co-therapy with a student or other staff member. In addition, supervisors often spend some time supervising the therapy of clients from previous practica. If an individual supervisor has an unusually large number of "carryover" supervisees or is doing supervision that is unusually time consuming, that person can consult with the PSC Director for a proportionate reduction in the number of practicum students assigned.

**Supervisor Assignment Process**

For PSC general practica, supervisors are assigned to students based on availability. A faculty member’s availability to supervise is based on a number of factors, including teaching load, supervisory credits, administrative responsibilities, commitments to specialty practica, and other responsibilities. Students doing in-house specialty practica should contact PSC clinical supervisors of interest to explore their availability and make arrangements well in advance of beginning this practicum, as some supervisors have practicum commitments up to a year in advance. All PSC supervision assignments are made by the PSC Director in consultation with the Director of Clinical Training and the Administrative Assistant.

**Student Evaluation of Practicum Supervisors**

**Introduction:**

Faculty supervisors are subject to the relevant University, UMFA, and/or department policy regarding faculty-course evaluation.

**Evaluation Process:**

Each student registered in a practicum (general and specialty) shall complete, at the completion of the practicum, a formal written evaluation of the practicum supervisor, using the revised Evaluation
of Practicum Supervisors (EPS) Form. This form consists of one quantitative section and two qualitative sections: Section One consists of 48 items pertaining to different dimensions of the practicum supervision process and requires the practicum student to complete quantitative ratings thereof. Of these items, 41 are modified versions of the Counsellor Evaluation of Supervisors scale (Bernard, 1981, in Bernard & Goodyear, 1993). Section two requires the practicum student to provide information regarding anything that was especially valued about the supervisor. Section three requires the practicum student to provide specific suggestions for improving supervisory skills. Upon completion of the EPS form, the practicum student shall return the form to the PSC Administrative Assistant.

Compilation Process:

Once an EPS is submitted, the Office Assistant compiles the quantitative scores of Section One and enters them into an electronic spreadsheet. The qualitative responses to Sections Two and Three are re-typed into the spreadsheet, and the original form is confidentially shredded, to ensure anonymity of the student.

When 4 EPS evaluations have been received for a given practicum supervisor, only the mean and range of respondent scores for Section One, and comments from Sections Two and Three are transferred to a final spreadsheet for confidential distribution to the practicum supervisor and the PSC Director, who reviews this information but does not retain a copy.

Copies of the most recent EPS compilations for external supervisors (i.e., supervisors who are not subject to the UMFA Collective Agreement) can be reviewed by students when choosing supervisors for future practica.

# General Information – PSC Operations

## PSC Office and Room Designations

### DAFOE BUILDING (UPPER)

<table>
<thead>
<tr>
<th>Room</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>161</td>
<td>Reception / Waiting Area</td>
</tr>
<tr>
<td>162</td>
<td>General Office</td>
</tr>
</tbody>
</table>
| 162A | Office Assistant  
  Andrea Labossiere |
| 163  | Assessment and Testing |
| 164  | Administrative Assistant  
  Ms. Kelly Kennedy |
| 165  | Practicum Student Room |
| 166  | Therapy Room |
| 168  | Therapy Room |
| 169  | Conference Room |
| 171  | PSC Director  
  Dr. Hal Wallbridge |
| 172  | Therapy Room |
| 173  | Supervision and On-duty Consultation |

### FLETCHER ARGUE (EAST)

<table>
<thead>
<tr>
<th>Room</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>109</td>
<td>Children and Families</td>
</tr>
<tr>
<td>109A</td>
<td>Observation/Supervision Room</td>
</tr>
<tr>
<td>110</td>
<td>Supervision Room</td>
</tr>
</tbody>
</table>
| 110A | Office  
  Dr. George Bednarczyk |
| 111  | Clinical Student Workspace |
| 112  | Clinical Student Workspace |
| 113  | Clinical Student Workspace |
| 115  | Seminar/Group Room |

### FLETCHER ARGUE (WEST)

<table>
<thead>
<tr>
<th>Room</th>
<th>Description</th>
</tr>
</thead>
</table>
| 105  | Offices F.A.  
  Dr. Michael LeBow |
| 106  | Dr. David Martin |
| 107  | Dr. Don Stewart |
| 108  | Dr. Diane Hiebert-Murphy |
PSC Hours of Operation

The PSC is normally open to students and clinical faculty members weekdays from 9:00 a.m. daily. The PSC is also open four evenings a week during the academic year to allow flexibility in scheduling. **Clients should only be scheduled within the hours designated for public access:**

<table>
<thead>
<tr>
<th>September to May</th>
<th>Monday: 9:00am – 4:30pm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tuesday: 9:00am – 8:00pm</td>
</tr>
<tr>
<td></td>
<td>Wednesday: 9:00am – 7:00pm</td>
</tr>
<tr>
<td></td>
<td>Thursday: 9:00am – 8:00pm</td>
</tr>
<tr>
<td></td>
<td>Friday: 9:00am – 3:30pm</td>
</tr>
<tr>
<td>June to August</td>
<td>Hours are adjusted according to need</td>
</tr>
</tbody>
</table>

Scheduling clients at times outside of the public access hours (e.g., Tuesday or Thursday morning) may be possible, pending discussion with PSC office staff and/or the Director, to ensure that staffing requirements for front desk coverage and on-duty clinical back-up can be met at these times. **Please do not confirm any client appointments outside of the designated public access hours without permission from PSC staff.**

Extenuating circumstances may occasionally dictate that clients are seen outside of regular PSC operating hours (e.g., after closing for the evening or on a weekend). **This may only occur with the knowledge and consent of the student’s practicum supervisor and the PSC Director.** Students are not permitted to see clients after hours or on the weekends without such consent. In addition, for any after-hours contact, the practicum supervisor **must be on-site** for the full duration of the appointment. To maintain safety and security, entry doors must remain locked whenever appointments occur outside of the PSC’s normal operating hours, or when students are working after hours on reports, test scoring, etc.

Students are reminded to dress appropriately for a professional setting when at the PSC, whether they are seeing clients or not.

**PSC Meetings and Inservices**

Tuesday afternoons are set aside for a variety of PSC meeting and training functions. The Tuesday schedule includes monthly clinical faculty meetings, clinical student meetings, and PSC in-service training. **It is mandatory that general practica students attend all in-service training sessions so please adjust your schedule accordingly.**
The schedule for these events is posted in the PSC General Office and on the PSC website.

**Clinical Faculty On-Duty Coverage**

Clinical faculty members are assigned one on-duty day per week during the academic year, with summer coverage adjusted based on availability. The role of the on-duty supervisor is to be available as needed for consultation/intervention for urgent situations or crises. Supervisor on-duty schedules are located on the bulletin boards in the General Office and in the Practicum Students Room 165. Note that these times coincide with the PSC public access hours, which ensures that clinical back-up is available during times when students normally meet with their clients. Students seeking to see clients at times outside of the public access hours must discuss this situation with PSC office staff and/or the PSC Director to ensure adequate coverage is available.

Students should not hesitate to contact their assigned supervisor, administrative staff, or the on-duty supervisor for advice or consultation in important or urgent situations.

**PSC Keys and After-Hours Access**

Keys to the supervision room (110A FA) and the file/archives room (170 Dafoe) are available at the front desk. Advise office staff if you are taking a key and return the key immediately after unlocking the door.

Students enrolled in practica at the PSC may sign out a sub-master key to the PSC for the duration of the current practicum (typically September to April) with a $25 cash deposit. This provides after-hours access to work on reports or view recorded sessions, since client files and client videos cannot leave the PSC. See the Office Assistant to sign out a key.

For the security of the PSC, guard your key carefully and do not keep it on you when not needed.

**Telephone Access**

There is a telephone available in the Practicum Students Room 165 for use in contacting clients. There is also a phone available to students in the Conference Room 169. Priority should be given to client/business calls and personal calls should be kept to the absolute minimum. Students who make personal long distance calls using PSC equipment must provide the Office Assistant with details of time, date, and number called in order to bill the students appropriately for their usage. Failure to pay bills may result in blocked registration privileges.

When using the phones at the PSC, please remember that you are ethically bound to ensure that all information exchanged between yourself and your client is confidential so make sure that you have privacy when making your calls. There is a phone available for faculty use in the Supervision and On-duty Consultation Room 164. **Students and staff are asked to refrain from using the Office Assistant’s phone in Room 162A (front desk).** Also note that all PSC lines have caller identification blocked so the receiving party will not be able to identify the source of the call.
Printer/Scanner/Copier/Fax Machine

The printer/scanner/copier/fax machine is located in the storage area adjacent to the general offices. Only PSC-related printing is free of charge. If a student intends to use the PSC computers/printers to print thesis or course-related material, personal documents, or documents from the Internet, the Office Assistant must first assign a four-digit photocopy code to record the number of pages printed. Students will be billed at a cost of 10 cents/page for non-PSC related copying/printing. With permission, for occasional use, students may also note the number of pages and pay the office staff directly for their printing.

Students who send personal faxes using PSC equipment must provide the Office Assistant with details of time, date, and number called in order to bill the students appropriately for their usage.

In all cases, bills must be paid promptly as outstanding bills may result in blocked registration privileges.

Computers for Student Use

There are six computers available in the Clinical Graduate Student Rooms 111, 112, and 113 Fletcher Argue. All are networked for general use, and have word processing and SPSS software. The machines in 111 also have software installed for scoring psychological tests. Files should be saved to personal, portable devices and not to the desktop as extraneous data is regularly cleared from all lab computers. Please ensure that no confidential material is stored on these computers. If problems arise, contact the PSC office staff, who will access IT support through the Psychology department. Please respect that staff computers are not available for student use.

Reference and Resource Material

Books and videos for reference and resource may be found in the General Office and Practicum Students room. They are available for use by students and staff and must be checked out through the PSC library checkout system.

Students may want to take the time to familiarize themselves with community resource and reference materials. A list of resource agencies is available at the front desk and in the student on-duty room. Additional resources may be found in the Student Resource Binder, and the Contact Community Resource Binders, found in Practicum Students Room 165.

Confidential Shredding Console

Please note that any personal health information collected about a client is subject to all of the PHIA provisions, including record retention and disposal schedules. Before destroying any materials, check with your supervisor and/or PSC administrative staff to ensure that the materials can/should be destroyed.

All confidential materials (e.g., draft notes or reports, messages, CDs or DVDs) that should be destroyed must be placed in the locked ‘Shred-it’ bin in the test storage/photocopier room adjacent to the General Office. Do not dispose of any confidential materials in the recycling bins or waste containers.
**Video Recording and Storage**

Cameras to record client sessions are available at reception for use by students doing practica at the PSC. **It is the responsibility of the student to ensure that the camera, and any forms of data collected, do not leave the centre and are locked up appropriately after use.** The cameras work in conjunction with the dedicated, non-networked lap top and secure video server in Supervision Room 164. Sessions should be uploaded directly from the camera (SD card) into your password secured folder. SD cards should be wiped as soon as video is uploaded to the supervision computer and both camera and sd card returned to the reception desk as soon as possible. Once reviewed with your supervisor, video files should be deleted from all sources to ensure confidentiality and open up storage space on the computer. This system is designed to ensure clients’ privacy rights are maintained while guarding against unauthorized access, as required by PHIA.

PSC Supervision protocol for viewing videos:

1) **Unique passwords** will be given to each student. You will need these passwords to access your data on an encrypted USB Drive given to you at the beginning of term. Without the password, you will get an error message when trying to view these videos. You are only given permission to access video data which are specific to your clients. Special permissions have been granted to supervisors as appropriate.

2) **All video files uploaded onto the encrypted USB Drive must be deleted in a timely manner.** Files should be deleted after every supervision consultation unless instructed otherwise and will be wiped at the end of winter and summer terms to ensure security.

3) **Each USB Drive has a maximum on 32 GB; this is to ensure that students are deleting their data at appropriate intervals. 32 GB is about equal to 15 videos.**

4) If you forget your password, only the Administrative Assistant and PSC Director will have access to a master list. Sharing your password with others is considered a security risk and is not permissible.

5) **Only encrypted USB Thumb Drives that are allowed to carry sensitive PSC data to alternative locations within the PSC for supervision purposes only.** These are encrypted and are only able to work in computers that have been pre-programmed specifically to identify those thumb drives. In accordance with PHIA legislation, all file transfers/deletions must be logged; therefore, all file transfers/deletions must be done only by PSC staff.

Tutorials for the older cameras may be found in Appendix 3.

**Equipment Repairs**

Whenever you experience any equipment difficulties, please let the office staff know the nature and location of the problem so it may be addressed. **Please do not simply find another piece of equipment.**
or alternative ‘work-around’ as this just leaves the problem to be re-discovered by the next person who tries to use the equipment. In addition, do not change settings on any computer equipment, or add or delete programs, without consent from PSC staff. When equipment is out for repair from a particular room, a notation will be made on the room-booking sheets in the general office so others will be aware.

**Personal Belongings**

Clinical Graduate Student Rooms 111, 112, and 113 are in close proximity to public access areas. As such, the rooms must **ALWAYS** have their doors closed and locked unless someone is in the room.

Personal belongings may be most safely kept in Room 113, which has a code lock to further secure it. Please do not leave personal belongings in other rooms as they are not secure. In any event, the PSC assumes no responsibility for the loss of any belongings left unattended anywhere on site. Students and staff leave their belongings in the PSC at their own risk.

**Personal Safety**

No student or staff at the PSC is expected to put themselves in a situation in which their physical safety is jeopardized. Students who feel unsafe with a particular client should immediately excuse themselves from the situation and consult with a supervisor, PSC Director, or available office or on-duty staff regarding the situation. For security purposes, there is a ‘panic button’ at the front office reception desk, a direct line to campus security in the hallway near the waiting room and portable personal alarms available at the front desk for in-session use. For any on-campus emergencies, dial 555 to reach the campus Security Services emergency line. Security Services will notify city police, fire station, or ambulance as appropriate, and guide them to the PSC to expedite service. There is also a campus SafeWalk program to escort students or staff safely to their vehicles. In addition, the university offers Nonviolent Crisis Intervention training, First Aid & CPR certification, and Self-Defense Classes for Women. Please see PSC staff for more details on any of these matters.

**Student Awards**

Each year the Psychological Service Centre awards two cash prizes to clinical graduate students. These awards are usually presented as part of the annual Psychology Department Researchpalooza event, where the departmental Vineberg Prize is also awarded. PSC Award amounts vary with current market values (e.g., 2012 values were $350 for each award).

The **Marion & Morgan Wright Award** is open to all students who have completed their fourth practicum in the current regular session and is awarded on the basis of demonstrated clinical excellence in practica.

The **Alumni Clinical Research Award** is also open to students who have completed their fourth practicum in the current regular session. Selection is based on strength of publications in the current
academic year. Students who have won the Vineberg Award cannot submit their winning paper for consideration for the Alumni Clinical Research Award.

Students and their supervisors can obtain more information about these awards from the PSC Director or Administrative Assistant.

**Clinical Student Office Assistants**

Two or more clinical students are normally hired each year to work on a casual basis at the PSC. These student office assistants provide reception services, answer the telephone, and assist with office work. If you are interested in becoming part of the PSC student staff team contact the Administrative Assistant to learn more.

**Working with Clients at the PSC**

**Intake and Intake Procedures**

**Intake Process Overview:**

The primary purpose of the PSC intake process is to ensure that there is a readily accessible pool of potential clients to meet the training needs of clinical practicum students. In principle, the PSC is open to referrals year-round, but the specific nature of acceptable referrals may vary over the course of the year and in response to the number and needs of practicum students. For example, at points the PSC may be closed to requests for service by individual adults but remain open to children, families, or assessment cases. Along with this, specific types of cases may sometimes be actively sought or recruited from the community in an effort to ensure practicum students’ training needs are met. At other times, such as when all of the students have met their case requirement needs, no new requests for service will be accepted until the beginning of the next training cycle. Information about the current status of our referral needs is posted on the PSC website under **Waiting List**.

In line with its primary purpose of providing appropriate clinical training cases for its student clinicians, the PSC does not guarantee service to any person who has made a request for service. Moreover, people whose service requests are not met by the end of the training cycle will be informed in writing that their request is being removed from our Request for Service List and provided with a list of alternative community resources to explore. People so-removed from our list are free to re-contact the PSC with a subsequent service request, should they desire to do so.

Initial contacts for service requests are usually handled by PSC front office staff, including clinical assistants, who complete a Request for Service form that very briefly documents the nature of the service being sought. Students who are seeking clients can then review these forms with their supervisors to determine potential cases of interest. Cases of interest can be ‘held’ by a student for **up to five working days** in order to discuss suitability with their supervisors. Holding cases longer than this does a disservice to other students and to potential clients awaiting service.
The following sections provide more detailed information about the steps involved in developing a caseload of clients suitable for a student’s practicum training needs.

**Initial Requests for Service:**

1. Initial service requests from the general public may take place by phone (usually) or in-person (occasional walk-ins). People who inquire about service through e-mail should be invited to contact the PSC directly via phone. Having been approached with an inquiry about service, PSC office staff, including clinical assistants, will work in conjunction with the potential client to fill in the first section of the yellow REQUEST FOR SERVICE FORM. It is the responsibility of the PSC staff/student involved in this initial contact to explain PSC intake and client assignment procedures, emphasizing that completion of this initial request for service does not ensure further service. While the PSC strives generally to pick up clients in chronological order, cases may be picked up out of sequence to fulfill specific training needs of students as determined by their supervisors. Moreover, as the PSC is a training clinic, services are not ordinarily extended to persons whose needs cannot be accommodated by the training requirements and capacity of our student clinicians and their supervisors.

2. The completed Request for Service form will be placed in the REQUEST FOR SERVICE BINDER located in the PSC general office.

3. If the service request consists of a fax or letter (e.g., a referral letter from a physician), the referral source should be contacted to advise that the potential client must contact the PSC directly. Once contacted by the potential client, a yellow Request for Service form should be completed as above, stapling the referral letter to the completed form. The form is then placed in the REQUEST FOR SERVICE LIST. In cases where the potential client does not subsequently contact the PSC, office staff will contact the referral source to advise them that the referral has not been completed. This contact should be documented and filed under REMOVED FROM REQUEST FOR SERVICE LIST by the Office Assistant.

4. Any incidents of concern that require consultation with other PSC staff or the on-duty clinical faculty member (e.g., safety concerns, suicidality, or aggressive behaviour by a client or person making a service request) should be noted on the CRITICAL INCIDENT REPORT FORM. These forms must be entered into the CRITICAL INCIDENT REPORTS binder with a copy attached to the yellow REQUEST FOR SERVICE FORM, if applicable. Incidents involving PSC clients should also be noted in the client file, where a copy of the Critical Incident Report is included, in addition to the original report placed in the Critical Incidents Report binder. PSC staff will alert the student clinician and their supervisor to any critical incidents involving their clients if these individuals are not already aware of the incident. Any additional follow-up by staff/supervisors for critical incidents must also be appropriately documented in the Critical Incidents Reports binder or client file, if an ongoing client.

5. 
Establishing a New Client:

1. When a new client is required by a student:
   a. Students and clinical supervisors may individually or jointly search the REQUEST FOR SERVICE LIST and select a potential client for an intake interview.
   b. The student, in consultation with the supervisor, will call the client and set an intake date and time.
   c. The student will book a room for intake, and indicate on the Room Booking Sheet that it is an INTAKE (as opposed to a regular) session – by highlighting the booking with a highlighter. The booking should be for one hour. Normally, the intake should be 30-45 minutes in duration.
   d. The REQUEST FOR SERVICE FORM for the potential client is then moved to the INTAKE SCHEDULED binder.
   e. The office staff may send out a contact letter confirming the appointment date and time (with a map on the reverse side), to clients whose Request for Service forms are in the INTAKE SCHEDULED binder, if time permits. Information about parking will also be included. If known, students must indicate to the office staff when they are aware that the client does NOT want a letter sent to his/her home address.

2. After an intake is scheduled:
   a. Clients are requested to arrive approximately 10 minutes earlier than scheduled to complete the registration and informed consent forms. The office staff will prepare the client file, placing the REQUEST FOR SERVICE FORM in the client file, and notify the therapist(s) when the client is ready.
   b. The intake is conducted by the student/supervisor.
   c. If the client does not show up for the scheduled intake, the student should attempt to contact the client for re-scheduling. If this is unsuccessful, then the intake should be filed under REMOVED FROM REQUEST FOR SERVICE LIST by the Office Assistant.

3. Following the intake, the student, in conjunction with the supervisor, will decide if the client is appropriate for services at the PSC.

4. If the intake requires additional information before making a decision, the client file should be placed in the PENDING FOLDER. This folder is a short-term alternative pending decisions about case suitability. Such decisions should normally be made within one week.

5. Once a decision is made, a photocopy of the completed REQUEST FOR SERVICE FORM will be made by the Office Assistant and placed in the ACCEPTED FOR SERVICE or REFERRED ELSEWHERE
folders. This step is important and will facilitate keeping track of service requests/needs for future.

6. If the client is appropriate for services at the PSC:
   a. The student, in consultation with his or her supervisor, wishes to accept the case; the client file should be placed in the **CLIENTS ASSIGNED** folder for processing by the Office Assistant. The client’s file will then be placed in the current client file cabinet.

7. If the student and supervisor decide not to accept the individual for services at the PSC:
   a. The case is closed at intake, and the file is placed in the folder marked **CASES CLOSED** for processing by the Office Assistant.
   b. The student is responsible for advising the person/agency of his or her decision, explaining the rationale for the decision, and suggesting alternative treatments.

**Students who have done the intake are responsible for following the file until completion**, regardless of whether or not the client is accepted for services at the PSC.

**Intake Interview:**

Students’ supervisors should function as their primary resource in preparing for the intake interview. Prior to entering into an intake interview with a client, students will want to review the Request for Service information with their supervisor, discuss the specifics of the interview, and work out a plan for how to conduct the intake (e.g., observing the supervisor conduct the interview, sharing the interview, conducting the interview under observation) consistent with their developmental skill set and their supervisors’ directives.

The most common concerns raised by clients at intake involve hesitation about signing the informed consent documents. Clients may have questions or concerns about being seen by a student, how supervision works, limits to confidentiality, or the need to record sessions. Practicum students need to be prepared to address these common questions and concerns, and should also be aware of the importance of allowing clients to raise these issues prior to their disclosure of any personal details. Without ensuring some minimal level of informed consent, clarity, and trust, the intake interview is not likely to prove satisfactory from either the client’s or the clinician’s perspective.

See **Appendix 4** for a suggested intake interview outline.

Along with these considerations, other issues that should ordinarily be addressed during the course of the intake interview include:

- Is the client at risk (e.g., suicidal, homicidal, psychotic, in crisis/traumatized)?
- Is there a reason to be concerned about physical or sexual abuse?
• Is there concern about possible substance use or abuse (including alcohol)?
• Is the client required to engage in therapy (e.g., court-mandated treatment)?
• Is custodial parental consent required (in the case of a minor)?
• Is the client on medication? What are the potential impacts?
• Is an agency/other contact (e.g., referral source) expecting feedback?
• Is the client involved in any legal actions? Could the situation result in the therapist being subpoenaed and asked to give testimony?
• Is the client actively seeing another mental health professional? Regarding what issues?

If during the course of the intake, or any other interview, it becomes evident that a client is in extreme distress or crisis, or issues come up that a student simply does not feel sufficiently experienced to handle, it is important to request immediate help from the on-duty supervisor. There are times when faculty may also feel a need for immediate consultation. None of us are ever so competent and experienced that we cannot benefit from a second opinion or support.

**Intake from Other Agencies:**

Occasionally a client may be referred to the PSC by an agency contact (e.g., Child and Family Services). It is important to be clear about the role of the agency, and all legal requirements, before the initial interview to ensure that appropriate release of information may be arranged, but especially for the collaborative care and consideration of your client. Interdisciplinary approaches can be very successful, both clinically and educationally, so do be open to these possibilities.

**Legal Involvement:**

Students should not be involved with clients whose request for service originates from or may be associated with legal actions. It is essential that student therapists are clear about client legal or court involvements (e.g., custody disputes, child and family guardianship, sexual/physical abuse, criminal charges, etc.), and every effort should be made to identify these issues prior to accepting a client for service. Supervisors may make an exception in some cases and recommend that a student be allowed to take on a case that could have legal involvement, but this must be discussed in advance and approved by the PSC Director.

**Room Bookings**

Students are responsible for ensuring rooms (and appropriate equipment) are booked for all therapy and supervision sessions.

*It is absolutely imperative to book ahead for all appointments! It is unfair to your clients, peers, and the PSC staff to show up for a session without having made and confirmed room/equipment availability beforehand. Ideally, appointments are booked no later than 24 hours in advance.*
circumstances do not permit such advance booking, no sessions should be finalized with clients without first contacting PSC office staff to confirm room/equipment availability.

Sessions booked in the last available slot of the day must end 10 minutes before closing time to provide time for post-session review and to allow our night staff to close the centre. Calendar-style sheets are used to indicate room bookings at the PSC. Sheets are located in the general office on top of Cabinet #4. Once you have been assigned a client and you have arranged an appointment, write your first name and your client’s initials in the chosen space in pencil, drawing a line to indicate the appointment duration. Rooms are typically booked for a 50 minute time period. Please respect these time limits, as rooms tend to be in heavy demand, and running overtime creates frustration for your peers and their clients. In addition, to alleviate over-booking in the evenings, please spread your appointments throughout the day as possible.

Please call the PSC if you have had a cancellation and won’t be using a therapy room that you have booked. PSC staff will make every effort to contact you if your client should cancel, especially in the case of same day cancellations. If you are travelling a long distance to meet with a client you may wish to call before you depart to confirm your client has not cancelled the appointment. As a reminder to students who are running long with their sessions, you may knock on (but not open) the door of a room you have booked if it is in use at the time you booked it.

If you are working with a client prone to crises or acting out, it is prudent to book a room proximal to the reception area and to let the front desk staff know about the situation in advance. If you are uncertain about the potential for such behaviour on the part of your client(s), discuss this with your supervisor before you begin the session. The emergency number for Campus Police (who will notify City Police if necessary) is 555. In case of emergency the campus police may be reached directly from the red phone in the reception area. We also have personal alarms that can be taken into sessions when indicated.

PSC Electronic Record-keeping / Time 2 Track Database

In 2011, the PSC adopted Time 2 Track (T2T) as a means of maintaining a database of clinical activities by students and staff members. Prior to this, there was an in-house PSC database used to track activities, but this did not provide the ability to record detailed information documenting students’ amount and range of professional activities.

T2T is a web-based, proprietary program accessed via an annual site license maintained by the PSC. All clinical students and faculty members are required to set up a T2T user account and log their clinical activities in the various available categories. By using T2T, the PSC is ensuring ease of compiling clinical activity hours in a format consistent with that required by the Association for Psychology Postdoctoral and Internship Centers (APPIC), which is the organization that oversees the internship matching process each year. Using a harmonized system such as T2T also means that summaries of activities can be easily compiled as needed throughout the training year, thereby ensuring that practicum supervisors have up-to-date information available for their supervisees when planning case loads, preparing for evaluations,
or composing letters of reference. As such, it is imperative that all clinical activities are entered in a timely manner.

For more information about T2T and setting up your free account, see the Administrative Assistant after viewing the site:

Time2Track

**PSC Paper Record-keeping / Client Files**

Consistent with our Code of Ethics and PHIA, students are expected to keep records of all their formal interactions with PSC clients. These records are contained in client files, which should include the following types of information: identifying data; intake/assessment information; treatment plan; case notes; administrative information (e.g., consent forms, correspondence); and termination summary.\(^\text{12}\)

**Opening a New Client File:**

1. Find a potential client out of the REQUEST FOR SERVICE binder and, after discussing suitability with your supervisor, arrange for an intake session. On the yellow REQUEST FOR SERVICE FORM, fill in the area provided regarding the INTAKE scheduled.

2. Place the yellow REQUEST FOR SERVICE FORM into the red INTAKE SCHEDULED binder.

3. At the intake session, office staff will require forms specific to the client be completed.
   a. **Registration Form** – Beige.
   b. **Informed Consent** – White. Requires a witnessing signature from whoever takes possession of the forms from the client.

4. After your intake session, come to the front desk for a new client file. Files must be processed in a numerically-ordered sequence.

5. The client file is always organized in reverse chronological order with the most recent contact at the front of the file and the first contact at the back.

**Client File Contents and Forms:**

The PSC has a variety of forms for a range of purposes. Not all forms will be applicable for all cases. As a guideline, client files should contain the components listed below and be organized in the following order, from back to front in the file:

- Request for Service form (yellow)

- Informed consent (white letterhead)
- Registration form (beige)
- Intake checklist (pink) and/or Intake Interview (white)
- Intake report (white)
- Contact sheet(s) (green)
- Collateral information & other correspondence (i.e. reference letters, external reports)
- Assessment data and protocols (assessment clients only)
- Detailed Therapeutic Workup (white)
- Termination note (white) (therapy clients only)
- Assessment report (white letterhead) (assessment clients only)
- Termination form (white)
- Client contact summary (white, inside left-hand side of folder)

6. Place the new client file into the green CLIENTS ASSIGNED folder on top of Cabinet 3 in 162 Dafoe. At this time the file will be administratively opened by office staff. To find the number assigned to your client, check the alphabetical Rolodex in Cabinet 3, where cards for each active client file are kept.

FILES ARE STORED IN NUMERICAL ORDER IN THE BROWN CLIENT FILE CABINETS LOCATED IN SECURE FILE ROOM 170 DAFOE. PLEASE ENSURE THIS ROOM REMAINS LOCKED AT ALL TIMES.

Detailed Therapeutic Workup. Detailed therapeutic workups are required by the fourth session of treatment for each case assigned to clinical psychology students.

Treatment summary. A chronological presentation of the course of therapy, with significant events, changes, dynamics, resistances, etc., should be set forth at some length. The ways and techniques with which the therapist dealt with the various kinds of material and reactions should be delineated. The various issues considered in the detailed therapeutic workup should be reviewed in light of what actually transpired over the course of therapy. At the end of the narrative report, the clinician, in consultation with the supervisor, is to indicate the overall success of the therapy following the scale below with some description of the reasons for your rating.

1 – Very Successful
2 – Moderately Successful
Clinically Closing a File

If the last session with the client is mutually agreed upon with the client, note that the client has been “clinically closed.”

If the last session is not mutually agreed upon with the client, but if instead the client begins to cancel or missed consecutive appointments or is hesitant to make any more appointments, closing with a client should be seriously considered by the student and discussed with the supervisor. In considering this decision and in communicating with the client, we wish to emphasize that this not be a punitive process, but rather be viewed as a final opportunity to be helpful to the client. Once the decision for closing has been made and finalized with the client, the student is to note on the file that the client has been “clinically closed.”

Administratively Closing a File

Once a case has been clinically closed, the student is expected to complete all remaining record-keeping for the client within 4 weeks of termination. Once all records are complete and placed in the client file and the Termination Report, Termination Form and Treatment Summary have been completed, the file will be placed in the CASES CLOSED folder.

Client File Audit Process

Client files at the PSC are subject to relevant legislation governing health records, as set out by the Personal Health Information Act, which provides guidance regarding various aspects of documenting clinical activities. The PSC client file audit process is our primary mechanism to ensure that client files are maintained to the standard required by PHIA legislation and the policies of the Psychological Service Centre. The client file audit is conducted under the auspices of the PSC Standards Committee, which is charged with ensuring that the centre is operating within contemporary professional standards.

Essentially, the goal of the client file audit is to ensure that the required client file information is complete and up-to-date. It does not indicate whether the specific content of each item is correct, nor does it verify the inclusion of any additional information a supervisor may have requested above the minimum standards. As such, auditing files ensures only that minimal standards of compliance with respect to accurate and adequate documentation of contacts and services have been met, and that essential information, such as informed consent for services, has been provided to the client. Client file audits do not ordinarily involve an evaluation of services received, merely the documentation of same.
Files audits are an ongoing process; any issues will be shared with both the student and their immediate supervisor, and may be discussed at clinical faculty meetings when reviewing student progress. The File Audit Checklist will be filled out by the auditor and placed in the client file for your review and attention. If you need clarification about your client file audit, please ask staff.

NOTE THAT STUDENTS AND THEIR SUPERVISORS WILL ALSO BE NOTIFIED VIA E-MAIL OF THE RESULTS OF THEIR MOST RECENT CLIENT FILE AUDIT. IT IS EXPECTED THAT ANY FILES REQUIRING ATTENTION WILL BE DEALT WITH IMMEDIATELY. FAILURE TO DO SO WILL BE REPORTED TO THE PSC DIRECTOR.

GRADES FOR PRACTICA WILL NOT BE ASSIGNED UNTIL CLIENT FILES ARE COMPLETE AND UP-TO-DATE. IN ADDITION, ANNUAL EVALUATIONS OR LETTERS OF PERMISSION FOR INTERNSHIP MAY BE WITHHELD PENDING COMPLETION OF OUTSTANDING CLIENT FILE DOCUMENTATION.

Psychological Testing at the PSC

The PSC maintains an extensive library of psychological test materials accessible by Clinical students and supervisors. Room 163 has been set up as a dedicated Assessment and Testing room, including computerized administration of some tests, and students are encouraged to book this space for their assessments. Most of the other therapy rooms have tables that can be used for testing as well, should the Assessment and Testing room 163 not be available.

The availability, distribution, and use of psychological test materials through the PSC is governed by the ethical standards of the profession of Psychology and agreements with test publishers, both of which state that practitioners must function within the limits of their training and competence. As such, there are limitations and restrictions on access to psychological test materials.

Limitations on Access to Psychological Test Materials: 13

1. Testing materials are available for use at the PSC to all clinical staff and clinical graduate students upon request. However, in their use of psychological tests, graduate students must be supervised by a clinical staff member. **All written reports or correspondence concerning test results of PSC clients must be co-signed by the supervisor.** The student’s supervisor has the ultimate ethical and legal responsibility for the assessment work done with PSC clients and for any information concerning clients (e.g., letter, reports) leaving the PSC.

2. Non-clinical psychology academic staff may examine test materials in the PSC. No photocopying of these sensitive, copyrighted materials is allowed. Those who wish to borrow test materials (e.g., for classroom demonstration) should direct their requests to the PSC Director for approval.

3. Non-clinical psychology graduate students may examine test materials in the PSC. Reproduction of psychological test material is a direct infringement of copyright rules and will not be

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tolerated. Anyone caught photocopying or scanning test material will be subject to disciplinary action.\(^{14}\)

4. Any Psychology graduate students (non-clinical or occasional) taking readings courses in psychology are eligible to borrow test material and may direct loan requests to the administrative assistant or the PSC Director.

5. Testing materials are not available to faculty or students registered outside of the Department of Psychology (e.g., Human Ecology, Education, Physical Education, Nursing, etc.). They may obtain permission to examine manuals at the PSC by contacting the PSC Director but these may not be removed from the premises.

While the PSC attempts to provide depth and breadth in its assessment training and to this end maintains an extensive test inventory for training purposes, we cannot assume the cost of test materials required by staff and graduate students in their research endeavours. Funding for test materials for research purposes should be sought from other sources.

Procedure for Accessing Psychological Test Materials:

Test materials may only be borrowed by students enrolled in practica, or by students enrolled in the Clinical assessment courses. Priority access is for students assessing clients as part of their practicum requirements.

Testing kits can be found in the back office in Cabinets A to F and additional test manuals and booklets may be found in Cabinet 6.

Cabinet 6 is opened daily while Cabinets A to F are locked. The keys for all of these cabinets can be found at the front desk. Please remember to be courteous regarding staff space and to communicate respectfully. Office staff may be occupied with clients, in-person or on the phone, and may require privacy. If the door is locked, the office staff should not be interrupted. Thank you in advance for your courtesy.

Be sure to reserve test materials, and to check on availability, including the Assessment and Testing Room 163 well in advance of your scheduled assessment. This is prudent from many aspects, and stands to benefit the client, student, and supervisor when all are informed.

All materials borrowed from the PSC must be signed out through the Office Assistant and the computerized library system. This includes test kits, test manuals, scoring keys, stop watches, tape recorders, textbooks, audiotape and videotapes.

\(^{14}\) See Copyright Office website www.umanitoba.ca/copyright for more information.
Please remember that permission from the Director, or the administrative assistant in the absence of the Director, is required prior to materials being taken outside the PSC. Loans of this type must be of short duration in order for materials to be available for others.

Upon returning the materials, please remember to have them checked in and place them in the correct location. Cabinets A-F have descriptions of what kits are inside while Cabinet 6 and the textbooks/audiotapes/videotapes are all in alphabetical order.

**Student Resources**

**University Resources**

The University of Manitoba provides a full range of support services to its students through the various units and departments comprising Student Affairs. For clinical students, some of the resources of interest include Accessibility Services, Student Advocacy, Student Counselling and Career Centre, and the University Health Service. For a listing of all student services offered through Student Affairs, and descriptions of the services offered, see this link:

See [Student Services](#)

In addition to these services for students, some services are open to any member of the campus community, including the Human Rights Advisory Service, which promotes a respectful working and learning environment and addresses concerns involving harassment, inequitable treatment, discrimination, and similar issues:

See [Human Rights Advisory Service](#)

A complete listing of all resources open to students can be accessed through this link:

See [Student Resources](#)

**Student-Supervisor Conflict Resolution Guidelines**

When people work closely together some differences of opinion or issues may arise, and it is worth articulating some principles for handling such situations.

The first and most important principle in handling disputes is to try to communicate directly with the other person about your concerns. This can be a complicated issue in a setting such as the PSC. There is an obvious disparity in power and influence that students may find intimidating. Rest assured that all PSC staff have a strong commitment to building an atmosphere of helpful community and try to be accessible and non-threatening.

If appropriate attempts at direct problem solving are not successful, a number of other avenues are available. Both students and staff are always invited to discuss any concerns with the PSC Director, whose job it is to mediate, manage and generally facilitate the functioning of the PSC. If the Director is
involved in the problem, the Associate PSC Director may be called upon to act as a mediator to resolve the issue. Discussions can range from individual problem solving talks to discussions among all parties involved, depending on the circumstances and the wishes of those involved. At times, students have approached the Clinical Student Representatives to act as intermediaries with the Director. In some cases, it may be possible to implement general solutions, such as changes in policy or publicizing of existing policies, to resolve issues in a more general way. If this process is unsuccessful, the matter will then be referred to the Department Head or the appropriate body considering appeals to resolve the issue. Please be aware of the various support services available to students who are experiencing problems with advisors, supervisors, or other members of the campus community, as outlined in the section above, ‘University Resources.’ The Office of Student Advocacy can be particularly helpful to students in advising them of their rights and ensuring that due process is followed in any undertakings:

See Student Advocacy

**PSC Complaint Review Process for Clinical Practicum Students**

<table>
<thead>
<tr>
<th>Action to be Taken</th>
<th>Who Takes Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review written complaint from complainant</td>
<td>PSC Director</td>
</tr>
<tr>
<td>2. Acknowledge in writing to complainant that complaint has been received</td>
<td>PSC Director</td>
</tr>
<tr>
<td>3. Advise student involved in the complaint in writing of the complaint</td>
<td>PSC Director</td>
</tr>
<tr>
<td>4. Meet with complainant to review complaint and clarify any ambiguities that may exist</td>
<td>PSC Director</td>
</tr>
<tr>
<td>• provide student with a copy of the written complaint</td>
<td></td>
</tr>
<tr>
<td>• request a written response to the complaint from the student</td>
<td></td>
</tr>
<tr>
<td>5. Convene a Complaint Review Committee to review complaint consisting of:</td>
<td>PSC Director</td>
</tr>
<tr>
<td>• Academic Advisor</td>
<td></td>
</tr>
<tr>
<td>• Practicum Supervisor</td>
<td></td>
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<tr>
<td>• PSC Director</td>
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</tbody>
</table>
6. Complaint Review Committee reviews complaint about and recommends action to be taken
   
7. Department Head and Graduate Studies Department Head advised of complaint and action recommended. Department Head advises Dean of Arts about complaint in an appropriate manner
   
8. A draft letter summarizing the recommended action(s) by the Complaint Review Committee is prepared to be sent to the complainant
   
9. Complaint Review Committee reviews letter and recommends changes, if necessary
   
10. Revised letter to complainant is reviewed by University Legal Department (if necessary)
   
11. Revised letter is sent to complainant under the PSC Director Signature

**Clinical Students’ Association**

The CSA is an informal association of students in the graduate clinical psychology training program at the University of Manitoba, who meet for educational, supportive, and decision-making purposes. We have two elected student representatives who represent student interests at the clinical faculty meetings. They report the business of clinical faculty meetings to the clinical students at monthly meetings. Special interest speakers, including practising professionals and specialists in certain fields, are invited to these meetings as determined by the students’ interests. These are great learning experiences. Attendance at monthly meetings is strongly encouraged as student input is very important and the Association is only as effective as the students that attend.

**Student Representatives**

The student representatives are elected to their position for a term of two years. One position comes up for election in September of each year. These students serve as representatives on the clinical faculty meetings and the Psychological Service Centre staff meetings. They are there to bring forward any opinions, concerns, complaints, or questions that students have. They may represent specific
student’s interests, clinical students’ interests as a whole, and vote on behalf of students in policy and decision making meetings concerning operations at the PSC. The student representatives are also available to talk to any student experiencing difficulty with any aspect of the clinical program (i.e., supervision, practicum training, courses, access to information, and peer relations). Also, if for any reason a particular issue related to a particular student is to be discussed at faculty meetings, the student can request CSRs to be present for support. Remember, this is by request; otherwise CSRs generally exempt themselves from discussions involving specific students. Please feel free to contact either of your student representatives if you experience any difficulty during your program, because we are here to listen and advocate for you. For more specific information, please refer to the documents included in the Orientation package entitled “Responsibilities of Clinical Student Representatives” and “Policy for Clinical Student Representative Attendance of Clinical Faculty Meetings”.

**Current Elected Representatives**

Christine Henriksen (September 2012-2014)

Sulaye Thakrar (September 2011-2013)

Two alternate student representatives are required to ensure full student attendance at staff meetings. These positions are up for election in September.

**Brown Bag Lunches and Monthly Meetings**

We organize monthly meetings for clinical students. The meetings will occur the last Tuesday of every month. You will be informed of the dates, times, and locations when they have been confirmed. During these meetings we will host guest speakers on various topics relevant to our future practice as clinical psychologists (e.g., registration, finding jobs, private practice, an academic career, etc.). If you have any ideas for topics or specific individuals, please let the CSRs know!

The monthly student meetings are also when the CSRs communicate any new business from the clinical staff meetings, PSC staff meetings, student concerns, or departmental business. Your attendance at these meetings is very valuable, because this is the forum for formulating and communicating ideas to the faculty (based upon students’ concerns related to program or practice) as well as discussing faculty proposals of program changes before they are voted on at faculty meetings.

These meetings are also an opportunity to talk with other students in the clinical psychology program about our experiences and to ask questions of other clinical students who might have more experience. We could organize a recommended book list, choose a topic for informal discussion, problem solve as a group of supportive peers, etc. Many students in the past have found value in speaking to students further along in the program. This is a great opportunity to get together.

**Responsibilities of Clinical Student Representatives**
Introduction

Graduate students registered in the Clinical Psychology Training Program (hereafter termed students) at the University of Manitoba (U of M) are represented by two of their peers. The mandate of these two Clinical Student Representatives (hereafter termed CSRs) is to serve the rights, needs, and interests of ongoing students that are relevant to their tenure in the clinical training program. Where possible, both Generalist and Behavioural Streams are represented by the CSRs.\(^\text{15}\)

Terms of the Position

Each CSR position begins in September and continues for two consecutive years (24 months), pro bono. At any given time, one of the two CSRs will have completed one year of the two-year term. That is, each position is filled on alternating years.

Election Process

Each September, following the completion of one of the CSR terms, to elect a successor, the current CSRs contact (e.g., via written posted announcements, memoranda) and convene all ongoing students. Among this group, one may self-nominate or nominate a fellow student for the open CSR position. Interested students not present at this meeting may provide their consent to be nominated in absentia. One of these nominees is elected by majority vote among the students present at the meeting. The CSRs then notify the PSC Director, the Department Head, their administrative assistants, and all current students of the election results.

Responsibilities and Duties

The CSRs shall:

- remain apprised of the general academic rights of U of M members (e.g., in the U of M General Calendar) and the program and departmental rights of fellow students (e.g., in the Graduate Study in Psychology handbook and PSC Operations Manual), and be especially familiar with U of M policy on the Responsibilities of Academic Staff with Regard to Students (U of M General Calendar).

- remain apprised of the needs and interests of students regarding any aspect of training (including research and theses; general and specialty practica and supervision; course work and candidacy exams; clinical in-services; and internships) via regular interaction with fellow students (i.e., through monthly student meetings and ongoing contact), communicate these issues to clinical staff, and provide feedback to students thereafter.

\(^{15}\) Clinical Psychology at UM has been an integrative program for many years and no longer has these streams.
 NOTIFY all students within the first two weeks of the position regarding their availability and their preferred means of contact with fellow students (e.g., office hours, phone number, voice mail, electronic mail address).

ATTEND all clinical faculty meetings (generally on the second Tuesday afternoon of every month, in the PSC Conference Room, 169 Dafoe); this includes active participation and voting on matters and policies discussed therein, and communication of relevant information to students (e.g., written summary of meetings).

COLLABORATE with the PSC Director in the compilation of formal student group evaluations of practicum supervisors.

OVERSEE the allocation of the Clinical Student Fund.

PARTICIPATE in other relevant activities (e.g., PSC committees, social events).

**Alternative Positions**

Where possible, each September the CSRs will oversee the election of up to two CSR Alternatives, whose function is to act in the place of the current CSRs should one or both be unavailable to perform any of their responsibilities (e.g., attending a given clinical faculty meeting). In this regard, the Alternatives are subject to the same mandate, terms, responsibilities, and duties of the position as outlined above.

**Policy for Clinical Student Representative Attendance of Clinical Faculty Meetings**

1. Clinical Student Representatives (CSRs), as elected representatives of students in the Clinical Psychology Training Program, will be present in all Clinical Faculty Meetings and Psychological Service Centre Staff Meetings, with the following exceptions:

2. CSRs will absent themselves from end-of-term Practicum Evaluation Meetings and Annual Evaluation Meetings.

3. All clinical students have the right to request that CSRs be removed from the meeting when a personal matter directly relevant to that student is brought up for discussion during a Clinical Faculty Meeting. This policy will be distributed at the beginning of the academic school year to all new students entering the clinical program. If a clinical student does not want CSRs (or a particular CSR) present for discussions when issues that related personally to that student are discussed, this student has the option of informing the PSC Director of this wish. A list of such students will be produced and provided to the CSRs, as well as kept by the PSC Director. CSRs will subsequently absent themselves from that portion of the meeting when informed by the PSC Director that a personal matter related to a particular student on this list is to be discussed.

4. A CSR will excuse himself/herself from the Clinical Faculty meeting when business arises that is perceived by that CSR to create a “conflict of interest” for the CSR. Examples of business leading to such a conflict of interest includes discussion regarding a fellow student about whom the CSR
feels that they may not be impartial or discussion of personal issues regarding the CSR himself or herself (e.g., specialty practicum request from the CSR). The presences of a conflict of interest for one CSR does not determine the presences of a conflict of interest for the second CSR; that is, each CSR must determine if there is a conflict of interest for himself or herself based on the specific circumstances. Thus, when one CSR absents himself or herself, the other CSR does not necessarily have to also absent himself/herself.

**Student-to-Student Tips for Surviving the Clinical Psychology Program**

The following is a tip sheet put together by senior clinical students, to hopefully make things a little smoother for you as you negotiate your way through the clinical program. Please note that things are not written in stone. That is, it is always your responsibility to verify facts, keep abreast of any changes, and gather as much information as you can to make informed decisions. Also, our interpretation of the way things are may or may not match others’ perceptions, so again, check into things. Having said that, we hope that you find our tips helpful, and please feel free to extend some tips of your own to the groups of students who will follow in your path.

**Funding**

There are many different types of funding available to graduate students. A copy of the book *Graduate Fellowships, Scholarships, Bursaries, and Awards*, which lists these sources, is available in the Grad Studies office in University Centre. Some of these scholarships are not awarded because there were no applicants. So, apply, apply, apply!

The **University of Manitoba Graduate Fellowship** is worth noting here as it is a large fellowship awarded to graduate students from all departments in the university. It is $12,000 for master’s students and $16,000 for doctoral students. One can hold this award up to four years over their entire graduate career at the university. You can hold this award a maximum of two years as a master’s student, but not past the second year of master’s studies. You can win this award and hold it up to three years as a doctoral student (as long as you do not exceed four awards total) but not past your fourth year of doctoral work. Information on this fellowship can be obtained from the graduate secretary in the Psychology department. Typically application forms are available around December and due mid-February. Applications are ranked by the department with a formula which includes GPA, research experience, publications, etc. Winners and those put on a waiting list are typically notified in early April.

**Courses**

Not all courses are offered every year, so plan ahead and check the course schedule early. The list for September courses is usually released around May and is available in the psychology general office. Our experience is that the following courses have not been offered every year: *Personality and Intellectual Assessment II (PSYC 7816), Professional Issues (PSYC 7807), Systems (PSYC 7733), and Advanced Therapeutic Interventions (PSYC 7731)*. There may be others, too. A list of the required courses for your MA and PhD is included in the “Graduate Study in Psychology” brochure available from the Graduate
Office in the Psychology Department. In your planning process, if you find a course that you wish to take, but whose schedule has not been set, speak to the faculty member offering the course or speak to the PSC Director during the registration process.

**Practica**

Practica are the experiential part of the clinical program. Clinical students complete general practica at the PSC to start and this usually takes place in your second year in the program. It is expected that you take your first practicum during first term, and your second practicum in second term. In addition to three general practica, students must take at least three additional specialty practica. These are often done off campus. There are endless possibilities for specialty practica. The PSC office has a basic list of options. Talk to other students to find out which ones they have done and any advice they may have to offer. The Administrative Assistant at the PSC keeps a list of specialty practica which have been completed in the past.

General practica usually consist of therapy with four individual clients, a couple or family, and an assessment. Each practicum involves a minimum of 150 “clinical activity” hours. Clinical activity involves at least 50 hours of direct client contact and 25 hours of supervision, with the remaining minimum hours involving writing progress notes, and writing reports. Check with your supervisor regarding number of hours and what you can include. Remember that it is your responsibility to track your hours as they will be required for your internship applications. There are also activities that you can include in your internship application that you may not be able to include in your practicum. EVERY MINUTE COUNTS!

You will be assigned your practicum supervisors no later than the beginning of September, with whom you will then meet to discuss the details of your upcoming practica (i.e., the types of clients you will be seeing, the therapeutic approach that will be emphasized, and expectations of each other), which will be formalized by a Practicum Contract. At the end of the practicum, you will be evaluated on your work by your supervisor using a PERF form that is available to you at the PSC. Another form, with which practicum students can evaluate their supervisors, is completed anonymously. Once four Evaluation of Practicum Supervisor forms have been received for a given supervisor, the data are compiled into a group evaluation. Copies of this group evaluation are given to the supervisor and the PSC Director. A copy is also placed in the supervisor’s faculty personnel file. Copies of all group evaluations are available to students in the Administrative Assistant’s office.

It is important to note that clinical students are not permitted to do any additional practica beyond their first two general practica at the PSC until their Master’s thesis is defended. So the moral is, *get your thesis done*!

**Clinical Students Association**

As a clinical student, you are automatically enrolled as a member of the Clinical Students Association (CSA)! We meet once a month (historically the last Tuesday of the month in room 115 Fletcher Argue in the PSC) to discuss questions/concerns about being a clinical student, provide support and information,
possibly bring in guest speakers, and whatever else you might find interesting and helpful. The meetings are an important way that information pertinent to the clinical program, PSC, and clinical practice in general, can be shared and discussed amongst students. They are led by two Clinical Student Representatives (CSR’s) who are elected into this position by their peers. Each CSR position begins in September and continues for two consecutive years. The positions are filled on alternating years such that at any given time, one of the two CSR’s will already have one year of being a CSR under their belt. Since the CSR’s attend clinical faculty meetings to represent student opinion, CSA meetings are great ways to take in information relevant to the program, as well as share your opinion with the CSR’s and other students. So come out and get to know your fellow clinical students. It’s your Association - be a part of it!

Socialize

Probably the best advice in getting through the program is to meet and talk with other fellow students. It may be reassuring and comforting to hear about similar experiences or concerns from students in your same year. Also, you may find it very helpful to talk to or seek advice from those who are ahead in the program – their own experiences could shed some light. As you know or will soon realize, graduate school is busy and it can be overwhelming at times, but that does not mean you have to face it alone...So the next time you bump into a clinical student at the PSC, in the hall of Duff Roblin, or at a CSA meeting, don’t be afraid to strike up a conversation. You’ll be surprised at what other “survival tips” they may have to share.
Appendices
Appendix 1

PSC Guidelines for De-identifying Personal Health Information for Electronic Transmission

At times students and their supervisors may find it necessary to transmit client information in electronic form to enable viewing, editing, etc. The Personal Health Information Act requires the protection of personal health information throughout its collection, storage, use, disclosure, and destruction. In order to ensure compliance with the Act and to protect the confidentiality of the information we possess, only de-identified PSC client data may be saved, stored, or shared in electronic form, and only then with additional safeguards, such as password protection or encryption. Any such data should be deleted as soon as it has fulfilled its intended purpose.

In order that a reasonable degree of protection is provided when client information is transmitted, at a minimum each of the following identifiers of the individual or of relatives, employers, or household members of the individual must be removed from the client information prior to transmission:

1. Names
2. All elements of addresses and locations
3. All elements of dates directly related to an individual, including birth date and dates of service
4. All uniquely identifying personal information numbers, including Manitoba Health registration and personal health ID, SIN, UM student ID, or any similar identifiers
5. Phone numbers, fax numbers, e-mail addresses, IP address numbers or similar identifiers
6. Photographic images or comparable images
7. Any other unique identifying number, characteristic, or code
8. Any unique contextual information that could be used to identify the client

If it is not possible to de-identify the client information according to these guidelines, then electronic transmission poses an unacceptable risk to the privacy of the client and an alternative method of sharing the information must be employed (e.g., hard copy review at the PSC).

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17 These guidelines pertain to information that is sent via e-mail or saved to a portable storage device such as a flash drive or laptop. The use of cloud-based storage systems, such as DropBox, even if only accessed by yourself, is expressly prohibited.

If you are in doubt about whether client information has been properly de-identified, you should consult with the Director of the PSC before transmitting the information. Additional information about your obligations under the Personal Health Information Act is available from the UM Access and Privacy Office, 233 Dafoe, 474-9462 or fippa@umanitoba.ca. See the link below for more details:

Appendix 2

WRHA Practicum Procedure Outline

All professional psychology training involving patients of WRHA and supervisors with academic and/or hospital appointments in the Department of Clinical Health Psychology fall under these guidelines. This outline is an amendment to the document entitled Clinical Practicum Training Policy & Application Outline for Supervisors (January 28, 2008), approved by the Clinical Health Psychology Training Committee on February 2, 2009.

It is recommended that the process for submitting a Practicum Request begin two to three months prior to the anticipated start date.

Requirements

1. Student must be enrolled in the Clinical Psychology PhD program (no students from a terminal master’s program will be accepted).

2. Approved for course credit by student’s graduate program.

3. Professional liability insurance. Training Committee requires written documentation that student is covered by home university insurance program, which includes professional and malpractice liability, or CPA/CPAP sponsored Professional Liability Insurance. In the case of coverage by the home university insurance program, a letter confirming this coverage is normally submitted with the practicum approval by the home program.

4. Sufficient coursework/clinical skills to ensure competence required to meet practicum objectives (i.e. can take students early in graduate school if judged by clinical supervisor to be sufficiently prepared for level of supervision available and clinical demands). Normally students enrol in a WRHA practica as an advanced or speciality practica.

Initial Enquiry

1. Student contacts potential clinical supervisor or Practicum Coordinator (Associate Training Director). Practicum Coordinator may directly enquire about potential supervisors’ interest/availability or circulate request to department members. When a prospective practicum has been found, the student should discuss this with their home program and obtain permission to proceed further (Note: acceptance by a WRHA supervisor is not sufficient for a practicum to proceed, the home program must be aware of and approve the proposed training plan as well).

2. The application then proceeds by the student obtaining the following:

   a. Letter of Intent or Practicum Proposal (many supervisors can provide a sample). This is essentially a contract between the student and practicum supervisor about their mutual responsibilities and the criteria for successfully completing the practicum.

   b. Student’s CV;
c. Graduate Transcripts. An e-copy of the student’s transcript is sufficient;
d. Criminal records check;
e. Child abuse registry check (the CRC and CAR can take some time and should be started as early as possible; normally the results of previous checks the student might have had done will be accepted, if less the two years old);
f. PHIA orientation (normally students have had this orientation already);
g. Confirmation of professional liability insurance (proof of policy or letter from graduate program Training Director); and
h. Confirmation of a completed Practicum Proposal with signatures from clinical supervisor and graduate program Training Director.

3. All of the above is submitted to the Practicum Coordinator:
   Hal Wallbridge, PhD., C.Psych.
   M4042, St. Boniface General Hospital
   409 Tache Avenue
   Winnipeg, MB R2H 2A6
   e-mail: hwallbri@sbgh.mb.ca

4. Practicum Coordinator reviews above and:
   a. Gives initial approval based on review of above and forwards all material to Erin Prodanuk (secretary at St. Boniface Hospital who coordinates this, eprodanuk@sbgh.mb.ca)
      OR;
   b. Consults with Training Director and/or Training Committee as required.

5. Final approval is obtained when the practicum proposal has the signatures of (1) the student, (2) the supervisor, (3) the practicum coordinator of the home program (normally the Director of the PSC), and (4) the Training Director of the WRHA Department of Clinical Health Psychology (a responsibility normally designated to the Practicum Coordinator). Students can not see patients until this final approval is obtained. Normally, notification of final approval is sent via e-mail to the parties involved by Erin Prodanuk. Erin will also notify Carrie Lionberg (Appointments Committee) and Maureen Barbeau (for clinician number) once the final approval has been made.

(updated July 5, 2013 by H. Wallbridge)
Appendix 3

It is advised that both cameras and laptops be plugged in while in use to avoid power failure.

**Sony Handycam Tutorial**

**Recording**

1. To turn the Sony camera on, attach the battery and open the side screen. If the camera does not respond, please connect the camera to the battery charging unit.

2. The camera may prompt you to open the lens cover. There is a simple switch located on the right hand side of the lens.

3. Located at the back of the camera is a red START/STOP button. Pressing this once will begin recording. Pressing this a second time will stop recording.

**Migrating Videos to USB or Desktop**

173 Dafoe Building is the designated area for video transfer and it is encouraged that videos be copied to the desktop in your designated folder. There are also two laptops available for transferring videos to USB ONLY. Do not save your videos to the laptops.

1. Turn the computer or laptop on.

2. Connect the USB cable from your camera bag to both the camera and computer.

3. The camera screen will prompt the transfer. Navigating is as simple as touching the screen. Choose CONNECT with the memory card image next to it.

4. Open MY COMPUTER.

5. Select REMOVEABLE DISK. If REMOVEABLE DISK has not appeared, refresh the window.


7. Select the strangely named folder to find your videos.

8. Save your videos to your file on the desktop or your USB and rename them with your client’s initials and date of session.

9. View files in Windows Media Player by double-clicking them.

**Deleting**

As with all USB connections, make sure it is safe to eject the camera from the computer.

1. Tap the screen on the camera.

2. Select the PLAY button in the lower left hand corner.
3. Select MENU in the upper left hand corner.

4. Select DELETE from the menu.

5. Select DELETE with the film icon next to it.

6. Choose DELETE with the film icon next to it again.

7. The left hand side allows you to scroll through videos. Select the videos you wish to delete by tapping them until a red checkmark is highlighted.

8. Press OK to delete and verify by pressing YES.

9. If all videos can be deleted from the camera at once, choose the DELETE ALL icon when prompted instead.

**Note: It is recommended that you delete your videos from the camera promptly to ensure privacy for your clients and to preserve space.

Hitachi Camera Tutorial

Recording

1. To turn the Hitachi camera on, attached the battery.

2. At the back of the camera is a dial switch. To turn the Hitachi camera on, press the gray button in while turning the dial to HDD. Do not save to any other setting.

3. Within the dial is a button with a red circle. This is the RECORD button. Press the RECORD button once to begin recording and a second time to stop recording.

Migrating Video to USB or Desktop

173 Dafoe Building is the designated area for video transfer and it is encouraged that videos be copied to the desktop in your designated folder. There are also two laptops available for transferring videos to USB ONLY. Do not save your videos to the laptops.

1. Turn the computer or laptop on.

2. Connect the USB cable from your camera bag to both the camera and computer.

3. Turn the camera on.

4. Open HITACHI IMAGE MIXER 3 on the desktop

5. Select EDIT VIDEO.

6. Select EDIT NEW MOVIE. NOTE: Do not change the settings.
7. Select HITACHI DVDCAM (HDD).
8. Select IMPORT.
9. Select your video in the CHAPTER box.
10. Specify the destination for the video (ie. Your USB or folder).
11. Select IMPORT. The import process will take a while.
12. The file is then saved to the specified destination.
13. Turn off the camera and eject it safely from the USB port before shutting the computer down.

**Deleting**

1. Select the DISC NAVIGATION button on the left hand side of the camera.
2. Select MENU from the left hand side of the camera.
3. Using the directional buttons on the left hand side of the camera, select the video you wish to delete.
4. Using the directional buttons on the left hand side of the camera, select EDIT.
5. Select DELETE.
6. Press PLAY to delete and YES to confirm.

*Note: It is the student’s responsibility to delete videos from the camera to preserve clients’ privacy and save space.*
Appendix 4

Intake Interview Outline

Revised July, 1997

The primary purposes of the intake interview are to assess clinical status and to provide treatment recommendations. The intake report summarizes these findings and recommendations. All information in the report should be directly relevant to the request for therapy. The clinical formulation and treatment recommendations take into consideration the clinical problem(s), the client’s personality and life situation, and the reasons for seeking psychotherapy. The report is written for other professionals such as a therapist who is deciding whether to see the client for therapy. At the end of therapy, the intake report is also useful for assessing change since the intake assessment. In addition, clients may request access to their files and read the report.

Depending on the client, an intake report is two or three pages in length, although the ideal is said to be a page and a half. Be sure that the essential information is contained in the introduction, clinical formulation and treatment recommendations as these may be the only sections that are read. In writing the report, strive to strike a balance between presenting a clinical formulation and conveying the uniqueness of this particular client. Avoid psychological jargon and excessive detail. Write in a formal and professional style, taking care to avoid colloquialisms and contractions (e.g., “don’t”). Keep in mind the limitations to the validity of the client’s self-report and your own inferences about the client. Consequently, unless you know for certain that something is a fact, your writing contains qualifying phrases such as “the client reported that ...” or “the client appears to be ...” Rather than saying that something did happen or the client is a certain way.

The following presents an organizing framework for writing an intake report with the types of information that need to be considered for each section of the report. This framework is one of many, as professions, agencies, and professionals vary in the expected structure of an intake report. Be sure to consult in advance (i.e., before the interview) with your supervisor about writing the intake report. For certain clients, a different organization may be better suited to synthesizing information obtained from the assessment. The following outline is for a report of the intake assessment of an adult individual.
Appendix 5

University of Manitoba Psychological Services Centre
Intake Interview

Name: ____________________________  Age: ______________

Intake Therapist: ____________________  Supervisor: ____________________

Presenting Problem

Description:________________________________________________________
________________________________________________________
________________________________________________________

When did problems start?

________________________________________________________
________________________________________________________
________________________________________________________

Antecedents/triggers? _____________________________________________

________________________________________________________

Course of problem (frequency, intensity, duration):________________________

________________________________________________________

If problems ongoing, what brought you in now?

________________________________________________________

Potentially harmful behaviour (e.g., suicidal ideation, substance misuse)?

________________________________________________________

Treatment History

Nonprofessional attempts to cope with problems:

________________________________________________________

________________________________________________________
Current treatments/therapies:
_________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________

Previous treatment:  
_________________________________________________________________________________________________________________________________

Efficacy of past treatments:  
_________________________________________________________________________________________________________________________________

Current and previous diagnoses:  
_________________________________________________________________________________________________________________________________

Relevant Medical History

Physical health concerns:  
_________________________________________________________________________________________________________________________________

Current medications (name, dose, and reason):  
_________________________________________________________________________________________________________________________________

Sleep quality:  
_________________________________________________________________________________________________________________________________

Sexual functioning:  
_________________________________________________________________________________________________________________________________

Family & Friends

Marital Status:  
_________________________________________________________________________________________________________________________________

Children:  
_________________________________________________________________________________________________________________________________

Family hx of mental illness:  
_________________________________________________________________________________________________________________________________
Family situation growing up:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Current family situation: _______________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Quality of social network and interpersonal relationships:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**Education / Occupation**

Educational history: _________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Occupation: ________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Economic stability: ________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**Treatment Motivation**

Approach factors: _________________________________________________________________

Avoidance factors: ________________________________________________________________

**Questionnaires**

**Psychopathology:**
1. DASS-21 to assess stress, anxiety, and depression

**Relationship to internal experiences:**
2. FFMQ to assess mindfulness
3. Thought-Action Fusion Scale to assess fusion with internal experience
4. Affective Control Scale to measure “fear of fear” or anxiety sensitivity as well as sensitivity to depression, anger, and positive affect

**Experiential avoidance:**
5. Acceptance and Action Questionnaire

**Values**
6. Valued Living Questionnaire
Appendix 6

Interviewing Parents

A well-conducted parental interview will serve to establish rapport and a positive working relationship with the parents. It can lay the groundwork for parental efforts to be a part of the intervention process.

It is important to know the parent’s marital status and whether there are any custody issues involved.

Tell me about your child...

Presenting Problem

Describe your child’s current difficulties: ________________________________

________________________________________________________________________

How long has this problem been of concern to you? ________________________

________________________________________________________________________

When was the problem first noticed? _________________________________

________________________________________________________________________

What seems to help the problem? _________________________________

________________________________________________________________________

What makes the problem worse? _________________________________

________________________________________________________________________

Have you noticed changes in your child’s abilities? ________________________

________________________________________________________________________

Have you noticed changes in your child’s behaviour? ________________________

________________________________________________________________________
Has your child received evaluation or treatment for the current problem? ____________________________

Has your child been treated for a medical illness? _____________________________________________

Is your child on medication at this time? ____________________________________________________

Has your child had a recent medical check-up? ______________________________________________

Are there concerns about physical sexual or emotional abuse? _________________________________

Educational History

At what age did your child begin kindergarten? ________________________________________________

Did your child exhibit separation anxiety? ____________________________________________________

Current grade? __________________________________________________________________________

Has your child experienced difficulties at school:

   Academically? __________________________________________________________________________

   Socially? ______________________________________________________________________________

   Behaviourally? __________________________________________________________________________

Has your child missed a lot of school? ______________________________________________________

Does your child have friends in school? ______________________________________________________

Does your child get invited to birthday parties? ______________________________________________

What extra-curricular activities is your child involved in? _____________________________________
Developmental History

Pregnancy

Any problems during the pregnancy? ______________________________________
______________________________________________________________________

Any complications during the delivery? ____________________________________
______________________________________________________________________

Was your child premature? ______________________________________________

Infancy

Child’s birth weight? _____________________________________________________

Any birth defects? _______________________________________________________

Any problems with feeding or sleeping? ____________________________________
______________________________________________________________________

First Years

Developmental milestones met at expected times? ___________________________
______________________________________________________________________

Did you child enjoy cuddling? _____________________________________________

Head banging? _________________________________________________________
______________________________________________________________________

Constantly into everything? ______________________________________________
______________________________________________________________________

Were there any problems in the growth and development of your child?________
Child’s Medical History

Has your child had any serious illnesses? ______________________________________
__________________________________________________________________________

Has your child been hospitalized? __________________________________________
__________________________________________________________________________

Has your child had any operations? _________________________________________
__________________________________________________________________________

Has your child had any accidents? __________________________________________
__________________________________________________________________________

Are your child’s immunizations up to date? __________________________________
__________________________________________________________________________

Does your child have any allergies? _________________________________________
__________________________________________________________________________

Family’s Medical History

Do any family members have any illnesses? __________________________________
__________________________________________________________________________

Have there been any recent deaths in the family? _____________________________
__________________________________________________________________________

Grandparent’s health? _____________________________________________________
__________________________________________________________________________

Other Information
**Child’s Activities**

What are your child’s favorite activities? ______________________________________
__________________________________________________________________________

What activities does your child like least? ________________________________
__________________________________________________________________________

What time does your child usually go to bed on weekdays? Weekends? ______
__________________________________________________________________________

Any pets? Names of pets? ________________________________________________
__________________________________________________________________________

What does your child call their private parts? ________________________________
__________________________________________________________________________

**Disciplinary Techniques**

What disciplinary techniques do you usually use when your child behaves inappropriately?
__________________________________________________________________________
__________________________________________________________________________

What are some of the inappropriate things your child does that require discipline? _____
__________________________________________________________________________
__________________________________________________________________________

**Family Activities**

What type of activities does your child participate in as a family? ________________
__________________________________________________________________________

What do you enjoy doing with your child? ________________________________
__________________________________________________________________________

What are your child’s assets or strengths? ________________________________
__________________________________________________________________________
Is there any other information that you think may help us in working with your child? ___

______________________________________________________________________

______________________________________________________________________

What prompted you to seek help at this time? _________________________________

______________________________________________________________________

Does your family celebrate Christmas? _________________________________

What do you do to celebrate? _________________________________

There undoubtedly will be additional areas to examine dependent upon the presenting problem.
Appendix 7

SAMPLE

University of Manitoba Psychological Service Centre
Intake Report

Name: John Doe
PSC File Number: XXXX
Date of Birth/Age: November 25, 1965; 42 years old
Gender: Male
Student Therapist: Nervous Nelly
Supervised by: Sigmund Ellis, Ph.D., C. Psych.
Date of Intake: March 1, 201X
Date of Report: Oct 25, 201X

Reason for Referral:
Mr. John Doe was referred to the Psychological Service Centre (PSC) by his family physician, Dr. Lu, to help him cope with significant social anxiety.

Background Information
Mr. Doe is a 42-year-old Asian male who has been married to his wife for 22 years; the couple has two children, aged 6 and 8. Mr. Doe and his wife immigrated to Winnipeg 8 years ago because they believed Canada would be a better place to raise their children. He reports that the move has been both stressful but also a positive one for his family. Mr. Doe has a grade 9 education and works in construction. His wife has a small but close network of friends, but Mr. Doe rarely socializes outside of his family and his interactions with colleagues at work. He is physically healthy and the only prescription medication he is taking is for his anxiety.

Presenting Problem:
Mr. Doe reported a long history of intense anxiety in social situations, dating back for as long as he can remember. While growing up, Mr. Doe’s mother was highly critical of him for being overweight and for not making a good impression on others when they were in social situations. Mr. Doe reported feeling constantly anxious at school and, as a result, dropped out in grade 10. He said that he has always been a loner, but that his anxiety in social situations has been worse since immigrating to Canada, and has become especially bad in the last few years as his children have become increasingly involved in school and sporting activities. He stated that the reason for seeking help at the PSC is that he is afraid his anxiety is having an increasingly negative impact on his family and work.
The only therapy Mr. Doe has received for his social anxiety is pharmacotherapy. His family physician, Dr. Lu, started him on Paxil (40 mg/day) four months ago, which he has found modestly helpful. Mr. Doe reported that he copes with his anxiety by avoiding social situations, and when that isn’t possible, by trying to distract himself or by using deep breathing, which he does not find that helpful. He reported that he is highly motivated to begin and continue with talk therapy and that his primary goal is to find social situations more relaxing and enjoyable. The only potential barrier he saw to engaging in treatment was the long drive to the PSC from his work and home in the North end of the city.

Clinical Observations

Mr. Doe appeared quite anxious throughout the intake interview, fidgeting constantly and making relatively little eye contact with the student therapist and her supervisor. Mr. Doe also spoke with a heavy Asian accent, although his English is good and he had no trouble communicating about his current and past difficulties. Throughout the interview Mr. Doe displayed good insight and psychological mindedness related to his anxiety, and he appeared genuinely invested in starting treatment.

CBT Working Hypothesis:

According to cognitive and behavioral theory, Mr. Doe’s anxiety is due to a combination of negative thoughts and behaviors. He experiences numerous negative thoughts about himself (e.g., there’s something wrong with me), other people (e.g., he must be wondering what’s taking me so long”), and the future (e.g., I’ll never be able to go out in public for long periods of time”). As a result of his negative thinking and resulting anxiety, Mr. Doe responds behaviorally by avoiding social situations whenever possible. This behavioral avoidance removes the possibility of embarrassing social interactions, but it also eliminates any possibility for successful socialization and enhanced social support, thereby maintaining the problem.

ABBT Working Hypothesis (provided only as an example of another formulation):

According to mindfulness and acceptance based behavioural theory, Mr. Doe over identifies with his anxious thoughts, which has led him to define himself as “socially anxious.” Mr. Doe views anxiety as unnatural and bad and he engages in unsuccessful attempts to eliminate it. Mr. Doe’s negative relationship with his anxiety has led to experiential avoidance where he avoids social situations that may increase his anxiety or endures social gatherings using distraction without being fully present. Finally, Mr. Doe’s negative relationship with his anxiety and his experiential avoidance has led him to fail to engage in valued actions. He values and loves his wife and children very much, but often refuses to engage in social activities that they enjoy because of his anxiety. This avoidance leads him to feel guilty and also serves to increase his anxiety.

Strengths and Assets:

Mr. Doe has stable life circumstances, a strong and supportive marital relationship, and he is motivated and committed to change due to internal (e.g., anxiety) and external (e.g., wants to spend more time with his family) reasons. He is also very psychologically minded.
Treatment Plan:

Goals:
1) Reduce the frequency of avoidance behavior and increase the frequency of social outings with his wife, children, and friends.
2) Begin attending occasional Friday social outings with his work colleagues
3) Enhance his self-confidence.

Modality: Weekly individual cognitive behavior therapy / acceptance based behavior therapy

CBT Interventions:
1) Exposure-based therapy involving gradual exposure to feared situations.
2) Cognitive restructuring to challenge negative automatic thoughts about himself and others in social situations.
3) Social skills training, including role-playing to initiate social activities.

ABBT Interventions:
1) Mindfulness meditation to enhance Mr. Doe’s ability to be present during anxiety-provoking situations and to be more accepting and less judgmental of his experiences.
2) Behavioral interventions to decrease experiential avoidance
3) Efforts to make Mr. Doe more aware of his values and to live life according to them

Adjunct Therapies: Continue with medication as prescribed by family doctor.

Obstacles: Very few people in Mr. Doe’s life, apart from his family, are aware of his social anxiety. He also has a very limited social support network, with his wife being his only significant source of emotional support.

____________________________
Nervous Nelly, M.A.
Student Therapist

____________________________
Sigmund Ellis, PhD, C.Psych
Supervising Psychologist

CM/2013
Appendix 8

Adult Learning Questionnaire

FORM A

Name: _________________________________  Intake date: _______________________

GENERAL

1. Reason for referral

2. Please list all part- and full-time employment experiences you have had (starting with most recent):

3. Vocational accommodations: Please indicate any learning accommodations (special arrangements) at work in the past:

SCHOOL HISTORY

ELEMENTARY SCHOOL (K – 8)

1. Where did you go to elementary school (and in what language): __________________________
   ______________________________________________________________________________
2. At what age did you start school? __________________________________________________

3. Did you have any problems learning in school? If YES, describe your difficulties: __________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

HIGH SCHOOL (9-13)

4. Where did you go to high school (and in what language): _______________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

5. How did you do in high school? PLEASE LIST GRADE AVERAGES FOR EACH YEAR:

   Grade 9 _______________    Grade 10 ______________  Grade 11 ______________
   Grade 12 _______________    Grade 13 ________________

6. Please list all subjects and the mark you received in each course of your last year of high school?
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

7. What were your best subjects throughout high school?
______________________________________________________________________________
______________________________________________________________________________

8. What were your worst subjects? ___________________________________________________
______________________________________________________________________________

9. Did you ever receive any help (remediation) in elementary or high school? _______
   If YES, when? __________________________________________________________________
   If YES, what type of help did you get? _____________________________________________
10. Please list any grades or courses failed _______________________________________
____________________________________________________________________________

12. Did you miss a lot of school? If so, when and why?
____________________________________________________________________________
____________________________________________________________________________

POST SECONDARY EDUCATION

12. Please list any post-secondary courses you have taken or are taking and the marks received:
____________________________________________________________________________
____________________________________________________________________________

13. Please list any problems you are having in school now? __________________________
____________________________________________________________________________
____________________________________________________________________________

14. How have you tried to reduce these difficulties? How successful were these efforts?
____________________________________________________________________________
____________________________________________________________________________

ACADEMICS

1. Reading

Do you think your reading speed is slow, fast, or average? ____________________________

Do you misread words? _________ How often? ________________________________________

Do you have problems understanding what you read? ________________________________

Do you lose your place when reading or use your finger/marker to help keep your place? _________

How long can you sit and read at one time? _________________________________________

2. Writing

Do you have problems expressing yourself in writing? _________________________________

Do you have difficulty organizing your writing? ______________________________________
Do you ever miswrite words? __________________________________________________________

Do you ever forget to write word endings, verbs, etc.? _________________________________

Do you have problems with grammar? ________________________________________________

Do you have problems spelling? ______________________________________________________

3. Speaking

Do you have difficulties expressing yourself verbally? _________________________________

Do you prefer written or verbal expression? ____________________________________________

Do you ever mispronounce words (give examples)? ______________________________________

What languages do you speak? ______________________________________________________

What was the first language that you learned to speak at home? __________________________

If English is NOT your first language, at what age did you learn English? ________________

Describe any problems you had in learning English _______________________________________

Describe any learning problems you had (have) in non-English language(s) ________________

4. Listening

Do you ever mishear words, or mix up words that sound the same? ______________________

If YES, please give examples: _________________________________________________________

Do you have problems listening and writing at the same time? ___________________________

5. Math

How are you at Arithmetic? __________________________________________________________
Do you know your times tables? ______________________________________________________

Do you ever misread/miswrite numbers? _________________________________________________

Do you have trouble making change at stores? ___________________________________________

6. Memory

Did you have problems with memory in school? __________________________________________

In everyday life? ___________________________________________________________________

What is your memory like for names? _________________________________________________

Memory for faces? __________________________________________________________________

7. Other

Are you comfortable using a computer? (if not, why?)_______________________________________

____________________________________________________________________________________

Describe your usual approach to studying, including time spent: _______________________________

____________________________________________________________________________________

ORGANIZATION AND TIME MANAGEMENT

How well do you organize and budget your time? _________________________________

____________________________________________________________________________________

SPATIAL SKILLS

1. Do you frequently get lost? __________________________________________________________________

2. Do you have a good sense of direction? __________________________________________________________________

3. Are you good at picturing something in your mind? __________________________________________________________________
4. Can you understand maps, charts, diagrams? ____________________________________________

5. Do you have any problems with fine motor co-ordination (e.g., treading a needle, using keys/tools)?
   _______________________________________________________________________________

6. What is your handwriting like (i.e., neat/sloppy, fast/slow)? ________________________________

**ATTENTION AND CONCENTRATION**

1. Do you have any problems paying attention to something or concentrating? _________________
   
   If YES, please explain (give examples) and go on to the following questions. _________________
   
   _______________________________________________________________________________
   
   _______________________________________________________________________________

2. How old were you when problems with attention began? ________________________________

3. Have you ever been diagnosed with Attention Deficit Disorder? __________________________
   
   When? ________________ By whom? ________________________________________________

4. Have you ever taken medication(s) for attention problems? (specify) ________________________

**HYPERACTIVITY AND IMPULSIVITY**

1. Do you or others thing that you are hyperactive at present? ________________________________
   
   What about as a child? _____________________________________________________________

2. Do you have problems being impulsive (e.g., acting or making decisions too quickly, being
   interrupting, being impatient while waiting? ____________________________________________
   
   What about as a child? _____________________________________________________________

3. Have you been in trouble with the law? _______________________________________________

**MEDICAL HISTORY**

1. To the best of your knowledge, did your mother experience any problems during her pregnancy with
   you (e.g., accident, illness)? ________________________________________________________
If YES, explain ____________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

2. What did you weigh at birth? ________________________________________________

3. As a child, did you ever experience anything other than the normal childhood illnesses (e.g., did you ever have seizures, very high fever for a long time, polio, etc.)? __________________________
   If YES, what? _____________________________________________________________

4. Have you ever had a head injury where you hit your head and lost consciousness? _______________
   If YES, when and how? ______________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

5. List any allergies or medical conditions from which you presently suffer: ___________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

6. If you are taking medication(s), please give the name(s), dosage, and reason for taking: _______
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

7. Do you have any vision problems? _______________________________________________
   Hearing problems? ___________________________________________________________
   If YES, do you need to use corrective lenses or a hearing aid? _____________________

PERSONAL AND SOCIAL

1. Describe use of alcohol and “street” drugs: _______________________________________
   Has your pattern of drinking or drug use changed? _____ How? ____________________
   ___________________________________________
2. Have you ever experienced emotional or psychological difficulties (e.g., depression, anxiety)?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Did you get treatment?

________________________________________________________________________________

3. Are you having any difficulties with stress, anxiety, depression, or other problem(s) now?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

4. Do you have any difficulties with peer and/or intimate relationships?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

5. Do you feel that you're learning problems have an impact on your relationships (i.e., understanding the use of humour, sarcasm, social convention)?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

6. What are your goals for the future?

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________
FAMILY INFORMATION

1. Parents’ occupations: _____________________________________________________________

2. Parents’ education: ______________________________________________________________

3. Brothers and sisters:
   Age: _________ Education: _______________________________________________________
   Age: _________ Education: _______________________________________________________
   Age: _________ Education: _______________________________________________________
   Age: _________ Education: _______________________________________________________
   Age: _________ Education: _______________________________________________________

4. Specify if anybody in your family ever had problems with schoolwork (e.g., reading, writing, spelling, arithmetic, etc.)____________________________________________________________
   Did they ever receive any special help? ____________________________________________

5. Has anybody in your family ever experienced emotional or psychological difficulties (e.g., depression, anxiety) which required treatment? ________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

6. How would you describe growing up in your family? _________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

7. What are your relationships like with your family now? ______________________________
   ____________________________________________________________________________
   ____________________________________________________________________________
Appendix 9

Outline for Psychological Assessment Reports


Style and presentation of the Assessment/Consultation Report

The general tone of the report should seek a balance between a crisp, professional style and a readable, informative approach. In particular, the report should be clear and concise. It should contain no more nor any less information than is essential to a complete understanding of the intake problem and assessment findings.

In writing the report it is important to consider who will be reading it. Psychological reports are used by different groups of individuals who have varying degrees of familiarity with the knowledge base and interpretive practices underlying psychological assessments. Broadly speaking, three distinct classes of users may be distinguished by their typical familiarity with the capacity to interpret assessment reports: Experts, allied professionals, and lay persons. Expert users include clinical psychologists who have a thorough grasp of the principles and procedures involved in your assessment. Colleagues in related disciplines such as psychiatry, medicine, nursing, counselling, social work, occupational therapy, education and law may have a general familiarity with the purpose and function of the psychological assessment report, but will vary in the amount of exposure they have had to them. Lay persons include all those for whom one should not assume any prior knowledge or familiarity with psychological assessments. This includes many groups such as police officers, insurance claims officers, and bureaucrats, but the most important member is your client (and his or her family/guardian).

In view of the potentially large range in background familiarity with psychological assessment of your audience, your report should be written with both the “expert” and “novice” users in mind. From the point of view of the expert, your report should be professional, display competence and expertise, and provide sufficient information about the evidence which served as the bases of your conclusions and recommendations (i.e., observations, and test performance) to allow an informed judgement about the latter’s reliability and validity. (Raw test materials should be kept on file – not in the report – for later examination by qualified psychologists only.) From the perspective of the layperson, particularly your client, the report should be clear, readable and should not contain material or language which lends itself to offensive or damaging interpretations. Remember that our client has the legal and moral right to read his or her report at any time. It is best therefore, to assume your client will read the report, and write it in a way you are prepared to justify to him or her. This does not mean that you should avoid drawing difficult or painful conclusions if warranted, but it does require you to present such information with due regard to your client’s dignity and well-being as a person.

As psychological reports are most frequently requested by non-psychologists, it is best to keep technical details and jargon to a minimum. For instance, in reporting an individual’s performance on an intelligence test it is good practice to report the range rather than the test score (e.g., “average range of
intelligence” rather than “I.Q. Of 97”). Providing feedback in the form of a range appropriately reflects the measurement error inherent in all tests.

Components of the Psychological Assessment Report

Below I have presented one way of organizing the information typically contained in a psychological assessment report. I have found these headings and way of presenting the information to be flexible enough to cover most assessment situations. However, there is nothing inherently correct or incorrect about this or any other way of organizing a report, so long as all the pertinent information is presented clearly and in some kind of logical arrangement. Although you may find it useful to rely on a “template” such as this at first, in time you will find it necessary and useful to alter it to suit the needs of particular assessments as well as your own style. Feel free therefore to use this organizational format as is or modify it according to the situation. NB. Before writing your report consult with your supervisor about preferences he or she may have about how the report should be organized. Do not assume that he or she will find this model acceptable just because it appears here!

In addition to describing the general purpose and types of information to be provided in each section, I have also sprinkled in examples from actual reports throughout. Again, a word of caution is in order. It is often tempting to simply “lift” the organization of a paragraph, or a particular turn of phrase from one report to another. However, if such “borrowing” is excessive it is unlikely to provide the best way of representing the uniqueness of your client’s problems and resources.

Finally, a word about how to best use this outline. In comparing this outline with the reports that I developed it from, I noticed two important differences. First this outline is much more comprehensive than any of the individual reports. Therefore, you should not feel it necessary to include information on all of the categories or subcategories within each section. This is an area where you will need to exercise your judgement as to whether including information about a given issue is really necessary to aid in the reader’s understanding. Secondly, the categories are presented in this outline as a series of discrete entities. However, in the actual reports they were derived from they frequently are found mingling together in the same paragraphs and sentences. Remember that the particular information you discover in your assessment as well as considerations of thematic unity and narrative flow should dictate the arrangement of the information, not this (or any other) arbitrary arrangement of categories.

Section I: Institutional/Professional identification and title of report

- Name of institution/clinic
- Address and phone #
- Title of report (e.g. “Psychological Assessment” or “Psychological Consultation Report”)
Section II: Identifying Data

Name: Examinee:

Sex: Assessment Date:

Birthday: Referred by:

Age: Chart #:

School: Date of Report:

Grade:

Section III: Reason for intake

Briefly indicate who initiated the intake, for an assessment/consultation which problems, and what the expectation or understanding is about the purpose of the assessment/consultation.

Examples:

1. Mr. B, a 66 year old male who suffered a right hemisphere cerebrovascular accident (CVA) in October 1992, was referred by Dr. L. for neuropsychological assessment of cognitive/perceptual deficits as well as counselling to adjust his expectations of complete recovery.

2. Ms. R, a 35 year old female with no previous psychiatric history was admitted to the inpatient unit of ... with complaints of suicidal impulses, paranoid ideation, and depression. Dr. C referred her for psychological assessment to aid in clarifying the diagnosis.

3. V. is a 12 year old boy who is having significant problems with reading, writing, and arithmetic. V was referred for a cognitive assessment in order to ascertain his current level of academic achievement in these areas. In particular, V’s school principal, Mrs. F, requested the assessment in order to help determine whether his difficulties stemmed from a specific attention or memory deficit, or from emotional difficulties associated with the recent divorce of his parents.

Section IV: Background Information

The purpose here is to summarize relevant information about the client’s life (past and present), that will provide the necessary context for a complete understanding of the assessment findings. In presenting this information it may be useful to note the source of the information (e.g., “the client’s mother reported that ...”) and to distinguish assertions of fact from inferences (e.g., “in view of her documented history of childhood abuse, one might hypothesize that this will place her at risk in intimate relationships”). Also, it is usually more effective to first present evidence then draw a conclusion, rather
than to merely present a conclusion. Background information may include, but need not be limited to, the following:

1. History of intake problem(s):
   - Time and circumstances of origin/discovery of problem
   - Symptom history and development
   - Chronicity of problem (e.g., constant vs. intermittent)
   - Factors associated with exacerbation/remission of problem

2. History or treatment for intake problems:
   - Nature, amount, timing, and duration of treatment interventions (e.g., “weekly one-hour sessions of insight-oriented psychotherapy for 18 months between June 1990 and January 1992;” “took X mg. of Fluoxetine daily between February and August 1989”)
   - Outcome of interventions (e.g., no improvement, partial success)

3. History and treatment of related problems:
   - Relevant Medical history (e.g., “Two months before her current episode of depression Mrs. A. discovered she was pregnant”)
   - Substance abuse/dependence (list types, as well as typical amount and frequency of usage)
   - Secondary reactions to intake problem (e.g., dysphoria following development of anxiety disorder)

4. Current/recent life situation (note whether each component acts as a stressor or coping resource):
   - Household members and their relationship to client
   - Social network (note breadth and depth/intimacy)
   - Employment/Occupational status
   - Financial situation
   - Noteworthy interests or pursuits (e.g., “Mr. K. is an amateur pilot, but since his depression began ...”)

5. Relevant life history (may alternatively be placed in assessment findings):
   - Summarize physical, emotional, and social development
   - Noteworthy or exemplary life history episodes (e.g., trauma, achievement, loss)
Section V: Current Psychological Functioning

a. Assessment Components

This is simply a point form list containing any or all of the following:

- Chart/File review
- Classroom (or other) observation
- Interviews with client, family, teacher, parents, spouse, friends, colleagues, others.
- Tests administered (include full name followed by abbreviation in parentheses)

b. General Observations

The general purpose of this section is to give the reader a feel for the individual’s presentation and demeanour during the assessment. Be sure to note contradictions between the client’s self-reports and other observations or reports. Also indicate any general characteristics of the individual or situation which might have influenced the outcome of the assessment should be noted here (e.g., medication use, noise or other distractions during testing).

1. Physical appearance
   - General physical make-up of individual (e.g., height, build, hair/skin colour)
   - General physical condition (i.e., cleanliness, grooming, energy level, wear and tear)
   - Attire (note appropriateness, neatness, and cleanliness if relevant)
   - Distinguishing physical marks (e.g., conspicuous birthmark, scar, tattoos, physical malformations, loss of limbs, signs of substance use (e.g., needle marks))

2. Personality and psychological functioning
   - Mood (depressed, cheerful, anxious)
   - Range of affect (constricted, labile, normal)
   - Thought processes (loose/rigid)
   - Though content (bizarre, delusional, violent)
   - Speech and language (flow of speech, idiosyncratic expressions or formulations)
   - Concentration and memory (impaired, intact)
   - Intelligence (concrete/abstract, good/poor comprehension/problem solving)
   - Tolerance for ambiguity
   - Self-esteem, confidence
   - Personality disorder symptoms (manipulativeness, narcissism, undue emotional intensity)

3. Interpersonal presentation
   - Attitude toward the examiner (e.g., pleasant, defensive, shy, hostile, withdrawn)

4. Approach to testing
C. Assessment Findings and Interpretation

The purpose of this section is to present a complete, coherent, integrated, accurate, and concise account of the assessment findings. To be complete, this section should indicate whether inferences are made on the basis of formal test scores or informal observations, and any limitations on these scores or observations. To be coherent and integrated, similar patterns of strengths and weaknesses observed across tests or psychological modalities should be highlighted. Overarching themes or prevailing stylistic or personality factors can also link together disparate types of both strength and weakness in the clients’ performance. To be concise, the assessment information must be considerable distilled from its voluminous state as raw observations and test data.

One common way of organizing this section is to present cognitive/neuropsychological tests first followed by measures or personality. The general idea behind this organization is to identify any cognitive or neuropsychological limitations which may explain problematic behaviour before making personality or behavioural attributions.

1. Cognitive/Neuropsychological tests and observations

   a. “Bottom-Up” organization

   - Arousal and alertness (evidence of fatigue, blackouts, hyper arousal)
   - Attention and concentration (distractible, restless, limited)
   - Memory (short, long-term; discrepancies between self-report and performance, recognition vs. free-recall)
   - Language and communication skills (verbal comprehension, expression, reading, writing, other languages (including sign, Braille))
   - Visual/spatial construction abilities (copying from model, independent construction)

   b. “Top-Down” organization

   - Overall level of intelligence (range)
   - Verbal component (comprehension, reasoning)
   - Performance component (perceptual organization, etc.)
   - V-P discrepancies
   - Short-term memory/attention (Freedom from distraction component)

2. Personality tests and observations

Whereas the natural categories of a cognitive assessment often warrant organizing the findings in like fashion, this is usually less true for personality findings. Here, it is often more helpful to
organize the results of each major test (e.g., TAT, Rorschach, MMPI-2) by the prevailing themes and conflicts, and note similarities across measures as you go.

- Validity of responses
- Recurrent themes, patterns, or deviant (or strongly positive) responses
- Personality resources and weaknesses
- Emotional conflicts
- Perceptual distortions
- Self-concept

Section VI: Summary

The purpose of this section is to provide a concise summary and integration of all of the above sections, preferably in a single paragraph. Stick to the highlights, as space is limited. Present conclusions and as clear a picture of the individual as your assessment findings warrant. Write this section in a straightforward, narrative style. It, along with the recommendations, may be the only part of the report that is actually read and/or understood, so make sure it says what you want it to.

Section VII: Recommendations

The general purpose of this section is to translate the assessment findings into recommendations for actions which address the reasons for the intake. Thus, there is not standard list of recommendations, simply because the reasons for intake are so varied. A second purpose is to provide recommendations which may go beyond the reason for intake, which are aimed at improving the client’s situation. In both cases the recommendations should be explicitly linked with the assessment findings. Note that the reason for the intake, and the assessment findings provide a set of problems in need of solutions. The solutions themselves, however, may require considerable creativity and ingenuity on the assessors’ part to develop. It is in this section that the assessor may employ his or her knowledge and experience of community resources, psychological interventions, etc, as a basis for recommendations. Number each recommendation. Keep them short; two or three sentences often suffice.

Frequent recommendations include:

- Psychotherapeutic interventions
- Additional assessment (e.g., medical, psychiatric, neurological, occupational)
- Diagnostic reformulation
- Assistance to client in acquiring material resources (e.g., shelter, transportation)
- Expert opinion (e.g., on legal competence, parenting suitability)

Section VIII: Name, titles, degrees, and registration status of student and supervising clinician and their signatures.
Appendix 10
Information for students considering applying for Internships

Corey Mackenzie, Ph.D., C.Psych.
June 2012

1. **Review your eligibility.**
   To be eligible to apply for an internship, clinical students *must* receive the approval of the Clinical Psychology Training Program. Before approval to apply for internship is given the following conditions must be met:
   
   a. Student has passed their thesis proposal by May 15, *including* any revisions
   b. Student has successfully completed all courses, practica, and candidacy exams before the beginning of internship.
   c. Student has submitted the *Request for Permission to Apply for Internship* form to the Director of Clinical Training

2. **Consider whether this is the right year to apply.**
   Assuming you are eligible to apply for internship this year, now ask yourself if you *should* apply for internship this year. When answering this question consider the following factors:
   
   a. **PhD thesis progress.** If your thesis has not progressed much beyond the proposal stage consider deferring your application for a year in order to defend the thesis prior to internship. Doing so has several very significant advantages:
      i. *Increases competitiveness.* In addition to finishing your dissertation research during that extra year, you will also have opportunities to gain additional clinical experience. Perhaps more importantly, internship programs will almost certainly be more interested in applicants who come to internship with their dissertations complete or nearly complete for at least three reasons. First, such interns perceived as more hard working, conscientious, and efficient. Second, such interns will be able to devote more time and energy to their internship. Third, such interns will be available to be hired by the internship site once the internship is complete.
      ii. *Opens employment opportunities.* When you have completed your thesis prior to internship you are able to accept any position requiring a Ph.D. immediately after the internship.
      iii. *Reduces thesis-related stress.* Every student intends to finish the thesis during internship but many do not – the internship year is busy, and energy and motivation to work on a dissertation can be hard to come by. It is extremely discouraging to complete internship and to have to turn down job opportunities in order to complete the dissertation. Further, many students take on substantial post-internship employment that can further delay its completion and increase the risk of never graduating. Conversely, those who do defend before internship have their evenings and weekends free (without guilt!), and don’t have to continue paying tuition fees after internship.
iv. **Shortens time to completion.** Historically students in our program who defended their thesis prior to or during internship year took an average of 2 years less to complete the Ph.D. than those who defended after internship.

b. **Application is time-intensive.** The application process is very time intensive, for both the written application and the process of interviewing. The significant time devoted to applying will necessarily slow your dissertation research progress.

c. **Personal considerations.** Other considerations may include the timing of internship with respect to your partner/family, acquiring other experiences (e.g. practica) to enhance your competitiveness, financial concerns, and how many years you have left in your program to apply.

3. **Know which internships you can apply to.**
   a. **APA or CPA accredited.** Strongly preferred because they have met rigorous quality standards, are required for some types of jobs, and allow for fast-tracking during licensure. CPA accredited programs also require that students of such programs completed accredited programs or those that are deemed equivalent ...
   b. **Equivalent to accredited.** Must be approved by the DCT **prior** to applying. The burden of proof to demonstrate that a site is equivalent to accredited lies with the student, who must complete the Criteria for Non-accredited Internship Equivalency form (available from the DCT and on the PSC website).

4. **Plan application strategy to maximize chances of successful matching.**
   a. Apply with a competitive number of direct service and supervision hours. CPA suggests a minimum of 600 hours and a reasonable maximum of 1000 practicum hours. More specifically, they have a minimum of 300 direct contact hours and 150 supervision hours, although students will not be competitive with the 450 minimum direct service and supervision hours. We suggest that our students aim for approximately 500-600 direct contact hours and 200-250 supervision hours. Please keep in mind, however, that both quantity and quality of hours is important, as is the match between your interests and experiences and those of the internship sites.
   b. **Apply to a competitive number of internship sites.** In Canada, the average number of rankings submitted per applicant was 6.7 for matched applicants and 3.4 for unmatched applicants in this year’s match. This means that successful applicants had at least 7 interviews and therefore likely applied to at least twice as many sites. We therefore believe that to be successful, students should apply to approximately 15 sites. When considering this advice please keep in mind the need to balance the number of sites applied to with the need for strategic applications (see point #3). Also keep in mind that applying to too many sites also has significant drawbacks in terms of costs (time and money) and your ability to customize your applications.
   c. **Apply strategically to internship sites.** The APPIC online directory ([http://www.appic.org/directory/search_dol_internships.asp](http://www.appic.org/directory/search_dol_internships.asp)) provides a wealth of data on each internship site affiliated with the match. In addition to information on rotations provided, number of spots available, stipends, etc. this site provides data on the number of applications the sites received in the past 3 years. Some of the most competitive sites in the US receive 300 or 400 applications for a handful of spots, and in Canada the most competitive sites receive
approximately 100 applications for a handful of spots. Therefore, even if you have an extraordinarily competitive application, your chance of success at these top sites is not great. In order to apply strategically, therefore, you should consider applying to some very competitive sites, some sites that are not that competitive, and some sites in the middle. Only applying to top spots is a recipe for not getting matched. If you really want to increase your chances of matching you might also consider applying to 1 or 2 non-accredited sites that are strong internships on their way to seeking accreditation.

d. Take the appropriate steps to get good letters of reference. Although these letters likely won’t greatly increase the strength of your application (because letters tend to be universally positive), letters that raise concerns or red flags may decrease your chances of getting invited for an interview. Get letters from supervisors who know you well, be sure to ask letter writers if they can provide you with a strong letter, and consider asking to see the letter.

e. Get feedback on your application materials. Don Stewart and I will be happy to provide you with feedback on your personal essays, and you should also get feedback on them from your colleagues and other people whom you trust to give you honest and helpful feedback.

5. Gather information from credible sources. Information about internships is available from the following sources:

a. **CCPPP.** The Canadian Council of Professional Psychology Programs (CCPPP). Web address is [http://www.ccppp.ca](http://www.ccppp.ca)
   i. **Directory.** CCPPP member pre- and post-doctoral internship programs in professional psychology are listed here. (Note: Not all Canadian internships are CCPPP members.) This site provides links to internship web pages and information about program accreditation with CPA and APA, membership in CCPPP, and APPIC.
   ii. **Match made on earth.** An excellent, detailed guide to the internship application process written by and for Canadian students. Available online at: [http://www.cpa.ca/documents/Internship_workbook.pdf](http://www.cpa.ca/documents/Internship_workbook.pdf)
   iii. **Tips for students seeking internships.** Interview questions, tips.
   iv. **Letter of reference Guidelines.** Voluntary, but encouraged/expected for Canadian internship sites.
   v. **Proposed timeline for APPIC internship applications.** Very useful.

b. **APPIC.** Association of Psychology Postdoctoral and Internship Centers. Web address is [http://www.appic.org](http://www.appic.org)
   i. **Internship directory.** Contains information on all APPIC internships. Searchable on a variety of criteria.
   ii. **AAPI.** Internship application form.
   iii. **Match Procedures.**
   iv. **Match-News E-mail list.**
   v. **Match Policies and Regulations.** Deadlines, rights and responsibilities of internships and applicants (e.g., binding nature of match).
   vi. **FAQs.**
   vii. **Phase II.** Procedures and information.

c. **Natmatch.com** is the website of the National Matching Services that administers the Match. On this website you’ll find information about
   i. Overview of the APPIC match (eligibility and rules)
ii. APPIC match policies
iii. Schedule of dates
iv. Description of the match process (examples & misunderstandings)
v. Rank order list submission & withdrawal
vi. How to participate as a couple
vii. Match results
viii. Lists of participating applicants and programs
d. American Psychologist. The December issue of American Psychologist lists the accreditation status of all internships that have applied for APA accreditation. Internships are listed as accredited, on probation, or denied accreditation.
e. Internships. In recent years most, if not all, internships have opted to put their information online.
f. U.S. Immigration info. If matched with U.S. site, consult with the site, with recent UM students who have interned in the U.S., with Director of Training at that internship, and with U.S. Dept. of Immigration and Naturalization (INS). Review useful APPIC newsletter articles (Rodolfo, March 2003; Bell & McArthur, May 2006; Illfelder-Kaye, May 2006).

Please note that the APPIC Board recently released the following important information for you to consider: "Each year, the APPIC Board receives feedback about the increasing number of enterprising individuals who have established businesses that focus on assisting applicants in obtaining an internship. Furthermore, the APPIC Board has heard comments and complaints about the claims that some of these individuals are making, the ways in which certain individuals are advertising their businesses and recruiting students, and the rates being charged to students (e.g., $100 or more per hour) for these services. While there may in fact be some legitimate and helpful services that are being offered, the Board remains very concerned about the potential for exploitation -- i.e., that some of these businesses may be taking advantage of the imbalance between applicants and positions by exploiting students’ fears and worries about not getting matched. We encourage students to be cautious and informed consumers when it comes to decisions about using any of these services. Please know that there are a number of no-cost and low-cost ways of obtaining advice and information about the internship application process, such as the workbook published by APAGS (as well as books written by other authors), the free information available on the APPIC and NMS web sites, discussion lists sponsored by APPIC, APAGS, and others, and the support and advice provided by the faculty of many doctoral programs”.

6. Register early for matching process at the National Matching Service online at: http://www.natmatch.com/psychint. The registration is completed online and includes a non-refundable fee. The deadline for registration is December 1. Once you have registered you will receive a “Match ID number” necessary to participate in the internship match process. This number must be included on your APPIC Application for Psychology Internship (AAPI) form that you will use to apply to internship programs.

7. Provide DCT with request & information. Provide the DCT with the following information by the dates indicated:
a. By early October
   i. Completed “Request for permission to apply for internship” form (available on the PSC website)
   ii. If you are planning on applying to any non-accredited internships complete the Criteria for Non-Accredited Internship Equivalency form (on the PSC website)

b. At least 2 weeks prior to due date of earliest application
   i. You will complete the APPIC “Internship Eligibility and Readiness” section of the online application. This will be sent to the DCT for Verification.
   ii. Once your eligibility and readiness are verified, the DCT is required to “Please identify areas of particular strength and areas of potential further development while on internship. If you do not have direct knowledge of this student, please gather the appropriate information from relevant parties”. As the DCT likely will not have comprehensive knowledge of your strengths and areas for further development, you should provide information s/he will need to write a strong reference letter (e.g., CV, summary of practicum evaluations).

8. Preparing for interviews. In late November or early December the DCT and Director of the PSC will arrange a meeting to discuss strategies for ensuring successful interviews and an eventual successful match. Each student participating in the match will also complete mock interviews and receive feedback to enhance interview performance. See the last page of this document for lists of questions.

9. Match information. The Match is conducted in two primary phases. There are also two potential post-match services for students who do not match in Phases I or II.

   a. Phase I requires all students and internships to submit their choices by Wednesday February 9, 2012 at 11:59 p.m. ET. The results are announced to students and DCTs on Match day (Friday Feb 24th, 2012). The list of programs with unfilled positions in Phase I will be provided on the Match website beginning at 11:00am ET on Friday Feb 24, 2012.
   b. Phase II is available only to those students who took part in Phase I at no additional fee. Eligible students can submit applications for this phase beginning on Friday Feb 24, 2012 using the APPIC Online application service. Internship sites will not be able to view applications until 11:00 am ET on Thursday March 1, 2012. Students and programs must submit their Rank Ordered Lists before the deadline on Monday March 19, 2012 at 11:59 pm ET. The results are announced (to participating students and DCTs) on Monday March 26, 2012.
   c. APPIC will operate a Post-Match Vacancy Service for unplaced students and programs with available positions, which will begin at 11:00 am ET on Monday March 26, 2012.
   d. CCPPP also operates a Post-Match Service for any CCPPP members that may have unmatched students and unfilled internship positions after both the APPIC Phase I and Phase II Match are completed, beginning on Monday March 26, 2012. Information about the number of unmatched students and their contact information should be forwarded by the DCT to Dr. Ian Nicholson at Ian.Nicholson@LHSC.ON.CA at the conclusion of the Phase II Match (Monday, March 26, 2012). The Past President acts as an information channel to inform doctoral programs about unfilled positions so that unmatched students can inquire into those positions and follow through with an application if appropriate. Follow-up contacts are subsequently made with member programs that access the Post-Match service to determine the outcome.
Internship Interview Sample Questions

There is obviously an infinite list of potential questions you might be asked during your interviews, but there are also some very likely core questions that we have tried to capture in the list below. If you have considered and thought about good answers to each of the following questions you should be in good shape during your interviews:

1. Why did you apply to our program?
2. What rotations or experiences are you interested in?
3. What do you see as your personal strengths and weaknesses?
4. What do you see as your clinical strengths and weaknesses? How do they influence your work? What have you done to manage your weaknesses?
5. Conceptualize a clinical case for us
6. What empirically-supported treatments are you familiar with?
7. What psychological tests are you familiar with?
8. What types of clients are most difficult for you to work with and why? What have you done in the past when working with such clients?
9. Tell us about your most difficult client situation and how you handled it.
10. How do you work with and understand people with different ethnic/cultural/sexual orientation/SES/etc backgrounds?
11. Tell us about an ethical problem you’ve encountered and how you handled it.
12. What sorts of supervisory styles do you work best with? What type of supervision hasn’t worked that well for you in the past?
13. What is the clinical relevance of your dissertation research?
14. What are your future professional goals and aspirations?
15. What else would you like us to know about you that perhaps isn’t apparent from your application materials?

Also, don’t forget that you are interviewing internship sites. Have your own list of questions you would like answered at each internship site and do your research on specific internship sites prior to interviewing with them so you can ask both generic questions and site-specific questions. The following is a list of potential questions you might ask at your interviews (please note that this is, in many ways, just as important as your answers to the previous list of questions as it conveys your interest and enthusiasm about the training sites):

1. Example of a site-specific question: “I’ve read in your brochure that you provide a rotation in (fill in blank), which I’m particularly interested in given my previous experience and future clinical aspirations. Can you tell me if that rotation would provide opportunities for me to (fill in blank)?
2. Ask questions about what it’s like to live there (e.g., cost of living, housing, etc).
3. Ask to speak with current interns and ask specific questions about their experiences.
Appendix 11

CLINICAL TRAINING PROGRAM OF STUDY:

Clinical Psychology Program of Study (revised June 2012)  

<table>
<thead>
<tr>
<th>M.A.</th>
<th>FALL</th>
<th>WINTER</th>
<th>SUMMER</th>
</tr>
</thead>
</table>
| M.A. 1 Year 1 | Quantitative Methods in Psychology I  
PSYC 7200 (3) | Personality and Psychological Assessment  
PSYC 7560 (3) | |
| | Intellectual and Cognitive Assessment  
PSYC 7550 (3) | Ethics and Professional Issues in Clinical Psychology  
PSYC 7520 (3) | |
| | Foundations of Evidence-Based Treatment  
PSYC 7320 (3) | Clinical Research Design  
PSYC 7140 (3) | M.A. Thesis Oral Proposal  
PSYC 7780 (0) |
| M.A. Thesis Proposal Development (Fall or Winter)  
PSYC 7780 (0) | | |

| M.A. 2 Year 2 | | | |
| | Psychopathology and Diagnosis  
PSYC 7290 (3)  
(formerly PSYC 7870) | | |
| | MA Ancillary:  
Clinical Neuropsychology  
PSYC 8230 (3)  
(strongly recommended)  
OR  
Human Brain Functions  
PSYC 8050 (3)  
Or a Biological Bases of Behaviour alternative approved by the DCT and the Associate Head (Graduate) | | |
| | Development & Its Deviations 1  
PSYC 8200 (3) | Quantitative Methods in Psychology II  
PSYC 7210 (3)  
(formerly PSYC 8420) | |
| | PSC Practicum I  
PSYC 7910 (0) | PSC Practicum II  
PSYC 7920 (0) | |
| | Case Conceptualization and Communication 2  
PSYC 7270 (0) | | |
| | Defend M.A. Thesis  
GRAD 7000 (0) | | Optional practicum  
(students are eligible to apply for this practicum only if the M.A. defense has been scheduled) | |
<table>
<thead>
<tr>
<th>Ph.D.</th>
<th>FALL</th>
<th>WINTER</th>
<th>SUMMER</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhD 1 Year 3</td>
<td>Cognitive and Behaviour Therapy PSYC 8430 (3)</td>
<td>Social Bases of Behaviour Elective ¹²</td>
<td>Social Psychology and Health PSYC 7190 (3) OR Person X Situation Interactionism PSYC 7620 (3) OR Alternative approved by the Director of Clinical Training &amp; Associate Head (Graduate)</td>
</tr>
<tr>
<td>PhD 2 Year 4</td>
<td>Social and Community Intervention PSYC 8100 (3)</td>
<td>Program Evaluation &amp; Consultation PSYC 8110 (3) (strongly recommended) OR School Psychology Research Design and Program Evaluation PSYC 7130 (3) If approved by DCT &amp; Associate Head (Graduate)</td>
<td>Candidacy exam GRAD 8010 (0)</td>
</tr>
<tr>
<td>PhD 3 Year 5</td>
<td>PSC Practicum III PSYC 7930 (0)</td>
<td>Senior Practicum ⁴ PSYCH 7940 (0)</td>
<td>Optional practicum</td>
</tr>
<tr>
<td>PhD 4 Year 6</td>
<td>Case Conceptualization and Communication 3 PSYC 8080 (3)</td>
<td>Ph.D. Thesis Proposal and Development (Fall or Winter) ⁵ PSYC 7790 (0)</td>
<td></td>
</tr>
<tr>
<td>PhD 2 Year 4</td>
<td>Doctoral Ancillary: History and Systems of Psychology PSYC 7280 (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PhD 3 Year 5</td>
<td>Optional Senior Practicum PSYC 7954 (0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PhD 4 Year 6</td>
<td>Ph.D. Dissertation Oral Final GRAD 8000 (0)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Internship PSYC 7980 (0)</td>
</tr>
</tbody>
</table>
NOTES:

1 Students may take an optional elective course at any point in their graduate program under the advisement of their advisor and/or advisory committee.
2 Although this course can be taken during any one of the first four terms of full-time study in the M.A. program (including the summer session), we recommend that students complete this requirement early in the course sequence.
3 This course can be waived by the DCT if students have taken 6 credit of suitable undergraduate course work meeting this basis requirement.
4 Three Senior Practica, also known as specialty practica, are required, for a total of 6 required practica. The phrase “optional Senior Practicum” therefore refers to the timing of when senior practica are completed and the fact that students, with the consent of their advisory committee, may take more than the required six practica to be competitive for internship applications. Senior practica are typically completed in the community, but may also be completed with a specific focus by clinical faculty at the PSC.
5 Although this course can be taken during any one of the first eight terms of full-time study in the PhD. Program (including the summer session), we recommend that students complete this requirement early in the course sequence.
6 This course can be waived by the DCT if students have taken 6 credits of suitable undergraduate course work meeting this basis requirement.
7 PhD oral proposal must occur and receive either an outright, or provisional, pass by May 15th of the year applications are due. If the pass is provisional, any required revisions to the written proposal must be fully completed and approved by the Department of Psychology in order for the student to receive approval to apply for internship.

Note: Number of credit hours is shown in parentheses

Note: This table presents an ideal sequence through the clinical program. Some modifications to this sequence may be necessary because of when courses are offered or because of student needs.

Note: CPA requires coverage in 5 core content areas through: (a) passing suitable exams in each area, or (b) completing 3 credits of graduate or 6 credits of undergraduate courses in each area. The five content areas are:

1 Biological bases of behaviour (e.g. neuropsychology, psychopharmacology, physiological psychology),
2 Cognitive-affective bases of behaviour (e.g., learning, thinking, motivation),
3 Social bases of behaviour (e.g., social psychology, group processes, sex roles),
4 Individual behaviour (e.g., personality theory, human development, individual differences, abnormal psychology)
5 Historical and scientific foundations of general psychology

Our program fulfills core content area 1 via the MA ancillary in Year 2, area 2 through the Cognitive-affective elective in PhD Year 4, area 3 through the Social elective in PhD Year 3, area 4 through PSYC 8200 (Development and Its Deviations), and area 5 through History and Systems of Psychology (Psych 7280).
Appendix 12

PSYC 7910, 7920, 7930 General Practicum

PSYCHOLOGY: CLERKSHIP PRACTICUM IN CLINICAL PSYCHOLOGY

COURSE SYLLABUS

FALL 2014

INSTRUCTOR

Dr. Harold Wallbridge
171 Dafoe Building
Phone: 204-474-9069
Email: Harold.Wallbridge@umanitoba.ca

COURSE OBJECTIVE

General Practicum Experiences

These training experiences occur at the early stage of the clinical training process and are intended to provide students with the basic practical skills related to clinical assessment and intervention. Specialty practicum experiences that occur later in the program build upon these basic skills. Three general practicum experiences at the PSC are required before specialty practicum experiences will be considered. These are supervised by clinical faculty on staff at the Psychological Service Centre. The most common case load for general practicum is to see three adult individual clients, one child or adolescent client, one couple or family, and one group. The student is also expected to complete at least one full assessment in each of the three general practica.

All practica training is based on gaining experience and developing proficiency in core competencies areas of interpersonal relationships, research, assessment and evaluation, intervention and consultation, ethics and standards.
Readings that complement the individual practicum objectives will be assigned by practicum supervisors.

No library support is required.

**COURSE DESCRIPTION**

Each practicum involves a minimum of 150 hours of **clinical activity** and should usually not exceed 200 hours. Each practicum includes a minimum of 25 hours of supervision and a minimum of 50 hours of direct client contact (e.g., providing therapy and assessment to clients, conducting intake interviews). Additional practicum hours involve a range of indirect clinical activities, such as writing process notes, preparing treatment plans, writing reports, scoring tests, reviewing sessions, and attending in-services. During the 13-week term the student will spend a minimum average of about 10-12 hours per week in clinical activity.

**STUDENT EVALUATION**

Competency based evaluation (Practicum Evaluation Rating Form).

**GRADING SCHEME**

A pass/fail grade will be assigned at the end of the term or at completion of the practicum.

The Faculty of Graduate Studies Policies on Cheating and Plagiarism

[http://umanitoba.ca/faculties/graduate_studies/566.htm](http://umanitoba.ca/faculties/graduate_studies/566.htm)

Information Regarding University Policies on Cheating and Plagiarism

- [Office of Student Advocacy plagiarism page](http://umanitoba.ca/faculties/graduate_studies/566.htm) (LINK)
- [Academic Dishonesty](http://umanitoba.ca/faculties/graduate_studies/566.htm) (PDF)
- [Complaint Handling Guide incl. process flowchart](http://umanitoba.ca/faculties/graduate_studies/566.htm) (PDF)
Appendix 13

PSY 7940, 7950, 7952, 7954, 7956 Specialty Practicum

PSYCHOLOGY: CLERKSHIP PRACTICUM IN CLINICAL PSYCHOLOGY

COURSE SYLLABUS

FALL 2012

INSTRUCTOR

Dr. H. Wallbridge

171 Dafoe Building

Phone: 474-9069

Email: Harold.Wallbridge@umanitoba.ca

COURSE OBJECTIVE

Specialty Practicum Experiences

These are considered to be more advanced and specialized training experiences that occur later in the clinical training program and provide students with clinical experiences more tailored to their individual needs and interests. These may be provided at the PSC but are commonly provided at clinical facilities off the Fort Garry Campus. They may be initially conceived and organized by psychologists in the community, students themselves, clinical faculty or the Director of Clinical Training and, in many instances, by some combination of all the above. In order for a psychologist who is not a clinical faculty member to supervise a specialty practicum he or she must be designated as a Clinical Associate by the Department of Psychology Clinical Faculty. Specialty practicum experiences must be reviewed and approved the Director of Clinical Training.

All practica training is based on gaining experience and developing proficiency in core competencies areas of interpersonal relationships,
research, assessment and evaluation, intervention and consultation, ethics and standards.

Readings that complement the individual practicum objectives will be assigned by practicum supervisors.

No library support is required.

COURSE DESCRIPTION
Each practicum involves a minimum of 150 hours of clinical activity and should usually not exceed 200 hours. Each practicum includes a minimum of 25 hours of supervision and a minimum of 50 hours of direct client contact (e.g., providing therapy and assessment to clients, conducting intake interviews). Additional practicum hours involve a range of indirect clinical activities, such as writing process notes, preparing treatment plans, writing reports, scoring tests, reviewing sessions, and attending in-services. During the 13-week term the student will spend a minimum average of about 10-12 hours per week in clinical activity. Modifications of these guidelines should be clearly outlined in this contract and approved by the director.

STUDENT EVALUATION
Competency based evaluation (Practicum Evaluation Rating Form).

GRADING SCHEME
A pass/fail grade will be assigned at the end of the term or at completion of the practicum.

The Faculty of Graduate Studies Policies on Cheating and Plagiarism
http://umanitoba.ca/faculties/graduate_studies/566.htm

Information Regarding University Policies on Cheating and Plagiarism

- Office of Student Advocacy plagiarism page (LINK)
- Academic Dishonesty (PDF)
- Complaint Handling Guide incl. process flowchart (PDF)
Appendix 14

PSC Client File Forms (hard copies available in the PSC Office)

Request for Service Form

Intake Questionnaire Form (Adult or under 18) - New

Registration Form

Informed Consent

Intake Checklist

Intake Interview

Client Contact Summary

Contact Sheet

Permission to Release / Exchange Personal Health Information

Consent to Release Information

Termination Form (individual or family)

Clinical Practicum Forms (available online or in the PSC Office)

Practicum Contracts

PSC Practicum Contract

Practicum Evaluations

Evaluation of Practicum Supervisor Form (EPS)

Practicum Evaluation Rating Form (PERF)

Clinical Program Forms
Evaluation

Annual Performance Appraisal Advisor Form
Annual Performance Appraisal Student Self Assessment Form

Internship

Request for Permission to Apply for Internship Form
Equivalency Criteria for Non-Accredited Internships Form
Evaluation of Internship Site and Supervisor