Faculty of Science
School of Psychology

Clinical Psychology &
Clinical Neuropsychology
Graduate Programs

Placement Guide 2013
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Introduction

Practicum work is a central part of your training as a practitioner. Your practicums are opportunities to apply what you have learned in class and to begin to develop your identity as a therapist. Being a practitioner usually involves working therapeutically with clients as well as working with others in providing those services. It also involves a suite of other competencies that support and inform this work. Your practicum opportunities have been designed to encourage the development of these competencies.

This Guide has been designed to be of use to you as you undertake the practicum component of your Clinical Psychology or Neuropsychology training. The Guide provides information that previous students have found useful in undertaking their practica.

As far as possible within the policy and procedure guidelines of UWA, this guide remains a work-in-progress. You are always welcome and should feel free to discuss or clarify the information in the Guide with the UWA staff responsible for the program.

This guide describes the placements undertaken in the Master of Psychology (Clinical)/Doctor of Philosophy, the Doctor of Psychology (Clinical), and the Master of Psychology (Clinical Neuropsychology)/Doctor of Philosophy courses. It is expected that all Clinical Students and Placement Supervisors will be familiar with the material in this guide.

Clinical placements both within and outside the University are an essential and important part of the training regimen. Placements are arranged to give students exposure to a range of clinical activities in different settings with a variety of assessment and therapeutic approaches.

To ensure that placements are conducted in a manner that provides appropriate experience for students, various guidelines have been developed by the University, the Australian Psychology Accreditation Council (APAC), the relevant Australian Psychological Society (APS) College, and the Psychology Board of Australia (PBA).

An up-to-date version of the material contained in this handbook (including forms) can be found at: http://www.psychology.uwa.edu.au/students/program-guides-and-forms/postgraduate-program-forms


Psychology Board of Australia (PBA): http://www.psychologyboard.gov.au

Australian Psychology Accreditation Council (APAC): http://www.apac.psychology.org.au

WA Health Department Agreement for Allied Health Student Clinical Placements Program: www.health.wa.gov.au/StudentPlacements/alliedhealth/docs/University%20of%20WA.pdf

Information in this publication is correct as at 1st March 2013 but may be subject to change. In particular, the University reserves the right to change the content and/or the method of presentation and/or the method of assessment of any unit of study, to withdraw any unit of study or program which it offers, to impose limitations on enrolment in any unit or program and/or to vary arrangements for any program. This guide should be read in conjunction with UWA Policy and Procedures - http://www.studentadmin.uwa.edu.au/welcome
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Placement Requirements and Expectations
Your individual placement program will be arranged in consultation with the Placement Coordinators. We encourage students to choose internal modules/placements that will provide them with a range of experiences and address the broad range of competencies outlined in Table 1.

Placements and Hours
Students in the MPsych (including the Extended degree) or MPsysyhc/PhD (Clinical) programs are required to complete three placements totalling a minimum of 1000 hours practical placement experience:
  - one internal placement (PSYC8678 and PSYC8679)
  - two external placements

Students in the MPsysyhc/PhD (Clinical Neuropsychology) program are required to complete a minimum of 3 placement units totalling at least a minimum of 1000 hours practical placement experience:
  - one internal placement of 10 months (PSYC8678)
  - two external placements units (within up to 3 placements, as required)

Students in the DPsych (Clinical) program are required to complete four placements totalling a minimum of 1500 hours practical placement experience:
  - one internal placement (PSYC8678 and PSYC8679)
  - two external placements
  - capstone placement in their third year of study

APS College Approval Guidelines define a placement as comprising at least 200 hours of practicum work and 80 hours of client contact:

(a) Clinical College Approval Guidelines mandate 400 hours of client contact out of the total 1000 hours for the MPsych and 600 out of 1500 for the DPsych. The APS recommended minimum requirement is 3 hours of client contact per 7 hour placement day.

(b) Clinical College Approval Guidelines mandate one hour of clinical supervision per 7 hour day of placement and a minimum of 180 hours for the 1000 hours of MPsysyhc placements. The minimum for the 500 hour DPsych Clinical Internship is 50 hours of supervision, in addition to the totals required for the MPsysyhc.

Internal practicums are completed on a portfolio system and so different students may construct their number of practicum hours in different ways. Some students may complete their practicum spread across the year, others may have clusters of hours according to opportunity, skill level and preferences.

A standard 45-day external placement (7.5 hour days, 337.5 total placement hours) should normally consist of:
  - 135 hours of client contact (a)
  - 60.75 hours of clinical supervision (b)
  - 141.75 hours of other activities

APS College Approval Guidelines also state that it is essential that the placements provide students with the experience of dealing with a wide range of client problems (e.g. acute as well as chronic disorders), across varying settings (e.g. inpatient/outpatient, community) and train students in a variety of clinical (assessment, treatment, and professional)
Students are also required to gain experience in working with both child and adult populations.

**Trainees' general responsibilities**

When dealing with the general public, a variety of expectations develop on the part of clients, colleagues, outside agencies, and professionals. Among these are:

- Appointments must be met exactly on time.
- Dress must be appropriate at all times and trainees are expected to present an appearance of professionalism when seeing clients.
- Deportment must be professional, in any space where students may meet the public (e.g. the Hub, NDU, CSC, other rooms in GP3).
- Trainees serve as representatives of the University during professional contacts with others from outside. Interactions should be professional and conversations and actions pre-planned whenever possible (with consultation from supervisor when necessary). These contacts will influence others' views of the University and our training programs, as well as the reception given others who subsequently contact the same source.
- Clear, complete, up-to-date, accurate records must be kept on every case.
- When terminated, cases must be closed formally and immediately.
- Office staff, colleagues, supervisors, the Hub secretary and the Internal Practicum Coordinator (Carmela Pestell) must be kept informed by trainees about particularly client experiencing difficulty or discontent who may contact the University.
- Attendance at the weekly clinic meetings is mandatory, and trainees are responsible for keeping informed about any issues covered during a meeting in the event they had to miss a meeting.
- Attendance at the supervision sessions is mandatory, and trainees must be prepared for the session.
- Trainees must thoroughly know and abide by the Ethical Principles of Psychologists and Code of Conduct.
- Trainees must be familiar with and follow the procedures outlined in this guide and in the Internal Practicum procedures Appendix.
Internal Placement (Introductory)

Your internal practicum experience at UWA is an exciting opportunity to make your first foray into clinical work and to develop your skills and identity as a practitioner. This practicum will support your continued learning about the application of psychology to real-world problems and to explore the range of ways in which we can assist clients to address the difficulties that they are facing.

Your internal practicum will centre on the development of a portfolio of experiences that support and document the emergence of your competence as a scientist-practitioner. That is, the practica will help you develop the range of core competences required by APAC (see table below). Different competences will be addressed within different modules of the practica. In order to engage and enable a breadth and depth of skill development relevant to a range of applied contexts, we will support you in drawing from the diverse range of practicum experiences available at UWA. Your internal practicum must include 400 hours of practicum work for Clinical students, including 160 hours of face-to-face work, and 300 hours of practicum work for Clinical Neuropsychology students. In turn, this face to face work must include both assessment, and intervention including a minimum of 16 hours of individual, adult psychotherapeutic work. The logbook information described below outlines all of the activities that contribute to these face to face hours and other practicum hours. Once your portfolio is consolidated, you will be ready to be considered for an advanced practicum opportunity in one of the many agencies providing psychological services to the W.A. community.

From the first weeks of the first semester, students begin their experiential learning through practicum activities. These activities evolve from very structured and heavily supported training, practice and implementation opportunities, to activities in which there is increasingly greater demand for the trainee to work more independently on more complex clinical tasks. There is a range of closely supervised opportunities within the Centres and Clinics at UWA to develop competencies in a broad range of assessment and intervention skills (see table below for a comprehensive list of competencies targeted in your internal practicum). This provides a firm footing on which to advance to more challenging clinical casework and associated professional activities. Students will undertake core adult practicum (Robin Winkler Clinic or similar) work. This includes face-to-face work with clients spanning assessment, formulation, intervention (including designing interventions), and monitoring of psychotherapeutic outcomes. They will then take additional modules to make up their required placement hours. In discussion with the Internal Practicum Coordinator (Carmela Pestell) and, if necessary, module coordinators, you should express a preference for the modules of interest to you. Module coordinators then select how many students they can take in a module: this selection process may involve an interview. As you will appreciate, spaces within modules may be limited, so all modules may not be available to all students but you will, none the less, be able to gain a broad portfolio of experiences sufficient to obtain the hours/experience you need, if you are suitably flexible in which modules you ask to take.

We have programs that involve training in detailed neurodevelopmental profiling and intervention planning, to therapeutic work with individual clients; from brief interventions to group work. We encourage students to try a wide range of activities to develop a broad and strong skill base. This internal practicum work is likely to extend for at least one year for Clinical students and 10 months for Clinical Neuropsychology students, and is co-ordinated through the internal practicum co-ordinator. Be aware that many students continue into the summer months to finalise their hours, which is why the placements are 10 months in length, to allow this flexibility to gain experience outside the standard 26 weeks of semester.
You are encouraged to find out more about each of the additional internal practicum opportunities available and to express your interest and preferences in weekly internal practicum clinic meetings or to the Internal Practicum Co-ordinator (Carmela Pestell). Allocation to a practicum experience will take into account availability; your preferences, experiences and skill set; as well as the ‘gaps’ in your portfolio. Your goal is to develop a well-rounded set of skills through engaging with diverse training opportunities. The following pages provide a brief description of some of these training options. Your internal practicum will culminate in psychotherapeutic work with an individual client.

Supervision is an important part of your internal practicum. You will experience supervision from a range of clinical and neuropsychology staff members with diverse areas of expertise. Sometimes you will be part of a supervision group with peers and at other times you will receive individual supervision. Openness to the process of supervision and critical self-reflection is a key part of a successful practicum. We are aware that supervision can be anxiety provoking for trainees. All supervising staff are committed to supporting you through your practicum experience.

Students on internal clinical or neuropsychology placement are normally expected to spend two days per week during semester and three days per week during the weeks of University vacations in supervised fieldwork.

**Core Internal practicum module**

**Robin Winkler Clinic**

The Robin Winkler Clinic is a Clinical Psychology Unit linked to the School of Psychology at the University of Western Australia. The clinic provides services to the Perth community and also functions as a training and research facility. Because it is a training clinic subsidised by the university, services are offered at discounted rates.

The Robin Winkler Clinic provides individual and group therapy for people of all ages and backgrounds with a wide range of difficulties including:

- Depression
- Anxiety
- Stress
• Sleep disturbances
• Relationship problems
• Anger
• Eating disturbances
• Weight management
• Smoking Cessation
• Substance Abuse and Gambling
• Behavioural and emotional problems in children

Client referral and intake
Upon referral, clients will make initial contact with the clinic secretary. The clinic secretary informs the clients about the intake process and sends out an application packet including introduction letter, information sheet, application forms, consent form, location map, and a reply paid envelope.

Upon receipt of the completed application and signed consent form, the client will be placed on the waiting list. The Clinic Coordinator (Carmela Pestell) screens all incoming applications and decides if the urgency of the request for services requires immediate action, in which case a prompt referral to an alternative, appropriate service provider will generally be made. Occasionally, urgent services for new clients may be offered at the Robin Winkler Clinic pending availability of appropriate therapists. At that initial screening, the Clinic Coordinator also determines whether or not the case is appropriate for our clinic, and if not, the client will be advised of alternative referral options. In all other cases, the client remains on the waiting list until a therapist becomes available.

Once a case has been assigned, the therapist should attempt to make contact with the client the same day to schedule an appointment within one week of the day the case has been assigned. It is the therapist's responsibility to make contact with the client as soon as possible after taking on a case.

As part of the assessment, all clients will complete our standard intake tests. It is the therapist's responsibility to enter all information from the standard intake tests into the clinic database accurately and in a timely fashion. Preparation for an assessment session will include use of the Client Information Sheet that was specifically designed to aid in the assignment of cases and planning of assessment interviews.

Upon completion of the assessment phase, the therapist will present the case and a decision about whether or not the client should be offered treatment at our clinic will be made. If the decision is to offer the client services at our clinic, a therapist will be assigned to the case to conduct the treatment. This may or may not be the same therapist who conducted the assessment.

Information about forms, standard tests, record keeping and recording can be found in the Internal Practicum Procedures Appendix.
Table 1. Internal practicum competencies and how each practicum module addresses these.
The competencies targeted by each of the internal practicum options can be seen in the table below. This will help you to think about which options may best broaden your skill development needs as you progress through your practicum.

<table>
<thead>
<tr>
<th>Competency</th>
<th>Core</th>
<th>Additional modules (trainees apply for these)</th>
</tr>
</thead>
<tbody>
<tr>
<td>An understanding of the ethical principles and professional issues that underpin clinical practice. This includes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction to the ethical and professional issues involved in the PBA/AHPRA (based on the codes of the APS)</td>
<td>X</td>
<td>X X X X X X X X X</td>
</tr>
<tr>
<td>Demonstrating punctuality and active engagement during all clinical and training sessions</td>
<td>X</td>
<td>X X X X X X X X</td>
</tr>
<tr>
<td>Adequate preparation for assessment and/or therapy sessions</td>
<td>X</td>
<td>X X X X X X X X</td>
</tr>
<tr>
<td>Adequate preparation for supervision sessions</td>
<td>X</td>
<td>X X X X X X X X</td>
</tr>
<tr>
<td>Protection of confidential information and effective sharing of information</td>
<td>X</td>
<td>X X X X X X X X</td>
</tr>
<tr>
<td>Knowledge and practice of professional ethics</td>
<td>X</td>
<td>X X X X X X X X</td>
</tr>
<tr>
<td>General record keeping of a high quality</td>
<td>X</td>
<td>X X X X X X X X</td>
</tr>
<tr>
<td>Writing timely and good quality case notes</td>
<td>X</td>
<td>X X X X X X X X</td>
</tr>
</tbody>
</table>

The ability to critically appraise existing knowledge and to be able to extrapolate from this knowledge base. These competencies include:

| Skills of critical analysis and synthesis of information                  | X    | X X X X X X X X |
| Keeping up to date with the literature                                  | X    | X X X X X X X X |
| The ability to be self-aware and reflective in clinical and research contexts, including being able to articulate the limits of one’s knowledge and skills | X    | X X X X X X X X |
| Knowledge of normal development                                          | X    | X X X X X X X X |
| Knowledge of abnormal development, of clinical populations               | X    | X X X X X X X X |
| Knowledge of the influence of society and culture on ‘normal’ functioning | X    | X X X X X X X X |

The ability to assess psychological problems as a basis for intervention. This
includes:

| The interpersonal skills and empathy necessary to carry out an appropriate assessment | X | X | X | X | X | X | X | X |
| Knowledge of and competence in the selection, administration, scoring and interpretation of standard psychometric tests | X | X | X | X | X | X | X | X |
| The ability to undertake structured observation and behavioural analysis | X | X | X | X | X | X | X |
| The ability to take a detailed history, and to demonstrate questioning and listening skills in interviews | X | X | X | X | X | X | X |
| The ability to formulate the client(s) problems in terms of a coherent theory, and to generate hypotheses based on this formulation. | X | X | X | X | X | X | X | X |
| The ability to reformulate or modify the formulation in response to the developing evidence. | X | X | X | X | X | X | X | X |

**Understanding the importance of evidence in clinical practice. This requires two attitudes to clinical practice:**

| Evidence-based practice which is the ability to select interventions based on a critical evaluation of the published evidence on effectiveness of the approach, given the formulation of the case. | X | X | X | X | X | X | X | X |
| Evidence-generating practice or the understanding that our knowledge base is incomplete, but that the individual clinician’s experience is an important means of extending that knowledge base. | X | X | X | X | X | X | X | X |

**The ability to undertake therapy skilfully and effectively. This requires:**

<p>| A high level of interpersonal skills with clients | X | X | X | X | X | X | X | X |
| Understanding and application of skills in a range of psychological treatments, including cognitive, behavioural, systemic, person-centred and psychodynamic methods | X | X | X | X | X | X | X |
| An understanding of the commonalities and divergences among approaches, and of ways in which these approaches can be integrated | X | X | X | X | X | X | X | X |
| Demonstration of effectively planning an evidence informed therapeutic intervention | X | X | X | X | X | X | X | X |
| Demonstration of effectively implementing therapeutic intervention | X | X | X | X | X | X | X | X |
| Evaluation of the progress and outcome of clinical work. This evaluation should be seen as the basis for modification of clinical practice, both for that client and for future clients. | X | X | X | X | X | X | X | X |
| An understanding of complexities, co-morbidities and complex risk factors that may be relevant for working with clients. | X | X | X | X | X | X | X | X |</p>
<table>
<thead>
<tr>
<th>Demonstration of critically reflective learning in relation to therapeutic practice</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The ability to demonstrate strong relational skills</strong></td>
<td></td>
<td></td>
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<tr>
<td>Developing strong rapport with clients</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maintains a client-focus in their sessions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Demonstrates empathic understanding</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maintains effective relationships with multiple parties when working systemically or in a team</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Demonstrates critically reflective practice</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Demonstrates authenticity in interactions with other including congruence between verbal and non-verbal behaviour</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Develops positive relationships with staff and other trainees</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maintains effective relationships with staff from other agencies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Engages fully and openly with the supervisory process</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Uses supervision to extend understanding and skills</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>The ability clearly to articulate and define the objectives of research and to undertake relevant studies. This requires:</strong></td>
<td></td>
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<tr>
<td>Understanding the wide range of research methods applicable to clinical psychology (and clinical neuropsychology)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>The ability to plan and carry out clinical research at a variety of levels (e.g., single-case designs, small-scale research, service-related research, large-scale research)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>The ability to be a critical consumer of clinical psychology research.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>The ability to integrate research into practice (e.g. translational research projects and evidence-based service design)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>The ability to communicate psychological knowledge. This requires:</strong></td>
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<tr>
<td>The ability to write clear, well-argued letters and clinical reports to clients and to referring agents, essays, papers and research reports</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Skilled verbal presentation (e.g., lectures, teaching, seminars, case meetings)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>The ability to teach in a manner that is appropriate to the setting, audience and demands</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>The ability to supervise and to provide consultancy skills</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>The ability to function effectively at all levels in Psychology-related services and the contexts in which they exist. This includes:</strong></td>
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<tr>
<td>An understanding of professional and service issues.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Awareness of philosophies and models of health care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>An understanding of planning, financial and managerial systems</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>The ability to assess the demands of the service and to evaluate priorities.</td>
<td>X</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>The ability to organise one's time and to provide an effective service.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Knowledge of organisational psychology (as it relates to change in clinical services)</td>
<td>X</td>
<td></td>
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<tr>
<td>The ability to function professionally and effectively in a multi-disciplinary team setting</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>The ability to present an effective case and to participate in decision making and committees</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
</tr>
<tr>
<td>Demonstrated case management skills</td>
<td>X</td>
<td></td>
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</tr>
</tbody>
</table>

The ability to work sensitively with special populations such as:

| Children | X | X | X |
| Young people | X | X | X | X |
| Adult | X | X | X | X | X |
| Older adults | X | X | X | X |
| People with disabilities | X | X | X | X |
| Indigenous clients | X | X |
| Clients from diverse cultures | X | X | X | X |
| People with mental illness | X | X | X | X |
| Clients with complex and comorbid presentations | X | X | X | X |
| Working with individuals | X | X | X | X | X |
| Working with families | X | X | X | X | X |
| Working with groups | X | X | X | X |
| Working with couples | X | X | X | X | X |
| Working with systems (e.g. schools, hospitals, services) | X | X | X |

Notes:
1 yes, except understanding and skills of psychodynamic methods is not required
2 is rare, but occasionally couples and/or family members attend the SCG or memory clinic together
3 this primarily pertains to the integration of cognitive, behavioural, and pharmacological approaches
4 participants frequently have a history of clinical anxiety and depression, which may become evident during the evaluation procedures
Internal practicum modules

Children’s Activity Programme (CAP)

At the CSC/NDU we work with children who are considered to be at neurodevelopmental risk from illness, injury or premature birth. These children are often considered ‘multi-risk’ and may be exhibiting signs of behavioural difficulty, mental illness, emotional difficulty as well as significant learning challenges. We work with children and families to identify children’s strengths and difficulties through our unique ‘whole-of-child’ assessment methodology known as Children’s Activity Programme (CAP). This process has been designed by clinicians interested in the ‘real-life’ context in which to assess children, which allows us to see how they cope with 1:1 problem solving tasks as well as social tasks with other children and adults. All of our assessment tasks are embedded in a day of games and activities which is enjoyed by both children and staff!

In 2013 our primary research practice is centred on the neurodevelopmental follow-up of school-aged children born extremely preterm (i.e. <28 weeks gestation and/or <1000g in birth weight). Completing part of your internal and/or external practicum placement training at the Neurocognitive Development Unit (NDU) in 2013 offers an opportunity for developing competence in:

(i) Working with children and families.
(ii) Working with clinical groups including children born prematurely who present with a range of developmental vulnerabilities and disorders.
(iii) Learning about our neurodevelopmental framework for understanding mental illness, behavioural difficulties, neurological problems and learning difficulties in children and adults.
(iv) Understanding brain development and brain plasticity and how it impacts clients with complex and comorbid presentations.
(v) Undertaking neurodevelopmental assessments that include behavioural observation of social and emotional development, psychometric testing, brain-based measures of functioning and a range of others.
(vi) Working within a multi-disciplinary team and with our health department partners.

We take a supportive, scaffolded approach to your training. In the first instance, new trainees will be provided with careful training in working with children in an ethical and whole-of-child approach to assessment. Opportunities to apply child-centred engagement and observations of children will be provided in the April school-holiday program (see key dates) followed by application of more autonomous advanced assessment skills during the July school-holidays (see key dates). Alternative arrangements may be discussed on an individual student basis.

Eligibility
There are a limited number of places available in the NDU CAP placement and students will be considered on the basis of:

a. Working with Children’s Check and recent federal police clearance (within 3 months)
b. Expression of interest in the placement emailed to Catherine.Campbell@health.wa.gov.au or allison.fox@uwa.edu.au
c. Interview with the representative chief investigators
d. Competency in child-centred test administration following phase 1 of the training, as depicted in a dvd of test administration plus a one-page critical reflection of practice.
Key Dates & Times:
- Training workshops Thursdays from 3pm – 5pm @ NDU (March 28 – July 4).
- April School Holidays (April 22 – May 3) * min 2 days required
- July School Holidays (July 8 – 19)* 10 days required

Training Phase: Practicum students interested in participating in the CAP placement will be asked to complete 2 hourly weekly training sessions between (March 28 and July 4) in preparation for their participation in the program as senior trainees during the July School holidays (July 8 – 19). During these sessions you will receive training in:
- (i) a neurodevelopmental framework for understanding vulnerabilities in developmental progress of children born extremely preterm
- (ii) the child-centred process and professional practice of working with children, young people and parents
- (iii) assessment and whole-of-child profiling of cognitive, social and emotional functioning
- (iv) working as part of a multidisciplinary team contributing to the running of a large scale paediatric assessment program.

The skills developed during this placement are cumulative and non-attendance at training sessions will seriously compromise your ability to successfully complete the placement. Practice is expected in your own time – we strongly encourage you to work with one another to practice your test administration, profiling, interviewing and child engagement work. Throughout this module of supervised training, your competence in each of the listed components will be assessed. Your incremental, scaffolded and supported exposure to face-to-face client work will depend upon your progress and assessment of your supervisors. Interested students will be provided with the opportunity to apply child-engagement strategies during the April school-holiday placement. Given our duty of care to the children attending the CSC/NDU, we have strict criteria for progressing to scaffolded and supported face to face work with children, and subsequently, to full completion of this practicum.

Please note that on an individually considered basis, it may be possible for students to attend the training workshops, but without engaging in the face to face work with the children and associated video assessment. If the face-to-face placement dates are a problem, please apply to the Practicum Coordinator who will consider your application against the needs of the project.

Completion of practicum: For those students who are assessed as having reached competence in each aspect of this work, a further opportunity will be offered to complete a more independent direct client-work component of the placement in the July school holidays. You may be allocated an individual client or a cluster of school-aged children with neurodevelopmental challenges. This program assesses cognitive, social and emotional development in local primary school aged children. In 2013 we will work with children born prematurely. There may be other projects that evolve throughout the year.

Practicum hours should be recorded in your logbook (hours will vary but one example might be as follows):

**Practicum Training & Supervision**
- Weekly training March-July (14 weeks X 2 hour) 28 hours
- Supervision (min 12 days X 1 hr during PKIDS) 12 hours
- Practice with test partner (14 weeks X 2 hours) 28 hours
  **TOTAL:** 68 hours

**Face-to-Face Client Practicum Hours**
- Face to face child-engagement contact (min 2 days x 8 hours) min 16 hours
- Face to face individual child assessment contact (10 days x 8 hours) 80 hours
  **TOTAL:** 96 hours
Healthy Ageing Research Project (HARP)

Project HARP is umbrella for a series of programmatic research projects focused on typical and atypical ageing (e.g. Parkinson’s, Sleep Apnoea, and Alzheimer’s). Projects have included evaluating predictors of independent functioning in healthy ageing individuals, and exploring the cognitive burden of obstructive sleep apnoea and its response to treatment.

All projects involve assessment of cognitive and emotional functioning, as well as functional outcomes, using measures standard in clinical practice. These studies have been conducted in collaboration with such clinical providers as: the Sleep Clinic at Sir Charles Gairdner Hospital and with the Parkinson’s Centre (ParkC) at ECU. Future collaborations will involve the McCusker Alzheimer’s Research Centre.

A standard de-briefing regarding the participant’s experience of having their cognitive skills assessed follows all assessments. During these sessions, some older adults report concerns about the changes they may have noticed in their thinking skills or mood, and procedures will include single session interventions, as appropriate, including psycho-education in basic memory strategies and advice about normal ageing. This may also include advising individuals about sources of support and/or referral to the UWA Memory Clinic (in conjunction with the GP).

This means that HARP offers an exciting opportunity for psychology students to gain extensive training and supervision in the administration, scoring, coding and interpretation of a wide range of computerized and pencil and paper measures, as well as gaining experience of psycho-education interventions with older adults.

The measures typically include assessments of mood (e.g. depression and anxiety); of sleep disturbance, sleepiness and fatigue; of memory complaints, and objective cognitive functions (including memory and executive abilities). Together, these have the potential to impact on older individuals’ ability to function both within their everyday lives and to engage with psychotherapy. Trainees who wish to work with older adults within a psychotherapy framework will, nonetheless, find it important to have an understanding of how mood and cognition may or may not change with normal ageing, and how they interact.

Which students?
HARP may be particularly useful for first year students, but is by no means exclusive to first year students. If you are interested in gaining the above training and experience please contact us.

Time commitments
You will be trained in the unique requirements in effectively engaging with older clients, as well as in the administration, scoring, interpretation and coding of a battery of mood and neuropsychological assessments. Before testing any participants you will need to be signed off as competent.

Training will begin in the two 3-hour workshops that form part of PSYC5678 – Internal Practicum 1. Students will need to read through the administration manual for the HARP project, so that they become fluent with the procedures and instructions. This detailed manual spells out what to do and say, and when for each test, in the order of administration. Consistency of delivery is essential to assure the data are valid and reliable.

Students will then observe and practice the procedures with HARP project team members (these may be staff, postgrads or undergrad students). Students are required to practice administering the assessments on other students (and may wish to pair up). Following this practice, there will be a final ‘competency’ assessment by one of the HARP directors, before students can begin assessments.
HARP assessments usually occur between May and October. Scheduling of the time commitment is negotiable with supervisor, but we would expect testing to be conducted within 3 months of being signed off as competent.

**Training and supervision**
1. Workshops – 2 * 3 hours (PSYC5678)
2. Orientation session – 1 * 2 hours
3. Students reading of the procedures manual – self paced
4. Students observe and practice HARP procedures – at least 1 observation, practices –self paced
5. Scoring and coding training – 1 * 2 hours
6. Assessment of competency – 1 * 2 hours
7. Group supervision
   a. Test interpretation and case conceptualization – 1 * 2 hours
   b. Report writing – 2 * 1 hour
   c. Presentation of individual reports – each student presents at least 1 report – 4 * 1 hour
   d. Individual final supervision – 1 hour

**Assessment of the practicum module**
Students will typically assess 15 older adults and will be supervised to write up as many as 10 of these as case reports. There will be a minimum requirement to write up 3 case reports. The project directors undertake to provide clinical supervision for these reports.

To pass the module, students will need to complete all components of the module to a satisfactory standard, as indicated by the supervisor’s placement evaluation.

**Contribution to your internal practicum hours**
Each assessment takes around 2.5-3 hours to complete. Combined with training, practice, reading, supervision, and report writing, this amounts to approximately 100 hours of placement (25% of your internal practicum). From this, you would be able to claim up to up to 40 of your required face-to-face hours.

**Supervision**
Each student will be assigned a primary supervisor (Bucks or Weinborn) who will sign off their placement contract and case reports.

**Assessment battery for 2013**
Following recruitment, through the approved procedures, participants are mailed an information sheet. Those who consent are then mailed a packet of paper and pencil questionnaires:

1. A demographic sheet asking for age, education level, and medical history;
2. Alcohol Use Disorder Identification Test (identifies individuals at risk of an alcohol-related disorder)
3. The Prospective and Retrospective Memory Questionnaire (a self-report measure, assessing complaints about types of memory functioning)
4. The Pittsburgh Sleep Quality Index (assesses difficulties with getting to sleep, staying asleep, sleep medication use, and daytime dysfunction)
5. Berlin Questionnaire (assesses risk of sleep disordered breathing)
6. Fatigue Severity Scale (self-report measure of daytime fatigue)
7. A self-report medication usage and attitudes survey
8. An informant report medication usage survey
9. The Activities of Daily Living Questionnaire (self and other: assesses changes in higher level day-to-activities, such as managing finances and household duties)
10. The World Health Organization Quality of Life Scale
11. Mini Markers Scale (a brief personality measure)
12. Other clinical measures as determined by the module supervisors.

Each of these is a short measure of the relevant construct, and the entire packet should take 30-35 minutes. Students are encouraged to use these measures in their case reports, and to consider the impact of any difficulties reported on the assessment of each participant.

Participants are then scheduled for a face-to-face session after completion of the survey packet. Measures completed during the face-to-face testing session are:

1. Mini Mental Status Examination (measures general cognitive status)
2. Australian National Adult Reading Test (AUSNART: used to estimate premorbid ability/IQ)
3. Repeatable Battery for the Assessment of Neuropsychological Status (a set of cognitive tests evaluating short and long-term memory, visuo-spatial and language function)
4. Trail making Test (a measure of set-shifting)
5. Stroop Neuropsychological Screening Test (a test of inhibition)
6. Verbal Fluency tests (a measure of language and problem solving)
7. Memory for Intention Screening Test (an assessment of prospective memory)
8. Assessment of Intentional Memory (an assessment of prospective memory)
9. University of California Performance-based Skills Assessment (UPSA: an objective assessment of the ability to carry out higher level everyday activities involving planning and problem-solving)
10. Epworth Sleepiness Scale (an assessment of daytime sleepiness)
11. Geriatric Depression Scale (short version) and PHQ-9
12. The Geriatric Anxiety Inventory and GAI-7
13. Medication usage survey (over last week)
14. Post-assessment debriefing & examiner’s report

The face-to-face session should take 2.5-3 hours, with breaks scheduled between testing blocks.

**Ethics Committee Approval**
HARP is covered by UWA HREC for collection of these data. All students must adhere to UWA HREC policy in relation to this study.

**Data processing**

**Creating a file**
Students will create a file for each participant they assess.

1. Front sheet – contains the following details
   a. Date participant seen
   b. Date scored
   c. Date entered
   d. Date data scoring and entry checked
   e. Corrections made

2. Record sheets
   a. Behavioural observations and testing notes
   b. Test protocols for each cognitive and mood measure
   c. Post-assessment debriefing & examiner’s report

*If you decide to write up a case for a case-report, remember that the case report must not contain any identifying information, nor should the case report be lodged in this*
above file! The case report should include the participant identification number, so that supervisors can review the original test records.

Scoring/re-scoring and Coding/recoding
Students are required to score and code data into a database. To ensure accuracy, each student’s scoring and coding is checked by another. Differences will need to be resolved before final scores are saved. Data processing is considered part of the practicum module responsibilities. Until all components of the practicum, including data for all individuals assessed are complete and approved, the practicum module will not be signed off.

Students will be paired. Student 1 will administer, score, and enter the data into SPSS. Student 2 will check the scoring and data entry of Student 1’s participant data (and vice versa). This means double-entering the data!

Data will be coded into two SPSS databases held in the Prospective Memory Lab (Weinborn). Raw data files will also be stored in the Prospective Memory Lab. Consent forms are stored separately from score records which should be marked with the participant’s ID code and the date, but no other identifying information.

1. All data must be scored and entered into the database within 5 working days of face-to-face contact with the participant.
2. All recoding/checking of coding must be conducted within 5 working days of the data being entered by Student 1

If you have any queries regarding this placement, please contact Mike Weinborn or Romola Bucks.

The Smoking Cessation Group
The smoking cessation program offered at our clinic is based on evidence from up-to-date research and best-practice recommendations from national health authorities in Australia, the UK, and the United States. The program was developed and is supervised by A/Prof Werner Stritzke, an addiction scientist and clinical psychologist from the UWA School of Psychology. The treatment manual that guides therapists and clients (Treatment Manual for Smoking Cessation Groups: A Guide for Therapists by Stritzke, Chong, & Ferguson) is published by Cambridge University Press and is available worldwide.

The SCG follows a manualised approach integrating behavioural, cognitive, and pharmacological approaches. It runs for 10 weeks plus a follow up session around 1 month after completion. Students receive 2 hours of supervision per session. In addition, students will conduct assessments using a structured interview format including a set of quantitative measures prior to the group for each prospective client (usually around 14-15 clients taking into account that a couple of clients tend to drop out after assessment, and 2 or 3 more before the end of the program). The student will have 3-4 supervision sessions prior to the group to discuss the assessments, and plan for the first couple of sessions. Prior to that there are usually a couple of briefer meetings to discuss scheduling and get recruitment underway.

Students write intake and termination reports for each client in the group, and keep client files as per usual procedures. It is also essential that students collect client data on a weekly basis, prepare graphical presentations of change patterns using templates for this purpose, and use these data and graphs in preparation for supervision and in-session with the clients to monitor progress, inform treatment planning, and evaluate outcomes. In addition to gaining experience in conducting a smoking cessation intervention from start to finish, students will receive training and supervision in considering group dynamics and interpersonal and ethical issues when conducting smoking cessation interventions in a group format.
UWA Weight Management Program

This group program is based on the cognitive-behavioural approach to the treatment of obesity and binge eating disorder that was developed and tested at the University of Oxford, and has been refined and modified for use in a group format at UWA.

The programme consists of 12 two-hour group sessions run over 12 weeks. The treatment has two main phases. In phase 1, the focus is on helping people to lose weight and cease disordered eating behaviours such as binge eating and emotional eating. In phase 2, the focus is on helping people to maintain a new lower weight and healthy eating attitudes and behaviours in the long term. Participants are assessed pre-treatment, post-treatment and at a 3 or 6 month follow-up.

The groups are led by two post-graduate clinical psychology trainees. These co-therapists work together to assess participants pre- and post-treatment, conduct all group sessions and ensure the smooth running of the programme. Additional assessors are sometimes required to ensure that all participants can be assessed in a timely manner. Usually, two groups are conducted (concurrently) each semester, depending on the length of the waiting list and therapist availability.

Brief Alcohol Intervention Training (BAIT)

Overview: Brief interventions are becoming increasingly common in many settings that psychologists offer clinical services. With third party payers limiting the number of sessions that clients can get reimbursed for, learning the skills necessary in progressing interventions quickly from assessment to goal-oriented treatment has become increasingly important. Training in the principles and skills required for brief alcohol interventions will provide trainees with competencies that readily transfer to other interventions (short or longer) where the aim is to initiate behaviour change. Excessive alcohol consumption is a significant problem amongst university students. Between one third and one half of tertiary students drink at levels that are harmful to their health, but many are unaware that they are drinking at risky levels, and only 5% seek alcohol-related help. There is a large evidence base showing that brief interventions can reduce excessive alcohol consumption among university students. These interventions involve providing students with personalised feedback about their drinking pattern, practical information about how to drink less, and using motivational interviewing principles and strategies to increase motivation to reduce their drinking or seek expert help if indicated.

The BAIT project involves a collaboration of the School of Psychology and the Health Promotion Unit of the UWA Medical Centre. Training and intervention activities are structured into three components: a 4-hour training workshop; supervised practice in delivering brief interventions; and supervised experience in delivering training workshops to health promotion volunteers and health care staff from UWA and external agencies in WA.

Training workshop: In the workshop students will be provided with alcohol-related knowledge and specific interventions skills used in brief interventions. The emphasis is on gaining skills in quick rapport building, transitioning quickly from brief assessment to commencing an intervention, and on applying motivational interviewing principles and strategies. The 4-hour workshop has several modules covering general knowledge about alcohol, assessment and intervention skills, discussion of brief training video segments illustrating all components of the intervention with different types of clients, introduction to materials and a resource kit used for the intervention, and practice sessions. Practice sessions are organised in small groups and workshop participants receive immediate and structured feedback after each practice run.

Practice in Brief Interventions: There are several opportunities throughout the year for trainees to participate in supervised brief intervention events. Some reach a large number of
students (100+), others are more targeted to smaller groups. Interventions are delivered in different settings, including (but not limited to) at a variety of university events, at the colleges, and at the medical centre. Trainees can sign up for one or more hours at these events. Events can range from 2-4 hours in duration. Trainees will always work in pairs with alternating the roles between delivering the intervention and observing the intervention while keeping a detailed checklist to monitor adherence to the intervention protocol and interviewing style and principles. Trained health promotion staff will provide briefings prior to each event and be present during each event.

**Practice in Delivering brief intervention training workshop:** Those trainees who have completed both the 4-hour workshop and practical experience in delivering brief interventions, can get supervised experience in running a BAIT workshop for volunteers or health care staff. Prior to conducting the workshop, students will receive 1 hour supervision to orient the students to the workshop materials. Trained health promotion staff will be present to assist and a supervisor will be available during the workshop. Following the workshop, there will be a 1-hour supervision session for feedback and debriefing.

**Student research projects**
Some postgraduate students offer therapy groups as part of their research project. Last year, for example, there were mindfulness groups. When these opportunities arise, practicum students may be offered the chance to co-facilitate a group.

**Practitioner-in-residence (PIR)**
We are currently introducing a practitioner-in-residence program. This will involve experienced clinicians working from the RWC or the NDU/CSC. They may see individual clients and they may run groups. Each clinician is likely to have their own area of specialization and will develop opportunities for students to share in this work and to receive expert supervision. This may include sitting in on client sessions or seeing your own client under supervision. Sometimes this work will contribute to research and may provide you with opportunities to learn about intervention evaluation.

**External Placements (Intermediate and Advanced)**

**Clinical Psychology trainees**
Students on external clinical placement are normally expected to spend two days per week during semester (typically Tuesday and Thursday) and three days per week during the weeks of University vacations in supervised fieldwork. As placements differ in their requirements, there may be some room for negotiation in terms of the hours/days spent on placement. Students enrolled in 2013 will undertake minimum 45-day external placements. Students enrolled before 2013 will undertake minimum 37-day external placements, unless they have negotiated fewer 45-day placements with the Practicum Coordinator and Program Director. These differences take account of changes to the way placements are now being organized but be assured they will meet your training needs.
Dates for 2013 external placements (recommended dates, but may vary according to placement requirements).

37-day placement:
1st Semester Placement:
  3 days/week: 5th February – 22nd February
  2 days/week: 25th February - 31st May

2nd Semester Placement:
  3 days/week: 9th July - 26th July
  2 days/week: 29th July 1st November

45-day placement:
1st Semester Placement:
  3 days/week: 5th February – 22nd February
  2 days/week: 25th February - 28th June

2nd Semester Placement:
  3 days/week: 9th July - 26th July
  2 days/week: 29th July - 29th November

Negotiating External Clinical Placements
In order to arrange an external placement, students will be asked to list three or more placement preferences several months before the start of each placement. While you list placement preferences, the responsibility for the approval and organisation of a placement rests with the Placement Coordinator. At no time should students contact a potential Field Supervisor to negotiate a placement.

It is important to note that placement positions are extremely competitive as there are a limited number of Clinical Psychologists in a position to offer placements to students, and high demand from all four WA universities. Please note that whilst the Placement Coordinator will endeavour to arrange a placement of your preference this will not always be possible, given the demand on placement positions, thus you need to be prepared to work in placement settings that you have not listed as a preferred placement.

If a placement position is available, you may then contact the Field Supervisor to arrange a meeting to discuss the proposed placement more fully. The interview allows both the student and Field Supervisor to make an informed decision about whether or not to commit yourselves to the placement. You should approach a pre-placement interview as you would a job interview. Take a copy of your resume, dress professionally and ensure you are on time. During this interview you can seek the supervisor’s advice on any necessary preparatory reading.

If both student and Field Supervisor agree to the placement then the Placement Contract should be negotiated, with a copy of the contract being submitted to the Placement Coordinator no later than one week after the commencement of the placement. It is your responsibility to ensure that your personal goals are included in the Placement Contract, as well as any goals identified by your Field Supervisor.

If the student and Field Supervisor do not agree to the placement, or are unable to negotiate a Placement Contract, then the student should contact the Placement Coordinator immediately regarding an alternative placement.
Please refer to your LMS placement unit for all paperwork relating to external placements

* A student who wishes to alter placement arrangements for research or other reasons must first discuss the proposed changes with the Placement Coordinator.

* Students interested in undertaking a placement at an agency not listed in the Placement File should discuss this with the Placement Coordinator. The qualifications and expertise of the prospective Field Supervisor, as well as the suitability of the opportunity offered by the agency, will be taken into account when considering whether an agency meets the requirements of an approved placement.

* It may be possible for students to negotiate placements interstate or overseas during University vacation periods. However, as it is difficult to arrange a placement outside WA, students need to have a strong case when seeking approval for such placements. You should make all requests of this nature to the Placement Coordinator.

Capstone Placement (DPsych only)

The Capstone Placement is taken in the final year of the DPsych program and provides students with extended clinical experience in a specialist area of interest. The placement is negotiated in the same way as other external placements within the Clinical program.

Given that by the third year of the DPsych program students will have clinical and coursework experience comparable to that of a Clinical Psychology Registrar, it is expected that they will take on greater responsibility and work with greater autonomy in this placement.

Supervision

Supervision of DPsych capstone placements should be carried out by more experienced Clinical Psychologists and we would recommend that your primary Field Supervisor be a Senior Clinical Psychologist or equivalent (i.e. with a minimum of 5 years’ experience post-qualification). The supervision at this more advanced level should emphasise a higher level of autonomy and responsibility, and higher level integration of theory and practice.

Duration of the Placement

The DPsych capstone placement is of 500 hours duration, and should include 200 hours client contact and a minimum of 50 hours of supervision. Attendance at workshops during the placement is encouraged, and can be counted as hours on placement, but not as supervision hours.

Clinical Neuropsychology trainees

The Neuropsychology Placement Coordinator will organise external neuropsychology placements according to individualized student training needs and placement availability. Students enrolled in the MPsych/PhD (Clinical Neuropsychology) must complete a minimum 1000 placement hours that satisfy the requirements of the College of Clinical Neuropsychologists. These requirements have considerable overlap with those detailed above for clinical psychology placements, but note that in addition to these students undertaking clinical neuropsychological placements must:

1. Be exposed to a range of clinical cases drawn from five defined patient groups of interest: acute neurology/neurosurgery, rehabilitation, psychiatric, geriatric, and paediatric populations.
2. Complete an additional logbook of 50 cases, confirmed by the supervisor (see page 48 below for requirements of these 50 logbook entries). All five patient groups must be represented in these 50 logbooks.

3. Complete a casebook of at least 10 detailed cases that demonstrate a practical and theoretical understanding of a wide range of neuropsychological syndromes (see page 48 below for requirements). All five patient groups must be represented in these 10 casebooks.

4. Students are required to submit their general logbook, neuropsychology-specific logbook, relevant casebook entries, and summary of placement hours, confirmed by the supervisor, at the completion of each placement.

Note: Prior to commencing any placement, students must complete the preparation for placement module contained within the larger clinical internal clinic in the Clinical Internal Practicum unit (as described in the internal practicum unit outline for Practicum I (PSYC5678) unit outline.

Typical Timeline:
Approximately 3 total clinical neuropsychological placements and some additional briefer internal and/or experiences are usually completed. This may TYPICALLY look like:

| Year 2, Semester 1: | Preparation for placement content |
|                   | Internal placement activities (e.g. Project HARP, Children’s Activity Programme (CAP), BAIT, Smoking cessation group) |
| Year 2, Semester 2: | Additional internal placement activities (e.g. Intellectual Disability Clinic, Memory Clinic, additional Children’s Activity Programme (CAP) or other intervention activities) |
| Year 3, Semester 1: | Additional internal placement activities, if required |
| Year 3, Semester 2: | External Placement 1 |
| Year 4, Semester 1: | Complete any final placement activities as needed |

Individual students may, after consulting with their thesis supervisor, request an alternate timeline if this would benefit their research progress. HOWEVER, THIS MUST BE APPROVED by the Neuropsychology Placement Coordinator.

All students completing a neuropsychology-focused placement are required to attend the weekly Neuropsychology Case Conference during the placement (on Monday evenings) and present two cases seen during that placement.

Procedures and Timeline

1. Following agreement of the placement, the student and supervisor should complete the Supervision Contract. A copy should be retained by the supervisor and student. The student should provide a copy of the contract to the Placement Coordinator within one week of beginning the placement. Students should discuss the requirement for case presentations at this time.

2. At mid-placement, the coordinator will contact field supervisors to monitor progress. If a meeting is felt necessary by the Coordinator, field supervisor, or student, one will be scheduled at this time. However, students should feel free to raise concerns at any point during the placement.
3. Upon completion of the placement, students should complete a Student Placement Report and submit this to the Coordinator within one week. Field supervisors will be asked to complete the Supervisor’s Placement Report within one week following completion of the placement. Copies of the Student and Supervisor’s Placement Reports can be found in your LMS placement unit.

4. Students should submit copies of the log book detailing cases and fieldwork, complete logbook reports for each case seen, as well as a minimum of two casebook reports, all signed by their supervisor within one week of completion.

5. The Coordinator will review the placement reports. It is a requirement that all students must successfully complete all placements, and the field supervisor’s report is a primary component in evaluation of outcomes. However, the unit Coordinator makes all final determinations regarding successful completion of external placements.

6. Students MUST make and retain copies of all placement documents in addition to submitting the originals to the placement Coordinator.

**Vacation policy**
Because continuity of care is important for the internal practicum and our clients, practicum activities take place throughout the calendar year and usually only cease for two weeks over the Christmas period. In addition to this period, trainees are allocated four weeks (20 working days) vacation time per year. Vacation requests must be submitted in writing and are subject to approval by the Clinic Coordinator.

When leaving on vacation or for other reasons, it is the trainee’s responsibility to:
- Arrange for another trainee to cover all cases while s/he is away and inform the client about the alternative arrangement in a timely manner
- Indicate in the progress notes of each client the dates of the vacation and the trainee who is providing coverage. Also document that information was given to the client about the trainee’s absence and, if appropriate, about alternative sources of coverage.
- Discuss in advance coverage arrangements with supervisor.

Taking vacation does not exempt the trainee from any aspects of unit requirements. For example, extensions for assignments are a separate issue and must be arranged via the appropriate procedures. Similarly, vacation time must be negotiated separately with external placement agencies.

Please refer to the Clinical Psychology Program Guide for further information on the program leave policy.

**External agencies providing placements**

**Clinical Psychology placements**
To assist in the planning of placements, a list of agencies who have previously offered placement opportunities is given below. Details of placements, supervisors and the type of experience available at these agencies are available in the Placement File, located in The Hub reception area.

**WA Department of Health**

- Adult Outpatient Clinics
- Avro Mental Health Clinic
Centre for Clinical Interventions (CCI)
Fremantle Adult Mental Health Services
Fremantle Older Adult Mental Health Community Service
Fremantle Pain Clinic
Joondalup Community Mental Health
Mills Street Centre (Bentley)
  • Adult Mental Health (inpatient & outpatient)
  • Geriatric Medicine (inpatient & outpatient)
  • Mental Health Service for Older Adults (inpatient & outpatient)
Mirrabooka Mental Health Services
Neurosciences Unit
Osborne Clinic
Peel Mental Health Services
Sexual Assault Referral Centre (SARC)
State Head Injury Unit
Swan Adult Mental Health Centre

Child and Adolescent Outpatient Clinics
Armadale Child and Adolescent Mental Health Service
Child and Adolescent Mental Health Services (Subiaco)
Clarkson Child & Adolescent Mental Health Service
Complex Attention & Hyperactivity Disorders Service (CAHDS) Murdoch
Fremantle Child & Adolescent Mental Health Service
Hillarys Child & Adolescent Mental Health Service
Joondalup Child & Adolescent Mental Health Service
Kalamunda Child and Adolescent Mental Health Service
Peel and Rockingham/Kwinana Child and Adolescent Mental Health Services
Swan Valley Child and Adolescent Mental Health Service
Warwick Child and Adolescent Mental Health Service
Youthlink

Armadale Community Health and Development Centre (CDC)
Bentley Child Development Service (formerly Andrea Way CDC)
Clarkson Child Development Service (CDC)
Fremantle Child Development Service (CDC)
Joondalup Child Development Service (CDC)
Koondooloa Child Development Service (CDC)
Lockridge Child Development Service (CDC)
Midland Child Development Service (CDC)
Peel Child Development Service (CDC)
Rockingham/Kwinana Child Development Service (CDC)
West Perth and State Child Development Service (CDC)

General Hospitals (Adult)
Fremantle Hospital
Hollywood Hospital
Joondalup Hospital
King Edward Memorial Hospital
Sir Charles Gairdner Hospital (QEII Medical Centre)
  • Psychiatric unit (primarily inpatient work)
  • Pain clinic
Royal Perth Hospital
  • Inner City Mental Health Service (inpatient & outpatient)
  • Inner City Mental Health Service for Older Adults
  • Consultation-Liaison Service (psychiatric treatment for medically ill patients at RPH)
  • Sexual Health Unit (HIV/AIDS) (inpatient & outpatient)
Royal Perth (Rehabilitation) Hospital
Psychiatric Hospitals
Early Psychosis Unit, Rockingham
Graylands Hospital
Sir Charles Gairdner Hospital (QEII Medical Centre)
  • Psychiatric unit (primarily inpatient work)

General Hospitals (Child and Adolescent)
Princess Margaret Hospital
  • General
  • Eating Disorders
  • Consultation-Liaison (psychiatric treatment for medically ill children at PMH)
Kalamunda Child and Adolescence Mental Health Service
Peel and Rockingham/Kwinana Child and Adolescent Mental Health Services
Swan Valley Child & Adolescent Mental Health Service
Warwick Child & Adolescent Mental Health Service
YouthLink

Older Adult Units
Armadale Older Adult Mental Health Service
Bentley Elderly Mental Health Service

Clinical Neuropsychology placements

<table>
<thead>
<tr>
<th>Location</th>
<th>Typical clinical groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Neurosciences Unit</td>
<td>Adult and paediatric rotations, or mixed, some geriatric and psychiatry</td>
</tr>
<tr>
<td>Shenton Park</td>
<td>Adult rehabilitation, outpatient, inpatient acute neurology</td>
</tr>
<tr>
<td>Neurocognitive Development Unit</td>
<td>Paediatric</td>
</tr>
<tr>
<td>Next Step</td>
<td>Drug and Alcohol, Psychiatry, residential and outpatient</td>
</tr>
<tr>
<td>State Head Injury Unit</td>
<td>Adult, rehabilitation</td>
</tr>
<tr>
<td>Princess Margaret Hospital</td>
<td>Paediatric</td>
</tr>
<tr>
<td>Osborne Lodge</td>
<td>Geriatric</td>
</tr>
<tr>
<td>Melville Professional Centre</td>
<td>Geriatric</td>
</tr>
</tbody>
</table>

Supervision
Supervision of clinical practice while in training is essential to the development of a clinician or therapist. Supervision is also a requirement of post-graduation registration.

Aims of Supervision
- To assist students in the application of knowledge and skills gained from studies in psychology to professional clinical practice (i.e. science-informed practice).
- To protect clients and students during the learning process.
- To promote ethical and professional standards of conduct and service.
- To support the professional development of students in ways that will increase their effectiveness and self-efficacy as future Clinical Psychologists.
- Activities include observation, evaluation, feedback, modelling and instruction, all within a collaborative relationship.

Appointment of Internal Practicum Supervisors and Field Supervisors
All placements must be supervised by a supervisor who is a member of, or holds qualifications which make them eligible for membership of the appropriate APS College, or of an APS College for supervision for a generalist course, and additionally, should have at least
two years relevant full-time experience as a psychologist, following the award of their postgraduate psychology degree. Supervisors must also be fully registered with the Psychology Board of Australia (PBA). External practica must have a field supervisor on site who meets these requirements.

In instances where there is an appropriate external placement opportunity but the above requirements cannot be met, then an available UWA staff member who meets the above requirements can be assigned responsibility for the placement in conjunction with a member of staff at the agency. (Note this should only occur during one practical placement and must constitute no more than 30% of a student’s total placement experience for that course. In addition, if the student is also completing a placement internally within the UWA School of Psychology, the supervising staff member must be a different person in each case).

Application to become a field supervisor is made by submitting an “Application to become a Field Supervisor” form (including PBA registration details) and current Curriculum Vitae to the External Placement Coordinator.

**Supervision Requirements**

Australian Psychology Accreditation Council (APAC) standards require one hour of direct supervision for each full day of placement. Direct contact supervision may include telephone, video conference or other electronic forms of real-time interaction, as long as the total percentage of supervision conducted by such electronic means across all casework units is never greater than 40% for any given student. Additionally, APS College Approval Guidelines for distance supervision should be met. Where supervision comprises a mix of individual and small group formats, no less than 50% can be individual supervision. Most of your supervision on external placement will be individual. More of your internal practicum will be group-based supervision. During these early stages of learning, students can learn a lot from listening to each other present cases in supervision.

**Policies and Procedures for Placements**

**Pre-Placement**

**Provisional Registration**

As a postgraduate student enrolled in an APAC accredited higher degree leading to general registration, you must be registered as a provisional psychologist with the Psychology Board of Australia (PBA). You will need to register from the commencement of enrolment in your higher degree and for the duration of enrolment; including during completion of your thesis. Please note that this process of registration can take several months. Not being registered may hold up your practicum work.


Once registered, a copy of your registration certificate must be given to the Postgraduate Administrative Assistant, to be filed on your student file.

Working with Children (WWC) Check
Students whose placements require them to work unsupervised with children must also apply for a Department for Child Protection “Working with Children Check” (WWC Check). As a student you are entitled to apply as a ‘volunteer’, with a reduced application fee. Please note that this application process can take several months. Not having a WWC may hold up your practicum work.

You will find further information on the Working with Children Check at:  

Please take your Working With Children Check card to the Postgraduate Administrative Assistant so that a copy can be made for your student file.

Police Check
Students are required to obtain a Police Check prior to client contact. Students must also notify the Placement Coordinator if their criminal record status changes during the course of their study. International students will need to obtain a police clearance from their home country.


To obtain a Clearance Card you will have to show a current (within the last 12 months) Police Check or you can pay a fee (approx. $33.00) for the Health Department to conduct their own criminal record screen.

You will find further information on Police Checks at:  

Please take your Police Check certificate to the Postgraduate Administrative Assistant so that a copy can be made for your student file.

Screening and Vaccination for Preventable Diseases: Requirement for WA Department of Health Placements
It is a requirement of the enabling agreement that allows students to undertake clinical placements in WA Department of Health facilities that students are screened for and vaccinated against the following vaccine preventable diseases before you go on placement (clause 4.17):
- Hepatitis B
- Measles
- Mumps
- Rubella (German Measles)
- Varicella (Chicken Pox)
- Poliomyelitis
- Diphtheria
- Tetanus
- Influenza
- Pertussis (Whooping Cough)
- Tuberculosis (TB)

(http://www.health.wa.gov.au/StudentPlacements/alliedhealth/docs/University%20of%20WA.pdf)
Methicillin-Resistant Staphylococcus Aureus (MRSA) clearance is also required if a student has been a patient or student, or has worked, in any hospital or residential care facility outside Western Australia in the 12 months before beginning a placement (clause 4.18).

As well as offering protection to patients and clients, these requirements support the University’s commitment to take all reasonable steps for the protection of students from dangerous communicable diseases during the period of their enrolment at the University.

Vaccination and Screening
A package of vaccination forms for your doctor to complete can be found in your placement LMS unit

You should take these forms to your doctor and explain that the above requirements need to be completed and documentary evidence submitted to the Postgraduate Administrative Assistant in the School of Psychology prior tocommencing your first external placement. As some vaccinations, such as Hepatitis B, need multiple inoculations over a period of time before immunity is achieved, screening and vaccination should be planned early.

Costs
It should be noted that screening and vaccination costs are your responsibility and will vary for individual students, based on your immunisation history. The costs are an investment in your future because vaccination brings permanent benefits to your professional practice and to your personal wellbeing.

Records
You are strongly advised to keep a copy of your screening/vaccination history in a safe place. Please take a photocopy of each completed form prior to submitting to the School.

Conscientious Objection
The University has an obligation to advise a health facility if you refuse, on the basis of conscientious objection, to be screened and/or vaccinated against any of the above vaccine preventable diseases. If there is a risk that patient safety may be compromised, you may be prohibited from undertaking a Department of Health clinical placement.

Students who choose not to be vaccinated are required to complete the UWA Acknowledgement of Declined Vaccination Form which can be found at: http://www.safety.uwa.edu.au/health-wellbeing/health/medical/immunisation-policy

However, students should still have a blood sample taken to see if they are immune to the infectious diseases listed above.

You will find further information on the UWA Immunisation Policy at: http://www.safety.uwa.edu.au/policies/immunisation

Personal and Professional Insurance
The University has Student Placement Insurance which will cover you as an enrolled student on an approved placement. While on placement, you will be covered by the following policies:

- Group Personal Accident Plan
- Public Liability
- Medical Malpractice
- Corporate Travel

You will find further information on insurance policies at the UWA Risk Management Division website: http://rm.uwa.edu.au/insurance/insurance_guidelines/student_placement_insurance.
**Occupational Health and Safety**
All students should familiarise themselves with the University’s Safety and Health Information for Students ([www.safety.uwa.edu.au/students](http://www.safety.uwa.edu.au/students)).

In the event of an accident or incident you should inform your Field Supervisor and Placement Coordinator as soon as possible. You must complete the University’s Incident/Injury Report Form ([www.safety.uwa.edu.au/forms/incident](http://www.safety.uwa.edu.au/forms/incident)) and any relevant paperwork for your placement agency (e.g. local incident reports, Workcover documentation). If you require medical attention you should seek this immediately. If leave is then required from placement, you will need to inform both your Field Supervisor and Placement Coordinator.

**Motor Vehicles/Transport**
The University is not liable for damage to any vehicles while students are on placement. Students are expected to make their own way to and from placement and are responsible for the insurance of their own vehicle. A student’s private vehicle must not be used to transport clients. Some placements may allow students to drive work vehicles, and this should be clarified during the orientation stage.

**Mandatory Notification by Education Providers and Practitioners In Relation to Impaired Students**

Education providers are required, under s.143 of the National Law, to make mandatory notifications in relation to students, if the provider reasonably believes:

a) A student enrolled with the provider has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm

b) A student for whom the provider has arranged clinical training has an impairment that, in the course of the student undertaking the clinical training, may place the public at substantial risk of harm.

Practitioners are required, under s.141 of the National Law, to make a mandatory notification in relation to a student if the practitioner reasonably beliefes that a student has an impairment that, in the course of the student undertaking clinical training, may place the public at substantial risk of harm.

In all cases, the student’s impairment must place the public at substantial, or considerable, risk of harm in the course of clinical training.

In relation to a student, ‘impairment’ is defined under s.5 of the National Law to mean the student ‘has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the student’s capacity to undertake clinical training’

a) As part of the approved program of study in which the student is enrolled; or
b) Arranged by an education provider.
Mandatory Notification Procedure for Psychology Postgraduate Programs
This procedure requires actions by:
- Coordinators of Psychology Professional Postgraduate programs
- Registered Psychologists involved in teaching, supervising, administering and arranging clinical training.

1) Students will be informed in all program guides/handbooks that the University is required to make Mandatory Notification of Impairment.

2) Students appearing to be experiencing mental distress/dysfunction or drug-affected, will be interviewed by program staff and appropriate risk management strategies will be adopted.

3) A student, who is observed to be impaired to a level that put the public at risk, will meet with the staff member who observed the action for clarification of current status and planned action. The student will be informed that the issue will be escalated to the relevant unit Coordinator and Program Coordinator at this time, even if this does not result in subsequent notification. The behaviour and the meeting with the student will be documented and kept on their academic file.

4) The staff member will then meet with the relevant unit Coordinator to assess level of risk to the public, proposed management plan within the program, and then decide whether the evidence of impairment warrants notification. This meeting will be documented and the outcome provided in writing to the student and kept on their academic file. If deemed not notifiable, appropriate risk management strategies will be put in place.

5) If reportable, the program Coordinator or their nominee will make a notification to the Australian Health Practitioner Regulation Agency (AHPRA). Notification can be made by any method outlined in the Guidelines for Mandatory Notification. Documentation will include full details of the incident in question, including the date/time/location the impairment was observed:


6) Whilst awaiting the PBA decision on action, the student will cease all placements as well as other activities as assessed as necessary on a case-by-case basis.

During Placement
Students are expected to adhere to all professional and ethical guidelines and codes whilst on internal and external placement. They are also expected to consult their Internal Supervisor or Field Supervisor for information on local policies and procedures that should be observed.

Student Concerns or Complaints
It is always advisable to raise any issues or concerns directly with the person concerned. In most cases, this is sufficient to resolve or reconcile an issue. It is our intention to work with students fully to address any questions they may have. We encourage you to think about the program, wonder about different ways of learning or working and share those thoughts/ideas/questions with us. At this level of training, we worry more about students who don’t ask questions than about students who do! It might take several conversations, but our philosophy is that this is how we can work through issues with you, and this is a good model for your training as a practitioner.

If, however, you feel unable to speak directly with the person concerned, speak with another member of staff or a Program Coordinator. Our preference will always be to support our
students, themselves, to find ways to resolve issues directly with the person concerned. Where this is not possible, we will support you in identifying the correct course of action.

On the rare occasion where an issue is not resolved in this way, the University has a clear set of guidelines for how to deal with complaints or grievances. See websites below for more information. It is our strong hope that we never get this far.

http://www.complaints.uwa.edu.au/home/students

http://www.guild.uwa.edu.au/welcome/support/academic

A philosophy of training and supervision in the context of a practicum

Practicum work frequently confronts trainees with new situations, unfamiliar expectations and uncertainties. This is to be expected as you enter into your first experience with clients. Trainees may experience personal problems whilst on placement, or have questions or concerns about some aspect of the placement. In trying better to understand these issues and find answers to these questions, trainees are encouraged to make use of the supervisory relationship. Supervision on placements is for this purpose – to guide you through unfamiliar territory and address the challenges that arise, within a learning framework. It is generally the case that all questions that arise in a practicum are suitable for raising within supervision. The professional expertise of your supervisor and the confidentiality afforded by supervision is designed to facilitate addressing challenges in a safe and supported way with a goal of furthering your learning. This does not mean that it will always be easy to raise issues with your supervisor – it can sometimes be anxiety provoking or uncomfortable. It can also be difficult to receive feedback about your performance in an open way. Learning to manage these feelings and uncertainties is part of your training as a clinician – broaching difficult or challenging issues is a core part of our work. The confidentiality of supervision protects you, your clients and the reputation of the service in which you are completing your practicum. It allows support to be provided, misunderstandings to be clarified, different perspectives to be discussed and problem solving to be undertaken within a learning framework. It also supports a process that allows resolution to be achieved over time – it may take more than one conversation to define the issues, develop an appreciation of different perspectives, think through options, reflect on feedback, decide together on a course of action, trial that course of action, review and refine that course of action. Patience, openness and reflection are key skills in problem solving in a respectful and relational way.

In the rare case in which you feel unable to resolve or discuss an issue with your supervisor, and where this issue relates to your client work or practicum work, speaking with your Practicum Co-ordinator is advised. Together you can review the situation and decide on the best course of action. Preference will generally be given to supporting you to find a way to resolve the issue with your supervisor. Where this is not possible, your Practicum Co-ordinator can advise you who best to speak with and how to go about this. Depending on the issue this may be someone within the practicum organisation or someone within the University. At all times, the guiding principle will be creating a course of action that supports resolution or problem-solving in a way that protects and is respectful of, the student, clients, the practicum agency and the university. In the rare case in which you feel unable to resolve or discuss the issue with your Practicum Co-ordinator or where this person is also your supervisor, you may approach the Program Director. The Program Director will be mindful of, and sensitive to, his or her responsibilities to all involved parties. In seeking support, it is important to be aware of your professional responsibility not to bring your profession or colleagues into disrepute, nor to behave in a way that may do harm to clients. Your Supervisor, Practicum Co-ordinator and Program Director are all aware of these ethical and professional guidelines and so can support you in addressing difficult issues whilst
maintaining these professional responsibilities. You can find these guidelines at the Australian Psychological Society website: http://www.psychology.org.au/about/ethics/.

If your questions relate to teaching issues or your broader program of learning it remains desirable first to try to address the issue directly with the person involved. Most issues can be quickly resolved this way with one or two meetings. If you have been unable to resolve your concerns, we would prefer that you respectfully let your tutor/lecturer/supervisor know that you would like to talk the issue through with the Practicum Co-ordinator, Program director, Director of Postgraduate studies or, eventually, Head of School. However, UWA procedures (http://www.complaints.uwa.edu.au/home/students) allow that students may prefer to seek advice initially from the Guild, Student Support, faculty or Head of School. None the less, the University encourages you to resolve all issues locally, wherever possible. These discussions, which may include talking between students, must not breach confidentiality of clients, colleagues, fellow students or staff.

Our aim is to resolve all issues safely, and, wherever possible, to the satisfaction of all parties. By approaching all discussions in a respectful and open way, most concerns can be resolved quickly.

Concerns of supervisors
Sometimes supervisors have concerns about an aspect of a student’s behaviour or practice. Just as has been outlined above, these will be raised with the student concerned, wherever possible, and then with the Practicum Coordinator if required. Usually, the mid-placement review will be a forum in which such issues are discussed and resolved.

Mid-Placement Review for External Placements
Students are required to nominate the date of a Mid-Placement Review on the Placement Contract at the start of each placement. The purpose of the Mid-Placement Review is to:
- review progress of goals outlined in the Placement Contract
- give mid-placement feedback to the student on his/her clinical performance
- allow the student to comment on the quality of the placement
- give mid-placement feedback to the supervisor on his/her supervision
- resolve any difficulties
- set targets for the second half of the placement

The Mid-Placement Review meeting should take place between the student and Field Supervisor, with the Mid-Placement Review Report being completed at this meeting. Your Field Supervisor will then send a copy of the report to the Placement Coordinator. A meeting with the student, Field Supervisor and Placement Coordinator will be convened if it is considered necessary by any of the relevant parties. This should ensure that any significant concerns that arise are addressed early.

A copy of the Mid-Placement Review form can be found in your LMS placement unit.

Post-Placement

Log Book Entries
Students must ensure that all completed and signed log book entries is filed in their Student Log Book and an electronic copy submitted to the Placement Coordinator. Student Log Books for students enrolled in the Clinical program will be held with the Postgraduate Administrative Assistant in the Hub Reception (GP3). See later section on log books for further detail.

Student’s Placement Report
Students are required to submit a Student’s Placement Report to the Placement Coordinator within one week of the end of the placement. Photocopies of these reports (minus the Field Supervisor’s comments) may be kept in the Placement File in the Clinical Unit for general
perusal by students. This provides a varied and insightful account of students' experiences in various agencies and helps to guide students and the Placement Coordinator in the selection of future Placements.

A copy of the Student Placement Report form can be found in your LMS placement unit.

**Supervisor’s Placement Report**

It is requested that the Supervisor’s Placement Report be completed by the Field Supervisor and forwarded directly to the Placement Coordinator no later than one week after the end of the placement. The purpose of the report is to provide the student with feedback on performance in the placement and to point to areas of strength and weakness in clinical skills, while providing information to Program Coordinators on how the student is performing in an applied setting.

**Please note:** It is a requirement of the program that you pass each of your placements. Whilst the Field Supervisor’s assessment of you during your placement and their subsequent Placement Report make a significant contribution to determining this outcome, the final decision for a Satisfactory Performance on Internal and External Practicum lies with the Placement Coordinator, and will be discussed with the Program Coordinator.

A copy of the Supervisor’s Placement Report form can be found in your LMS placement unit.

**Placement Checklist**

**Planning**
- Enrol in the correct placement unit
- Ensure you are provisionally registered with the Psychology Board of Australia (PBA)
- Ensure your Police Check and Working With Children (WWC) Check are complete
- Complete your placement preferences form
- Prepare your Curriculum Vitae
- Once notified by the Placement Coordinator of a placement opportunity arrange an initial meeting with your potential Field Supervisor
- Confirm placement arrangements with the Placement Coordinator and Postgraduate Administrative Officer
- Confirm placement dates with your Field Supervisor

**Preparation**
- Read the Placement Guide
- Complete preparatory reading
- Undertake any required skills preparation
- Negotiate and prepare your Placement Contract
- Submit your Placement Contract to the Placement Coordinator no later than one week after the commencement of placement
- Obtain a copy of the placement organisation’s relevant policies and procedures

**Supervision**
- Maintain log books
- Maintain reflective journal (optional)
- Prepare client reports and case notes as required
- Ensure that your mid-placement review occurs
- Ensure that you receive adequate supervision and consult the Placement Coordinator if you have any concerns

**Completion**
- Debrief with your Supervisor
Submit a placement folder containing your log books, placement reports etc. Please ensure you keep copies of all relevant documentation before submission of your placement folder. If you intend to apply for accreditation overseas at any time in the future, you will be required to produce these documents.

Ensure your Internal Supervisor or Field Supervisor submits the Supervisor’s Placement Report

Responsibilities

Student’s Responsibilities

- Enrol in the correct placement unit, and ensuring you withdraw from the unit prior to the census date if your placement does not proceed as anticipated.
- Register with the Psychology Board of Australia (PBA).
- Plan your placement with the Placement Coordinator, Internal Supervisor or Field Supervisor, and identify any necessary preparatory work (such as pre-reading, skills practice, expertise or familiarity with psychological tests).
- Complete the required preparatory work before starting placement.
- Identify personal goals for the placement (especially areas for development as identified with previous supervisors) and include them in your Placement Contract.
- Document the agreed Placement Contract and submit it to the Placement Coordinator no later than one week after the commencement of your placement.
- Notify the Placement Coordinator of any modifications made to the Placement Contract.
- Seek your Field Supervisor’s advice on, and carefully adhere to, (i) the role and place of students within the agency and (ii) the agency’s policies and procedures.
- Maintain a log book of (i) activities and (ii) supervision sessions. Ensure that your Field Supervisor’s comments on areas that require further development are recorded in your log book.
- Inform your Field Supervisor if (i) you feel that adequate guidance or opportunities for development are not being provided or (ii) you feel unable or unwilling to follow your Field Supervisor’s instructions.
- Organise your mid-placement review.
- Notify the Placement Coordinator of any problems within the supervisory relationship that cannot be resolved in discussions between you and your Field Supervisor.
- Attend to areas (knowledge and skills) identified by your Field Supervisor as areas for development.
- Inform your Field Supervisor immediately if you have concerns about the safety of a client.
- Ensure confidentiality at all times.
- Ensure that your Field Supervisor approves all client reports (verbal or written).
- Submit written reports, case formulations and case/file notes at a standard that is satisfactory to your Field Supervisor.
- Submit a Student Placement Report at the end of placement for inclusion in the placement information book. With your consent a copy may be sent to your Field Supervisor.
- Submit a placement folder to the Placement Coordinator within one month of placement completion and preferably before commencing a new placement.

Supervisor’s Responsibilities

- Provide relevant information to the University, including a Curriculum Vitae and PBA registration details.
- Undertake ongoing professional development related to supervision.
- Negotiate an appropriate Supervision Agreement which includes the relevant goals proposed by the student.
- Ensure the goals and tasks of supervision can be realistically met within the designated placement hours, or contract with the student and Placement Coordinator a longer placement.
• Create a positive, collaborative relationship with the student which enhances their professional development and self-efficacy.
• Ensure that clients are informed of the student’s status as a Provisional Psychologist who is undertaking advanced or specialised training in Clinical Psychology.
• Provide the Student with written policy statements for any special or emergency procedures (i.e. managing a threat of suicide in-session) and contact details of people available for an urgent consultation if a serious problem arises.
• Provide comments on the student’s progress in their log book; in particular, ensuring that areas (knowledge and skills) requiring special attention or development are documented as they become evident.
• Take the lead in addressing any problems or conflicts that arise with the student.
• Inform the student, at the earliest possible time, if there are concerns with their work. Suggest possible methods of remediation and document relevant information in the student's log book.
• Inform the student and the Placement Coordinator, at the earliest possible time, if they foresee any reason why the student is unlikely to meet the requirements of the placement.
• Conduct a mid-placement review with the student and, if necessary, modify the placement goals.
• Ensure appropriate confidentiality for the Student at all times and inform them of legal or contractual limits (such as with the agency or University) on confidentiality within the supervisory relationship.
• Provide no reports to any party on the student's performance except as specified in the Placement Contract or following the student’s written request or consent.
• Discuss all reports with the student before submitting them to the Placement Coordinator.
• Provide the student and Placement Coordinator with a final placement report.

Placement Coordinator’s Responsibilities
• Assist the student in selecting a suitable program of placements.
• Consider student choices and specific learning requirements when assigning placements.
• Liaise with the Internal Supervisor or Field Supervisor.
• Ensure the student has received appropriate preparation for commencing placement.
• Ensure that previously identified areas for development have been incorporated into the Placement Contract that the student negotiates with their Field Supervisor.
• At the request of either the student or the Field Supervisor, visit the agency for a three-way discussion of any identified problems.

Log Books
In keeping a log book...

‘...we take something from inside ourselves and we set it out: it is a means of discovering who we are, that we exist, that we change and grow. The personal journal has been used for hundreds of years to articulate the human drama of living and to explore new knowledge.’


APAC/registration requirements
APAC standard 5.1.17 (June 2010) requires that every postgraduate professional coursework student maintains a single log book of practica, casework and supervision experiences. The log book must detail the nature and hours of all placement or other practica undertaken (internal and external), as well as the dates, nature and hours of supervision, with group supervision clearly differentiated from individual (i.e. one-on-one) supervision and with the log book clearly specifying the nature of client work undertaken. It is essential that log books be completed in detail, and that copies are retained both by the
student and the School. In reviewing graduates' eligibility for registration or membership, and/or the accreditation of the School, Registration Boards and professional bodies are entitled to view this information on request. The placement log books establish that each trainee has seen an adequate range of presenting problems occurring across the lifespan, from childhood to older age, and, under supervision, has applied a range of assessment and treatment methods. The log book should provide a rich source of information both of (i) activities undertaken in client contact and supervision and (ii) student progress. The responsibility for maintaining an ongoing record of details of client contact and supervision falls with the student. Details to be provided by students include activities undertaken; areas covered in supervision; client characteristics, issues and diagnoses; context of client contact; assessment and/or intervention procedures; contact with carers/school teachers etc.

Supervisors are required regularly to endorse, by signed notation, that the log book is a true reflection of the practica undertaken and log books must be available for inspection by APAC if requested during an audit or accreditation assessment. Supervisors are encouraged to note relevant issues regarding student progress over time in the “supervisor comments” column. A final check of the log book must be a requirement of the course and this check must be confirmed by the signature of the/a primary supervisor on the log book itself.

A copy of the log book will be retained by the School for a period of 10 years following the graduation of the student which can be inspected by APAC or the Registration Board on request.

The log book should be carried over into the 2nd year of postgraduate training and subsequent years of professional postgraduate training and a copy retained by the School for a period of 10 years following the graduation of a student which can be inspected by APAC or the Registration Board on request.

Copies of updated pages of the log book should be provided by the student to the Placement Coordinator on a regular basis. This provides the Placement Coordinator with regular and ongoing information regarding progression of the placement, in addition to the three “formal” pieces of placement documentation: (i) Placement Contract, (ii) Mid-Placement Review and (iii) End of Placement Review/Supervisor’s Report. Furthermore, communication from either student or Field Supervisor by email or telephone is encouraged throughout the placement should any issues arise that cannot be resolved between the student and Field Supervisor.

A copy of the Excel log book template can be found in your LMS placement unit. Log book entries must be regularly printed off, signed by your supervisor and stored in your personal log book file.

The structure of the logbook

This log book serves a variety of different purposes:

1. It documents the clients you have seen and what you did with them;
2. It documents the supervision you have received and your experience of that supervision;
3. It serves as a record of your progress in developing your practical clinical skills;
4. It records your learning, both when and what you learned;
5. It provides a space for you to reflect on your experiences, and reflection is associated with deeper learning: a personal understanding of the content of your courses, placement or research.

As a result, it has four different sections which, together, address these purposes.

A log book of this type is helpful at a number of levels:

1. It provides a log of your training activity so allowing you to demonstrate that you have achieved the requirements necessary for passing each placement and, for graduation, and, once you graduate, for registration;
2. Such records personalise and deepen the quality of your learning, by helping you to integrate the material (whether that is from academic units, personal study, practical or life experience or learning) with what you already know. The more you write: the better you will remember;

3. Records of this type help you to identify and meet your learning needs: for example, identify your strengths and areas where further development is required;

4. A personal record encourages you to be actively involved in and, more importantly, take ownership of your learning;

Such records are highly individual so your records may be quite different from another student’s. It will take time to build these records; time which you need to set aside regularly. What you record, especially in your reflective diary is entirely up to you. If you like structure: be structured. If you like to record your impressions in an unstructured way, then do that.

The first three sections are required. The last one (Section D), the reflective log, is entirely optional. However, evidence suggests that students find the reflective log very helpful, and a useful adjunct to the more ‘number crunching’ style of the first three log sections (A to C).

**Recording of Practicum Activities (Section A)**

An entry into the record of practicum activities must be made on a daily basis and contain the following information:

a) Supervisor and placement agency details
b) Date of practicum activity
c) Client ID and presenting issues
d) Description of practicum activity
   I. detail direct client contact including details of psychological assessment and/or intervention/prevention/evaluation
   II. Detail other client-related activity including details of activities related to problem formulation, treatment planning/modification and reporting/consultation.

e) Client details:
   - Client Age - choose from one of the following dropdown options:
     Infant (0-3)
     Child (4-13)
     Young Person (14-25)
     Adult (26-50)
     Older Adult (50+)
   - Client Type: choose from one of the following dropdown options:
     Individual
     Couple
     Family
     Group
     System/Organisation (e.g. school, nursing home, hospital ward)

f) Mode of activity - choose from one of the following dropdown options:
   Direct client contact:
   - In person
   - Telephone
   - Videoconference
   - Observation
   - Observation of supervisor with client

   Or

   Other client-related activity:
- Consultation with other health care staff (e.g. OT, SLT, Psychiatrist etc.)
- Designing an intervention
- Discussions with placement Coordinator
- Negotiating workplace agreements (e.g. drafting placement contract)
- Note taking
- Peer discussions (with fellow trainees)
- Preparatory reading
- Record keeping
- Reflection (self-assessment/self-evaluation)
- Report writing
- Reviewing client videos
- Selecting assessment instruments
- Writing log books/casebooks
- Other Activity (Not otherwise specified)

g) Duration of the activity: in hours to the nearest quarter hour.

**Recording of Supervision (Section B)**

The record of supervision must contain the following information for each supervision session:

a) Supervisor and placement agency details
b) Date of the supervision session
c) Description of the supervision session - including issues brought to supervision for discussion and a brief record of content of discussion and issues
d) Mode of supervision - choose from one of the following dropdown options:
   - Face to face discussion
   - Discussion by videoconference
   - Direct observation and feedback
   - Viewing of client session tape and feedback
e) Duration of the supervision session (individual or group supervision)
f) Action points and reflection - including plans for follow-up activities and/or discussion and plans for further development of knowledge and skills relevant to the core capabilities
g) Supervisor’s comments and feedback

**Recording of Professional Development Activities (Section C)**

Students are required to keep a record of their professional development activities throughout their enrolment in the program.

The primary aim is to encourage students to take advantage of relevant professional development activities during their enrolment, to develop an awareness of available professional development activities (e.g. APS College events, School Colloquium, …), to network with practicing Clinical Psychologists, to develop specialist skills both those taught and those not taught within the program, and to record this in a way which is consistent with the requirements of registration and accreditation bodies.

Students should document professional development activities in Section C (Record of Professional Development) of their online log books. Where appropriate, students should provide verification of participation in a professional development activity (e.g. tax invoice for registration at a conference/workshop/seminar) including documents that show the content of the activity.

Any queries regarding the recording of professional development should be directed to the Program Coordinator.
**Neuropsychology Log books and Case books**

Students completing clinical neuropsychology relevant experiences must record their placement activities and all cases seen in individual log book reports. *(note these logbook reports are different to, and IN ADDITION TO the general logbook described above).* In addition, a more detailed description of 10 cases must be completed in the casebook. All logbooks and casebook entries undertaken during a placement must be completed and approved by the field supervisor PRIOR to the completion of the placement.

**Log book cases**

In addition to the log book entries required above, neuropsychology trainees are required to complete a minimum of 50 neuropsychology-relevant cases they have seen, about which they have written at least a brief report or intervention plan. Such log entries are meant to be self-contained but relatively brief (e.g. about 1 page), and include:

- location the patient was seen
- date(s) the patient was seen
- referral question
- brief synopsis of the report or neuropsychological intervention program (e.g. the “summary” section of the report)
- The diagnostic category/clinical population (Paediatric, Geriatric, Psychiatric, Rehabilitation, or Acute Neurology/Neurosurgery)
  - Note: use ONLY the above five categories. Some patients may fit in more than one category, if this is the case, list all that are relevant
  - The category/categories must be approved by the supervisor, and the supervisor must sign all logbook cases.

**Casebook cases**

Further, neuropsychology students are required to complete a more detailed casebook containing a subset of at least 10 of the cases reported in the logbook cases above. The casebook is meant to demonstrate that the student has developed an understanding of a wide variety of neuropsychological syndromes and populations, and should include at least one case each of the five populations listed above. The student should demonstrate understanding of both theoretical and practical issues related to providing ethical and competent services to a diverse range of individuals. The casebook entries should include:

- referral question
- detailed developmental, medical, and psychosocial history
- other relevant background information
- a discussion of
  - the hypotheses that were tested through the assessment procedures
  - the rationale for the choice of assessment instruments and techniques
  - results of the tests and techniques used
  - theoretical models and/or research literature that contributed to the case formulation (with references)
- an integrative summary
- recommendations and treatment options
- photocopied de-identified test protocols for each casebook case
- While the clinical report written for the placement agency would provide a solid foundation upon which to build the casebook entry, it would typically be insufficient for this purpose. That is, the casebook entry is expected to include a greater level of detail and discussion of the case formulation process than would be seen in most clinical reports.
- Each casebook entry must be signed by the field supervisor who supervised the case. This must be completed PRIOR to completion of the placement.
Students usually complete three full-length (i.e. 37 or 45 day) placements in addition to other placement experiences, so students should aim for approximately three cases for each placement.

**Oral case presentation guide**

**Time and format**
Your presentation should run for no more than 40 minutes allowing 20 minutes for questions.

You may choose to use PowerPoint but it is not essential (nor even desirable in some situations).

You may choose to include a classroom demonstration to illustrate a key point.

You may include a short transcript from the case if this will help to illustrate a point.

You should prepare your presentation as though your client will be in the room during your talk. This will help you to be mindful of being judgemental in your framing or interpretation of their situation.

**Choosing a case**
You may choose an individual, couple, family or group that you have worked with – you may present with a colleague if you have been working together. In this case you will need to let me know who prepared which parts of the presentation.

It is not necessary to choose a ‘successful’ or even a completed case though you may wish to do so. You can also choose a case that has been particularly challenging for you or that you are currently still struggling with.

**We will be interested in**
Your client’s initial presentation and any initial challenges that you faced with engagement.

Your conceptualisation of the case – this may be a formulation or a hypothesis, or even a series of hypotheses. Also, how you differentiated between hypotheses.

Difficulties that you encountered and how you interpreted and responded to these. We are also interested in the subsequent impact of these choices on both you and your client.

Important clinical moments in your work together e.g. critical turning points, moments of rupture or impasse, and also of re-engagement.

Progress or lack of progress and how you assessed this

In sum, we are interested in your process of clinical decision making as well as learning about the particular issues that were confronting your client.

****Critical reflections on what you learned and/or what you might do differently next time, are a key element of a successful oral presentation in this unit.****

**Other**
You should bring some key references and resources to share with your colleagues that relate to this case. These will be an assessable part of this presentation. These may include journal articles, resources for clients, treatment guides, multimedia relevant to this particular case etc.
APPENDIX A: Reports, Summaries and Progress Notes

General
All reports and letters leaving the Clinic are to be on a Clinic letterhead. All reports, letters and envelopes containing client information are to be stamped “Confidential”.

Contact Summary Forms
Every file that is created has a Contact Summary Form (see Appendix B). The date and nature of all client contacts (e.g. telephone calls, sessions, missed sessions) should be noted on this form and initialled by the person making the entry. The date and nature of other client-related matters should also be recorded on this form, for example, the date that intake, progress, and termination reports were presented at clinic meetings or reports are filed. For each entry on the Contact Summary Form, there must be a corresponding entry in the Progress Notes.

File Summary Forms
Every file that is created has a File Summary Form (see Appendix C). The first entry in this form is the name of the client, the name of the therapist, the date the client was assigned to the therapist and the date the therapist first made contact with the client (to make the first appointment). The purpose of this form is to assist therapists to keep track of when reports are due to be written and presented to the clinic meeting, when further sessions are due to be negotiated, and when psychometric assessments need to be re-administered.

Intake/Assessment Reports
A report must be written after an initial interview with a client. If necessary, the gathering of assessment information can be continued during one or two additional fifty minute sessions. Outlines for adult and child/adolescent assessment reports are shown in Appendices D and E.

As noted on these outlines, all of the items are not necessarily included in the report; information should be included only if it is relevant to the particular client and his/her problems and life circumstances. The adult intake report can be adapted for couples and families; relevant background information for each person should be highlighted, including each person’s perception of the problem, and comments about the clients’ interaction patterns should be included.

A DSM-IV and ICD-10 diagnosis and code number must be included in the assessment report, and the reasons for the diagnosis must be stated in the case formulation. Any changes in the diagnosis during the course of treatment should be noted in the progress notes and in subsequent reports (e.g. progress report). If a diagnosis made during the assessment process is provisional, this should be clearly stated and must be followed up in subsequent reports.

A note should be made in the progress notes specifying when the intake process has been completed (e.g. that sufficient background information has been obtained for the report).
Final intake reports are due two weeks after the intake information has been gathered. In the event that the final report is delayed (e.g. supervisor needed more time to review and sign report), it is the therapist's responsibility to file a draft of the intake report (labelled “Draft”) with a note stating by when filing of a final report is expected.

Update Reports
These provide a periodic review of client progress, therapy goals, and means used to achieve those goals. An Update Report needs to be written at each transition point in therapy. For instance, if at intake it was decided to offer therapy for an initial 8 sessions and after these sessions therapy was extended, then an update report should be written after the initial 8 sessions. This report is to be filed within 2 weeks of the decision to extend therapy. Reports should be one half page to one page long.

The following information should be included in a summary: a brief statement of the presenting problem(s), the number of sessions and the inclusive dates that services have been provided since the client began therapy (e.g. Ms P was seen for eight sessions between November 16, 2009 and March 29, 2010). The summary should also highlight the following information:

1. The target areas that have been the focus of therapy and the therapeutic approaches used.
2. The client's progress (e.g. the goals that have and have not been achieved).
3. The goals of the additional sessions.

The update report provides an excellent opportunity for therapists to reassess their diagnostic decisions and treatment strategies for clients. Documentation of client progress must include reference to objective assessment data.

Transfer Reports
These are written when a client is transferred from one clinic therapist to another and are similar to an update report; the topics specified for the update report are covered from the beginning of treatment to the time of the transfer. The recommended goals and approaches for future therapy are also given. Finally, the reason for the transfer is stated and the name of the therapist to whom the client is being transferred is given.

The therapist who is transferring the client writes transfer summaries. Transfers should be noted in the contact summary form. This report is to be filed within 1 week of the last session conducted by the transferring therapist.
**Termination Reports**

These are written when a therapy case is closed (they are not needed for cases that are strictly assessments). Sometimes a specific decision to terminate a client will not be made but the client will fail to contact to reschedule missed appointments. If the therapist’s efforts to contact the client by telephone are unsuccessful, then the therapist should send a letter to the client stating: (1) the client’s last contact with the clinic and the therapist’s efforts to contact the client, (2) that it will be assumed that the client is no longer interested in services if s/he does not contact the clinic by a specified date (usually two weeks from the time the letter was sent), and (3) that, if the client decides to decline further services at this time, s/he should feel free to contact the clinic if services are desired in the future. The case should be closed if the client does not respond to the letter by the specified date.

The summary covers the entire course of therapy and the heading and topics are the same as for the transfer report. Statements concerning the reason for termination and whether termination was mutually agreed upon should be included, as should recommendations for future treatment if appropriate. Termination reports are due two weeks after the contact with the client in which the decision to terminate was made.

**Case Re-openings**

If a former client requests services after a previous termination from the clinic, then a case reopening report is written. This is almost identical to an intake report except that it clearly indicates that the client has previously received services in the clinic and background information does not need to be described in as much detail; the reader can be directed to see the previous intake report(s) for more detailed information (the date(s) of the previous intake report(s) should be specified). The case reopening report must update the previous intake and note any changes that have occurred. This report is to be filed within 2 weeks of the first session with the client.

**Progress Notes**

These provide records of all interactions and actions concerning the client (including phone messages left or received, letters sent or received, etc.) as well as an up-to-date summary of therapy sessions. Every contact with the client (by phone, in person, or by mail), or concerning the client, must be recorded in the progress notes. Each entry should be legibly written, dated, and signed by the person writing the notes. Additional sheets should be added below existing notes so that the record proceeds from front to back in the file. Supervisors need to countersign case notes.

Notes should also be used to provide records of dates of intake and testing sessions (including what tests were administered on a given day), efforts to call clients who have failed to return for treatment, and dates and content of phone calls with clients or with others concerning the client (e.g. GP, psychiatrist, teacher, probation officer; this assumes that a signed release of information form is in the client’s file), no matter how trivial the call may seem. Essentially, all events relevant to the client should be recorded in the progress notes.

A progress note should be written immediately after an interaction or event. If this is not possible, then the note must be written within 24 hours.

**Signatures**

The therapist and the supervisor must sign all letters and assessment reports. Therapists should use the title “Postgraduate Psychology Trainee (Clinical)”. The title for supervisors should be “Supervisor,” and “MPsych” or Ph.D.” should be placed after their name.
**Typing Reports and Letters**

Therapists are responsible for typing their own reports, summaries, and letters. A series of computers are available in the computer room (1.08) in the Clinic for this purpose. This room is to remain locked to prevent unauthorized entry. A login called 'room108' with password 'room108' is to be used in the IT Room/Library 108, First Floor GP3 building. On this login you will have the two printers (copier and laser) already connected and also the web browser is setup to go through the proxy so you should use this login in preference to your personal account (if you have one) in this room. Remember these computers are not backed up and are accessible by others, therefore, so do not leave any of your documents/files on these systems.

Files containing reports in progress are to be stored on therapists’ own USB Flash Drive/Thumb drive, not on the hard disk of any computer. Some special considerations must be taken when doing reports on computers. USB Flash Drives with client information must be treated with the same consideration and security that you would give to a hard copy of the report. **Flash Drives (like any other material) with identifying client information on them must not be taken out of the clinic.** A code (such as Ms X or Mr E) is to be used in place of the client’s name until the final report is ready to be printed. The code can be replaced with the actual name of the client immediately before printing. After printing, files with identifying client information must be deleted. Once the final report is on file, any disk copies must be erased.

**Filing Reports and Letters**

For any reports that are to be sent out of the clinic, therapists should print two versions and have original signatures on both. One is filed in the client’s file and one is mailed. A final version is one that is free of typing mistakes, single spaced, on letter head paper, and signed by the therapist and supervisor. Copies of all other correspondences to a client or to others concerning a client must be placed in the client’s file. All filed reports and letters must be recorded on the Contact Summary Form and in the Progress Notes.

**Mailing Reports and Letters**

Therapists are responsible for ensuring that reports and letters are mailed, if appropriate (e.g. if a signed release of information form is in the file and if the release is approved by the supervisor). The office assistant may be asked for assistance. It is also the therapist’s responsibility to record on the Contact Summary Form and in the Progress Notes the materials that were sent, the date they were sent, and the name and address of the person or agency to which they were mailed.

**Sample Reports**

Examples of the various types of reports typically written at the clinic are available in the therapist’s room. These are not meant to be “perfect” reports, rather they show the general structure and organisation used in the reports and the type of content that is often included.
# APPENDIX B: Contact Summary

## CONTACT SUMMARY

Client: ____________________________

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APPENDIX C: File Summary Form

FILE SUMMARY FORM

CLIENT NAME: _______________________________ M / F D.O.B: / /

DATE ASSIGNED: / / DATE CLIENT CONTACTED BY THERAPIST: / /

THERAPIST NAME: ___________________________ SUPERVISOR: _______________________

INTAKE

DATE OF 1ST ASSESSMENT: / / DATE ASSESSMENT COMPLETED: / /

ASSESSMENT TOOLS ADMINISTERED: ________________________________________________________________

PROJECTED DATE INTAKE REPORT DUE (2 weeks from completed assessment): ____________________________

REPORT PRESENTED TO CLINIC MEETING AGREED NO. SESSIONS: __________

DRAFT INTAKE REPORT COMPLETED & FILED __________________________________________________________

FINAL INTAKE REPORT COMPLETED & FILED __________________________________________________________

PROGRESS

<table>
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<tr>
<th>Date of decision to extend therapy</th>
<th>Sessions completed</th>
<th>No. of further sessions</th>
<th>Date Progress Report (P.R) due</th>
<th>Date P.R given at Clinic meeting</th>
<th>Assessment tools administered</th>
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TERMINATION

DATE OF FINAL SESSION: / / TOTAL NO. SESSIONS: __________

ASSESSMENT TOOLS ADMINISTERED: ________________________________________________________________

PROJECTED DATE TERMINATION REPORT DUE (2 weeks from final session): ____________________________

DATE REPORT PRESENTED TO CLINIC MEETING: ______________________________________________________

DATE TERMINATION REPORT COMPLETED & FILED _____________________________________________________
APPENDIX D: Confidential Intake Report (Child)

CONFIDENTIAL INTAKE REPORT (CHILD)

NAME:
DATE OF BIRTH:
AGE:
SEX:
RACE:
SCHOOL:
GRADE:
DATE(S) OF INTERVIEW:
INTERVIEWER:
SUPERVISOR:

PRESENTING PROBLEM
ONE OR TWO SENTENCE DESCRIPTION OF WHY CLIENT CAME TO THE CLINIC AND REFERRAL SOURCE, IF ANY.

BEHAVIOURAL OBSERVATIONS/MENTAL STATUS:
TO BE ITEMISED IF RELEVANT:

- Appearance (height, weight, manner of dress, grooming: does child appear to be well cared for?)
- Behaviour/Movement (withdrawn, hyper, coordination)
- Appropriateness of affect (flat, blunted, labile)
- Mood (depressed, elevated, anxious)
- Appropriateness of interpersonal interactions (including eye contact)
- Orientation to time/place/person
- Intellectual functioning
- Observable idiosyncrasies (tics, odd behaviours)
- Reported hallucinations and/or delusions
- Suicidal and/or homicidal ideation (always include a statement addressing whether or not the client, in your judgement, is suicidal or homicidal; indicate what you are basing your conclusion on, e.g. client’s response to your question suicide checklist)

If evidence of depression or suicidal ideation:

Administer Suicide Checklist.....If client scores in the high moderate or severe range, seek out your supervisor immediately to determine whether the client may safely leave the clinic.

OBSERVATION OF PARENTS AND PARENT/CHILD INTERACTION:

- Patterns of exchange between members (do members talk to each other or only to the therapist? Do the parents relate easily to each other? Does the child easily approach parents or does s/he appear hesitant to interact with them?)
- Interactional styles (e.g. aggressive, empathic, hostile, respectful)
- Dynamics between members (Who appears to be in control, be submissive, be neglected, be struggling for attention?)
BACKGROUND INFORMATION: (include remarkable information only)

Family

- Where born/how many times moved since birth?
- Marital status of parents
- Family members
- Where born/how many times moved since birth?
- Marital status of parents

Family members

- Ages
- Education
- Occupations
- Health/living
- Birth order
- Relationship with each member
- History of mental illness/substance abuse/suicide
- Natural children vs. adopted

- How does child get along with brothers/sisters?
- How does child get along with mother/father?
- Any relatives nearby? How does child get along with them?

Social Situation/Peer Relationships

- Description of child’s friends
- How does the child get along with peers?
- What does the child enjoy doing for fun?

Educational History

- Who is the child’s teacher?
- What grade is the child in? Any grades repeated?
- History of and current academic performance
- Child’s behaviour in school
- Any significant changes in behaviour of performances in school? When did changes occur?
- Does the child like school?
- School phobia/separation anxiety?

Developmental History

- Any problems with pregnancy, labour or delivery?
- Planned/unplanned pregnancy?
- When did child first walk?
- When did child first talk?
- When did child feed self?
- When did child drink from a cup?
- When was child first toilet trained?
- Any significant problems achieving developmental milestones?

Medical History

- Major illnesses/accidents/hospitalizations, prescription medications
- Alcohol/drug use/abuse/dependence
- Changes in sleep/appetite/libido
- Nutritional habits
• Physical exercise
• When was the most recent exam? Results?
• Any allergies?
• Has child been tested for vision and hearing? If so, were any problems detected?

**Miscellaneous**

• Physical environment
• Family financial information
• Religious considerations
• Parents occupation/job satisfaction/job security
• Any record of delinquent behaviour/court involvement?

**Psychiatric History**

• Hospitalisations
• Previous psychotherapy/counselling? Where? When? Who?
• Medications
• Suicide attempts?

**History of presenting problem:** (include remarkable information only)

• Nature of the problem
• When first noticed? Sudden vs. gradual onset? Life circumstances at onset?
• Under what conditions is it most problematic? Was there a change in pattern?
• Under what conditions is it least problematic? Was there a change in pattern?
• Dimension of the problem (frequency, duration, pervasiveness, magnitude)
• Consequences to child for engaging in the problematic behaviour(s)?
• Corrective measures attempted in the past
• To what extent and how were they helpful in attenuating the symptoms?
• Who sees it as a problem (child, parent, teacher, court)?
• What does the child find reinforcing?
• What is the child’s perception/understanding of why s/he is seeing a therapist?

**SCREENING/TESTING**

Provide a brief summary of results and interpretation (attach complete test results as an appendix). Be sure to state clearly what the results mean, i.e. avoid jargon and provide descriptors of what scores reflect etc. If norms are available use them and state who they represent. Be sure to include in your summary the following information:

• Is it valid?
• Is score or profile consistent with information obtained from interview?
• Is score or profile consistent with information obtained from other tests?
• In your interpretation state explicitly how test results related to the specific presenting problem and/or referral question.
• Indicate with a sentence or two how the information gained from the test might lead to specific treatment goals/recommendations (to be stated in detail below)

**SUMMARY AND RECOMMENDATION**

A summary should not include new information. It concisely presents a restatement of the referral question and an integration of the most pertinent information regarding background, observations, test results and test interpretation.
If appropriate, a diagnostic impression should be given by listing a DSM-IV diagnosis and code number.

List recommendations, which would be specific and practical. They may include treatment goals and strategies, referrals to other agencies, or further assessment. Primary recommendations should relate to the referral question.
APPENDIX E: Confidential Intake Report (Adult)

CONFIDENTIAL INTAKE REPORT (ADULT)

NAME:
DATE OF BIRTH:
AGE:
SEX:
RACE:
EDUCATION:
OCCUPATION
MARITAL STATUS:
DATE(S) OF INTERVIEW:
INTERVIEWER:
SUPERVISOR:

PRESENTING PROBLEM

ONE OR TWO SENTENCE DESCRIPTION OF WHY CLIENT CAME TO THE CLINIC AND REFERRAL SOURCE, IF ANY.

BEHAVIOURAL OBSERVATIONS/MENTAL STATUS:

TO BE ITEMISED IF RELEVANT:

- Appearance (height, weight, manner of dress, grooming
- Appropriateness of affect (flat, blunted, labile)
- Mood (depressed, elevated, anxious)
- Appropriateness of interpersonal interactions (including eye contact)
- Orientation to time/place/person
- Insight/judgement (poor, fair, good)
- Speech/thought content and process (logical, coherent, rational sentence structure, goal oriented)
- Observable idiosyncrasies (tics, odd behaviours)
- Reported hallucinations and/or delusions
- Suicidal and/or homicidal ideation (always include a statement addressing whether or not the client, in your judgement, is suicidal or homicidal; indicate what you are basing your conclusion on, e.g. client’s response to your question suicide checklist)

If evidence of depression or suicidal ideation:

Administer Suicide Checklist....If client scores in the high moderate or severe range, seek out your supervisor immediately to determine whether the client may safely leave the clinic.
BACKGROUND INFORMATION:

**Family of Origin**

- Where born/grew up?
- Marital status of parents
- Family members
- Family members
- Ages
  - Education
  - Occupations
  - Health/living
  - Birth order
  - Relationship with each member
  - History of mental illness/substance abuse/suicide

**Social Situation**

- Who do they live with?
- Same info on each person in household as with family of origin.
- Support network
- Relationships with members of the same/opposite sex
- Dating history
- Ability to make friends/keep friends
- How spend free time/leisure activities/hobbies?

**Educational History/employment History**

- School history grades/degrees completed, did client enjoy school?)
- Steadily employed vs. frequent job changes
- Satisfied with current job?
- Ever fired/quit a job? Why?
- Is current job congruent with education level?

**Medical History**

- Major illnesses/accidents/hospitalizations, prescription medications
- Alcohol/drug use/abuse/dependence
- Changes in sleep/appetite/libido
- Nutritional habits
- Physical exercise

**Miscellaneous**

- Physical environment
- financial information
- Religious considerations
- Legal history (arrests/probations/prison)
Psychiatric History

- Hospitalisations
- Previous psychotherapy/counselling? Where? When? Who?
- Medications
- Suicide attempts?

History of presenting problem: (include remarkable information only)

- Nature of the problem
- When first noticed? Sudden vs. gradual onset? Life circumstances at onset?
- Under what conditions is it most problematic? Was there a change in pattern?
- Under what conditions is it least problematic? Was there a change in pattern?
- Dimension of the problem (frequency, duration, pervasiveness, magnitude)
- Corrective measures attempted in the past
- To what extent and how were they helpful in attenuating the symptoms?
- Who sees it as a problem (client, significant other, court)?
- Why is client seeking help now?

SCREENING/TESTING

Provide a brief summary of results and interpretation (attach complete test results as an appendix). Be sure to state clearly what the results mean, i.e. avoid jargon and provide descriptors of what scores reflect etc. If norms are available use them and state who they represent. Be sure to include in your summary the following information:

- Is it valid?
- Is score or profile consistent with information obtained from interview?
- Is score or profile consistent with information obtained from other tests?
- In your interpretation state explicitly how test results related to the specific presenting problem and/or referral question.
- Indicate with a sentence or two how the information gained from the test might lead to specific treatment goals/recommendations (to be stated in detail below)

SUMMARY AND RECOMMENDATION

A summary should not include new information. It concisely presents a restatement of the referral question and an integration of the most pertinent information regarding background, observations, test results and test interpretation.

If appropriate, a diagnostic impression should be given by listing a DSM-IV diagnosis and code number.

List recommendations, which would be specific and practical. They may include treatment goals and strategies, referrals to other agencies, or further assessment. Primary recommendations should relate to the referral question.
APPENDIX F: Confidentiality and Disclosure

Guidelines for communicating to clients, extent and limits of confidentiality

All clients must be informed by the therapist or assessing psychologist at the beginning of the first session (usually the initial assessment session) about the extent and limits of confidentiality. If a therapist takes on a client for therapy after another therapist has completed the initial assessment, extent and limits of confidentiality should be briefly reviewed with the client at the beginning of the first therapy session.

An example of how this information can be communicated to the client follows (Note: This is meant as an example to illustrate the level of detail and clarity that needs to be communicated, but it is not intended as a prescription of how it "must" be said verbatim).

"I like to take a few minutes to explain some of the clinic procedures to you and give you an opportunity to ask any questions you might have about our services here."

"First, you should know that in general everything we talk about in here is confidential. Of course, creating a safe place for talking about things that are often difficult to talk about and can make one feel very vulnerable, is very important in our work together."

"As you know, this is a training clinic, and so, information about a client is regularly discussed between therapists and supervisors and at case meetings attended by therapist trainees and supervisors. That is also why many of the sessions are videorecorded. You should know that these videotapes are not permanently stored. They are only a tool to aid in ongoing supervision and are typically erased shortly thereafter or taped over with subsequent sessions."

"Do you have any questions about the video recording?"

"There are three circumstances, that I need to tell you about, where I might be required by professional standards and the law to disclose information about our sessions to parties outside our clinic:

1. The first one is that, if you were to tell me that you were planning to harm yourself or others, I would be required to take some appropriate action to prevent you from doing that and to help and assist you further in that situation.

2. The second area relates to information about abuse or severe neglect of children or the elderly. In that case, I would have to notify appropriate authorities to provide assistance with that situation.

3. The third area, where I might have to release information is when I or the clinic gets a subpoena for client reports or test results from a judge or court."

"Do you have any questions regarding any of these issues relating to confidentiality?"

[At this point, you would also briefly review with the client the payment procedure, i.e. restate what the fee is and that payment is due on the day of the session. Ask if the client has any questions regarding the fees etc. After this, you make a brief transition statement, outlining the structure and goals of this session, and then you "turn it over" to the client: "Ok then, what brings you here?" ]
APPENDIX G: Patient Confidentiality

OPERATIONAL CIRCULAR

Enquiries to: Bronwyn Peters Tel: 9222 4038
Supersedes: CP 1970/05

Number: CP 2050/06
Date: 13 April 2006
File No: 05-00418

Subject: PATIENT CONFIDENTIALITY AND DIVULGING PATIENT INFORMATION TO THIRD PARTIES


This document has been prepared to replace Operational Circular 1970/05 by removing the sections on the CWA. Its purpose is to provide a broad overview to public hospital/health service and Departmental staff of the:

a. Common law duty of confidentiality owed by health professionals to patients. Except to the limited extent mentioned in paragraph 5, 6.4 and 8 below, a discussion of statutorily imposed duties of confidence is outside the scope of this document.

b. The general circumstances in which confidential patient information may be disclosed to third parties under the common law.

A separate Operational Circular has been issued to cover key provisions under the CCSA including those dealing with disclosures of confidential information to the Department for Community Development.

This document is not intended to be, nor should it be relied upon as, a substitute for legal or other professional advice. Public hospital, health service and Departmental staff who are unsure of applicable legal obligations, should request legal advice tailored to the individual circumstances from Legal & Legislative Services. Royal Perth Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital, King Edward Memorial Hospital and Princess Margaret Hospital may alternatively seek legal advice from the State Solicitor’s Office.

Dr Neale Fong
DIRECTOR GENERAL
DEPARTMENT OF HEALTH
# PATIENT CONFIDENTIALITY AND DIVULGING CONFIDENTIAL PATIENT INFORMATION TO THIRD PARTIES

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Definitions

1. Terms used in this document have the following meanings:

- **Child or minor**: A person who is under the age of 18 years.
- **CCSA**: Children and Community Services Act 2004.
- **Health professional**: Medical practitioners, nurses and allied health professionals providing medical treatment and care to patients.
- **Patient**: Is synonymous with 'client' and 'consumer'.
- **Parental responsibility**: In relation to a child, means all the duties, powers, responsibilities and authority that, by law, parents have in relation to their children.
- **Public health authority**: Department of Health or any area health service, public hospital or other agency within WA Health.
- **Third party**: Is a person other than the person to whom the patient has disclosed or caused to be disclosed confidential information in the course of obtaining medical treatment and care.

Duty of confidence

2. Health professionals (including public health authorities) are under a duty to maintain the confidentiality of all information that comes to them in the course of providing medical treatment and care to patients. The duty protects information created, disclosed or acquired (directly or indirectly) by health professionals in their professional capacity.

3. All persons including administrative staff, who come into contact with the information as part of the health care process, have a duty to maintain the confidentiality of that information.

4. The general principle is that the duty of confidence prevents the disclosure of the information to individuals and organisations not involved in the particular health care process. However, not all information obtained during the professional relationship is confidential. Information in the public domain is not confidential. Trivial or useless information will similarly not fall within the scope of the duty.

5. The duty of confidence can arise by statute, under the common law and in equity. The duty does not end when the professional relationship with the patient has ceased. Nor does it end with the death of the patient.

Consequences of breach of confidentiality

6. A breach of the duty of confidence can have a number of potential consequences. For instance, it may lead to:

6.1 Disciplinary action by the employer of the person who made the unauthorised disclosure.
6.2 An action for damages against the person who made the unauthorised disclosure and/or his or her employer.

6.3 A disciplinary proceeding under the health professional’s regulatory statute.

6.4 The imposition of a fine where there is a contravention of a statutory duty of confidence.

Disclosure of patient information

7. There are a number of exceptions to the duty of confidence where otherwise confidential information may be disclosed to third parties. Where the duty arises under the common law or in equity, these exceptions include:

7.1 Where consent has been given by or on behalf of the patient.

7.2 Where disclosure is required or permitted by operation of the law.

7.3 Where an overriding public interest justifies disclosure of the information.

8. Where a statutory duty of confidence exists, it is necessary to look to the relevant statutory provision for the circumstances (if any) in which the confidential information may be disclosed to third parties.

Disclosure by consent

Generally

9. Where a mentally competent adult patient expressly consents to the disclosure of his or her confidential information to a third party, it will not be a breach of the duty of confidence to disclose the information provided disclosure is consistent with the consent given. In other words:

9.1 Only the persons or organisations to which the consent has been given may divulge the information to the third party.

9.2 Only information falling within the scope of the consent given may be disclosed.

9.3 The information may only be disclosed to those persons or organisations in respect of which consent has been given.

10. Consent to release confidential information need not be expressly given in each circumstance and may be implied in certain situations. The concept of ‘implied’ consent looks to the circumstances in which the information was provided to the health professional and asks whether they were such that the patient must be taken to have implicitly consented to a disclosure of the type being contemplated.

11. For example, individuals within a particular health care facility who have a legitimate therapeutic interest in the care of the patient may generally have access to the information they need to know in order to provide appropriate medical treatment and care. Consent to the sharing of information in these circumstances will generally be implied. Similarly, patients will generally be taken to have accepted impliedly the administrative procedures of the health care facility involved.
12. If a health professional wants advice, or simply wishes to talk over the patient's treatment with a colleague who is not involved with the patient's care but the patient has not expressly consented to the same, identifying information should not be given.

13. Where the information is required for emergency treatment at another health care facility, the information should be given but after verification of the requesting body or person, by taking their name and telephone number and ringing back. A note should be made of the information released, to whom it was released, and the reason for the request. Where the request is non-urgent, the patient's express consent should be obtained before the information is released.

14. Wherever there is doubt about whether a patient has consented to the release of his or her confidential information in a given circumstance, the express consent of the patient should be sought.

Consent on behalf of minors and mentally incompetent adult patients

15. The parents of a patient who is a minor are usually the appropriate persons to give consent to the release of the minor's confidential information to third parties. In the case of a mentally incompetent adult patient, the patient’s legal guardian (if any) should ordinarily give consent.

16. Parents have full parental responsibility for each of their children who are under 18 years. Parental responsibility is not affected by changes to relationships (i.e., if the parents separate, divorce or remarry).

17. This means either parent may in general give consent to the release of confidential information on behalf of their children who are minors. However, the consent of both parents is preferable where possible to avoid potential conflict.

18. Parental responsibility can be varied by court order in which case, consent to the release of confidential information pertaining to the child concerned will have to be obtained in accordance with the court order.

19. In a family breakdown situation (i.e., separation or divorce), parental responsibility may be varied where the court makes an order stipulating that one parent has certain responsibilities to the exclusion of the other parent. The court can make 4 types of parental orders: residence orders, contact orders, child maintenance orders and specific issues orders. The court may make any combination of these types of orders.

19.1 A residence order or specific issues order may stipulate that one parent has sole responsibility for the child's day-to-day care, welfare and development. If this type of order has been made, that parent will be the only parent that can consent to the release of information pertaining to the child the subject of the court order.

19.2 If there is an arrangement for the child to live with one parent for part of the time and the other for part of the time, this is a residence order. Both parents retain full parental responsibility for the child. The consent of either parent would be sufficient to authorise the release of confidential information pertaining to his or her child the subject of the court order.

19.3 If a specific issues order is made granting one parent the sole responsibility for health care decisions, that parent will be the only parent that can consent to the release of health information pertaining to his or her child the subject of the court order.
19.4 A maintenance order provides for the financial support of the child. Both parents retain full parental responsibility for the child. The consent of either parent would be sufficient to authorise the release of confidential information pertaining to his or her child under the subject of the court order.

20. Protection orders made under the Children and Community Services Act 2004 ("CCSA") can (depending on the type of protection order made) vary parental responsibility. While parental responsibility for children placed in or taken into provisional protection and care or subject to a Negotiated Placement Agreement under the CCSA generally remains with the parents, the Chief Executive Officer of the Department for Community Development ("DCD") has statutory authority to make decisions on behalf of such children in specified circumstances.

21. As a general rule, it is reasonable to assume that either parent can consent (alone) to the release of confidential information relating to his or her child unless information is available to suggest different arrangements are in place (e.g., a court order varying parental responsibility or a child in provisional protection and care of DCD). In that event, further enquires should be made to identify the appropriate person with authority to give consent on behalf of the child. In some cases, this will include obtaining a copy of any applicable court order.

22. If a parent asserts there are no court orders concerning the custody or care of the child but doubt remains it may be prudent to have the parent sign a fresh authority to release with an express declaration that his or her parental responsibility has not in any way been fettered by court order before releasing any information.

Mature minors

23. Minors may consent to the release of confidential information on their own behalf provided they adequately understand and appreciate the reason for and consequences of the information to be released.

24. Whether a patient who is a minor is sufficiently mature to make decisions concerning the release of confidential information on his or her behalf, will vary from case to case. There is no fixed age rule. Consequently, it cannot be said with any certainty that a minor who has reached a certain age is capable of making a decision in respect of his/her own person. Equally, it cannot be said that below a certain age a minor is incapable of doing so.

25. Where a health professional has appropriately assessed a child patient to be a 'mature minor', it will be more difficult for the patient's parents or other legal guardian to subsequently assert their parental rights have been interfered with in the event confidential patient information pertaining to that child is released to third parties as agreed to by the mature minor.

26. Health professionals who assess a patient as a 'mature minor' should make a note of the factors taken into account in reaching that conclusion.

27. If in any doubt as to the 'maturity' of the minor to consent to the release of his or her confidential information, it is prudent to obtain the consent of the minor's parents or other persons vested with parental responsibility for the child, unless the minor objects.
Deceased Patients

28. In the case of a deceased adult patient, the deceased’s personal representative (i.e., an executor under a Will or administrator where the deceased is intestate) is the relevant person to give consent to the release of confidential information.

29. However, the availability of the personal representative’s consent will not covariate the need to follow the third party consultation process under section 32 of the Freedom of Information Act 1992 where access to a deceased patient’s confidential medical records are sought pursuant to that legislation unless, of course, the personal representative is also the deceased’s ‘closest relative’ within the meaning of that provision.

Disclosure by operation of the law

30. Disclosure of confidential information may be permitted or required by operation of the law. For example:

Statutory disclosure

31. A statute may impose a legal duty on health professionals and other individuals to disclose certain information. For example, Section 302 of the Health Act 1911 requires medical practitioners to give notification to the Department of Health’s Executive Director, Public Health of any person with a venereal disease in an infectious stage.

32. Alternatively, a statute may permit the disclosure of otherwise confidential information in specified circumstances without creating a legal obligation to do so. For example, sections 129(1)(a) and 23(3) of the CCSA which permit information to be divulged to DCC in specified circumstances.

33. Where confidential information is disclosed to the responsible body pursuant to a statutory authority there will be no actionable breach of confidence. However, information disclosed must be limited to that necessary to comply with the statutory requirement or to that permissible under the relevant statutory provision.

Subpoenas and summonses

34. A subpoena (sometimes called a summons) is an order of the court that requires the subpoenaed party to attend the court or either produce documents, give evidence or both.

35. A subpoena cannot compel the creation of a document that does not already exist. In other words, it cannot compel a health professional to prepare a medical report for use by a party to legal proceedings.

36. Failure to comply with a valid and properly served subpoena can amount to contempt of court.

37. Confidential communications between health professionals and patients are not privileged. Consequently, health professionals can in general be compelled at law to disclose clinical or other information concerning a patient in court by means of a subpoena to produce documents or a subpoena to give oral evidence. Where confidential patient information is divulged to a court in response to a valid subpoena no breach of confidence will arise.
38. Where a patient's medical records are subpoenaed, the patient should be informed of the subpoena where the patient is not a party to the proceedings. The patient should be advised of the date of compliance (return date) for the subpoena as well as the place, date (generally the same as the return date) and time of any court hearing that has been listed for the return of the documents. The patient should be provided with this information as soon as possible to allow sufficient time for the patient to arrange to attend the court should he/she wish to raise objections to the documents subpoenaed.

39. It is possible for a subpoenaed party to apply to the court for an order to set aside a subpoena or raise objections to production of documents the subject of a subpoena in certain circumstances. For example:

39.1 Abuse of process – It may be possible to have the subpoena set aside where a party to legal proceedings compels production and inspection of documents other than for a legitimate forensic purpose (for example, the subpoenaed documents are not relevant to the issues in dispute in the action).

39.2 Oppression – It may be possible to have the subpoena set aside where the terms of a subpoena are so wide and insufficiently precise as to make compliance (the collation and production of documents) onerous. Similarly, it may be possible to set aside the subpoena where it is used for the purpose of "fishing" for information that a party hopes but does not reasonably expect is in existence.

39.3 Public interest immunity – It may be possible to set aside a subpoena where the public interest that would be served by withholding certain documents is so strong that it overcomes the public interest in following due process. For example, documents which may affect national security or some other extraordinary public interest.

39.4 Legal professional privilege – Communications between a solicitor and client, or between a solicitor and another person, created for the dominant purpose of the client being provided with legal advice or professional legal services relating to a pending or anticipated court proceeding may be protected from disclosure in court proceedings.

39.5 Qualified privilege – Qualified privilege applies to quality improvement committees that have been formally established pursuant to the provisions of the Health Services (Quality Improvement) Act 1994. Section 10 of that Act operates to prevent documents created by or at the request of an approved quality improvement committee (or solely for the performance of the committee’s functions) being used in civil proceedings unless the document has been made available to the public or given to the Minister or the governing body of the Committee. Similarly, any person who acquires information solely as a result of an approved quality improvement committee performing its functions is neither competent nor compelled in civil proceedings to divulge or communicate that information to any court.

40. Depending on the complexity of the case, advice should be sought before lodging a challenge to a subpoena or before assuming that the confidentiality of a patient communication will be immune from court-ordered disclosure.

41. At the same time, officers within the VHA Health should not freely or without question disclose to the court information that they have an ethical or legal duty to keep confidential. Courts are sensitive to legitimate claims to client confidentiality, will hear argument on them, and will act fairly to preserve them in appropriate circumstances.
42. As a general principle, the 'public interest' exception recognises that there may on occasion be a need to breach confidentiality because of an overriding public interest favouring disclosure of the information to a third party. In such circumstances, the disclosure of the information to a responsible authority may be justified.

43. The public interest exception to the duty of confidence is founded in public policy. It is the most important and controversial exception to a health professional's duty of confidence.

44. Where there are competing public interests, one favouring the preservation of confidentiality and one favouring disclosure, the more compelling public interest should prevail.

45. The notion of public interest is flexible but has no clearly defined rules governing when disclosure is permitted and when it is not. It can therefore sometimes be difficult to determine where the balance of public interest lies in a given case.

46. Disclosure of confidential information in the public interest will only be justified in exceptional circumstances. This usually arises in circumstances where there is a real and identifiable risk of danger to the public (which can include a single person), requiring immediate action. The risk must be sufficiently grave.

47. In these circumstances, confidential information may be disclosed to a responsible authority. Disclosure must only be made to a responsible authority with a proper interest in receiving the information. Disclosure must not be made to the world at large. Further, the risk to the public or an individual must be a 'real risk' and only the facts necessary to reduce or eliminate the risk concerned should be disclosed.

48. For example, a health professional in possession of confidential patient information that suggests there is an immediate and real danger posed by a patient to the life or health of a child requiring urgent action to avert the danger, may be justified in disclosing that information to the DCO or the police where that is the only means by which to address the particular risk concerned. Similarly, an overriding public interest may justify a disclosure to the DCO or the police where the person's whose life or health is in immediate and real danger is the patient who is a minor (i.e., a person under 18 years of age).

49. The law in the area of what constitutes a 'public interest' is complex and uncertain. Whether disclosure of otherwise confidential information is justified in the public interest is a question of fact to be determined in the circumstances of each individual case. This necessarily involves determining whether the public interest served in maintaining the confidence is outweighed by the public interest in disclosing it.

50. Any decisions as to whether information in relation to a patient should be provided to third parties on the basis of an overriding public interest should be made only at a senior level within the relevant public health authority’s administration. Wherever practicable, it is recommended that there be consultation with the treating medical practitioner. The factors taken into account in reaching a decision to disclose confidential information in the public interest should be well documented.
51. It is recommended that legal advice be sought before a 'public interest disclosure' is made.

**Disclosing confidential information to the WA Police Service**

52. In Western Australia, there is no general legal obligation on health professionals and other individuals to report the commission or suspected commission of an offence to the police. However, some statutes permit the reporting of certain offences (e.g., the Firearms Act 1973).

53. Health professionals and other WA Health officers are not legally required to assist the police with their enquiries by answering questions, providing witness statements or preparing medical reports or other documentation not already in existence. The police cannot compel compliance with such requests, which may be declined without any offence being committed.

54. However, where assistance is given to the police, the individual providing the assistance must not give false or misleading information. Any active steps taken to prevent or obstruct the discovery or investigation of an offence by the police will constitute an offence. Consequently, whilst it would be an offence to mislead the police, it would not in Western Australia be an offence to simply decline to volunteer information to the police.

55. However, the police do have the power to compel the production of pre-existing documentation by means of a valid search warrant or similar court order.

56. In the absence of a valid search warrant or similar court order, the circumstances in which confidential patient information may be disclosed to the police without a breach of confidence arising are:

56.1 Where the police provide the written consent of the patient (or other person with legal authority to consent on the patient's behalf such as the parents or other legal guardian of a patient who is a minor) and information is disclosed in accordance with the consent given.

56.2 Where disclosure is made pursuant to a statutory protection. For example, the Firearms Act 1973. Under that Act, if a medical practitioner is of the opinion that a person is seeking or has sought medical assistance for an injury in which the practitioner believes a firearm or ammunition has been involved, the medical practitioner may inform the Commissioner or Police of that opinion. The medical practitioner may inform the Commissioner notwithstanding any duty of confidentiality. Where the medical practitioner acts in good faith in this regard, no criminal or civil action or remedy will arise.

56.3 The disclosure can be justified on the basis of an overriding public interest.

In the absence of specific statutory protection or appropriate patient consent, health professionals wishing to report a suspected crime, will need to be satisfied the disclosure falls within the public interest exception to the duty of confidentiality.

It will be a question of judgment in each case whether the gravity of the offence or suspected offence, or the risks to the individual patient or to the public generally of non-disclosure, justifies information about a patient being revealed to relevant
authorities in the public interest. The disclosure of a non-trivial breach of the
criminal law will be easier to justify in the public interest than less serious crimes.

It is recommended that advice be sought before a ‘public interest disclosure’ is
made.

56.4 Disclosure of confidential patient information in response to a summons to produce
documents or to give evidence must be made to the court and not the police.

**Disclosing confidential information to the Corruption and Crime Commission**

57. The Corruption and Crime Commission (‘the CCC’) has powers that enable it to gain
information from a public authority or public officer. There are a number of methods by
which the CCC can request the information.

58. Request for a Statement of Information: A written notice pursuant to section 94 of the
Corruption and Crime Commission Act 2003 (‘the CCC Act’) may be served on a
public authority or public officer which requires the authority or officer to produce a
statement of information. The notice must specify or describe the information required,
fix a time and date by which the statement of information must be produced and
specify the person (being an officer of the CCC) to whom the production is to be
made. The notice may allow another person acting on behalf of the public authority or
public officer to produce the statement of information.

59. Request to produce a record or other thing: A written notice pursuant to section 95 of
the CCC Act may be served on a person requiring that person to attend the CCC and
produce to the person specified in the notice a record or other thing specified in the
notice. Similarly to a section 94 notice, a section 95 notice may allow another person
to satisfy the requirement.

60. Summons for witness to attend and produce things: The CCC may issue a summons
(section 96 of the CCC Act). The summons needs to be signed and served on the
person to whom it is addressed. The summons may require the person to attend
before the CCC at an examination to give evidence, produce any record or other thing
in the person’s custody or control that is described in the summons, or do both of
these things.

61. If a notice or summons is valid, it should be complied with. Failure to comply, without
reasonable excuse, places a person in contempt of the CCC (section 158 of the CCC
Act). The fact that disclosure may breach an obligation to keep information or
documents confidential does not constitute a reasonable excuse under the CCC Act
(section 157 of the CCC Act).

62. There is protection from civil or criminal liability for compliance or purported
compliance in good faith with a requirement made under the CCC Act (section 221 of
the CCC Act).

63. The CCC may include a notation on a section 94 or 95 notice or a summons to the
effect that disclosure of information about the notice or summons, or about any
investigation, examination or court proceedings relating to the notice or summons is
prohibited (section 99 of the CCC Act). If there is a notification prohibiting disclosure it
must be accompanied by a written statement describing the effect of section 167 of
the CCC Act.
64. Even if there is a notation prohibiting disclosure there are certain circumstances in which disclosure can occur, for example, in accordance with any circumstances specified in the notation or to a legal practitioner for the purpose of obtaining legal advice or representation. If you think you need to disclose something prohibited in order to comply with a notice or summons please contact legal services before doing so.
APPENDIX H: Assessment of Suicide Risk

(Adapted from Page & Stritzke, 2006. Clinical Psychology for Trainees)

“The burden of determining when clients are at risk to harm themselves or others weighs heavily on any therapist, especially on the inexperienced trainee. With respect to self-harming behaviours, the disconcerting fact is that they cannot be reliably predicted at the level of the individual (Rudd, Joiner, Jobes, & King, 1999). Suicidal states are variable and usually time limited in nature, and they are modifiable in response to treatment. Therefore, the continual monitoring, assessment, and documentation of current risk level is an essential part of good case management. Science can serve as an ally in the effective management of risk (Seligman, 1996a), because the burden of uncertainty can be allayed somewhat with the help of empirically derived practice guidelines on how to assess and manage suicidal clients.

An empirically grounded decision framework for determining the level of risk associated with suicidal symptoms, and what actions to take depending on the severity of risk, has been described by Joiner and his colleagues (Joiner, Walker, Rudd, & Jobes, 1999). According to this decision framework, the mere presence of some suicidal ideation is not very useful in determining risk status, because some suicidal thoughts are encountered routinely among treatment-seeking individuals and are not uncommon even in the general population. The most crucial variables determining suicide risk are history of prior attempts combined with the nature of current suicidal symptoms and the number of other known risk factors. Accordingly, the first step in the assessment of suicide risk severity is to determine if the client can be categorized as a multiple attempter or non-multiple attempter, because the baseline risk for multiple attempters is always elevated compared to single attempters and mere ideators. Therefore, risk is assessed differently for multiple and non-multiple attempters (see Figure below). The presence of at least one risk factor translates into at least a moderate risk level for multiple attempters, but not necessarily for non-multiple attempters, unless it involves resolved plans and preparation to commit suicide. Thus, the second step in assessing risk severity is to determine if the client has a plan, how specific that plan is, if the means and opportunity to execute the plan are available, and if the client has made any preparations for the attempt. One should also consider here the duration and intensity (rather than frequency) of suicidal desire and ideation. The third step in suicide risk assessment is to identify if there are additional risk factors that can raise the level of risk beyond that associated with the domains of resolved plans and preparation or suicidal desire and ideation alone. These risk factors include (a) recent stressful life events (e.g., divorce, legal troubles), (b) diagnostic comorbidity (especially mood and anxiety disorders, alcohol use, and hopelessness), (c) chaotic or abusive family history, (d) impulsive behavioural style, and (e) limited social connectedness.

Once the level of risk severity has been classified as either low to mild, moderate, or severe to extreme, different risk management strategies are called for depending on the level of risk. The Table below summarizes the various risk management activities associated with each level of severity. It also provides example statements of how to discuss with clients the risk management activities at each level of intervention. It is recommended that patients at moderate risk be given a crisis response plan on a card that they can carry with them at all times (Joiner et al., 1999; Oordt et al., 2005). The card has a step-by-step list of what to do when thoughts about suicide occur, including phone numbers of alternative support services (e.g., “If the thoughts continue, and I find myself preparing to do something, I call the clinic at: _____”; or “If I cannot reach anyone at the clinic, I call: _____”).

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A decision framework for the assessment of suicide risk severity (based on Joiner, Walker, Rudd, & Jobes, 1999)
Table 8.1. Summary of what to do in response to different suicide risk categories

<table>
<thead>
<tr>
<th>Risk Severity</th>
<th>Risk Management Activities</th>
<th>Example Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW to MILD</td>
<td>- continued risk assessment</td>
<td>“In the event that you start feeling that you want to harm yourself, here’s what I want you to do: First, use the skills for self-control we’ll discuss, such as challenging your negative thoughts and seeking social support. If suicidal feelings remain, contact me or the clinic. If you are unable to reach anyone, or, if you feel you need assistance straight away, call or go to the emergency room – here is the number.” “Have you had any thoughts of harming yourself since I last saw you?”</td>
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<tr>
<td>MODERATE</td>
<td>- increase frequency of sessions</td>
<td>“It is important that we put some strategies in place that keep you safe and help you gain control over your suicidal feelings.” “One of the things that will help you is…” “Until you feel things are under control again, I recommend that for the next [time period] we schedule more frequent visits.” “I want you to carry this crisis response plan card with you at all times. It lists the steps you need to take when thinking about suicide. Do you agree to follow those steps when thinking about suicide?”</td>
</tr>
<tr>
<td>SEVERE to EXTREME</td>
<td>- accompany and monitor patient</td>
<td>“At the moment you are not safe on your own.” “Is there someone in your family that we can contact right now?” “I am calling emergency services so they can assist us getting you to the hospital for evaluation and crisis care.” “I am going to ask my colleague/supervisor [add name] to come and join us while we are waiting for your family/emergency staff to get here.”</td>
</tr>
<tr>
<td></td>
<td>- evaluate for hospitalization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- involve emergency services</td>
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<tr>
<td></td>
<td>- involve family members</td>
<td></td>
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<tr>
<td></td>
<td>- seek consultation</td>
<td></td>
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<tr>
<td></td>
<td>- document risk status</td>
<td></td>
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<tr>
<td></td>
<td>- document clinical decisions</td>
<td></td>
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<tr>
<td></td>
<td>- document actions taken</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- document risk resolution</td>
<td></td>
</tr>
</tbody>
</table>

Note: If highest risk category becomes apparent during a phone contact, ask the following questions right away: “Where are you? [do your best to determine the exact location]” “What is the phone number there, in case we get disconnected?” “Are you alone or is someone with you?” “Have you eaten or did you drank anything that is dangerous to your health?” “Have you harmed or injured yourself?”

The importance of routinely documenting all decisions and interventions for maintaining the safety of clients until the suicidal risk has been resolved cannot be overstated (Rudd et al., 1999). In terms of the characteristics of good records, more detail than usual is appropriate, because details are highly relevant in the context of risk management. In this instance, failure to be thorough can compromise patient safety, as well as the therapist’s ability to prove that the level of care conformed to professional standards of empirically grounded practice.

In addition to assessing and managing any risks to a patient’s own safety, it may also become necessary to respond to situations where the patient’s behaviour, or expressed intent to act,
constitutes an imminent risk to others including the therapist. When such a crisis situation arises, the therapist must initiate emergency procedures. Although it is likely that a supervisor will be at hand to assist with or handle a crisis situation, every trainee has the responsibility to not only be aware of the emergency procedures pertaining to their training clinic or clinical placement sites, but to know them by heart. Once a crisis unfolds, it is too late to consult the procedures manual for guidance. Emergency procedures are usually tailored to specific demands associated with the locale, type of client population, availability of onsite staff, and proximity of support services such as police and psychiatric emergency response teams. Because these demands can vary considerably across sites, the onus is on the trainee to become thoroughly familiar with the emergency procedures specific to each training site. In general, all emergency procedures share the following core principles:

- Foremost, be aware of your own safety and that of others in close proximity.
- If necessary, get yourself and others away from the danger.
- Notify everyone in the clinic of the emergency situation (e.g., activate ‘panic button’ in the consulting room; alert the reception staff).
- Notify any available supervisors.
- Request intervention by security staff, police, or psychiatric emergency response units.

When it becomes necessary to involve especially trained emergency response personnel, the therapist needs to be prepared to tell them everything they want to know about the client and to listen to their advice on how the situation is to be handled. They are the experts, and once they are on the scene, they are in charge and the responsibility for the patient’s wellbeing rests with them.

Finally, there are situations where the risk is not imminent, but where a client’s behaviour nonetheless poses a potentially serious risk to others. For example, an HIV-positive patient might tell the therapist that he or she is engaging in unprotected sex with their partner(s) who are unaware of the patient’s disease status. In many jurisdictions, therapists have a legal obligation to report infectious diseases to health authorities. In some jurisdictions, there are also provisions for health care providers to protect and notify identifiable others. In these situations it is good practice for therapists to seek legal advice on reporting infectious and potentially harmful conditions without the patient’s consent (Luepker, 2003). As always, all activities associated with the risk management of such cases must be carefully documented in the client’s file.”

These guidelines will be periodically reviewed at the weekly clinic staff meeting, and all therapists must be thoroughly familiar with these guidelines!