Youth Services Department
Palm Beach County

Practicum Trainee
2018-2019

Handbook

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http://pbcgov.com/youthservices/EducationCenter
http://highridgecenter.com

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Introduction and Mission

The mission of the Youth Services Department is to "Administer programs and initiatives of the Board of County Commissioners to ensure the healthy growth, development, education, and transition of children and youth to young adulthood and the workforce." The Doctoral Internship at the Youth Services Department is offered through the Residential Treatment and Family Counseling Division, which offers specialized programs to families who need professional support in their efforts to raise healthy functioning children. The Division strengthens families through competent, caring, and comprehensive services. The Division is committed to fostering healthy individual and family functioning in families where youth have been exposed to various forms of danger, harm, or loss. Without adequate protective factors, these youth are often at higher risk of entering the juvenile justice system, dropping out of school, getting involved with gangs, running away from home, substance use, and entering the child protective system. This goal is accomplished through family, group, and individual therapy, psycho-education, parent training, psychological evaluation, consultative services, and community outreach offered across community-based, office, and residential settings. Services are provided free to Palm Beach County residents.

The Division employs psychologists, clinical social workers, marriage and family therapists, mental health counselors, residential counselors, and nurses. The agency is also an interdisciplinary training site for psychology postdoctoral fellows, psychology doctoral interns, psychology practicum students, social work interns, mental health counseling interns, and marriage and family therapy interns.

RTFC Division Structure

The Residential Treatment and Family Counseling Division (RTFC) is comprised of three sections: Highridge Family Center (residential), Education and Training (outpatient), and Youth and Family Counseling (outpatient).

Highridge Family Center

Highridge Family Center is a 60-bed residential facility serving at-risk youth between the ages of 11 and 16 who reside in Palm Beach County. Typically, the families seeking services through Highridge have been struggling with conflicted family relations, poor academics, disruptive school behavior, drug experimentation, poor peer group choices, minor law infractions, and emotional difficulties. In conjunction with the School District of Palm Beach County, residents of Highridge are provided alternative education while they are enrolled in the program. Referral sources include schools, parents, prevention and diversion programs, as well as former clients. The facility is divided into five (three male and two female) dormitory-style "houses," each with the capacity for 12 residents. The residents live at the facility Monday through Friday, returning to their homes on weekends and school holidays to practice newly learned skills with their families. A therapist provides family, group, and individual therapy, and three residential counselors (two day shift, one night shift) provide behavior management and therapeutic milieu activities for each house.

Education and Training

The Education and Training Center is a community resource for primary prevention through education, training, and professional development, providing free services to parents, children, families, school personnel, and mental health professionals in Palm Beach County. Clinical staff includes licensed psychologists.

The Education and Training Center serves as a training site for doctoral interns, postdoctoral residents, and doctoral level practicum students. Family, individual (only age 18-22), and group therapy services are offered to families and youth up to age 22 utilizing brief therapy models. Parenting is also offered in individual and group formats. In addition, psychological evaluations may be provided to youth already involved in the agency's clinical services. Families seek services for a variety of reasons, including behavioral disorders, school/academic problems, parent-child relational problems, adjustment to parental separation or divorce, grief/loss issues, abuse or neglect, and to fulfill requirements for diversionary programs.

The Education and Training Center trainees and staff are also responsible for developing and implementing trainings, workshops, and community outreach activities and are approved to offer continuing education units to licensees in various mental health disciplines. Trainings are provided to schools, community agencies, and Bachelor's level counselors and Master's level therapists from the other Youth Services outpatient offices located throughout the county.

Youth and Family Counseling

The Youth and Family Counseling (YFC) Program is a three to four month community-based program that provides family, individual, and group therapy, parenting, psychoeducational school based groups, and on-site school based services for families with children and youth up to age 22 years of age. Families seek services to address many concerns, including behavioral disorders, school/academic problems, parent-child relational problems, adjustment to parental separation or divorce, grief/loss issues, abuse or neglect, and to fulfill requirements for diversionary programs. There are several area offices and satellite offices located throughout the county. YFC collaborates with community agencies, such as the School district of Palm Beach County and the 15th Judicial Circuit Courts (Family Violence Intervention Program). Clinical staff includes Master's level therapists from various mental health fields.

Mission, Goals, and Objectives of the Training Program

The overall goal of the training program at the Youth Services Department is to support the development of graduate students into professional psychologists. Psychology trainees will develop fundamental skills consistent with the mission of the Youth Services Department. This training program incorporates a developmental training model and a strengths-based perspective, which has been a cornerstone in the Division's philosophy of training as well as prevention and intervention work with children, adolescents, parents, and families. Additionally, Palm Beach County is a culturally, ethnically, and socioeconomically diverse area, and residents will have opportunities to work with a range of diverse populations with a variety of presenting issues.

It is expected that by the end of the training year, trainees will have accomplished the following goals:

Goal 1: Trainees will achieve competence appropriate to their professional developmental level in the area of *evidence-based practice in intervention*
Objectives related to this goal include the achievement of competence in the following:

- Case conceptualization and treatment planning
- Implementation of therapeutic interventions
- Crisis Intervention
- Therapeutic Skills

Goal 2: Trainees will achieve competence appropriate to their professional developmental level in the area of *evidence-based practice in assessment*
Objectives related to this goal include the achievement of competence in the following:

- Diagnostic Skill
- Instrument selection, administration, and scoring
- Test Interpretation
- Clinical Formulation
- Report Writing
- Communicating Results

Goal 3: Trainees will achieve competence appropriate to their professional developmental level in the area of *interprofessional and interdisciplinary consultation*
Objectives related to this goal include the achievement of competence in the following:

- Multidisciplinary collaboration
- Theories and Methods of Consultation

Goal 4: Trainees will achieve competence appropriate to their professional developmental level in the area of s*upervision*
Objectives related to this goal include the achievement of competence in the following:

- Theories and Methods of Supervision
- Effective use of supervision
- Develop knowledge and skills providing clinical supervision

Goal 5: Trainees will achieve competence appropriate to their professional developmental level in the area of *individual and cultural diversity*
Objectives related to this goal include the achievement of competence in the following:

- Cultural awareness
- Effects of cultural considerations on clinical activities
- Evidence-informed approach to cultural considerations

Goal 6: Interns will achieve competence appropriate to their professional developmental level in the area of *research*
Objectives related to this goal include the achievement of competence in the following:

- Application of scientific knowledge to practice

Goal 7: Trainees will achieve competence appropriate to their professional developmental level in the area of *ethical and legal standards*
Objectives related to this goal include the achievement of competence in the following:

- Knowledge of ethical, legal, and professional standards
- Adherence to ethical principles and guidelines

Goal 8: Trainees will achieve competence appropriate to their professional developmental level in the area of *professional values and attitudes*
Objectives related to this goal include the achievement of competence in the following:

- Professional awareness
- Interpersonal relationships
- Self-awareness
- Clinical documentation
- Case Management

Goal 9: Trainees will achieve competence appropriate to their professional developmental level in the area of *communication and interpersonal skills*
Objectives related to this goal include the achievement of competence in the following:

- Provides clear and effective written communication
- Exemplifies respectful and professional interpersonal skills
- Presents scholarly information to an audience of professionals

Training Model

The training program integrates a practitioner-scholar model with psychological training and service delivery that is sequential, cumulative, and graded in complexity. The practitioner-scholar training model emphasizes the integration and application of critical thinking and skillful reflection across a broad range of experiential activities. By the end of the training year, trainees will be prepared with the knowledge, awareness, and skills of a practitioner specializing in youth and families. Our trainees are well prepared for professional careers working with children and their families in an outpatient setting who present with a wide range of presenting concerns.

Training Activities

The following is a list of the major training activities that take place at the Youth Services Department. For specific information on the requirements and expectations for each type of Trainee (Postdoctoral Resident, Doctoral Intern, Practicum Student) and the training location (Outpatient or Residential) please refer to the Requirements and Expectations section of each respective Handbook.

Therapy

Therapy is provided throughout the Division in a variety of treatment modalities, including family therapy, group therapy, individual therapy, and milieu therapy. Therapy takes place in outpatient (Ed Center/YFC) and residential (Highridge) settings and includes individuals from a diverse range of age ranges, racial and ethnic groups, and socioeconomic levels. Individual therapy is reserved for youth between the ages of 18-22 in the outpatient office setting. Therapy is also conducted by some trainees at sites of collaborative partners, such as the Youth Empowerment Center. Trainees will develop treatment plans with specific goals and objectives for each of their therapy cases.

Parenting

The Youth Services Department offers a variety of parenting services that can be provided via an individual or group format. Curriculums developed from evidence-based programs aimed at helping caregivers raise children in a safe, stable, and healthy environment may be utilized. Behavioral parent training for select families of younger children may also be offered through an evidenced-based treatment, in which parents learn behavior management strategies to increase their child's engagement in desirable behaviors while learning effective discipline procedures to reduce engagement in disruptive behaviors. Parent support groups are also offered depending on need.

Psychological Evaluation

Referrals for psychological testing come from within the Division. Trainees may also make referrals for their therapy clients to be tested. Full batteries include clinical interviews and assessment of intellectual, behavioral, and personality/social functioning. Psychoeducational testing may also be included in the full assessment batteries. With supervisor approval, less inclusive partial batteries determined by the needs of the family may be completed. The evaluation process involves consultation with referring therapists, administering measures, writing integrated reports, and holding feedback sessions in a timely manner.

Intake Assessment

Intake assessments involve developing interviewing skills and gathering pertinent clinical information during intake interviews. All clients are seen for an initial intake interview to assess their eligibility and need for services and/or to make appropriate referrals.

Risk Assessment, Abuse Reporting, Crisis Intervention, and Safety Planning

With close supervision, trainees will facilitate risk assessments and treatment of crisis situations. Safety planning and abuse reports will be implemented when necessary.

Multidisciplinary Consultation

Consultation takes place on an ongoing basis with staff, administrators, the Division's collaborative organizations, school personnel, case managers, psychiatrists, and/or other collateral sources. Onsite consultation at the Highridge School is also performed regularly.

Case Management

Ongoing case management is provided for all families/clients served, as determined by each family's needs.

Didactic Training

Didactic activities include attending and presenting at weekly Youth Services Department formal trainings. Trainings take various forms, including lecture and demonstration, formal continuing education workshops, and presentations from agencies that work in collaboration with the Youth Services Department. The goals of these trainings are to maintain awareness of recent empirical literature, to inform clinical practice with evidence based findings, and to develop skills in making professional case presentations. The didactic training schedule is intended to compliment clinical supervision, assist professional development, and promote peer relationships. A tentative schedule is distributed at the beginning of the training year and updated periodically. Some topics include ethics, professional development, intervention strategies, diagnostic issues, psychological testing, child maltreatment, domestic violence, diversity considerations, and supervision. Many of the trainings offer continuing education units because the Youth Services Department is an approved CEU sponsor of the American Psychological Association (APA) and the State of Florida Department of Health's Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. Opportunities to attend local workshops and conferences are also available.

Community Outreach

Opportunities to preset trainings on a variety of mental health topics arise and involve developing and providing such presentations at various community agencies. Outreach may also include discussing the services offered at the Youth Services Department at resource events/fairs in the community.

Supervision

Each practicum trainee will be assigned a psychology intern or postdoctoral fellow to mentor and help them during their practicum. This supervisor can supplement the direction that practicum trainees receive from the licensed supervisors, at times expanding on themes from those supervisors or clarifying implementation of techniques. Practicum trainees may call upon the intern or fellow on an as-needed basis or schedule weekly meetings. Group supervision sessions for multiple practicum trainees may be scheduled.

A psychologist licensed in the state of Florida provides individual supervision to psychology doctoral trainees of all levels. Moreover, a minimum of 2 additional hours is provided weekly in a group supervision format with the clinical team at each office location. Trainees are expected to present and discuss therapy and evaluation cases at group supervision meetings. Trainees are expected to present session audio/video recordings during these presentations and, at times, be observed through a one-way mirror.

Requirements & Expectations

Education and Training Center: Practicum-Specific

1) Complete 8 months of training.
2) Complete a minimum of 20 hours per week.
   - Schedules will be determined by the supervisors before the start of the training year based on the direct hours each trainee needs, office space availability, and client needs.
   - Full workdays are generally from 8:30 a.m. to 7:00 p.m. with 1/2 hour for lunch.
   - A minimum of two evenings are required to meet direct contact hour expectations.
   - One early morning start (7:30am) is required to assist with the Highridge School.
3) Complete a minimum of 320 hours with at least 50% being direct service (at least 160).
   - On average, practicum trainees should carry a caseload of 6 to 8 cases. This caseload will be built at a rate corresponding with the strengths and prior experience, client needs, as well as the direct service hours required.
4) Complete a minimum of 3 psychological evaluations. Based on client demand and training needs, more testing cases may be assigned at supervisor discretion.
5) Participate in a minimum of 1 hour weekly face-to-face individual supervision with a licensed psychologist. Supplemental audio/video recordings should be reviewed.
6) Submit monthly hour logs to supervisor.
7) Participate in supervision, as needed, provided by a psychology postdoctoral fellow or intern. Supplemental audio/video recordings should be reviewed.
8) Submit monthly hour logs to supervisor.
9) Attend weekly didactic trainings (2 hours) and submit evaluation forms for each.
10) Pass mid-year supervisor evaluations on all competencies provided by the trainee's graduate program. Passing criteria will be determined in conjunction with graduate training program requirements
11) Pass final supervisor evaluations on all competencies provided by the trainee's graduate program. Passing criteria will be determined in conjunction with graduate training program requirements.

Education and Training Center: All Trainees

1) Provide therapeutic activities that emphasize family therapy, but may also include parenting, group therapy, and individual therapy (18-22 year olds).
   - Most cases will require incorporation of psychoeducation related to parenting skills and child development.
   - Risk assessment and safety planning will be conducted on an as-needed basis.
2) Provide school-based consultative services at the Highridge School a minimum of one morning each week (guidelines are outlined in Handbook).
3) Attend 3 days of orientation trainings and submit evaluation form.
   - If any part of orientation training is missed due to illness or pre-approved vacation, the trainee is expected to obtain/read the information and find a time to review the content with trainee supervisor as soon as possible.
4) Complete pre- and post-assessments of each family therapy case (with family consent) to monitor treatment outcomes.
5) Complete intake assessments.
   - Assignments will vary based on demand and schedule.
6) Complete all documentation in a timely manner.

- Case notes must be entered within 2 business days.
- All phone calls, significant interactions, and information about clients should be documented within 2 business days.
- Intake reports must be submitted within 2 business days.
- Genograms must be provided to supervisor before the 2nd session.
- Psychosocial summary drafts must be submitted to supervisor before the 4th session.
- Treatment plans must be submitted to supervisor before the 4th session.
- Closing summaries must be completed within 5 business days of the final session.

7) Complete psychological evaluations in a timely manner.
    - Consultation with referring therapists regarding psychological evaluation referral questions is expected prior to testing.
    - Parent interview should be completed prior to testing session(s) with youth.
    - All interviews and administration of evaluation measures should be completed within 2 weeks (or 3 weeks under special circumstances and with supervisor approval).
    - Evaluation reports are to be completed in a timely manner, with an initial draft due no later than 2 weeks after administration of assessment measures are complete. Awaiting return of self-report measures should not delay this timeline. Second drafts should be completed no more than 1 week after the initial draft is returned with feedback.
    - Subsequent revisions should be turned in within 24 hours.
    - Feedback session with the family regarding evaluation results and recommendations should be scheduled within 1 week of the signed final report.
8) Send case notes to supervisor for approval until permission is granted to finalize notes independently.
    - Psychosocial summaries, treatment plans, and closing summaries are automatically sent to supervisor for approval.
9) Attend, participate in, and present cases with supplemental audio/video recordings during weekly group supervision (2 hours).
    - A minimum of <u>2 case presentations</u> is expected.
10) Conduct a minimum of <u>2 live session</u> with at least one clinical supervisor observing.
    - Other team members may be invited to observe the live session, depending on availability.
11) On occasion, the trainee may be expected to help with duties of a clerical or statistical nature.
12) Learn and comply with policies and procedures, confidentiality, and ethical guidelines.
13) Complete all evaluation forms (e.g., self, supervisor, and program).
14) Submit a final hour log on the last day.
15) Satisfactorily complete any due process and/or remediation plans.

Highridge Family Center: Practicum-Specific

1) Complete 20 hours per week.
   - A minimum of 1 evening is required in addition to morning and afternoon hours in order to meet clinical contact hour expectations.
2) Attend 3 days of orientation trainings and submit evaluation form.
   - If any part of orientation training is missed due to illness or pre-approved vacation, the trainee is expected to obtain/read the information and find a time to review the content with trainee supervisor as soon as possible.
3) Provide clinical services including psychological evaluations, intake assessments, behavioral observation and interventions at Highridge School and on dorms, group therapy, and crisis intervention.
4) Orient to assigned dorm with immediate goal to gain working knowledge of the Highridge program to include Sanctuary Model of trauma-informed care.
5) Send case notes to supervisor for approval until permission is granted to finalize notes independently.
   - Psychosocial summaries, treatment plans, and closing summaries are automatically sent to supervisor for approval.
6) Complete all documentation in a timely manner.
   - All case notes (therapy, phone calls, etc.) must be entered same day or within 24 hours.
   - Intake assessments must be submitted within 2 business days.
   - Genograms must be provided to supervisor before the 2nd session.
   - Psychosocial summary drafts must be submitted to supervisor within 5 working days of the initial session.
   - Treatment plans must be presented to the family by the third session.
   - Closing/Discharge summaries must be completed within 5 working days of the final session.
7) Case management of all assigned intakes to include appropriate communication with others involved in case
8) Complete a minimum of <u>3 psychological evaluations</u>, although more is encouraged in preparation for internship.
9) Complete psychological evaluations in a timely manner.
   - Consultation with referring therapists regarding psychological evaluation referral questions is expected prior to testing.
   - Parent interview should be completed prior to testing session(s) with youth.
   - All interviews and administration of evaluation measures should be completed within 2 weeks (or 3 weeks under special circumstances and with supervisor approval).
   - Evaluation reports are to be completed in a timely manner, with an initial draft due no later than 2 weeks after administration of assessment measures are complete. Awaiting return of self-report measures should not delay this timeline. Second drafts should be completed no more than 1 week after the initial draft is returned with feedback.
   - Subsequent revisions should be turned in within 24 hours.
   - Feedback session with the family regarding evaluation results and recommendations should be scheduled within 1 week of the signed final report.
10) Send case notes to supervisor for approval until permission is granted to finalize notes independently.

- Intake reports, psychosocial summaries, treatment plans, and closing summaries are automatically sent to supervisor for approval.

11) Conduct a minimum of 2 live sessions with at least one clinical supervisor observing.
    - One should be conducted prior to the midyear evaluation and the other before the final evaluation.
    - Other team members may be invited to observe the live session, depending on availability.
12) Participate in a minimum of 1 hour weekly face-to-face individual supervision with a licensed psychologist, which may consist of 30 minutes clinical supervision and 30 minutes of testing supervision, depending on the need.
    - Supplemental audio/video recordings should be reviewed.
    - Additional supervision and consultation may be provided by other professionals or licensed psychologists as needed.
13) Participate in 1 hour of weekly group supervision provided by a psychology postdoctoral resident. Supplemental audio/video recordings should be reviewed.
14) Submit monthly hour logs to supervisor.
15) Learn and comply with policies and procedures, confidentiality, and ethical guidelines.
16) Attend weekly didactic trainings (2 hours) and submit evaluation forms for each.
17) Pass mid-year supervisor evaluations on all competencies provided by the trainee's graduate program. Passing criteria will be determined in conjunction with graduate training program requirements
18) Pass final supervisor evaluations on all competencies provided by the trainee's graduate program. Passing criteria will be determined in conjunction with graduate training program requirements
19) Complete all evaluation forms (e.g., self, supervisor, and program).
20) Submit a final hour log on the last day.
21) Satisfactorily complete any due process and/or remediation plans.

Professional Conduct Expectations

The Palm Beach County Youth Services Department Training Program is committed to the professional growth of trainees. To help achieve this commitment, it is everyone's responsibility to nurture and maintain a work environment of honesty, trust, and respect. Some basic expectations with regard to professional conduct include:

1. *Adherence to a professional dress code*. Trainees are expected to dress in business casual attire. We understand that everyone has their own unique style; however, certain items are simply inappropriate (e.g., miniskirts, t-shirts/jerseys, shorts, clothing that is tight or revealing, sneakers, clear heels, rubber/plastic flip-flops, excessive perfume/cologne).
2. *Act with care and diligence in the course of job performance*. Trainees are expected to adhere to the schedule agreed upon with their supervisor at the start of their rotation. Punctuality, whether or not a client is scheduled, is of utmost importance. Forgetting about appointments or double booking clients can be avoided by keeping Outlook calendars up to date. Trainees must abide by agency office hours and notify their supervisor when there will be any change to their schedule.
3. *Communication with supervisors and office staff when absent*. If a trainee expects to be absent from the office due to illness or another cause, communication with supervisors and office staff is essential to ensure clients are properly and ethically served. When a trainee is to be absent from or late to the office, a telephone call to the main office phone line is necessary. Emails, text messages, or calls to supervisor cell phones may be missed if a supervisor is in another meeting. A telephone call to the main office phone line will ensure that a person has been notified about absence. Clients can then be contacted regarding their sessions. Personal cell phones should never be used to contact clients.
4. *Behave honestly and with integrity at all times*. Trainees are required to behave and conduct themselves in a professional business manner. Any conduct that is considered hostile, verbally offensive, disruptive to the work environment, or is perceived to be intimidating or undermining will not be tolerated. Office etiquette includes avoiding the use of profanity or speaking loudly in the hallways. Turn the volume on cell phones off when you are in the office, as ring tones can be loud and disturbing to clients and staff.
5. *Cooperation with colleagues is essential*. Trainees may be asked to share office space with their fellow trainees or other staff members. Trainees are expected to work together to resolve scheduling and decorating conflicts related to office space in which to conduct therapy, store personal belongings, and share voicemail.
6. *Clients deserve undivided attention while they are here for services*. Do not answer office phones or cellular phones during a therapy session. Do not read or respond to emails or text messages during a therapy session.
7. *Confidentiality and dual relationships.* If a client of Youth Services is known to the trainee from another field placement, another agency where employed, or from other life roles (e.g., realtor, childcare, etc.), care must be taken to ensure confidentiality and decrease breaches in dual relationship ethics. It is unethical and against Palm Beach County policy to continue services with your clients upon termination from Youth Services.

Supervision Descriptions

Individual Supervision Description

Trainees receive a minimum of one hour of weekly individual face-to-face clinical supervision. This is routinely supplemented by brief and spontaneous discussions between supervisors and trainees.

Appointment of Supervisors. A licensed psychologist provides each trainee with weekly individual supervision. Additional supervision may be provided by a postdoctoral resident.

Supervisor Selection Standards. Minimum standards for appointment as supervisor are as follows:

1. Doctorate in psychology from an APA accredited institution.
2. Completion of an APPIC-member internship in clinical or counseling psychology.
3. Licensure under Florida statute as "Psychologist" or a Psychology Resident under the supervision of a licensed psychologist, with the Resident's supervision of the intern being the focus of the licensed psychologist's supervision time with the Resident.
4. Knowledge and experience in the activities to be supervised.

Term. Supervision assignments are for the duration of each rotation, with the exception of extenuating circumstances. If a supervision assignment is made after the start of the rotation, the assignment will end at the completion of the rotation.

Supervision Sessions. Individual supervision can take two forms. One of these is in-vivo supervision, with the supervisor present to coach and observe during the provision of services by the intern. The other is scheduled, one-to-one, face-to-face self-report of relevant professional clinical activities and progress toward training goals as well as review of audio/video recordings. Unscheduled supervisory consultation may be utilized as needed.

Work Products. Supervisors will review and approve intake assessments, psychosocial reports, genograms, treatment plans, substantive case notes, written correspondence, and closing/discharge summaries, and evaluation/assessment reports. Supervisors co-sign closing/discharge summaries and evaluation/assessment reports. Students will be expected to produce documents that meet agency and professional standards. All written work products must be completed in a timely manner as determined by the supervisor.

Taping Sessions. Supervisors require trainees to audiotape or videotape evaluation or treatment sessions for supervision purposes, with the consent of the client. Trainees are expected to record at least one therapy session for each case. Audio/video records are used both as an assessment tool in the evaluation of client's responses within the treatment process and in the ongoing monitoring of the trainee's work. They are essential to the work of the therapist both in reflective process and in their use within supervision. If clients do not wish to sign for audio/video recordings, they are not recorded but then must be open to participating in a live supervision observation.

Site Mentors. Role models are available at each rotation site, including staff from other disciplines (e.g., social work, mental health counseling, marriage and family therapy) and non-licensed psychology staff. While not appointed clinical supervisors, these site mentors are available for counsel and instruction in their particular professional areas of competence. The individual supervisor may incorporate professional peer-consultation into a trainee's individual supervision.

Group Supervision Description

Trainees attend a minimum of 2 hours per week of group supervision with a licensed psychologist and the therapists working at each site. Initial group supervision sessions will include training on various topics to acclimate students to YSD, such as CAFAS administration, Sanctuary Model, and collaborative programs. The group may also be asked to read articles/book chapters for discussion during group supervision. Trainees are expected to present and discuss therapy and evaluation cases at group supervision meetings. Live sessions may be scheduled.

What to include in a group supervision case presentation:

- Question to the team, reason this case is being presented
- A complete genogram (Ideally three generations)
- Reason the family initiated services
- Description of the family
- The presenting problem from the perspective of
    - the referral source
    - the family
    - the therapist
- Number of sessions attended
- Diagnosis considered
- Treatment goals
- Sources of stress for the family
- Family's strengths and resources
- Course of treatment
- The family's response to intervention
- A self-evaluation of your effectiveness
- Rationale and evidence based support for case conceptualization
- If available, tape of a session, cued to a relevant segment
- Comments
- Reiterate question to the team, reason why case is being presented

Telesupervision Description

The Youth Services Department (YSD) is equipped to use telesupervision, or the supervision of psychological services through a synchronous audio and video format for individual supervision on occasion. YSD recognizes the importance of supervisory relationships. In order to provide all trainees with the opportunity to experience a breadth of supervisory relationships beyond their rotation supervisor, the Training Director provides an additional hour of individual supervision per week to each trainee throughout the year. Given the geographical distance between training sites, this model allows trainees to form a greater connection to the entire training faculty than would be experienced otherwise. It is expected that the foundation for this supervisory relationship will be initially cultivated during orientation and subsequently during didactic training meetings. When feasible, the Training Director schedules face-to-face supervision with the trainee; however, when scheduling does not permit, telesupervision is scheduled instead.

Telesupervision is utilized in accordance with the Guidelines and Principles set forth by the American Psychological Association. Telesupervision is only utilized when in-person supervision is not possible. This form of supervision is regarded as consistent with the YSD's overall model of training in that it best approximates the in-person format of supervision and ensures continuity in the supervisory experience.

When more than supervisor is assigned, the primary rotation, on-site supervisor maintains full professional responsibility for the clinical cases under the care of the trainee unless arrangements are made with at least one other licensed psychologist to cover for non-scheduled consultations, time-sensitive issues, and crisis situations. When utilizing telesupervision, both the trainee and supervising psychologist assure that privacy and confidentiality for both the client and trainee are maintained. Finally, telesupervision can only be viewed as a legitimate form of supervision if it is determined by both the professional supervisor and the trainee that both the audio and video quality of the connection is adequate for the proper conduction of supervision.

All telesupervision utilized by the training program occurs over a secure network. Supervision sessions using this technology are never recorded. A webcam and Jabber software is set up at the trainee's computer. All trainees are provided with instruction regarding the use of the webcam equipment at the outset of the training year. In addition, a Jabber account is established for each Trainee and they are instructed on how to use this software. Technical difficulties that cannot be resolved on site are directed to the Network Operations Center at (561)355-HELP or by submitting an online request for IT support.

Licensed Psychologists at the Youth Services Department

Shayna Ginsburg, Psy.D., Training Director/Chief of Clinical Services, Education and Training Center
Twila Taylor, Psy.D., Chief of Residential Clinical Services, Highridge Family Center
Amanda Terrell, Psy.D., Psychologist, Highridge Family Center
Loren Berry, Psy.D., Psychologist, Education and Training Center
Laura Cruz, Ph.D., Psychologist, Education and Training Center
Tony Spaniol, Psy.D., Director, Residential Treatment and Family Counseling Division

*All psychologists are licensed in the state of Florida.

Formal Evaluations

The evaluation process is continuous and mutual. The Training Director is responsible for ongoing systematic evaluation of trainee progress and program quality.

Rating of Trainee Performance
Clinical supervisors may formally or informally evaluate trainees at any time during the training year, and submit assessment of trainee performance to the Training Director. Clinical supervisors formally evaluate the performance of their assigned trainees in writing at the midpoint and end of year. Trainees complete a self-assessment baseline at the beginning of the training year, and then assess their performance on the same schedule as supervisors.

Rating of Trainee Experience
Trainees rate their clinical supervision at the end of the training year. Ratings of weekly didactic trainings are provided after each training.

Communication with Graduate Programs
The Training Director, or designee, is responsible for informing each doctoral program's Director of Clinical Training about the performance of each trainee. For interns, a letter from the Training Director is sent to the graduate program detailing the trainee's progress at midpoint and end of the training year.

Ethical Behavior
Psychology trainees and clinical supervisors adhere to the published ethical guidelines of the American Psychological Association (APA). Complex ethical issues are addressed in an ongoing manner through supervision and didactic training. In-service trainings for Division staff include topics such as treatment consent and choice, confidentiality, dual relationships, and diversity training. In addition, Performance Standards are delineated for each trainee. By signing that form at the beginning of the training year, trainees attest that they are aware of these standards, and will abide by them.

Diversity and Non-discrimination Policy

The Youth Services Department strongly values diversity and believes that diversity promotes and enhances the training experience. As a department, Youth Services embraces diversity in the workplace, and fosters an atmosphere that promotes respect and acceptance. Practicing mutual respect for qualities and experiences that may be different from our own and celebrating the rich dimensions of diversity is a priority of the training program. Trainings and educational opportunities are offered over the course of the year which are aimed to broaden and deepen trainee's appreciation of diversity issues.

Youth Services welcomes applicants from diverse backgrounds and believes that a diverse training environment contributes to the overall quality of the program. Youth Services provides equal opportunity to all prospective trainees and does not discriminate because of a person's race, color, religion, disability, sex, age, national origin, ancestry, marital status, familial status, sexual orientation, gender identity and expression, or genetic information, or any other factor that is irrelevant to success as a psychology trainee. Applicants are individually evaluated in terms of quality of previous training, clinical experiences, and fit with the program's mission.

The goal of incorporating diversity into various trainings at Youth Services is to ensure that trainees develop the knowledge, skills, and awareness necessary to provide competent psychological services to all members of the public. To this end, the Youth Services training program expects a competency in diversity training and strives to ensure that psychology trainees demonstrate acceptable levels of knowledge, skills, and awareness to work effectively with diverse individuals. Diversity experiences and training are interwoven throughout the training program to ensure that trainees are both personally supported and well trained in this area.

Clinical Staff Job Descriptions

Education and Training Center

Chief of Clinical Services, Education and Training

The Chief of Clinical Services at the Education and Training Center requires a Doctoral degree in psychology and license to practice in the state of Florida. As the administrator of the Education Center, responsibilities include supervising the clinical and clerical staff, overseeing therapy and psychological evaluation services, program development, evaluation of services provided, and adherence to policies and procedures. The Chief of Clinical Services provides clinical supervision to graduate and post-graduate level trainees completing clinical placements. As the director of the Education and Training Center, the Chief of Clinical Services is responsible for facilitation of training for staff, trainees, and community members, and maintenance of continuing education sponsor approval. As Training Director, the Chief of Clinical Services ensures compliance with standards of the American Psychological Association (APA) and the Association of Psychology Postdoctoral and Internship Centers (APPIC), and serves as the liaison between trainees and school programs.

Youth Services Psychologists

The Youth Services Psychologists require a Doctoral degree in psychology and license to practice in the state of Florida. The psychologists provides family, group, and individual therapy services to youth and their families who are experiencing emotional and/or behavioral difficulties, family discord, school or academic difficulties, problems with peers, and other presenting issues. In addition to working with families, the psychologists interact with schools, social service agencies, and other professionals in order to provide client-needed services. The psychologists may also conduct psychological evaluations with children in order to identify and diagnose areas in need of improvement and offer recommendations. In addition, the psychologists provide psychoeducational services to parents, community groups, and mental health professionals, including parenting skills, professional development seminars, continuing education trainings, and community outreach. The psychologists also provide clinical supervision to graduate and post-graduate level trainees completing clinical placements, and serve as assistants to the Training Director for training-related matters.

Youth and Family Counseling Program

Chief of Community Based Clinical Services

The Chief of Community Based Clinical Services is responsible for developing, managing, and delivering care to the community through the administration of outreach services and clinical services in Palm Beach County. The Chief of Community Based Clinical Services is responsible for supervising Youth Services Coordinators, and directly or indirectly supervising clinicians and support staff at Youth and Family Counseling offices (Belle Glade, Delray and West Palm Beach) and satellite locations. As the administrator of Youth and Family Counseling, responsibilities the Chief of Clinical Services serves as is responsible for facilitation of training and intern placements at Youth and Family Counseling locations.

Youth Services Coordinator

The Youth Services Coordinator is responsible for planning, coordinating, supervising and providing clinical services to clients of Youth and Family Counseling. Additionally, the Youth Services Coordinator is responsible for the supervision of clinical and clerical staff within each office and consults with the Chief of Community Based Clinical Services regarding training, supervision, intern placements, client cases, special problems, crises, or emergencies.

Program Coordinator

The Program Coordinator is responsible for coordinating referrals and supervising clients involved the Family Violence Intervention Program (FVIP). The Program Coordinator is responsible for supervising the FVIP Court Case Advisors. Referrals for Youth Services FVIP Services are accepted by the FVIP Program Coordinator. Additionally the Program Coordinator consults with the Chief of Community Based Clinical Services training, supervision, intern placements, client cases, special problems, crises, or emergencies.

Therapist/Licensed Therapist

The Licensed Therapist has a Florida state license in their field of study. The Therapist requires a Master's or Doctoral degree in social work, marriage and family therapy, mental health counseling, or psychology, and experience working with families and youths. Both Therapists provide family, individual, and group therapy services to the youth and family in a variety of crisis and non-crisis situations. Therapists perform a psychosocial interview, develop a treatment plan with the family, work with the family for approximately 90 days, and develop a case summary with recommendations at the end of treatment. Therapists also provides School Based Services and interacts with social service agencies and other professionals in order to provide client-needed services. Referrals and follow-up may be required. Therapists are able to meet with adolescent self-referral clients age 13 to 22.

Court Case Advisor

The Court Case Advisor contacts/meets with the family after receiving the referral from the State Attorney's Office and offers the family the choice to participate in the Family Violence Intervention Program (FVIP) diversion program to avoid adjudication. The Court Case Advisor is the point of contact for families involved in the FVIP Program and monitors the family's progress with Case Plan and the completion of the FVIP Program. Referrals for Youth Services FVIP Services are only accepted by the Court Case Advisors after consultation with the Program Coordinator.

Highridge Family Center

Chief of Residential Clinical Services

The Chief of Residential Clinical Services is a licensed psychologist who serves as the administrator of the Highridge Family Center. The Chief is responsible for the day to day operations of Highridge Family Center and supervises the Residential Counseling Coordinator, the Residential Nurse Manager, and clinical staff, evaluates program efficacy, program development, adherence to policies and procedures, as well as consults with alternative education/school board personnel, the 15th Circuit Court Juvenile Division, and various social service agencies. The Chief of Residential Clinical Services provides individual and/or group supervision to graduate and postgraduate psychology trainees.

Residential Counseling Coordinator

The Residential Counseling Coordinator is responsible for managing, planning, coordinating, and directing the residential services provided to residents at Highridge. Additionally, the Residential Counseling Coordinator is responsible for the supervision of all residential staff and the interviewing and selection of such staff. Other responsibilities include providing staff training hours and consulting with counseling, residential, therapy and trainee staff as special problems, crises, or emergencies arise within the milieu.

Psychologist, Sanctuary Coordinator

The Psychologist and Sanctuary Coordinator is responsible for the implementation of the Sanctuary Model and trauma informed services at Highridge. This includes coordination and provision of training and the utilization of trauma informed tools at the facility. The Sanctuary Coordinator oversees the process of shifting to trauma informed programming in conjunction with the Chief of Residential Clinical Services with the ultimate goal of certification in the Sanctuary Model. The Sanctuary Coordinator collects data through surveys, measures, interviews, and meetings to drive program change and improvement. The Psychologist and Sanctuary Coordinator also provides individual and/or group supervision to graduate and postgraduate psychology trainees.

Licensed Family Therapist

The Licensed Family Therapist requires a Master's or Doctoral degree in social work, marriage and family therapy, mental health counseling, or psychology, in addition to a Florida state mental health license, and experience working with families and youth. The therapist works as part of the treatment team, providing family, group, individual therapy, crisis intervention and risk assessments to the youth and family. The therapist develops a treatment plan with the family, makes recommendations regarding the youth's progress on the milieu, works with the family throughout the child's stay at Highridge, and writes a discharge summary with recommendations at the end of treatment.

Residential Youth Counselor

Residential Counselors are Bachelor's level counselors responsible for providing daily care and supervision to the residents of Highridge Family Center. Residential Counselors work as part of the treatment team, assisting the adolescents with the development of coping skills such as emotional regulation, conflict resolution, facilitating community groups, and developing the therapeutic milieu using the Sanctuary Model.

Juvenile Residential Technician

Juvenile Residential Technicians have an Associate's Degree and are responsible for providing daily care and supervision to the residents of Highridge Family Center. Juvenile Residential Technicians are primarily assigned as behavioral staff at the school or work at night on the dorms. They are part of the treatment team and assist youths in emotional regulation, conflict resolution, and development of a therapeutic milieu using the Sanctuary Model.

Residential Nurse Manager

The Residential Nurse Manager supervises 2 LPNs, the school behavioral staff, the night shift and is on call for nursing, clinical, and behavioral consultations. Additionally, the Residential Nurse Manager attends treatment team meetings to provide staff with updates regarding medication changes, issues, or concerns and to address any questions the staff may have regarding a child's medical condition. The nursing team ensures open communication with the child's parents and treating physician regarding any medication side effects and when refills are needed. The Residential Nurse Manager is considered the supervisor on duty when present, unless otherwise specified.

Nurse

Highridge Family Center has a team of two Licensed Practical Nurses and a Registered Nurse to provide 24 hour nursing coverage while the youth are in residence. The nursing team is responsible for initial routine medical screens, medication administration, sick calls, and any urgent matters. For emergencies, 911 is called. The nursing team ensures all staff maintains up to date certification in CPR and First Aid and is available for consultation on any resident-specific issues and staff training necessary, such as having a child in residence with diabetes or food allergies.

Trauma-Informed Care at the Youth Services Department

Adversity and challenges are universal in the human experience. Repeated trauma-related stress responses can impair a family's functioning and lead to problematic long-term health outcomes. The Youth Services Department emphasizes the importance of trauma-informed care within our organization and with the families we serve. Trauma-informed care also places great importance on the physical, psychological, and emotional safety of our families and staff members, and helps survivors rebuild a sense of control and empowerment.

During August 2016, the Youth Services Department began a three-year process to initiate implementation of the Sanctuary Model, an evidence-based trauma informed care model. The model was created by Sandra Bloom, a psychiatrist, Joseph Foderaro, a social worker, and Ruth Ann Ryan, a nurse manager. Around 1985, the treatment team began to realize that most of the people they were treating in an inpatient setting and in outpatient treatment had survived overwhelmingly stressful and often traumatic experiences, usually beginning in childhood. The Sanctuary Model was created to harness the healing power of relationships to help overcome adversity and decrease the more punitive aspects of treatment in an acute care psychiatric unit in a general hospital north of Philadelphia. To help us ask the question "What happened to you" instead of "What's wrong with you?" The model also acknowledges restorative practices, in that it is about working ***with*** people instead of doing things ***to*** them or ***for*** them. The model is based upon the following commitments to youth and their families, as well as fellow staff, and as a wider organization: nonviolence, emotional intelligence, social learning, open communication, social responsibility, democracy, growth, and change.

Trainees will receive training throughout the year and will attend meetings and events related to the Sanctuary Model. In particular, trainees will become familiar with Community Meetings (see Handbook section under Miscellaneous Information) and participate in these meetings each week. Trainees will expand their skills in trauma-informed practice and begin to view families through a trauma lens.

Family Therapy Overview

Family Therapy Modalities

Structural Family Therapy

Structural Family Therapy is a therapeutic approach directed at changing or realigning the family organization of structure in order to alter dysfunctional transactions and clarify subsystem boundaries. Structural family therapists tend to present themselves to the family as warm and empathic but also firm and directive. This attitude is recognized as an important attribute for successful intervention. Ultimate goal is to see the family transact differently without the therapist's involvement. In the beginning, the therapist is likely to be more forceful in structuring the contexts within which the family members will interact. When family members autonomously maintain the functional, restructured relational patterns and also resolve the problems for which they asked for help, the therapy is completed

Joining: In this process, the therapist allies with family members by expressing interest in understanding them as individuals and working with and for them. Joining is considered one of the most important prerequisites to restructuring. It is a contextual process that is continuous.

This occurs in **four** ways:

1. **Tracking**: In tracking, the therapist follows the content of the session, using open-ended questions and provides the family feedback on what he or she has heard
2. **Mimesis**: The therapist behaves in ways similar to those of various family members – e.g. posture, pace, vocabulary, etc.
3. **Confirmation of a family member**: Using a feeling word to reflect an expressed or unexpressed feeling of that family member. E.g. an empathic remark
4. **Accommodation**: The therapist makes personal adjustments in order to achieve a therapeutic alliance, e.g. tries to adopt the family's frame of reference and options, as they exist for the family

Reframing: The technique of reframing is a process in which a perception is changed by explaining a situation in terms of a different context. For example, if the therapist reframes a behavior as caring when in the past it has been seen as controlling- "It seems your Mom shows she cares by staying up waiting for you to come home at night"

Unbalancing: This is a procedure wherein the therapist supports an individual or subsystem against the rest of the family. For instance, a therapist may sit next to a daughter who is being accused of not living up to the family's values. When this technique is used to support an underdog in the family system, a chance for change within the total hierarchical relationship is fostered

Enactment: The process of enactment consists of families bringing problematic behavioral sequences into treatment by showing them directly to the therapist in the session. The result is that family members experience their own transactions with heightened awareness. In examining their roles, members often adapt new, more functional ways of acting

Working with Spontaneous Interaction: Structural family therapists concentrate on spontaneous behaviors in sessions. In occurs whenever families display behaviors in session that are disruptive of dysfunctional, such as members yelling at one another or parents' withdrawing from their children. Therapists then point out the dynamics and sequencing of behaviors. It is important that therapists help families recognize patterns of interaction and what changes they might make to bring about modification

Boundary Formation: Part of the therapeutic task is to help the family define, or change the boundaries within the family. The therapist also helps the family to either strengthen or loosen boundaries, depending upon the family's situation

Intensity: The structural method of changing maladaptive transactions by using strong affect, repeated intervention, or prolonged pressure

Restructuring: This procedure is at the heart of the structural approach, which involves changing the structure of the family by altering the existing hierarchy and interactional patterns. It is accomplished through the use of enactment, unbalancing, and boundary formation

Shaping Competence: The family therapist helps families and individuals become more functional by highlighting and reinforcing positive behaviors

Cognitive Interventions

1. Advice & information are derived from experience and knowledge of the family in therapy. They are used to calm down anxious members of families or reassure these individuals and families about certain actions

2. **Pragmatic fictions** are to help families and their members to change. For example, therapist may tell children that they are acting younger than their years

3. **Paradox** is to motivate family members to search for alternatives. Family members may defy the therapist and become better or they may explore reasons why their behaviors are as they are and make changes in the ways members interact

Strategic Family Therapy

Clients were not seen as sick and were "depathologized," being seen instead as trying to move toward a state of equilibrium or homeostasis in an unfolding life cycle. Strategic Family Therapy allows the therapist to view the family system from different perspectives. Examples include a therapist viewing the family system as a whole, isolating recurrent emotional patterns, or viewing the family from a hierarchical point of view. The perspective used is based upon the compelling symptoms of the family and is the defining element for the formulation of prescriptive strategies. Grounded in the *here and now*, this approach does not address subjective or intrapsychic experience but concentrates on changing behaviors. Haley based this upon a major assumption that "Families make common sense but misguided attempts to solve their problems." The solution selection is governed by the *family system rules*. The result is a *positive feedback loop* that only worsens the problem." Haley distinguished between *covert* and *overt* communication. He saw that these two modes of communication were often in conflict and that this was a way in which the client could feel in control. In other words, Haley looked for either the "hoped for pay-off" or the "pay-off that kept a client locked into place." The direct goal of this approach was to upset the homeostasis of the family thus shaking loose a rigid family system. Haley would do this through prescribing certain courses of behavior.

Key interventions:

a. The therapist acts as a catalyst to initiate change and thus is responsible for assuming an active role

b. Symptom prescription is based upon the therapist's understanding of perverse triangulation and the family hierarchy and the emotional pay-offs that are sought. These prescriptions were not recommendations, but commands to behave in a certain way or perform certain tasks, rituals, or rites. Very often, the symptoms themselves would be prescribed (paradoxical intention).

c. Identifying the feedback loop, finding the rules governing it, and changing the rules

d. Through injecting paradoxes into the family system, the family homeostasis is upset. This reduces the rigidity in the family system. The paradoxes are meant to counter the feedback loop and consequently unstuck families. One of his best known paradoxes is to have the family take control of a rebellious pseudo-autonomous adolescent. By taking control of their rebellious adolescent, they are actually liberating their child to become more differentiated.

Milan Systemic Family Therapy

Influenced by the work of Gregory Bateson, cybernetic epistemology of family systems, and communication theorists. ***Circular*** and ***relational questions*** as ways of conducting a systemic exploration of the changes and differences in family relationships (Palazzoli Selvini et al., 1980). Behaviors and beliefs do not occur in isolation and individuals are best understood within their *interrelational contexts*. A circular perspective emphasizes *cyclical sequences* of interactions, which interconnect with family beliefs. Symptoms are viewed as *communicative acts* between two or more members in the family and have a unique function within the network of relationships

Circular questions: tools to gather information about the family and to develop an awareness of the interrelated behaviors and beliefs within a system; follow a theoretical shift from linear (cause and effect) thinking to punctuating *interactional sequences* and *formulating circular hypotheses* and questions. Circular and interactional questions serve to elicit information from each family member regarding their opinion and experience related to: the presenting problem; interactions or alliances between family members regarding the presenting concern; changes in the relationships over time

- These questions explore the interaction around the problem. A circular view of the presenting problem is obtained when a full cycle of repeated interactions is clear (Boscolo et al., 1987).
- Who noticed the problem first?
- Who is most affected by the problem in the family?
- Who was most hyperactive in the family, before Johnny?
- Who agrees most with Mom that this is a problem?
- Who generally sides with whom?
- Who generally argues with whom the most?
- Who most understands a certain member in the family?
- Who spends the most time with whom else?
- Who else feels this way?
- Sequence of interaction questions
- These questions examine the interactions related to the presenting problem
- Who does what to whom and when?
- Then what happens?
- Where is she or he when this happens?
- How does she /he respond to this problem?
- When he/she does not respond (problem definition) what happens?

    - The information gathered in this style of interviewing provides the therapist with a systemic frame of the problem and enables the therapist to generate hypotheses and create interventions to interrupt unhealthy (dysfunctional) patterns of interrelating and challenge “system supporting beliefs and myths” (Minuchin & Fishman, 1981, Palazzoli Selvini et al, 1980)

Hypothesizing: Rooted in the ideas of *constructivism*, hypotheses are formulated as temporary guesses about the family system. The data gathered from working with the family either support or reject the initial hypotheses and new hypotheses are formulated

- Hypotheses are not categorized as true or false but rather prove to be useful in the sense of leading to new information that moves the family along to healthier functioning. Hypotheses are tools to actively obtain information about the family. The information gathered eventually explains logically why and how a symptom serves a particular function in the family

- Hypotheses must be “systemic,” in the sense that it takes into account all the elements about the presenting a problem.
- Hypotheses are grounded in the belief that as therapists we work with observations, operate with limited knowledge; and we live with ambiguity and uncertainty. All we really have available is our own constructions of others and the world. This view has a long lineage in the works and ideas of Kant and Piaget.

Key Interventions:

a. Interventions focus on positively or logically connoting the problem-maintaining behaviors of all members of the system and give particular attention to the most symptomatic member
b. The intervention captures the meaning of “not changing” at a certain moment for the system.
c. The therapist usually comments to the family on the logical or positive roles played by the family members in the maintenance of the system by their actions and behaviors
d. From this perspective, the therapist is free from blaming one or more members of the system for their inability to change, or for their hurtful or peculiar behaviors. For example, a child that may display psychotic behaviors may be described as attempting to keep alive the memory and the presence of a dead grandparent, with the intention of trying to get the parents to cooperate better and keeping them from breaking up their marriage, and/or trying to alleviate their grief.

Bowen's Family Systems Theory and Therapy

In the mid-1950's, Bowen and others considered mother-patient symbiosis and then larger family emotional systems in the etiology of schizophrenia. In the late 1950's, Bowen worked to develop a general family therapy theory that would explain the development of all emotional illness and symptomatology. Therapeutic goal is for the patient to become *differentiated* from the family without being *fused* with family members. In addition to relationship fusion, there is ***fusion within individuals***, which is due to the lack of differentiation of thought and feeling functions. There is an ***intergenerational transmission*** from grandparents to parents to children of decreased or increased levels of emotional differentiation, relationship fusion, and interpersonal anxiety. Certain children in the family may escape the parental projection or do not absorb the parental anxiety due to receiving other insulating protective, surrogate parenting or developing their own idiosyncratic internal emotional firewalls

Terms and Definitions

Differentiation: emotionally connected but separated from family members

- Individuals having low internal emotion/thought differentiation capabilities tend to be dominated by their emotions (or pseudo self) and are therefore prone to excessive anxiety, which in turn disposes them to forge undifferentiated, emotionally fused relationships with others
- Individuals with a learned higher level differentiation of self can move more freely in and out of feelings and intellect, and are therefore able to move flexibly in and out of relationships as well, not being inordinately dependent on relationships for their sense of identity (or solid self)
- More highly differentiated individuals tend to more easily balance the need of emotional closeness to overcome human isolation and the requirement of emotional space to not be overwhelmed by relationship togetherness

Fused: caught up emotionally with family members' anxieties or relationship fusion difficulties

Pseudo self: individuals having low internal emotion/thought differentiation capabilities and who tend to be dominated by their emotions

Solid self: individuals with learned higher level of differentiation of self

Scale of Differentiation: ranges from 1 (pseudo self) to 100 (solid self)

Family Projection Process: how emotional differentiation, relationship fusion, and interpersonal anxiety are transmitted from grandparents to parents to children

Genogram: diagram of family relationships and nodal events

Emotional cut-off: maneuver to avoid emotional closeness with other family members who have been the source of fused emotional hurt or anger

"**I-position**": individual's emotional communication or stance about a family matter or circumstance from his/her own differentiated, non-blaming, and personal responsibility-taking perspective

Triangles: the three-person family relationship subunits that make up an extended intergenerational family system

- Triangles are the most basic, stable emotional/relational unit
- When there is stress or tension in the family, the increased resultant anxiety that centers in one triangle may spread to other family members, creating adjoining or interlocking triangles with debilitating fusion or anxiety
- Family triangles are constantly in motion, i.e. twosomes and a third are continually forming and dissolving throughout any family emotional system
- **Provoker – victim – rescuer** triangles are often found in families dealing with chemical dependency and are characterized by members quickly and continuously switching their maladaptive roles with one another
- A two-person dyad is considered the most unstable family relationship subunit-when subjected to stress, one of the twosome will typically seek to "triangle in" a third person (or activity) to absorb some of the interpersonal tension and anxiety that is making one or both of the pair uncomfortable

Triangulation: where a child is being looked to be unhappy, covertly conflicting parents for consolation or distraction from their own problems, thereby requiring in a real sense the child to be symptomatic

Interventions

a. By researching and developing with the family a genogram, therapists determine how the emotional fusion and anxiety of the parents in a nuclear family originated from the upline generation and is now projected onto the downline generation
b. When parents are found to have sustained serious deficits of parenting, or parental projection of emotional fusion, anxiety, immaturity, or scapegoating, or have done emotional cut-offs due to unresolved fusion or attachment issues with their families of origin, they and their children are then coached by the therapist to overcome these deficits, projections and cut-offs by adopting stronger, solid-self, unfused, better differentiated, "I-position" communications, emotional reactions, and action stands with formerly fused with, projectively hurtful family members
c. Reduction in excessive emotionality, anxiety, or fusion in any of the relationship sides of overlapping or interlocking triangles of the family, will result in modification of the entire emotional system of the family
d. The family dysfunction, anxiety, and emotional fusion will manifest as marital conflict, dysfunction of a spouse, or impairment of the children
e. The therapist works to resolve the leftover pain, rage, and anxiety within the interlocking, intergenerational triangles
f. When triangulation occurs, the therapist's goal is to extricate the child from the parents' relationship by helping the couple look at and deal with their own hidden relationship anxiety and fusion with each other and from their families of origin
g. In instances of triangulation, in order to keep emotional reactivity to one another minimal, the parents are to talk directly only to the therapist, who remains emotionally and relationally unaligned with either person
h. Making the covert couple conflict (together with its underlying emotional and relational fusions) become overt so that the child's symptoms are no longer needed to protect the couple's pseudo equanimity

Solution Focused Therapy

Major Contributors: Milton Erickson, Steve de Shazer, Insoo Kim Berg, Peter DeJong, Bill O'Hanlon

a. Basic tenets
   i. Family members are the experts of their life situations
   ii. Focus on the family's strengths and abilities
   iii. Families have the resources for change
   iv. Find what is working and do more of it
   v. Focus on when the problem is not a problem

b. Additional focus
   i. Focus on strengths & solutions rather than problems
   ii. Building on past successes empowers family & leads to Solutions
   iii. Utilization of specific questioning techniques to elicit
   iv. Information to connect past successes with future possibilities
   v. Focus on "what is happening in your life that you want to continue to happen
   vi. What will your family (life) look like when you feel you no longer need to come for therapy? Re-writing future script. Emphasis on future possibilities.

II. Techniques

a. Joining technique
   i. Therapist must picture self in family's context
   ii. Respect the family's problem definition, negotiate goals
   iii. Compliment what the family is doing well & their cooperation through direct & indirect compliments
   iv. Support each family member
   v. Encourage parent to assist in finding solutions (co-therapist)

b. Questioning technique
   i. Past Successes: consider ways to bring past successes to the present and then apply them to the future. Example: Was there ever a time in the past when you were able to… How were you able to do that?
   ii. **Exceptions**: those times when the "problem" does not happen. Example: Is there ever a time when your husband is helpful to you? What would have to happen for him to be helpful again?
   iii. **The Miracle Question/Crystal Ball/Magic Wand**: Envision yourself in the future (tomorrow, next week) and the problem is no longer a problem…..describe what you are doing differently. What would your children notice that is different?
   iv. **Scaling Questions**: use to assess things considered too abstract. Self-esteem/confidence, willingness to change, hopefulness. Example: On a scale of 1 to 10, where would you put yourself? What would have to happen to go one point higher? What would your family notice that you are doing differently?
   v. **Coping Questions**: Use when client cannot think of any successes or exceptions. Example: There are so many difficult things going on in your life now-how do you do it? How do you manage…?

c. Therapist Tasks
   i. Identify when exceptions occur
   ii. Identify the family member most interested in finding solution
   iii. Identify & utilize everyone's strengths and resources
   iv. Discover who tried what, where, how
   v. Rule out what did not work
   vi. Together, establish small realistic behavioral goals
   vii. Present the next task as the next step
   viii. Continually observe and evaluate
   ix. Review & compliment successes, accomplishment and strengths at every session

Provide homework (reinforcement) after each session. Example: Having members note exceptions to report next session

Developed by Thorana S. Nelson, PhD and Students

STRUCTURAL FAMILY THERAPY

LEADERS • Salvador Minuchin • Charles Fishman	**ASSUMPTIONS:** • Problems reside within a family structure (although not necessarily caused by the structure) • Changing the structure changes the experience the client has • Don't go from problem to solution, we just move gradually • Children's problems are often related to the boundary between the parents (marital vs. parental subsystem) and the boundary between parents and children

CONCEPTS:
Family structure
• Boundaries
  ○ Rigid
  ○ Clear
  ○ Diffuse
  ○ Disengaged
  ○ Normal Range
  ○ Enmeshment
  ○ Roles
  ○ Rules of who interacts with whom, how, when, etc.
• Hierarchy
• Subsystems
• Cross-Generational Coalitions
• Parentified Child
	GOALS OF THERAPY:
	• Structural Change
	  ○ Clarify, realign, mark boundaries
	• Individuation of family members
	• Infer the boundaries from the patterns of interaction among family members
	• Change the patterns to realign the boundaries to make them more closed or open

ROLE OF THE THERAPIST: • Perturb the system because the structure is too rigid (chaotic or closed) or too diffuse (enmeshed) • Facilitate the restructuring of the system • Directive, expert—the therapist is the choreographer • See change in therapy session; homework solidifies change • Directive	**ASSESSMENT:** • Assess the nature of the boundaries, roles of family members • Enactment to watch family interaction/patterns
INTERVENTIONS: • Join and accommodate ○ mimesis • Structural mapping • Highlight and modify interactions • Unbalance • Challenge unproductive assumptions • Raise intensity so that system must change	**CHANGE:** • Raise intensity to upset the system, then help reorganize the system • Change occurs within session and is behavioral; insight is not necessary • Emotions change as individuals' experience of their context changes

Structural Family Therapy, Continued

Interventions • disorganize and reorganize • Shape competence through Enactment (therapist acts as coach)	
TERMINATION: • Problem is gone and the structure has changed (2nd order change) • Problem is gone and the structure has NOT changed (1st order change)	**SELF OF THE THERAPIST:** • The therapist joins with the system to facilitate the unbalancing of the system • Caution with induction—don't get sucked in to the content areas, usually related to personal hot spots
EVALUATION: • Strong support for working with psychosomatic children, adult drug addicts, and anorexia nervosa.	
SUPERVISION INTERVENTIONS:	
RESOURCES: Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press. Minuchin, S., & Fishman, H. C. (1981). *Family therapy techniques*. Cambridge, MA: Harvard University Press. Minuchin, S., Rosman, B. L., & Baker, L. (1978). *Psychosomatic families*. Cambridge, MA: Harvard University Press. Fishman, H. C. (1988). *Treating troubled adolescents: A family therapy approach*. New York: Basic Books. Fishman, H. C. (1993). *Intensive structural therapy: Treating families in their social context*. New York: Basic Books.	

NOTES

STRATEGIC THERAPY (MRI)

LEADERS:
- John Weakland
- Don Jackson
- Paul Watzlawick
- Richard Fisch

ASSUMPTIONS:
- Family members often perpetuate problems by their own actions (attempted solutions) --the problem is the problem maintenance (positive feedback escalations)
- Directives tailored to the specific needs of a particular family can sometimes bring about sudden and decisive change
- People resist change
- You cannot not communicate--people are ALWAYS communicating
- All messages have report and command functions-- working with content is not helpful, look at the process
- Symptoms are messages -- symptoms help the system survive (some would say they have a function)
- It is only a problem if the family describes it as such
- Based on work of Gregory Bateson and Milton Erickson
- Need to perturb system – difference that makes a difference (similar enough to be accepted by system but different enough to make a difference)
- Don't need to examine psychodynamics to work on the problem

CONCEPTS:
- Symptoms are messages
- Family homeostasis
- Family rules -- unspoken
- Cybernetics
  - Feedback Loops
  - Positive Feedback
  - Negative Feedback
- First order change
- Second order change
- Reframing
- Content & Process
- Report & Command
- Paradox
- Paradoxical Injunction
- "Go Slow" Messages
- Positive Feedback Escalations
- Double Binds
- "One down" position
- Patient position
- Attempted solutions maintain problems and become problems themselves

GOALS OF THERAPY:
- Help the family define clear, reachable goals
- Break the pattern; perturb the system
- First and second order change- ideally second order change (we cannot make this happen-- it is spontaneous)

ROLE OF THE THERAPIST:
- Expert position
- Responsible for creating conditions for change
- Work with resistance of clients to change
- Work with the process, not the content
- Directive

ASSESSMENT:
- Define the problem clearly and find out what people have done to try to resolve it
- Elicit goals from each family member and then reframe into one, agreed-upon goal
- Assess sequence patterns

Strategic Therapy (MRI), Continued

Interventions • Skeptical of change • Take a lot of credit and responsibility for change; however, therapist tells clients that they are responsible for change • Active	
INTERVENTIONS: • Paradox • Directives ○ Assignments ("homework") that interrupt sequences • Interrupt unhelpful sequences of interaction • "Go slow" messages • Prescribe the symptoms	**CHANGE:** • Interrupting the pattern in any way • Difference that makes a difference • Change occurs outside of session; insession change is in viewing; homework changes doing • Change in viewing (reframe) and/or doing (directives) • Emotions change and are important, but are inferred and not directly available to the therapist
TERMINATION: • Client decides when to terminate with the help of the therapist • When pattern is broken and the client reports that the problem no longer exists • Therapist decides	**SELF OF THE THERAPIST:** • Therapist needs to be VERY careful with ethics in this model; it can be very manipulative (paradox) and a lot of responsibility is on the therapist as an expert
EVALUATION: • Very little research done • Do clients report change? If so, then it is effective	
SUPERVISION INTERVENTIONS:	
RESOURCES: Watzlawick, P., Weakland, J., &, Fisch, R. (1974). *Change: Principles of problem formation and problem resolution.* New York: Norton. Fisch, Richard, John H. Weakland, and Lynn Segal (1982). *The tactics of change: Doing therapy briefly.* San Francisco: Jossey-Bass. Watzlawick, P., J. B. Bavelas, and D. J. Jackson. (1967). *Pragmatics of human communication.* New York: W. W. Norton. Lederer, W. J., and Don Jackson. (1968). *The mirages of marriage.* New York: W. W. Norton.	

NOTES:

STRATEGIC THERAPY (Haley & Madanes)

LEADERS:

- Jay Haley
- Cloe Madanes
- Influenced by Minuchin

ASSUMPTIONS:

- Family members often perpetuate problems by their own actions (attempted solutions) --the problem is the problem maintenance (positive feedback escalations)
- Directives tailored to the specific needs of a particular family can sometimes bring about sudden and decisive change
- People resist change
- You cannot not communicate--people are ALWAYS communicating
- All messages have report and command functions-- working with content is not helpful, look at the process
- Communication and messages are metaphorical for family functioning
- Symptoms are messages -- symptoms help the system survive
- It is only a problem if the family describes it as such
- Based on work of Gregory Bateson, Milton Erickson, MRI, and Minuchin
- Need to perturb system – difference that makes a difference (similar enough to be accepted by system but different enough to make a difference)
- Problems develop in skewed hierarchies
- Motivation is power (Haley) or love (Madanes)

CONCEPTS:

- Symptoms are messages
- Family homeostasis
- Family rules – unspoken
- Intergenerational collusions
- First and second order change
- Metaphors
- Reframing
- Symptoms serve functions
- Content & Process
- Report & Command
- Incongruous Hierarchies
- Ordeals (prescribing ordeals)
- Paradox
- Paradoxical Injunction
- Pretend Techniques (Madanes)
- "Go Slow" Messages

GOALS OF THERAPY:

- Help the family define clear, reachable goals
- Break the pattern; perturb the system
- First and second order change- ideally second order change (we cannot make this happen-- it is spontaneous)
- Realign hierarchy (Madanes)

ROLE OF THE THERAPIST:

- Expert position
- Responsible for creating conditions for change
- Work with resistance of clients to change
- Work with the process, not the content
- Directive
- Skeptical of change
- Take a lot of credit and responsibility for change; however, therapist tells clients that they are responsible for change
- Active

ASSESSMENT:

- Define the problem clearly and find out what people have done to try to resolve it
- Hypothesize metaphorical nature of the problem
- Elicit goals from each family member and then reframe into one, agreed-upon goal
- Assess sequence patterns

Strategic Therapy (Haley & Madanes), Continued

INTERVENTIONS:	CHANGE:
• Paradox • Directives ○ Assignments ("homework") that interrupt sequences • Interrupt unhelpful sequences of interaction • Metaphors, stories • Ordeals (Haley) • "Go slow" messages • Prescribe the symptoms (Haley) • "Pretend" techniques (Madanes)	• Breaking the pattern in any way • Difference that makes a difference • Change occurs outside of session; insession change is in viewing; homework changes doing • Change in viewing (reframe) and/or doing (directives)
TERMINATION: • Client decides when to terminate with the help of the therapist • When pattern is broken and the client reports that the problem no longer exists • Therapist decides	**SELF OF THE THERAPIST:** • Therapist needs to be VERY careful with ethics in this model; it can be very manipulative (paradox) and a lot of responsibility is on the therapist as an expert

EVALUATION:
- Very little research done
- Do clients report change? If so, then it is effective

RESOURCES:

Madanes, Cloe. (1981). *Strategic family therapy*. San Francisco, CA: Jossey-Bass.

Madanes, Cloe. (1984). *Behind the one-way mirror: Advances in the practice of strategic therapy*. San Francisco, CA: Jossey-Bass.

Madanes, Cloe. (1990). *Sex, love, and violence: Strategies for transformation*. New York: W. W. Norton.

Madanes, Cloe. (1995). *The violence of men: New techniques for working with abusive families*. San Francisco: Jossey-Bass.

Haley, Jay. (1980). *Leaving home*. New York: McGraw-Hill.

Haley, Jay. (1984). *Ordeal therapy: Unusual ways to change behavior*. San Francisco, CA: Jossey Bass.

Haley, Jay. (1987). *Problem-solving therapy* (2nd Ed.). San Francisco: Jossey-Bass.

NOTES:

MILAN FAMILY THERAPY

LEADERS:
- Boscolo
- Palazzoli
- Prata
- Cecchin

ASSUMPTIONS:
- problem is maintained by family's attempts to fix it
- therapy can be brief over a long period of time
- clients resist change

CONCEPTS:
- family games (family's patterns that maintain the problem)
  - dirty games
  - psychotic games
- there is a nodal point of pathology
- invariant prescriptions
- rituals
- positive connotation
- difference that makes a difference
- neutrality
- hypothesizing
- therapy team
- circularity, neutrality
- incubation period for change; requires long periods of time between sessions

GOALS OF THERAPY:
- disrupt family games

ROLE OF THERAPIST:
- therapist as expert
- neutral to each family member – don't get sucked into the family game
- curious

ASSESSMENT:
- Family game
- Dysfunctional patterns (patterns that maintain the problem)

INTERVENTIONS:
- Ritualized prescriptions
- Rituals
- Circular questions
- Counter paradox
- Odd/even day
- Positive connotation
- "Date"
- Reflecting team
- Letters
- Prescribe the system

CHANGE:
- Family develops a different game that does not include the symptom (system change)
- Requires incubation period

TERMINATION:
- Therapist decides, fewer than 10-12 sessions

EVALUATION:
- Not practiced much, therefore not researched
- Follow up contraindicated

SUPERVISION INTERVENTIONS:

Milan Family Therapy, continued

RESOURCES:

Campbell, D., Draper, R., & Huffington, C. (1989). *Second thoughts on the theory and practice of the Milan approach to family therapy*. New York: Karnac.

Campbell, D., Draper, R., & Crutchley, E. (1991). The Milan systemic approach to family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of Family Therapy (Vol. II)* (pp. 325-362). New York: Brunner/Mazel.

Cecchin, G. (1987). Hypothesizing, circularity, and neutrality revisited: An invitation to curiosity. *Family Process, 26*(4), 405-413.

Cecchin, G. (1992). Constructing therapeutic possibilities. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 86-95). Newbury Park, CA: Sage.

Palazzoli, M. S., Boscolo, L., Cecchin, G., & Prata, G. (1978). *Paradox and counterparadox: A new model in the therapy of the family in schizophrenic transaction.* New York: Jason Aaronson.

Palazzoli, M. S., Boscolo, L., Cecchin, G., & Prata, G. (1978). A ritualized prescription in family therapy: Odd days and even days. *Journal of Marriage and Family Counseling, 48,* 3-9.

Palazzoli, M., & Palazzoli, C. (1989). *Family games: General models of psychotic processes in the family*. New York: W. W. Norton & Company.

NOTES:

SOLUTION-FOCUSED BRIEF THERAPY

LEADERS:

- Steve de Shazer
- Insoo Kim Berg
- Yvonne Dolan
- Eve Lipchik

ASSUMPTIONS:

- Clients want to change
- There's no such thing as resistance (clients are telling us how they cooperate)
- Focus on present and future except for the past in terms of exceptions; not focused on the past in terms of cause of changing the past
- Change the way people talk about their problems from problem talk to solution talk
- Language creates reality
- Therapist and client relationship is key
- A philosophy, not a set of techniques or theory
- Sense of hope, "cheerleader effect"
- Nonpathologizing, not interested in pathology or "dysfunction"
- Don't focus on the etiology of the problem: Solutions are not necessarily related to problems
- Assume the client has strengths, resources
- Only need a small change, which can snowball into a bigger change
- The problem is not occurring all the time

CONCEPTS:

- Problem talk/ Solution talk
- Exceptions
- Smallest difference that makes a difference
- Well-formed goals (small, concrete, measurable, important to client, doable, beginning of something, not end, presence not absence, hard work)
- Solution not necessarily related to the problem
- Clients are experts on their lives and their experiences
- Therapeutic relationships: customer/therapist, complainant/sympathizer, visitor/host

GOALS OF THERAPY:

- Help clients to think or do things differently in order to increase their satisfaction with their lives
- Reach clients' goals; "good enough"
- Shift the client's language from problem talk to solution talk
- Modest goals (clear and specific)
- Help translate the goal into something more specific (clarify)
- Change language from problem to solution talk

ROLE OF THERAPIST:

- Cheerleader/Coach
- Offer hope
- Nondirective, client-centered

ASSESSMENT:

- Assess exceptions—times when problem isn't there
- Assess what has worked in the past, not necessarily related to the problem; client strengths
- Assess what will be different when the problems is gone (becomes goal that might not be clearly related to the stated problem)

INTERVENTIONS:

- Help set clear and achievable goals (clarify)
- Help client think about the future and what they want to be different
- Exceptions: Amplify the times they did things that "worked" when they didn't have the problem or it was less severe
- Compliments:
  -"How did you do that?"
  -"Wow! That must have been difficult!"
  - "That sounds like it was helpful; how did you do that?"
  -" I'm impressed with ...."
  -"You sound like a good ...."

Solution-Focused Brief Therapy, Continued

<table>
<tr><td colspan="2"><u>Interventions</u>
• Formula first session task: Observe what happens in their life/relationship that they want to continue
• Miracle question:
-Used when clients are vague about complaints
-Helps client do things the problem has been obstructing
-Focus on how having problems gone will make a difference
-Relational questions
-follow up with miracle day questions and scaling questions
-pretend to have a miracle day
• Scaling questions</td><td>• Midsession break (with or without team) to summarize session, formulate compliments and bridge, and suggest a task (tasks used less in recent years; clients develop own tasks; therapist may make suggestions or suggest "experiments"), sometimes called "feedback" (feeding information back into the therapy with a difference)
• Predict the next day, then see what happens</td></tr>
<tr><td><u>TERMINATION:</u>
• Client decides</td><td colspan="2"><u>SELF OF THE THERAPIST:</u>
• Accept responsibility for client/therapist relationship
• Expert on therapy conversation, not on client's life or experience of the difficulty</td></tr>
<tr><td colspan="2"><u>EVALUATION:</u>
Therapy/Research:
• Simple (not necessarily easy)
• Can be perceived that therapist as insensitive- "Solution Forced Therapy"
• Crucial that clients are allowed to fully express struggles and have their own experiences validated, BEFORE shifting the conversation to strengths</td><td>• Techniques can obscure therapist's intuitive humanity
• Many outcome studies show effectiveness, but no controlled studies

Progress of therapy:
• Can clients see exceptions?
• Are they using solution talk?</td></tr>
<tr><td colspan="3"><u>SUPERVISION INTERVENTIONS:</u></td></tr>
<tr><td colspan="3"><u>RESOURCES:</u>
de Shazer, S. (1982). Patterns of brief family therapy: An ecosystemic approach. New York: Guilford.
de Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I. K. (2007). More than miracles: The state of the art of solution-focused brief therapy. New York: Haworth.
Berg, I. K., & Miller, S. (1992). Working with the problem drinker. New York: Norton.
Berg, I. K. (1994). Family-based services: A solution-focused approach. New York: Norton.
De Jong, P., & Berg, I. K. (2007). Interviewing for solutions (3rd ed.). Pacific Grove, CA: Brooks/Cole.
Dolan, Y. (1992). Resolving sexual abuse. NY: W.W. Norton.
Lipchik, E. (2002). Beyond technique in solution focused therapy. New York: Guilford.
Miller, S. D., Hubble, M. A., & Duncan Barry L. (Eds.). (1996). Handbook of solution-focused brief therapy. San Francisco: Jossey-Bass.
Nelson, T. S., & Thomas, F. N. (Eds.). (2007). Handbook of solution-focused brief therapy: Clinical applications. New York: Haworth.</td></tr>
</table>

NOTES:

NARRATIVE THERAPY

LEADERS:

- Michael White
- David Epston
- Jill Freedman
- Gene Combs

ASSUMPTIONS:

- Personal experience is ambiguous
- Reality is shaped by the language used to describe it – language and experience (meaning) are recursive
- Reality is socially constructed
- Truth may not match historic or another person's truth, but it is true to the client
- Focus on effects of the problem, not the cause (how problem impacts family; how family affects problem)
- Stories organize our experience & shape our behavior
- The problem is the problem; the person is not the problem
- People "are" the stories they tell
- The stories we tell ourselves are often based on messages received from society or our families (social construction)
- People have their own unique filters by which they process messages from society

CONCEPTS:

- Dominant Narrative - Beliefs, values, and practices based on dominant social culture
- Subjugated Narrative – a person's own story that is suppressed by dominant story
- Alternative Story: the story that's there but not noticed
- Deconstruction: Take apart problem saturated story in order to externalize & re-author it (Find missing pieces; "unpacking")
- Problem-saturated Stories - Bogs client down, allowing problem to persist. (Closed, rigid)
- Landscape of action: How people do things
- Landscape of consciousness: What meaning the problem has (landscape of meaning)
- Unique outcomes – pieces of deconstructed story that would not have been predicted by dominant story or problem-saturated story; exceptions; sparkling moments

GOALS OF THERAPY:

- Change the way the clients view themselves and assist them in re-authoring their story in a positive light; find the alternative but preferred story that is not problem-saturated
- Give options to more/different stories that don't include problems

ROLE OF THERAPIST:

- Genuine curious listener
- Question their assumptions
- Open space to make room for possibilities

ASSESSMENT:

- Getting the family's story, their experiences with their problems, and presumptions about those problems.
- Assess alternative stories and unique outcomes during deconstruction

INTERVENTIONS:

- Ask questions
    - Landscape of action & landscape of meaning
    - Meaning questions
    - Opening space

CHANGE:

- Occurs by opening space; cognitive
- Client can see that there are numerous possibilities
- Expanded sense of self

Narrative Therapy, Continued

<table>
<tr><td colspan="2">
<u>Interventions</u>

Preference
Story development
Deconstruction
To extend the story into the future

Externalize problems
Effects of problem on family; effects of family on problem
Restorying or reauthoring
Self stories
Letters from the therapist
Certificates of award

</td><td></td></tr>
<tr>
<td><u>TERMINATION:</u>
Client determines</td>
<td><u>SELF OF THE THERAPIST:</u>
Therapist's ideas, values, prejudices, etc. need to be open to client, "transparent"
Expert on conversation</td>
<td><u>EVALUATION:</u>
No formal studies</td>
</tr>
<tr><td colspan="3"><u>SUPERVISION INTERVENTIONS:</u></td></tr>
<tr><td colspan="3"><u>RESOURCES:</u>
Freeman, Jennifer, David Epston, and Dean Lobovits. (1997). Playful approaches to serious problems: Narrative therapy with children and their families. New York: W.W. Norton.
Freedman, Jill, and Gene Combs. (1996). Narrative therapy: The social construction of preferred realities. New York: W. W. Norton.
White, Michael, and David Epston (Eds.). (1990). Narrative means to therapeutic ends. New York: W.W. Norton.
White, Michael. (2007). Maps of narrative practice. New York: W.W. Norton.
</td></tr>
</table>

NOTES:

COGNITIVE-BEHAVIORAL THERAPY

LEADERS:
- Ivan Pavlov
- Watson
- Thorndike
- B. F. Skinner
- Bandura
- Dattilio

ASSUMPTIONS:
- Family relationships, cognitions, emotions, and behavior mutually influence one another
- Cognitive inferences evoke emotion and behavior
- Emotion and behavior influence cognition

CONCEPTS:
- Schemas- core beliefs about the world, the acquisition and organization of knowledge
- Cognitions- selective attention, perception, memories, self-talk, beliefs, and expectations
- Reinforcement - an event that increases the future probability of a specific response
- Attribution- explaining the motivation or cause of behavior
- Distorted thoughts, generalizations get in way of clear thinking and thus action

GOALS OF THERAPY:
- To modify specific patterns of thinking and/or behavior to alleviate the presenting symptom

ROLE OF THERAPIST:
- Ask a series of question about assumptions, rather than challenge them directly
- Teach the family that emotional problems are caused by unrealistic beliefs

ASSESSMENT:
- Cognitive: distorted thoughts, thought processes
- Behavioral: antecedents, consequences, etc.

INTERVENTIONS:
- Questions aimed at distorted assumptions (family members interpret and evaluate one another unrealistically)
- Behavioral assignments
- Parent training
- Communication skill building
- Training in the model

CHANGE:
- Behavior will change when the contingencies of reinforcement are altered
- Changed cognitions lead to changed affect and behaviors

TERMINATION:
- When therapist and client determine

SELF OF THE THERAPIST:
- Not discussed

EVALUATION:
- Many studies, particularly in terms of marital therapy and parenting

SUPERVISION INTERVENTIONS:

RESOURCES:

Jacobson, N. S., & Margolin, G. (1979). *Marital therapy: Strategies based on social learning and behavior exchange principles*. New York: Brunner/Mazel.

Jacobson, N. S., & Christensen, A. (1998). *Acceptance and Change in Couple Therapy: A Therapist's Guide to Transforming Relationships*. New York: Norton.

Epstein, N. B., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples*. Washington, DC: APA Books.

Resources

Dattilio, F. M. (1998). *Case studies in couple and family therapy: Systemic and cognitive perspectives*. New York: Guilford.

Dattilio, F. M., & Padesky, C. (1990). *Cognitive therapy with couples*. Sarasota, FL: Professional Resource Press.

Beck, A. T., Reinecke, M. A., & Clark, D. A. (2003). *Cognitive therapy across the lifespan: Evidence and practice*. Cambridge, UK: Cambridge University Press.

NOTES:

CONTEXTUAL FAMILY THERAPY

LEADERS:
- Ivan Boszormenyi -Nagy

ASSUMPTIONS:
- Values and ethics are transmitted across generations
- Dimensions: (All are intertwined and drive people's behaviors and relationships)
  - Facts
  - Psychological
  - Relational
  - Ethical
- Trustworthiness of a relationship (relational ethics): when relationships are not trustworthy, debts and entitlements that must be paid back pile up; unbalanced ledger gets balanced in ways that are destructive to individuals and relationships and posterity (e.g., revolving slate, destructive entitlement)

CONCEPTS:
- Loyalty: split, invisible
- Entitlement (amount of merit a person has based on trustworthiness)
- Ledger (accounting)
- Legacy (we behave in ways that we have been programmed to behave)
- Relational ethics
- Destructive entitlement (you were given a bad ledger and it wasn't fair so it's ok to hand it on to the next person—acting out, neglecting important others)
- Revolving slate
- Posterity (thinking of future generations when working with people) this is the only model that does
- Rejunctive and disjunctive efforts

GOALS OF THERAPY:
- Balanced ledger

ROLE OF THE THERAPIST:
- Directive
- Expert in terms of assessment

ASSESSMENT:
- Debts
- Entitlements
- Invisible loyalties

INTERVENTIONS:
- Process and relational questions
- Multi-directional impartiality: Everybody and nobody feel special—all are attended to but none are more special
- Exoneration: Help people understand how they have been living out legacies and debts-ledgers—exonerate others
- Coach toward rejunctive efforts

CHANGE:
- Cognitive: Awareness of legacies, debts and entitlements
- Behavioral: Very action oriented—actions must change

TERMINATION:
- Never- totally up to the client

SELF OF THE THERAPIST:
- Must understand own legacies, entitlements, process of balancing ledgers, exoneration

EVALUATION:
- No empirical evaluation

SUPERVISION INTERVENTIONS:

Contextual Family Therapy, Continued

RESOURCES:

Boszormenyi-Nagy, I. (1987). *Foundations of contextual therapy: Collected papers of Ivan Boszormenyi-Nagy.* New York: Brunner/Mazel.

Boszormenyi-Nagy, I., & Krasner, B. (1986). *Between give and take: A clinical guide to contextual therapy.* New York: Brunner/Mazel.

Hargrave, T. D., & Pfitzer, F. (2003). *The new contextual therapy: Guiding the power of give and take.* New York: Brunner-Routledge.

van Heusden, A., & van den Eerenbeemt, E. (1987). *Balance in motion: Ivan Boszormenyi-Nagy and his vision of individual and family.* New York: Brunner/Mazel.

NOTES:

BOWEN FAMILY THERAPY

LEADERS:
- Murray Bowen
- Michael Kerr (works with natural systems)
- Edwin Friedman

ASSUMPTIONS:
- The past is currently influencing the present
- Change can happen—individuals can move along in the process of differentiation
- Differentiation: ability to maintain self in the face of high anxiety (remain autonomous in a highly emotional situation)
    - Change in experience of self in the family system
    - Change in relationship between thinking and emotional systems
- Differentiation is internal and relational—they are isomorphic and recursive
- Anxiety inhibits change and needs to be reduced to facilitate change
- High intimacy and high autonomy are ideal
- Emotions are a physiological process—feelings are the thoughts that name and mediate emotions, that give them meaning
- Symptoms are indicators of stress, anxiety, lower differentiation
- Anyone can become symptomatic with enough stress; more differentiated people will be able to withstand more stress and, when they do become symptomatic, recover more quickly

CONCEPTS:
- Intimacy
- Autonomy
- Differentiation of Self
- Cutoff
- Triangulation
- Sibling position
- Fusion (within individual and within relationships)
- Family projection process
- Multigenerational transmission process
- Nuclear family
- Emotional process
- 4 sub-concepts (ways people manage anxiety; none of these is bad by itself – it's when one is used to exclusion of others or excessively that it can become problematic for a system):
    - Conflict
    - Dysfunction in person
    - Triangulation
    - Distance
- Societal emotional process
- Undifferentiated family ego mass

GOALS OF THERAPY:
- Ultimate—increase differentiation of self (thoughts/emotions; self/others)
- Intermediate—detriangulation, lowering anxiety to respond instead of react
- Decrease emotional reactivity—increase thoughtful responses
- Increased intimacy one-on-one with important others

ROLE OF THERAPIST:
- Coach (objective)
- Educator
- Therapist is part of the system (non-anxious and differentiated)
- Expert—not a collaborator

ASSESSMENT:
- Emotional reactivity
- Degree of differentiation of self
- Ways that people manage anxiety/ family themes
- Triangles
- Repeating intergenerational patterns
- Genogram (assessment tool)

Bowen Family Therapy, Continued

<table>
<tr>
<td colspan="2"><u>INTERVENTIONS:</u>
• Genogram (both assessment and change tool)
• Plan for intense situations (when things get hot, what are we going to do – thinking; process questions)
• Process questions-- thinking questions: "What do you think about this?" "How does that work?"
• Detriangulating one-on-one relationships, one person with the other two in the triangle
• Educating clients about the concepts of the model
• Decrease emotional reactivity—increase thoughtful responses
• Therapist as a calm self and calm part of a triangle with the clients
• Coaching for changing own patterns in family of origin</td>
<td><u>CHANGE:</u>
• Reduced anxiety through separation of thoughts and emotions – cognitive
• Reduced anxiety leads to responsive thoughts and actions, changed affect, changed relationships
• When we think (respond), change occurs (planning thinking) -- when you know how you would like to behave in a certain emotional situation, you plan it, it makes it easier to carry through with different consequences</td>
</tr>
<tr>
<td><u>TERMINATION:</u>
• Ongoing—we are never fully differentiated</td>
<td><u>SELF OF THE THERAPIST:</u>
• Important with this model; differentiated, calm therapist is main tool
• We don't need to join the system
• We must be highly differentiated so we can recognize and reduce reactivity
• Our clients can only become as differentiated as we are; we need coaching to increase our own differentiation of self</td>
<td><u>EVALUATION:</u>
• Research suggesting validity: not much, not a lot of outcome
• Did not specify symptom reduction
• Client report of different thoughts, actions, responses from others, affect is evidence of change</td>
</tr>
<tr>
<td colspan="3"><u>SUPERVISION INTERVENTIONS:</u></td>
</tr>
<tr>
<td colspan="3"><u>RESOURCES:</u>
Bowen, M. (1978). Family therapy in clinical practice. New York: Jason Aaronson.
Friedman, E. (1987). Generation to generation: Family process in church and synagogue. New York: Guilford.
Kerr, M. E., & Bowen, M. (1988). Family evaluation: An approach based on Bowen theory. New York: W. W. Norton and Company.</td>
</tr>
</table>

NOTES:

PSYCHODYNAMIC FAMILY THERAPY (OBJECT RELATIONS)

LEADERS:

- Freud
- Erik Erikson
- Nathan Ackerman
- Several others who were trained, but their models were not primarily psychodynamic: Bowen, Whitaker, etc.
- Object relations: Scharff & Scharff
- Attachment theory: Bowlby

ASSUMPTIONS:

- Sexual and aggressive drives are at the heart of human nature
- Every human being wants to be appreciated
- Symptoms are attempts to cope with unconscious conflicts over sex and aggression
- Internalized objects become projected onto important others; we then evoke responses from them that fit that object, they comply, and we react to the projection rather than the real person
- Early experiences affect later relationships
- Internalized objects affect inner experience and outer relationships

CONCEPTS:

- Internal objects- mental images of self and others built from experience and expectation
- Attachment- connection with important others
- Separation-individuation- the gradual process of a child separating from the mother
- Mirroring- When parents show understanding and acceptance
- Transference-Attributing qualities of someone else to another person
- Countertransference – Therapist's attributing qualities of self onto others
- Family Myths- unspoken rules and beliefs that drive behavior, based on beliefs, not full images of others
- Fixation and regression-When families become stuck they revert back to lower levels of functioning
- Invisible loyalties- unconscious commitments to the family that are detrimental to the individual

GOALS OF THERAPY:

- To free family members of unconscious constraints so that they can interact as healthy individuals
- Separation-Individuation
- Differentiation

ROLE OF THERAPIST:

- Listener
- Expert position
- Interpret

ASSESSMENT:

- Attachment bonds
- Projections (unrealistic attributions)

INTERVENTIONS:

- Listening
- Showing empathy
- Interpretations (especially projections) Family of origin sessions (Framo)
- Make a safe holding environment

CHANGE:

- Change occurs when family members expand their insight to realize that psychological lives are larger than conscious experience and coming to accept repressed parts of their personalities
- Change also occurs when more, full, real aspects of others are revealed in therapy so that projections fade

Psychodynamic Family Therapy (Object Relations), Continued

TERMINATION: Not sure how therapy is terminated
EVALUATION:
SUPERVISION INTERVENTIONS:
RESOURCES: Sander, F. (2004) Psychoanalytic Couples Therapy: Classical Style in Psychoanalytic Inquiry Issue on Psychoanalytic Treatment of Couples ed. By Feld, B and Livingston, M. Vol 24:373-386. Scharff, J. (ed.) (1989) Foundations of Object Relations Family Therapy . Jason Aronson, Northvale N.J. Slipp, S. (1984). *Object relations: A dynamic bridge between individual and family treatment.* Northvale, NJ: Jason Aronson.

NOTES:

EXPERIENTIAL FAMILY THERAPY

LEADERS:	ASSUMPTIONS:
• Carl Whitaker • Virginia Satir	• Family problems are rooted in suppression of feelings, rigidity, denial of impulses, lack of awareness, emotional deadness, and overuse of defense mechanisms • Families must get in touch with their REAL feelings • Therapy works from the Inside (emotion) Out (behavior) • Expanding the individual's experience opens them up to their experiences and helps to improve the functioning of the family group • Commitment to emotional well being

CONCEPTS:	GOALS OF THERAPY:
• Honest emotion • Suppress repression • Family myths • Mystification • Blaming • Placating • Being irrelevant/irreverent • Being super reasonable • Battle for structure • Battle for initiative	• Promote growth, change, creativity, flexibility, spontaneity, and playfulness • Make the covert overt • Increase the emotional closeness of spouses and disrupt rigidity • Unlock defenses, enhance self-esteem, and recover potential for experiencing • Enhance individuation

ROLE OF THE THERAPIST:	ASSESSMENT:
• Uses their own personality • Must be open and spontaneous, empathic, sensitive, and demonstrate caring and acceptance • Be willing to share and risk, be genuine, and increase stress within the family • Teach family effective communication skills in order to convey their feelings • Active and directive	• Assess individual self-expression and levels of defensiveness • Assess family interactions that promote or stifle individuation and healthy interaction

INTERVENTIONS:	CHANGE:
• Sculpting • Choreography • Conjoint family drawing • Role playing • Use of humor • Puppet interviews • Reconstruction • Sharing feelings and creating an emotionally intense atmosphere • Modeling and teaching clear communication skills (Use of "I" messages) • Challenge "stances" (Satir) • Use of self	• Increasing stress among the family members leads to increased emotional expression and honest, open communication • Changing experience changes affect; need to get out of head into emotions; active interventions change experience, emotions

Experiential Family Therapy, Continued

TERMINATION:	SELF OF THE THERAPIST:
• Defenses of family members are broken down • Family communicating openly • Family members more in touch with their feelings • Members relate to each other in a more honest way • Openness for individuation of family members	• Through the use of humor, spontaneity, and personality, the therapist is able to unbalance the family and bring about change • The personality of the therapist is key to bringing about change

EVALUATION:

- This model fell out of favor in the 80s and 90s due to its focus on the emotional experience of the individual while ignoring the role of family structure and communication in the regulation of emotion
- Emotionally Focused Couples Therapy (Sue Johnson) and Internal Family Systems Therapy (Richard Schwartz) are the current trend
- Need to assess in-therapy outcomes as a measure of success due the fact that they often result in deeper emotional experiences (and successful sessions) that have the potential to generalize outside of therapy

SUPERVISION INTERVENTIONS:

RESOURCES:

Satir, V. (1967). *Conjoint family therapy*. Palo Alto, CA: Science and Behavior Books.
Satir, V. (1972). *Peoplemaking*. Palo Alto, CA: Science and Behavior Books.
Napier, A. Y., & Whitaker, C. A. (1978). *The family crucible*. New York: Harper & Row.

NOTES:

EMOTIONALLY FOCUSED THERAPY

LEADERS:

- Susan Johnson
- Les Greenburg

ASSUMPTIONS:

- "The inner construction of experience evokes interactional responses that organize the world in a particular way. These patterns of interaction then reflect, and in turn, shape inner experience" (Johnson, 2008, p. 109)
- Individual identity can be formed and transformed by relationships and interactions with others
- New experiences in therapy can help clients expand their view and make sense of the world in a new way
- Nonpathologizing, not interested in pathology or "dysfunction"
- Past is relevant only in how it affects the present.
- Emotion is a target and agent of change.
- Primary emotions generally draw partners closer. Secondary emotions push partners away.
- Distressed couples get caught in negative repetitive sequences of interaction where partners express secondary emotions rather than primary emotions.

CONCEPTS:

- Attachment needs exist throughout the life span.
- Negative interactional patterns
- Primary and secondary emotions
- Empathic attunement
- Cycle de-escalation
- Blamer softening
- Withdrawer re-engagement

GOALS OF THERAPY:

- Identify and break negative interactional patterns
- Increase emotional engagement between couple
- Identify primary and secondary emotions in the context of negative interactional pattern
- Access, expand, and reorganize key emotional responses
- Create a shift in partners' interactional positions.
- Foster the creation of a secure bond between partners through the creation of new interactional events that redefine the relationship

ROLE OF THERAPIST:

- Client-centered, collaborative
- Process consultant
- Choreographer of relationship dance

ASSESSMENT:

- Assess relationship factors such as:
    - Their cycle
    - Action tendencies (behaviors)
    - Perceptions
    - Secondary emotions
    - Primary emotions
    - Attachment needs
- Relationship history, key events
- Brief personal attachment history
- Interaction style
- Violence/abuse/drug usage
- Sexual relationship
- Prognostic indicators:
    - Degree of reactivity and escalation- intensity of negative cycle
    - Strength of attachment/commitment
    - Openness – response to therapist – engagement
    - Trust/faith of the female partner (does she believe he cares about her).

Emotionally Focused Therapy, Continued

<table>
<tr><td><u>INTERVENTIONS</u>
Reflection
Validation
Evocative questions and empathic conjecture
Self-disclosure</td><td>Tracking, reflecting, and replaying interactions
Reframe in an attachment frame
Enactments
Softening
Heightening and expanding emotional experiences</td></tr>
<tr><td><u>TERMINATION:</u>
Therapy ends when the therapist and clients collaboratively decide that the following changes have occured:
Negative affect has lessened and is regulated differently
Partners are more accessible and responsive to each other
Partners perceive each other as people who want to be close, not as enemies
Negative cycles are contained and positive cycles are enacted</td><td><u>SELF OF THE THERAPIST:</u>
Accept responsibility for client/therapist relationship
Expert on process of therapy, not on client's life or experience of the difficulty
Collaborator who must sometimes lead and sometimes follow</td></tr>
<tr><td><u>EVALUATION:</u>
Therapy/Research:
Difficult model to learn
When using the EFT model, it is important to move slowly down the process of therapy. This can be difficult to do.
Learning to stay with deepened emotions can sometimes be overwhelming, but the therapist must continue to reflect and validate.
Empirically validated, 20 years of research to back up.</td><td><u>CHANGE:</u>
Change happens as couples have a new corrective emotional experience with one another.
When couples are able to experience their own emotions, needs, and fears and express them to one another and experience the other partner responding to those emotions, needs, and fears in an accessible, responsive way.</td></tr>
<tr><td colspan="2"><u>SUPERVISION INTERVENTIONS:</u></td></tr>
<tr><td colspan="2"><u>RESOURCES:</u>
Johnson, S. M. (2004). The practice of emotionally focused couple therapy (2nd ed.). New York: Brunner-Routledge.
Johnson, S. M., Bradely, B., Furrow, J., Lee, A., Palmer, G., Tilley, D., & Wolley, S. (2005). Becoming an emotionally focused couple therapist: The workbook. New York: Routledge.
Johnson, S. M. (2008). Emotionally focused couple therapy. In A. S. Gurman (Ed.), Clinical handbook of couple therapy (4th ed., pp. 107-137). New York: Guilford.
Johnson, S. M., & Greenburg, L. S. (1994). The heart of the matter: Perspectives on emotion in marital therapy. New York: Brunner/Mazel.</td></tr>
</table>

Gottman Method Couple Therapy

LEADERS:
- John Gottman
- Julie Gottman

ASSUMPTIONS:
- Therapy is primarily dyadic
- Couples need to be in emotional states to learn how to cope with and change them
- Therapy should be primarily a positive affective experience
- Positive sentiment override and friendship base are needed for communication and affect change

CONCEPTS:
- Negative interactions (four horsemen) decrease acceptance of repair attempts
- Most couples present in therapy with low positive affect
- Sound marital house
- Softened startup
- Love maps

GOALS OF THERAPY:
- Empower the couple
- Problem solving skills
- Positive affect
- Creating shared meaning

ROLE OF THE THERAPIST:
- Coach
- Provide the tools that the couple can use with one another and make their own

ASSESSMENT:
- Four horsemen are present and repair is ineffective
- Absence of positive affect
- Sound marital house

INTERVENTIONS:
- Sound Marital House
- Dreams-within-conflict
- Label destructive patterns
- Enhancing the Marital friendship
- Sentiment override

CHANGE:
- Accepting influence
- Decrease negative interactions
- Increase positive affect

TERMINATION:
- When couples can consistently develop their own interventions that work reasonably well

SELF OF THE THERAPIST:
- Not discussed

EVALUATION:
- Theory is based on Gottman's research

SUPERVISION INTERVENTIONS

RESOURCES:

Gottman, J. (1994). *Why marriages succeed or fail.* New York: Simon & Schuster.
Gottman, J. M. (1999). *The marriage clinic.* New York: Norton.

Family Therapy Outline

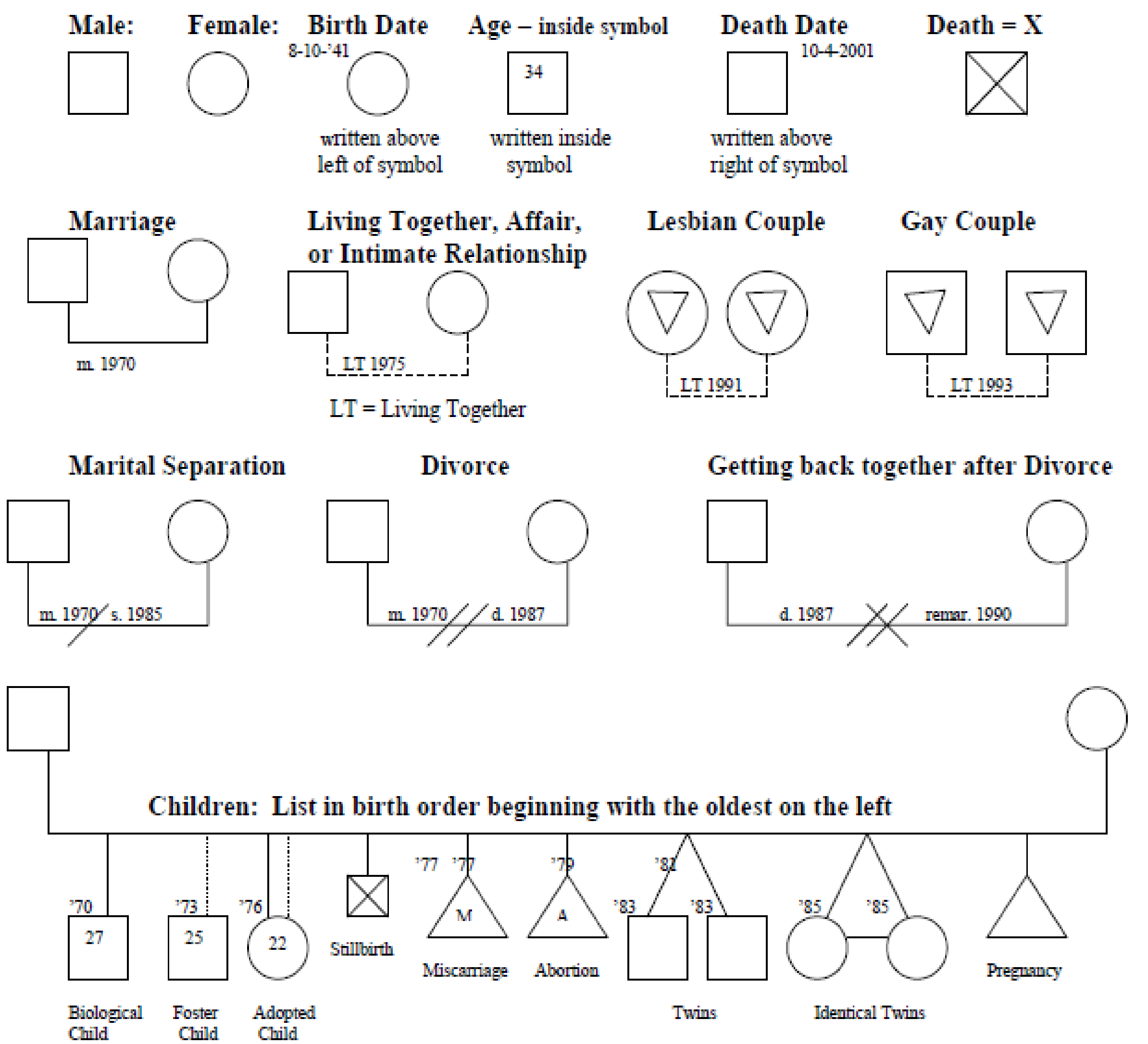
I. Initial Stages – Sessions 1-3
   a. Genograms
   b. Joining – observation
   c. History
   d. Hypothesis Formation
   e. Goal Formation
   f. Treatment Strategies (Process/discharge planning)

II. Middle Stages – Sessions 4-8
   a. Overcoming resistance
   b. Implementation of strategy
   c. Reformulate hypothesis
   d. Renegotiate treatment goals
   e. Noticing reinforcing changes
   f. Stuck Points
   g. Prepare for discharge

III. Final Stages – Sessions 9-12
   a. Discharge planning – linkages
   b. Validity/Nurturing change
   c. Maintaining change
   d. Saying goodbye
   e. Recap/Sharing observations

Genograms

The Basic Genogram Symbols

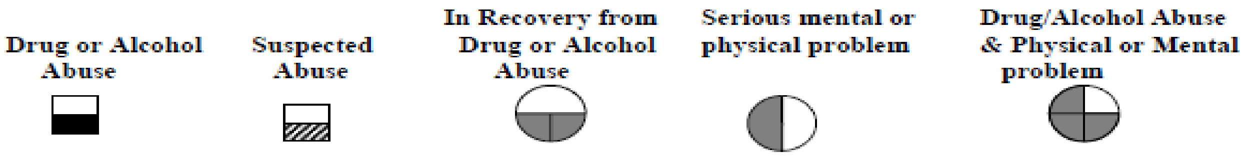


- Two people who are married are connected by lines that go down and across, with the husband on the left and the wife on the right.
- Couples that are not married are depicted with a dotted line.
- Children are drawn left to right, going from the oldest to the youngest.

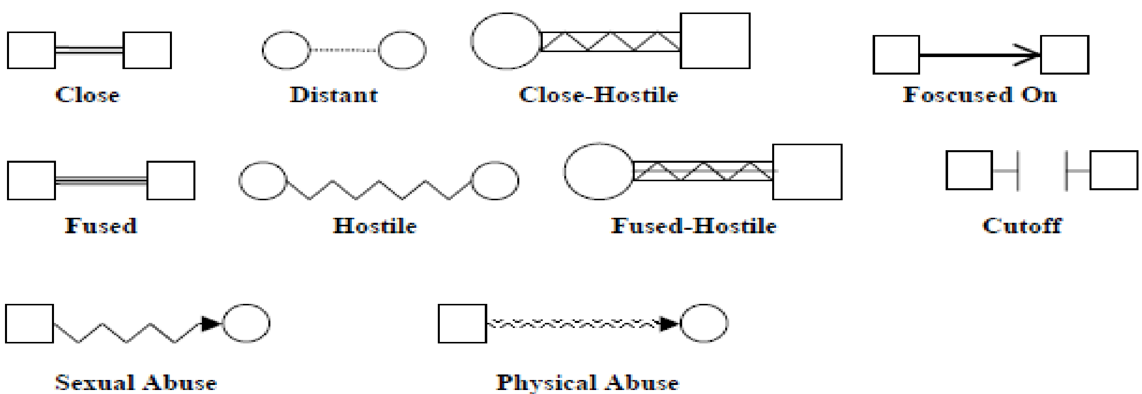
CMP 105
Family / Child Assessment
12/2005
SJ

Adapted from: Power, Thomas A., ACSW.
Family Matters: A Layperson's Guide to Family functioning. Hathaway press,
New Hampshire, 1992

Symbols Denoting Drug, Alcohol, and/or Mental Problems



Symbols Denoting Interactional Patterns between People



Parenting Overview

The Youth Services Department offers a variety of parenting services that can be provided via an individual or group format. Curriculums developed from evidence-based programs may be utilized, including Systematic Training for Effective Parenting (STEP), which includes psychoeducation on child/adolescent development and parental stress management. Behavioral parent training for select families of younger children may also be offered through an evidenced-based treatment known as Parent-Child Interaction Therapy (PCIT), in which parents learn behavior management strategies to increase their child's engagement in desirable behaviors while learning effective discipline procedures to reduce engagement in disruptive behaviors. Parent support groups are also offered depending on need.

During the intake process, families are screened to determine the best parenting intervention based on the presenting problem. Factors that may influence the determination of the appropriate parenting intervention recommended for a family may include: when a group is being offered, parent's level of cognitive and mental health functioning, child's age, if the child is residing outside of the caregiver's home, and primary language spoken by the parents.

Referrals for parent education, parent support, and parent training services come from a variety of sources, including, but not limited to, Youth Services therapists, caseworkers from the Department of Children and Families (DCF), probation and parole officers from the Department of Corrections (DOC), agencies working with prospective adoptive parents, and previous attendees.

Referrals can be made for parenting services at either the Education and Training Center or at one of the Youth and Family Counseling offices. Below is an outline of each of the parenting services, noting which offices can provide the particular services as well.

Systematic Training for Effective Parenting (STEP)

STEP parenting services are offered in an individual or group format. This service is appropriate for parents of children ages 0-18. Individual STEP can be provided at the Education and Training Center or at one of the Youth and Family Counseling offices. Group STEP is offered at the Education and Training Center. Check with a team member from the Education and Training Center to determine group days and times.

The individual and group formats follow the same outline. STEP can be offered to parents in Spanish or English. Parents in the group complete a Pre-Survey and Post-Survey and attend 7 sessions, for a total of 10.5 hours of parent education instruction. Parents attending individual sessions will complete a Pre-Survey and Post-Survey and attend 7 sessions, for a total of 7 hours of parent education instruction. STEP Chapter Outlines for group attendees are completed during group and chapters from STEP book are provided to review throughout the week. The chapters correspond to weekly sessions broken down by the modules listed below. After all sessions have been attended, parents complete a Post-Survey and may receive a certificate of completion.

Outlines and handouts for group facilitators and attendees can be found on the Common (G:) drive, EDUCATION and TRAINING CENTER folder, Parenting folder, STEP Parenting Outlines & Handouts folder. Scanned copies of STEP book chapters in English and Spanish are available on the Common (G:) drive, EDUCATION and TRAINING CENTER folder, Parenting folder, Parenting Book folder. The certificate of completion can be found on the Common (G:) drive, EDUCATION and TRAINING CENTER folder, Parenting folder, Certificates folder. Remember to delete the client's name once the certificate has been printed.

Outline for STEP Sessions

- Session 1: **Introduction and Overview of STEP Curriculum**
  - pre-survey
  - review confidentiality, Bill of Rights and Consent for Treatment, and Release of Information
  - parenting goals and challenges
  - parenting styles
  - influences on children's development
  - four goals of misbehavior
  - ingredients of a strong parent-child relationship
- Session 2: **Misbehavior and Belief Systems**
  - steps/responses to misbehavior
  - development of children's beliefs systems
  - family values
  - models and modeling of appropriate behavior
  - birth order characteristics
- Session 3: **Self-esteem and Praise versus Encouragement**
  - how can you build self-esteem in your children through praise and encouragement
  - loving and accepting your child and self
  - having faith in your child and self
  - noticing effort and improvement
  - appreciating your child, self and others
- Session 4: **Communication and Stress Management**
  - respectful communication
  - reflective listening
  - I messages
  - verbal and non-verbal communication cues
  - relaxation techniques
- Session 5: **Cooperation**
  - how to gain cooperation from children and others
  - problem-solving techniques
  - deciding who owns the problems
  - developing and structuring family meetings
- Sessions 6: **Discipline versus Punishment**
  - discipline vs. punishment
  - discipline strategies for younger children
  - discipline strategies for older children
  - natural versus logical consequences
  - building resiliency
- Sessions 7: **Emotional and Social Development**
  - understanding emotional development
  - emotional development challenges
  - understanding social development
  - social development concerns
  - post-survey

Parent-Child Interaction Therapy (PCIT)

PCIT services are offered in an individual format but can include more than one caregiver involved in parenting a child at a time (i.e., two parent household). PCIT services can only be provided by a trained provider and as such PCIT is only available at the Education and Training Center. The service is available for parents of children between the ages of 2-7, although children up to 12 years old may be considered for the intervention based on their developmental and socio-emotional functioning. Both parents and children participate in this parenting service together. PCIT can be provided in English or Spanish.

PCIT services are offered following a selective prevention model, which typically entails 10-12 sessions. Child behavior progress is monitored each session by having parents complete the Eyeberg Child Behavior Inventory (ECBI) at the start of each session. Parent acquisition of parenting skills is also monitored regularly via in session coding of parent application of skills. PCIT is divided into two phases of treatment, Child Directed Interaction (CDI) and Parent Directed Interaction (PDI).

- CDI Focus:
    - Decrease child's frequency, severity, and/or duration of tantrums
    - Decrease child's engagement in hyperactivity
    - Decrease child's engagement in negative attention-seeking behaviors (i.e., whining)
    - Decrease parental frustration
    - Increase child's feelings of security, safety, and attachment to the primary caregiver
    - Increase child's attention span
    - Increase child's self-esteem
    - Increase child's engagement in pro-social behaviors (i.e., sharing)

- PDI Focus:
    - Decrease child's frequency, severity, and/or duration of aggressive behavior
    - Decrease child's frequency of destructive behavior (i.e., breaking things)
    - Decrease child's defiance
    - Increase child's compliance with adult requests
    - Increase child's respect for house rules
    - Improve child's behavior in public
    - Increase parental calmness and confidence during discipline

Diversion Programs

Palm Beach County School Police Youth Court

Youth Services and the Palm Beach County School Police Youth Court Program have developed a collaboration to provide services to school-age children and adolescents up to 18 years of age who have been charged with a crime in Palm Beach County. Youth offenders who accept Youth Court as a diversionary program avoid criminal prosecution in the state courts which might lead to a criminal record. Typical offenses include theft, battery, and possession of marijuana under 20 grams, loitering, disorderly conduct, or trespassing. These offenders are diverted to Youth Court by the State Attorney's Office or participating police agencies. These children must be first-time offenders if referred directly by police agencies. Those clients referred to Youth Court are sent to Lincoln Elementary School at 1160 Avenue N, Suite 1-269, Riviera Beach, FL 33404. Subsequent trials and arbitrations are held at the North County Courthouse at 3188 PGA Blvd, Palm Beach Gardens, FL 33410, the South County Courthouse at 200 West Atlantic Ave, Delray Beach FL 33444, the Belle Glade Courthouse at 38844 SR80, Belle Glade, FL 33430, the Gun Club Courthouse at 3228 Gun Club Road, West Palm Beach, FL 33406, and at Forest Hill Elementary School at 6901 Parker Ave, West Palm Beach, FL 33405. Some cases that are processed by Youth Court will receive an order to come to Youth Services for counseling as part of their sanctions. The consequence of the client failing to complete the Youth Court sanctions is typically removal from the program and legal prosecution for the offense.

Youth Court clients are typically considered appropriate for treatment at Youth Services. Clients may be excluded from treatment if they are on probation psychiatrically or medically unstable and in need of a higher level of care, or in need of residential substance abuse treatment. If a client was arrested while carrying a weapon, a decision as to whether or not the client may enter the program is made. If it is determined that the weapon was being carried because the client had safety concerns or was afraid of aggression by others, he/she may be admitted; if the weapon was being carried for malicious reasons (i.e., to instill fear or hurt someone), a case-by-case analysis will determine admission into the Youth Services program.

Youth Court clients are referred via a faxed copy of the Court Referral for Services form as well as a Case Journal. Youth Services contacts the family, sets up and completes an intake, and transfers the case to the appropriate Youth Services office for services. If the client is referred for residential treatment at Highridge Family Center, the family's participation in treatment will be monitored by consulting with the therapist and treatment team in order to verify that the child is complying with all sanctions.

Families are expected to complete the standard treatment protocol of 12 family therapy sessions unless a variation is determined as clinically appropriate or necessary by the therapist, in concurrence with his/her supervisor. It is explained to the family that Youth Court clients are expected to attend all therapy sessions. The therapist should make it clear that unless the sessions are attended regularly and the client participates in the process of therapy, no notification indicating compliance with the Youth Court program will be provided. If an emergency arises and the family misses a session, they are expected to call and reschedule within the week. Youth Court is to be notified when any Youth Court Client is not attending consistently. If the child is being seen at Youth and Family Counseling Program or the Education and Training Center, contact with Youth Court will be made by the therapist. If the child is at Highridge, the court liaison will keep Youth Court informed. This allows Youth Court to further reinforce the need for appropriate attendance. Issues addressed in session are left to the therapist to determine the course of treatment based on the needs of the client and his/her family. If a family complies and attends therapy on a regular basis, it is not necessary to contact Youth Court during treatment.

During the course of treatment, possible consequences of the child's behavior will be reviewed. This discussion includes the potential consequences of the instant offense to the client and other persons. In addition, the possible consequences should the client fail to complete the Youth Court sanctions are processed. These include removal from the program and legal prosecution. Other objectives are designed by the therapist to meet the needs of the specific child and family. Treatment goals may include decreasing impulsivity, learning anger management skills, improving relationships, increasing positive school behaviors, improving school participation, learning parenting skills, building self-esteem, and not reoffending.

At the end of successful treatment completion, the Youth Services Client Summary (located in the CMP Tasks) will be provided to Youth Court indicating their completion of this sanction. The Youth Services Client Summary is faxed to Youth Court at 561-494-1558.

If a family is noncompliant with treatment, the therapist should notify his/her supervisor and also report it directly to Youth Court. After discussing the case with Youth Court staff, the decision will be made if the client will be given one more chance to comply or if the client will be sent back to the Youth Court without issuing a confirmation of having completed treatment goals. When Youth Court clients contract to attend therapy as part of their agreement with Youth Court, non-compliance with that contractual obligation is typically addressed by the client's case being sent back to the State Attorney's Office by the Youth Court. Those families that do not complete therapy have a copy of the Youth Services Client Summary provided to Youth Court indicating that this sanction was not completed. The Client Summary should be faxed to Youth Court at 561- 494-1558.

Contact Personnel:

Youth Court Contacts		Youth Services Contact
Officer Scott Dean	Officer Chantres Allen-Smith	John Harre
Phone: (561) 494-1567	Phone: (561) 494-1560	Phone: (561) 625-2547
Fax: (561) 494-1558	Fax: (561) 494-1558	Fax: (561) 840-4545
deans@palmbeach.k12.fl.us	chantres.allensmith@palmbeachschools.org	jharre@pbcgov.org

References

Andrews, D.A. (1995). The psychology of criminal conduct and effective treatment. In J. McGuire (Ed.), *What Works: Reducing Reoffending.* New York: John Wiley, pp. 35-62.

Anonymous. (1996). Adult treatment of juvenile offenders may aggravate recidivism. *Law Enforcement News, May 15* p.8.

Brown, W.K., Miller, T.P., & Jenkins, R.L. (1991). The human costs of "giving the kid another chance." *International Journal of Offender Therapy and Comparative Criminology, 35*, 296-302.

Butts, J.A., Buck, J., & Coggeshall, M. (2002). *The Impact of Teen Court on Young Offenders,* Washington, DC: The Urban Institute.

Fisher, M. (2002). *Youth Courts: Young People Delivering Justice.* Chicago: American Bar Association.

Goodwin, T.M., Steinhart, D., & Fulton, B. (1996). *Peer Justice and Youth Empowerment: An Implementation Guide for Teen Court Programs.* Washington DC: National Highway Traffic Safety Administration and Office of Juvenile Justice and Delinquency Prevention.

Scott, L.M. (2002). *Street Law for Youth Courts: Educational Workshops.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

Williamson, D., Chalk, M., & Knepper, P. (1993). Teen court: Juvenile justice for the 21st century? *Federal Probation, 57*(2), 54-58.

Family Violence Intervention Program (FVIP)

Family Violence Intervention Program (FVIP) History

The Family Violence Intervention Program (FVIP) was initiated in 1999 through a grant to the Palm Beach County Juvenile Court. This is a diversionary program with the goal of keeping youth out of the Juvenile Justice System and help encourage healthier ways for families to communicate without violence. Under the jurisdiction of Juvenile Court, youth charged with the offense of Domestic Battery are removed from the home by law enforcement and placed in a secure Juvenile Detention Facility.

If the parent or guardian is unwilling to take the juvenile home, and there is no family, friend or respite facility then the juvenile can remain in a secure Juvenile Detention Facility for a short period of time. The age range for the youth is typically 9 to 18 years. A Court Case Advisor contacts/meets with the family after receiving the referral from the State Attorney's Office and offers the family the choice to participate in the FVIP diversion program to avoid adjudication. If the family agrees to participate, the FVIP staff member arranges for the youth to return home or stay with a relative and refers the family for services, usually preventing the youth from remaining in detention. A mediation conference is conducted where the case plan is developed and the appropriate services are recommended and agreed upon.

The Youth Services Department (YSD)'s Residential Treatment and Family Counseling Division (RTFC) programs: Education & Training Center, Youth and Family Counseling, Highridge Family Center and FVIP work closely together to determine appropriate services (group, individual, and/or family therapy or residential services) for youth arrested for domestic battery and their parents/guardians. Participants are families where youth up to the age of 18 are alleged to have committed domestic violence, typically against their parent(s), caretaker(s), or sibling(s). Youth are considered first-time offenders, as this is the first time there was involvement with law enforcement for family violence. Parents/guardians must also participate in the group sessions and/or the family therapy sessions.

Youth Services FVIP Client Referrals and Intake-Assessment Process

Referrals for Youth Services FVIP Services are only accepted from the FVIP Program Coordinator and Court Case Advisors. FVIP clients/referrals will be scheduled for an intake within 10 business days of the referral. All Youth Services Clerical/ staff scheduling the appointment will inform FVIP clients to bring their FVIP case plan to the intake session. The following forms will be completed at intake: Bill of Rights and Consent for Treatment, FVIP Group Therapy Contract, FVIP Family Therapy Contract, Family Information Form (FIF) and all other tasks/paperwork under the Intake FVIP Service.

After completing the intake, the Youth Services staff member, and their supervisor determine whether the family will be placed in group therapy or family therapy. Factors to consider for placement in group or family therapy include: group capacity (i.e. maximum 10 teens/youth in a group) and client availability (ex. youth/family are need of an appointment on specific day and time and declines other appointments offered) for either service. When an immediate opening for group, individual or family therapy is available, the family will be notified and scheduled for the first appointment. FVIP will be notified of the scheduled appointment via the CMP FVIP report.

The FVIP Court Case Advisor is also notified and recommendations for a random drug screening are made:

- If the youth has substance abuse problems which have been noted in the FVIP case plan.
- The youth has informed the YSD therapist/case manager of the substance use, and/or;
- The YSD therapist/case manager has observed the youth's behavior as being under the influence of drugs/alcohol.

If substance abuse is not indicated in the case plan and the youth and/or parents indicate in the intake, group or family therapy session that substance abuse is occurring, the parent is advised to call the FVIP Program Coordinator and/or their Court Case Advisor and a random drug screening will be administered at the courthouse Tuesday- Friday from 9:00 a.m. – 4:00 p.m. for a cost of $25.00 or with a private provider.

Attendance Requirements

A family may start in group therapy and change to family therapy or vice versa. Additionally, a family may participate in both family therapy and group therapy. Clinical consultation with a supervisor should occur in these instances. Once a family completes 12 sessions of family or group therapy they are to be informed to contact their FVIP Court Case Advisor to set up an exit interview to determine a successful completion of FVIP program or if other services are needed. The **FVIP Court Case Advisor(s) should be notified prior to terminating with the family and closing the client's case, if the family has been non-compliant with treatment.**

The family/client is informed by their Court Case Advisor and it is written on the FVIP case plan which family members are required to participate in FVIP Therapy Services. Exceptions should be discussed with supervisor and in consultation with the client's FVIP Court Case advisor.

A group attendance sign-in sheet for both the teen and parent groups are completed for each group session and provided to the YFC Program Liaison after each group session. At all YFC offices as well as the Education and Training Center, a weekly CMP FVIP attendance form is compiled and provides the date of intake, family therapy session or group session and whether the client attended, no showed, or canceled the session scheduled for the week. FVIP attendance reports for intake, family therapy sessions, and group therapy sessions are obtained weekly via CMP by the FVIP Program Coordinator and FVIP Court Case Advisors.

If a family/client misses a standing individual, group or family therapy session without notifying the YSD staff member (therapist/group facilitator) the YSD staff member contacts the family to let the family know that if they miss another session (cancellation or no show) the case will be closed. The FVIP staff will be notified about attendance in a weekly FVIP Report in CMP. If the family either no shows or cancels (misses) 2 sessions the family may be discharged from the YSD FVIP services.

The FVIP Program Coordinator and the **FVIP Court Case Advisors must be notified prior to terminating with the family and closing the client's case. For YFC cases, the YFC Program Liaison will be notified prior to case closure and for follow-up with FVIP staff.** A consultation must be arranged when a teen and family are being considered for termination from the program or transfer from one intervention to another. The consultation should include the therapist, **YFC Program Liaison**. FVIP Program Coordinator, group facilitators, and the Court Case Advisor. The family will then be notified of the team's decision. These clients are mandated to attend therapy. The consequence for not attending therapy is that the client's case may be sent back to the court.

The FVIP Client Summary is a CMP document which contains information related to client attendance, treatment goals, and progress related to communication and conflict resolution/anger management. Upon completion of individual, group and/or family therapy, the FVIP Program Coordinator and Court Case Advisors are notified via email that the FVIP Client Summary has been completed.

Recommendations for Group and Family Therapy

Group therapy is recommended when the youth is 13 to 18 years old, when there has been an isolated incident of family violence and the teen and parent would benefit from psychoeducation and learning new conflict resolution, communication and emotion regulation skills. **In families where the violence occurred between the youth and a parent, that parent is strongly encouraged to attend all sessions.** The other parent or caregivers can also attend the parent group. Youth under the age of 13 may be accepted in group therapy after clinical consultation with a supervisor.

Family therapy is recommended when the youth is 13 to 18 years old, the youth has cognitive impairment, a learning disability, trauma history, has been physically, emotionally, or sexually abused. In families where the violence occurred between the youth and a parent, that parent must attend all sessions. Family therapy may also be recommended when the family violence has occurred between siblings, when there have been recurring incidents of family violence, or when the youth has been aggressive with peers, at school, or in the community.

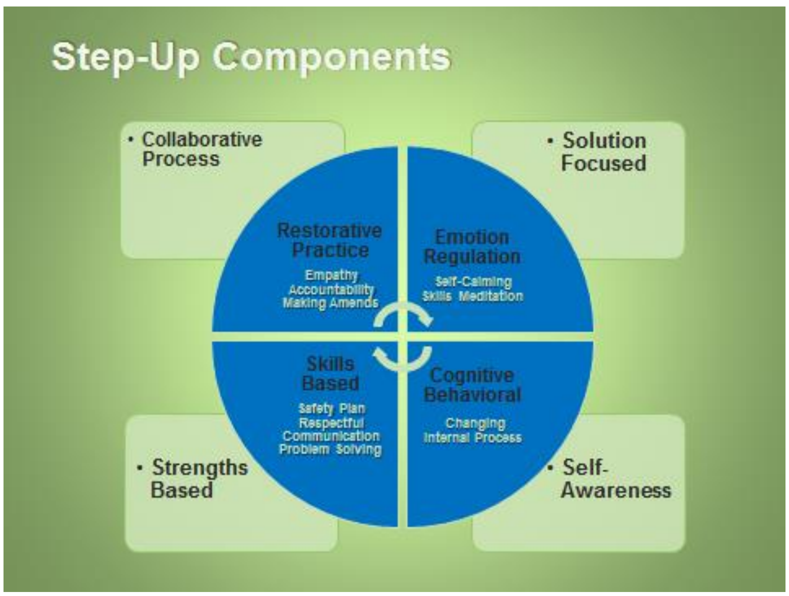
FVIP Family Therapy and FVIP Individual (18 years or older) Therapy Services Overview

Families and clients 18-22 years of age are required to complete 12 family therapy sessions in order to meet the requirements of the FVIP. However, fewer sessions may be provided if improvement is made within the family unit and **there is consensus between Youth Services therapist, Supervisor, and FVIP Court Case Advisor and/or the FVIP Program Coordinator**. If additional family therapy sessions are necessary, the therapist must request an extension from their supervisor. The youth and parent and/or sibling who were involved in the incident are required to attend each therapy session, but the other parent is encouraged to also attend. The family/client is informed by the Court Case Advisor and it is written on the FVIP case plan which family members are required to participate in therapy sessions. Exceptions should be discussed with supervisor and in consultation with the client's FVIP Case advisor.

Treatment goals may include: no further incidents of physical violence, improve impulse control, greater respectful communication between parent and youth and develop healthy coping skills. The objectives for family therapy include anger management and impulse control for the youth, improvement of family relationships, and improved communication among family members. Parenting skills are addressed, including setting boundaries and assisting parents to determine logical rewards and consequences for behavior. Awareness of possible legal consequences of the youth's behavior will be reviewed, particularly the consequence of re-offending, which can be removal from the program and legal prosecution.

FVIP Group Therapy Services Overview

The Youth Services FVIP Group Curriculum is adopted from the Seattle Cook County Step- Up program. Step-Up developed a unique 21 sessions of cognitive behavioral, skills and restorative practice based curriculum used in a group setting with youth and parents. The Youth Services FVIP group curriculum has been condensed to12 sessions. Teens and parents both come to group once a week for 90 minutes.



The Step-Up Curriculum employs practices that have been researched and are considered best practices for behavioral change. These include cognitive behavioral learning, skill development, solution focused and motivational interviewing techniques to help youth move from external to internal incentive to change. The objectives for the group program include anger management and impulse control for the youth, improvement of family relationships, and improved communication among family members. In the parents' group sessions, parenting skills are addressed. These are likely to include setting boundaries and assisting parents to determine logical rewards and consequences for behavior. Awareness of possible legal consequences of the youth's behavior will be reviewed in the teen and parent group components, particularly the consequence of re-offending, which may be removal from the FVIP program. A restorative practice approach is used with teens and parents together to address violent incidents that have occurred. A restorative inquiry process is used to help youth take responsibility for their behavior, cultivate empathy and make amends for hurtful behavior. The restorative process is enhanced by taking place in a community of other families where they support and learn from each other as they go through the restorative steps to facilitate change. Family safety is a priority of the intervention with development of a ‘Safety Plan’ followed by weekly check-ins within the family group to assess the youth’s progress in staying non-violent and safe with family members. Weekly goals related to non-violence and respect are set by the youth with progress reported each week in group, fostering accountability for behavior and keeping a focus on using the skills they have learned at home (http://kingcounty.gov/courts/superior-court/juvenile/step-up/about/Program.aspx).

Teens work in a youth group to learn skills to prevent the use of violent and abusive behavior and gain understanding about violence, abuse and power vs. respect, trust and safety in family relationships. Parents attend a parent group where they learn safety planning and parenting skills to support their youth in using nonviolent behavior. In a combined parent/teen group, families learn a respectful family model for addressing conflict. Together, parents and teens learn and practice skills for respectful communication and problem solving (http://kingcounty.gov/courts/superior-court/juvenile/step-up/about/Program.aspx).

The youth and the parent who were involved in the family violence incident must participate in group therapy. The family/client is informed by their Court Case Advisor and it is written on the FVIP case plan which family members are required to participate in therapy sessions. Exceptions should be discussed with supervisor and in consultation with the client’s FVIP Case advisor. Families must complete 12 group sessions to complete the FVIP group. The group is an “open” group so members may join at any session. New families may enter the group each week. Every effort is made to maintain a group no larger than 10 teen participants. Each parent and teen signs a group contract consenting to the requirement that they will be on time **(arrive at 5:30pm sharp)** for the group session. Families are given a pass for the first time they are tardy. If the family is tardy a second time they are given a choice of staying in the group for that session, with no credit for that group, or returning to group the following week. Refer to the FVIP Group Parent/Teen Group Contract.

There are two FVIP group locations:

- **YFC-South** office provides group services on **Tuesdays** from **5:30 p.m. to 7:00 p.m.**
    - This group takes place at 345 South Congress Avenue Delray Beach, FL 33445; 561-276-1340

- **YFC- Four Points** office provides group services on **Wednesdays** from **5:30 p.m. to 7:00 p.m.**
    - This group takes place at 50 South Military Trail, West Palm Beach, FL. 33415; 561-242-5714

Families from Education and Training and Highridge who are recommended for group therapy can attend an FVIP group at the YFC- South or YFC Four Points office. Refer to the group curriculum below for the weekly topics covered.

<u>Contact Personnel</u>
Natalie Macon, LCSW, Youth Services Coordinator/ YFC Program Liaison (561) 276-1340.

Stacey King, MA-FVIP Program Coordinator- (561) 355-2678. In general, the FVIP Program Coordinator is contacted if a decision is made to recommend that the client be referred back to the Court.

FVIP Court Case Advisors include:

- **Tiffany Phillips, BS- 561-355-4655**,
- **Gabriel “Gabe” Munoz, MA-** (561) 355-1662

Court Case Advisors may be contacted directly, and will contact the Youth Services personnel directly when communication is needed about a family.

FVIP Parent Group Description

Session #1 – **Introduction, Strengths, Challenges, Changes and Making Changes**

- Meet and Greet
- Expectations of group members/what they expect to get from the group
- Begin the process of building supportive relationships in the group
- Identify strengths and challenges as a parent (Use parent curriculum workbook session). Group rules and punctuality.
- Discussion: Making Another Person Change
- Exercise: Making Another Person Change
- Discussion: Changing Your Own Behavior
- Exercise: What Happens When We Try to Make Our Teens Change
- Discussion: Goal Planning
- Exercise: Goal Planning

Session #2 – **How to Respond When Your Teen is Violent**

- Discussion: Your Priorities When Your Teen Becomes Violent
  - Safety
  - What message am I giving my teen?
- Discussion: How to Respond When Your Teen Becomes Violent
- Discussion: Safety Planning
- Exercise: Safety Planning for Our Home

Session #3– **Combined– Taking Time Out and Understanding Warning Signs**

- Discussion: How to Take a Time-Out
- Discussion: Disengaging from Power Struggles
- Discussion: Self-Calming Thoughts
- Exercise: Identifying Your Own Red Flags (30 minutes)
- Discussion: Red Flags
- Exercise: My Red Flags, Identifying Red Flags in Your Teen
- Discussion: Self-Calming Thoughts
- Exercise: Role Play Time-Out Scenarios

Session #4 – **Time Out for Parents and When Your Teen Is Abusive Effects on Parenting**

- Discussion: Review Progress
- Discussion: Why Take a Time-Out?
- Exercise: Identifying Your Own Red Flags
- Discussion: Red Flags
- Effects on Parenting (20 minutes)

Session #5 – **Adolescent Development and Consequences for Behavior**

- Review Progress
- Discussion: Remembering Your Teen Years
- Discussion: Developmental Characteristics and Tasks of Adolescence
- Discussion: Distinguishing Between Difficult Adolescent Behavior and Abusive Behavior

Session #6 – **Encouraging Your Teen and Empowering Teens to be Responsible for Their Behavior**

- Discussion: Review Progress
- Discussion: Discussion with teens about responsibility
- Discussion: About appropriate consequences
- Exercise: Practice encouragement

Session #7 – **Combined– Making Amends**

- Discussion: Review Progress
- Discussion: What Are Amends? How do we make amends?

Session #8 – **What Kind of Message Are You Giving Your Teen?**

- Discussion: Review Progress
- Discussion: How Do You Give Underlying Messages When You Talk To Your Teen?
- Discussion: How do These Messages Affect Your Teen's View of Him/Herself?
- Exercise: Communicating in a Way that Makes Your Teen Feel Responsible and Capable

Session #9 – **Combined Session – Assertive Communication and Using "I" Messages**

- Discussion: Review Progress
- Discussion: What is an "I" Statement?
- Discussion: How to make an "I" Statement
  - I feel (feeling)
  - When (behavior or situation)
  - Because (how it is a problem for you)
- Discussion: 'You' statements vs.: 'I' statements
- Discussion: I statements avoid shaming and blaming

Session #10 – **Listening to Your Teens**

- Discussion: Review Progress
- Discussion: Discussion How to Listen
- Discussion: How NOT to Listen
- Discussion: Acknowledge Feelings
- Exercise: Role Play Acknowledging Feelings Scenarios

Session #11 – **Combined–Guidelines for Respectful Communication and Problem Solving Together**

- Discussion: Review Progress
- Discussion: Talking about a problem without blaming or criticizing
- Discussion: Listening to the other person's feelings and view of a problem
- Discussion: Don't talk, listen carefully, do not interrupt
- Discussion: Describe what the other said and the other person was feeling
- Discussion: Problem Solving Together
- Discussion: What are some things that people do that get in the way of problem solving?
- Discussion: Two people "working out a problem", what would they look like?

Session #12 – **Supporting Positive Changes in Your Teen**

- Discussion: Review Progress
- Discussion: Talk about positive changes in your teen and how you contributed to that change
- Discussion: What you need to continue to work on to support your teen's positive behavior
- Discussion: Sharing Idea of what they learned in the group
- Discussion: Recommendations

FVIP Teen Group Description

Session #1 – **My Family Relationship and Goal Planning**
- Discussion: What things about your family are good (strength)?
- Exercise: My Family Relationships
- Discussion: What Behaviors Strengthen Family Relationships? Which Behaviors Damage Them?
- Discussion: How can Conflict Strengthen Family Relationship?
- Discussion: Goal Planning
- Exercise: Goal Planning

Session #2 – **Understanding Violence (Abuse Wheel handout)**
- Discussion: What are violence and Abusive Behavior?
- Discussion: Identify Payoffs, Outcomes, and Consequences of Violence and Abuse

Session #3 – **Combined Session – Taking a Time-Out and Understanding Warning Signs**
- Discussion: Time-Out as a Strategy for De-escalating Difficult Situations
- Discussion: How to Take a Time-Out
    - Pay attention to your warning signs
    - Make a decision for prevention
    - Tell the other person
    - Self-calming thoughts
    - Examine your choices
    - Try and work out the problem
- Discussion: Substance Abuse and violence
- Discussion: Termination from the program

Session #4 – **Understanding Power and Understanding Feelings**
- Discussion: Review Progress
- Discussion: Negative and positive use of power
- Discussion: Identify personal power
- Discussion: Ways teen can use their personal power in positive ways

Session #5 – **Understanding Self Talk and Understanding Beliefs**
- Discussion: Review Progress
- Discussion: What is Self-Talk?
- Discussion: How can Self-Talk help me to control my behavior?
- Exercise: Turning Negative talk into positive self-talk
- Discussion: How Do Our Beliefs Affect Our Actions?
- Discussion: What Beliefs do People Have About Anger and Abuse?

Session #6 – **Hurtful Moves/Helpful Moves and Accountability**

- Discussion: How does observation of Abuse and Violence Affect Dating Relationships?
- Discussion: How might it carry over into conflicts with boy's/girls friends?
- Discussion: Healthy and Unhealthy responds to difficult situations
- Discussion: How can you change your behavior and become more assertive and less aggressive?
- Discussion: How Have your changes affected your relationship with your family?

Session #7 – **Combined Session – Making Amends**
- Discussion: Review Progress
- Discussion: What Are Amends? How do we make amends?

Session #8 – **Responsibility**

- Discussion: Review Progress
- Discussion: Taking responsibility without
    - Denying
    - Justifying
    - Minimizing
    - Blaming

Session #9 – **Combined Session – Assertive Communication and Using ‘I’ Messages**

- Discussion: Review Progress
- Discussion: What is an “I” Statement?
- Discussion: How to make an “I” Statement
    - I feel (feeling)
    - When (behavior or situation)
    - Because (how it is a problem for you)
- Discussion: ‘You’ statements vs.: ‘I’ statements
- Discussion: I statements avoid shaming and blaming

Session #10 – **Understanding Empathy**

- Discussion: Review Progress
- Discussion: How empathy can have a positive impact on relationships
- Discussion: What is empathy?
- Discussion: What does empathy have to do with mutual respect?
- Can you have empathy with someone even when you don’t agree with his or her point of view?

Session #11 – **Combined Session – Guidelines for Respectful Communication and Problem Solving Together**

- Discussion: Review Progress
- Discussion: Talking about a problem without blaming or criticizing
- Discussion: Listening to the other person’s feelings and view of a problem
- Discussion: Don’t talk, listen carefully, do not interrupt
- Discussion: Describe what the other said and the other person was feeling
- Discussion: Problem Solving Together
- Discussion: What are some things that people do that get in the way of problem solving?
- Discussion: Two people “working out a problem”, what would they look like?

Session #12 – **Healthy Dating Relationship**

- Discussion: How does observation of Abuse and Violence Affect Dating Relationships?
- Discussion: How might it carry over into conflicts with boys/girls friends?
- Discussion: Healthy and Unhealthy responds to difficult situations
- Discussion: How can you change your behavior and become more assertive and less aggressive?
- Discussion: How Have your changes affected your relationship with your family?

<u>FVIP Teen and Parent Group Curriculum Outline</u>

Session	Teens	Combined	Parents
1	**My Family Relationships and Goal Planning**		**Strengths, Challenges, Changes and Making changes**
2	**Understanding Violence****(Abuse wheel handout)***		**How to Respond When Your Teen Is Violent**
3		**Taking a Time Out and Understanding Warning Signs**	
4	**Understanding Power and Understanding Feelings *** ***(Respect Wheel Handout)***		**Time Out for Parents and When Your Teen Is Abusive: Effects on Parenting**
5	**Understanding Self Talk and Understanding Beliefs**		**Adolescent Development and Consequences for Behavior**
6	**Hurtful Moves/Helpful Moves and Accountability**		**Encouraging Your Teen and Empowering Teens to Be Responsible for Their Behavior**
7		**Making Amends**	
8	**Responsibility**		**What Kind of Message Are You Giving Your Teen?**
9		**Assertive Communication and Using "I" messages**	
10	**Understanding Empathy**		**Listening to Your Teen**
11		**Guidelines for Respectful Communication and Problem Solving Together**	
12	**Healthy Dating Relationships**		**Supporting Positive Changes in Your Teen**

******Topic- **Moving Forward** will be given as homework on an as needed basis for those group members leaving the group****** Introductions, Group Rules, Attendance and Punctuality discussed/reviewed in each session. Based on King County Step-Up Program, Seattle, WA

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Youth Firesetter Intervention Program (YFIP)

Youth Services has developed a memorandum of understanding with Palm Beach County Fire Rescue for families with children or adolescents who set fires/bombs or who present with an interest in fire. The program is available as a diversionary program for youth who have been apprehended by police, firefighters, or Fire Marshalls for criminal firesetting behavior, including but not limited to setting fires, setting off incendiary devices, being present when another person sets a fire, or making bombs. The program is also available as a prevention program for youth who demonstrate an interest in fire and firesetting.

The program requires attendance at a Firesetter Education class provided by Fire Rescue for the youth and his/her parents and siblings. At the class, information is given to the families in order to prevent repetition of firesetting behavior, to prevent property damage, injury, and/or death, and to keep first time offenders out of the Juvenile Justice system. Once the Firesetter Education class has been attended, the youth and his/her caregiver(s) attend a clinical assessment with Youth Services. The assessment is completed in order to screen for emotional, behavioral, and social difficulties that may benefit from intervention. The clinical assessment must be completed by youth attending YFIP as a diversionary program. Upon completion of the class, clinical assessment, and any recommendations derived from the assessment, a certificate of completion is issued by Fire Rescue.

Diversionary

- For families with children or adolescents through age 17 who are caught engaging in criminal firesetting behaviors, such as setting fires, setting off incendiary devices, being present when another person sets a fire, and are apprehended by the police, firefighters, or State Fire Marshalls. When the Firesetter Education class and clinical assessment are both completed, any pending charges are not filed for prosecution with the State Attorney's office.
- These children/adolescents must be first-time offenders. Often there is another agency involved, including Palm Beach County School Police Youth Court, Palm Beach Sheriff's Office, or Juvenile First Offender Program, as well as sanctions that must be completed.

Prevention

- For families with children or adolescents through age 17 who may have an unhealthy interest in fires, matches, lighters, etc. In order to participate in the program, the parents may call Fire Rescue directly, or may be referred into the program by a counselor, therapist, teacher, physician, or acquaintance that is familiar with the program.

Youth Services Firesetter Assessment procedure

- When a youth has been identified as a firesetter, Fire Rescue contacts the family by mail and informs them of the YFIP program requirements and dates of the Fire Education class, which is held on the second Tuesday of each month.
- Fire Rescue will send a referral packet to Youth Services, which may include the following documents: rough arrest, probable cause, investigator's reports, what sanctions have been set, and school records. The referral packet should also contain a release of information signed by the family allowing communication between Youth Services and the referral source.

- After the family has attended the Firesetter Education class, which takes place the second Tuesday of each month, the family contacts Youth Services Education Center within 3 days to schedule the Firesetter Assessment.
- For the diversionary program, each child/adolescent who was involved in the firesetting incident and one caregiver, or adult who is able to provide consent for services, must attend.
- For the prevention program, the child/adolescent and one caregiver, or adult who is able to provide consent for services, must attend.
- It is the responsibility of the parent to contact Youth Services within 3 days of the Fire Education class to schedule the Firesetter Assessment. When they contact Youth Services to schedule, they are notified that they must designate a 2 hour block of time for the assessment. They are also informed that the recommendation(s) of the evaluator will be sent to fire rescue.
- Parents must choose an available intake assessment time. Live sessions are offered when available. If they no show or cancel their scheduled appointment, they are only entitled to reschedule one time. If they call to reschedule their appointment before missing their session, they are still only entitled to reschedule one additional time.
- If the caregiver does not speak English fluently, they must bring an adult with them that can translate. If they do not bring a translator, the appointment will not proceed.
- When the family arrives they should complete the Family Information Form (FIF). The evaluator should have the family sign the Bill of Rights and Consent to Treatment.
- A Releases of Information YFIP should also be signed, allowing Youth Services to provide Fire Rescue with information related to client status and any recommendations generated from the assessment.
- An ROI Youth Court may also need to be completed if the referral came through Fire rescue via Youth Court.
- Interviews should be completed with both the child and parent/guardian.
- Document attendance and completion of the Firesetter Assessment using the Firesetter Assessment/Office note and contact type in CMP.
- An Intake Report is generated in CMP.
- A separate document, <u>Assessment Recommendations</u>, is generated enumerating **only the enforceable recommendations**, including but not limited to family therapy, residential services, or a psychological evaluation. Assessment Recommendations <u>are sent via fax to</u> Fire Rescue 616-7084 and/or Officer Dean at Youth Court 494-1558.
- If additional clinical services through Youth Services are recommended, a new appointment is scheduled at the time of intake. If the family is unable to schedule at that time, the family is responsible for following up.
- When all Firesetter Assessment tasks have been completed, a Supervisor Request to end the service should be made in CMP.
- At the end of treatment, those families that complete family therapy will have a copy of the Client Summary (located in CMP) provided to the referral source indicating their completion of this sanction.
- The Client Summary is faxed to the referral source, which is always Fire Rescue and may include Youth Court as well.
- Once the family successfully completes all recommendations, Fire Rescue will issue a certificate of completion to the family.

Treatment
If a recommendation is made for a family to participate in family therapy services, they may contact any Youth Services office to schedule sessions. Families are expected to complete the standard treatment protocol of 12 family therapy sessions unless fewer are determined as clinically necessary by the family therapist, in concurrence with his/her supervisor. It is explained to the family that YFIP clients are expected to attend all therapy sessions. The therapist should make it clear that unless the sessions are attended regularly and the client participates in the process of therapy, no notification indicating compliance with the YFIP program will be provided. If an emergency arises and the family misses a session, they are expected to call and reschedule within the week.

Issues addressed in session are left to the therapist to determine the course of treatment based on the needs of the client and his/her family. Treatment goals for firesetter clients participating in family therapy services vary greatly according to the family system as well as the circumstances that motivate the firesetting behavior. Treatment goals for a family that includes a child/adolescent firesetter may include: Improving positive self-esteem, Increasing impulse control, Anger management, Handling peer pressure, Developing adaptive coping skills, Using problem solving skills, Parenting skills, Improving family communication.

Evaluation
If further evaluation is determined to be necessary, the family may contact the Youth Services Education Center to schedule an appointment. Ideally, the evaluation will be completed by the same person who completed the clinical intake assessment. A parent must sign consent forms and participate in a clinical interview, as well as complete self-report measures to be used as part of the evaluation. The family must attend a feedback session to review the results of the evaluation. Enforceable recommendations will be sent to the referral source.

Contact Personnel

Shayna Ginsburg, Psy.D.
YFIP Project Manager
Youth Services Department
(561) 233-4460
sginsbur@pbcgov.org

Captain Bob Smallacombe
Community Education Coordinator
Palm Beach County Fire Rescue
(561) 616-7024
bsmallac@pbcgov.org

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Sample First Week Schedule

Outpatient – Education and Training Center

Palm Beach County Youth Services Department
Residential Treatment and Family Counseling Division
Education and Training Center

Outpatient Track Sample Schedule

	Monday 8/6/2018	Tuesday 8/7/2018	Wednesday 8/8/2018	Thursday 8/9/2018
8am	Psychological Evaluation	Parent Education Group 8:30-10:00		Psychological Evaluation
9am			Didactic/Training Highridge Family Center 9:30 am -11:30 am	
10am				
11am				
12pm	Lunch	Lunch	Lunch	Lunch
1pm			Group Supervision 1:00 - 3:00	
2pm	Supervision	Supervision		
3pm				
4pm	Family Session	Family Session	Family Session	Family Session
5pm	Family Session	Family Session	Family Session	Family Session
6pm	Family Session	Family Session	Family Session	Family Session

*Unmarked spaces in the schedule are devoted to intervention planning, case management, consultation, scoring and report writing, documentation, and other miscellaneous clinical activities.

Residential – Highridge Family Center

Palm Beach County Youth Services Department
Residential Treatment and Family Counseling Division

Residential Track Sample Schedule

	Monday 8/6/2018	Tuesday 8/7/2018	Wednesday 8/8/2018	Thursday 8/9/2018
9am			Didactic Training 9:30-11:30	Group Supervision 10:00-12:00
10am	Supervision			
11am	*Small Girls' Tx Team*	*Large Girls' Tx Team*		
12pm	Lunch	Lunch	Lunch	Lunch
1pm				Supervision
2pm	*Weekend Wrap Up Group*	*Therapy Group*	*Anger Mgmt Group*	
3pm	Individual Session	Individual Session	Individual Session	Level Meeting
4pm	Individual Session	Individual Session	Individual Session	*Level Process Group*
5pm		Individual Session		
6pm	Family Session	Family Session	Family Session	
7pm	Family Session	Family Session	Family Session	Family Session

*Unmarked spaces in the schedule are devoted to intervention planning, case management, consultation, scoring and report writing, documentation, and other miscellaneous clinical activities.

Scheduled Meetings and Office Closings

Didactic/Training Schedule

2018-2019

DATE	TIME	LOCATION	TOPIC	SPEAKER	CEs
8/6/2018	8:00am-4:00pm	Ed Center	YSD Orientation for Psychology Trainees	Ed Center Team, Chiefs, etc.	
8/7/2018	8:00am-4:00pm	Ed Center	YSD Orientation for Psychology Trainees	Ed Center Team, Chiefs, etc.	
8/8/2018	8:00am-4:00pm	HRFC	YSD Orientation for Psychology Trainees	Ed Center Team, Chiefs, etc.	
8/9/2018	8:00am-5:00pm	Clayton Huchinson	YSD Department Retreat	YSD	
8/15/2018	9:30am-11:30am	HRFC	Paper Tigers	Documentary and Discussion	
8/22/2018	9:30am-11:30am	HRFC	Diversion Programs: FVIP & Youth Court	Stacey King & Officer Scott Dean	
8/29/2018	9:30am-11:30am	Ed Center	Psychological Evaluations	Shayna Ginsburg, PsyD	
9/5/2018	9:30am-11:30am	HRFC	Genograms	Kelly Everson, PsyD	2 CE's
9/12/2018	9:30am-11:30am	HRFC	Florida Laws & Rules	Shayna Ginsburg, PsyD	2 CE's
9/19/2018	9:30am-11:30am	HRFC	Structural Family Therapy	Kelly Everson, PsyD	2 CE's
9/26/2018	9:30am-11:30am	HRFC	Strategic Family Therapy	Kelly Everson, PsyD	2 CE's
10/3/2018	9:30am-11:30am	HRFC	Suicidality	Kelly Everson, PsyD	2 CE's
10/10/2018	9:30am-11:30am	HRFC	Attachment	Kelly Everson, PsyD	2 CE's
10/17/2018	9:30am-11:30am	HRFC	Trauma 101	Loren Berry, PsyD	2 CE's
10/24/2018	9:30am-11:30am	HRFC	Self Injury	Stephanie Larsen, PsyD	2 CE's
10/31/2018	9:30am-11:30am	HRFC	Motivatinal Interviewing	Shayna Ginsburg, PsyD	2 CE's
11/7/2018	9:30am-11:30am	HRFC	Ethics - Boundaries	S Ginsburg, PsyD & L Berry PsyD	2 CE's
11/14/2018	9:30am-11:30am	HRFC	Compassion Fatigue	Loren Berry, PsyD	2 CE's
11/21/2018			HAPPY THANKSGIVING		
11/28/2018	9:30am-11:30am	HRFC	The Trouble With Evan	Documentary & Discussion	
12/5/2018	9:30am-11:30am	HRFC	Foundations of Cinical Supervision	Shayna Ginsburg, PsyD	2 CE's
12/12/2018	9:00am-11:30am	Ed Center	Psychology Internship AAPI Review	Training Committee	
12/19/2018	9:30am-11:30am	HRFC	Your Brain on Poverty	Amanda Terrell, PsyD	2 CE's
12/26/2018			HAPPY HOLIDAYS		

DATE	TIME	LOCATION	TOPIC	SPEAKER	CEs
1/2/2019	8:30am-4:40pm	HRFC	CPI Training	John Harre, BSW	
1/9/2019		HRFC	INTERVIEWS		
1/16/2019		HRFC	INTERVIEWS		
1/23/2019		HRFC	Internship Rank List Meeting	Training Committee	
1/30/2019	9:30am-11:30am	HRFC	Professional Development: CV's, Postdoc, Licensure, Loan	Shayna, Loren, Laura	
2/6/2019	9:30am-11:30am	HRFC	TBD	Postdoc	2 CE's
2/13/2019	9:30am-11:30am	HRFC	Working with Disabilities	Craig Kramer, PsyD	2 CE's
2/20/2019	9:30am-11:30am	HRFC	TBD	Postdoc	
2/27/2019	9:30am-11:30am	HRFC	Domestic Violence	Kelly Dambra, LMHC & Marisa DeStefano	2 CE's
3/6/2019	9:30am-11:30am	HRFC	Clinical Supervision	Shayna Ginsburg, PsyD	2 CE's
3/13/2019	9:30am-11:30am	HRFC	Diversity Considerations	Laura Cruz, PhD	2 CE's
3/20/2019	9:30am-11:30am	HRFC	The Negative Impact of Social Media on Youth	Stephanie Larsen, PsyD	2 CE's
3/27/2019	9:30am-11:30am	HRFC	Youth Exposure to Family Violence	Allyson Crehan, MS & Kimberly Ho, MA	
4/3/2019	9:30am-11:30am	HRFC	Exceptional Student Educaiton	Melissa Singh, PhD	
4/10/2019	9:30am-11:30am	HRFC	Conduct Disorder	Pamela Scannell, MS	2 CE's
4/17/2019	9:30am-11:30am	HRFC	Best Practices for Therapeutic Work with LGBTQ+ Clients	Bartell Rivera, MS	2 CE's
4/24/19	9:30am-11:30am	HRFC	TBD	Postdoc	2 CE's
5/1/2019	9:30am-11:30am	HRFC	Co-Occurring Disorders	Brandi Rials, PsyD	2 CE's
5/8/2019	9:30am-11:30am	HRFC	Compassion Fatigue	Loren Berry, PsyD	2 CE's
5/15/2019	9:30am-11:30am	HRFC	PCIT: Manageing Difficult Chidhood Behaviors	Laura Cruz, PhD	2 CE's
5/22/2019	9:30am-11:30am	HRFC	Mindfulness	Intern	
5/29/2019	9:30am-11:30am	HRFC	Transition Challenges and Interventions for At-Risk Youth	Peter Caproni, PhD & Christina Kamien, MS	2 CE's
6/5/2019	9:30am-11:30am	HRFC	Developmental Sexuality	Ricky Siegel, PhD, LMHC, CST, CSTS	2 CE's
6/12/2019	8:00am-5:00pm	Atlantic HS	SMHaWC		
6/19/2019	9:30am-11:30am	HRFC	Program Evaluaiton & Consultation	Ed Center Team	
6/26/2019	9:30am-11:30am	HRFC	The Storm & Stress of Adolescence	Patty Russo, PsyD	
7/3/2019	9:30am-11:30am	HRFC	Promoting Socio-Emotional Regulation: An Integrative Approa	Laura Cruz, PhD	2 CE's
7/10/2019	9:30am-11:30am	HRFC	HOLIDAY		
7/17/2019	9:30am-11:30am	HRFC	Trauma & Dissociation	Intern	
7/24/2019	9:30am-11:30am	HRFC	DBT Family Therapy Techniques	Amanda Terrell, PSyD	2 CE's
7/31/2019	9:30am-11:30am	HRFC	Academic & Behavioral Multi-Tiered System of Supports in	Melissa Singh, PhD	2 CE's

Office Closure Dates

2018 Holiday Schedule County Offices will be closed on these dates.	
Holiday	**Date**
New Year's Day	**Monday, January 1, 2018**
Martin Luther King, Jr. Day (3rd Monday in January)	**Monday, January 15, 2018**
President's Day (3rd Monday in February)	**Monday, February 19, 2018**
Memorial Day (4th Monday in May)	**Monday, May 28, 2018**
Independence Day	**Wednesday, July 4, 2018**
Labor Day (1st Monday in September)	**Monday, September 3, 2018**
Columbus Day (2nd Monday in October)	**Monday, October 8, 2018**
Veterans Day	**Monday, November 12, 2018**
Thanksgiving Day	**Thursday, November 22, 2018**
Floating Holiday	**Friday, November 23, 2018**
Floating Holiday	**Monday, December 24, 2018**
Christmas Holiday	**Tuesday, December 25, 2018**
PLEASE NOTE: January 1, 2019 falls on a Tuesday and will be the first holiday for 2019.	

2019 Holiday Schedule County Offices will be closed on these dates.	
Holiday	**Date**
New Year's Day	**Tuesday, January 1, 2019**
Martin Luther King, Jr. Day (3rd Monday in January)	**Monday, January 21, 2019**
President's Day (3rd Monday in February)	**Monday, February 18, 2019**
Memorial Day (Last Monday in May)	**Monday, May 27, 2019**
Independence Day	**Thursday, July 4, 2019**
Labor Day (1st Monday in September)	**Monday, September 2, 2019**
Columbus Day (2nd Monday in October)	**Monday, October 14, 2019**
Veterans Day	**Monday, November 11, 2019**
Thanksgiving Day	**Thursday, November 28, 2019**
Floating Holiday	**Friday, November 29, 2019**
Christmas Holiday	**Tuesday, December 24, 2019**
Floating Holiday	**Wednesday, December 25, 2019**
PLEASE NOTE: January 1, 2020 falls on a Wednesday and will be the first holiday for 2020.	

Tracking Hours

Hours Log

Training Year: Date - Date *only use .25 intervals*													
	Aug Hours	**Sept Hours**	**Oct Hours**	**Nov Hours**	**Dec Hours**	**Jan Hours**	**Feb Hours**	**Mar Hours**	**Apr Hours**	**May Hours**	**Jun Hours**	**July Hours**	**TOTAL HOURS TO DATE (Auto Sums)**
DIRECT SERVICE													
Intervention													
Client Consultation (includes "professional consultations")													0
Co-therapy													0
Crisis Intervention													0
Family Therapy													0
Group Therapy													0
Individual Therapy													0
Intake/Structured Interview													0
Milieu Therapy													0
Outcome Assessment of Programs or Projects													0
Program Dev/Outreach													0
School Consultation/Direct													
School Consultation													0
School Observation													
Supervision of Other Students													0
Sys. Interv./Org. Consult/Perf. Improv.													0
Other-Interventions													0
Intervention Total (Auto Sum)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Assessment (Face-to-Face Only)													
Providing Feedback to Clients/Patients													0
Psychological Test Administration													0
Assessment Total (Auto Sum)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Direct Total (Auto Sum)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

INDIRECT SERVICE													
Support													
Assessment Report Writing													0
Case Management													0
Chart Review													0
Clinical Writing/Progress Notes													0
Didactic trainings/Seminars/Workshops													
Intervention Planning													0
Professional Development													0
Psychological Assessment Scoring/Interpretation													0
Reading/Research/Preparation													0
Video-Audio-Digital Recording Review													0
Other- Support													0
Support Total (Auto Sum)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Supervision													
Individual Supervision- Licensed Psychologist													0
Group Supervision- Licensed Psychologist													0
Supervision Total (Auto Sum)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Indirect Total (Auto Sum)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Grand Total (Indirect+Direct Auto Sum)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Trainee Leave Request Form

Name ______________________________________

From Date	Time	Through Date	Time	Total Hours
________	________	________	________	_________
________	________	________	________	_________
________	________	________	________	_________
________	________	________	________	_________

Hours taken off to date: ___________

Hours off remaining: ___________

In the event that you need to be contacted for emergency client situations while you are out, please provide your contact information:

Email: _________________________ Phone: ______________________________

I understand that it is my responsibility to notify clients in advance of my planned absence. It is also my responsibility to reschedule supervision if I will be missing a scheduled meeting. If I am an intern or postdoc and I miss a didactic, supervision series, or journal club due to illness or pre-approved vacation, I am expected to obtain/read the information and discuss the content with my supervisor the following week.

____

Trainee Signature Date

____

Approved by Supervisor Date

____

Approved by Training Director Date

Community Resources

Frequently Called Agencies

FREQUENTLY CALLED AGENCIES	CONTACT	PHONE	FAX
Alliance for Eating Disorders Awareness		561-841-0900	561-653-0043
Alpert Jewish Family & Children's Service		561-684-1991	None
Big Brothers, Big Sisters Mentoring of Palm Beach		561-727-3450	None
Boy's Town of South Florida		561-366-9400	561- 366-4848
Catholic Charities, Diocese of PBC		561-775-9500	None
Center for Child Counseling	Reneé Layman, MS, LMHC	561-244-9499	561-345-3800
	Clarissa DeWitt, MS, LMHC,RPT		
Center for Family Services	Lynne Bernay-Roman, LCSW	561-514-0564	None
Children's Home Society (CINS/FINS)		561-868-4300	None
Easter Seals Florida, Inc.		561-471-1688	None
Employee Assistance Program (EAP)	Marcy Weiss, PhD	561-233-5461	
Families First of PBC	Lynn Varela	561-721-2802	561-721-2893
Firesetter (YFIP)	Bob Smallacombe	561-616-7074	561-616-7084
	Terry Lazor	564-616-7017	561-616-7088
Florida Department of Children & Families IX (DCF)	Administrative Offices	561-837-5078	561-837-5378
	Service Ctr.-Riviera Beach	561-841-2100	(561) 882-3575
Florida Sheriff's Youth Ranches, Inc.		800-765-3797	None
Hospice of Palm Beach County		561-848-5200	None
Lutheran Services Florida		561-233-1600	
Multicultural Community Mental Health Ctr.		561-653-6292	561-653-6297
Multilingual Psychotherapy Center, Inc.		561-712-8821	561-712-8070
National Alliance on Mental Illness (NAMI)		561-588-3477	None
Project Access Program - Palm Beach Medical Society	Lauren Stoops	561-433-3940	561-433-2385
Parent Child Center		561-841-3500	None
Safe Harbor Runaway Center		561-868-4300	None
Safe Kids (Center for Family Services)		561-616-1222	
Sheriff's Department		561-688-3000	Non-emergency
Veteran's Administration (VA)		561-422-8262	
Victim's Services		561-355-2418	
West Palm Beach Fire Rescue		561-616-7000	
West Palm Beach Police Dept		561-822-1600	Non-emergency
Youth Court	Main	561-494-1567	561-494-1558
	Officer Scott Dean	561-494-1561	
	Officer Chantres Allen-Smith	561-494-1560	
SUBSTANCE ABUSE			
CARP, Inc.		561-844-6400	None
Children's Services Council of Palm Beach County		561.740.7000	
Drug Abuse Foundation (DAF)		561-732-0800	None
Drug Abuse Treatment Assn. (DATA)		561-844-3556	None
Kelly Center (School District of PBC)		561-494-0040	561-494-0001

Crisis Contact Numbers

Emergency	911- ask for a CIT officer
Crisis and Information- 24 hours	211
Mobile Crisis- North County	(561) 383-5777
Mobile Crisis- South County	(561) 637-2102 or (877) 858-7474
National Suicide Prevention Lifeline	(800) 273-TALK or (800) 273-8255
Florida Abuse Hotline	(800) 96ABUSE or (800) 962-2873
Teen Hotline	211 or (561) 930-8336
JFK Medical Center North Campus	(561) 881-2670
Jerome Golden Center	(561) 383-8000
South County Mental Health	(561) 737-8400 in north/central county
South County Mental Health	(561) 495-0522 in south county
Victim Services – 24 hours	(561) 833-7273 or (866)891-7273
Elder Hotline	(561) 214-8600
First Call for Help (Broward)	(954) 537-0211
National Center for Missing & Exploited Children	(800) 843-5678 or (800) THE-LOST
National Runaway Safeline	(800)786-2929

Link to Child Abuse Reporting Numbers for other states https://www.childwelfare.gov/organizations/?CWIGFunctionsaction=rols:main.dspList&rolType=Custom&RS_ID=%205

Toll-Free Crisis Hotline Numbers
https://www.childwelfare.gov/pubs/reslist/tollfree/

Clinical Procedures and Guidelines (alphabetical order)

Community Meeting Guidelines

Here is some information regarding the rationale behind community meeting as well as practical requirements. I am also re sending the community meeting fidelity checklist which contains the components of a successful community meeting. If someone gives a response that is not preferred according to this information, for example, if someone says "good" in lieu of a feeling, or says the person that can help them is someone not in the room, please remember to gently urge them, or ask "is there anything else you're feeling" or " is there anyone in this room that you can ask for help" instead of correcting. We want to be nonjudgmental in our approach to community meeting as much as possible.

WHAT IS IT?

A Community Meeting is a deliberate, repetitive transition ritual intended to psychologically move people from some activity that they have been doing into a new group psychological space preparing the way for collective thought and action. For all members of any group it provides a predictable bridge that directly and indirectly reinforces community norms. It is not a therapy group – although therapeutic things are likely to happen during it – and for the purposes of the Sanctuary Model it is meant to be brief and meaningful in a way that does not interfere with the logistics of the meeting or the day ahead.

For Community Meetings to be most effective they must be inclusive of all members of whatever community is having the meeting and the meeting itself must embody the Seven Commitments of the Sanctuary Model and therefore be enacting the group norms on a regular basis. As people become accustomed to the form they actively can demonstrate concern for others, interpersonal safety, open communication a sense of social responsibility, a willingness to learn and to listen, and a shared commitment to the well-being of the whole group. The form in physical space of the meeting, and the opportunity for everyone to have a voice, represents the concept of democracy at its most basic.

WHAT'S THE PURPOSE?

The regular and repetitive enactment of Community Meeting is a necessary practice for deep democracy. In the form and content of the meeting, people nonverbally and overtly pressure each other to conform to community norms and expectations. Rules are made and administered by authority figures and are likely to be broken. Norms emerge out of a group and most people are influenced by group norms. Community Meeting gives everyone a voice and offers a safe and nonthreatening environment within which people can begin finding words for feelings on a regular basis and it conveys to the community that emotional intelligence is important while at the same time recognizing that feelings are "no big deal" because everyone in the community can watch feelings, even distressing feelings, come and go, wax and wane even over the course of a fifteen minute meeting. The leveling of hierarchy that is expressed in the group through the form of it tells everyone in the community that "we are in this together" and reinforces the notion of social responsibility while keeping the importance of relationship in the forefront. Once the skill and safety of Community Meeting is established, then it becomes a natural and spontaneous process that any member of the community can use when trouble is brewing, tension is rising, or an untoward event has occurred. In this way, Community Meeting becomes an extremely effective tool for creating and sustaining an atmosphere of nonviolence.

WHAT MAKES COMMUNITY MEETING "TRAUMA-INFORMED"?

Community Meeting is trauma-informed because of the format of the questions. The first question is "*Who are you*?" and even in a group where everyone knows everyone else, the question is an affirmation of identity, a particularly important issue for people who are being or have been hurt a lot, when they feel their very sense of identity has been jeopardized.

"What are you feeling today?" requires people to focus internally on what they are actually feeling and then find a word for it. We know that children are just learning how to do this and traumatized children and adults have especially difficult time putting words to feelings – it's called "alexithymia". It's well established that people who cannot talk about their feelings are more likely to show what they feel through behavior including physical symptoms, without even knowing that is what they are doing.

"*What's your goal for today*?" (or this class, or this meeting) is the future-oriented question. People who are exposed to situations that are repeatedly frightening often are spending too much time in the immediate here-and-now because of the impact of fear. They may lose or never gain the capacity to be calm enough to anticipate future action. Pausing for a moment in a safe environment and asking this question allows the exercise of this vital function and helps develop the capacity for self-control, planning, and reflection, all necessary for living and working in complex settings.

"*Who can you ask for help – someone here with us to day – if you need it*? This is the norm setting question for the entire group. The question emphasizes the social responsibility we have to be concerned about the well-being of everyone in the group all the time. It's important that each person chooses someone present, not someone who they may be able to see later, or not see at all. This is the question that connects the group together as a whole.

DCF Reporting Procedures

Telephone: 800-962-2873
This toll free number is available 24/7; counselors are waiting to assist you.
http://www.myflfamilies.com/

Phone Options
Press 1 to report suspected abuse, neglect or abandonment of a child
Press 2 to report suspected abuse, neglect or exploitation of the elderly or a vulnerable adult
Press 3 to verify the identity of a child protective investigator who recently visited you
Press 4 for information/referrals to other services in your local area.
Be prepared to provide specific descriptions of the incident(s) or the circumstances contributing to the risk of harm, including who was involved, what occurred, when and where it occurred, why it happened, the extent of any injuries sustained, what the victim(s) said happened, and any other pertinent information are very important. Information callers should have ready includes:

- Name, date of birth (or approximate age), race, and gender, for all adults and children involved.
- Addresses or another means to locate the subjects of the report, including current location.
- Information regarding disabilities and/or limitations of the victims (especially for vulnerable adult victims).
- Relationship of the alleged perpetrator to the child or adult victim(s).
- Other relevant information that would expedite an investigation, such as directions to the victim (especially in rural areas) and potential risks to the investigator, should be given to the Abuse Hotline Counselor.

For a complete list of information please see the What We Need to Know page.

Fax:
To make a report, via fax, please send a detailed written report with your name and contact telephone or FAX contact information using the Florida Abuse Hotline's fax reporting form to:
800-914-0004
*This form is available in PDF Format, (requires that you use Adobe Acrobat to view and print).

NOTIFICATION OF REPORT:
- Telephone reporters will always be told prior to concluding your conversation, whether the information provided has been accepted as a report.
- Fax reporters will only be notified if they request notification in the designated area on the fax reporting form.

Please do not fax multiple allegations of abuse or neglect for multiple families at a time. By submitting them **one** at a time, they will likely get processed **faster**.

Be Prepared to Provide:
- Reporter name (this is required for professionally mandated reporters).
- Victim name, possible responsible person, or alleged perpetrator name(s).

- Complete addresses for subjects, including a numbered street address, apartment or lot number, city, state, and zip code and/or directions to their location.
- Telephone numbers, including area code.
- Estimated or actual dates of birth.
- A brief, yet concise, description of the abuse, neglect, abandonment, or exploitation, including physical, mental or sexual injuries, if any.
- Names of other residents and their relationship to the victim(s), if available.
- A brief description of the victim's disability or infirmity (required for vulnerable adults).
- The relationship of the alleged perpetrator to the victim.

When contacting the Florida Abuse Hotline, please have as much of the information listed below available before you call. This information is important to know no matter who is reporting or what method they choose to report. If you are unable to obtain some of the information below, you may still call the Hotline and a counselor will assess the information available to see if it meets statutory criteria for the Department of Children and Families to initiate a protective investigation.

Baker Act Form

Certificate of Professional Initiating Involuntary Examination

ALL SECTIONS OF THIS FORM MUST BE COMPLETED AND LEGIBLE (PLEASE PRINT)

I have **personally examined** (printed name of person) ________________________________ at (time)______ ☐ am ☐ pm (time must be within the preceding 48 hours) on (date)__________ in________________ County and said person appears to meet criteria for involuntary examination.

☐ CHECK HERE if you are a physician certifying non-compliance with an involuntary outpatient placement order and you are initiating involuntary examination. (If so, personal examination within preceding 48 hours is not required. However, please provide documentation of efforts to solicit compliance in Section IV on page 2 of this form.)

This is to certify that my professional **license number** is: ____________________________ and I am a licensed *(check one box)*:

☐ Psychiatrist ☐ Physician (but not a Psychiatrist) ☐ Clinical Psychologist ☐ Psychiatric Nurse
☐ Clinical Social Worker ☐ Mental Health Counselor ☐ Marriage and Family Therapist ☐ Physician's Assistant

Section I: CRITERIA

1. There is reason to believe said person has a mental illness as defined in section 394.455, Florida Statutes:

"Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

Diagnosis of Mental Illness is: List all mental health diagnoses applicable to this person.		DSM Code(s) (if known)

AND because of the mental illness (check all that apply):

☐ a. Person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **AND/OR**

☐ b. Person is unable to determine for himself/herself whether examination is necessary; **AND**

2. Either (check all that apply):

☐ a. Without care or treatment said person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his/her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **AND/OR**,

☐ b. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both) ☐ **self** ☐ **others** in the near future, as evidenced by recent behavior.

Section II: SUPPORTING EVIDENCE

Observations supporting these criteria are (including evidence of recent behaviors related to criteria). Please include the person's behaviors and statements, including those specific to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury.

Certificate of Professional Initiating Involuntary Examination

Section III: OTHER INFORMATION

Other information, including source relied upon to reach this conclusion is as follows. If information is obtained from other persons, describe these sources (e.g., reports of family, friends, other mental health professionals or law enforcement officers, as well as medical or mental health records, etc.).

Section IV: NON-COMPLIANCE WITH INVOLUNTARY OUTPATIENT PLACEMENT ORDER

Complete this section if you are a physician who is documenting non-compliance with an involuntary outpatient placement order: This is to certify that I am a physician, as defined in Florida Statutes 394.455, F.S. and in my clinical judgment, the person has failed or has refused to comply with the treatment ordered by the court, and the following efforts have been made to solicit compliance with the treatment plan:

Section V: INFORMATION FOR LAW ENFORCEMENT

Provide identifying information (if known) if requested by law enforcement to find the person so he/she may be taken into custody for examination:

Age: ______ ☐ Male ☐ Female Race/ethnicity: ______________________

Other details (such as height, weight, hair color, what wearing when last seen, where last seen):

If relevant, information such as access to weapon, recent violence or pending criminal charges:

This form must be transported with the person to the receiving facility to be retained in the clinical record. Copies may be retained by the initiating professional and by the law enforcement agency transporting the person to the receiving facility.

Section VI: SIGNATURE

______________________	______________	________	☐ am ☐ pm
Signature of Professional	Date Signed	Time	
______________________	______________________		
Printed Name of Professional	Phone Number (including area code))		

By authority of Rule 65E-5.260, F.A.C.
CF-MH 3052B, Jun 2016 (Mandatory Form)

BAKER ACT

Highridge School Guidelines for Trainees

Residents of Highridge attend an alternative education program on campus, the Highridge School, facilitated cooperatively by the Palm Beach County School District and Highridge Family Center. During the school year, the school day begins at 7:30am and trainees typically stay until 11:30-12pm. There is variance to the schedule during the summer and during weeks with holidays.

Highridge classrooms differ from general education settings. Residents are provided academic instruction by a teacher and the Highridge behavioral staff are in the classroom to provide behavioral management and implement the token economy. Trainees will spend time in the classroom and/or cafeteria providing additional support.

It is important to remember that trainees are not a substitute for the teacher or behavioral staff in the room. Trainees are not responsible for the implementation of teaching, assigning points, administering consequences, or overall classroom management. Any intervention provided by a trainee should not impact a resident's earned points for the day. While trainees do not need permission from the teacher to pull residents from the classroom, trainees should be mindful and respectful so as to not disrupt the teacher's lesson.

Trainees will be assigned to a grade level by Ms. Porter and will remain with that grade from one classroom to the next throughout the morning. If behavioral supports are needed in other classrooms, Ms. Porter may contact the trainee to assist.

When there are changes to a trainee's scheduled time to be at Highridge school (e.g., due to meetings or psychological evaluation testing), the trainee will provide advanced notice via email to his/her supervisor and clerical, Ms. Porter, and Dr. Terrell.

Each morning at school, trainees will checkout walkie-talkies located at the main office and return them to charge before leaving Highridge. Trainees should ensure that walkie-talkies are <u>turned off</u> to allow for proper charging.

<u>Highridge School duties of a trainee include:</u>

- Assisting teacher in the implementation of behavior management.
    - De-escalation and crisis intervention.
    - Praising or providing positive reinforcement for the resident (e.g., keeping verbal interactions respectful and not confrontational).
    - Encouraging and supporting residents to develop independent problem-solving strategies that will promote autonomy within the classroom related to completing coursework or having prosocial peer interactions.

- Monitoring residents for signs of distress.
    - Walking around the classroom and engaging in brief "check-ins" with each resident, especially following an argument with a teacher, resident, or behavioral staff.
    - Checking in with residents who appear distraught or upset regarding their points earned.
    - Prompting and supporting the implementation of a "coping plan," a go-to reference residents create with coping skills they can use to support emotion regulation.

    - If behaviors are not escalated, then residents <u>should not</u> be removed from the classroom.
    - Removing residents from the classroom for therapeutic intervention <u>are allowed</u> when de-escalation efforts within the classroom are unsuccessful.
        - Taking residents to the "Sanctuary Room," a designated space to facilitate implementation of coping skills. Once there, therapeutic skills including reflective listening and nonjudgmental questions can be used to process and explore situations in the classroom. Therapeutic tools for emotion regulation can be briefly discussed and practiced.
        - Taking residents for a walk, for the purpose of de-escalation, around the Highridge loop may be appropriate and acceptable in certain situations. Client background and history should be considered when making this clinical judgment. When taking a resident for a walk make sure a Highridge behavioral staff member is notified. Trainees should always have a walkie-talkie in hand.

- Teach and model socially acceptable replacement behaviors by redirecting resident behaviors in a positive and pro-social manner
    - Reducing resident and staff agitation with one another, such as maintaining a calm tone and approaching individuals in a nonthreatening manner.
    - Using labeled praise to reinforce prosocial behavior and positive interactions.

- Prepare a short introduction you can use with residents to explain your role as part of the treatment team.

- End meetings with residents by encouraging the resident to follow up with his/her therapist at Highridge along with noting your plan to do so. This emphasizes the treatment team being unified in supporting the resident.

- Always complete appropriate documentation in CMP after interacting one-on-one with a resident.
    - The following should be used for documentation purposes:
        - Service: Residential Service
        - Note Type: Highridge School
        - Contact Type: School
        - Status: Present
    - Note Examples:
        - Therapist met with the resident after he became triggered in the classroom and was not responding to in-class intervention. The therapist walked the Highridge loop with the resident while exploring his thoughts and feelings to allow him to process the situation. Once the resident appeared de-escalated, the therapist facilitated the resident in exploring alternative reactions for future conflicts and solutions to the current conflict. The resident was willing to re-join class.
        - The resident became triggered by another resident during class. The therapist stepped out of the classroom with the resident, as she was not responding to intervention in the classroom. The therapist facilitated the resident in recognizing how her behavior impacted the situation and explored alternative ways of expressing her feelings in future situations.

The therapist explored the resident's plan to re-join class and the coping skills she can use if she recognizes herself becoming triggered.

- Always follow up with a resident's Highridge therapist (and copy Ms. Porter) via confidential email, noting documentation in CMP of the discussion and your availability if additional follow-up is necessary.
    - Depending on the nature of the interaction, an email alerting the therapist to read the Highridge School note may be sufficient, and a case management note should be written in CMP to document this email.
    - If the therapist requests additional consultation, a consultation note should be written in CMP.

- While a walkie-talkie should always be with a trainee while at Highridge School, save important contacts in your cellphone to facilitate quick communication as needed, including Ms. Porter and the front desk staff at Highridge.

- If a resident requests a meeting with his/her therapist, the trainee first tries to provide the support. If this does not alleviate the resident's presenting concerns, Ms. Porter should be notified. If this does not deescalate the concern, then the therapist may be contacted by Ms. Porter.

- Many tools are implemented by the treatment team at Highridge to facilitate positive behavioral change in residents. Below you will find a quick summary of some of the language used often by staff and residents to refer to such tools. The Highridge Handbook (located on the common drive) should be reviewed to increase your understanding of these terms and the overall treatment provided.
    - Point card (0,1,2), levels 0-4, privileges – aspects of the token economy system
    - Redirections, redirection class, chair times, 24-hour freeze, 48 hour freeze, 72 hour freeze, level zero, commitment check, overnight parent intervention (OPI), and case staffing – different levels of consequences that residents can receive for behavior that breaks rules
    - Code Max – urgent radio call to notify other staff that there is an out of control resident(s) who may be in danger to themselves or others. A Response team will immediately proceed to that particular area to use Crisis Prevention techniques to deescalate the situation.
    - Green, yellow, orange, and red status – the level of privileges earned by house/dorm based on entire dorm's points.

Highridge Therapists

Girl's dorms:

- Palmetto – Raquel Lumia, LMHC
- Buttonwood – Lauren Steel, LMHC

Boys Dorms:

- Sawgrass- Henry Esformes, LCSW
- Mangrove – Manny Signo, LMHC
- Oak – Postdoctoral Resident

Highridge School Personnel

School Behavioral Staff:

- Ms. Porter
- Mr. Folks
- Ms. A (Aikhionbare)
- Ms. Morales
- Ms. Brenda

Teachers:

- Dr. Hutchinson - Science
- Ms. Tedesco – High School English
- Ms. Ajlani- Reading, Middle/High School History
- Ms. Ikonen - Math

School Counselor:

Lisa Keough 561-494-0007

Assistant Principal:

Shelia Harvey-Lawrence 561-494-0015

School Secretary:

Ms. Danise 561-494-0004

Intake Assessment Guidelines

Outpatient Offices

(Education & Training/ Youth and Family Counseling)

1. Prior to the intake, obtain referral information by opening client in CMP, double clicking on Appointment Service, and finding the referral source information in the box that opens. Refer to documentation written by clerical team when scheduling appointment for additional information. If applicable, review closing/discharge summary from previous episode(s) of care.
2. When the client arrives at the Youth Services office, a clerical team member will end the Appointment Service and open the appropriate Intake Assessment Service. When this is completed, tasks associated with the Intake Assessment Service are populated on the lower, right side of the screen.
3. Check that the FIF has been filled out properly by the parent/guardian. If there is missing data, ask the family to complete it during intake. If information shared during intake differs from information on the form, make the change and add your initials.
4. Ensure that ACEs Questionnaire has been completed by the youth (age 10 and older) or parent on behalf of youth (age 12 and under).
5. Verify that Release or Transfer of Student Information has been signed by the parent/legal guardian and that the student ID has been included. The end date should be the date the child will be 18 years old.
6. Review consent forms and explain confidentiality and its limits.
    a. Bill of Rights and Consent for Treatment (includes Consent to Work with Students and Consent for Audio/Video)
    b. Consent for Research
    c. Assent for Research
7. Obtain appropriate Releases of Information (ROI) to allow for correspondence between other agencies/individuals and Youth Services
    a. School
    b. Referral Source (i.e. Youth Court, FVIP, YFIP, etc.)
    c. Relevant service providers currently or formerly involved with the family, such as psychiatrist, therapist, etc.)
    d. Legal (DCF, DOC, etc.)
    e. Non-legal guardians or other adults that may be involved in treatment, such as a step-parent, aunt/uncle who lives in the home, adult siblings, etc.
8. Conduct intake interview. Refer to Note Writing Guidelines in the Handbook as a reference.
    a. Determine presenting issues
    b. Ensure there are no immediate safety concerns
        i. If necessary, conduct Risk Assessment. Always consult with a supervisor regarding concerns.
        ii. If necessary, create safety plan with youth/family (use YSD safety plan form on common drive and add Safety Plan task)
9. Explain how treatment works:
    a. Family therapy-one parent/legal guardian MUST be present.
    b. Typically 12 weeks (variance allowed with supervisor approval)

    c. Two missed sessions (no show/cancellation) and case will be closed (unless supervisor approval to continue is obtained).
10. Explain other treatment options if appropriate:
    a. Highridge
        i. For adolescents ages 11-16.
        ii. Residential facility that provides PBC residents with 3-4 months of services, including family therapy, group therapy, individual therapy, and milieu therapy, as well as alternative PBC school.
        iii. Reside at the facility during the week and return home on Friday afternoon (Thursday night during summer) for the weekends with the family.
        iv. Two $75 fees (Application & Activity).
        v. Call John Harre to schedule a tour of the facility and complete paperwork.
            1. 4200 North Australian Ave, WPB, FL 33407
            2. (561) 625-2540
    b. Parenting: *group days/times subject to change
        i. Groups at Ed Center: (7 weeks; 1.5 hr. sessions, Dates TBD as needed)
        ii. Individual Sessions may be provided at all offices
    c. Healthy Connections Group:
        i. Dates TBD as needed
11. Discuss Custody.
    a. If necessary, gather appropriate consent documentation. You will be responsible for custody related case management prior to case being approved for continued services. Refer to Documentation Manual for additional information. Consult with supervisor as needed.
    b. Follow up with family regarding custody documentation no later than 1 week after intake
    c. Provide deadline of 1 more week to provide documentation or case will be closed
12. Obtain days/times family will be available for services and note these on the Intake Report.
13. Ensure that address and phone numbers are correct and complete.
14. If there are additional household members not already listed, obtain info for those individuals.
15. Make sure family chooses Yes or NO for ALL items in the Questionnaire section. DO NOT leave blank.
16. Provide completed FIF and other intake forms to clerical for entry into CMP.
17. Complete intake notes and task:
    a. Intake Assessment/Office/Attended: “Family attended and completed intake assessment.” (If Family does not attend intake, enter Intake Assessment note indicating that family No Showed.). The note should reflect the time that was allotted for paperwork, appointment, and documentation (typically 2 hours).
    b. Write up Intake Report using the dynamic form listed under Tasks in CMP. Make sure that all sections of the dynamic form are completed.
    c. Update demographic information in CMP.
18. Write a final note when the Intake Report has been entered into CMP and all Tasks have been completed:
    a. Supervisor Request/Office: “Intake complete. Case is ready for assignment” or “Intake complete. Service is ready to be ended.” Save this note and mark as “Needs Approval.”

Residential Intake Assessment Guidelines

Highridge Family Center

- Informed Consent confidentiality and overview of the purpose of the Session

Overview of the Program

- 3-4 month residential program 11-16 (can turn 17 in program but must be admitted at 16)
- 12 residents per dorm maximum - 3 male and 2 female dorms
- Drop off is Monday Morning and pick up is Friday afternoon; Summer and holiday hours vary
- Referrals come from schools, outpatient, community, and court system
- Residents are on a point level system; parents to complete cards on the weekends
- Family therapy is mandatory one time per week; 2 absences may result in dismissal from program
- Immediate pick up for serious disciplinary violations (OPI) or illness
- Residents receive individual, group, and family therapy
- School is a Palm Beach Co Public school provide contact # for school for credit questions, etc. Guidance Counselor: Lisa Keough 561-494-0007 Assistant Principal-Shelia Lawrence 561- 494-0004
- Program is "voluntary" –Assess willingness to attend program; if they *ARE* willing, proceed with the rest of intake
- Cost-$75 to be collected by Ms. Pat at time of intake and $75 to be collected upon admission

Collect Information

- Presenting Problems
- Family relationships
- FVIP or court charges
- School (Special classes? Grades? Suspensions/Expulsions? For what behaviors?)
- Social Interests
- Strengths
- Trauma history
- Risk- Suicidal ideation, self-harm behaviors, abuse
- Substance abuse? Amount? Frequency?
- Hospitalizations-How many? When? Circumstances?
- Allergies/health issues
- Medications-name, dosage, and prescribing Dr.

Forms for Signature

Tasks/Forms Needing Signatures
1. **Bill of Rights/Consent for Treatment**
2. **Highridge Parent/Guardian Agreement**
3. **Consent for Psychological Evaluation**
4. **Consent for Research**
5. **Assent for Research**
6. **Community Response Team Permission**
7. **Emergency Contact & Transportation List**
8. **Medical Care**
9. **Consent for Emergency Medical Treatment**

10. **ROI School- if attending Public School, if not add ROI general and add name of school**
11. **All other ROI's as indicated during Intake i.e. ROI's must be completed for any and all adults participating in family session that are not the biological/adoptive/legal guardians. ROI for any recent/current therapist, psychiatrist, pediatrician, community agency.**

"Take home" Information –Give them the Highridge application packet/supply list and the school registration form. The school form can be completed and brought to orientation.

Copies -Make a copy of guardian's identification and potential resident's insurance card.
Tour-Complete a tour of the facility

Admission Approval/Denial-Inform the family that the Clinical Director makes all admissions decisions. Highridge will call when a decision has been reached.

Case Management- Fax releases and forms to psychiatrist or doctor, follow up with any necessary paperwork, scan FIF, parent ID, and forms, then attach to file electronically. Alert John to any potential issues or questions as well as your supervisor.

Tasks/No Signatures Needed	Rationale
1. Assess Custody, Upload Proof of Custody	**Adoption, Guardianship**
2. Scan and Attach DL and Insurance Card	
3. Scan and Attach FIF, Medical History, School Data Request, ACEs Questionnaire	
4. Complete Intake Report	**Informational Report**
5. Write Intake Service Note	**Tracks Direct Service Hrs**
6. Provide School Registration to Family	**Add form to "take home" info re: orientation**
7. Complete Referral Source Info (Appt-Res only)	**To ensure we capture referral source info – ONLY ONCE**
8. Update client and family member details	**If Different than FIF data entry**
9. Review FIF, medical history and ACES	
10. Fax all Requests for Information (to include ROI, form, and fax cover sheet)	**Med/Psych Clearance, Diet/Allergy Forms**
11. Follow up to ensure all requested information is received to complete case for review	

When all is complete, put an end date for self as case manager in Intake-Residential and Appointment-Residential services and add Twila Taylor and Shaneisha Arrebato as case managers.

ACEs Questionnaire
TO BE COMPLETED BY YOUTH

Your Name: ____ Today's Date: ______________________

Parent's Name: ____ Date of Birth: ______________________

Many children have stressful life events that can affect their physical, social, and emotional health and development. The results from this form will help us with your treatment. Please read the statements below. Count the number of items that apply to you and write the total number in the box provided.

Please DO NOT mark the items that apply to you – We just need the number.

1) Of the items in section 1, HOW MANY apply to you? Write the total number in the box.

Section 1. *At any point since you were born…*

- Your parents or guardians were separated or divorced
- You lived with a household member who went to jail or prison
- You lived with a household member who was depressed, mentally ill or attempted suicide
- You saw or heard household members hurt or threaten to hurt each other
- A household member swore at, insulted, humiliated, or put you down in a way that scared you OR a household member acted in a way that made you afraid that you might be physically hurt
- Someone touched your private parts or asked you to touch their private parts in a sexual way that was unwanted, against your will, or made you feel uncomfortable
- More than once, you went without food, clothing, a place to live, or had no one to protect you
- Someone pushed, grabbed, slapped or threw something at you OR you were hit so hard that you were injured or had marks
- You lived with someone who had a problem with drinking or using drugs
- You often felt unsupported, unloved and/or unprotected

2) Of the statements in section 2, HOW MANY apply to you? Write the total number in the box.

Section 2. *At any point since you were born…*

- You have been in foster care
- You have experienced harassment or bullying at school
- You have lived with a parent or guardian who died
- You have been separated from your primary caregiver through deportation or immigration
- You have had a serious medical issue or life threatening illness
- You have often seen or heard violence in the neighborhood or in your school neighborhood
- You have been detained, arrested or incarcerated
- You have often been treated badly because of race, sexual orientation, place of birth, disability, or religion
- You have experienced verbal or physical abuse or threats from a romantic partner (i.e. boyfriend or girlfriend)

Release or Transfer of Student Information

THE SCHOOL DISTRICT OF PALM BEACH COUNTY
THE DEPARTMENT OF SAFE SCHOOLS

Release or Transfer of Student Information

This form is used to facilitate communication of student information to authorized individuals.

Student ID # (Opt)	Student First Name	Middle	Last	Birth Date

Parent/Legal Guardian Name	School Name

Request for: ☒ release of student records ☐ discussion of student/student records

Agency/Individual/Advocacy				
Palm Beach County Youth Services Department				
Contact Name	Phone #	Ext.	E-mail	
Marlene E. Etienne	242-5752		metienne1@pbcgov.org	
Mailing Address	City		State	Zip Code
50 S. Military Trail, Suite 203	West Palm Beach		FL	33415

Send Records To *(if address is different from above)*				
Contact Name	Phone #	Ext.	E-mail	
Mailing Address	City		State	Zip Code

List the specific information requested *(medical, psychological, psychiatric, educational records or student information)*

All records of prior enrollment/attendance, grades, GPA, graduation, W10, WGA, WGD, absences, in school suspension, out of school suspension, foster care status, schools attended and number of days in attendance, homelessness status, 504 plan status, EBD status, and ESE status.

I understand the the purpose of this release is to facilitate the communication of student information to authorized individuals. The Family Educational Rights and Privacy Act (FERPA) of 1974, as amended, protects the privacy of education records, and student related information. I understand and agree that this information will not be disclosed to any third party without the express consent of the parent or adult student.

Signature of person receiving records ____________________ Date __________

I authorize: ☒ The School District of Palm Beach County ☐ other to

☒ release

☐ receive the following medical, psychological, psychiatric, and/or educational records of the above named student

☐ discuss student records or other student related information

This release is active from: date __________ to date __________ unless otherwise specified by the parties.

Signature of Parent/Legal Guardian *Date*

Signature of Student if 18 Years of Age or Older *Date*

The following is to be completed by the person releasing records

Print name of person releasing records *Phone No./PX*

PBSD 0313 (Rev. 10/7/2015) ORIGINAL - School COPY - Parent/Legal Guardian

Missed Appointment Documentation and Extension Request Procedures

An Extension Request is needed any time therapy services (e.g., group, individual, or family therapy) will continue past 12 weeks. *This is based on the length of time the client is receiving therapy services and* ***not*** *based on the amount of sessions attended.* The following steps should be followed when monitoring client appointments in CMP to ensure Extension Requests are appropriately requested and documented:

1. Any time a client is not seen for a period of time that exceeds 7 days, a service note (e.g., Group Therapy, Family Therapy, or Individual Therapy) should be written documenting whether the original scheduled appointment for that week was Cancelled, Rescheduled, or a No Show appointment. Please refer to the options below for each note status type:
    a. Cancelled – Used when a client cancels session with prior notification (e.g., client informs therapist of sickness or a planned vacation). This is only used if the session is not reschedule within the week.
    b. No Show- Used when a client does not show for a session and does not provide prior notification.
    c. Rescheduled – Used when a missed appointment will be made up within the same week period or when the therapist is the one to cancel the appointment due to therapist absence (e.g., sick or vacation) or holiday office closing.
2. YSD provides services according to a brief therapy model. If the therapist feels the client/family could benefit from continuing past 12 weeks for any reason, the therapist should consult with a supervisor to determine the need for an extension. This request should be thoughtful, and should therefore occur before the originally scheduled 12 weeks expire. Please note the following when making an Extension Request note in CMP:
    a. Extensions can be requested and approved by a supervisor in increments of up to, and no more than, 4 weeks.
    b. In rare cases, multiple extension requests may be needed. In these cases, an Extension Request note with supervisor approval is needed for each extension increment. (e.g., if a 2 week extension was requested and another 4 weeks is needed, then another Extension Request note is needed before the 2 week extension expires).

Professional Presentation Guidelines

Psychology interns and postdoctoral fellows may be required to develop and present a professional training(s) to Youth Services Department's Residential Treatment and Family Counseling Division staff and trainees. Other trainees are encouraged to present as desired to enhance their professional development. The topic should be relevant to the mission and population served by the Division. It is acceptable for the presentation to be the trainee's dissertation topic. The presentation must be at least one hour duration, with an available time allotment of two hours. Appropriate visual aids, such as a PowerPoint presentation, are required. Recent professional references from the past five years must be included. No more than two to three learning objectives should be addressed. Guidelines for writing learning objectives appear below.

When preparing a presentation, please refer to the following guidelines:

- PowerPoints and handouts should be emailed to your supervisor prior to the supervision time the week prior to a presentation so feedback/support can be provided as needed.
- The PowerPoint version that you want printed and any other handouts need to be emailed to Giselle Badillo by the day before your didactic (Tues) at 3pm so there is sufficient time to make copies.
- The final version of your PowerPoint should be emailed to Dr. Ginsburg by the day of your presentation (Wed) at 6am so that it can set up at Highridge in the morning.
- Please arrive at presentation locations 30 minutes early in order to ensure that everything is set up and working correctly.

Learning Objective Guidelines

Behavioral Objectives Describe the expected learner outcomes in behavioral terms that are attainable, measurable and relevant to current practice. Clearly indicate what the learner will do, and when.	**Subject Matter** Adjacent to each objective, outline the subject matter that corresponds to the objective. Content should be current, accurate and listed in logical order.
○ In stating behavioral objectives, use words that describe actions that can be observed and measured. ○ At the completion of the program, the participant will be able to: *write, choose, contrast, select, explain, state, recite, identify, construct, compare, solve, list, differentiate, demonstrate, find, etc.* ○ Words that describe something happening in the learner's head are difficult to quantifiably measure. **<u>The following terms should be AVOIDED:</u>** *know, learn, be familiar with, think, recognize, understand, comprehend, be aware of, have knowledge of, be acquainted with, perceive, have empathy for…*	○ Subject matter must correspond to each objective and reflect appropriateness for continuing education for that target audience. ○ Material outlines must be consistent with the time allotted to meet objectives. ○ Currency and accuracy of the subject matter must be documented by the reference list or bibliography materials published within the last five (5) years and must be referenced from professional literature.
Teaching Strategies List methodologies and learning activities. Utilize principles of adult education.	**Evaluation Methods** Identify methods used to evaluate whether the stated behavioral objectives have been met.

o Principles of adult education indicate that participants learn better with interactive experiences than with a straight lecture format. Adults need auditory, visual and hands-on learning techniques to better integrate the content that the presenter is delivering. Lecture alone is not acceptable. Methods that support adult learning include use of case studies, games, question and answer periods, pre and post-tests, group exercises, use of workbooks/handouts/onscreen presentations, interactive discussions, etc.	o Evaluation for this purpose is the means to determine that the learner has gained the desired knowledge in the context of this offering, i.e., that she/he has met the objectives. This is not an evaluation of the methods of instruction, presenters, physical facility, or other criteria generally included on a program evaluation tool. This is directed toward the provider and faculty member determining whether the learner is indeed able to: *Define, state, list, describe, compare, relate, etc.* o Methods for evaluation can include pre and post-tests, evaluation of case studies, and competent performance on a skills assessment, result of individual or group activities, questions/answers.

Examples

Topic: Communication
Objectives:

- Explain four basic principles of communication (verbal and non-verbal) and active, empathetic listening
- Outline four barriers and bridges to communication
- List at least four ways communication skills which encourage staff involvement will help create a positive work environment

Topic: Parent Child Interaction Therapy
Objectives:

- Demonstrate a general understanding of the theoretical underpinnings of Parent Child Interaction Therapy (PCIT)
- Summarize the efficaciousness of PCIT
- Explain the utility of PCIT in treating disruptive behaviors in young children
- Identify PCIT skills that can be used across therapy sessions to improve child behavior

Psychological Evaluation Procedures

Psychologists, postdoctoral fellows, doctoral interns, and psychology practicum students complete psychological and psychoeducational evaluations over the course of the training year. Full batteries include clinical interviews and assessment of intellectual, academic, behavioral, and personality/social functioning. All evaluators completing the evaluations are to consult with referring therapists, properly administer and score measures, hold feedback sessions, and complete reports in a timely manner. Youth Services does not utilize a standard battery. Rather, selection of measures is determined based on the referral question, consultation, review of previous records, clinical interview(s), and information garnered during the assessment process.

Referrals are made by the Youth Services Department's Residential Treatment and Family Counseling Division team members who submit referral questions via the CMP computer case note application. The Chief of Clinical Services, Education and Training or designee reviews the referral and, if appropriate, assigns the case to a psychology resident, intern, or practicum student. The assigned evaluator <u>first contacts the referring therapist to consult about the reason for referral</u>. During consultation, the evaluator determines the utility and necessity of proceeding with testing. If the decision is made to proceed, the evaluator must obtain and review supporting documentation, including but not limited to prior testing reports, Individualized Education Plan (IEP), 504 Accommodation Plan, and/or Response to Intervention (RTI) Report. It is the responsibility of the referral source to ensure that previous reports have been obtained from the family. The evaluator then contacts the family and schedules the clinical interview(s) **<u>and</u>** evaluation sessions. The clinical interview is conducted with the child's caregiver(s) where they complete the *consent form for assessment, evaluation, and psychological testing*, appropriate *releases of information*, and provide a family history. Attempts to interview both parents/caregivers should be made. Ideally, interviews should be scheduled and completed within one week of assignment to the case. Testing should be started no later than one week after the parent interview and all testing should be completed within 2 weeks. Evaluators should consult with their supervisor if unable to meet this deadline. When scheduling an evaluation session, keep in mind that the optimal time to evaluate a child is during the morning hours. Some measures, such as the TOVA and WISC, are of questionable validity if timing of administration is not within optimal hours.

Evaluation measures and kits are located at the Education Center in the file cabinet labeled 'Testing Materials' in the file/copy room. Evaluators should reserve measures in advance when possible. All tests, manuals, and other assessment materials must be signed in and out by the evaluator. Tests should remain in the office and not taken home overnight. Manuals should not be signed out to a single person for an extended period of time, as manuals are shared by all evaluators. Protocol forms should be used only as needed and evaluators should communicate with supervisors when the number of forms is low so that additional forms can be ordered.

There is a designated testing computer on which certain psychological evaluation measures can be administered and scored, which is located in the Education and Training Center conference room. Scoring programs are available for the following measures: ARES, ASRS, BRIEF-2, CAFAS, KTEA-3, MMPI-A, RIAS-2, Rorschach, TOVA, WISC-V, and WJ-IV. The ARES requires a key fob (located in the testing cabinet) to be inserted prior to scoring. There is a specific computer located in the conference room, on which the TOVA must be administered and scored, and the Rorschach must be scored. Web based scoring and reporting software is also available for the majority of measures. Passwords for accessing specific scoring programs are provided on a spreadsheet located in the Student-Trainee folder on the Common drive. This list is updated periodically.

Important due dates regarding testing are listed in the Requirements and Expectations section of the Handbook. An initial draft of the report is due to the designated supervisor within two weeks of the final testing administration. Raw data should also be turned over to the supervisor at this time to ensure scoring accuracy. The supervisor will review the draft and provide feedback. Once the report is finalized and signed by both the evaluator and supervisor, the evaluator contacts the family to schedule a feedback session. The parent(s) is provided with an original signed report at the feedback session. The referring therapist should also be contacted and invited to the feedback session, particularly if the therapy case is still open. The referring therapist is notified that the report is complete and has been scanned into CMP for their review.

Psychological Evaluation interviews, testing sessions, and feedback sessions should be documented using the **Psychological Evaluation/Office** note type. A **Case Management/Office** note is written to document that the materials (raw data and original report) are filed at the Education and Training Center. A report is also scanned into CMP. Throughout testing, **Scoring/Interpretation/Report Writing** notes should be written to documented all time related to scoring, interpretation, and report writing. When all tasks noted above have been completed a **Supervisor Request/Office** note should be entered to end the Psychological Evaluation Service.

Psychological Evaluation Process and Timeline

- Consultation with referring therapists regarding psychological evaluation referral questions is expected prior to testing.
- Parent interview should be completed prior to testing session(s) with youth.
- All interviews and administration of evaluation measures should be completed within 2 weeks (or 3 weeks under special circumstances and with supervisor approval).
- Evaluation reports are to be completed in a timely manner, with an initial draft due no later than 2 weeks after administration of assessment measures are complete. Awaiting return of self-report measures should not delay this timeline. Second drafts should be completed no more than 1 week after the initial draft is returned with feedback.
- Subsequent revisions should be turned in within 24 hours.
- Feedback session with the family regarding evaluation results and recommendations should be scheduled within 1 week of the signed final report.

Psychological Assessment Measures

1. **Ages and Stages Questionnaire (ASQ)**
    - Parents can check their child's progress and learn more about what to expect their child to be able to do at each stage of development
    - 3 months to 5 years
2. **Anger Regulation and Expression Scale (ARES)**
    - Comprehensive, self-report assessment of the expression and regulation of anger for children and adolescents
    - Assesses tendencies towards inward and outward expressions of anger along with the range and duration of anger experiences.
    - Full-length version and a short version (ARES[S]).
    - 10 to 17 years
    - Administration Time : 5 minutes (Short Version), 15 minutes (Long Version)
    - Computerized scoring available
3. **Autism Spectrum Rating Sales (ASRS)**
    - Multi-informant measure to identify symptoms, behaviors, and associated features of Autism Spectrum Disorders.
    - 2 – 18 years
    - Administration Time: Full form: 20 minutes, Short form: 5 minutes (15 items)
    - Scores/Interpretation: ASRS Scoring Software or manual scoring
4. **Beck Depression Inventory, 2nd Edition (BDI-II)**
    - Instrument for measuring the severity of depression
    - 13 to 80 years
    - Administration Time: 5 minutes
5. **The Beery-Buktenica Developmental Test of Motor Coordination, 6th Edition (Beery MI)**
    - Screens for motor coordination issues
    - 2 to 100 years
    - Administration Time: 5 minutes
6. **The Beery-Buktenica Developmental Test of Visual-Motor Integration, 6th Edition (Beery VMI)**
    - Measures the extent to which individuals can integrate their visual and motor abilities.
    - Commonly used to identify children who are having significant difficulty with visual-motor integration and to determine the most appropriate course of action.
    - Suitable for respondents with diverse environmental, educational, and linguistic backgrounds
    - 2 to100 years; Updated norms for ages 2 through 18. Adult norms are also included for age 19 and above, but were not updated
    - Short format usually used with children ages 2-8
    - Administration Time: 10–15 minutes each (Short and Full Format)

7. **The Beery-Buktenica Developmental Test of Visual Perception, 6th Edition (Beery VP)**
    - Screens for visual deficits
    - 2 to 100 years
    - Administration Time: 3 minutes
8. **Behavior Assessment System for Children, 3rd Edition (BASC-3)**
    - A comprehensive set of behavior rating scales and forms including the Teacher Rating Scales (TRS), Parent Rating Scales (PRS), Self-Report of Personality (SRP), Student Observation System (SOS), and Structured Developmental History (SDH). 2:0 through 21:11 (TRS and PRS); 6:0 through college age (SRP).
    - Spanish version available.
    - Administration Time : 10-20 minutes (TRS and PRS), 30 minutes (SRP)
    - Q-Global scoring
9. **Behavior Rating Inventory of Executive Function, 2nd Edition (BRIEF-2)**
    - A comprehensive measure of executive functioning including Parent, Teacher, and Self Report
    - 5-18 years
    - Administration Time: 10-15 minutes; Scoring Time: 15 minutes
10. **Child and Adolescent Functional Assessment Scale (CAFAS)**
    - Objective measure completed on computer by therapist following clinical interview
    - Measures day-to-day youth functioning across 8 Domains
    - Generates an Assessment Report and Family Report that shows gains over time and focuses on strengths and goals
    - 5 to 19 years
    - Completion Time:10-15 minutes
11. **Children's Apperception Test (CAT)**
    - Projective Personality Assessment
    - Help identify dominant drives, sentiments, conflicts and complexes
    - 3 to10 years
    - Administration Time : 20-45 minutes
12. **Children's Depression Inventory, 2nd Edition (CDI-2)**
    - Self-report scale that measures cognitive, affective, and behavioral signs of depression in school-age children and adolescents
    - Self-Rating, Parent, and Teacher versions in full length and short forms
    - 7 to 17 years
    - 1st grade reading level
    - Administration Time: 5 minutes
13. **Conner's Rating Scale, 3rd Edition (CRS-3)**
    - Behavior Assessment
    - Measure hyperactivity in children and adolescents
    - Parents and teachers of children and adolescents ages 6 to 18 years
    - Adolescent self-report ages 12 to17 years

- 6th–9th grade reading level
- Administration Time: Long Version: 15–20 minutes, Short Version: 5–10 minutes

14. The Devereux Early Childhood Assessment Clinical Form (DECA-C)

- Designed to support early intervention efforts to reduce or eliminate significant emotional and behavioral concerns in preschool children
- Can be used to: (1) Guide interventions, (2) Identify children needing special services, (3) Assess outcomes and (4) Help programs meet Head Start, IDEA, and similar requirements
- 2 to 5 years
- Administration Time: 10 minutes

15. Eyberg Child Behavior Inventory (ECBI)

- A measure of conduct problems in children
- Assesses the frequency of disruptive behaviors occurring in the home
- Reported by parents
- 2 to 16 years
- Administration Time: 5-10 minutes; Scoring Time: 5 minutes

16. Expressive Vocabulary Test, 2nd Edition (EVT-2)

- A measure of expressive vocabulary and word retrieval for Standard American English
- Co-normed with PPVT
- Make direct comparisons of receptive and expressive vocabulary with PPVT-III
- 2 to 90+ years
- Administration Time: 15 minutes

17. Family Adaptability and Cohesion Scales, 4th Edition (FACES-IV)

- 62-item self-report instrument
- Assesses dimensions of Circumplex Model (family cohesion, adaptability, communication) and family satisfaction
- Designed to be administered to families across the life cycle
- 12+ years
- Administration Time: 15 minutes

18. Gilliam Asperger’s Disorder Scale (GADS)

- Can help discriminate persons with Asperger's Disorder from persons with autism
- 3 through 22 years
- Administration Time: 5 to 10 minutes

19. Gilliam Autism Rating Scale, 2nd Edition (GARS-II)

- Identify and diagnose autism in children and young adults
- 3 to 22 years
- Administration Time: 5 to 10 minutes

20. House-Tree-Person Drawings (H-T-P)

- Projective personality assessment
- Assessment of brain damage or overall neurological functioning

21. Kaufman Brief Intelligence Test, 2nd Edition

- Measures verbal and nonverbal intelligence quickly
- 4 through 90 years
- Administration Time: 20 minutes

22. Kaufman Test of Educational Achievement, 3rd Edition (KTEA-3)

- Measure of academic achievement for grades pre-kindergarten through 12 or ages 4 through 25 years
- Has two independent, parallel forms (A and B)
- Criterion-referenced assessment in the domains or reading, mathematics, written language, and oral language
- Link to KABC-2 and WISC-V
- Q-Global scoring
- Administration time: 15 to 85 minutes

23. Kinetic Family Drawing (KFD)

- Projective Assessment
- Children are asked to draw a picture of "a family doing something together"
- Elicits the child's attitudes toward his or her family and the overall family dynamics.

24. Minnesota Multiphasic Personality Inventory- Adolescent (MMPI-A)

- Personality Assessment
- 14 to18 years
- 6th grade reading level
- Administration Time : 45-60 minutes
- Q-Global scoring

25. Parenting Stress Index, 4th Edition (PSI-4)

- Designed to evaluate the magnitude of stress in the parent-child system,
- Three domains: child characteristics, parent characteristics, situational/demographic life stress
- Parents of children ages 1 month to12 years
- Spanish version available
- Administration Time : 20 minutes; scoring 5 minutes

26. Peabody Picture Vocabulary Test, 4th Edition (PPVT-4)

- A wide-range measure of receptive vocabulary for standard English, and a screening test of verbal ability (Co-normed with EVT)
- 2-6 to 90+ years
- Administration Time : 10-15 minutes

27. Revised Children's Manifest Anxiety Scale, 2nd Edition (RCMAS-2)

- A quick measure of the level and nature of anxiety in children
- CD available to read questions if child has reading difficulties
- 6 to 19 years
- Administration Time : Less than 10 minutes

28. Reynolds Intellectual Assessment Scales, Second Edition (RIAS-2)

- Assesses intelligence and its major components
- Optional memory and speeded processing subtests are available.
- 3 to 94 years
- Administration Time: 40-45 minutes
- Q-Global scoring

29. Roberts Apperception Test for Children, 2nd Edition (Roberts-2)

- Evaluate children's social perception (either adaptive or maladaptive/atypical)
- Free-narrative storytelling format
- Alternate versions available for Caucasian, African American, and Hispanic children
- 6 to18 years
- Administration Time: 30 to 40 minutes

30. Rorschach

- Projective assessment that examines personality characteristics and emotional functioning
- Identifies basic personality structure and problem-solving strategies in children, adolescents, and adults
- Exner scoring system; RIAP Computer scoring available
- 5 years and older
- Administration: untimed
- Computerized Exner scoring available

31. Rotter Incomplete Sentences Blank, Second Edition (RISB-2)

- Semi-structured projective technique
- Subject is asked to complete a sentence for which the first word or words are supplied
- High School level
- Administration: untimed

32. Sentence Completion Tests

- A class of semi-structured projective techniques
- Provides indications of attitudes, beliefs, motivations, or other mental states
- Child and Adolescent versions
- Administration Time: 5-15 minutes

33. Screen for Child Anxiety Related Disorders (SCARED)

- Used to screen for childhood anxiety related disorders
- 41-item self-report inventory
- Child and Parent versions
- 8-18 years
- Administration Time: 10 minutes

34. State-Trait Anger Expression Inventory, Child and Adolescent, 2nd Edition (STAXI-2C/A)

- 35-item self-report inventory
- Measures the intensity of anger as an emotional state (State Anger) and the disposition to experience angry feelings as a personality trait (Trait Anger), as well as anger expression and control
- 9 to 18 years
- 4th grade reading level
- Administration Time: 10 minutes; Scoring Time: 10 minutes

35. Sutter-Eyberg Student Behavior Inventory-Revised (SESBI-R)

- A measure of conduct problems in children
- Assesses the frequency of disruptive behaviors occurring in the home
- Reported by teachers
- 2 to 16 years
- Administration Time: 5-10 minutes; Scoring Time: 5 minutes

36. Test of Auditory Processing Skills, 3rd Edition (TAPS)

- Measures what children and teens do with what they hear; helps to diagnose auditory processing difficulties, imperceptions of auditory modality, language problems, and/or learning disabilities in both children and teens
- Provides overall score, and cluster scores: Basic Auditory Skills, Auditory Memory, Auditory Cohesion
- 4 through 18 years
- Administration: 1 hour (untimed); scored in 15 to 20 minutes

37. Test of Everyday Attention for Children (TEA-Ch)

- Assess the different attentional capacities in children and adolescents
- **Age Range:** 6:0–15:11
- **Administration:** 55 to 60 minutes

38. Test of Variables of Attention (TOVA)

- Objective, neurophysiological screening measure of visual and/or auditory attention
- Administered and scored on the designated testing computer
- Very simple "computer game" that measures your responses to either visual or auditory stimuli.
- 4 to 80+ years
- Administration Time: 21.6 minutes long

39. Test of Visual Perceptual Skills, 4th Edition (TVPS)

- Used to determine visual perceptual strengths and weaknesses
- 4-0 through 18-11
- Administration Time: 25 minutes (untimed)

40. Thematic Apperception Test (TAT)

- Projective Personality Assessment
- Interpersonal Relationships
- Help identify dominant drives, sentiments, conflicts and complexes
- 10 years or older
- Administration Time: 20-45 minutes

41. Trauma Symptom Checklist for Children (TSCC)

- Self-report measure of posttraumatic stress and related psychological symptomatology in children who have experienced traumatic events (e.g., physical or sexual abuse, major loss, natural disaster, witnessed violence)
- 8 to16 years
- Administration Time: 15-20 minutes

42. Universal Nonverbal Intelligence Test, 2nd Edition (UNIT-2)

a. Assessment of intelligence for individuals who have speech, language, or hearing problems; have different cultural or language backgrounds; and are verbally uncommunicative
b. 5 to 21 years
c. Administration Time: Abbreviated Battery – 10-15 minutes; Standard Battery – 30minutes; Full Scale Battery – 45-60 minutes

43. Vineland Adaptive Behavior Scale, 3rd Edition

- Measure of personal and social skills from birth to adulthood
- 0-90 years
- The leading instrument for supporting the diagnosis of mental retardation
- Q-Global scoring

44. Wechsler Intelligence Scale for Children, 5th Edition (WISC-V)

- Intelligence test for children
- 6 to16 years
- Administration Time: 65-85 minutes
- Q-Global scoring

45. Wide Range Achievement Test, 4th Edition (WRAT-4)

- Measures the basic academic skills of reading, spelling, comprehension, and mathematical computation necessary for effective learning, communication, and thinking
- Helpful in diagnosing learning disabilities, assessing academic progress over time, evaluating and achievement/ability discrepancies
- 5 to75 years
- Administration Time: 45-90 minutes

46. Woodcock-Johnson Tests of Achievement, Fourth Edition (WJ-IV)

- Designed to measure academic achievement
- 2 to 90+ years
- Administration Time: 60 -70 minutes
- Computerized scoring available

Referral Guideline

Competent training in evidence-based practice of psychology requires trainees to be aware of both the impact of his/her values as well as the values of the client on the competent provision of mental health services. Value conflicts will occasionally pose challenges for conducting therapy, regardless of how open minded and compassionate the clinician.

There may be times when a referral is considered because of an unresolved and interfering value conflict with a client. Clinicians are obligated to protect the welfare of their clients, which means ensuring that one is intellectually and emotionally ready to provide the best care to every client, or to see that the client has a referral option if he/she serving as the clinician is not in the client's best interest.

Some clinicians believe they should and can work with any client or presenting concern. Others may be quick to refer anyone who causes them discomfort. Somewhere between these extremes are the cases in which one's values and those of one's client clash to such an extent that a clinician may question his or her ability to be helpful. The challenge is to recognize when a clinician's values clash with a client's values to the extent that the clinician is not able to function effectively. Merely having a conflict of values does not necessarily require a referral; it is possible to work through such conflicts successfully. It is best to consider a referral only as a last resort.

A referral may be appropriate in any of the following cases: (1) if the client wants to pursue a goal that is incompatible with your value system, (2) if you are unable to be objective about the client's concerns, (3) if you are unfamiliar with or unable to use/learn a treatment requested by a client, (4) if you would be exceeding your level of competence in working with the client (even with close supervision), or (5) if, when working with multiple individuals, you favor one person more than another due to personal biases and emotional reactions.

<u>Model for Addressing Client-Clinician Value Conflicts*</u>

1. Detection of a possible value conflict
    - Discomfort or dissonance is identified and explored.
2. Value examination
    - Identify specific value causing discomfort and articulate the associated beliefs and specific behavioral implications.
    - This may include locating the specified value within the clinician's cultural, religious, familial, or political experiences and background.
3. Categorization of the value conflict
    - Articulate the implications of the value conflict for the provision of therapy. Categorize as Preemptive, Adjacent, Operational, or Unarticulated in order to follow corresponding recommendations.
4. Recommendations for clinicians
    - For a preemptive conflict: Termination training
    - For an adjacent conflict: Focused supervision; Diversity exposure; Avoid over-interpretation; Informed Consent
    - For an operational conflict: Diversity education; Breadth in clinical recommendations
    - For an unarticulated conflict: Focused supervision; Outcome tracking; Diversity education; Values articulation; Termination training; Psychotherapy

5. Disposition of the case
    - Clinicians will continue to provide services to the client unless it can be clearly articulated how the value conflict is preemptive in nature or when the value conflict is negatively impacting the provision of competent services.
    - When referral is necessary, clinicians remain ethically responsible for the emotional welfare of the client. Clinicians should exercise discretion when informing clients about a need for a referral. Clinicians should emphasize their professional limitations in serving the client's needs and their desire that the client have access to competent services.

*Farnsworth, J.K. and Callahan, J.L. (2013). Model for addressing client-clinician value conflict. *Training and Education in Professional Psychology*, 7(3), 205-214.

Other Procedures and Guidelines (alphabetical order)

Audio and Video Recording Guidelines

The Youth Services Department follows a code of confidentiality in the treatment and observation of all clients, with the purpose of ensuring that all clients have their right to privacy protected during their episode(s) of care.

- Recordings may not be completed unless the consent for audio and video section of the Bill of Rights form or the Consent for Audio and Video form in CMP has been electronically signed by the client(s). Verbal consent is also obtained prior to recording. You are not permitted to record until each individual in the room is aware that recording will take place and has given their consent.
- Therapists should explain carefully to clients the procedure and rationale for taping.
- Clients may decide for or against recording at any time during the course of therapy.
- Families are advised that services are not contingent upon their permission to audio or video tape, but are contingent upon the supervision of all cases.
- Recordings are made for training and educational purposes only and are not considered part of the clinical record.
- Clients sometimes change their minds about their willingness to be recorded. It is also possible that a client who were previously unwilling to sign a release may now feel comfortable signing it. In either case, an addendum to the Consent for Audio and Video Recording form needs to be signed.
- All audio and video recordings are considered confidential information, and are not to be listened to or viewed by anyone not immediately involved with evaluation or treatment of the client, without written permission of the client.
- Audio and video recordings will be maintained in a restricted access environment and will be accessible only to authorized individuals.
- Observers of diagnostic and treatment sessions and tapes are limited to clinical staff and students in training within the Youth Services Department.
- Any other persons wishing to observe may do so only with the expressed permission of the client(s).

More details regarding audio/video recordings may be found in the section below:

Frequently Asked Questions

Can I make audio or video recordings of my clients at the Youth Services Department?
Audio and video recordings of clients may only be made with specific written authorization from your client and/or their legal guardian. Please make sure that the youth and their parent/legal guardian has reviewed and signed authorization PRIOR to making any video or audio recordings. These authorizations must be updated every 12 months. Please remember that your client has the right to refuse this, and in that case, no recordings may be made.

What can I use to make audio recordings of my clients?
Audio recordings may be made with the Education and Training Center’s designated audio recorder or a personal audio recorder, as long as there is no video component. Cell phones are not permitted as recording devices, even if the phone is password protected.

How do I check out the Education and Training Center’s audio recorder?
The audio recorder is available to all trainees to record sessions. Please sign your name on the Audio Recorder Check-Out sheet with the date you borrow and return the recorder.

Where can I save my audio recording?
Audio files may be saved on the common drive in the EDUCATION and TRAINING CENTER folder, within the Recordings folder.

Can I save audio recordings and play them outside the Youth Services Department?
Ideally, audio recordings should only be played while at the Youth Services Department and must be erased immediately after they are reviewed. They may not be played in a publically audible manner in a place where unauthorized people can hear. If you must review audio data outside the clinic, you must first ensure that your client's full name or other identifying information cannot be heard on the recording. If that is the case, you may review the recording in a private environment, making sure no unauthorized person can hear it. Erase the recording immediately after you are done.

Can I use a recording for my Clinical Competency Exam (CCE)?
Students who wish to record sessions for a CCE should first discuss this with their YSD supervisor. The previously mentioned procedures regarding consent should be followed in addition to any necessary authorization required by the student's school. Upon completion of the CCE, all recordings of the client(s) should be destroyed.

I need to make a video recording and review it after a session. How do I do this?
Our live therapy room also has a video recorder. This can be activated and controlled through the conference room. Recordings are saved to a disc provided by the Training Director. These recordings can be reviewed on a laptop or DVD player while in the office. Discs must be returned to the Training Director for destruction after use.

How do I figure out how to use the video recorder?
An instructional guide for using the video recorder is available on the common drive in the Education and Training Center's 'Recordings' folder.

May I take a video recording home to review?
Video recordings may only be viewed within the Youth Services Department office. No video recording, in any format, may be removed from the office. Exceptions to this rule may be granted on a case by case basis and only for educational purposes.

Computer and Social Media

Palm Beach County Network

Trainees are provided with a username and password for access to the Palm Beach County computer network. The network is accessible at each of the Division offices. After the initial login, each user must change their password. Users will be required to periodically change the password. As the Division is part of a government agency, use of the network is monitored.

There are many computer drives for which interns have access. Most of the work will be completed on the (H:) drive, which is the individual user's network drive, available from any network computer. Use of the (C:) drive, the individual computer drive, should be minimal. The common (G:) drive (EDUCATION and TRAINING CENTER, YOUTH and FAMILY COUNSELING, HIGHRIDGE FAMILY CENTER Folders) provides access to information and materials used by many people within the Division. Trainees are provided with access to the common drive to review and print documents (although some documents require supervisor privilege for viewing). With supervisor approval, trainee may upload documents to share with others or for supervisors to review.

Youth Affairs Application (YA)

The Youth Affairs Application is the former electronic client filing system. From time to time, notes from this application may need to be reviewed.

Case Manager Pro (CMP)

Case Manager Pro is the newest Youth Services electronic charting system. There is a user guide and procedure manual for use with CMP. Usernames and passwords for the CMP are the same as they are for the Palm Beach County Network.

Internet

Trainees are able to use the Internet for work related purposes. As the Division is part of a government agency, use of the internet is monitored.

Use of Social Media

Trainees who use social media (e.g., Facebook, Twitter, YouTube, LinkedIn, blogs) and other forms of electronic communication should be mindful of how their communication may be perceived by clients, colleagues, staff, and others. As such, trainees should make every effort to minimize material that may be deemed inappropriate for a psychologist in training. To this end, trainees should set all security settings to private and should avoid posting information/photos or using any language that could jeopardize their professional image. Trainees should consider limiting the amount of personal information posted on these sites, and should never include clients as part of their social network, or include any information that might lead to the identification of a client, or compromise client confidentiality in any way. Trainees are reminded that, if they identify themselves as a trainee, the Youth Services Department has some interest in how they are portrayed. If trainees report doing, or are depicted on a website or in an email as doing something unethical or illegal, then that information may be used by Youth Services to determine probation or even dismissal. As a preventive measure, the Youth Services Department advises that trainees (and staff) approach social media carefully. In addition, the American Psychological Association's Social Media/Forum Policy may be consulted for guidance: http://www.apa.org/about/social-media.aspx

Outlook
Email accounts are created for trainees and all Division staff for work-related use. To maintain confidentiality, email correspondence with clients is prohibited.

Outlook Webmail
To access your Palm Beach County email account on the internet, use the following address: https://webmail.pbcgov.org/

The Outlook Calendar is used to keep track of scheduled appointments. Each individual email account has the Calendar feature, and there is a shared Calendar ("YSD-RTFC-Central and Glades Daily Activity Log") so supervisors and clerical staff will be aware of scheduled appointments. Appointments created in CMP are automatically sent to the Outlook calendar. All items in the CMP calendar should be synchronized with Outlook by checking the 'Synchronize with Outlook' box in the CMP calendar.

Shared Outlook Calendar
To use the shared Calendar and the New Meeting Request feature:

1. Choose 'Meeting Request'
2. To: YSD-RTFC-Central and Glades Daily Activity Log
3. Subject: is the activity being completed (therapy session with client #, psychological evaluation with client #, group supervision, etc.). Examples: Jane FT #45678; Dr. Smith supervision with Jane
4. Location: is the location of the activity (YFC-S, HRFC, Ed Center, etc.)
5. Start Time: is the start date and time of the activity
6. End Time: is the end date and time of the activity

CMP Calendar
To use the CMP calendar:

1. Click on Appointment and find your name
2. Double click in the column with your name and a dialogue box will appear
3. Subject: is the activity being completed (This information will automatically populate if you are scheduling though the client service)
4. Location: is the location of the activity (Ed Center, YFC, HRFC)
5. Start Time: is the start date and time of the activity
6. End Time: is the end date and time of the activity
7. If applicable, click on 'Recurrence' and enter recurrent pattern (day, time, etc.)
8. Click Save and Close on the dialogue box
9. Click Save and Close again on the calendar view

Psychological Evaluation Measures
There is a designated testing computer on which certain psychological evaluation measures can be administered and scored, which is located in the Education and Training Center conference room. Scoring programs are available for the following measures: ARES, ASRS, BRIEF-2, CAFAS, KTEA-3, MMPI-A, RIAS-2, Rorschach, TOVA, WISC-V, and WJ-IV. The ARES requires a key fob (located in the testing cabinet) to be inserted prior to scoring. The Rorschach and TOVA must be scored on a specific computer located in the testing room. Web based scoring and reporting software is also available for the majority of measures. Passwords for accessing specific scoring programs are provided on a spreadsheet located in the Student-Trainee folder on the Common drive. This list is updated periodically.

IT Support/Helpdesk

If you are having problems with any of the programs on your assigned computer, you **MUST** send a request for assistance to the computer technicians. This is done by visiting the Home page on Internet Explorer. Scroll to the bottom of the page and on the right-hand side to 'IT Support.' Click on "Submit ISS HelpDesk Ticket," then click on the computer icon on the top left-hand side of the screen to submit a problem, which will allow you to describe your problem in detail. You may be contacted by the ISS staff member to whom your case has been assigned. You should receive an email notification when the case has been resolved and closed.

Dress/Grooming/Hygiene Guidelines

Purpose

The Youth Services Department recognizes that the presentation of its trainees in the workplace contributes to a professional environment and the public image that has contributed to the success of the department. Therefore, the Youth Services Department expects trainees to be well groomed and professional in appearance when coming to work or engaged in work-related tasks with clients and colleagues.

These guidelines have been developed to ensure that all trainees understand the importance of appropriate dress, grooming, and hygiene in the workplace or when otherwise representing the Youth Services Department.

Procedures

Every trainee is expected to practice hygiene and grooming habits as set forth in further detail below:

- **Body** - Maintain personal cleanliness, including proper oral hygiene and absence of body odors.
- **Hands** - Hands and nails should be kept clean.
- **Hair** - Hair should be neatly trimmed or arranged. Unkempt hair is not permitted. Sideburns, mustaches, and beards should be neatly trimmed.
- **Clothing-** Clothing should be business casual. Clothing should be clean, pressed, in good condition and fit appropriately.
    - **The following items are <u>not</u> permitted**

- Hats
- Sweatpants or sweatshirts
- T-shirts
- Low-cut tops
- Halter tops
- Spaghetti strap tops
- Shirts or pants that expose the midriff
- Exercise pants
- Blue jeans or ripped/distressed pants
- Shorts
- Mini-skirts
- Any clothing in which an undergarment (bra or underwear) is exposed
- Any form of clothing that is generally offensive, controversial, disruptive, or otherwise distracting
- Any form of clothing that is overtly commercial, contains political, personal, or offensive messages
- Rubber/Plastic flip-flops
- Tennis shoes/Sneakers
- Clear heels

    - ***Note:*** Theme days are occasionally approved by the department that allow certain casual clothing to be worn (as long as business will not be affected). Additionally, certain articles of clothing listed above may be permitted in extenuating circumstances (such as in instances related to medical/health needs).

- **Make-Up** - Make-up must be professional and conservatively applied.
- **Fragrance** - Colleagues and clients in the workplace may have sensitivities or allergies to fragrant products, including but not limited to perfumes, colognes, fragrant body lotions or hair products. Therefore, fragrant products should be avoided or used in moderation.
- **Jewelry** - Conservative jewelry may be worn in moderation.
- **Tattoos** – Visible tattoos should not be of a provocative or offensive nature.

Violations - Every trainee is responsible for exercising sound judgment and common sense for his or her attire at all times. If a trainee is deemed to be wearing inappropriate attire, his/her supervisor is responsible for coaching the trainee accordingly. The trainee may be asked to leave work until compliant. Continued violations of this guideline will result in discipline, up to and including termination.

Exceptions - Trainees seeking an exception from any of the above standards should speak with his/her supervisor.

Due Process and Grievance Procedures

Introduction

This document provides an overview of the identification and management of trainee problems and concerns, a listing of possible sanctions, and an explicit discussion of the due process procedures. Also included are important considerations in the remediation of problems. We encourage staff and trainees to discuss and resolve conflicts informally; however if this cannot occur, this document was created to provide a formal mechanism for the Youth Services Department to respond to issues of concern.

Definitions

Trainee: Any person in training who is working in the agency, including a doctoral practicum student, doctoral intern, postdoctoral fellow, social work intern, marriage and family therapy intern, or mental health counseling intern.

Supervisor: A staff member who oversees trainees' clinical activities at the Youth Services Department.

Training Director: The staff member who oversees all training activities at the Youth Services Department. The Training Director will always be consulted prior to consulting with the Youth Services Department's Residential Treatment and Family Counseling Division Director.

Division Director: The staff member who oversees the Youth Services Department's Residential Treatment and Family Counseling Division.

Training Committee Staff: The group comprised of the Training Director and the clinical supervisors.

Working days: Days in which the office is open for business, which include Monday through Thursday from 8:00am-7:00pm (Education & Training/Youth & Family Counseling) and from 9:30am-8:00pm (Highridge), not including federal holidays.

Due Process: The basic meaning of due process is to inform and to provide a framework to respond, act, or dispute. These procedures are implemented in situations in which a concern is raised about the functioning of a trainee. Due process ensures that decisions about trainees are not arbitrary or personally based. It requires that the training program identify specific procedures which are applied to all trainees' complaints, concerns, and appeals. These procedures are a protection of trainee rights and are implemented in order to afford the trainee with every reasonable opportunity to remediate problems and to receive support and assistance. These procedures are not intended to be punitive.

Problematic Behavior: Problematic Behavior is defined broadly as an interference in professional functioning which is reflected in one or more of the following ways:

1. An inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior;
2. an inability to acquire professional skills in order to reach an acceptable level of competency; and/or
3. an inability to control personal stress, strong emotional reactions, and/or psychological dysfunction which interfere with professional functioning.

Professional judgment is used to identify when a trainee's behavior becomes problematic rather than of concern. Trainees may exhibit behaviors, attitudes, or characteristics which, while of concern and requiring remediation, are not unexpected or excessive for professionals in training. Problematic behavior typically becomes identified when one or more of the following exist:

1. The trainee does not acknowledge, understand, or address the problem when it is identified;
2. the quality of services delivered by the trainee is sufficiently negatively affected;
3. the problem is not merely a deficit of skills that can be rectified by training;
4. more than one area of professional functioning is affected;
5. a disproportionate amount of attention by training personnel is needed to address the problem;
6. the trainee's behavior does not change as a function of feedback, remediation efforts, or time;
7. the problematic behavior has potential ethical or legal ramifications if not addressed;
8. the trainee's behavior negatively impacts the public view of the agency;
9. the problematic behavior negatively impacts the training cohort;
10. the problematic behavior potentially causes harm to a patient; and/or,
11. the problematic behavior violates appropriate interpersonal interactions with agency staff.

Grievance: An official statement of a complaint over something believed to be wrong or unfair.

Due Process Procedures

Informal Review

When a supervisor believes that a trainee's behavior is becoming problematic, the first step in addressing the issue should be to raise the issue with the trainee directly and as soon as feasible in an attempt to informally resolve the problem. This may include increased supervision, didactic training, and/or structured readings. This process should be documented in writing (Informal Training Plan may be used) in supervision notes and discussed with the Training Director, but will not become part of the trainee's professional file.

Formal Review

If a trainee's problem behavior persists following an attempt to resolve the issue informally, or if a trainee is not meeting minimal expectations on any competency area on a supervisory evaluation, the following process is initiated:

The supervisor will meet with the Training Director within 3 working days to discuss the problem and determine what action needs to be taken to address the issue. If the Training Director is the trainee's direct supervisor, an additional supervisor who is also a member of the Training Committee Staff will be included in the meeting.

After discussing the problem, reviewing informal steps that have already been taken, and in the case of doctoral interns and postdoctoral fellows, utilizing APPIC's Informal Problem Consultation process, the supervisor and Training Director may determine one of the following four courses of action:

1. *Formal Training Plan* is a time-limited, remediation-oriented, closely supervised period of training designed to return the trainee to a more fully functioning state. Its purpose is to assist the trainee in responding to difficulties attaining competencies in the required areas and/or personal

reactions to environmental stress, with the full expectation that the trainee will complete the clinical placement.

This period will include more closely scrutinized supervision conducted by the site supervisor in consultation with the Training Director. Several possible and perhaps concurrent courses of action may be included in a Formal Training Plan. These include but are not limited to:

1. increasing the amount of supervision, either with the same or additional supervisors;
2. changing the format, emphasis, and/or focus of supervision;
3. recommending personal therapy;
4. reducing the trainee's clinical or other workload;
5. requiring specific academic coursework.

The Formal Training Plan contains an acknowledgment statement:

a) that the supervisor(s) and Training Director are aware of and concerned with the problem;
b) that the problem has been brought to the attention of the trainee;
c) that the supervisor(s) will work with the trainee to specify the steps necessary to rectify the problem or skill deficits addressed by the inadequate evaluation rating; and,
d) that the problem is not significant enough to warrant further remedial action at this time.

The Formal Training Plan will be developed at a meeting between the supervisor(s) and trainee, and will become part of the trainee's permanent file. It will be approved by the Training Director, and sent to the Director of Clinical Training at the trainee's graduate institution.

The length of time that the Formal Training Plan is in effect will be determined by the supervisor in consultation with the Training Director, and will be no longer than 8 working days, after which time the status is reviewed by the supervisor in consultation with the Training Director, and discussed with the trainee. If the problem has been rectified to the satisfaction of the supervisor and the trainee, the graduate institution and other appropriate individuals will be informed and no further action will be taken. If concerns remain, the Formal Training Plan may be extended, and modified if necessary, for up to another 8 working days. This process may be repeated as needed.

2. ***Probation*** is another time-limited, remediation-oriented, more closely supervised training period that is added when a Formal Training Plan has not adequately resolved the concern, and the trainee requires additional restriction from clinical and/or professional activities. Its purpose is to assess the ability of the trainee to complete the program and to return the trainee to a more fully functioning state. Probation defines a relationship in which the supervisor and Training Director systematically monitor, for a specific length of time, the degree to which the trainee addresses, changes, and/or otherwise improves the behavior. The length of the probation period will depend upon the nature of the problem and will be determined by the trainee's supervisor and the Training Director. In the case of doctoral interns and postdoctoral fellows, APPIC's Informal Problem Consultation process should be utilized.

   A written Probation Statement is shared with the trainee and the Director of Clinical Training at the trainee's graduate institution within 3 working days of the decision for probation and includes:

   1. the specific behaviors or areas of professional functioning that are particularly problematic;
   2. the direct relationship of these behaviors to written evaluations;
   3. the specific recommendations by which the problem can be rectified;
   4. the time frame for the probation period after which a final review will be conducted prior to dismissal, if not remediated, or reinstatement if remediated; ,
   5. the procedures designed to ascertain whether the problem has been appropriately rectified; and,

6. due process procedures available and the time frame in which the trainee can appeal the decision.

At the end of the probation period, the Training Director will provide a written statement indicating whether or not the problem has been remediated. This statement will become part of the trainee's permanent file and also will be shared with the trainee and sent to the Director of Clinical Training at the trainee's graduate institution. If the probation period interferes with the successful completion of the training hours needed for completion of the program, this will be noted in the trainee's file and the trainee's graduate institution, and APPIC in the case of doctoral interns and postdoctoral fellows, will be informed.

3. *Leave of Absence* involves the temporary withdrawal of all responsibilities and privileges at the Youth Services Department. This may be recommended by the supervisor, in consultation with the Training Director, or requested by the trainee in some circumstances. The Training Director will inform the trainee of the effects the leave of absence will have on the trainee's stipend, privileges, and estimated date of completion. If the leave of absence interferes with the successful completion of the training hours needed for completion of the program, this will be noted in the trainee's file, and the Director of Clinical Training at the trainee's graduate institution will be informed. In the case of doctoral interns and postdoctoral residents, APPIC will also be informed.

4. *Dismissal* involves the permanent withdrawal of all agency responsibilities and privileges. When the aforementioned formal review steps have been attempted and specific interventions do not, after a reasonable time period, rectify the problem behavior or concerns, and the trainee seems unable or unwilling to alter his/her behavior, the Training Committee Staff will discuss with the Division Director the possibility of termination from the training program. The Division Director will make the final decision about dismissal.

   Immediate dismissal may be necessary under extenuating circumstances, and involves the immediate permanent withdrawal of all agency responsibilities and privileges. Immediate dismissal would be invoked, but is not limited to cases of severe violations of the Code of Ethics, or when imminent physical or psychological harm to a client is a major factor. In addition, in the event that a trainee compromises the welfare of a client(s), the agency, or the community by an action(s) which generates grave concern from the supervisor(s) or Training Director, the Division Director may immediately dismiss the trainee from the Youth Services Department.
   This dismissal may bypass the other formal review steps identified above.

   In the case of doctoral interns and postdoctoral fellows, APPIC's Chair must be notified before dismissal takes place. APPIC acknowledges there is a formal match agreement and wants assurance that all policies including due process have been completed. When a trainee has been dismissed, the Training Director will communicate to the Director of Clinical Training at the trainee's graduate institution that the trainee has not successfully completed the training program.

   In the event of dismissal, the following steps may occur:

   a. consultation conducted by the Training Director with internal and external sources (e.g., legal consultation, APA, and APPIC);
   b. letter given to trainee reiterating probation criteria, trainee's response, and reasons for dismissal;
   c. copy of letter forwarded to trainee's academic department no later than 3 working days following the dismissal meeting with the trainee in order to ensure all parties are informed;

d. determination of how and when the trainee's status with YSD will change, with consideration of protecting client welfare;
e. specification of due process procedures and time frame in which the trainee may appeal the decision.

Appeals Process

If the trainee wishes to challenge a Probation or Dismissal decision, he/she may request an Appeals Hearing before members of the Training Committee Staff. This request must be made in writing (an email will suffice) to the Training Director within 3 working days of notification regarding the decision made above. If requested, the Appeals Hearing will be conducted by a review panel convened by the Training Director and consisting of him/herself (or another supervisor, if appropriate), the trainee's supervisor, and at least one other member of the Training Committee Staff. The trainee may request a specific member of the Training Committee Staff to serve on the review panel. If the trainee requests the presence of a representative who is not affiliated with YSD to also serve on the review panel, this request will be considered for appropriateness by the Training Director (or another supervisor, if appropriate). The Appeals Hearing will be held within 5 working days of the trainee's request. The review panel will review all written materials and have an opportunity to interview the parties involved or any other individuals with relevant information. The review panel may uphold the decisions made previously or may modify them. The review panel has final discretion regarding outcome.

Grievance Procedures

Grievance Procedures are implemented in situations in which a psychology trainee raises a concern about a supervisor or other staff member, trainee, or the training program. These guidelines are intended to provide the trainee with a means to resolve perceived conflicts. Trainees who pursue grievances in good faith will not experience any adverse professional consequences. The following procedures are followed in situations in which a trainee raises a grievance about a supervisor, staff member, trainee, or the training program:

Informal Review
The trainee should raise the issue as soon as feasible with the involved supervisor, staff member, other trainee, or Training Director in an effort to resolve the problem informally.

Formal Review
If the matter cannot be satisfactorily resolved using informal means, the trainee may submit a formal grievance in writing, with all supporting documents, to the Training Director. If the Training Director is the object of the grievance, the grievance should be submitted to another member of the Training Committee Staff. The individual being grieved will be asked to submit a response in writing within 3 working days. The Training Director (or Training Committee Staff member, if appropriate) will meet with the trainee and the individual being grieved within 3 working days of receiving the written response from the individual being grieved. In some cases, the Training Director or other Training Committee Staff member may wish to first meet with the trainee and the individual being grieved separately. The goal of the joint meeting will be to develop a plan of action to resolve the matter. The plan will include:

1. the behavior associated with the grievance;
2. the specific steps to rectify the problem; and,
3. procedures designed to ascertain whether the problem has been appropriately rectified.

The Training Director or other Training Committee Staff member will document the process and outcome of the meeting. The trainee and the individual being grieved will meet with the Training Director (or other Training Committee Staff member, if appropriate) within an established number of working days, but no longer than 8 working days. At this meeting the plan of action will be reviewed and the Training Director (or Training Committee Staff member, if appropriate) will determine whether the issue has been adequately resolved.

Review Panel

If the plan of action fails, the Training Director (or other Training Committee Staff member, if appropriate) will convene a review panel consisting of him/herself and at least one other member of the Training Committee Staff within 3 working days. The trainee may request a specific member of the Training Committee Staff to serve on the review panel. The review panel will review all written materials and have an opportunity to interview the parties involved or any other individuals with relevant information. The review panel has final discretion regarding outcome. Within 3 working days, the review panel will submit a written report, which will be shared with necessary parties.

Record Keeping Guidelines

The Main Reasons To Keep Records:
(from http://www.zurinstitute.com/recordkeepingguidelines.html)

- Good records help therapists provide quality care by providing therapists with continuity where they do not need to rely on their memory to recall details of their patients' lives and the treatment provided.
- Not keeping any records is below the standard of care, is unethical and, in many states, illegal.
- In case of civil, criminal, or administrative litigation, it is often not the therapist's word against the client's, but the client's word against the psychotherapy records. Many boards make the decision of whether to pursue a case based on experts who develop their opinion from reading the clients' complaints and the therapists' records but not necessarily interviewing the therapists themselves.
- If the treating therapist becomes disabled, dies, or cannot continue to provide care for other reasons, clinical records can help the next treating therapist with information and the clients with continuity.

Content of Records Needed per APA:
(APA, 2007)

A psychologist strives to maintain accurate, current, and pertinent records of professional services as appropriate to the circumstances and as may be required by the psychologist's jurisdiction. Records include information such as the nature, delivery, progress, and results of psychological services, and related fees. For complete information on "use of language" and "content of records," please refer to the article Record Keeping Guidelines (APA, 2007).

Content of the Records Mandated by Florida law:
http://www.apadivisions.org/division-31/publications/records/florida-record-keeping-laws.pdf

Florida law sets forth specific record-keeping guidelines for psychologists at Chapter 64B19-19 of its Administrative Code. In addition, various other Florida laws set forth below address recordkeeping by psychologists who work in certain settings or health care providers generally. Neither the Florida Statutes nor the Administrative Code adopt the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct ("APA Code of Ethics") explicitly. The law, however, implies that Florida psychologists are subject to the Code of Ethics and its recordkeeping provisions.
Florida law calls for an intake and evaluation note, and progress notes. Additionally, a termination note will likely reduce exposure to arguments about continued duty of care, and reduce the risk of responsibility in a duty to protect/warn jurisdiction.

Florida Statute 64B19-19.0025 states:

To serve and protect users of psychological services, psychologists' records must meet minimum requirements for chronicling and documenting the services performed by the psychologist, documenting informed consent and recording financial transactions.

> (1) Records for chronicling and documenting psychologists' services must include the following: basic identification data such as name, address, telephone number, age and sex; presenting symptoms or requests for services; dates of service and types of services provided. Additionally, as applicable, these records must include: test data (previous and current); history including relevant medical data and medication, especially current; what transpired during the service sessions; significant actions by the psychologist, service user, and service payer; psychologist's indications suggesting possible sensitive matters like threats; progress notes; copies of correspondence related to assessment or services

provided; and notes concerning relevant psychologist's conversation with persons significant to the service user.
(2) Written informed consent must be obtained concerning all aspects of services including assessment and therapy.
(3) A provisionally licensed psychologist must include on the informed consent form the fact that the provisional licensee is working under the supervision of a licensed psychologist as required by Section 490.0051, F.S. The informed consent form must identify the supervising psychologist.
(4) Records shall also contain data relating to financial transactions between the psychologist and service user, including fees assessed and collected.
(5) Entries in the records must be made within ten (10) days following each consultation or rendition of service. Entries that are made after the date of service should indicate the date the entries are made, as well as the date of service.

Rulemaking Authority 490.004(4), 490.0148 FS. Law Implemented 490.002, 490.0051, 490.009(2)(s), (u), 490.0148 FS. History–New 11-23-97, Amended 10-22-98, 5-14-02

Note Writing Guidelines

- Be sure you have the right chart!
- Think about what you are going to write and formulate before you begin
- Proofread
- Use proper spelling, grammar, and sentence structure
- Document all participants referring to adults as Mr./Mrs./Ms. and referring to youth with their first name (rather than stating client, parent, etc.)
- Always document as soon as possible after the intervention/session (ideally immediately after)
- Document all contacts or attempted contacts
- Content should be **concise, consistent, and in sync with your treatment plan**
- Because no records are immune from disclosure, be careful in your documentation and do not include details that can cause unnecessary harm for clients or others, if they are disclosed or become public
- Avoid labels, personal judgements, value-laden language, or words open to personal interpretation (e.g., uncooperative, manipulative, abusive, obnoxious, normal, spoiled, dysfunctional, functional, drunk)
- Use only standard abbreviations and avoid slang. It is important that your documentation can be understood by anyone reading the health record
- Keep quotes to a minimum. Use when clinically pertinent. "The goal (of a note) is not to give a verbatim account of what the client says, but rather reflect current areas of client concern and to support or validate the counselor's interpretations and interventions in the assessment and plan section… (Cameron, & turtle-song, 2002)."
- Give description if using the words "seems" or "appeared" in order to provide evidence for observations, such as:
    - "Client appeared dysphoric as evidenced by tearfulness."
    - "Client remains at risk for ______________ as evidenced by ____________"
    - "Client continues to be depressed as evidenced by _____________"
    - "Client continues to have suicidal ideation as evidenced by the following comment made to this writer: _____________"
- Document (as applicable), give the clinical rational and, when appropriate, ethical considerations for:
    - Gifts received, loans of books, or CDs
    - Extensive use of touch or self-disclosure
    - Recording or videotaping of sessions
    - Phone therapy or any other telehealth practices, including a special disclosure if these practices are the basic mode of therapy.

    - Dual relationship: The nature, extent, etc.
    - Out-of-office experiences, such as attending graduations, weddings, or funerals, school visits/observations, and clinically meaningful incidental/chance encounters
- Your note can be brief to the extent that you can communicate your competence, thoughtfulness, decision-making ability, capacity to weigh available options, rational for treatment selection and knowledge of clinically, ethically, and legally relevant matters
- If creating/choosing a note-writing template, make sure it works for you and your setting/ client population
- Before every session with a client, the previous two or three notes should be opened and read. This will give you a clear understanding of where you need to go in the current session. Without this type of methodology every therapy session is just a random discussion of the client's current events. The sessions don't really go anywhere productive.
- In order to be clear and concise, and present information in a succinct and coherent manner, client documentation can be easily accomplished with note types such as DAP, PAIP or SOAP.

Different Note Types Pros and Cons:

SOAP= most commonly used, especially if notes will be shared with the medical community. Good for process-oriented therapies because it focuses more on the client's response during session and your assessment that day. However, the "*subjective*" field used as the "*S*" in *SOAP* can be related to the medical field, thus, be sure to include pertinent information about what the family reports to ensure psychological crossover. The *Subjective* field should only contain what the family tells you.

DAP= popular and possibly the most simple. Good for process-oriented therapies.

PAIP= allows you to focus in on a problem area, but also has sections for your assessment, as well as the interventions you provided. **If you use a modality where you provide specific interventions**, this may be a great template for you.

SOAP, DAP, and PAIP Note Type Descriptions:

SOAP:

***S**ubjective* – Client-based *subjective* feelings, concerns, and thoughts only. There should be no indication of objectivity as observed by the therapist. The *Subjective* portion of a *SOAP Note* often starts like: "Client states that she feels..."
***O**bjective* – The *Objective* portion of the session note contains observable and identifiable characteristics and behaviors that the therapist sees (in spite of what the client says). It is common to use the phrase "It appears…." or "It is apparent…." (with descriptors)
***A**ssessment* – *Assessment* should include clinical findings. It may be more philosophical than the *Objective* portion. This should tie everything (the *Subjective* and the *Objective*) together.
***P**lan* – What do you plan to do with the information that has been gathered? More than just planning based on what has been observed in this single session, what is the broader *Plan* based on previous information gathered from previous sessions? How has the overall *Plan* been modified or adjusted by this new information? What needs to be done during the next session? What type of short-term goal can be achieved in the next three sessions? What homework has been given at the conclusion of this session to attempt to fulfill the *Plan*?

DAP:

***D**ata* – The *Data* portion of the session note contains observable and identifiable characteristics and behaviors that the therapist sees. It is intermingled with the *subjective* statements of the client, where those *subjective* observations may be appropriate and relational to the overall direction of the session. This is what a therapist sees and observes during the session that has a bearing on the next two session note areas. Includes progress on presenting problem and review of homework. This section responds to the phrase "*What did I see?*" and "What did the client/family say or feel"

***A**ssessment* – See SOAP *Assessment* above. This field should contain similar information. Working hypothesis and gut hunches. This section responds to the statement: "*What does it mean to me?*" "What's going on**?"**

***P**lan* – See SOAP *Plan* above. It is the response or revision to interventions. This section answers the question: "*What am I going to do about it*?" and "What is my follow up plan?" and "What homework was given?"

PAIP:

***P**roblem-* Describe what the problem is that brought the family through the door or the focus of the session.

***A**ssessment-* What are your general clinical observations about this family?

***I**ntervention-* What did you do?

***P**lan-* What will you do next?

These should be included no matter which note type you choose:

- Who was present: Anyone who was present during at least part of a session should be recorded here. It does not matter who they are or why they were part of the session.
- If late
- Date and time of next scheduled session

SOAP Note Example:

(S) Mrs. Doe reported that John is improving in his behavior in the home as evidenced by his ability to readily engage in household chores and earn his daily privileges. On the other hand, Mrs. Doe reported that she continues to experience difficulty communicating with John during conflict scenarios, noting that they "get into screaming matches." John corroborated Mrs. Doe's reports.

(O) Mrs. Doe and John arrived on time to the session. Mrs. Doe presented in euthymic mood with congruent affect; meanwhile, John initially presented in a slightly dysphoric mood as evidenced by tearfulness and slouched posture. During the session, Mrs. Doe evidenced improved ability to engage in effective communication techniques as demonstrated by her shifting from interrupting and raising her voice to an increased use of "I" statements and appropriate modulation of voice volume. In response to Mrs. Does' effective engagement in communication strategies, John became increasingly euthymic as evidenced by smiling and increased engagement in reciprocal conversation with Mrs. Doe.

(A) At this time, Mrs. Doe presents with ongoing improved ability to engage in effective communication strategies, following therapist feedback and guidance. John also evidences improved engagement in desirable behaviors (i.e., chore completion) in the home, in response to Mrs. Doe's effective use of behavior management strategies (providing reinforcement for his engagement in target behaviors).

(P) Therapist will continue to encourage the family's development of effective communication via modeling, role-playing, and explicit guidance of communication strategies in session. Implementation of behavior management plan in the home will continue to be monitored. Therapist will also begin to prepare the family for transition to termination. Next appointment scheduled for Thursday 3/9/18 at 5pm.

DAP Note Example:

(D) This therapist met only with Ms. Jones and Mr. Jones for session. Mr. Jones reported that he was sleeping less and able to concentrate more at work, but does not think it is due to starting Prozac two weeks ago. Both Ms. Jones and Mr. Jones report an increase in the frequency and effectiveness of their communication due to their "speaker-listener" homework. Ms. Jones stated that "Mr. Jones still doesn't seem to open up that much." Mr. Jones disagrees with Ms. Jones' assessment and feels that he is really "spilling his guts." The rest of the session focused on their differing views of openness and possible relationship to family-of-origin issues *(note: you may want to list these).* During this discussion Ms. Jones interrupted Mr. Jones four times to add to his statement; after the fourth time Mr. Jones sat quietly and stated Ms. Jones could finish for him. Ms. Jones shouted at Mr. Jones that he was a quitter and after a few moments apologized.

(A) Mr. Jones' symptoms of depression appear to be lessening. The couple has improved their communication style, but have not rebuilt their trust and safety. Ms. Jones continues to view Mr. Jones as not trying and thus not caring.

(P) Next session scheduled for 2/3/18 at 6pm. The plan is to continue working on building safety for communication. Homework for the couple is to think about the question: "What did you learn about being a husband/wife/parent from your parents?"

PAIP Note Example:

(P) Tim, Jane, and Mr. Smith attended the family therapy session. The main focus of session was Mr. Smith's continued concerns regarding communication throughout the week. Mr. Smith reported that there were two days when the children still did not tell him where they were going after school. He tried giving lectures to them about safety, but said the problem persists.
(A) Tim presented in session as calm and tired as evidenced by his slouched posture and reports of being exhausted from testing at school. Jane was quiet, apologetic, and tearful when explaining that she forgets to tell her father when she gets excited to go over to a friend's home. Mr. Smith was observed often blaming and interrupting Tim and Jane. The family seems to have made some progress on their goal of increased communication over the week. Mr. Smith showed progress with his communication skills as evidenced by educating the children about safety during the week, but the lecturing, blaming, and interrupting is still present.
(I) The therapist complimented the children's accomplishment of increasing the days they do tell their father where they are going after school from last week. The therapist also helped the family set clear, realistic expectations about when and what information needs to be communicated regarding after school plans. The session ended with the therapist reviewing the communication skills list the family learned about last week in session and reminding Mr. Smith how to provide information to the children without lecturing.

(P) Next session scheduled for 2/3/18 at 6pm. The plan is to continue to encourage the family's development of effective communication via modeling and explicit guidance of communication strategies in session. After school communication expectations will continue to be monitored and adjusted with the family as needed.

Safety Plan

PALM BEACH COUNTY
YOUTH SERVICES DEPARTMENT
RESIDENTIAL TREATMENT & FAMILY COUNSELING

This safety plan has been created for:

______________________________________ on ____________________

Client's Full Name — Date

Step 1:
Warning signs (e.g., thoughts, feelings, mood, situation, behavior) that a crisis may be developing:

☐ Crying a lot	☐ Intense worry/anxiety	☐ Death of someone close
☐ Changes in appetite	☐ Feeling angry/aggressive	☐ Anniversary of trauma
☐ Increased use of alcohol/drugs	☐ Feeling humiliated/ashamed	☐ Financial/legal problems
☐ Isolated/closed off from others	☐ Missing doctor appointments	☐ Too many responsibilities
☐ Changes in sleep	☐ Thinking "I can't cope"	☐ Health problems
☐ Poor hygiene	☐ Overreacting to minor things	☐ Family arguments
☐ Getting lost in thought	☐ Divorce	☐ Difficulty in school/work
☐ Feeling restless, fidgety	☐ Relationship break-up	☐ Being scolded or screamed at
☐ Others:		

____

____

____

Step 2:
Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (e.g., relaxation, physical activity, mental activity):

____

____

____

Step 3:
People and social settings that can provide distraction:

Name=________________________________ Phone=________________________

Name=________________________________ Phone=________________________

Place=________________________________ Place= ________________________

Step 4:
People I can ask for help (e.g., therapist, parent, family member, friend):

Name=________________________________ Phone=________________________

Name=________________________________ Phone=________________________

Name=________________________________ Phone=________________________

Step 5:
How to make the environment safe:

- ☐ Remove guns from my home and/or places I visit frequently (or have others remove them)
- ☐ Lock up medicine (or have others lock them)
- ☐ Remove drugs and alcohol (or have others remove them)
- ☐ No environment changes needed at this time
- ☐ Others:

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____

Step 6:
What has kept me alive so far? What do I look forward to in the future? What things are important to me and worth living for?

____

____

____

Step 7:
Professionals or agencies I can contact during a crisis:

☐	911		
☐	Crisis or Information	=	211
☐	Crisis Text Line	=	Text TWT to 741741
☐	National Suicide Prevention Lifeline	=	1-800-SUICIDE (1-800-784-2433)
☐	National Domestic Violence Hotline	=	1- 800-799-SAFE (7233)
☐	Florida Child Abuse Hotline	=	1-800-96- ABUSE (22873)
☐	Mobile Crisis North County	=	(561) 383-5777
☐	Mobile Crisis South County	=	(561) 637-2102 or (877) 858-7474
☐	South County Mental Health	=	(561) 737-8400 from North and Central County
☐	South County Mental Health	=	(561) 495-0522 from South County

Other:

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APA Ethical Principles and Code of Conduct

AMERICAN PSYCHOLOGICAL ASSOCIATION

ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT

Adopted August 21, 2002
Effective June 1, 2003
(With the 2010 Amendments
to Introduction and Applicability
and Standards 1.02 and 1.03,
Effective June 1, 2010)

With the 2016 Amendment
to Standard 3.04
Adopted August 3, 2016
Effective January 1, 2017

http://www.apa.org/ethics/code/ethics-code-2017.pdf

Acknowledgment Statement

I acknowledge that I have received and reviewed the Youth Services Department Handbook and Documentation Manual, including all of the policies within. I agree to abide by all policies and procedures outlined in these documents. I have read and understand the following (please initial next to each):

- ___ YSD Training Program Handbook
  - ___ Requirements & Expectations
  - ___ Professional Conduct Expectations
  - ___ Individual Supervision Description
  - ___ Group Supervision Description
  - ___ Telesupervision Description
  - ___ Formal Evaluations of Trainee Performance
  - ___ Diversity and Non-Discrimination Policy
  - ___ Referral Guidelines
  - ___ Audio and Video Recording Guidelines
  - ___ Computer and Social Media Policy
  - ___ Dress/Grooming/Hygiene Guidelines
  - ___ Due Process and Grievance Procedures
  - ___ APA Ethical Standards and Code of Conduct
- ___ YSD Documentation Manual

I also understand that I may access these documents and any updates to them on the Youth Services Department website (http://www.pbcgov.com/youthservices).

Print Name ____

Signature ____ Date______________