Youth Services Department
Palm Beach County

Practicum Trainee
2025-2026

Handbook

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

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Introduction

Youth Services Department

Mission: Growing brighter futures by providing quality services, education, and access to resources and opportunities.

Vision: Empowering youth and families to realize their full potential and be the driving force of a thriving community.

The clinical training program at the Youth Services Department is offered through the Residential Treatment and Family Counseling Division, whose mission is to provide free, accessible, professional trauma-informed mental health services and educational programs to youth and families in Palm Beach County to support healthy development and promote overall wellbeing. 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 resilience and other protective factors, these youth are often at higher risk of trauma and toxic stress, that if left unaddressed, may lead to increased use of unhealthy behaviors, which in turn increases their 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 & Family Counseling Division (RTFC) is comprised of three sections: Highridge Family Center (residential), Education and Training (outpatient, training, and outreach), and Youth and Family Counseling (outpatient and school-based).

Highridge Family Center

Highridge Family Center is a 60-bed residential facility serving Palm Beach County youth between the ages of 11-16 and their families through the Sanctuary Model of trauma-informed care. 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/or 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 youth 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 structure and therapeutic milieu activities for the youth on each house.

Education & Training Center

The Education & 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 services may be provided via telemental health or in-person. Clinical staff includes licensed psychologists.

The Education & Training Center serves as a training site for doctoral interns, postdoctoral fellows, and doctoral level practicum trainees. 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/or to fulfill requirements for diversionary programs. Family and individual (only ages 18-22) therapy services are offered to families and youth up to age 22 utilizing brief therapy models. Younger children, between the ages of 2 and 8, may also receive Parent-Child Interaction Therapy (PCIT). 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 or referred through select agency partners..

The Education & 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 and nursing disciplines. Trainings are provided to schools, community agencies, as well as Bachelor's level counselors, Master's level therapists, and Psychologists from Youth Services offices located throughout the county.

Youth & Family Counseling

The Youth & 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. Clinical services may be provided via telemental health or in-person. 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.

More information on the Palm Beach County Youth Services Department's Residential Treatment and Family Counseling Division, can be found at the following link: http://www.pbcgov.com/youthservices/counseling. Additional information on the training programs can be found by visiting the website at http://www.pbcgov.com/youthservices/EducationCenter.

Practicum Placement

The practicum placement is offered at the outpatient Education & Training Center, where practicum trainees are responsible for providing short-term (3 to 4 months) family therapy, individual therapy (only ages 18-22), intake assessments, provisional diagnosis, treatment planning and implementation, consultation, and case management. Trainees complete psychological evaluations, provide parent education/support/training, and conduct outreach activities, including presentations to staff, schools, and community agencies.

Aim and Competencies

The overall aim of the doctoral psychology training program at the Youth Services Department is to support the development of graduate student psychology trainees into professional psychologists by focusing on each of the nine broad profession-wide competency areas. Psychology trainees develop fundamental skills consistent with the mission of the Youth Services Department. The 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 psychology trainees will have opportunities to work with a range of diverse populations with a variety of presenting issues.

By the end of the practicum placement, trainees are expected to achieve competence appropriate to their professional developmental level in the following areas:

Competency 1: E*vidence-based practice in intervention*
Achievement of competence in the following broad areas is expected:

- Case conceptualization and treatment planning
- Implementation of therapeutic interventions
- Crisis intervention
- Therapeutic skills

Competency 2: E*vidence-based practice in assessment*
Achievement of competence in the following broad areas is expected:

- Diagnostic skill
- Instrument selection, administration, and scoring
- Test interpretation
- Clinical formulation
- Report writing
- Communicating results

Competency 3: *Interprofessional and interdisciplinary consultation*
Achievement of competence in the following broad areas is expected:

- Multidisciplinary collaboration
- Theories and methods of consultation

Competency 4: S*upervision*
Achievement of competence in the following broad areas is expected:

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

Competency 5: *Individual and cultural diversity*
Achievement of competence in the following broad areas is expected:

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

Competency 6: *Research*
Achievement of competence in the following broad areas is expected:

- Application of scientific knowledge to practice

Competency 7: *Ethical and legal standards*
Achievement of competence in the following broad areas is expected:

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

Competency 8: *Professional values and attitudes*
Achievement of competence in the following broad areas is expected:

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

Competency 9: *Communication and interpersonal skills*
Achievement of competence in the following broad areas is expected:

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

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. The training program is committed to evidenced-based practice by integrating the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. By the end of the year, trainees will be prepared with the knowledge, awareness, and skills of a practitioner specializing in youth and families. Our trainees are prepared for professional careers working with children and their families in an outpatient setting who present with a wide range of concerns.

All training activities are structured according to a developmental model, with trainees initially provided with closer and more detailed supervision as appropriate, with opportunities to master fundamentals in assessment, intervention, supervision/consultation, and laws/ethics. In all training experiences, trainees are challenged to build on their past experiences and to think autonomously.

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 Fellow, 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, individual therapy, group therapy, and milieu therapy. Therapy takes place in outpatient (Education & Training Center) and residential (Highridge) settings and includes individuals from a diverse range of ages, social and cultural groups, and socioeconomic levels. Individual therapy is reserved for youth between the ages of 18-22 in the outpatient office setting. Trainees will develop treatment plans with specific goals and objectives for each of their therapy cases. Telemental health services may be provided when appropriate.

Parent-Child Interaction Therapy (PCIT)

The Education & Training Center offers PCIT, an evidenced-based dyadic treatment, to select families with children between the ages of 2 and 8 who display disruptive behaviors. Internet (I-PCIT) services may be offered when appropriate. Interns may have the opportunity to shadow a PCIT case. Under some circumstances, interns may be involved in PCIT training in order to work towards requirements for obtaining certification as a PCIT Therapist.

Parenting

The Youth Services Department offers parenting services that can be provided via an individual or group format. During the outpatient rotation, curriculums developed from evidence-supported programs aimed at helping caregivers raise children in a safe, stable, and healthy environment may be utilized (i.e., STEP, ACT). Parent support groups are also offered depending on need. During the residential rotation, psychoeducation on parenting and parent groups are provided on a monthly basis.

Psychological Evaluation

Referrals for psychological testing come from within the Division and from select agencies funded by the Department. Trainees may also make referrals for their therapy clients to be tested. Full batteries include clinical interviews and assessment of intellectual, academic, 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 and scoring measures, obtaining peer review of scoring accuracy, writing integrated reports, and holding feedback sessions in a timely manner.

Intake Assessment

Intake assessments involve developing interviewing skills and gathering pertinent biopsychosocial and 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. Interns may also be involved in the initiation of involuntary hospitalization (Baker Act) as applicable to clients on their caseload.

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. During the residential rotation, multidisciplinary treatment teams meet regularly to discuss client care. 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 Activities

Didactic activities include attending and presenting at weekly YSD formal trainings, primarily offered virtually. Trainings take various forms, including lecture and demonstration, formal continuing education workshops, and presentations from practitioners and agencies that work in collaboration with YSD. 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 and assist with professional development. A tentative schedule is distributed at the beginning of the training year and updated periodically. Some topics include laws and ethics, professional development, intervention strategies, diagnostic issues, trauma informed care, child maltreatment, domestic violence, diversity considerations, and supervision. Many of the trainings offer continuing education units because YSD is an approved CEU sponsor by 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 and present at local workshops and conferences are also available.

Community Outreach

Opportunities to present trainings on a variety of mental health topics arise, and involve developing and providing such presentations at county-sponsored events as well as various community agencies. Developing and recording social media posts, creating mental health-related activity books, and writing articles on mental health topics is also considered an outreach activity. Outreach may also include discussing the services offered at the Youth Services Department at resource events/fairs in the community.

Supervision

Psychologists licensed in the state of Florida provide individual supervision to psychology doctoral trainees of all levels. Interns may provide mentorship to practicum trainee(s) as needed. 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.

Training Requirements & Expectations

The following requirements must be met to the satisfaction of the Training Director and clinical supervisors to receive a satisfactory certification of internship completion.

Education and Training Center: Practicum-Specific

1) Complete 8 months of training (minor variances may be approved).
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.
    - Participation required at Group Supervision (Tuesdays @ 1pm-3pm) and Didactic Trainings (Wednesdays @ 9:30am-11:30am).
3) Complete a minimum of 450 hours with at least 40% being direct service (at least 180).
    - On average, practicum trainees should carry a therapy caseload of 4 to 6 cases. This caseload will vary based on several factors including requests for services and time of the year. Caseload will also build at a rate corresponding with the strengths and prior experience of the trainee, as well as the direct service hours required.
    - Trainees are expected to monitor their hours and take the initiative to seek out additional activities to ensure their hour expectations are met.
4) Complete a minimum of 2 psychological evaluations. Based on client demand and training needs, more testing cases may be assigned at supervisor discretion.
    - Under circumstances in which the minimum testing requirement cannot be fulfilled (e.g., extended office closure due to natural disaster), trainees will be required to meet the competency via alternate means which may entail role-play, group supervision, didactic training, etc.
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) Attend, participate in, and present cases with supplemental audio/video recordings during weekly group supervision (2 hours).
    - A minimum of 4 case presentations with audio/video recording are expected.
7) Submit a minimum of 1 recorded session to a clinical supervisor for review prior to each evaluation period. A live session observation is also acceptable.
8) Attend weekly didactic trainings (2 hours) and submit evaluation forms for each.
    - If a didactic is missed due to illness or pre-approved vacation, the trainee is expected to review the recording of the didactic, obtain/read the handouts and discuss the content with their supervisor the following week.
    - No more than 2 trainings may be missed throughout the year. It is the trainee's responsibility to take this into account when planning time out of the office.
9) Provide a minimum of 1 community outreach presentation. When community needs arise, it is the expectation that trainees take advantage of opportunities presented by the Training Director or their direct supervisor regardless if minimum expectation has been met.

Education and Training Center: All Trainees

1) Attend 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 their supervisor as soon as possible.
2) Participate in Sanctuary Module Training of Trauma Informed Care training modules.
3) Provide therapeutic activities that emphasize family therapy, but may also include parenting, PCIT, 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.
4) Complete pre- and post-assessments of each family and individual therapy case (with consent). ACES and, if indicated the ITQ, should be completed with each applicable client.
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 the supervisor before the 3rd session. Information should be continuously added to the genogram while the family is in services.
    - ACEs questionnaire and Pre-ITQ/ITQ-C/A should be completed by identified patient before the 4th session.
    - Treatment plans (which include a case conceptualization) must be submitted to supervisor before the 4th session.
    - Post-ITQ/ITQ-C/A should be completed after the 10th session.
    - Satisfaction Surveys should be sent to or presented to each client/family no later than the final 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.
    - At least two 3 to 4 hour blocks of testing time should be scheduled at the onset of an assessment to ensure the family's commitment to the process.
    - 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 2 days.
    - 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.
    - Intake reports, treatment plans with case conceptualizations, and closing summaries should be sent to direct supervisor via email in a password protected Word document for review before being entered into CMP.
    - Once entered into CMP, psychosocial summaries, treatment plans/case conceptualizations, and closing summaries are automatically sent to supervisor for approval.
9) Attend weekly didactic trainings (2 hours) and submit evaluation forms for each the same day the training takes place.
    - During virtual trainings, trainees are expected to have their cameras on and should be attentive to the presenter and participatory in the chat. Trainees should not be multitasking during trainings.
    - If a didactic is missed due to illness or pre-approved vacation, the intern is expected to review the recording of the didactic, obtain/read the handouts and discuss the content with intern's supervisor the following week.
    - No more than 3 trainings may be missed throughout the year. It is the trainee's responsibility to take this into account when planning time out of the office.
    - The didactic trainings on Laws & Rules, Maintaining Professional Boundaries, Supervision, Consultation, and Program Evaluation are required to meet specific competencies and can only be missed under the most extenuating circumstances, and need to be made up in that event. Didactic trainings offered up until Thanksgiving provide foundational information for the training year. Therefore, it is strongly suggested that those also not be missed.
10) Leave (vacation or sick) may be taken as needed in accordance with the hours stipulated on the Trainee Leave Request Form. Prior approval, preferably 2 weeks in advance, must be obtained from all direct supervisors as well as the Training Director. Please note that a request for leave is not a guaranteed approval. It is the trainee's responsibility to notify clients in advance of any planned absence. It is also the trainee's responsibility to reschedule supervision if missing a scheduled meeting. If a didactic training, supervision series, or journal club is missed due to illness or pre-approved vacation, trainees are expected to obtain/read the information and discuss the content with their supervisor the following week. No leave time may be taken during the final week of the training program.
11) On occasion, trainees 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, program, didactic training).
14) 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 representatives of the Youth Services Department and of the County, and therefore dress and appearance should be professional. Trainees are expected to dress in business casual attire. We understand that everyone has their own unique style; however, certain items are simply inappropriate. Please refer to the 'Dress, Grooming, and Hygiene Guidelines' for more detailed information and consult with supervisors if any questions remain.
2. *Adherence to deadlines*: Trainees are expected to complete and submit tasks (e.g., didactic presentation PowerPoints, Journal Club articles, psychological evaluation reports) by the deadline that is assigned by supervisors. If a trainee believes they are unable to complete the task by the deadline given, they should communicate this and discuss with their supervisor in a timely manner.
3. *Punctually attend and engage in scheduled activities.* 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. Additionally, forgetting about appointments or double booking clients is unacceptable and poor customer service. These errors can be avoided by keeping Outlook and CMP calendars up to date. Trainees must abide by agency office hours and request permission from their supervisor(s) in advance when they expect any change to their schedule.
4. *Communication with supervisors and office staff when absent or late*. If a trainee expects to be absent from or late to 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 is notified, and the information may be passed on. Clients can then be contacted regarding their sessions. If session cancellations are necessary, trainees are expected to specify which clients need to be contacted on their behalf. Personal cell phones should never be used to contact clients.
5. *Responsiveness to emails*. Trainees are expected to respond to supervisor(s) and other work-related emails in a timely fashion. As a general rule, emails should be reviewed and responded to within the same business day they are received.
6. *Behave honestly, appropriately, and with integrity at all times*. Trainees are required to behave and conduct themselves in a professional business manner. Any conduct that is considered to be 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. Avoid the use of cell phones as well as multitasking during didactic trainings and other group meetings. Everyone is expected to remain focused on the activity at hand and avoid distractions that impede the learning process.
7. *Cooperation with colleagues is essential*. Trainees and staff consist of a variety of disciplines and must work together in the best interests of the youth and their family. Disagreements about an intervention or course of treatment are to be expected, and should be resolved in a respectful and professional manner. 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 their shared office space in which they conduct therapy, store personal belongings, and share voicemail.
8. *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, whether in-person or virtual.
9. *Confidentiality and dual relationships.* If a client of Youth Services is known to a trainee from another field placement, another agency where employed, or from other life roles (e.g., realtor, child care, etc.), care must be taken to maintain confidentiality and honor ethical guidelines regarding dual relationships. It is prohibited to initiate or solicit any contact outside of the therapeutic work environment with any current clients. It is unethical and against Palm Beach County policy to continue services with your clients upon termination from the Youth Services Department.

Supervision

Individual Supervision Description

Interns receive a minimum of 2 hours of individual clinical supervision each week by licensed psychologists. This is routinely supplemented by brief and spontaneous discussions between supervisors and interns.

Supervisor Selection Standards. Minimum standards for appointment as intern 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. Telesupervision will be utilized in conjunction with in-person supervision, depending on the locations of the supervisor and the trainee. Please refer to Telesupervision Policy for more specific information on this supervision modality.

Work Products. Supervisors review and approve intake assessment reports, genograms, treatment plans, case conceptualization/psychosocial summaries, substantive case notes, written correspondence, closing/discharge summaries, and evaluation/assessment reports. Supervisors co-sign closing/discharge summaries and evaluation/assessment reports. Trainees receive ongoing instruction/feedback on documentation and 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, and as outlined in the intern expectations and the Documentation Manual. Refer to 'Record Keeping Guidelines' for additional information.

Recording Sessions. Supervisors require trainees to audio and/or video record evaluation or treatment sessions for supervision purposes, with the consent of the client. Audio/video recordings 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. Refer to 'Audio and Video Recording Guidelines' for additional information.

Site Mentors. Role models are available at each rotation site, including other psychologists as well as postdoctoral fellows, staff from other disciplines (i.e., social work, mental health counseling, marriage and family therapy, nursing) and non-licensed mental health 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

Within each six-month rotation, interns attend a minimum of 2 hours per week of group supervision with a minimum of one licensed psychologist as well as the therapists and trainees working at each site. Initial group supervision sessions may include training on various topics to acclimate students to YSD, which may include follow-up discussions on orientation content, ongoing announcements, and overviews of collaborative diversion programs. Subsequent group supervision meetings may include brief presentations from organizations funded by YSD and community partners that offer services relevant to clients served. The group will also be asked to read articles/book chapters for discussion during group supervision. Interns are expected to present and discuss therapy and evaluation cases at group supervision meetings. They are expected to bring audio/video clips to accompany their presentation. Live sessions may also be scheduled. Group supervision case presentations should include the following outlined topics. It is up to the presenter to determine the best way to cover all of the information.

Case Presentation Outline

- Question(s) to the team, reason this case is being presented
- Description of the family
    - complete genogram (ideally three generations)
        - note intergenerational trauma
        - note trauma reenactments
        - note areas of loss and change
    - cultural considerations (e.g., race, ethnicity, sexual orientation, religion, SES, etc.)
    - sources of trauma and adversity for the family (ACES)
    - family's resiliency factors
- Presenting problem through a trauma lens from the perspective of
    - the family
    - the therapist
- Number of sessions attended
- Diagnoses considered
- Treatment goals – identify elements of Safety, Emotions, Loss, and Future (SELF)
- Course of treatment, trauma-informed interventions, and family's response to interventions
    - Integrate 7 Commitments
- A self-evaluation of your effectiveness
- Case conceptualization (consider evidence-based treatment and incorporate SELF)
- Recording of a session, cued to a relevant segment
- Reiterate question(s) to the team, reason why case is being presented

Telesupervision Description

The Youth Services Department (YSD) uses telesupervision, or the supervision of psychological services through a synchronous audio and video format. YSD recognizes the importance of supervisory relationships. Given the geographical distance between training sites, this model allows trainees to form a greater connection to the entire training faculty and training cohort than would be experienced otherwise. It is expected that the foundation for supervisory relationships will be cultivated initially during orientation and subsequently during other in-person meetings and interactions. When feasible, supervision is scheduled face-to-face; however, when scheduling does not permit and/or travel is an obstacle, telesupervision may be used instead. Trainees involved in peer supervision may also utilize telesupervision when they work at different training sites.

Telesupervision is utilized in accordance with the Standards of Accreditation set forth by the American Psychological Association. 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 in-person supervision is not feasible.

When more than one supervisor is assigned, the primary rotation's on-site supervisor(s) maintain(s) full professional responsibility for the clinical cases under the care of the intern unless arrangements are made with at least one other licensed psychologist or other licensed mental health professional to cover for non-scheduled consultations, time-sensitive issues, and crisis situations. Intern caseloads should be divided up amongst on-site supervisors so it is clear to everyone which supervisor maintains primary responsibility for each case. When utilizing telesupervision, both the intern 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 supervisor and the intern that both the audio and video quality of the connection is adequate for the proper conduction of supervision.

All telesupervision utilized by YSD occurs over a secure network. Supervision sessions using this technology are never recorded unless explicitly consented to. A remote videoconference platform (i.e., Zoom) is utilized. Each trainee is set up with a HIPAA-compliant Zoom account, and Zoom training is provided during orientation. 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 & Training
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*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. 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.

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 using the graduate program's evaluation form. Trainees complete a self-assessment baseline at the beginning of the training year, and then assess their performance on the same schedule as supervisors. Supervisors are expected to review these evaluations with trainees and provide an opportunity for discussion and feedback.

Rating of Trainee Experience

In order to provide feedback that will inform any changes or improvements to the training program, trainees are encouraged to informally provide feedback on their experience throughout the training year. Trainees formally rate their clinical supervisors at the midpoint and end of the training year. A Program Evaluation is also completed at the midpoint and end of the training year to evaluate the overall experience of the trainee during each semester. In addition, 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 practicum trainees, this is done by completing and submitting the graduate program's evaluation forms at midyear and end of the training program. If significant clinical or professional concerns arise that are not able to be remediated by informal means, the graduate program is notified of any further action that may be taken by as a result of the Due Process procedures, up to and including termination from the program. The Due Process guidelines can be found in the Handbook.

Selection and Academic Preparation Requirements

Application Process

To be considered for the Youth Services Department practicum program, trainees must meet the following requirements before the start of practicum:

- Receive doctoral training in clinical psychology from an APA-accredited doctoral program
- Complete coursework in intellectual assessment, intervention, diversity, and ethics (may be concurrent with practicum)
- At least 1 year of experience in face-to-face clinical contact (i.e., conducting intakes, biopsychosocial interviews, and some form of therapy)
- Demonstrate potential for a career in clinical psychology with an emphasis on child, adolescent, and/or family clinical assessment and intervention
- Demonstrate cultural sensitivity
- Exhibit good interpersonal and organizational skills, flexibility, and ability to handle multiple tasks
- Before the start of the placement, Youth Services Department trainees must complete a Level 2 background check with fingerprints. Disqualifying offenses are listed in the Florida statues under Chapter 435.04(2). The following is a link to this statute for reference: Statutes & Constitution: View Statutes: Online Sunshine (state.fl.us).

Interested trainees should submit the following materials to the Training Director:

- Cover letter
- Current Curriculum Vita
- A de-identified child or adolescent psychological evaluation report
    1. must contain a measure of intellectual assessment
    2. preferably non-neuropsychological report

Interview Process

Interested trainees (applicants, those assigned by the graduate program, etc.) will be invited for in-person interviews. Depending on which setting (outpatient or residential) the applicant it interested in, psychologists from either the Education & Training Center or Highridge Family Center will conduct interviews.

The Youth Services Department practicum training program will base its decision to accept students on the interview, materials provided, and criteria noted above. The following is also considered when making this determination:

- Experience working with children, adolescents, and families
- Training and/or class(es) in family and systemic theory
- Psychological/psychoeducational testing experience (for the outpatient placement)
- Experience working in a residential facility (for the residential placement)
- *Individuals with Spanish bilingual skills are strongly encouraged to apply*

The timeline of the interview process and notification of acceptance is determined by the trainee's graduate program's deadlines.

Training Director Contact Information

Shayna Ginsburg, Psy.D.
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email: sginsbur@pbc.gov
website: http://www.pbcgov.com/youthservices/EducationCenter

Clinical Staff Job Descriptions

Residential Treatment and Family Counseling Division

Division Director

Oversees all clinical programming within the Youth Services Department's Residential Treatment and Family Counseling Division, which includes the following programs: Education & Training, Youth & Family Counseling, Highridge Family Center, Family Violence Intervention Program, and Court Psychology.

Education & Training Center

Chief of Clinical Services, Education & Training

The Chief of Clinical Services at the Education & Training Center requires a doctoral degree in psychology and license to practice in the state of Florida. As the administrator of the Education & Training Center, responsibilities include supervising the clinical and clerical staff, overseeing therapy and psychological evaluation services, program development, evaluating services provided, maintaining the electronic system of agency clients, and serving on the management team developing and implementing the Division's 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 & 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), serves as the liaison between trainees and graduate school programs, and provides clinical supervision to graduate and post-graduate level trainees.

Youth Services Psychologists

The Youth Services Psychologists require a doctoral degree in psychology and license to practice in the state of Florida. The psychologists provide 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 to 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 Beach, and West Palm Beach) and satellite locations. As the administrator of Youth and Family Counseling, the Chief of Community Based Clinical Services 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 the Youth and Family Counseling (Belle Glade, Delray Beach, and West Palm Beach) offices. 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.

Family Violence Intervention (FVIP) Program Coordinator

The FVIP Program Coordinator is responsible for coordinating referrals and supervising clients involved in the Family Violence Intervention Program (FVIP). The FVIP 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 FVIP Program Coordinator consults with the Chief of Community Based Clinical Services on 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 youth and families 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 3 to 4 months, and develop a case summary with recommendations at the end of treatment. Therapists also provide school based services and interact with social service agencies and other professionals in order to provide client-needed services. Referrals and follow-up are required. Therapists may also provide clinical/task supervision to interns from graduate programs.

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 staff. The Chief also evaluates program efficacy, implements changes for program development, encourages adherence to policies and procedures, and handles personnel and client-related issues. 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 a licensed clinician and 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 the residential youth counselors who work on the dorms and the interviewing and selection of such staff. Other responsibilities include providing staff training and consulting with staff as situations arise within the milieu. The Residential Counseling Coordinator is available as an additional resource and support person for doctoral psychology trainees and other staff in the absence of a licensed psychologist and/or clinical supervisor.

Psychologist, Sanctuary Coordinator

The Psychologist and Sanctuary Coordinator is responsible for the ongoing 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 ensures that facility staff continue to provide trauma-informed programming that meets recertification standards of 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 provide individual and/or group supervision to graduate and postgraduate psychology trainees.

Court Psychologist

Provides forensic evaluations and expert testimony for court referred youth. Participates in clinical supervision and programming at Highridge Family Center and is a member of the Sanctuary Core and Training Teams. The court psychologist also provide clinical supervision to doctoral psychology trainees completing clinical placements.

Therapist

The Therapist requires a master's or doctoral degree in social work, marriage and family therapy, mental health counseling, or psychology, and has 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 youth and families. 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 and 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 youth in emotional regulation, conflict resolution, and development of a therapeutic milieu using the Sanctuary Model.

Residential Nurse Manager

The Residential Nurse Manager supervises 2 Licensed Practical Nurses (LPNs), the school behavioral staff, and the night shift. 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 medical 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.

Management of Training Program

Training Director

The Training Director is the overall supervisor of the training program. The Training Director is responsible for administration of the internship, and ensuring that training standards are met.

Appointment. The Training Director is a designated career-service Psychologist position reporting to the Director of the Youth Services Department's Residential Treatment & Family Counseling Division. The appointment is limited to individuals who meet the following criteria:

1. Earned a doctoral degree in clinical psychology from an APA accredited institution.
2. Completed an APPIC-member internship in clinical or counseling psychology.
3. Licensed under Florida statute 490 as "Psychologist."

Responsibilities. The Chief of Clinical Services, Education & Training is responsible for serving as the Training Director. Responsibilities assigned to the Training Director include:

1. Chairing the Training Committee.
2. Coordinating trainee selection and recruitment.
3. Assisting trainees with entering and exiting the county personnel system at the beginning and end of the training year.
4. Coordinating the designation and assignment of rotations/tracks.
5. Reviewing performance evaluations and expectations with trainees and supervisors.
6. Meeting regularly with the trainee cohorts (e.g., Training Director Meeting).
7. Coordinating schedules of training events.
8. Ensuring that the internship and fellowship adhere to Association of Psychology Postdoctoral and Internship Centers (APPIC) guidelines and policies.
9. Ensuring the internship meets American Psychological Association (APA) accreditation standards.
10. Ensuring the program complies with applicable Agency Affiliation Agreements.
11. Preparing reviews and self-studies of the training program to submit to the Youth Services Department administrative officers.
12. Monitoring clinical supervision.
13. Coordinating midyear and final evaluations and submission of reports to graduate programs.
14. Coordinating didactic training, seminars, and workshops.

Training Committee Members

1. Training Director/Chief of Clinical Services, Education & Training
2. Chief of Residential Clinical Services
3. Other Youth Services Psychologists
4. Division Director, Residential Treatment & Family Counseling

Responsibilities. The psychologists at Highridge and the Education & Training Center serve as clinical supervisors. Site supervisors are aware that the Training Director has an open door policy with regard to issues or concerns regarding the training program and the trainees.

The Training Committee meets on an established date/time each month. During monthly training committee meetings, each trainee's progress toward achieving direct service and supervision hours is reviewed and general training issues/concerns are discussed. Training committee meetings are the forum for training matters. Decisions made by the Committee are used as recommendations for the Training Director, who makes the final decision regarding training related matters.

Meetings. The Training Committee meets on the second or third Monday of each month, unless rescheduling is necessary due to office closure or other circumstances. A tentative schedule is distributed at the beginning of the training year. Special meetings may be called as needed. Committee members are expected to attend and participate.

The Training Director and Site Supervisors meet periodically in clinical team meetings to address the management of the practicum, internship, and postdoctoral programs, as well as trainee progress. A discussion of evaluations occurs at these meetings. If a trainee concern must be addressed or due process procedures need to be initiated, a meeting with the appropriate participants is scheduled.

Bi-weekly management meetings are attended by the Division Director; the Chief of Clinical Services, Education & Training; the Chief of Residential Clinical Services; and the Chief of Community Based Clinical Services. The Department Director is occasionally in attendance at these meetings. Although all business related to the Division is discussed during these meetings, this is also the forum to address programmatic and/or personnel concerns related to the training program.

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 and whole health 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. Our focus is on facilitating safe, healthy relationships so families can heal together in our community.

The Youth Services Department operates within a trauma-informed care environment as outlined by Sanctuary Model®. During August 2016, the Youth Services Department began a three-year process to initiate implementation of the Sanctuary Model®, an evidence-supported trauma-informed care model. This included training, education, and changes to department and program policies. In May of 2019, Highridge Family Center became certified in the Sanctuary Model®.. Highridge is the first child and adolescent residential facility of its kind to be certified in Florida. The Youth Services Department then embarked upon the expansion of the Sanctuary Model®. department-wide, and was awarded initial certification in September 2022. A re-certification site visit took place in May 2025, and the Youth Services Department successfully maintained its certified status. In three years, another re-certification site visit will be scheduled.

The Sanctuary Model® was created by Sandra Bloom, a psychiatrist; Joseph Foderero, a social worker; and Ruth Ann Ryan, a nurse manager. Around 1985, this treatment team began to realize that most of the people they were treating in a psychiatric unit 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. The model demands an organizational culture shift in mindset to help us ask the question "What happened to you" instead of "What's wrong with you?" The Sanctuary Model®, also acknowledges restorative practices, in that it is about working ***with*** people instead of doing things ***to*** them or ***for*** them. Sanctuary 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. These seven commitments are incorporated into our interactions with families, including therapy and psychoeducation.

Trainees will receive didactic training and other materials/resources at the beginning of the program related to the Sanctuary Model®. Throughout the year, trainees will be required to attend meetings related to the Sanctuary Model. Trainees will expand their skills in trauma-informed practice and begin to view families through a trauma lens utilizing the SELF-framework and incorporating the 7 commitments. The SELF framework is a way of problem solving that targets the areas disrupted by trauma or significant life events, (i.e., Safety, Emotions, Loss, and Future). Additionally, trainees will become more familiar with trauma conceptualizations and utilize the following tools of the Sanctuary toolkit: community meeting, safety plans, Solutions in Motion (SIM) meetings, psychoeducation, treatment planning, team meetings, and self-care.

Family Therapy Overview

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

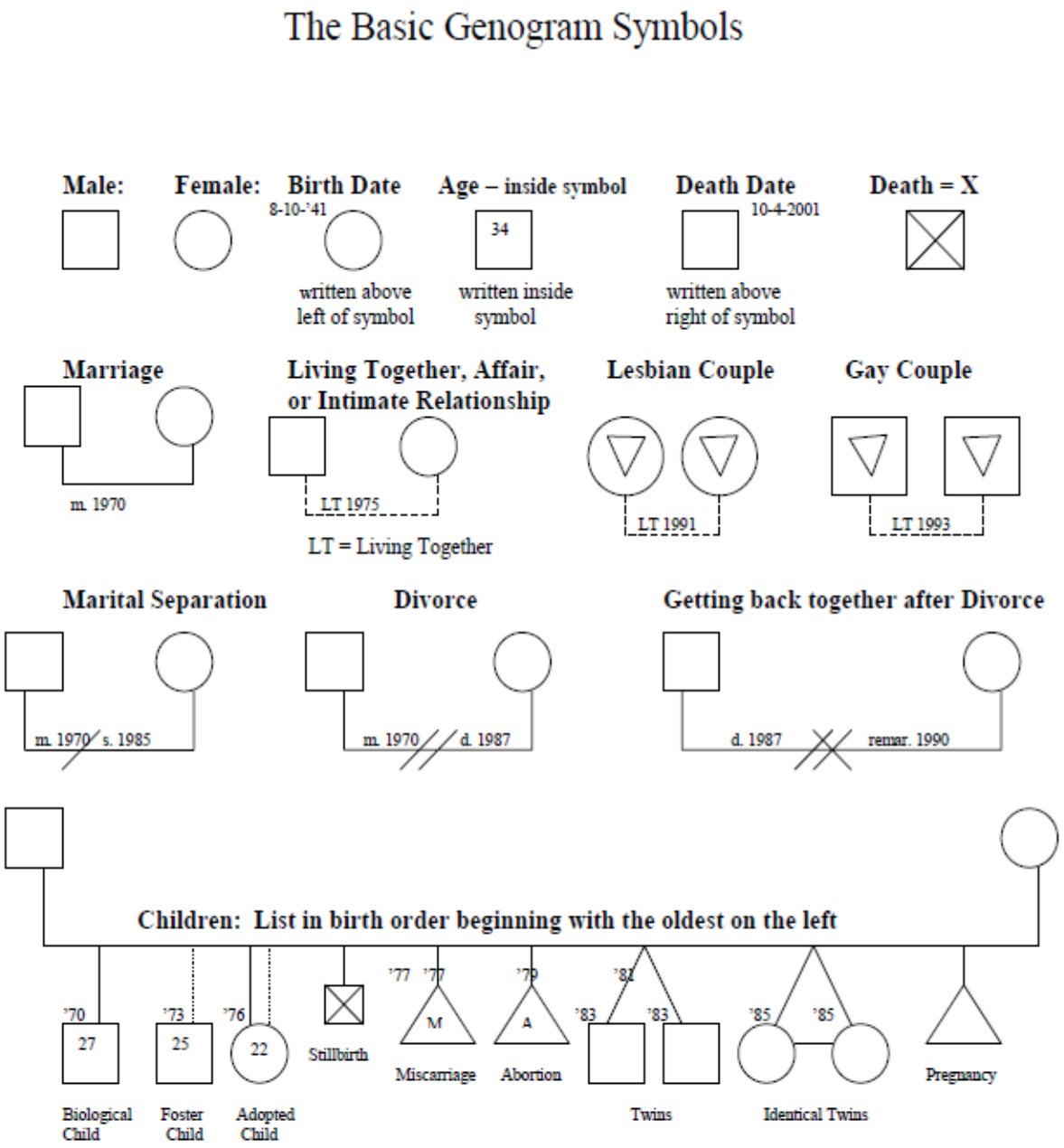
Documents on family therapy modalities and major marriage and family therapy models are available on the common drive with detailed information on specific forms of family therapy.

Family Therapy Deadlines

1.) Genogram – Initial draft completed by 3rd session and scanned into CMP. Information should be continuously added to the genogram while the family is in services, with the final genogram scanned into CMP at termination.
2.) Pre-ITQ/ITQ-C/A and ACEs questionnaire completed by for the 4th session.
3.) Treatment Plan with Case Formulation– Completed and signed by family by 4th session
4.) Treatment Plan Review – Completed between 6-8th session of treatment
5.) Post-ITQ/ITQ-C/A completed after the 10th session.
6.) Satisfaction Survey – Completed before last session
7.) Closing Summary- Due to supervisor within 5 days of final session

*Trainees are encouraged to utilize the Case Tracker spreadsheet found in the Student-Trainee Folder in the common drive to keep track of above deadlines. If deadlines are not being met, the Case Tracker may be required by the supervisor(s).

Genograms

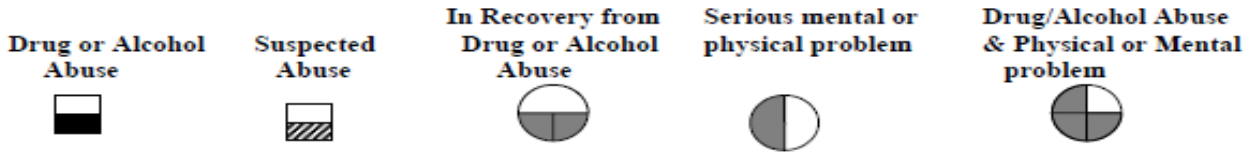


- Two people who are married are connected by lines that go down and across, with the husband on the left and the wife on the right.
- Couples that are not married are depicted with a dotted line.
- Children are drawn left to right, going from the oldest to the youngest.

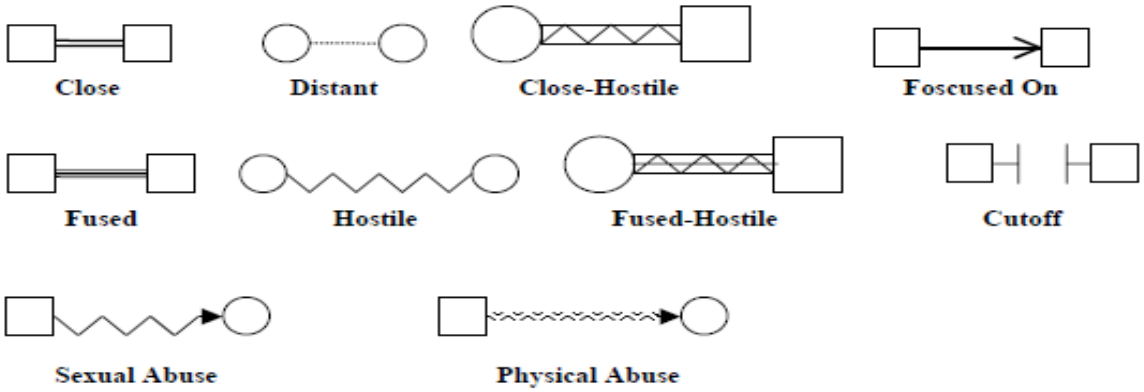
CMP 105
Family / Child Assessment
12/2005
SJ

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



Permanent Resource Book

Parenting Services 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 & Training Center or at one of the Youth & 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 & Training Center or at one of the Youth & Family Counseling offices. Check with a team member from the Education & Training Center to determine availability for group format.

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 are completed during sessions and chapters from STEP book are provided to review throughout the week. There are different versions of the STEP book available for young children, school-aged children, and adolescents. 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 for Children (please see additional outlines for Young Children and Teens located on the (G:)drive)

- 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 is a dyadic parenting intervention aimed at improving the family system by modifying the behavior of both the parent and the child (Kennedy et al., 2014). PCIT services are offered in a dyadic 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 certified provider and as such, PCIT is only available at the Education & Training Center. The service is available for parents of children between the ages of 2 through 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 services are offered following a selective prevention model, which typically entails 12 to 18 sessions. Child behavior progress is monitored each session by having parents complete the Eyberg 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

Youth Court - Palm Beach County School Police

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 Turning Point Academy (1950 Benoist Farms Road, Community 1, **West Palm Beach, Florida 33411).** Subsequent trials and arbitrations are held at the North County, South County, or Belle Glade Courthouse, or at Forest Hill Elementary School. Some cases that are processed by Youth Court will receive an order to come to Youth Services for therapy 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, they 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.

Once a client meets with a representative of the Youth Court program, they are instructed to contact Youth Services to schedule services. When the family calls, an intake is scheduled and the therapy case is seen by the appropriate Youth Services office. Other times, Youth Court clients are referred via a faxed copy of the Court Referral for Services form as well as a Case Journal. When a faxed referral is received, Youth Services contacts the family, schedules an intake, and the therapy case is seen by the appropriate Youth Services office.

Treatment at YSD

- 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. 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 also faxed to Youth Court at 561-434-8356.
- *For Ed Center team members, a full "Discharge Closing summary" should also be added to the client's chart and completed.*
- 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 another opportunity 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- 434-8356.

Youth Court Contact Personnel

***Officer Cecil Wagner**	Phone: (561) 310-5370	Fax: (561) 434-8356	**Cecil.Wagner@palmbeachschools.org**
Officer Anthony Morales	Phone: (561) 310-5370	Fax: (561) 434-8356	**Anthony.Morales@palmbeachschools.org**
Officer Tyron Arnett	Phone: (561) 891-8118 (O) (561) 261-2674 (M)	N/A	**Tyron.Arnett@palmbeachschools.org**
Pamela Torres, Case Manager	Phone: (561) 310-5370	Fax: (561) 434-8356	**Pamela.Torres@palmbeachschools.org**
Marie Nazaire Administrative Assistance	Phone: (561) 310-5370	Fax: (561) 434-8356	**Marie.Nazaire@palmbeachschools.org**

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 & 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 in person or via telemental health.

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), Telemental Health Consent 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 6 families/participants 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.

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;

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 14 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.

FVIP attendance reports for intake, family therapy sessions, and group therapy sessions are obtained 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. If the family either no shows or cancels (misses) 3 sessions the family will be closed from outpatient 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.** 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, 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 that 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 client will contact their court case advisor for next steps.

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 14 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 often 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 Court 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 result in 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 to 14 sessions. Teens and parents both attend 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 14 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 6 families/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. If a family is late 15 minutes or more, they will not be admitted to the group. 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.

The FVIP group location is as follows:

- **YFC-Four Points** office provides group services on **Wednesdays** from **5:30pm to 7:00pm.**
    - This group takes place at 50 South Military Trail, Suite 203, West Palm Beach, FL 33415; 561-242-5714.

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

Contact Personnel

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**
- **Stephanie Singletary, BS (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 a Safety Plan**

- 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.
- Making a Safety Plan and Safety Plan Rules
    - Exercise: Strengths, Challenges, Changes
- Discussion: Changing Your Own Behavior
    - Exercise: What Happens When We Try to Make Our Teens Change
- Discussion: Goal Planning
    - Exercise: Goal Planning
- Discussion: Overview of the Safety Plan
    - Exercise: Make Your Personal Safety Plan
    - Exercise: Share Safety Plans with the Group

Session #2 – **Understanding Warning Signs**

- Identify Personal Red Flags
- Identify Self Calming Thoughts
- Discussion: Red Flags
    - Exercise: Identifying Red Flags in Your Teen
    - Exercise: My Own Red Flags: Identifying Parent Red Flags
- Discussion: Self-Calming Thoughts
    - Exercise: My Self-Calming Thoughts

Session #3– **Combined– Understanding Feelings**

- Identify Relationship Between Power and Anger
- Discussion: Using Anger to Justify and Gain Power
- Discussion: Identifying Feelings
    - Exercise: Identifying Feelings
    - Exercise: Anger Scenarios

Session #4 – **Understanding Self-Calming**

- Discussion: Review Progress
- Gain Understanding About How the Brain and Nervous System Function in Relation to Emotion, Anxiety and Stress
- Learn Specific Strategies to Calm the Nervous System and Improve Mood
- Discussion: You Can Change Your Brain
- Discussion: Understanding your Brain and Nervous System
- Discussion: Brian's Story
- Discussion: Calming Strong Emotions
    - Exercise: How Can We Activate Our Pre-frontal Cortex?
    - Exercise: My Self-Calming Plan
    - Exercise: Mindfulness Meditation

Session #5 – **Combined- Understanding Self-Talk and Beliefs**

- Discussion: Review Progress Understand Self Talk and Beliefs
- Meditation / Relaxation Activity
- Discussion: Who Controls Our Behavior Discussion: Self Talk
- Discussion: Changing Negative Self Talk Into Helpful Self Talk
    - Exercise: Changing Negative Self Talk Into Helpful Self Talk

Session #6 – **When Your Teen Is Abusive: Effects on Parenting**

- Discussion: Review Progress
- Understand How Living With A Teen Who Becomes Abusive or Violent Can Impact Parenting
- Discussion: Parenting A Teen who Becomes Violent or Abusive
- Discussion: Challenges for Parents
    - Exercise: Feelings, Thoughts and Responses to Your Teen's Behavior
    - Exercise: Changing Your Thinking

Session #7 – **How to Respond When Your Teen is Violent**

- Discussion: Review Progress
- Help Parents Think About Their Priorities When Their Teens are Becoming Violent
- Understand That Safety is the First Concern When Anyone is Using Violent Behavior
- Discussion: Your Priorities When Your Teen Becomes Violent
- Discussion: How to Respond When Your Teen Becomes Violent
- Discussion: What To Do After: Addressing Violent Behavior
- Discussion: Safety Planning
    - Exercise: Safety Plan for Our Home
- Discussion: Prevention Strategies- Disengaging from Power Struggles with Your Teen

Session #8 – **Combined – Assertive Communication/Using "I" Statements**

- Discussion: Review Progress
- Examine Different Styles of Communication
- Learn Skills for Assertive Communication
- Learn How to Use "I" Statements
- Discussion: Styles of Communication
    - Exercise: Styles of Communication Scenarios
    - Exercise: Practicing Assertive Communication

Session #9 – **Guiding Change in Your Teen with Restorative Parenting and Safety Plan Review**

- Discussion: Review Progress
- Learn About Restorative Process
- Discussion: Reframing Consequences
- Discussion: The Purpose of Consequences
- Discussion: Restorative Parenting
- Discussion: Applying Restorative Parenting to a Scenario
- Practice: Applying Restorative Parenting Role Plays
- Review Safety Plans and help with revisions, if needed.

Session #10 – **Combined- Accountability through Restorative Practice**

- Discussion: Review Progress
- Understand the True Meaning of Accountability Recognize How We Avoid Accountability
- Discussion: What is Accountability
- Discussion: What People Do Instead of Being Accountable
    - Exercise: Avoiding Accountability Scenarios
- Discussion: Taking Responsibility for Behavior Using Six Restorative Steps
- Practice: Applying the Six Restorative Steps

Session #11 – **Empowering Teens to Be Responsible for Their Behavior**

- Discussion: Review Progress
- Identify Parent Responsibilities and Teen Responsibilities
- Help Teens Take Responsibility for Their Behavior
- Discussion: Who is Responsible for What?
    - Exercise: Giving My Teen Responsibility
- Discussion: Empowering Teens to Be Responsible for Their Behavior

Session #12 – **What Kinds of Messages Are You Giving Your Teen**

- Discussion: Review Progress
- Recognize How You Give Underlying Messages Whenever You Talk To Your Teen
- Realize How These Messages Affect Your Teen's View of Himself Herself
- Discussion: What Kind of Message Are You Giving Your Teen?
    - Exercise: Messages We Give Our Teens
    - Exercise: Giving Our Teens the Message That They Are Capable

Session #13**- Combined – Guidelines for Respectful Communication and Problem Solving Together**

- Discussion; Review Progress
- Learn and Practice Talking About a Problem
- Learn and Practice How To Listen and Say Back What You Heard
- Apply Respectful Communication Skills Learned to Solve A Problem
- Discussion: Guidelines for Respectful Communication
    - Exercise: Respectful Communication Exercise
- Discussion: What Is Problem Solving?
- Discussion: Tips for Problem Solving.
- Discussion: Ten Steps for Solving A Problem.
    - Exercise: Problem Solving Practice.

Session #14- **Listening To Your Teen**

- Discussion: Review Progress
- Discussion: What Is Not Listening
- Discussion: How to Listen
- Discussion: Acknowledging Feelings
- Exercise: Acknowledging Feelings Scenarios
- Discussion: Tips for Acknowledging Feelings

FVIP Teen Group Description

Session #1 – **My Family Relationship and Making a Safety Plan**

- 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
- Discussion: Overview of the Safety Plan
    - Exercise: Make Your Personal Safety Plan
    - Exercise: Share Safety Plans with the Group

Session #2 **– Understanding Warning Signs and Understanding Violence**

- Identify Personal Red Flags and Self Calming thoughts
- Define Violent and Abusive Behaviors and the Payoffs, Outcomes and Consequences of Violence and Abuse
- Discussion: Red Flags
    - Exercise: My Red Flags
    - Exercise: My Own Red Flags: Identifying Parents Red Flags
- Discussion: Self- Calming Thoughts
    - Exercise: My Self-Calming Thoughts
- Discussion: Violent and Abusive Behavior
- Discussion: Payoffs, Outcome and Consequences of Violent and Abusive Behavior
    - Exercise: Payoffs, Outcomes and Consequences
- Discussion: Choices

Session #3 – **Combined Session – Understanding Feelings**

- Identify Relationship Between Power and Anger
- Discussion: Using Anger to Justify and Gain Power
- Discussion: Identifying Feeling
    - Exercise: Identifying Feelings
    - Exercise: Anger Scenarios

Session #4 – **Learning Self Calming**

- Discussion: Review Progress
- Gain Understanding About How The Brain and Nervous System Function
- To Learn Specific Strategies To Calm The Nervous System and Improve Mood.
- Discussion: Review Progress
- Discussion: You Can Change Your Brain
- Discussion: Understanding Your Brain and Nervous System
- Discussion: Brian's Story
- Discussion: Calming Strong Emotions
    - Exercise: How Can We Activate Out Pre-Frontal Cortex? How Can We Activate Our Para-Sympathetic Nervous System
    - Exercise: My Self-Calming Plan
    - Exercise: Mindfulness Meditation

Session #5 – **Combined – Understanding Self-Talk and Beliefs**

- Discussion: Review Progress
- Understand Self Talk And Beliefs
- Meditation / Relaxation Activity
- Discussion: Who Controls Our Behavior
- Discussion: Self Talk
- Discussion: Changing Negative Self Talk Into Helpful Self Talk
- Exercise: Changing Negative Self Talk Into Helpful Self Talk

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

- Discussion: Review Progress
- Learn To Identify Feelings, Self-Talk And Beliefs Experienced During Difficult Situations
    - Exercise: Turning Hurtful Moves Into Helpful Moves
    - Exercise: Turning Your Own Hurtful Moves Into Helpful Moves

Session #7 – **Understanding Power and Respect (Wheel Handout)**

- Discussion: Review Progress
- Identify Personal Power
- Identify Negative and Positive Uses of Power
- Discussion: How We Use Power In Positive And Negative Ways
- Discussion: Ways We Have Personal Power Using Our Strengths And Skills.
    - Exercise: Identifying Our Personal Strengths And Skills
    - Exercise: Using Personal Power

Session #8 – **Combined – Assertive Communication/ Using "I" Statements**

- Discussion: Review Progress
- Examine Different Styles Of Communication
- Learn Skills For Assertive Communication
- Learn How to Use "I" Statements
- Discussion: Styles Of Communication
    - Exercise: Styles Of Communication Scenarios
    - Exercise: Practicing Assertive Communication

Session #9 – **Making Amends and Safety Plan Review**

- Discussion: Review Progress
- Learn To Show Accountability By Identifying Specific Things That Can Be Done To Make Amends For Abusive/Violent Behavior
- Discussion: Making Amends
    - Exercise: Making Amends Scenarios
    - Exercise: Making Amends Worksheet
- Review Safety Plans and Make Revisions, If Needed.

Session #10 – **Combined – Accountability through Restorative Practice**

- Discussion: Review Progress
- Understand The True Meaning Of Accountability
- Recognize How We Avoid Accountability
- Discussion: What Is Accountability

- Discussion: What People Do Instead of Being Accountable
    - Exercise: Avoiding Accountability Scenarios
- Discussion: Taking Responsibility for Behavior Using Six Restorative Steps
- Practice: Applying The Six Restorative Steps

Session #11 –**Understanding Responsibility**

- Discussion: Review Progress
- Compose a Responsibility Letter To The Victim Of The Teen's Violence
- Discussion: What Is A Responsibility Letter
- Discussion: Sample Responsibility Letter
    - Exercise: Two Versions of What Happened.
    - Exercise: Practice Responsibility Letter
    - Exercise: Writing the Responsibility Letter

Session #12 – **Understanding Empathy**

- Discussion: Review Progress
- Define Empathy And How It Can Have A Positive Impact On Relationships
- Discussion: Empathy And Its Impact On Relationships
    - Exercise: Empathy Letter

Session #13- **Combined- Guidelines for Respectful Communication and Problem Solving Together**

- Discussion; Review Progress
- Learn and Practice Talking About a Problem
- Learn and Practice How To Listen and Say Back What You Heard
- Apply Respectful Communication Skills Learned to Solve A Problem
- Discussion: Guidelines for Respectful Communication
    - Exercise: Respectful Communication Exercise
- Discussion: What Is Problem Solving?
- Discussion: Tips for Problem Solving
- Discussion: Ten Steps for Solving A Problem
    - Exercise: Problem Solving Practice

Session #14- **Healthy Dating Relationships**

- Discussion: Review Progress
- 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?

Session	Teens	Combined	Parents
1.	My Family Relationships Making a Safety Plan		Introduction to Parent Group: Strengths, Challenges, Changes Making a Safety Plan
2.	Understanding Warning Signs Understanding		Understanding Warning Signs
3.		Understanding Feelings	
4.	Learning Self-Calming		Understanding Self-Calming
5.		Understanding Self - Talk and Beliefs	
6.	Hurtful Moves/Helpful Moves		When Your Teen is Abusive: Effects on Parenting
7.	Understanding Power and *(Respect Wheel Handout)*		How to Respond When Your Teen is Violent
8.		Assertive Communication/ Using "I" Statements	
9.	Making Amends Safety Plan Review		Guiding Change in Your Teen with Restorative Parenting Safety Plan Review
10.		Accountability through Restorative Practice	
11.	Understanding Responsibility		Empowering Teens to Be Responsible for Their Behaviors
12.	Understanding Empathy		What Kinds of Messages Are You Giving Your Teen
13.		Guidelines for Respectful Communication and Problem Solving Together	
14.	Healthy Dating		Listening to 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

Youth Firesetter Prevention and Intervention Program (YFPI)

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 their 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, youth and their caregiver(s) attend a clinical intake 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 YFPI 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

- In addition to the required forms signed at intake, a **Release of Information YFPI** 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.
- Interviewer should use the CANS Firesetter Questions as a guide when assessing firesetting behavior (See Appendix).
- Document attendance and completion of the Firesetter Assessment using the Firesetter Assessment note and contact type in CMP.
- An Intake Report is generated in CMP.

- A separate document, Assessment Recommendations, is generated enumerating **only the enforceable recommendations**, including but not limited to family therapy, residential services, or a psychological evaluation. Assessment Recommendations are sent via email to Fire Rescue Community Educator Supervisor Elyse Brown, YFPI Administrative. Assistant Terry Lazor, and the Primary Community Educators.
- 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 (which is always Fire Rescue and may include Youth Court as well) indicating their completion of this sanction.
- 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, developing emotional regulation skills, handling peer pressure, developing adaptive coping skills, using problem solving skills, improving parenting skills, and improving family communication. Reference materials related to firesetting may be found on the common drive.

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.
YFPI Project Manager
Youth Services Department
(561) 233-4460
sginsbur@pbc.gov

Elyse Weintraub Brown
Community Education Supervisor
Community Risk Reduction Division
Palm Beach County Fire Rescue
(561) 616-7024
ebrown@pbc.gov

Fire Rescue Administrative Assistant
Terry Lazor
561-616-7033
tlazor@pbcgov.org

Fire Rescue Community Educators
Fatou Benoit
561.712.6512
fbenoit@pbc.gov

Jeff Heinz
561-616-7049
jheinz@pbc.gov

Required Meetings

Testing Training Series

2025-2026

Date	Time	Topic	Presenter
August 26th	9:30am-11:00am	Intro to Psychological Evaluations: The Basics	Dr. Ginsburg
September 2nd	9:30am-11:00am	Best Practices in SLD assessment – WISC-V and WJ-V-ACH	Dr. Andreou and Dr. Yadira
September 9th	9:30am-11:00am	Administering and Scoring the new WJ-V Cog and Ach Assign trainees tests to review on September 23rd	Dr. Andreou
September 16th	9:30am-11:00am	ELL assessment and administering the UNIT (nonverbal IQ)	Dr. Hargrove and Yadira
September 23rd	9:30am-11:00am	Present on another commonly used IQ or ACH test (RIAS, KTEA, KBIT, PPVT, EVT) Each trainee selects measure and presents for 20 minutes to cohort	Dr. Hargrove, Dr. Yadira, and Trainees
September 30th	9:30am-11:00am	Personality Assessments (MMPI-A, PAI-A)	Dr. Hargrove
October 7th	9:30am-11:00am	Intro to Rorschach administration & scoring	Dr. Ginsburg
October 14th	__	SKIP	SKIP
October 21st	9:30am-11:00am	Roberts-2 and projective drawings (H-T-P, K-F-D, Person in the Rain)	Dr. Hargrove and Dr. Yadira
October 28th	9:30am-11:00am	Interpretation and diagnosis (application with sample cases)	Dr. Hargrove and Dr. Sosu

*Testing Training Series is typically offered during the first few months of the program. The series is designed to provide a foundation for administering, scoring, and interpreting some of the most commonly used psychological assessment measures, and is expected to build the assessment competency.

Didactic/Training Schedule

Didactic Schedule 2025-2026				
DATE	**TIME**	**LOCATION**	**TOPIC**	**SPEAKER**
8/6/2025	9:30am-11:30am	Zoom	Trauma 101	Brittany Grimshaw, PsyD
8/13/2025	9:00am-12:00pm	Zoom	The Basics of Telemental Health	Shayna Ginsburg, PsyD
8/20/2025	9:30am-11:30am	Zoom	Genograms: Uncovering Family Trends	Kelly Everson, PsyD
8/27/2025	9:30am-11:30am	Zoom	Structural Family Therapy	Kelly Everson, PsyD
9/3/2025	9:30am-11:30am	Zoom	Strategic Family Therapy	Kelly Everson, PsyD
9/10/2025	9:00am-12:00pm	Zoom	Florida Laws & Rules of the Board	Shayna Ginsburg, PsyD
9/17/2025	9:30am-11:30am	Zoom	Suicidality	Kelly Everson, PsyD
9/24/2025	9:30am-11:30am	Zoom	Understanding Non-Suicidal Self-Injury: Facts, Figures, and How to Help	Diane Kelly, PhD
10/1/2025	9:00am-12:00pm	Zoom	Ethics: Maintaining Professional Boundaries	Shayna Ginsburg, PsyD & Diane Andreou, PhD
10/8/2025	9:30am-11:30am	Zoom	Identification & Treatment of Domestic Violence in Clinical Practice	Kelly Dambra, LMHC & Christel Brydegaard, LMHC
10/15/2025	9:30am-11:30am	Zoom	Impact of Racial/Ethnic Implicit Bias and Microaggressions	Danniella Jones, PsyD
10/22/2025	9:30am-11:30am	Zoom	TBD	TBD
10/29/2025	9:30am-11:30am	Zoom	Professional Development: Postdoc, Licensure, & Loans	Shayna Ginsburg, PsyD, Diane Andreou, PhD, Rachelle Sosu, PsyD
11/5/2025	9:30am-11:30am	Zoom	Upholding Ethical and Competent Practice	Diane Andreou, PhD
11/12/2025	9:30am-11:30am	Zoom	The Ultimate Guide to Facilitating a Cohesive Group, Part 1	Amber Snedden, PsyD
11/19/2025	9:30am-11:30am	Zoom	The Ultimate Guide to Facilitating a Cohesive Group, Part 2	Amber Snedden, PsyD
11/26/2025	N/A	N/A	HAPPY THANKSGIVING	N/A
12/3/2025	9:30am-11:30am	Zoom	Corporal Punishment	Allie Picardi, PsyD
12/10/2025	8:00am-12:00pm	Ed Center	Psychology Internship AAPI Review	Training Committee
12/17/2025	9:30am-11:30am	Zoom	Documentary & Discussion- TBD	N/A
12/24/2025	9:30am-11:30am	Zoom	HAPPY HOLIDAYS	N/A
1/1/2026	N/A	N/A	HAPPPY NEW YEAR	N/A
1/7/2026	N/A	N/A	INTERVIEWS	N/A
1/14/2026	8:30am-12:30pm	Zoom	Rank List Meeting	Training Committee
1/21/2026	9:30am-11:30am	Zoom	Understanding & Identifying Human Trafficking	Kelly Dambra, LMHC & Christel Brydegaard, LMHC

1/28/2026	9:30am-11:30am	Zoom	Work Hard, Self-Care Harder	Amber Snedden, PsyD
2/4/2026	9:30am-11:30am	Zoom	Intern Presentation	Jillian Hersman, MS
2/11/2026	9:30am-11:30am	Zoom	Intern Presentation	Alexandra Perez, PsyD
2/18/2026	9:30am-11:30am	Zoom	Dreaming of Sleep: Behavioral Strategies for Families	Steve Arcidiacono, PhD
2/25/2026	9:30am-11:30am	Zoom	Autism Spectrum Disorder	Marcela Galicia, PhD, NCSP
3/4/2026	9:30am-11:30am	Zoom	Foundations of Clinical Supervision	Shayna Ginsburg, PsyD
3/11/2026	9:30am-11:30am	Zoom	The Impact of Parental Incarceration on Families	Rachelle Sosu, PsyD
3/18/2026	9:30am-11:30am	Zoom	Game Changer: Developing Healthy Video Game Habits in Youth	Steve Arcidiacono, PhD
3/25/2026	9:30am-11:30am	Zoom	Resilience/Protective Factors	Sarah Barr, PsyD
4/1/2026	9:30am-11:30am	Zoom	Mindfulness for Mental Health Professionals	Amber Cope, PsyD
4/8/2026	9:30am-11:30am	Zoom	Spotlight on Family Therapy Subsystems: Sibling Rivalries	Brittany Grimshaw, PsyD
4/15/2026	9:30am-11:30am	Zoom	Parental Accommodations and Youth Anxiety	Alyssa Payne, MS
4/22/26	9:30am-11:30am	Zoom	Sexual Assault	Kelly Dambra, LMHC & Christel Brydegaard, LMHC
4/29/2026	9:30am-11:30am	Zoom	Understanding and Supporting a Grieving Child	Kerry DeBay, LMHC
5/6/2026	9:30am-11:30am	Zoom	Acculturation	Yadira Diaz Romero, PsyD
5/13/2026	9:30am-11:30am	Zoom	Diagnosis and Treatment of Social Anxiety and Selective Mutism	Rachelle Sosu, PsyD
5/20/2026	9:30am-11:30am	Zoom	An Introduction to Psychopharmacology and Other Biological Interventions in Child and Adolescent Healthcare	Marshall Teitelbaum, MD
5/27/2026	9:30am-11:30am	Zoom	Disability: Culture, Treatment, and Assessment	Craig Kramer, PsyD
6/3/2026	9:30am-11:30am	Zoom	Creating a Safe Space for Everyone: LGBTQ+ Informed Individual and Family Therapy	Emily Deming, PhD
6/10/2026	9:30am-11:30am	Zoom	Eating Disorders	Maria Bayron, PsyD
6/17/2026	9:30am-11:30am	Zoom	Postdoc Presentation TBD	Yadira Diaz Romero, PsyD
6/24/2026	9:30am-11:30am	Zoom	Your Brain on Poverty: The Psychological Effects of Living With Financial Scarcity	Amanda Terrell, PsyD
7/1/2026	9:30am-11:30am	Zoom	Intern Presentaiton	Lisa Carter, MS
7/8/2026	9:30am-11:30am	Zoom	Multidisciplinary Consultation/Program Evaluation	Rachelle Sosu, PsyD
7/15/2026	9:30am-11:30am	Zoom	Impact of Social Media on Mental Health	Michelle Sidhom, PsyD
7/22/2026	9:30am-11:30am	Zoom	Resilience Documentary	Documentary & Discussion
7/29/2026	9:30am-11:30am	TBD	Intern & Postdoc Farewell Retreat	Trainees & Training Committee

Office Closure Dates

Holiday Schedule for Year : 2025

County Offices will be closed on these dates

Holiday Name	Holiday Date
New Year's Day	Wednesday, Jan. 01, 2025
Martin Luther King, Jr. Day (3rd Monday in January)	Monday, Jan. 20, 2025
President's Day (3rd Monday in February)	Monday, Feb. 17, 2025
Memorial Day (last Monday in May)	Monday, May. 26, 2025
Juneteenth Day (June 19th)	Thursday, Jun. 19, 2025
Independence Day	Friday, Jul. 04, 2025
Labor Day (1st Monday in September)	Monday, Sep. 01, 2025
Columbus Day (2nd Monday in Oct)	Monday, Oct. 13, 2025
Veterans Day (11th Day of November)	Tuesday, Nov. 11, 2025
Thanksgiving Day	Thursday, Nov. 27, 2025
Floating Holiday	Friday, Nov. 28, 2025
Floating Holiday	Wednesday, Dec. 24, 2025
Christmas Day	Thursday, Dec. 25, 2025

Please Note: Thursday, Jan. 01, 2026 will be first holiday in 2026

Tracking Hours

Hours Log

Training Year: August _____ - July _____ *only use .25 intervals													
*only write in the white boxes (all grey boxes are Auto Sums)	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													
Co-therapy													
Crisis Intervention													
Family Therapy													
Group Therapy													
Individual Therapy													
Intake/Structured Interview													
Milieu Therapy													
Outcome Assessment of													
Program Dev/Outreach													
School Consultation/Direct													
School Observation													
School Other													
Supervision of Other Students													
Sys. Interv./Org. Consult/Perf.													
Other-Interventions													
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													
Psychological Test Administration													
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, Case Mgmt, Chart Reviews, Clinical Writing/Notes, Didactic trainings/Seminars/Workshops, Intervention Planning, Professional Development, Psychological Assessment Scoring/Interpretation, Reading/Research/Preparation, Video-Audio-Digital Recording Review, etc.													
Support Total (Auto Sum)	0	0	0	0	0	0	0	0	0	0	0	0	0
Supervision													
Individual Supervision- Licensed Psychologist													
Group Supervision- Licensed Psychologist													
Supervision Total (Auto Sum)													
Indirect Total (Auto Sum)	0	0	0	0	0	0	0	0	0	0	0	0	

*It may be advisable to track the modality of therapy (i.e. in-person, telemental health) for your future reference.

Monthly Activity Report

*Each month, trainees are asked to submit an activity report including the information detailed below. All trainees should email their Trainee Hours Monthly Log as well as the Activity Report EXACTLY as it appears below to the Training Director and their individual supervisor(s) by the date and time designated in the email received from the Training Director. You should attach your comp log as well for review. ***Please remember to copy Cristal Montepeque, who will be maintaining the log.* **

THERAPY
Range of therapy cases for the month (*not* including testing cases)=

PSYCH EVALS
Psychological Evaluations Completed this month (including feedback)=
Psychological Evaluations Completed Year-to-Date=
Psychological Evaluations currently in progress=

PRESENTATIONS
Community Outreach Presentation(s) this month (including topic)=
Community Outreach Presentation(s) Year-to-Date (including topics)=
Community Outreach Presentation(s) scheduled for upcoming months (including topic(s) if already determined)=

Didactic Presentation(s) given this month (including topic)=
Didactic Presentation(s) given Year-to-Date (including topics)=
Didactic Presentation(s) scheduled for upcoming months (including topic(s) if already determined)=

SUPERVISION
Individual Supervision Hours this month =
Individual Supervision Hours Year-to-Date=

Group Supervision Hours this month =
Group Supervision Hours Year-to-Date=

Group Supervision Case Presentations this month (state if with audio recording or live)=
Group Supervision Case Presentations Year-to-Date (state if with audio recording or live)=

HOUR TOTALS
Direct Service Hours this month (Intervention and Assessment Hours)=
Direct Services Hours Year-to-Date (Intervention and Assessment Hours)=

Indirect Service Hours this month (Support and Supervision Hours)=
Indirect Services Hours Year-to-Date (Support and Supervision Hours)=

Total hours this month (Direct & Indirect)=
Total Hours Year-to-Date (Direct & Indirect) =

LEAVE & COMP TOTALS
Total Vacation Hours Used this Month=
Total Vacation Hours Used to Date=

Total Sick Hours Used this Month=
Total Sick Hours Used to Date=

Total Comp Hours Earned this Month=
Total Comp Hours Earned to Date=

Total Comp Hours Used this Month=
Total Comp Hours Used to Date=

Trainee Leave Request Form

Name _____

From Date	Time	Through Date	Time	Total Hours
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Type of Leave	Hours	Comp Time Required
Vacation	80 hours (unpaid)	No
Vacation	20 hours (as needed)	Yes
Sick	100 hours (as needed)	Yes
Holidays	130 hours	Yes

Vacation hours at start of year: 100
Vacation hours already taken prior to this request: - _____
Vacation hours requesting off (on this form): - _____
Vacation hours remaining (after this request): = _____

Sick hours at start of year: 100
Sick hours already taken prior to this request: - _____
Sick hours requesting off (on this form): - _____
Sick hours remaining (after this request): = _____

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.

*I agree to scan the approved form and email to all of my supervisors with CC to the Training Director.

_____
Trainee Signature Date

_____
Approved by Onsite 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 Services		561-684-1991	None
Big Brothers, Big Sisters Mentoring of Palm Beach		561-727-3450	None
Boys 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
Center for Family Services of PBC	Lynne Bernay-Roman, LCSW	561-514-0664	None
Center for Trauma Counseling		561-444-3914	None
Children's Home Society (CINS/FINS)		561-868-4300	None
Community Services Department		833-CSD-WILL	
		833-HHA-WILL	None
Compass, Inc.	Amanda Canete	561-533-9699	
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
Youth Firesetter Intervention Program (YFIP)	Elyse Weintraub Brown	561-616-7051	None
	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
Home Safe	Chere Brodi	561-383-9800	561-832-4786
Hospice of Palm Beach County		561-848-5200	None
Lutheran Services Florida		561-233-1600	
Multilingual Psychotherapy Center, Inc.		561-712-8821	561-712-8070
National Alliance on Mental Illness (NAMI)		561-588-3477	None
Pace Center for Girls, Inc. – Palm Beach		561-472-1990	561-472-1991
Project Access Program - Palm Beach Medical Society	Lauren Stoops	561-433-3940	561-433-2385
Safe Harbor Runaway Center		561-868-4300	None
Safe Kids (Center for Family Services)		561-616-1222	
Palm Beach County Sheriff's Office (PBSO)		561-688-3000	Non-emergency
Veteran's Administration (VA)		561-422-8262	
Victim Services		561-355-2418	
Palm Beach County Fire Rescue		561-616-7000	
West Palm Beach Police Department		561-822-1600	Non-emergency
Youth Court	Main	561-681-0080	561-434-8356
	Officers Cecil Wagner & Anthony Morales	561-310-5370	
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
Walter D. Kelly Center		561-844-9661	None

Emergency/Crisis Contact Numbers

Emergency	911
American Medical Response, Inc. (AMR)	(561) 533-5633
Child Abuse Reporting Numbers for other states https://www.childwelfare.gov/organizations/?CWIGFunctionsaction=rols:main.dspList&rolType=Custom&RS_ID=%205	
Crisis and Information- 24 hours	211 (Mental Health crisis, when prompted press 1)
Disaster Distress Helpline	(800) 985-5990
Domestic Violence Hotline	(800) 500-1119
Drug Abuse Foundation	561-278-0000 or Emergency Walk-in at 400 S. Swinton Ave, Delray Beach, FL 33444
Elder Helpline	(561) 214-8600
First Call for Help (Broward)	(954) 537-0211
Florida Abuse Hotline	(800) 96ABUSE or (800) 962-2873
JFK Medical Center North Campus	(561) 842-6141
Marchman Act Filing Locations	Main Courthouse: 205 N. Dixie Hwy, West Palm Beach, FL 33401 North County Courthouse: 3188 PGA Blvd., Palm Beach Gardens, FL 33410 South County Courthouse: 200 W. Atlantic Ave., Delray Beach, FL 33444
Mobile Crisis- North County * serving West Palm Beach all the way up to Tequesta and west to Southern Blvd	(561) 693-8681
Mobile Crisis- South County * Delray Beach main	(561) 637-2102 or (877) 858-7474
Mobile Crisis- West * serving Belle Glade, Pahokee, Loxahatchee, and Royal Palm Beach	(561) 382-3556
NAMI Helpline	1-800-950-NAMI (6264) In a crisis, text "NAMI" to 741741
National Center for Missing & Exploited Children	(800) 843-5678 or (800) THE-LOST
National Runaway Safeline	(800) 786-2929 or 1-(800)-RUNAWAY
National Suicide Prevention Lifeline	(800) 273-TALK or (800) 273-8255 988 *Anyone having a mental health crisis can call or text the three digits and be diverted to a local crisis center.
Palm Beach County Sheriff's Office (PBSO) (Highridge jurisdiction)	(561) 688-3000
Teen Hotline	211 or (561) 930-8336

Toll-Free Crisis Hotline Numbers https://www.childwelfare.gov/find-help-personal-situation/	
Victim Services – 24 hours	(561) 833-7273 or (866) 891-7273
Walter D. Kelly Treatment Center, Drug Abuse Treatment Ass. (DATA)	561-844-9661
West Palm Beach Police Department (Ed Center and YFC Four Points, South, North, West jurisdiction)	(561) 822-1900 – ask for a CIT officer

Clinical/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. *Once the recording has begun, please have each person in the room provide their verbal consent again, so that their consent is verbally confirmed on the recording.*
- AI Companion should not be used to transcribe sessions and create summaries. This Zoom feature should be manually turned off so recordings do not take place inadvertently.
- Therapists should explain carefully to clients the procedure and rationale for recording.
- Clients may decide for or against recording at any time during the course of therapy. Clients are advised that services are not contingent upon their permission to audio or video record, but are contingent upon the supervision of all cases. *Please note, recordings may be needed for psychological evaluations to ensure accurate transcriptions of some measures. PCIT cases are also recorded for supervision of cases and to review coding, when needed.
- Recordings are made for training and educational purposes only and are not considered part of the clinical record. Therefore, recordings will NOT be released through a records request.
- Clients sometimes change their minds about their willingness to be recorded. It is also possible that a client who was 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 in clinical care of clients at the Youth Services Department.
- 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 recordings are limited to clinical staff and trainees within the Youth Services Department.
- Any other persons wishing to observe may do so only with the expressed permission of the client(s).
- Recordings will be discarded after their intended use.

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

Frequently Asked Questions –Video/Audio Recordings

Video recordings via Zoom is the preferred method. Audio recording with a specified recording device may be used as an alternative under extenuating circumstances.

Can I make video/audio recordings of my clients at the Youth Services Department?
Audio and video recordings of clients may only be made with specific written and verbal authorization from your client and/or their legal guardian. Please make sure that the youth and their parent/legal guardian have 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/video recordings of my clients?
Audio recordings may be made with an office 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. The HIPAA compliant Zoom app on a County computer may be used to record audio and/or video from a session.

Can I use AI Transcription recording for Zoom Therapy Sessions?
No. AI Companion should be manually turned off on all Zoom accounts so confidential sessions are not inadvertently recorded without a client's permission.

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

Can I save video/audio recordings and take/play them outside the Youth Services Department?
Ideally, video/audio recordings should only be played while at the Youth Services Department and must be erased immediately after the intended purpose. They may not be played in a publicly audible manner in a place where unauthorized people can hear. If you must review recordings outside the clinic, you must take reasonable steps to guarantee that the recording is kept in a secured environment at all times, and you must ensure that your client's full name and/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. If needed, you can set-up the Zoom app to save recordings on the Zoom Cloud in order to be accessed outside the office, with supervisor approval. Erase the recording immediately after its intended purpose.

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 Youth Services Department 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 of an in-person session and review it after a session. How do I do this?
All YSD computers have access to the Zoom app that allows for video and audio recording of both virtual and in-person sessions. In addition, the Education & Training Center and

Highridge Family Center have live therapy rooms that also have a video recorder. This can be activated and controlled through the conference rooms. Recordings are saved to a disc provided by the Training Director or supervisors. These recordings can be reviewed on a laptop or DVD player while in the office. Discs must be destroyed after use.

How do I use the video recorder in the Education & Training Center's conference room?
An instructional guide for using the video recorder is available on the common drive in the Education & 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 maybe granted on a case-by-case basis and only for educational purposes and with supervisor approval.

If I am unable to record on Zoom, how do I check out the Education & Training Center's audio recorder?
The audio recorder is available to all trainees to record sessions when Zoom is not an option. Please sign your name on the Audio Recorder Check-Out/Check-In sheet at the administrative assistant's desk with the date you borrow and return the recorder.

Frequently Asked Questions – Zoom Recordings

Will clients be aware that I am recording the session?
Clients must always explicitly consent to recording before the record feature is utilized and provide verbal consent again at the beginning of the recording. Zoom will always notify meeting participants that a meeting is being recorded. It is not possible to disable this notification. For participants joining audio by phone, they will hear an audio prompt when they first join the meeting if it is already being recorded or at the time that recording is started. For participants joining by computer or mobile device, the screen below will display a recording notification and they will be prompted to either continue or leave the meeting if they do not wish to be recorded.

Can clients record sessions?
Recording is only permitted by the therapist; clients are not permitted to record sessions. This feature may be disabled on your Zoom account.

How do I figure out how to use the recording function on Zoom?
All trainees are provided with an overview of Zoom and are required to view tutorials on Zoom functions prior to utilizing the platform for telemental health sessions. Additional training on Zoom functionality may be provided as needed.

If I am teleworking at a location other than a Youth Services office, can I record my sessions? *Note: Teleworking may only occur under the most unusual of circumstances and only with supervisor approval.
It is our policy that sessions can only be recorded or reviewed from within the Youth Services Department office to maintain the confidentiality of the clients we serve. No audio or video recording, in any format, will be permitted outside the office.

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 individual) _____ at (time) _____ ☐ am ☐ pm

on (date) _____ in _____ County and said individual appears to meet criteria for involuntary examination (time noted must be within the preceding 48 hours).

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 Assistant ☐ Advanced Practice Registered Nurse under s. 464.0123 F.S.

Section I: CRITERIA

1. There is reason to believe said individual 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 dementia, traumatic brain injury, antisocial behavior, or substance abuse.

Diagnosis of Mental Illness is: List all mental health diagnoses applicable to this individual & DSM/ICD Codes: ☐☐☐☐☐☐

_____

_____

_____

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

☐ a. Individual has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination;

OR

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

2. Either (check all that apply):

☐ a. Without care or treatment said individual 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; **OR,**

☐ b. There is substantial likelihood that without care or treatment the individual 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

Document observations supporting the criteria in Section I (including evidence of recent behaviors related to criteria). Include the individual's behaviors and statements, including those specific to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury. If school personnel are involved, describe the nature of their involvement.

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: INVOLUNTARY EXAMINATION FOR OUTPATIENT SERVICES ORDERS IN ACCORDANCE WITH 394.4655, F.S.

Complete this item ONLY if this involuntary examination is being initiated by a physician as defined by section 394.455(33), F.S. and, in your clinical judgment, the individual has failed or refused to comply with an involuntary outpatient services order.

For Section IV only, a personal examination within the preceding 48 hours is not required. In the box below, provide documentation of efforts to solicit compliance with the outpatient services treatment plan. The following efforts have been made to solicit compliance:

Section V: INFORMATION FOR LAW ENFORCEMENT

Provide identifying information (if known) if requested by law enforcement to find the individual 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 individual 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

Signature of Professional | Date Signed | Time ☐ am ☐ pm

Printed Name of Professional | Phone Number (including area code)

Community Meeting Guidelines

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 IS 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.

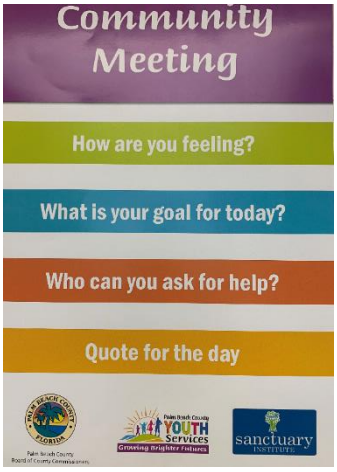
WHAT MAKES A COMMUNITY MEETING "TRAUMA-INFORMED"?

"How are you feeling?" 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 is 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 is your goal?*" 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.*

*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.*



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 any county office. After the initial login, each user must change their password. Users will be required to periodically change the password when prompted. As the Division is part of a government agency, use of the network is monitored.

There are many computer drives to which trainees 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 folders and/or documents require supervisor privilege for viewing). With supervisor approval, trainees may upload documents to share with others or for supervisors to review.

There is a Scanned Files folder on the (G:) drive for each RTFC section. Once an item is scanned into the computer from the copy machine, it should be pulled from the scan folder and attached to the appropriate permanent location. The scanned document should then be immediately deleted from the scan drive. All contents of the Scanned Files folder will be deleted every Thursday at 6pm. This is in accordance with a Department Policy and Procedures Manual (PPM). All PPM's may be accessed via the intranet or via the following link: https://pbcportal.pbcgov.org/youthservices/default.aspx.

Case Manager Pro (CMP)

Case Manager Pro is the Youth Services electronic charting system. Usernames and passwords for 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

This policy is not intended to infringe on a trainee's first amendment rights to freedom of speech. This policy is intended to give guidance to relevant general parameters based on their role as trainees at the Youth Services Department. Trainees who use social media (e.g., X, Instagram, TikTok, Reddit, Snapchat, Facebook, YouTube, LinkedIn, Facebook, blogs, etc.) 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 or other mental health provider 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 any client, client family member, or other people connected to their client as part of their social network, or include any information that might in any way lead to the potential or actual identification of a client, or compromise client confidentiality in any manner.

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 sanctions, including 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 guidelines on "Technology in Practice" maybe consulted for guidance: https://www.apaservices.org/practice/business/technology.

Participation in Publicized Events

If a trainee participates in an outside event that has the potential to be publicized in local, state, or national news and they wish to share their affiliation with the Youth Services Department, they must speak with a supervisor and ask the Training Director, who will seek approval from the Department Director, prior to participating in the event. Any statement that may be shared related to the Youth Services Department should be first relayed to the Department Director and permission must be given before there is any mention of YSD.

Social Media is intended to provide individuals with the ability to access information quickly and communicate with others. The Youth Services Department utilizes its website and social media platforms to disseminate information to staff, clients, and the community in a variety of ways, including through the circulation of training flyers, sharing training recordings, and providing community outreach through online psychoeducation and mental health tips. Trainees are encouraged to reference and contribute to this information, while being mindful of the caveats listed above.

Outlook

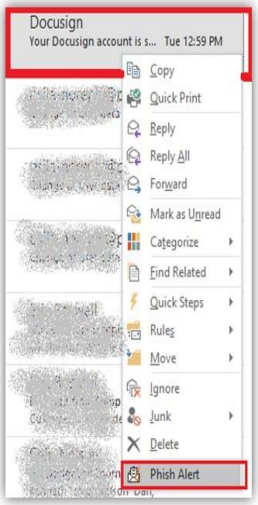
Email accounts are created for trainees and all Division staff for work-related use. If you are sending an email that you believe is exempt from disclosure under public records law, all users should include "PREX" (public records exempt) in the subject line. This will help flag the email in the event of a public records request.

To maintain confidentiality, email correspondence with clients is prohibited from individual user accounts. Emails containing any client identifying information must be flagged as confidential. Any electronic content that is to be sent via email to clients may only be sent from approved email accounts created for each site within the Division. Only specific staff have access to sending and receiving emails from these accounts, but may do so on behalf of others. All such emails should be flagged as Confidential and must include "PREX" in the subject line. The format should appear as follows: [Subject: Joe Smith FT Session 6/24/21 (PREX)]

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. Appointments created in CMP are automatically sent to the Outlook calendar, with de-identified information. *All items in the CMP calendar should be synchronized with Outlook by checking the 'Synchronize with Outlook' box in the CMP calendar. However, appointments that are first scheduled via Outlook will need to be to be manually added into CMP.



Suspicious Emails

If you receive suspicious emails, do not open any links or attachments. Please follow the directions below:

1. Right click the suspicious email in you Outlook inbox to bring up the drop down menu
2. Scroll down the list and select the Phish Alert button, which will delete the email and report the email to ISS for review.
3. If you are missing the Phish Alert button, please contact ISS at 561-355-4357.

CMP Calendar Scheduling

To schedule a *client-related service* appointment (e.g., family therapy, intake):

1. Go into the client file.
2. Double click on the service name.
3. Click on the "Calendar" button on next to "Appointments."
4. Locate the correct date and time on the calendar and double click on the desired slot.
5. Ensure that all information entered in the dialogue box is accurate.
    a. Subject: the activity being completed (this information will automatically populate if you are scheduling through the client service)
    b. Location: the location of the activity (Ed Center, YFC, HRFC)
    c. Start Time: the start date and time of the activity
    d. End Time: the end date and time of the activity
    e. If applicable, click on the 'Recurrence' icon located on the top of the dialogue box and enter the desired recurrent pattern (day, time, etc.)
6. Click Save and Close on the dialogue box.
7. Click Save and Close again on the calendar view.
    a. Make sure the "Synchronize with Outlook" box is checked so the information will populate in your Outlook calendar as well.

To schedule *non-client related* appointments (e.g., didactic training, supervision, etc.):

1. Click the "Appointment" calendar icon located at the top banner of the CMP homepage.
2. Follow steps #4 through 7 above.

Zoom

Zoom accounts are created for all trainees in order to provide telemental health services and participate in other remote meetings. All trainees are required to visit the Zoom Learning Center to review specific Zoom tutorials (Getting Started with Zoom, Joining a Meeting, In-Meeting Navigation, Screen Sharing, Layouts & Views) in order to learn how to use the videoconferencing platform, and everyone must submit a certificate to their supervisor acknowledging that these trainings were completed. The trainings can be accessed from the following link: https://learning.zoom.us/learn/signin. Additionally, the required didactic training, "Basics of Telemental Health" is offered during the first few weeks of the training year. A recording of this training is also available on the Education & Training Center website.

Psychological Evaluation Measures

Most measures can be accessed from any computer by visiting the designated website and entering the username and password. Usernames and passwords can be found in the (G:) drive in the respective folder. Please check this document prior to accessing tests or scoring content, as passwords are updated periodically. There is a designated testing computer on which certain psychological evaluation measures can be administered and scored, which is located in the Education & Training Center conference room. Scoring programs are available for the following measures: ARES, Roberts-2, and Rorschach,. The ARES and Roberts-2 require a key fob to be inserted prior to scoring (already inserted in the testing computer). Scoring software for the Rorschach (RIAP) is found on this computer.

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 through the Edge browser (https://pbcportal.pbcgov.org/Pages/Default.aspx). Scroll to the bottom of the page and on the right-hand side to the 'IT Support' section Click on "Submit ISS HelpDesk Ticket," then click on the computer icon on the top left-hand side of the IT Support section to submit a problem, which will allow you to describe your problem in detail. You may also reach the ISS Help Desk by calling 355-4357. 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.

PCIT Therapy Equipment

At the Education & Training Center, the conference room is equipped with a one-way mirror and PCIT technology equipment that allows the therapist to hear, see, speak to, and record the clients in the other room. This equipment includes a mixer, microphone, bug-in-the-ear device, camera, and monitor. Trainees involved in the delivery of in-person PCIT services may use this equipment following supervisor training and approval to do so. Trainees are expected to return equipment to the same location and in the same condition it was in when they began using it. Shared equipment (e.g., microphone and headsets) must be sanitized after each use.

DCF Reporting Procedures

As described in Chapters 39 and 415, Florida Statutes, the Florida Department of Children & Families is charged with providing comprehensive protective services for children who are abused, neglected or at threat of harm and vulnerable adults who are abuse, neglected or exploited in the state by requiring that reports of abuse, neglect, threatened harm, or exploitation be made to the Florida Abuse Hotline. Refer to the following for additional information: https://www.myflfamilies.com/services/abuse/abuse-hotline/laws-abuse-hotline

***If you suspect or know of a child or adult that is in immediate danger, call 911.**

*When reporting allegations of abuse or neglect, your identity is held confidential and can only be provided to authorized DCF agents.

*Screening Criteria: In order for the Hotline to accept a report for investigation, the following criteria must be met: (a) The victim must be a child, as defined in statute: born alive, under the age of 18, and not emancipated or married. (b) There must be an alleged perpetrator or caregiver responsible based on statutory and administrative definitions. If the alleged perpetrator's relationship to the child is unknown but all other screening criteria have been met, a report will be accepted. (c) There must be an alleged maltreatment as defined in CFOP 170-4. (d) There must be an acceptable means to locate the child.

TELEPHONE: 1-800-962-2873 (1-800-96-ABUSE)
The Florida Abuse Hotline accepts reports 24 hours a day and 7 days a week.
http://www.myflfamilies.com/

*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. Reporters should have the following information ready when making an abuse 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.

- Reporter Name (required for professionally mandated reporters)
- Victim Name, possible responsible person, or alleged perpetrator name(s)
- Name, date of birth (or approximate age), race, and gender, for all adults and children involved and/or living in the home.
- 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 visit: https://www.myflfamilies.com/services/abuse/abuse-hotline/how-report-abuse/what-you-need

REPORTER PORTAL: https://reportabuse.myflfamilies.com/s/
To make a report using the Reporter Portal (Online) you should register for an account. Registered users will have the ability to access historical submissions and save credentials.

You will be asked to provide the following:

- Reporter details (required for professionally mandated reporters)
- Incident details (WHAT happened, WHO'S involved, WHEN and WHERE did the incident occur, impacts/effects on the victim(s), a description of injuries and/or threat of harm, the frequency of occurrence, and the history of occurrences.)
- Person details (information about the victim and alleged perpetrator(s) as well as other non-victim children or adults residing in the home.)
- Attachments (if applicable)

Once the aforementioned information has been entered you will be asked to review for accuracy prior to submitting the report. Print this page because once submitted, details cannot be added or modified and the report will no longer be available. *The report submission should be uploaded to CMP.*

NOTIFICATION OF REPORT:

- Telephone reporters will always be told prior to concluding your conversation whether the information provided has been accepted as a report.
- The online reporting portal may be monitored as needed/desired for progress updates on whether the report has been accepted or not, and the reason for the decision. All YSD therapists should request at the time of submission to receive an email with the decision, which will be uploaded to CMP.

Documentation of Abuse Reporting
*All DCF reports should be documented in CMP.

For Hotline reports: Note content should include a summary of the suspected abuse, reporter ID of the individual taking the report, and whether or not the report was accepted for further inventigation. Refer to the Documenttion Manual for a sample note.

For Reporter Portal reports: Note content should include a summary of the suspected abuse (may be taken directly from 'descripton of the incident' section of online report). Online report submission should be uploaded to CMP as an attachment. Once an email is received regarding report status, another note should be entered indicating whether or not the report was accepted for further inventigation. Refer to the Documenttion Manual for a sample note.

Dress/Grooming/Hygiene Guidelines

Purpose

The Youth Services Department recognizes that the presentation of trainees in the workplace contributes to a professional environment and public image that contributes to the success of the Department. All trainees are representatives of the County and 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 colleagues, clients, and the public. Dress and appearance should promote a positive working environment and ensure/promote safety while at work. Trainees are expected to dress in a manner that is normally accepted in comparable settings and should make every effort to limit distractions caused by dress and appearance.

The following 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. 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. Undergarments MUST be worn.

The following items are NOT 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**
- **Jumpsuits**
- **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**
- **Athletic shoes**
- **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 with supervisor approval (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 their attire at all times. If a trainee is deemed to be wearing inappropriate attire, their 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 their 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 and 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 provides a formal mechanism for the Youth Services Department to respond to issues of concern.

Definitions

Department Director: The staff member who oversees the Youth Services Department.

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

Due Process: 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 that 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.

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

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

Trainee: Any person in training who is working in the agency, including a doctoral practicum student, doctoral intern, and postdoctoral fellow.

Training Committee: The group comprised of the Training Director and the agency's psychologists who serve as clinical supervisors.

Training Director: The staff member who oversees all training activities at the Youth Services Department.

Working days: Days in which the office is open for business, which typically include Monday through Thursday from 8:00am to 7:00pm (Education & Training) and from 9:30am to 8:00pm (Highridge), not including federal holidays. There may be variances in schedule due to holidays, events, and other circumstances.

Problematic Behavior: Problematic Behavior is defined broadly as an interference in professional functioning that 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 that interfere with professional functioning.

Professional judgment is used to identify when a trainee's behavior becomes problematic rather than simply of concern. Trainees may exhibit behaviors, attitudes, or characteristics that, 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.

Rights and Responsibilities

Trainees are responsible for functioning within ethical and legal standards, and demonstrate relevant professional standards. Trainees are responsible for demonstrating proficiency in the requisite skills required to successfully provide clinical services. Trainees are expected to further develop and deepen psychological skills and the ethics of practice during their training year, which is also a time to focus on intrapersonal and interpersonal processes through self-reflection. They are responsible for completing all requirements and expectations of the training program, as outlined in each respective handbook.

At all stages of training, the Training Committee assumes the responsibility for assessment and continual feedback to the trainees in order to improve skills, remediate problem areas, and/or to prevent individuals unsuited in either skills or interpersonal limitations from entering the professional field of practice. The Training Committee is responsible for monitoring trainee progress to benefit and protect the public and the profession, as well as the trainee.

Trainees have the right to receive clear statements of the standards and expectations by which they are evaluated. These standards and expectations are thoroughly reviewed during the orientation, addressed in supervision throughout the training year, and provided written and verbal feedback during formal evaluations at designated times. Trainees have the opportunity to ameliorate any deficiencies or misconduct prior to the midyear or final evaluation, unless continuation of service delivery would be deemed a detriment to clients.

Trainees have the right to provide input and suggest changes and modifications to the training program. Regular meetings with the Training Director enable the Training Director to assess and discuss strengths of and concerns/problems with the program.

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 (but is not limited to) increased supervision, didactic training, and/or structured readings. This process should be documented in writing (Support Plan may be used) in supervision notes and discussed with the Training Director, but will not become part of the trainee's professional file. Support Plans will be maintained in the Training Director's records, but will not become part of the trainee's professional file. However, if the support plan evolves into a Formal Training Plan, then it will be kept in 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 supervisor(s) and Training Director will discuss the problem and determine what action needs to be taken to address the issue as soon as is reasonably feasible. The Training Committee will also be consulted about potential actions to be taken to address the concern.

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 if indicated, the supervisor(s) and Training Director may determine one of the following four courses of formal action:

1. *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 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;
   6. requiring the trainee to re-read the handbook or review orientation recordings;
   7. assigning specific articles or other readings on a particular topic;
   8. requiring the trainee to research a particular topic.

   The 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 Training Plan will be developed by the supervisor(s) in consultation with the Training Director, and then presented to the trainee. Feedback from the trainee may be incorporated, and the trainee signs the document, indicating acknowledgement of the contents of the document. The Training Plan will become part of the trainee's permanent file. It will be approved by the Training Director and supervisor(s) and sent to the Director of Clinical Training at the trainee's graduate institution, if applicable.

   The length of time that the Training Plan is in effect will be determined by the supervisor(s) in consultation with the Training Director, and will be between 8 and 16 working days, after which time the status is reviewed by the supervisor(s) in consultation with the Training Director, and discussed with the trainee. *Note: In some cases the supervisor(s) and Training Director may agree to monitor the status of a training plan over a shorter or longer period based on the competencies that need to be addressed and/or the length of time that may be needed to notice and measure progress.

   If the problem has been rectified to the satisfaction of the supervisor(s) and the trainee, the graduate institution, and other appropriate individuals, as applicable, the trainee will be informed verbally and in writing, and no further action will be taken. If concerns remain, the Training Plan may be extended, and modified if necessary, for another 8 to 16 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 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(s) 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(s) and the Training Director. In the case of doctoral interns and postdoctoral fellows,

APPIC's Informal Problem Consultation process should be utilized. In these circumstances, APPIC serves to consult and guide, but will not make decisions about your program.

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 will be informed, in the case of doctoral interns and postdoctoral fellows. All information related to this decision will be documented on a Training Plan.

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(s), in consultation with the Training Director, or may be requested by the trainee. 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, if applicable, will be informed. In the case of doctoral interns and postdoctoral fellows, APPIC will also be informed. All information related to this decision will be documented on a Training Plan.

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 their behavior, the Training Committee 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, when applicable, 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, they may request an Appeals Hearing by sending a written request (an email will suffice) to the Division Director within 3 working days of notification regarding the decision made above. All relevant documentation must be provided at the same time the hearing request is made. No additional documents will be considered. If requested, the Appeals Hearing will be conducted by a review panel convened by the Division Director and consisting of themself, the training director, and at least one other member of the Training Committee. Members will be determined based on the specific issue at hand. These parties will review the information to determine if the complaint warrants further action. If no further action is warranted, the formal grievance will be terminated, and the trainee will be provided with a brief explanation.

If further review is warranted, an Appeals Committee is appointed as soon as possible by the Division Director. In special circumstances, the YSD Department Director and/or a representative from the Palm Beach County attorney's office may be included. The trainee may request a specific member of the Training Committee 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 Division Director.

The Appeals Hearing will be held within 5 working days of the trainee's request. The review panel will review all written materials that were provided at the time of the hearing request, and have an opportunity to interview the parties involved or any other individuals with relevant information. Witnesses may be interviewed as needed. A majority vote of the committee is required to finalize its conclusion. The review panel may uphold the decisions made previously or may modify them.

The Appeals Committee will provide a written recommendation, with justification to the Training Director and appropriate supervisor(s)/administrator(s) for review and response. 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. If the training program is the object of the grievance, the grievance should be submitted to the Division Director's appointed designee (e.g., YSD Director or Assistant Director). The individual(s) being grieved will be asked to submit a response in writing within 3 working days. The Training Director (or Training Committee member or Division Director, or other designee, if appropriate) will meet with the trainee and the individual(s) being grieved within 3 working days of receiving the written response from the individual(s) being grieved. In some cases, the Training Director, other Training Committee member, Division Director, or other designee may wish to first meet with the trainee and the individual(s) 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, other Training Committee member, Division Director, or other designee will document the process and outcome of the meeting. The trainee and the individual(s) being grieved will meet with the Training Director (or other Training Committee member, or Division Director, or other designee, if appropriate) within an established number of working days, but no longer than 4 working days. At this meeting the plan of action will be reviewed and the Training Director (or Training Committee member, Division Director, or other designee, if appropriate) will determine whether the issue has been adequately resolved.

Appeals Process

If the plan of action fails, an Appeals Committee is appointed as soon as possible by the Division Director. In special circumstances, the YSD Department Director and/or a representative from the Palm Beach County attorney's office may be included. The trainee may request a specific member of the Training Committee 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 Division Director.

The review panel will meet within 5 working days to review all written materials and have an opportunity to interview the parties involved or any other individuals with relevant information. Witnesses may be interviewed as needed. A majority vote is required to finalize its conclusion. The Appeals Committee may uphold the decisions made previously or may modify them.

Written recommendation, with justification to the Training Director and appropriate supervisor(s)/administrator(s) will be submitted for review and response. The review panel has final discretion regarding outcome.

Fire Setting Interview Guidelines (CANS)

FIRE SETTING

SERIOUSNESS *Please rate most recent incident*

0 Child has engaged in fire setting that resulted in only minor damage (e.g. camp fire in the back yard which scorched some lawn).

1 Child has engaged in fire setting that resulted only in some property damage that required repair.

2 Child has engaged in fire setting which caused significant damage to property (e.g. burned down house).

3 Child has engaged in fire setting that injured self or others.

HISTORY *Please rate using time frames provided in the anchors*

0 Only one known occurrence of fire setting behavior.

1 Youth has engaged in multiple acts of fire setting in the past year.

2 Youth has engaged in multiple acts of fire setting for more than one year but has had periods of at least 6 months where he/she did not engage in fire setting behavior.

3 Youth has engaged in multiple acts of fire setting for more than one year without any period of at least 3 months where he/she did not engage in fire setting behavior.

PLANNING *Please rate most recent incident*

0 No evidence of any planning. Fire setting behavior appears opportunistic or impulsive.

1 Evidence suggests that youth places him/herself into situations where the likelihood of fire setting behavior is enhanced.

2 Evidence of some planning of fire setting behavior.

3 Considerable evidence of significant planning of fire setting behavior. Behavior is clearly premeditated.

USE OF ACCELERANTS *Please rate most recent incident*

0 No evidence of any use of accelerants (e.g., gasoline). Fire setting involved only starters such as matches or a lighter.

1 Evidence suggests that the fire setting involved some use of mild accelerants e.g. sticks, paper) but no use of liquid accelerants.

2 Evidence that fire setting involved the use of a limited amount of liquid accelerants but that some care was taken to limit the size of the fire.

3 Considerable evidence of significant use of accelerants in an effort to secure a very large and dangerous fire.

INTENTION TO HARM *Please rate most recent incident*

0 Child did not intend to harm others with fire. He/she took efforts to maintain some safety.

1 Child did not intend to harm others but took no efforts to maintain safety.

2 Child intended to seek revenge or scare others but did not intend physical harm, only intimidation.

3 Child intended to injure or kill others.

COMMUNITY SAFETY *Please rate highest level in the **past 30 days***

0 Child presents no risk to the community. He/she could be unsupervised in the community.

1 Child engages in fire setting behavior that represents a risk to community property.

2 Child engages in fire setting behavior that places community residents in some danger of physical harm. This danger may be an indirect effect of the youth's behavior.

3 Child engages in fire setting behavior that intentionally places community members in danger of significant physical harm. Child attempts to use fires to hurt others.

RESPONSE TO ACCUSATION *Please rate highest level in the **past 30 days***

0 Child admits to behavior and expresses remorse and desire to not repeat.

1 Child partially admits to behaviors and expresses some remorse.

2 Child admits to behavior but does not express remorse.

3 Child neither admits to behavior nor expresses remorse. Child is in complete denial.

REMORSE *Please rate highest level in the **past 30 days***

0 Child accepts responsibility for behavior and is truly sorry for any damage/risk caused. Child is able to apologize directly to effected people.

1 Child accepts responsibility for behavior and appears to be sorry for any damage/risk caused. However, child is unable or unwilling to apologize to effected people.

2 Child accepts some responsibility for behavior but also blames others. May experience sorrow at being caught or receiving consequences. May express sorrow/remorse but only in an attempt to reduce consequences.

3 Child accepts no responsibility and does not appear to experience any remorse.

LIKELIHOOD OF FUTURE FIRE SETTING *Please rate highest level in the **past 30 days***

0 Child is unlikely to set fires in the future. Child able and willing to exert self-control over fire setting.

1 Child presents mild to moderate risk of fire setting in the future. Should be monitored but does not require ongoing treatment/intervention.

2 Child remains at risk of fire setting if left unsupervised. Child struggles with self-control.

3 Child presents a real and present danger of fire setting in the immediate future. Child unable or unwilling to exert self-control over fire setting behavior.

Intake Assessment Guidelines

1. Prior to the intake, obtain referral information by opening the client in CMP, double clicking on Appointment Service, and finding the referral source information in the box that opens. (In the event this information is missing, please complete this section based on information obtained during the intake.) 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 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. If telemental health is provided, therapist must notify clerical team member whether or not client presents to the appointment, so the appropriate services can be opened and/or closed.
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 the intake. If information shared during intake differs from information on the form, make the change and add your initials. ***Note: Family MUST provide income data in order to participate in services.**
4. Ensure that ACEs Questionnaire has been completed by the youth (age 13 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. If student is not yet school age or attends a private school, there will likely not be a student ID. *The Form should still be completed with* a note included at the top, indicating the reason no student ID is included (e.g., child is too young, child attends private school, not enrolled in PBC district school). The end date should be the date the child will turn 18 years old. ***Note:** Form must be completed or reason declined to sign must be included on the form (e.g., child attends private school, child is not yet school age, refused).
6. Review consent forms and explain confidentiality and its limits.
    a. Bill of Rights and Consent for Treatment (includes Consent to Telemental Health, Consent to Work with Trainees, Consent for Audio/Video Recording, and Consent/Assent to Participate in Research)
7. Obtain appropriate Releases of Information (ROI) to allow for correspondence between other agencies/individuals and Youth Services, when applicable.
    a. School
    b. Referral Source (Youth Court, FVIP, YFPI, 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 stepparent, aunt/uncle who lives in the home, adult siblings, etc.
8. Conduct intake interview.
    a. Use Intake Outline on the G drive (located at G:\EDUCATION and TRAINING CENTER\Students - Trainees\Intakes\Intake Outline 2023) as a guide.
    b. Determine presenting issues (assess reasons for seeking treatment and goals for therapy)

c. Collect notable information regarding household family members (e.g., medical, school, behavior, substance use, legal, emotional, social, family relationships, abuse/neglect, trauma, prior psychiatric/psychological services, and behavioral observations)
d. Ensure there are no immediate safety concerns.
    i. If necessary, conduct Risk Assessment. *Always consult with a supervisor before the intake appointment has been completed regarding concerns in case there is a need to ask follow-up questions.
    ii. Administer CSSRS if suicidal ideation is endorsed. Refer to Risk Assessment Guidelines for more details.
    iii. If necessary, create a safety plan with youth/family (use YSD safety plan form on common drive (located at G:\EDUCATION and TRAINING CENTER\Students - Trainees\Risk Assessment-Abuse Reporting-Baker Act\Safety Plan) and add/complete Safety Plan task in CMP)
    iv. Always include a statement about abuse, neglect, suicidal/homicidal concerns, and substance use in the intake report, even if the family denied.
    v. Write Risk Assessment note in CMP. Refer to Risk Assessment Guidelines for more details.

9. Explain how treatment works:
    a. Family therapy-at least one parent/legal guardian MUST be present.
    b. Typically 12 weeks (variance allowed with supervisor approval and extension request when applicable)
    c. Two missed sessions (no show/cancellation) and case will be closed (unless supervisor approval to continue is obtained)
    d. Telemental health may be appropriate under certain circumstances
10. Explain other treatment options if appropriate:
    a. Individual Therapy (18-22)
        i. Youth between the ages of 18-22 may consent to their own individual therapy.
        ii. If a parent will participate in any of these sessions, the youth must sign an ROI allowing their participation.
    b. Parent-Child Interaction Therapy (PCIT)
        i. Most appropriate for parents with young children, between the ages of 2 through 7. Children between the ages of 8-12 may also be appropriate for PCIT, based on presenting problem. Consult with supervisor to determine appropriateness for PCIT.
        ii. This dyadic intervention works best for parents who struggle to effectively manage the disruptive behaviors of their children. The intervention is usually done with only one child, and later in treatment, siblings are incorporated.
        iii. PCIT typically ranges from 12-18 sessions and utilizes a bug-in-the-ear coaching method.
        iv. Internet-based PCIT (I-PCIT) is preferred but in-office PCIT may be offered.
    c. Highridge
        i. For adolescents ages 11 through 16.
        ii. Residential facility that provides PBC residents with 3 to 4 months of services, including family therapy, group therapy, individual therapy, and milieu therapy, as well as alternative PBC school.
        iii. Youth reside at the facility during the week and return home on Friday afternoon (Thursday night during summer) for the weekends with the family.

*Note: There may be variances in this schedule due to school district calendar/holidays.

iv. $75 fee (Activity Fee for sports and festivities).
v. Call Highridge at (561) 625-2540 to schedule a tour of the facility, complete paperwork, and schedule separate intake with John Harre.
vi. Address: 4200 North Australian Ave, WPB, FL 33407

d. Parenting:
    i. Individual Sessions may be provided at all outpatient offices.
    ii. Groups at Ed Center are limited and scheduled only with demand: typically 7 weeks; 1 to 1 ½ hr. sessions, Dates TBD as needed
e. FVIP Group
    i. Offered at YFC location below:
        - **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, Suite 203, West Palm Beach, FL 33415; 561-242-5714
    ii. Step-Up Curriculum (anger management group) is offered over the course of 14 group sessions. Additional information on the group content can be found in the FVIP section of the Handbook.
    iii. Group 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.
    iv. If the group is required by FVIP, 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. The youth (offender) and at least one parent (preferably the victim) are required to participate. If the victim is another sibling or family member (not the parent), they are strongly encouraged to participate in services.

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 one more week to provide documentation or case will be closed.
12. Ensure that address, phone numbers, and email addresses are correct and complete.
13. If there are additional household members not already listed, obtain information for those individuals and write their information on the FIF so clerical team member can input all household members into CMP.
14. Make sure family chooses Yes or NO for ALL items in the Questionnaire section. *DO NOT leave blank.
15. Obtain days/times family/client will be available for services. Note availability on the Intake Report and inform clerical via email upon completion of intake if the client can be scheduled immediately.
16. If time permits, complete appropriate International Trauma Questionnaire (ITQ) child or adult version with identified patient. Review results with parents/guardians prior to end of intake.
17. On Intake Report, indicate preference for in-person services or telehealth.
18. Provide completed FIF and other intake forms to clerical for data entry and scanning into CMP.
19. Complete intake notes and task:

a. Intake Assessment/Office or Video/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). In cases in which the family completes paperwork prior to the intake appointment, the allotted time is usually 1.5 hours. *Note: The full time that was scheduled for the intake should be documented regardless of the actual completion time of the intake assessment. If the intake runs over the scheduled time, document the actual length of time.
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. Write a case management note for the time it took to complete the intake report (e.g. “Intake report completed and entered into CMP”).
d. Clerical will update demographic information in CMP.
e. 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 “Waiting for Approval.”

Residential Intake Assessment Guidelines

If family is a no-show:

- Enter No-Show Note in CMP under Appointment-Residential Service
    - Note Type: Intake Assessment
    - Contact Type: Office
    - Status: No-Show
    - "Family did not arrive to intake assessment scheduled for XX/XX at XXpm. Family did not attempt to contact the office to cancel or reschedule."
- Notify via email to let her know that family no-showed and needs a follow-up call to reschedule.
- Receptionist or Intake Coordinator will follow up with family, and close case if appointment is unable to be rescheduled or they are unable to contact.

If family arrives to intake appointment:

Before beginning an intake:

- Receive paperwork from receptionist and verify paperwork has been completed fully
    - Medical history
    - Family Information Form (FIF)
        - Must be signed – counts as consent for the intake
    - ACEs
    - Release of Student Information
    - Check to ensure that School Data Release Form has been filled out completely and **must include the child's school ID #.** Also, advise that the dates for the release are from *TODAY'S DATE until DATE OF CHILD'S 18TH BIRTHDAY.* This allows the school district to provide longer term data for program evaluation
- Triple check for signatures!

The Interview

- Check that parent has agreed to have intake conducted by a student (on consent form and on FIF).
- Review Informed Consent, confidentiality (mandated reported status), and overview of the purpose of the session (information gathering as opposed to therapy)
    - Overview of Session:
        - Review paperwork.
        - Participate in intake interview, information gathering.
        - Overview of Highridge program and how it can support the family based on presenting concerns.
        - If interested in program, complete required CMP paperwork and provide with take-home paperwork and forms.

Intake Questions (can use Intake Template in the G-Drive)

- Custody.
- Student ID #.
- Household members.
- Presenting Problems (reasons for seeking treatment).
- Medications – Past & Current (name, dosage, prescribing doctor).
- Hospitalizations – How many? When? Circumstances?
- Medical Concerns.
    - Allergies/Health Issues.
- Behavior.

- Family relationships.
- Abuse/neglect history?
- Risk Assessment - Suicidal or Homicidal Ideations, self-harming behaviors, abuse.
- Arrests/Legal Involvement/DCF Involvement
    - FVIP, Youth Court, or other court charges.
- Substance Abuse (youth AND family).
    - How often? How much? What specific substances?
- School (Exceptional Student Education? Grades? Suspensions/Expulsions? For what behaviors?)
    - Retention.
    - Individualized Education Plan/504 Accommodation Plan.
- Prior psychiatric/psychological services (hospitalizations, counseling, treatment, diagnoses etc.).
- History of Trauma and Adversity.
- Social Interests.
- Strengths.
- Write behavioral observations.
- Assess risk (suicide, homicide, abuse, neglect) and safety plan, if needed. Make an abuse report when needed.

Give Overview of the Program:

- 3-4 month residential program, ages 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 (6:45am) and pick up is Friday afternoon (as soon as school lets out) 12:45pm; Summer and holiday hours vary; typically the program is closed on Fridays during the summer and pickup is scheduled for Thursday afternoon.
- Referrals come from schools, outpatient, community, and court system.
- Philosophy of care is trauma-informed and family systems based.
- Residents are on a point system; parents to complete point cards on the weekends.
- Family therapy is mandatory one time per week; 2 missed family sessions may result in dismissal from program.
- Immediate pick up for serious safety issues (Overnight Parental Intervention - OPI) or illness (please see medical information for specifics).
- Residents receive individual, group, and family therapy.
- On-site school is a PBC School District public school – grades transfer in and transfer out when they leave.
- Provide contact # for school, 504/IEP, and credit questions, etc. Highridge School 561-494-0040.
- Program is "voluntary" – Assess willingness to attend program, **if child is adamant about not coming, pull parents in without child to explain voluntary nature of the program**.
- $75 ACTIVITY FEE (for rewards and incentives for youth in the program) to be collected upon admission. If family does not have the funds, they can pay at orientation and/or develop a payment plan.
- *Can take family to tour dorm if no residents are present.*

If client seems like a good fit and is willing to attend, continue below:

Encourage family to complete this step at intake appointment even if unsure, as will have to schedule follow-up appointment to complete otherwise.

- Contact Ms. Noelia to open a new service "Intake-Residential" (can also be opened by Ms. White, Mr. Harre, Dr. Terrell and Dr. Hargrove).
- Have parents/guardians and youth (when appropriate) sign the following forms:

    - Bill of Rights and Consent for Treatment (parents & youth).
    - Highridge Parent Guardian Agreement.
    - Consent for Psychological Evaluation (parents & youth).
    - Emergency Contact and Transportation Agreement.
        - Must provide three alternative contacts.
    - Consent for Emergency Medical Treatment.
    - Medical Care.
    - ROI General for relevant parties.
        - Pediatrician required.
        - Psychiatrist (if needed).
    - ROI School Board.
    - COVID Assumption of Risk

Note: these forms should automatically populate in the Tasks bar of CMP
Note: some forms need to be "Finalized" to have access to the signature boxes

- Make a copy of parents/guardians driver's licenses or other identification.
- Give parents/guardian packet to bring home.
    - "What happens next" document.
    - School registration – inform parents they can complete and bring to orientation.
    - Clothing supply list.
    - Overview of Sanctuary.
    - General Medical Clearance.
    - Medical forms if needed
        - Psychiatric Clearance.
        - Diet & Allergy Form.
- Print the following signed forms and provide to family:
    - Bill of rights.
    - Highridge parent/guardian agreement.
    - Medical care.
- Explain to parents that the information will be provided to the program administration who will conduct the review process, which doe takes time. Inform that the process of review cannot formally begin until all necessary paperwork has been received, whether from the parent or from doctor, psychiatrist, etc.
    - If family follows-up on status of admission at any time, inform them that information is under review with program administration who will contact the family once a decision has been reached. Record contact in CMP and inform supervisor of status request.

Forms for Signature

Tasks/Forms Needing Signatures

1. **Bill of Rights/Consent for Treatment (parents & youth).**

PRINT COPY FOR PARENT

2. **Highridge Parent/Guardian Agreement.**

PRINT COPY FOR PARENT

3. **Consent for Psychological Evaluation (parents & youth).**
4. **Emergency Contact & Transportation List.**
5. **Medical Care.**

PRINT COPY FOR PARENT

6. **Consent for Emergency Medical Treatment.**
7. **COVID Assumption of Risk.**
8. **ROI School- if attending Public School. If not a public school, add ROI general and add name of school.**
9. **ROI for any recent/current therapist, psychiatrist, pediatrician, community agency.**
10. **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.

If client is unwilling to attend, or does not seem like a good fit:

- Complete intake service note under Appointment – Residential Service.
  - Note Type: Intake Assessment
  - Contact Type: Office
  - Status: Attended
  - "Family attended and completed the intake session. Intake assessment completed by this clinician on XX/XX at XXpm."
- Complete case management note with summary of client information and paragraph why client is not being recommended to Highridge and what resources (if any) were provided to the family under Appointment – Residential Service.
  - Note Type: Case Management
  - Contact Type: Office
  - Example Write Up: "Youth is a 14-year-old, White, Non-Hispanic female currently enrolled in the 9th grade at High school, who resides with her mother. Youth's mother reported that Youth endorses significant behavioral concerns including academic underperformance, poor attendance, and frequent class skipping, along with consistent refusal to complete assignments. Youth's mother disclosed multiple instances of police involvement in the home due to Youth's behaviors, including eloping with friends whom Youth's mother identified as a negative peer group. Youth disclosed current engagement in alcohol and marijuana use, and reported a history of nicotine use within her peer group. Youth's mother indicated that Youth has previous involvement with mental health providers, including therapists and psychiatrists, and was prescribed Wellbutrin and Abilify. Youth's mother reported that Youth has been diagnosed with ADHD and Disruptive Mood Dysregulation Disorder (DMDD). Youth's mother reported initiating a Baker Act in September 2024 following Youth's disclosure of a plan to engage in self-harm, and again in November 2024 due to concerns with expression of suicidal ideation. Youth reported experiencing infrequent suicidal ideation but denied current plan, stating she was "too strong in her faith" to have intent. Youth reported engaging in self-harm behaviors within the past month without intent to die, indicating she had a desire to stop

the act once she cut deep enough on her arm that it began to bleed. Youth stated her refusal to participate in residential treatment services at the time of intake, though the family reported they would discuss commitment to participate in treatment over the weekend. Family was encouraged to contact the office should Youth reconsider involvement in the program."

- Example End Paragraph: "Based on information shared and observed, it was determined that Client's symptoms do not meet the criteria for residential treatment. Client was recommended to receive an updated psychiatric/medication evaluation to address his mood difficulties. Ms. Mom was also encouraged to look for providers in network with their insurance."

After the family leaves:

- Scan and upload FIF, parent ID, and other completed forms to (CMP) under Intake-Residential Service.
  - Scan and upload each form individually, as well as together in a Complete Intake Paperwork PDF.
  - Make sure that student ID number is entered in the demographic details field for the client. Alert John and your supervisor to any potential issues or questions. These might include court charges, psychiatric or medical issues, history of violence, and/or questions related to goodness of fit for the program.
- Complete intake service note under Intake – Residential Service.
  - Note Type: Intake Assessment
  - Contact Type: Office
  - Status: Attended
  - "Family attended and completed the intake session. Intake assessment completed by this clinician on XX/XX at XXpm."
- Complete intake report and case management note in CMP.
- Complete tasks / mark tasks complete:
  - Scan and attach driver's license.
  - Intake service note written.
  - Assess custody, upload proof of custody.
  - Scan and attach FIF and medical history.
  - Intake Report.
- Data entry tasks such as FIF and medical history, will be completed by receptionist (Ms. Noelia) once you inform them that documents have been scanned and uploaded to CMP chart.
- Leave task "*Appt-Res Service Only* Referral Source Information Completed"
  - Do **NOT** mark this completed, reception will take care of it!
- Place intake report and completed forms in folder labeled with the case number and child's last name in the Pending Mailbox outside of the administrative offices.
  - If family returns medical paperwork, scan, upload to CMP and then place in Nursing review mailbox.
  - If all paperwork is uploaded and completed, give file to Ms. White for review.

One Week Follow-up:

- Clinician is responsible for 1st contact attempt to follow-up with family regarding status of paperwork completion.
  - Enter case management note to document follow-up contact/attempt.
- If forms are obtained, scan, upload to CMP and ensure labeled folder is placed in appropriate Mailbox.
- Email receptionist informing her status of intake after the follow-up.

- In next supervision, request that supervisory put end date for self as case manager in Intake-Residential and Appointment-Residential services and add Amanda Terrell/Andrea White and receptionist as case managers.

Tasks/No Signatures Needed	Rationale
1. Assess Custody, Upload Proof of Custody.	**Adoption, Guardianship**
2. Scan and Attach DL and Insurance Card.	**Need ID of parent on file**
3. Scan and Attach FIF, Medical History, School Data Request, ACEs Questionnaire.	**Allows for data entry by clerical**
4. Complete Intake Report.	**Informational Report**
5. Write Intake Service Note. **and include any case management actions taken (faxing forms, etc.).**	**Tracks Direct Service Hours**
6. Provide School Registration and other take home forms to Family.	**Add form to "take home" info re: orientation** ***CMP: "Upon Admission"***
7. Follow up to ensure all requested information is received to complete case for review.	

ACEs Questionnaire
TO BE COMPLETED BY YOUTH

Parent's Name:_____ Today's Date:_____

Your 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 check each that apply to you.

1) Of the statements 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)

Revised 01/24/23

Release or Transfer of Student Information

PLEASE NOTE: Student ID# box is ***REQUIRED***. It must be entered on the form below. If student is not yet of school age or attends a private school, there will likely not be a student ID. *The Form should still be completed and signed* and a note should be included at the top, indicating the reason that no student ID is included (e.g., child is too young, private school, not enrolled in PBC school, refused)

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**
Donna Goodwin	242-5732		DGoodwin@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

Professional Presentations Guidelines

Psychology interns and postdoctoral fellows will 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. Topics should be grounded in research, and relevant to the mission and population served by the Division. It is usually acceptable for the presentation to be the trainee's dissertation topic, provided the topic relates to the Youth Services' mission. A two-hour presentation is expected. Trainees should determine with their supervisor and/or the Training Director if the presentation will be appropriate to present to the public, in addition to YSD staff and trainees. Some trainings may be appropriate to offer Continuing Education (CE) credits to attendees. A trainee interested in opening their presentation up to the public and/or offering CE credits must complete their PowerPoint and deliver an abbreviated mock presentation to a supervisor at least three weeks in advance for approval. Standards set forth by the American Psychological Association (APA) should be followed. Trainings are primarily delivered remotely via the Zoom platform. Appropriate visual aids, such as a PowerPoint presentation, are required and multimodal learning strategies should be incorporated (e.g., videos, Zoom polls). At least five professional references from the past five years must be included. Only 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:

- The Presenter Info Form should be completed and returned to your supervisor for review, and then sent to Dr. Ginsburg for approval at least 4 weeks prior to the scheduled presentation date. This timeline is important in order for training flyers to be prepared, posted, and sent out with ample notice.
- PowerPoints and handouts should be emailed to your supervisor two weeks prior to a presentation so feedback/support can be provided as needed. Dr. Ginsburg will review the final version.
    - Include the YSD logo, credentials and title, and identify Education & Training Center on your title page.
    - Include a slide with YSD referral information at the end of your presentation.
- The PowerPoint version that you want printed and any other handouts need to be emailed to Dr. Ginsburg and Cristal Montepeque by the day before your didactic (Tues) at 3pm so there is sufficient time to prepare a PDF to send out and/or to make copies.
- If video clips are included in your presentation, you must provide the links in a separate document so training facilitator(s) can easily access them in the event that backup is required due to unforeseen technology issues. Embedding videos is strongly recommended.
- Please arrive at the presentation location (virtual or in-person) at least 30 minutes early in order to ensure that everything is set up and working correctly. A test Zoom training is recommended to resolve any screen sharing or audio/video issues. Be sure to have your presentation on a jump drive to ensure ease of access to your presentation (in case of technology issues).

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. **The following terms should be AVOIDED:** *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.
○ 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.	○ 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 they have 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.* ○ 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)
- 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)
- 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

Standards and Criteria for Continuing Education

Presenters who intend to offer Continuing Education (CE's) for their trainings should refer to Standards C and D from the Standards and Criteria for Approval of Sponsors of Continuing Education for Psychologists (APA, 2015).

STANDARD C

EDUCATIONAL PLANNING AND INSTRUCTIONAL METHODS

PRINCIPLE

Successful continuing education in psychology requires: (1) careful educational planning that results in a clear statement of educational objectives; (2) the use of appropriate educational methods that are effective in achieving those objectives; (3) a clear connection between program content and the application of this content within the learner's professional context; and (4) the selection of instructional personnel with demonstrated expertise in the program content.

CRITERIA

1. Sponsors must develop educational objectives that clearly describe a) what participants are expected to learn; and b) how participants can apply this knowledge in practice or other professional contexts.
2. Sponsors must include instructional methods that actively engage the learner to enhance acquisition of knowledge and, where appropriate, facilitate translation into practice.
3. Sponsors must select instructors with expertise in the program content and who are competent to teach this program content at a level that builds upon a completed doctoral program in psychology.

Educational and Technical Assistance

Every program offered for CE credit must have predetermined learning objectives. Rather than a description of topics to be covered, learning objectives should clearly define what the participant will know or be able to do as a result of having attended the program, and these objectives must be stated in measurable terms. When determining how many Learning Objectives (LO) should be established, the following guidelines should be utilized (please note that the quality and quantity should be considered of LO for all programs, particularly for those longer than 8 hours):

- *2-3 LO for 1-3 hours*
- *3-4 LO for 4-6 hours*
- *5-6 LO for 7-8 hours*

CE activities can be delivered via numerous methods which include, but are not limited to: workshops, seminars, conferences, conventions, grand rounds, lectures, books, videotapes, audiotapes, CD-ROMs, and web-based activities. All CE activities, regardless of the delivery method, must adhere to the Standards of the APA Approval of Sponsors of Continuing Education for Psychologists.

Although it is not required that instructors be psychologists, they must have expertise and be competent in the areas in which they teach. Expertise might be demonstrated by some combination of the following: relevant educational experience such as holding a doctoral degree in psychology, review of records of previous teaching experiences, years of clinical experience, publications in areas relevant to the content being taught, evaluation forms from previously offered programs, personal knowledge of the instructor's teaching ability, and references.

For additional application support materials, please refer to our Resources page.

STANDARD D

CURRICULUM CONTENT

PRINCIPLE

The content of continuing education is the crucial component intended to maintain, develop, and increase conceptual and applied competencies that are relevant to psychological practice, education, and science. All CE programs offered for CE credit for psychologists must comply with Standard D criteria. CE programs must be grounded in an evidence-based approach. CE programs that are focused on application of psychological assessment and/or intervention methods must include content that is credibly supported by the most current scientific evidence. CE programs may also provide information related to ethical, legal, statutory or regulatory policies, guidelines, and standards that impact psychology.

CRITERIA

1. Sponsors must document that the content of each CE program meets one of the following:
    - 1.1 Program content focuses on application of psychological assessment and/or intervention methods that have overall consistent and credible empirical support in the contemporary peer reviewed scientific literature beyond those publications and other types of communications devoted primarily to the promotion of the approach;
    - 1.2 Program content focuses on ethical, legal, statutory or regulatory policies, guidelines, and standards that impact psychological practice, education, or research;
    - 1.3 Program content focuses on topics related to psychological practice, education, or research *other than* application of psychological assessment and/or intervention methods that are supported by contemporary scholarship grounded in established research procedures.
2. Sponsors are required to ensure that instructors, during each CE presentation, include statements that describe the accuracy and utility of the materials presented, the empirical basis of such statements, the limitations of the content being taught, and the severe and the most common risks.
3. Sponsors must offer program content that builds upon the foundation of a completed doctoral program in psychology.
4. Sponsors must be prepared to demonstrate that content is relevant to psychological practice, education, and/or science.
5. Sponsors must have a process to identify any potential conflict of interest and/or commercial support for any program offered, and they must clearly describe any commercial support for the CE program, presentation, or instructor to program participants at the time the CE program begins. Any other relationship that could be reasonably construed as a conflict of interest also must be disclosed. Individual presenters must disclose and explain the presence or absence of commercial support or conflict of interest at the time the CE program begins.

Psychological Evaluation Procedures

Psychologists, postdoctoral fellows, doctoral interns, and psychology practicum trainees 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 with referral source, review of previous records, clinical interview(s), and information garnered during the assessment process.

Referrals are made primarily by the Youth Services Department's (YSD) Residential Treatment & Family Counseling Division team members who submit referral questions via the CMP electronic charting system. Referrals also are made by Community Based Agencies funded by the YSD through completion of an electronic or paper referral form. The Chief of Clinical Services, Education & Training or designee reviews referrals and, if appropriate, adds them to the Testing Waitlist. When an evaluator becomes available, the Testing Supervisor assigns the case to a psychology fellow, intern, or practicum trainee. The assigned evaluator first contacts the referring therapist to consult about the reason for referral. During consultation, the evaluator determines the utility and necessity of proceeding with testing. It is the responsibility of the referral source to ensure that previous reports have been obtained from the family. In some instances, teletesting may be utilized/incorporated as part of the evaluation. Due to potential ethical and validity concerns regarding teletesting, decisions regarding teletesting will be made on a case-by-case basis by the Testing Supervisor.

The evaluator then contacts the family and schedules the clinical interview(s) **and** evaluation sessions. The clinical interview can be completed in-person at the Education & Training Center or via Zoom (see clerical staff to send out Zoom link). The clinical interview is conducted with the child's caregiver(s), or if client is an adult (18 to 22), the interview is conducted with the client where they complete the *consent for psychological evaluation* and appropriate *releases of information*, as well as discuss relevant history. Additional measures (e.g., rating scales, objective measures) deemed necessary for the evaluation should be given to caregivers upon completion of the interview. Attempts to interview both parents/caregivers should be made. Ideally, interviews should be scheduled and completed within one week of assignment of the case. If the decision is made to proceed following the interview, 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) documentation. Testing should start 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 CPT and WISC-V, are of questionable validity if timing of administration is not within optimal hours.

Evaluation measures and kits are located at the Education & Training Center in the file cabinet labeled 'Testing Materials' in the testing library 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. If tests, manuals, and other assessment materials are being used outside the Education & Training Center, please return the items within 24 hours after the session.

In rare circumstances, assessment materials may be checked out overnight if not needed by another evaluator. 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. Trainees must

note all protocols utilized during an assessment so number of protocols used and remaining can be adequately tracked.

Most measures can be accessed from any computer by visiting the designated website and entering the username and password. Usernames and passwords can be found in the G-Drive in the respective folder. Please check this document prior to accessing tests or scoring content, as passwords are updated periodically. There is a designated testing computer on which certain psychological evaluation measures can be administered and scored, which is located in the Education & Training Center conference room. Scoring programs are available for the following measures: ARES, Roberts-2, and Rorschach. The ARES and Roberts-2 require a key fob to be inserted prior to scoring (already inserted in the testing computer).

Important due dates regarding psychological evaluations are listed in the Requirements and Expectations section of the Handbook. Raw data should be given to a peer upon completion of scoring for an interrater reliability scoring check. An initial draft of the report along with raw data is due to the designated supervisor within two weeks of the final testing administration (after all measures have been scored and checked for accuracy via an interrater reliability check). The supervisor will review the draft and provide feedback. Password protection should be used when writing and transmitting report drafts. 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/are provided with an original signed report or a password protected PDF copy (clerical at the Ed Center can add a password to a PDF using the child's date of birth in this format MMDDYYYY) 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 (or Video if telehealth)** note type. A **Case Management/Office** note is written to document that the materials (raw data and original report) are filed at the Education & Training Center. A report is also scanned into CMP. Throughout testing, **Scoring/Interpretation/Report Writing** notes should be written to document 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 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 (consult with supervisor if unable to meet the deadline).
- 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. **Adverse Childhood Experiences (ACEs)**
   - Measures the number of adverse childhood experiences experienced
   - Parents/Caregivers can complete on behalf of youth; 10 years or older can complete on their own
   - Form given by clerical to all clients as part of intake paperwork
   - Additional copies can be found on the G:Drive
   - Administration: <5 minutes

2. **Anger Regulation and Expression Scale (ARES)**
   - Comprehensive, self-report assessment of expression and regulation of anger for children and adolescents
   - Assesses tendencies towards inward and outward expressions of anger and the range and duration of anger experiences
   - Full-length version and a short version (ARES[S])
   - 10 to 17 years
   - 5th grade reading level
   - Administration Time : 5 minutes (Short Version), 15 minutes (Long Version)
   - Scores/Interpretation: Computerized scoring available requires a key fob (kept plugged in the testing computer located in the conference room)

3. **Autism Diagnostic Observation Schedule, Second Edition (ADOS-2)**
   a. Used in assessing and diagnosing autism spectrum disorders across age, developmental level, and language skills
   b. Specialized training required prior to administration
   c. 12 months to adulthood
   d. Administration Time: 40 to 60 minutes
   e. Scores/Interpretation: Manualized scoring

4. **Autism Spectrum Rating Scales (ASRS)**
   - Multi-informant measure to identify symptoms, behaviors, and associated features of ASDs
   - Parent form for children 6-18 years old available in both paper form and online
   - All other forms are available online through MHS.
   - 2 – 18 years
   - Administration Time: Full form: 20 minutes, Short form: 4 minutes
   - Scores/Interpretation: Manual scoring or ASRS Online Scoring Software on MHS

5. **Beck Depression Inventory, 2nd Edition (BDI-II)**
   - Self-report instrument for measuring the severity of depression
   - 13 to 80 years
   - 5th grade reading level
   - Administration Time: 5 minutes
   - Scores/Interpretation: Manual scoring

6. **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
- Scores/Interpretation: Manual scoring

7. 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
- 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 2-7
- Administration Time: 10–15 minutes each (Short and Full Format)
- Scores/Interpretation: Manual scoring

8. The Beery-Buktenica Developmental Test of Visual Perception, 6th Edition (Beery VP)

- Screens for visual deficits
- 2 to 100 years
- Administration Time: 5 minutes
- Scoring/Interpretation: Manual scoring

9. 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 to 21 years (TRS and PRS); 8 years through college age (SRP), with 2nd grade reading level
- Spanish version available
- Administration Time : 10-20 minutes (TRS and PRS), 30 minutes (SRP)
- Scoring/Interpretation: Q-Global online scoring

10. Behavior Rating Inventory of Executive Function, 2nd Edition (BRIEF-2)

- Comprehensive measure of executive functioning includes Parent, Teacher, and Self-Report
- 5 to18 years (parent and teacher forms); 11 to 18 years (self-report form)
- 5th grade reading level
- Administration Time: 10-15 minutes
- Scoring/Interpretation: PAR online scoring; Takes about 15 minutes to score

11. Child and Adolescent Functional Assessment Scale (CAFAS)

- Objective measure completed on computer by HRFC 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
- Scoring/Interpretation: Online completion and scoring

12. Children's Apperception Test (CAT)

- Projective Personality Assessment
- Help identify dominant drives, sentiments, conflicts and complexes
- 3 to10 years
- Administration Time: 20-45 minutes
- Scoring/Interpretation: Qualitative scoring of stories

13. 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
- Scoring/Interpretation: Manual scoring

14. Comprehensive Assessment of Spoken Language, 2nd Edition (CASL-2)

- Individually administered performance tests measuring Lexical/Semantic, Syntactic, Supralinguistic, and Pragmatic Language
- 3 to 21 years
- Administration Time: 45 minutes for General Language Ability Index
- Scoring/Interpretation: Online scoring on WPS Online Evaluation System

15. Conners 4th Edition (Conners 4)

- Comprehensive assessment of symptoms and impairments associated with ADHD and common co-occurring problems and disorders in youth.
- Parents and teachers of children and adolescents ages 6 to 18 years
- Self-report ages 8 to18 years
- 3rd grade reading level for self-report
- Spanish version available for parent reports
- Administration Time: Long Version: 12-15 minutes, Short Version: 5–7 minutes
- Scoring/Interpretation: Online administration and scoring on Q-Global; paper forms also available on G:Drive

16. Conners Continuous Auditory Test of Attention (CATA)

a. Computerized assessment of auditory processing and attention-related problems
b. 8 years and older
c. Administration Time: 14 minutes
d. Scoring/Interpretation: Online administration and scoring on MHS

17. Conners Continuous Performance Test 3rd Edition (CPT 3)

a. A task-oriented, computerized assessment of attention-related problems, including inattentiveness, impulsivity, sustained attention, and vigilance.
b. 8 years and older
c. Administration Time: 14 minutes
d. Scoring/Interpretation: Online administration and scoring on MHS

18. Columbia-Suicide Severity Rating Scale (C-SSRS)

- Supports suicide risk screening through a series of simple, plain-language questions
- Determines risk for suicide, severity and immediacy of risk, and level of support needed
- All ages
- Covers three areas: suicidal ideation, intensity of ideation, and suicidal behavior
- Administration Time: 5-15 minutes
- Scoring: Manual scoring

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

- Supports early intervention efforts to reduce or eliminate significant emotional and behavioral concerns in preschool children
- Uses: (1) Guide interventions, (2) Identify children needing special services, (3) Assess outcomes, (4) Help programs meet Head Start, IDEA, and similar requirements
- 2 to 5 years
- Administration Time: 10-15 minutes
- Scoring/Interpretation: Manual scoring

20. Eyberg Child Behavior Inventory (ECBI)

- Measures conduct problems; Assesses frequency of disruptive behaviors in the home
- Reported by parents
- 2 to 16 years
- Administration Time: 5-10 minutes
- Scoring/Interpretation: Manual scoring takes 5 minutes; online scoring for PCIT families at the Ed Center

21. Expressive Vocabulary Test, 3rd Edition (EVT-3)

- Measures expressive vocabulary and word retrieval for Standard American English
- Co-normed with PPVT to directly compare receptive and expressive vocabulary
- 2 to 90+ years
- Administration Time: 15 minutes
- Scoring/Interpretation: Manual scoring

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

- Projective personality assessment to evaluate personality, emotional state, and cognitive functioning
- Instructions are in testing library cabinet
- Administration Time: Variable
- Scoring/Interpretation: Qualitative interpretation; see interpretation guide on G:Drive

23. International Trauma Exposure Measure (ITEM)

- Checklist of traumatic life events
- Measures exposure to various traumatic life events across different developmental periods (childhood, adolescence, and adulthood)
- Co-developed with the International Trauma Questionnaire
- Administration Time: 10 minutes
- Scoring/Interpretation: Qualitative interpretation; see administration and interpretation guide on G:Drive

24. International Trauma Questionnaire (ITQ) and Child and Adolescent Version (ITQ-CA)

- Brief measure of symptoms of PTSD and complex PTSD (CPTSD) defined by ICD-11
- Child and adolescent version is for ages 7 to 17 years
- Adult version for ages 18 and older
- 2nd grade reading level
- Administration Time: 10 minutes
- Scoring/Interpretation: Manual scoring; See interpretation guide on G:Drive

25. Kaufman Brief Intelligence Test, 2nd Edition, Revised

- Measures verbal and nonverbal intelligence quickly
- Ages 4 through 90 years
- Administration Time: 20 minutes
- Scoring/Interpretation: Manual scoring and online scoring on Q-Global

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

- Measure of academic achievement for grades pre-k thru 12 or ages 4 thru 25 years
- Criterion-referenced assessment in the domains of reading, mathematics, written language, and oral language
- Co-normed with KABC-2 and WISC-V
- Administration time: 15 to 85 minutes
- Scoring/Interpretation: Q-Global online scoring

27. 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 their family and the overall family dynamics
- Administration Time: Variable
- Scoring/Interpretation: Qualitative interpretation

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

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

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

- Designed to evaluate the magnitude of stress in the parent-child system
- Domains: child characteristics, parent characteristics, situational/demo life stress
- Completed by parents of children ages 1 month to12 years
- Spanish version available
- Administration Time: 20 minutes
- Scoring/Interpretation: Manual scoring takes about 5 minutes

30. Peabody Picture Vocabulary Test, 5th Edition (PPVT-5)

- Measures receptive vocabulary for standard English and a screening test of verbal ability
- Co-normed with EVT-3
- 2:6 to 90+ years

- Administration Time: 10-15 minutes
- Scoring/Interpretation: Manual scoring

31. Personality Assessment Inventory- Adolescent (PAI-A)

- An objective personality assessment for use with adolescents
- 12 to 18 years
- 4th grade reading level
- Administration Time: 25-35 minutes
- Scoring/Interpretation: PAR online scoring

32. 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
- Elementary reading level
- Administration Time: 10-15 minutes
- Scoring/Interpretation: Manual scoring

33. 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
- Scoring/Interpretation: PAR online scoring

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

- Evaluates children's social perception (either adaptive or maladaptive/atypical)
- Free-narrative storytelling format
- Alternate picture cards available for Caucasian, African American, and Hispanic children
- 6 to18 years
- Administration Time: 30 to 40 minutes
- Scoring/Interpretation: Computerized scoring available
- Requires a key fob (kept plugged in the testing computer located in the conference room) for scoring.

35. Rorschach

- Projective assessment examines personality characteristics and emotional functioning
- **Identifies basic personality structure and problem-solving strategies in children, adolescents, and adults**
- Exner scoring system utilized at Ed Center
- 5 years and older
- Administration Time: 45-60 minutes
- Scoring/Interpretation: Computer scoring using RIAP program on testing computer in the conference room; Scoring Time: 40 minutes (experienced evaluator)

36. 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 Time: 20-40 minutes
- Scoring/Interpretation: Manual scoring

37. 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
- Scoring/Interpretation: Qualitative Interpretation

38. 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
- Scoring/Interpretation: Manual scoring

39. Social Responsiveness Scale, Second Edition (SRS-2)

a. Identifies presence and severity of social impairment within the autism spectrum and differentiates it from that which occurs in other disorders
b. Parent and teacher rating scales for ages 2 years, 6 months to 18 years; adult self-report and other-report for ages 19 and up
c. 2 years, 6 months through adulthood
d. Administration Time: 15-20 minutes
e. Scoring/Interpretation: Online scoring on WPS Online Evaluation System

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

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

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

- A measure of conduct problems in children
- Reported by teachers
- 2 to 16 years
- Administration Time: 5-10 minutes
- Scoring/Interpretation: Manual scoring takes about 5 minutes

42. 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)
- Scoring/Interpretation: Manual scoring

43. Thematic Apperception Test (TAT)

- Projective personality assessment of interpersonal relationships, dominant drives, emotions, and conflicts
- 5 years and older
- Administration Time: 40-60 minutes
- Scoring/Interpretation: Qualitative interpretation

44. Trauma Symptom Checklist for Children (TSCC)

- Self-report measure of posttraumatic stress and related psychological symptomatology in children who have experienced traumatic events
- 8 to16 years
- Administration Time: 15-20 minutes
- Scoring/Interpretation: Manual scoring

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

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

46. Vineland Adaptive Behavior Scale, 3rd Edition

- Measure of adaptive functioning in communication, daily living, and socialization
- Interview and Parent/Caregiver Form for individuals 0-90 years; Teacher Form pertains to youth 3-21 years
- Comprehensive versions and Domain-level versions
- The leading instrument for supporting the diagnosis of intellectual disability
- Administration Time: Varies depending on version selected
- Scoring/Interpretation: Manual or Q-Global online scoring

47. Wechsler Adult Intelligence Scale, Fifth Edition (WAIS-5)

- Measure of cognitive abilities for adolescents and adults
- 16 to 90 years
- Administration Time: 45 minutes for FSIQ; 60 minutes for the 10 primary index subtests
- Scoring/Interpretation: Manual or Q-Global online scoring

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

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

- Scoring/Interpretation: Manual or Q-Global online scoring

49. Woodcock-Johnson Tests of Achievement, Fifth Edition (WJ-V ACH)

- Digitally administered measure of academic achievement
- 2 to 90+ years
- Administration Time: 60 -90 minutes for broad academic achievement
- Scoring/Interpretation: Administer and score on iPad while logged into WJ Score

50. Woodcock-Johnson Tests of Cognitive Abilities, Fifth Edition (WJ-V COG)

- Digitally administered measure of cognitive processing strengths and weaknesses
- Can also be used to obtain CALP score
- 2 to 90+ years
- Administration Time: 5 minutes per subtest
- Scoring/Interpretation: Administer and score on iPad while logged into WJ Score

Record Keeping Guidelines

The Main Reasons To Keep Records:
(from https://www.apa.org/practice/guidelines/record-keeping*)*

- Record keeping documents the psychologist's planning and implementation of an appropriate course of services, allowing the psychologist to monitor his or her work. 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.
- The process of keeping records involves consideration of legal requirements, ethical standards, and other external constraints, as well as the demands of the particular professional context. 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 of care.

Content of Records Needed per APA:
(from https://www.apa.org/practice/guidelines/record-keeping*)*
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).

Minimum APA Requirements for Therapy Note Content:

- Date of service and duration of session (automatically included in all CMP notes)
- Type of service (e.g., consultation, assessment, therapy)
    - Note how or where services were provided (in office, virtual, phone, etc.)
- Nature of professional intervention or contact (e.g., treatment modalities incorporated in the session)
- Formal or informal assessment of client status (e.g., client presentation, client response to the intervention used during the session)
- Plan (e.g., next scheduled session and intervention plans)

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 in 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 (Standards for Records) 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; 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 are documenting in the correct CMP 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, resident, parent, mom, dad, 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, passed away)
- 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, funerals, school visits/observations, and clinically meaningful incidental/chance encounters
- Be sure to document all completed risk assessments and abuse assessments
- 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 do not really go anywhere productive.
- In order to be clear and concise, 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 (Subjective, Objective, Assessment, Plan) = most commonly used, especially if notes will be shared with the medical community. Good for process-oriented therapies because they focus 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 (Data, Assessment, Plan) = popular and possibly the simplest. Good for process-oriented therapies.

PAIP (Problem, Assessment, Intervention, Plan) = allows you to focus 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.

Referral Guidelines

Competent training in evidence-based practice of psychology requires trainees to be aware of both the impact of one's 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 may be considered because of an unresolved and interfering value conflict with a client. There may be other times when a referral is considered due to a clinician's personal triggers in relation to the client's presenting problem or experiences. Clinicians should utilize self-reflection and seek supervision to explore personal triggers and identify signs that the client may no longer be the focus of treatment. 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 the individual 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 their ability to be helpful. Value conflicts must be distinguished from mere discomfort treating a person from any protected class. 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 and only after thoughtful reflection and consideration of the model outlined below. For this reason, trainees are encouraged to regularly explore how their personal values and lived experiences might influence their approach to training during supervision.

A referral may be appropriate in any of the following situations: (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 (despite the provision of the supervision), (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 the 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 that the value conflict is preemptive in nature or when the value conflict is negatively impacting the provision of competent services.
    - When a 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.

Resources:

American Psychological Association Task Force on Race and Ethnicity Guidelines in Psychology. (2019b). Race and ethnicity guidelines in psychology: Promoting responsiveness and equity. Retrieved from https://www.apa.org/about/policy/guidelines-race-ethnicity.pdf.

American Psychological Association, APA Task Force on Psychological Practice with Sexual Minority Persons. (2021). Guidelines for Psychological Practice with Sexual Minority Persons. Retrieved from https://www.apa.org/about/policy/psychological-sexual-minority-persons.pdf.

*Dunn, R., Callahan, J.L., Farnsworth, J.K., & Watkins, E. (2017). A proposed framework for addressing supervisee-supervisor value conflict. *The Clinical Supervisor, 36(2)*, 203-222, DOI: 10.1080/07325223.2016.1246395

*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.

Substance Use Assessment Guidelines

While the Youth Services Department does not provide specialized treatment for Substance Use Disorders, therapists, in consultation with their supervisor, should gather information needed in order to classify someone's substance use behaviors. When combined with clinical judgment, therapists can help determine levels of risk and aid in making clinical decisions about treatment and next steps to take.

*Note: For residents at Highridge Family Center, therapists are expected to follow the guidelines outlined in the HRFC specific PPM for substance use (PPM# YSD-RTFC-HRFC-O-010 Substance Use Protocol). For outpatient offices, consult with your supervisor for specific procedures related to your program needs and expectations.

For clients currently under the care of Youth Services, therapist will:

1. Assess for the type of substance(s) being used, duration of use (e.g., 6 months, 2 years), and frequency of use (e.g., daily, weekly).
2. Assess for functional impairment in the following areas
    a. Academic/Work
    b. Relationships
    c. Parenting
    d. Legal
3. Consider change behaviors
    a. Do they view their substance use as a problem?
    b. Has there been any attempt to decrease and/or stop use?
    c. How likely are they to maintain sobriety if they were required for work, school, residential care, participation in a diversion program, etc.?
4. Determine severity of substance use for youth
    a. Minimal/Mild [i.e. has only "tried" them; does not use them; infrequent intoxication or uses only marijuana (no other substances) without serious consequences]
    b. Moderate (i.e. Intoxication or drug use once or twice a week)
    c. Severe (i.e. frequent intoxication- 3 or more times a week, use of substances is associated with serious negative consequences)
        i. In severe cases and in some moderate cases, YSD services may not be appropriate and referrals to specialized substance abuse treatment should be provided.

When working with individual clients (18-22) or parents/caregivers:

5. If a client's substance use interferes with their ability to attend, engage in, and/or benefit from treatment, the clinician should make a referral to a community based agency that can provide specialized substance use treatment. In addition, clinicians should also consider risks for child abuse/neglect related to parental substance use such as lack of adequate child supervision due to parental intoxication, exposure and/or access to substances in the home, or child endangerment (e.g., driving a child while under the influence).

Although YSD does not provide specialized services to treat substance misuse, therapists may incorporate some of the interventions and techniques below into their individual and family therapy.

- Create genograms to explore familial patterns of substance use and trauma (especially given substance misuse and trauma/adversity often co-occur)
- Utilize motivational interviewing strategies (e.g., explore "readiness" to change, develop discrepancies, roll with resistance, improve self-efficacy)
- Identify warning signs/triggers and develop a plan for coping and distress tolerance
- Increase effective communication and problem-solving
- Increase supports
    - Provide resources and referrals (e.g., mentorship, economic support services, psychiatry for medication management)
    - Help client build a positive social/peer group
    - Improve connections for clients (e.g. LGBTQ groups, religious and/or spiritual mentorship)
- Identify and reinforce individual and familial strengths
- When indicated, utilize harm reduction strategies such as reducing the frequency of use, delaying the behavior (e.g., set a timer for five minutes when they have the urge to smoke marijuana), and avoiding dangerous activities while under the influence (e.g., swimming, driving).

Telemental Health Guidelines

Use this checklist to help structure Telemental Health sessions with your families/clients.

*For all clients engaging in telemental health, their appropriateness for this modality of treatment should be assessed during the intake as well as the initial therapy session. If at any time the therapist no longer considers this modality to be appropriate, the family will be notified and rescheduled for in-person therapy.

Establish Ground Rules

- A Zoom link for all sessions will be provided by Youth Services at the start of treatment. The client should save this link and use the same one over the course of treatment.
- Under extenuating circumstances with connectivity issues, it may be deemed appropriate to use the telephone in lieu of videoconferencing software for a telemental health session, but these instnces should be limited.
- Therapists and clients should be on time for sessions.
- If a client needs to cancel or reschedule a telemental health session, the client should notify the office by calling or emailing 24 hours prior to the scheduled session.
- At the initial intake and therapy session, therapist should confirm client's identity by asking for specific identifiers (i.e. D.O.B, Address).
- Clients are expected to adhere to professional/school appropriate dress code for telemental health sessions. They should dress as though they are coming into the office for session.
- Due to the possibilitiy of encoutering technical difficulties during session, clients must agree to develop a plan at the beginning of each session, which may include providing an alternate phone number, restarting a device, or reconnecting to a program in order to resume services.
- Therapists will explain that telemental health will be provided over a password protected, secure network. It is the client's responsibility to ensure a secure connection from their end. Clients should be informed that despite security measures in place, breaches to security are possible.
- Sessions will NOT be recorded unless explicitly consented/assented to in writing prior to the inception of treatment and also verbally at the beginning of each session to be recorded. See 'Audio and Video Recording Guidelines' for additional information.
- Parent/guardian or other adult appointed by the child's parent/guardian must be present at the same location as any child under age 18 at the time of the session.
- If the client is having suicidal or homicidal thoughts, or experiencing a mental health crisis that cannot be resolved remotely, telemental health services may not be appropriate and either in-person services or a higher level of care may be required.

Emergency Protocols

- At the start of each session, the therapist must obtain the location/address of the client.
- The client is encouraged to establish an emergency contact (Name, Relationship, Address, Phone Number). An ROI should be signed in the event that the individual(s) identified is not the consenting caregiver already involved in treatment.
- In some instances, an emergency contact should be identified for the parent. Therapist discretion is expected in these situations.
- In the event of an emergency, therapist may need to contact the identified emergency contact and/or appropriate authorities.

- If the client is having suicidal or homicidal thoughts, or experiencing a mental health crisis, the therapist should conduct a risk assessment as needed.
- Therapist should complete a safety plan when appropriate and send a copy of the plan to the youth and parent/guardian.

Setting Up the Environment

- The client must designate a therapy area, which should be a quiet, well-lit, and private space that is free from distractions.
- Everyone participating in session must limit chances of distractions and interruptions (e.g., cell phones, emails, apps, notifications). No one should be engaged in any other activities during session (e.g., driving, cooking).
- Everyone participating in session must be in camera view so the therapist can see who is participating. This is also clinically useful for the therapist to observe all participants' facial expressions and other nonverbals.
- Therapist should be mindful of their own appearance, attire, background, and positioning.
- In the event that subsystem work is deemed appropriate for the family, each client should designate a safety word with the therapist to indicate that someone is within earshot to hear what is being discussed in session.

PALM BEACH COUNTY
YOUTH SERVICES DEPARTMENT
RESIDENTIAL TREATMENT & FAMILY COUNSELING DIVISION

SAFETY PLAN

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:

☐ Anniversary of trauma	☐ Family arguments	☐ Intense worry/anxiety
☐ Being scolded or screamed at	☐ Feeling humiliated/ashamed	☐ Isolated/closed off from others
☐ Breaking items	☐ Feeling angry/aggressive	☐ Missing doctor appointments
☐ Changes in appetite	☐ Feeling restless, fidgety	☐ Overreacting to minor things
☐ Changes in sleep	☐ Financial/legal problems	☐ Poor hygiene
☐ Crying a lot	☐ Getting lost in thought	☐ Relationship break-up
☐ Death of someone close	☐ Giving away possessions	☐ Thinking "I can't cope"
☐ Difficulty in school/work	☐ Health problems	☐ Too many responsibilities
☐ Divorce	☐ Increased use of alcohol/drugs	☐ 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)
- ☐ Remove access to knives or other sharp objects
- ☐ Increase supervision
- ☐ No environment changes needed at this time
- ☐ Others:

_____

_____

_____

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		
☐ Calm Harm – manage self-harm	=	Download App
☐ Crisis or Information	=	211
☐ Crisis Text Line	=	Text TWT to 741741
☐ Florida Child Abuse Hotline	=	1-800-96- ABUSE (22873)
☐ National Suicide Prevention Lifeline	=	988
☐ National Domestic Violence Hotline	=	1- 800-799-SAFE (7233)
☐ South County Mental Health Center Mobile Response North County	=	(561) 693-8681 (north of Southern)
☐ South County Mental Health Center Mobile Response South County	=	(561) 637-2102 (south of Southern)
☐ Trevor Project Suicide Hotline	=	(866) 488-7386 or TEXT 678678

Other:

_____

_____

_____

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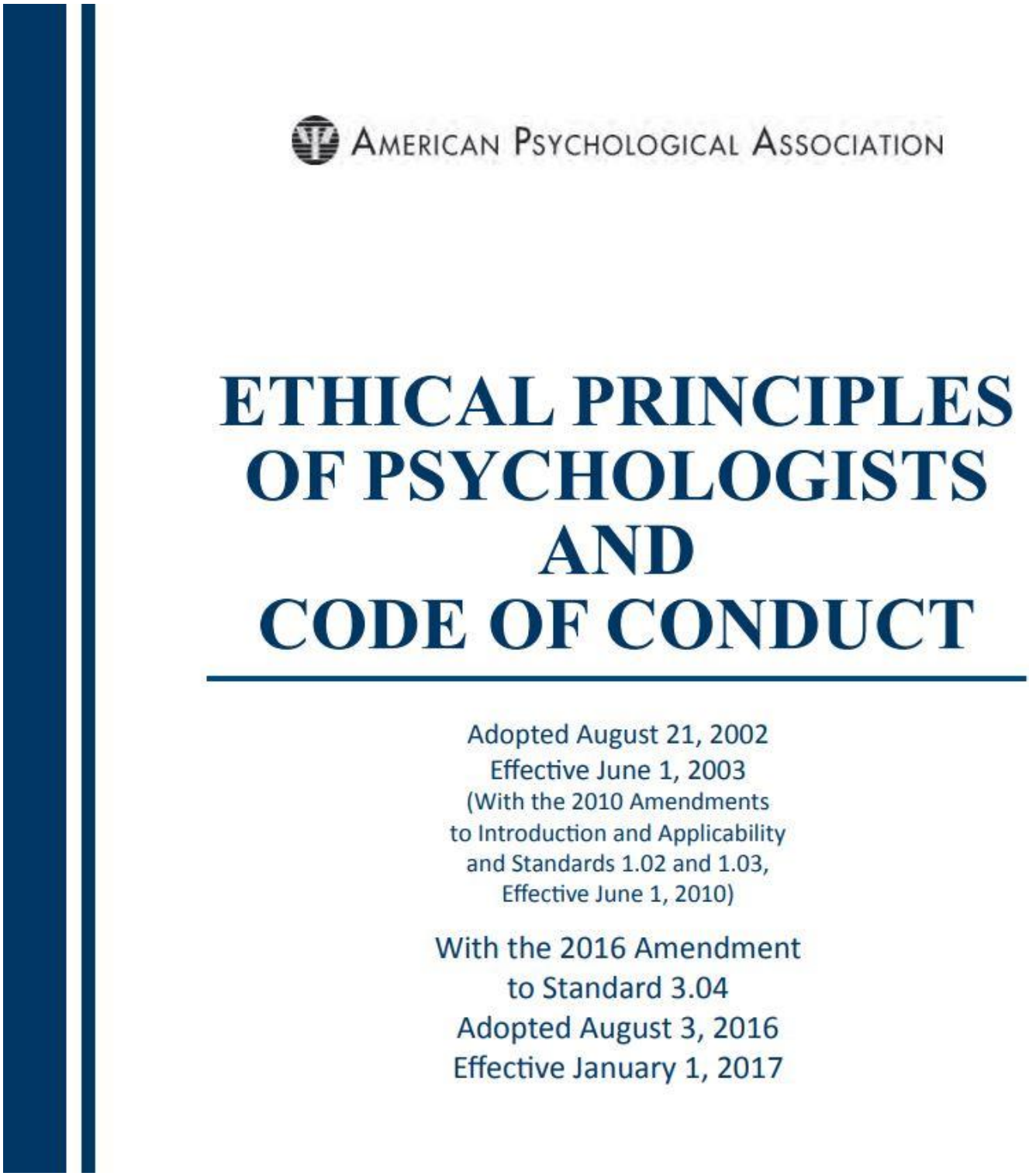

http://www.apa.org/ethics/code/ethics-code-2017.pdf

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
  - ___ Training Requirements & Expectations
  - ___ Professional Conduct Expectations
  - ___ Supervision
  - ___ Licensed Psychologists at the Youth Services Department
  - ___ Formal Evaluations
  - ___ Selection and Academic Preparation Requirements
  - ___ Diversity and Non-discrimination Policy
  - ___ Trauma-Informed Care at the Youth Services Department
  - ___ Family Therapy Overview
  - ___ Parenting Services Overview
  - ___ Diversion Programs
  - ___ Required Meetings
  - ___ Didactic/Training Schedule
  - ___ Tracking Hours
  - ___ Community Resources
  - ___ Clinical Procedures and Guidelines
    - ___ Audio and Video Recording Guidelines
    - ___ Baker Act
    - ___ Community Meeting Guidelines
    - ___ Computer and Social Media Policy
    - ___ DCF Reporting Procedures
    - ___ Dress/Grooming/Hygiene Guidelines
    - ___ Due Process and Grievance Procedures
    - ___ Firesetting Interview Guidelines (CANS)
    - ___ Intake Assessment Guidelines
    - ___ Professional Presentations Guidelines
    - ___ Psychological Evaluation Procedures
    - ___ Record Keeping Guidelines
    - ___ Referral Guidelines
    - ___ Substance Use Assessment Guidelines
    - ___ Telemental Health Guidelines
  - ___ Safety Plan
  - ___ APA Ethical Principles and Code of Conduct
- ___ YSD Documentation Manual
    - ___ Risk Assessment and Safety Planning
    - ___ Missed Appointment Documentation
    - ___ Extension Request Procedures

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) and/or the Common (G:): Drive.

Print Name _____

Signature_____ Date_____