



Operating a University Counseling and School Psychology Training Clinic in a Global Pandemic

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Abstract

The COVID-19 global pandemic has shaken the status quo including the way university counseling and assessment centers provide training to graduate students and psychological services to the community. The pandemic brought high levels of uncertainty and contradictory telehealth guidelines across organizations. Guidelines related to telehealth assessment services were especially challenging to navigate. Center directors worked collaboratively with faculty and campus leadership to follow best practices and mitigate training and service disruptions to the best of their ability. The tension created by the pandemic offered an opportunity for centers to challenge long-standing practices, experiment with new practices, and ultimately enhance their programs. This paper offers reflections on our experiences in following best practice guidelines for telehealth counseling and psychoeducational assessment service delivery within a university counseling and diagnostic training center. Training considerations for directors and faculty affiliated with counseling and diagnostic training centers are provided.

Keywords Counseling · School psychology · Assessment · Graduate training · COVID-19

The number of confirmed COVID-19 cases in the USA has continued to rise since the World Health Organization labeled the illness a global pandemic on 11 March 2020. Currently, the number of confirmed cases exceeds 7 million individuals in the USA alone, and this number is expected to rise (CDC, [n.d.](#)). The global pandemic has shaken the status quo. Across domains of functioning, people and institutions have had to adapt to a new normal. A normal that places the health and wellbeing of individuals at the forefront. To that end, the COVID-19 pandemic has changed the way counseling and assessment is taught and practiced in university settings with many institutions of higher education having shifted from in-person instruction to distance learning. Programs with existing university-based counseling and assessment centers (UCAC), which provide graduate training and supervision in psychological services, experienced unique challenges. Given the immediate crisis, clinic directors and faculty were forced

to make quick decisions while balancing competing goals, often with limited guidelines. Telehealth guidance regarding therapeutic and assessment practice first became available around mid-March 2020 (Krach et al., 2020). Since that time, organizations continue to put out new or revised guidelines. These guidelines are generally theoretical in nature and often do not take into account the individual characteristics of training programs or the communities which they serve. In general, many training programs made a rapid shift from in-person service delivery to telehealth. Telehealth has been defined as “the use of electronic information and telecommunications technologies to support long-distance clinical health care” (Health Resources and Services Administration, 2020, para. 3). Telehealth services provided by UCAC may include intake interviews, individual therapy, group therapy, consultation, supervision, psychological assessment, and psychoeducational assessment. Telehealth practices may also include exchange of communication via video conferencing, voice calls, e-mail, and text, as well as electronic data storage. The purpose of this manuscript is to provide a reflection on the writers’ experiences in applying best practice guidelines for telehealth service delivery within a university counseling and assessment center.

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University-Based Counseling and Assessment Training Centers

UCAC are psychological service training clinics generally associated with a higher education institution's department of education or psychology. Graduate students are trained to provide a variety of psychological services to members in the community while under the supervision of a credentialed or licensed clinician. Although the services offered and the clients served may differ across UCAC, most centers are created for the common goal of providing graduate students with quality practical experience in psychological services within a controlled environment. Prior to COVID-19, telehealth services offered by UCAC were minimal. Although telehealth services have been in practice for decades, they were generally reserved for individuals living in rural areas where access to mental health professionals is limited. The Association for University and College Counseling Center Directors (LeViness et al., 2019) obtained telehealth data on 473 counseling centers and found that only 7.6% provided telephone counseling sessions and 3.4% provided video-counseling sessions. As such, many UCAC were not adequately prepared to shift to telehealth services when COVID-19 became a global pandemic.

Impact of COVID-19 on Training

Starting in March 2020, most universities in the USA seized all in-person instruction forcing many UCAC to also seize or modify in-person operations. Faculty had to reconsider how to provide practical training experiences to students. National and local accrediting agencies such as the National Association of School Psychologists (NASP) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) issued memorandums granting flexibility in how accreditation requirements could be met for practicum and internship experiences (NASP, 2020b, March; CACREP, n.d.). In turn, programs relaxed their requirements in these areas. For example, instead of administering a cognitive test battery to a child in a school, some school psychology graduate students were able to administer the test to a relative in their home or view a training video on cognitive test administration. Similarly, the meaning of the term “face-to-face” was broadened by many accrediting agencies (e.g., Board of Behavioral Sciences, n.d.) to include virtual service delivery of therapy and supervision. By relaxing accreditation standards, programs were able to quickly transition to a telehealth model of service delivery.

Challenges to Traditional Face-to-Face Practice

The rapid transition from face-to-face to telehealth services necessitated extensive training, flexibility, and ingenuity (Richards & Debonis, 2020) to allow graduate students to obtain supervised experience and continue to provide high-quality treatment to clients. Faculty and UCAC directors navigated what seemed like daily e-mails regarding guidelines and mandates from various agencies and made their best attempt at consolidating information to provide evidence-based telehealth training to their students. Issues regarding legal, equitable, and ethical practices surfaced as the pandemic continued. For example, programs offering telehealth services needed to consider issues of client confidentiality. Furthermore, programs had to ensure all trainees had access to reliable Internet and technology. Guidelines also needed to be put in place to assess whether telehealth was appropriate for individual clients, including client access to phone or video conferencing. More importantly, the pandemic disrupted the typical developmental training sequence for many programs. In summary, challenges included the need to maintain the integrity of training; facilitate trainee progress; continue clinical service delivery; manage the safety and wellbeing of trainees, faculty, staff, and clients; and adhere to emergency orders (Bell et al., 2020).

As universities slowly began to issue waivers for lab-based courses, including practicum and internship, programs within such institutions had to decide whether to re-engage in face-to-face instruction, continue telehealth practices, or adopt a hybrid model with some services provided face-to-face and others provided via telehealth. Decisions such as these are not taken lightly and require consideration of various factors, such as health and safety concerns, program goals, accreditation standards, and college and university mandates.

Navigating Conflicting Telehealth Guidance

When making training decisions in light of COVID-19, many program leaders turned to professional organizations for guidance given the limited empirical support for some aspects of telehealth. Although there is empirical evidence to support the practice of providing psychotherapy services via telehealth platforms (Bashshur et al., 2016), empirical evidence regarding the use of psychoeducational testing via telehealth is limited. As such, many UCAC providing assessment training sought guidance from various agencies regarding whether to use adapted forms of assessment via telehealth or substitute traditional face-to-face experiences with alternative learning opportunities, such as case studies. Initial recommendations for adapted assessment delivered via telehealth platforms became available in mid-March 2020 (Krach et al., 2020);

however, conflicting messages were being communicated across entities. The majority, 53.8%, of professional organizations surveyed by Krach et al. (2020) recommended caution when administering tests via telehealth while only 42.9% of government agencies and 40% of test publishers made similar recommendations. Another 38% of professional organizations and 57.1% of government agencies recommended this type of assessment not be used at all; not surprisingly, test publishers never recommended against adapted assessment via telehealth (Krach et al., 2020).

In contrast to advice generated from test publishers, Farmer et al. (2020) identified several factors to dissuade practitioners and training programs from engaging in remote psychological assessment, including limited access to electronic test materials, proctors, and technology; lack of well-designed studies assessing the validity of norm-referenced cognitive and achievement test batteries; and potential scope of practice limitations for school-based professionals. Given the different perspective on assessment via telehealth, it was imperative for UCAC to consult a variety of sources to make final decisions to institute program wide.

Guidelines for Telehealth Service Delivery

In order to support university programs related to education and training, the Council of Chairs of Training Councils (CCTC, 2020) issued guiding principles to facilitate decision-making. The four principles include balance, developmentally sensitive trainee focus, flexibility, and creativity in developing trainee competency and meeting responsibilities, and social responsiveness. Additionally, the CCTC (2020) provided six specific recommendations (a) limit in-person contact, (b) adjust educational and licensing requirements, (c) minimize adverse impact on trainee finances and program completion, (d) pursue access to training beyond distance education, (e) minimize critical resource disparities, and (f) use consultation to address challenges. These guidelines reflect a spirit of prioritizing the needs of trainees including their health and progress toward degree completion.

NASP (2020a) also provides recommendations specific to telehealth service delivery that are guided by ethics, equity, and prevention. NASP (2020a) makes several recommendations relevant to UCAC that serve school psychology trainees. Some general recommendations include obtaining specific parental consent when providing telehealth services to minors and utilization of an ethical decision-making process that includes collaborative problem-solving and ongoing evaluation of selected solutions. Recommendations related to counseling services include having a plan in place to manage emergencies such as threats of self-harm and reviewing whether goals remain relevant in light of the crisis. Recommendations related to assessment include using tests in a manner in which they

were developed and validated. Adaptations for telehealth must be supported by “high-quality evidence that such adaptations produce results that are similarly reliable and valid to the face-to-face administration” (NASP, 2020a, para. 7). Furthermore, appropriate training must be completed by those administering assessments via telehealth and utilize appropriate platforms for service delivery. Additionally, examiners must take into consideration that the examinee’s behavior may differ as a result of the pandemic and issues of validity should be reported in writing.

The American Psychological Association’s Joint Task Force for the Development of Telepsychology Guidelines for Psychologists (2013) issued the following telehealth recommendations: competence, standards of care in the delivery of telepsychology services, informed consent, confidentiality of data and information, security and transmission of data and information, disposal of data and information and technologies, testing and assessment, and interjurisdictional practice. These guidelines emphasized the importance of professional competence with technology and ongoing evaluation of the match between selected technologies and client needs. Standard of care includes adherence to ethical standards throughout treatment, including assessing the environment for risk of potential breaches of privacy. Proper security measures should be in place to protect data and information related to clients from unintended access or disclosure, including proper disposal of information. Regarding assessment, it is recommended that the conditions of administration indicated in the test manual are preserved in order to maintain the integrity of test reliability and validity and not jeopardize test security. If using telehealth to conduct assessments, norms derived from telehealth technologies should be used if available. Additionally, it is vital that clinician and client have access to the necessary technologies and hardware requirements that are needed. Clinicians are encouraged to specify whether the assessment has been completed via telehealth and to describe any accommodations or modifications made. Finally, clinicians are encouraged to recognize limitations of assessment processes conducted via telehealth and address the limitations and potential impact of those procedures such as being aware of psychological processes that underlie task performance and how they may be affected by alternative assessment practices. Other recommendations that have been made include widening confidence intervals when making conclusions and clinical decision.

Application of Theory to Practice

Many best practice guidelines for telehealth reviewed were created prior to the pandemic and revisions to those guidelines were often aspirational in nature. UCAC worked quickly and diligently to maintain the integrity of their programs while

considering the health and safety of trainees, staff, and clients. Below is a description of a UCAC and its effort to implement best practices for counseling and psychoeducational assessment. Reviewing the center’s process of decision making may shed light on the practical nature of recommended best practices as well as opportunities for growth and development for this and other UCAC.

Overview of the Center for Counseling and Diagnostic Services

The Center for Counseling and Diagnostic Services (CCDS) is located within one of the California State Universities and offers three distinct services: counseling, psychoeducational assessments, and reading intervention. These services are offered to the local community at a significantly reduced cost, often waived altogether, and are provided by masters-level students. The focus of this section is on counseling and psychoeducational assessment service delivery provided at the CCDS.

The physical space of the CCDS is located with the college of education’s building and is displayed in Fig. 1. The CCDS includes a front office, waiting room, consultation room, two

classrooms, and ten individual cubicles for counseling and testing. Both classrooms and cubicles are equipped with one-way mirrors and microphones enabling supervisors to watch and listen to trainee sessions live. The CCDS is staffed by a director, center coordinator, and a part-time student assistant. The CCDS director works in conjunction with faculty, department staff, and community agencies and partners to ensure the optimal and effective functioning of the center. The director may serve as back-up for instructors, provides consultation to faculty and trainees, hires and supervises student assistants, and assumes responsibility for the collection of fees. The center coordinator manages and coordinates services and activities within the CCDS. This includes scheduling and monitoring client visits, greeting clients and visitors to the center, adjusting students’ and clients’ schedules, creating and monitoring budgetary reports, maintaining office equipment, ordering supplies and equipment, and answering phones. Student assistants provide support to the center with scheduling, answering phones, and tasks assigned as needed.

The CCDS offers a variety of counseling options: rehabilitation, career, marriage, couple, children and family. Rehabilitation counseling involves assisting individuals with disabilities in major life areas. Career counselors provide guidance to clients with

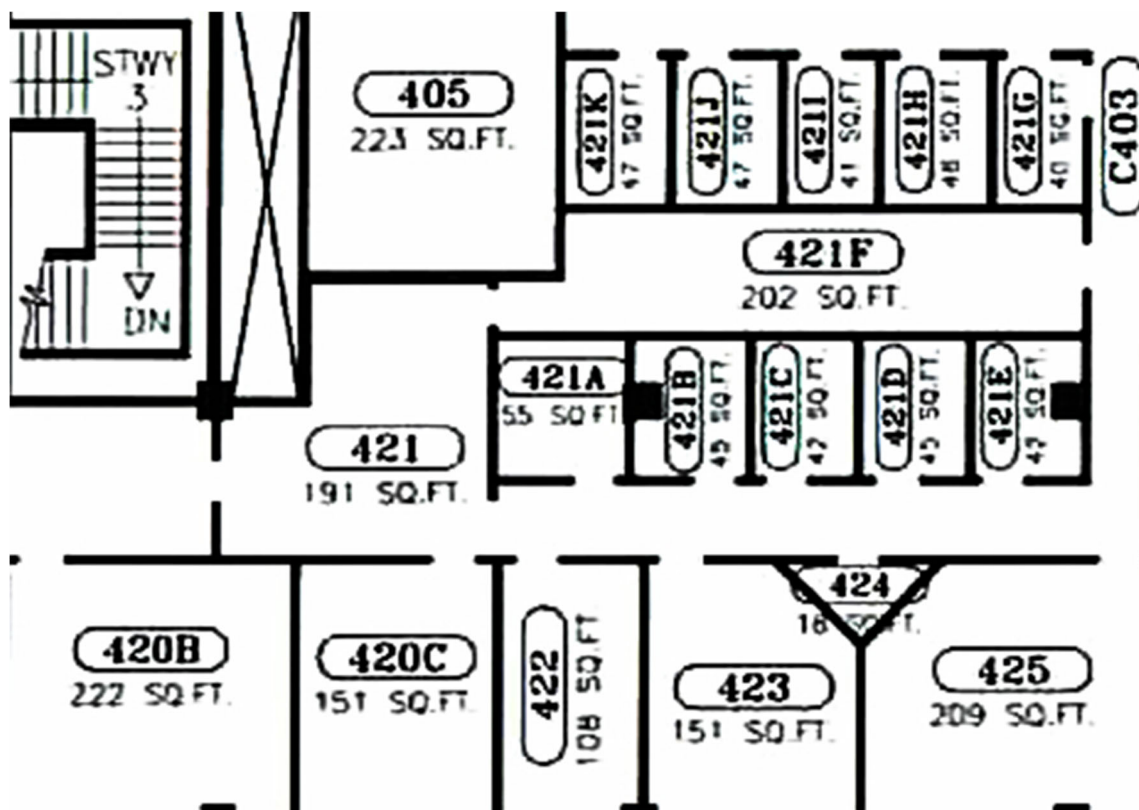


Fig. 1 Floor plan of the Center for Counseling and Diagnostic Services. *Note.* Room 420B serves as a consultation room and trainee workspace. Room 420C is the front office. Room 421 is the lobby for the center. Rooms 421A–421E and 421G–421K are cubicles used for counseling and testing sessions. Room 423 is classroom 1. Room 425 is classroom

2. Room 421F is a dark room where supervisors can view rooms 421A–421E and 421G–421K through a one-way mirror. Room 424 is also a dark room where supervisors can view rooms 423 and 425 through a one-way mirror

career exploration, interview preparation, and workplace conflict. Finally, marriage, couple, and family counselors help individuals with problems with depression, anxiety, stress, and relationships. All counseling sessions are 50 min and are supervised by an appropriately licensed or credentialed faculty supervisor.

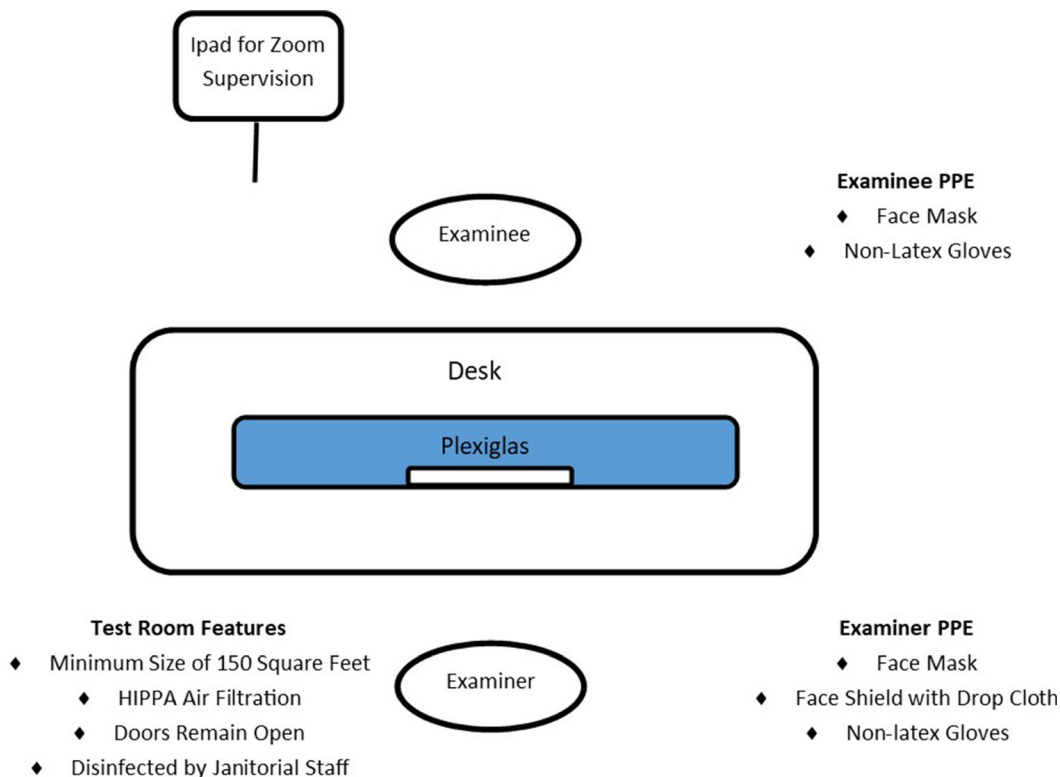
School psychology trainees conduct psychoeducational assessments for children and adolescents in the community. Common referring concerns include learning disabilities, social-emotional concerns, as well as attention-deficit hyperactivity disorder and autism-like characteristics. Students work individually with children across two 3-h appointments. There is a final appointment where students provide a written report to caregivers and explain results. Each academic year, there are generally four sections of this practicum offered in the Fall semester and approximately five to six trainees are enrolled per section.

Prior to COVID-19 restrictions, the CCDS adopted some practices to engage in telehealth; however, most of the center’s practices required an individual to be physically present. For example, prior to the pandemic, the CCDS utilized virtual tools such as e-mail, an electronic scheduling system, and Zoom video conferencing for those caregivers who could not attend a session in-person. Although the CCDS did not have robust telehealth logistics and assessment tools prior to the pandemic, staff and faculty were able to quickly adapt.

Concerning assessment tools, the CCDS had taken steps toward telehealth prior to COVID-19. The center invested in digital manuals for tests, cloud-based scoring software, cloud-based rating scales (e.g., Behavior Assessment System for Children, Third Edition), and application-based assessment tools (e.g., Q-Interactive).

Transitioning to Telehealth Training and Service Delivery

Faculty and clinic staff monitored changing accreditation standards, university regulations, and national and local mandates in order to plan how to proceed with training and psychological service delivery to CCDS clients at the start of the national pandemic. The university required all face-to-face instruction to stop in March 2020 as a response to COVID-19. Soon after, adjustment of credential and licensing requirements were made by accreditation agencies, provided counseling and school psychology programs the opportunity to adjust program requirements and limit in-person contact. The need to limit in-person contact motivated the CCDS to transition towards adoption of more telehealth practices.



Note. PPE = Personal Protective Equipment.

Fig. 2 Room set-up and PPE used during face-to-face psychoeducational testing

Telehealth Model for Counseling

During the initial weeks of the COVID-19 pandemic, the Board of Behavioral Sciences (BBS) adjusted their training requirements from requiring trainees to receive direct contact hours through an in-person modality to allowing direct contact hours be obtained through telehealth. Within a week of the BBS loosening training requirements, the CCDS moved all counseling services to a virtual format as faculty identified sufficient empirical support for counseling to be provided in this modality. All counseling related services were transitioned to telehealth eliminating the need for trainees and faculty to be on campus. Although services were provided remotely, students continued to provide counseling services from a confidential location and updated client charts remotely. Trainees met remotely with their clients on a weekly basis, while also having weekly supervision meetings. In conjunction with the information technology (IT) department on campus, an encrypted file upload system was created. This allowed students to securely upload client-related documents for their supervisors to review. Feedback from clients indicated, in general, they felt secure with telehealth services and appreciated the option of being in the comfort of their homes while receiving counseling. Given the success of telehealth counseling services, counseling trainees continued to obtain their practicum hours through this modality during the subsequent semester.

Hybrid Model of Psychoeducational Evaluations

Similar to counseling accreditation standards, school psychology credential requirements were modified in response to the global pandemic, which allowed the use of telehealth practices. The remainder of the semester for trainees entailed providing direct services (e.g., caregiver feedback) and supervision (e.g., analyzing case study data) provided via telehealth. After the Spring 2020 semester, school psychology faculty reviewed student and program needs, best practices, and university guidelines to determine the best course of action for the program moving forward. The CCDS decided that there were not enough quality studies to support the use of telehealth for administration of standardized, norm-referenced cognitive processing and achievement tests and agreed with the advice of many that standardized, norm-referenced testing should not be administered via telehealth due to issues of test security and validity. Additionally, a major goal of the school psychology program is to provide trainees with direct experience with such measures. In order to continue to provide students with direct training opportunities while limiting face-to-face contact, a hybrid model for the practicum course was viewed as the best option to continue to provide students with practical experience in assessment while minimizing risk of exposure to COVID-19. As such, program faculty petitioned for a

university waiver to allow face-to-face test administration for the psychoeducational assessment practicum course.

Designing a Plan For efficiency, a lead faculty was selected to oversee the details of the transition plan in collaboration with the CCDS director. The lead faculty member and the CCDS director designed a preliminary plan to present to school psychology faculty, the department chair, and the college dean. The plan was designed to conform to university policy; accreditation standards; best practices; program needs; student needs; and trainee, faculty, staff, and client health and safety concerns. The transition from primarily face-to-face to primarily telehealth service delivery consisted of collaboration, evaluation of resources, and considerations for professional ethics and the health and safety of individuals.

Collaboration Planning for the Fall 2020 CCDS practicum in psychoeducational assessment consisted of collaboration between department and college leadership, the departments of health and safety and IT, the clinic director, and lead faculty. The early planning stage was facilitated by review of program goals, review of best practices, and consultation with faculty from local universities.

Health and Safety At the forefront of the plan was consideration for the health and safety of all individuals during in-person sessions. Faculty, staff, and trainees were required to complete a university created training course on COVID-19 that provided information related to symptoms and ways to reduce exposure to the virus as well as university protocol for reporting diagnosis. Additionally, all individuals entering the CCDS were required to complete an online health screening prior to coming to campus for each testing session. Parents and guardians were also given a symptom checklist to assess their child and sign a form attesting to their child's health.

In addition to ensuring all individuals were properly trained to minimize risk to COVID-19 exposure, personal protective equipment (PPE) was selected. PPE for faculty, staff, and trainees included face masks, face shields with draped cloth, HEPA air purifiers, and non-latex gloves. Clients were required to wear face masks and non-latex gloves when handling manipulatives. Additionally, Plexiglas shields with an opening to slide test stimuli were installed in each testing room. PPE was located at the front of the CCDS office and provided by the university. Test room set up with PPE is displayed in Fig. 2.

In order to ensure appropriate sanitation for individuals, hand sanitizer was placed in every room. Additionally, students were instructed to engage in appropriate hand washing before and after test sessions. Trainees used non-latex gloves to handle test materials. Trainees were instructed to sanitize materials with disinfecting wipes as appropriate. In order to reduce the cross contamination, trainees were assigned their own cognitive and achievement test kits for the semester.

Testing rooms were deep cleaned by janitorial staff after each testing session. Additionally, HEPA air filters were installed in every room and air flow was maximized by leaving windows and doors open.

Another important goal when designing the plan was to increase physical distance while at the CCDS. As such, rooms were inspected by the university health and safety department to ensure adequate physical distance and sufficient air flow. Ten of the 12 CCDS rooms were deemed too small (421A–421K) because they would not allow sufficient physical distance between individuals. Given that no other classes were in session, alternative classrooms adjacent to the CCDS were identified with larger square footage. Faculty supervisors were placed in their own room and provided with technology to be able to remotely provide live supervision of test administration. Specifically, iPads on tripods were added to each of test room and in combination with ZOOM break out rooms allowed the supervisor to monitor trainees. Trainees were provided instruction to maintain a minimum of 6 ft of distance between individuals while at the CCDS.

In order to reduced face-to-face contact between clients, staggered appointments were scheduled in 5-min increments. Additionally, caregivers checked-in clients over the phone. Trainees went outside to escort clients to their testing rooms. Only clients tested were allowed in the building. Once testing was completed, caregivers were notified and the trainee once again escorted the client outside.

A test checkout protocol was created by the director and coordinator for trainees needing to administer additional tests not assigned to them for the semester. An excel document listed test kits available for check-out as well as dates and times trainees could pick-up kits for practice. Trainees completed a document stored on the shared drive to indicate their desired pick up time. This reduced contact between students. Test kits were left in the lobby for trainee pick up while the CCDS coordinator monitored pick-up behind the glass divider that separated the reception area and the waiting room.

Ethical Considerations In addition to considering the health of individuals, maintaining the integrity of the profession by adhering to ethical guidelines was critical in the design. Consent, confidentiality, and test security are examples of ethical considerations made. To ensure informed consent, the CCDS director modified the existing consent form to include information related to COVID-19. Specifically, the risks associated with face-to-face testing as well the steps taken to mitigate those risks were outlined. This form also released the CCDS from liability if COVID-19 was contracted on site. Additionally, risk of online communication was included on the consent form. Students were given email accounts to use specifically for practicum related electronic communication and were required to include a specific signature line that included limits of confidentiality of information shared via

e-mail, the time frame email address would remain active, and emergency contact information.

Protocols to reduce breach of confidentiality were reviewed with trainees. Specifically, the course syllabus included a section on requirements for engaging in telehealth service delivery and included topics such as using headphones and being in a private room. Additionally, trainees were instructed on proper documentation and transport of information. Specifically, identifying information had to be removed if it were to leave the CCDS and documents needed to be transported in a locked case. Caregivers could submit records of their children electronically if they desired; however, trainees were instructed to remind caregivers of risks associated with electronic transmission of data.

Evaluating Resources Prior to design, resources available to faculty and trainees were evaluated. Resources reviewed included access to technology, reliability of internet connection, number of test kits, number of electronic manuals, types of electronic rating forms, and faculty readiness to utilize telehealth practices. CCDS staff led the effort to obtain most of the identified information. Prior to presenting a plan to faculty, the feasibility of acquiring necessary resources to carry out the plan was discussed with college leadership.

Although the CCDS had some materials available online, there were several materials that needed to be purchased in order to decrease time trainees spent on campus. Faculty were asked to indicate tests they most readily had trainees use and efforts were made to ensure access to these materials. For example, remote administration of the BASC-3 rating scales was purchased so that trainees can send caregivers a link to complete an electronic version of the form. Additionally, remote access to several test manuals was made available to trainees in collaboration with publishing companies to facilitate training and paper-pencil scoring when electronic scoring was not feasible. Additionally, a shared drive was updated to include publically available rating scales that can be administered and scored remotely, such as the Screen for Child Anxiety-Related Disorders (SCARED). Furthermore, the special education department faculty loaned the CCDS achievement test kits that were needed to allow every student to be assigned a kit.

In consultation with college leadership and IT personnel, technology needed to implement the health and safety plan were identified. In order to ensure each student had access to their own test kits, one section of the clinic was designated to use Q-Interactive, an iPad based assessment system. The faculty supervisor for the designated clinic had extensive training in this modality. In order for all students in the clinic to use Q-Interactive, additional iPads were needed. In addition, several iPads were needed to allow for live supervision via Zoom as the tunnel with 1-way mirrors was no longer able to be used. The college was able to temporarily allocate the necessary

iPads that were previously purchased for the teaching credential program because they would not be used by the program while in distance learning.

In regard to resources for telehealth services, the university provided hot spot access to faculty and students in need. Supervisors made sure to inform students of these resources at the beginning of the semester. Additionally, Zoom, OneDrive, and Adobe were free for faculty and students to download. As previously mentioned, a shared OneDrive folder was created. Faculty and CCDS staff were granted access to make changes to the folder while students could access all documents but could not make changes to files. This allowed students to have immediate access to any changes in procedures.

Plan Dissemination The proposed plan included six face-to-face testing sessions with PPE and nine telehealth sessions, which would allow trainees to complete three psychoeducational assessment cases throughout the semester. In-person sessions were scheduled to occur before Thanksgiving Break as it was anticipated that a surge in COVID-19 cases would arise due to family gatherings for the holiday. Telehealth sessions included client and caregiver interviews, group supervision, case consultation, and review of test results with the client and caregiver.

All faculty, including adjunct faculty, agreed upon the specified plan. The plan was then sent for approval to college and university leadership, including the health and safety department. Once the plan was approved by the university, it was documented in detail in the course syllabus and supporting resources were disseminated via the shared drive.

The plan was reviewed in detail with trainees and their concerns were addressed individually. Trainees were told that individualized instruction for students with health concerns would be provided as an option on a case-by-case basis. Three students expressed initial concern but after further review of safety measures taken, all students chose to participate in the hybrid model.

Feedback from students and faculty was obtained after the initial face-to-face session. All faculty and CCDS staff met to share strengths and areas for growth. Modifications were made based on feedback received. Modifications included greater access to electronic scoring and rating forms and having iPad cameras available in classroom 1 and classroom 2 (see Fig. 1). For the initial session, faculty had to walk from their assigned room to room 424 to observe trainees assigned to these classrooms. Other minor changes were made as the need arose. Although some rescheduling occurred due to clients reporting symptoms of COVID-19 prior to coming to the clinic, there were no instances of COVID-19 transmission during the semester and all trainees were able to successfully complete course requirements.

Services Provided During the Fall 2020 semester, 69 psychoeducational assessments were completed by 23 graduate trainees across four course sections. Each graduate trainee worked with three clients throughout the semester, which was the standard expectation prior to the global pandemic. Therefore, although changes to the implementation process were made, service to the community did not decrease in quantity.

Caregiver Satisfaction In order to assess the quality of psychoeducational services provided to families following changes necessitated by COVID-19, an electronic anonymous survey was emailed to caregivers at the end of the semester. The survey was used to help identify strengths and areas for growth. Of the 69 families who were emailed the survey, 7 responded (10% response rate). Lack of feedback may be the result of sending the form during the holiday season. Results of the survey may be found in Table 1. In general, caregivers reported feeling safe having their child assessed at the CCDS and they believed safety precautions were clearly presented and sufficient. In addition, 6 of 7 respondents indicated that results of the evaluation were clearly explained to them by trainees and all respondents indicated that they would recommend the CCDS. These data suggest that high quality services were provided to the community.

Protocol for Hybrid Psychoeducational Practicum Training

Utilizing the experiences of designing and implementing a successful training experience for graduate students in counseling and school psychology, a protocol for training programs to consider as they reevaluate courses for the upcoming terms is presented. Given its complexities, design of a hybrid program for psychoeducational testing is emphasized. Components that should be considered when designing a hybrid practicum and recommendations for delegating tasks are provided in Table 2. Key components include incorporating a health and safety plan, adhering to ethical guidelines, and evaluating resources.

Health and Safety Plan

The clinic director in collaboration with lead faculty and the campus health and safety department should design a feasible psychoeducational testing plan that places the health and safety of faculty, staff, students, and clients at the forefront. CDC guidance and current knowledge of virus transmission should be considered when designing the plan. Minimum considerations should include providing education on COVID-19, assessment of COVID-19 related symptoms, personnel

Table 1 Frequencies of caregiver responses for perceived safety and quality of services at the Center for Counseling and Diagnostic Services during a global pandemic

Item	Strongly agree		Somewhat agree		Neither agree nor disagree		Somewhat disagree		Strongly disagree	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
During the COVID-19 pandemic, I felt safe having my child assessed at the CCDS.	6	85.71	1	14.29	0	0	0	0	0	0
Safety precautions were presented clearly to me.	6	85.71	1	14.29	0	0	0	0	0	0
Safety precautions during the assessment seemed sufficient.	5	71.43	1	14.29	1	14.29	0	0	0	0
Communication from the CCDS was easy to understand.	5	71.34	2	28.57	0	0	0	0	0	0
When we arrived on campus, I had difficulty finding the CCDS	0	0	3	42.86	0	0	1	14.29	3	42.86
The graduate student clearly explained my child's test results.	6	85.71	1	14.29	0	0	0	0	0	0
This evaluation helped to better understand my child's academic strengths and weaknesses.	5	71.43	2	28.57	0	0	0	0	0	0
I would recommend the CCDS to others.	7	100.00	0	0	0	0	0	0	0	0

Note: $N = 6$. Participants were parents or legal guardians of children and adolescents assessed due to learning or behavioral challenges at the Center for Counseling and Diagnostic Services

protective equipment, sanitation protocol for individuals, materials, and physical space, and efforts to maximize physical distance between individuals.

Education

In order to ensure that staff, faculty, and trainees are familiar with symptoms of COVID-19 and the impact of the virus on their and others' health, all should receive information on this topic prior to entering the center. Many universities have designed COVID-19 related online training modules and should be made available to everyone working on campus. If such trainings are not available, it is recommended that the director collaborate with the health and safety department to design a virtual dyadic seminar.

Health Screening

The importance of staying home if there has been potential exposure to the virus or if the individual is not feeling well should be emphasized throughout the semester. Additionally, there should be a plan to assess whether individuals are healthy prior to entering the center. This may include having appropriate personnel check temperatures prior to entering and/or requiring individuals to complete an online health-screening checklist.

PPE

PPE has been found to reduce the transmission of airborne COVID-19 particles. As such, it is recommended that PPE for examiners include both face masks and face shields with cloth drapes as well as non-latex gloves for handling test

materials. It is recommended that PPE for clients include face masks and non-latex gloves for handling manipulatives and other test materials. The use of Plexiglas screens is also recommended. The university should supply all necessary PPE. As such, it is important that the clinic director inform the appropriate department of anticipated PPE needs to ensure sufficient supplies are available.

Sanitation Protocol

Sanitation procedures for individuals, materials, and physical space used for testing should also be reflected in the health and safety plan. It is imperative that a proper hand washing and hand sanitizer protocol be reflected in the plan. Similarly, expectations for sanitizing test materials that may have been exposed to germs be made clear to trainees. If possible, test kits should be assigned to trainees for the semester to reduce potential transfer of germs. Finally, sanitation of the physical space used for testing should be outlined. Once again, the university should supply necessary materials needed for sanitizing. Although trainees may be responsible for disinfecting test materials they touched, the janitorial staff should sanitize the physical space. Sanitizing the physical space may warrant the use of disinfecting spray in order to remove as many airborne particles. It is important when scheduling clients to take into consideration the time needed for janitorial staff to properly clean rooms used for testing.

Maximizing Physical Distance

Another important feature of the health and safety plan is the effort to maximize physical distance between individuals

Table 2 Delegation of action items necessary to transition a university-based counseling and assessment center to hybrid model of service delivery

Action item	Delegated lead personnel	Other contributors
Health and safety		
Education of COVID-19	UCAC director	Supervising faculty
Health screening	University health department	UCAC director
Student safety checklist	Faculty lead	Supervising faculty UCAC director
Selection of personnel protective equipment	UCAC director University health department	Supervising faculty
Obtaining personnel protective equipment from university	UCAC director	–
Sanitation protocol for individuals, materials, and physical space	UCAC director	Supervising faculty UCAC coordinator
Protocol for maximizing physical distance: check-in procedures, breaks, size of test rooms, etc.	UCAC director	Supervising faculty UCAC coordinator
Obtaining university approval for safety plan	UCAC director	–
Implementing and monitoring safety plan	UCAC director	Supervising faculty UCAC coordinator
Ethical considerations		
Informed consent: revising consent form	UCAC director	–
Informed consent: e-mail disclaimer	Faculty lead	UCAC director Supervising faculty
Documentation of threats to validity	Faculty lead	Supervising faculty
Limit potential breeches of confidentiality: protocol for engaging in telehealth at home and protocol for transportation of data	UCAC director Faculty lead	Supervising faculty UCAC coordinator
Test materials		
Identify most frequently used materials not currently available for UCAC remotely	Faculty lead	Supervising faculty
Evaluate financial and other resources available to meet needs	UCAC director	Faculty lead
Select and obtain materials for remote practice: electronic manuals, online rating scales, etc.	UCAC coordinator	UCAC director
Technology		
Identify technology needs	Faculty lead	UCAC director
Evaluate financial and other resources available	UCAC director	Faculty lead
Obtain iPad and other technology related materials	UCAC director	UCAC coordinator
Train faculty to use acquired technology	Faculty lead	UCAC director UCAC coordinator
Logistics		
Creating test session schedule	Faculty lead	Supervising faculty
Scheduling clients	UCAC coordinator	UCAC director
Test check-out protocol	UCAC director	UCAC coordinator
Scheduling coordination meetings	Faculty lead	
Document changes to syllabus	Faculty lead	

Note. UCAC, University Counseling and Assessment Center. Action items that were necessary to transition a UCAC to a hybrid model of service delivery for psychoeducational testing are listed in the table. The delegated lead is the individual primarily responsible for completing the action item. Other contributors are individuals who may provide input and support the lead in some capacity

while at the center. It is recommended that face-to-face testing sessions be reserved for test administration only. All other data necessary to address the referral should be obtained through telehealth. For example, caregivers and teachers may be sent electronic rating scales to complete. Caregiver interviews and explanation of consent and limits of confidentiality may be completed via telecommunication. Similarly,

primary rapport building with the client may be completed remotely.

Test rooms are recommended to be a minimum of 150 ft² when two individuals are in the space (examiner and examinee) in order to ensure physical distance. Considering client check-in and checkout procedures, client breaks, and test checkout procedures is

imperative. For example, the center may stagger client check-ins and allow only clients who will be tested into the center. It is important that clients are scheduled at different times to avoid multiple individuals arriving at the same time. If clients need a break with their caregivers outside the center, breaks should also be staggered. Furthermore, trainees should be familiar with rules for maintaining maximum physical distance when in the clinic.

Physical distance between supervisor and trainees should also be considered. It is suggested that the faculty supervisor be in their own room. Although trainees and supervisors may need to be physically present in the center, effort to minimize contact between parties should be implemented. As such, communication between parties should rely primarily on telecommunication.

Implementation

In order to properly implement the health and safety plan, staff, faculty, and trainees should have access to the plan in writing and faculty and clinic staff should remind trainees of their responsibilities. To facilitate the implementation of the plan, it is recommended that a Student Safety Checklist be created (see Table 3 for an example). Finally, the clinic director should be made aware of any challenges to plan implementation to provide remediation.

Adherence to Ethical Guidelines

Ethics is a cornerstone of the psychology profession. As such, every effort must be made to adhere to a high level of ethical decision making when outlining changes to current practice. At a minimum, issues related to informed consent, validity, and confidentiality need to be addressed.

Informed Consent

In order to ensure that training clinics are adhering to ethical guidelines, it is imperative that appropriate informed consent be discussed with caregivers and clients. Revision of current consent documents should be made to include the risks associated with face-to-face testing as well as the steps the center is taking to mitigate those risks. If communication will be available through e-mail and teleconference platforms, caregivers should also be made aware of the level of security of information exchanges via these modes of communication. For example, e-mails may contain a default signature that

includes a notice of the potential for breach of confidentiality.

Documenting Threats to Validity of Test Scores

The psychoeducational report completed by trainees should explicate outline modifications to standardization procedures made, including modifications to the testing environment and PPE use. A statement of how these changes may impact the validity of obtained test scores should also be considered. Faculty may wish to report 95% confidence intervals in lieu of standard scores to account for issues of validity. Any diagnostic interpretations made should consider the impact of COVID-19 on the client's development. Please reference Appendix 2 for sample language that may be incorporated into psychoeducational reports.

Confidentiality

Given that many telehealth services related to psychoeducation assessment (i.e., caregiver interview) may require video conferencing, it is imperative that trainees and faculty are able to maintain client confidentiality from their home. This may include having access to headphones and a private area that is quiet. It may be helpful to create a handout for trainees regarding expectations when working with clients from home via teleconference platforms.

Transmission of confidential data also warrants attention. In order to reduce the spread of COVID-19, it may become necessary for trainees to take test protocols home to score and interpret after a test session. If this is the case, transfer of such documents should be outlined. Transfer protocol should minimize exposure of confidential information. Examples of practices that may reduce potential exposure include, excluding confidential information on the test protocol (e.g., client name) and using a locked case to transfer and maintain protocols while at home.

Evaluating Test Material Needs and Resources

UCAC have limited budgets; therefore, it is important to evaluate the current practices and needs of the UCAC in order to allocate resources accordingly. The director in collaboration with faculty should determine the tests used most frequently at the center and that are preferred by faculty in order to prioritize where monies will be allocated. Selecting tests that limit the need for trainees to come to the center should be emphasized. For example, the center may currently have a scoring software that trainees use to obtain standard scores that is only available on one or two computers in the center. This would require

trainees to spend additional time on campus to score test responses. Training sites may wish to purchase remote scoring software or electronic scoring manuals that are available for such tests that are frequently used. Otherwise, faculty may discourage use of such tests and use alternative tests where scoring remotely is an option. Considerations of rating scales and other tests that may be free, psychometrically sound, and able to be scored remotely should be considered.

Evaluating Technology Needs and Resources

Utilizing technology helps minimize the need for traditional face-to-face services. Therefore, UCAC should assess current technology, technology needs, and options for obtaining needed technology. Determining whether technology is needed for didactics, case consultation, supervision, interviews, test scoring, interpretation, psychoeducational reports, and feedback sessions should be considered. For example, direct test administration supervision of trainees may be possible if tablets are placed on tripods within each testing room and a secure videoconferencing software is used. In this way, the supervisor can easily supervise multiple students with a simple click of a button while maintaining physical distance. It is important to have knowledge of existing university licenses and utilize university-approved software.

Trainees and faculty should have access to a reliable internet connection and software and materials needed to perform course requirements outside of the clinic such as a computer and telecommunication software. The clinic should collaborate with the university in assisting students who may not have access to such resources. UCAC may consider working with the IT department on campus to create temporary secondary student e-mails for all clinic related communication between clients and trainees. In this way, client access to trainee contact information is limited to their time at the UCAC.

Once technology is selected and obtained, it is important to assess faculty and student familiarity with selected technology. Training and support for individuals should be provided as needed to ensure effective implementation of training and services. For example, training videos can be recorded on how to email electronic rating forms to caregivers or how to set use a shared drive. Many companies already have existing training videos that the director or lead faculty can compile in a reference file.

Evaluation

A final key aspect of the transition process worth mentioning is program evaluation. Input from faculty, staff, trainees, and client / caregivers should be obtained throughout the process. Based on the input, decisions to retain or modify practices

should be made. Although many procedures and practices may prove to be effective, some may require modification.

Coordination

There are many logistical considerations that need to be addressed to prepare and monitor face-to-face psychoeducational testing sessions in light of COVID-19. It is advised that the clinic director, lead faculty, and supervising faculty meet virtually at least twice during the semester to communicate the newly adopted clinic policies and procedures. Virtual meetings can also be a time to obtain faculty input and reflect on areas of strength and areas for growth in plan implantation. Finally, to facilitate consistency across different faculty who utilize the clinic, documenting expectations for practice in the course syllabus for the practicum is recommended.

Discussion

The COVID-19 global pandemic has shaken the status quo including the way university counseling and assessment centers provide training to graduate students and psychological services to the community. The pandemic brought high levels of uncertainty and contradictory telehealth guidelines across organizations. Guidelines related to telehealth assessment services were especially challenging to navigate. Center directors worked collaboratively with faculty and campus leadership to mitigate graduate training and service disruptions to the best of their ability. The tension created by the pandemic offered an opportunity for UCAC to challenge long-standing practices, experiment with new practices, and ultimately enhance their programs.

By focusing on collaboration and safety, the CCDS was able to implement a telehealth service delivery model for counseling that eliminated the need for faculty, trainees, and clients to be physically present at the center. Additionally, a hybrid model for assessment was designed and implemented that took into consideration ethical, legal, and health and safety concerns. Given the unique challenges of face-to-face interaction, the hybrid model was more challenging to design and implement. Based on preliminary feedback from staff, faculty, trainees, and clients and their caregivers, the hybrid model has been successful. The success of the model may be attributed to early planning, assessment of resources and faculty and student needs, ongoing communication and collaboration with key personnel, documentation of decision-making, opportunities to receive training on new technology and procedures, a shared file system to communicate changes in procedures or resources, ongoing evaluation of current practices, and openness for modifications based on feedback.

Lessons Learned

The process of transitioning a UPAC to a telehealth or hybrid model of service delivery can be challenging; however, it provides an opportunity to change the future of school psychology practice for the better. By equipping UPAC with materials that allows trainees with greater access to remote training materials, trainees have more time and flexibility to practice novel skills. Similarly, a telehealth or hybrid model of psychological service delivery makes these services more accessible to families who have busy work schedules or live in remote areas by not requiring families to travel as frequently and reduce the time needed to complete the evaluation.

In addition, the pandemic challenged professionals' conceptualization of an evaluation and forced them to reconsider the data collection methods necessary to address referral concerns. At times, clinicians equate a high quality evaluation with the number of tests administered. Furthermore, there is sometimes a reliance on a standard battery that is administered to all clients regardless of the referral concern. Faculty supervisors were provided an opportunity to engage in meaningful conversations with trainees about the value of clinical interpretation skills and the limits of test scores. There was also opportunity for faculty to help trainees design focused and targeted assessment plans based on specific client needs.

This training can increase the efficiency and meaningfulness of psychoeducational evaluations.

The use of technology to advance the field of psychology has been paramount through this transition. The pandemic afforded an opportunity for clients, faculty, and trainees to be open to providing and receiving telehealth services and learn new ways of practicing psychology, such as using application-based tests. Publishers responded to the need for remote tools by increasing access to electronic materials. These methods make the evaluation process more efficient.

Future Directions

Programs who train graduate students to complete psychoeducational testing need to decide whether to incorporate face-to-face sessions for assessment services (hybrid model) or adopt a telehealth only model. Currently, there is not unified consensus regarding the appropriateness of psychoeducation testing via telehealth. Given the possibility for a resurgence of individuals diagnosed with COVID-19, there is an immediate need for research on the validity of telehealth practices for administration of cognitive and achievement tests. As such, researchers are encouraged to engage in work that would expand the knowledge base in this area.

Appendix

Table 3 In-Person Assessment Safety Checklist

Before test day

1. Meet with your supervisor to prioritize assessments and set an assessment plan
2. Obtain PPE
3. Review CCDS safety protocol
4. Receive safety training on **the Training Portal**. Search for *COVID-19 Safety Training*. **Upload a copy of your certificate to this OneDrive.**
5. Confirm client start time, scheduled break time, and test room location
6. Call family the night before assessment to confirm appointment and remind them of safety protocol, including completing health screening
7. The night before assessment, complete the [Daily Health Self-Screening online form](#)

Test day

1. Check in to clinic as instructed
2. Go to testing room and properly disinfect materials as needed
3. Set-up testing room and verify all PPE supplies and test materials are in place
4. Wash hands and ensure PPE is on properly
5. Once notified by clinic staff, go to the first floor elevators to pick up client. Escort client to CCDS and stay in the testing room until notified.
6. Warm up activity. A warm up activity is likely to help the client feel comfortable with the unfamiliar environment.
7. Remember to take the scheduled break.
8. Once testing is complete, notify the front desk. They will let you know when it is safe to bring the client back to their caregiver (outside first floor elevator).
9. Properly disinfect test materials
10. Properly dispose of gloves and wash hands

COVID-19 Psychoeducational Report Statements

COVID-19 Cautionary Statement

This evaluation was conducted during the COVID-19 pandemic. Safety precautions informed by guidelines set by the Center for Disease Control and Prevention (CDC) and CSUS were implemented in order to keep everyone safer from exposure to the virus. As such, face-to-face contact was limited to direct testing. In-person testing was administered with adherence to wearing personal protective equipment (PPE), maximizing social distancing, and hand washing and sanitizing. PPE included facial covering, Plexiglas dividers, and non-latex gloves. A strict cleaning and disinfecting protocol was utilized for all test materials used.

Validity Statement

Standardized administrations procedures do not include the use of PPE and social distancing; therefore, results of in-person tests may not be as precise or accurate as they would be under normal circumstances. Furthermore, interruptions in normal instruction further limit the accuracy of test results. In order to account for validity issues, a 95% confidence interval is reported for overall scores. Furthermore, issues of validity were considered in forming diagnostic impressions.

Declarations

Research Involving Human Participants and/or Animals On behalf of all authors, the corresponding author states that no studies with human participants or animals were conducted.

Informed Consent On behalf of all authors, the corresponding author states that there was no need for informed consent as the manuscript focused on the experiences of the authors and no data from individuals were obtained.

Conflict of Interest Statement The authors declare no conflict of interest.

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