



Counselor Education Training Clinic

C. E. T. C.

Helping Individuals, Couples, and Families to Thrive

Clinical Policies and Procedures Handbook

2017 – 2018

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Student Confidentiality / Responsibility Form

As a student in the Department of Professional Studies – Counseling Program, I understand that my work as a student will give me access to confidential information pertaining to clients, other individuals, providers or institutions.

I understand that it is my responsibility to maintain the confidentiality of this information at all times in accordance with the provisions of Title 42 Code of Federal Regulations (42 CFR 480), the Quality Improvement Organization Manual, Chapter 10, the Health Insurance Portability and Accountability Act (HIPAA) (42 CFR 160, 162 and 164) and any applicable state statutes. These statutes are enumerated in CETC's confidentiality policy. This document signifies that I have reviewed this policy in the CETC Clinical Policies and Procedures Handbook. This document also signifies that I have been made aware and do understand that for the unauthorized disclosure of CETC's data and information I could be fined not more than \$1,000 and/or imprisoned not more than six months, under Section 1166(6) of the Social Security Act.

I also understand that I am responsible for and will be held accountable for the all the information presented in the Clinical Policies and Procedures Handbook, in particular those related to confidentiality, safety, and other ethical and professional standards. I understand that violating the policies and procedures outlined in the Handbook puts at risk my privilege to see clients in the Counselor Education Training Clinic as well as my progress in the Counseling Program. I will review these materials carefully, and if I have questions concerning these materials I will ask for clarification from my immediate supervisor, other faculty and/or the Clinic Director.

Student Name (Printed)

Student Signature

Date

The signed form must be placed in the student's file each year in order for the student to do clinical work in the CETC (Including seeing clients and supervising other clinicians)

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Clinical Policies and Procedures Handbook, 2017 – 2018

Introduction:

A vital component of your degree in Counseling involves learning, applying, and continually refining the skills necessary to work in a professional setting and help clients. The faculty is committed to graduating students who have developed excellent clinical knowledge and skills. Supervised experiential activities are vital to this development. Throughout your training you will participate in a variety of experience-based activities ranging from in-class role-plays to providing counseling services to individual clients and groups from the college and/or community.

Your practicum experiences are your opportunity to apply the knowledge and skills you are learning with clients seeking the professional services of a counselor. For most counselor trainees, it means finally being able to do what you enrolled in your graduate program to do. Your experiences in pre-practicum and practicum are designed to prepare you for future work as a knowledgeable and competent professional counselor.

Please familiarize yourself with the information in this handbook, since it serves to guide your CETC clinical experiences, and sets forth important policies and guidelines for meeting legal, ethical, and professional standards of client care. *You are responsible for all information herein, and are expected to strictly adhere to these standards.*

Clinic Mission: The Counselor Education Training Clinic (CETC) is a state-of-the-art venue for the preparation of counselors, supervisors and counselor educators. Operating from a humanistic philosophy, graduate students and faculty provide counseling services to individuals, couples and families across the lifespan. Values supported by the faculty and students, include social justice, advocacy and leadership. The CETC serves clients from the university and broader community.

Clinic Goals:

1. Develop student competence in core humanistic skills as counselors and supervisors.
2. Develop trainee competence as generalists who can provide counseling with clients across the lifespan.
3. Build doctoral supervisor knowledge and skill across multiple supervisory modalities (live, individual, triadic, group).
4. Provide counseling services to the community, with particular attention to underserved populations.
5. Increase workforce competency in play therapy, substance abuse assessment and referral, early childhood mental health, and couples and family services.

Clinic Services:

1. Individual counseling
2. Group counseling
3. Couple / family counseling
4. Play Therapy (individual, group, filial)
5. Early childhood mental health education and intervention
6. Live, individual, triadic, group supervision
7. Substance abuse assessments
8. Student skills training (clinical and supervisory), individual and group
9. Resource / research center for early childhood mental health and play therapy
10. Faculty research

Non-Discrimination Policy: The CETC does not deny services nor discriminate in any way on the basis of sex, race, color, creed, sexual orientation, handicap, or age. This is in accordance with UW policies, as well as Title IV of the Civil Rights Act of 1964, as amended, 42 USC 2000d, Title XI of the Education Amendments of 1972, 20 USC 1681-1686 and s. 504 of the Rehabilitation Act of 1973, as amended, 29 USC 794, and the Americans with Disabilities Act of 1990, as amended, 42 USC 12101-12213. Our services will respect and comply with clients' rights requirements as specified in standards.

In addition, our services are available and accessible to all persons regardless of cultural background, criminal history, medical status, and drug of choice, so long as client needs fit within the scope of the services we provide. You have or will receive training on these issues in Ethics class, and Multicultural class, among others.

Drug-Free Workplace Policy: The CETC fully supports and follows the UW Drug-free workplace policy. This includes a prohibition on the use of tobacco products by anyone throughout the entire building where the CETC is located (Education building), and is indicated in the clinic by the posted no-smoking signs. The policy covers all who work in the clinic. Although we do not have a policy for drug testing, all who work in the clinic are regularly evaluated by supervisors and program faculty. If concerns about a student's wellbeing, substance use / relapse, or other arise, the student must meet with the faculty. Program faculty will ultimately determine any student's appropriateness for work in the clinic, and may require a remediation plan or other steps before a student may resume any clinical work.

Ongoing Training: As students, your training will be ongoing. Some important topics that will be covered in your coursework, as well as in supervision and other program activities, include the following (with courses where these topics are covered in parentheses): *Trauma Assessment and Management* (Diagnosis, Pre-Prac, Prac, Internship, Life-Span Development); *Cultural Competency* (Ethics, Pre-Prac, Multicultural Counseling); *Client Rights* (Ethics, Pre-Prac, Prac); *Family Centered Services* (Couple and Family Counseling); *Work-Place Violence* (All Classes – professionalism statement, student performance reviews); *Confidentiality* (Ethics, Pre-Prac, Prac, Internship); *Professional Conduct* (Ethics, Pre-Prac, Prac, Professionalism statement); *Ethics* (Ethics, Pre-Prac, Prac); *Special Populations* (Addictions, Pre-Prac, Prac).

In addition, the Addictions class will give you training, education and knowledge in the treatment of the criminal population per TIP 44 Substance Abuse Treatment for Adults in the Criminal Justice System.

Quality Assurance: As counselors, we have an obligation to the public and the profession to insure that we meet certain standards of practice. The quality of services provided in the clinic is maintained through the training and treatment protocol required in the program, including the policies outlined in this handbook. Use of clinical teams, live observation and supervision, mid-session consultations, weekly individual/triadic and group supervision are some of the procedures used to insure that all clinical services students provide through the clinic meet accepted ethical and practical standards. In addition, client files are regularly reviewed in supervision for compliance and professionalism, and are reviewed a minimum of once every 90 days in file audits by the Clinic Coordinators. The multiple forms of supervision and file reviews help provide checks and balances to insure that we all meet the standards of service provision, thus protecting our clients, the program/clinic, and the profession.

Roles and Responsibilities:

Clinical courses are structured to be similar to work in a clinical setting. These classes serve as a bridge between the theoretical foundations and the experiential focus of your clinical internship and

provides an opportunity to integrate theoretical knowledge and practical skills. Your time commitment in clinical courses will involve not only the 3 hour course, but time seeing clients and in individual/triadic supervision.

Clinical-Course Instructors: Clinical Course instructors oversee all functions of your class / clinic experience. Instructors are responsible for facilitating class meetings, helping screen prospective clients, helping assign clients to students, providing group supervision, assigning students to a clinical block and individual supervisor, reviewing all case documentation, monitoring client-contact hours, and designating a final course grade (refer to your course syllabi for details on grading). When a difference in clinical judgment arises between an instructor and a block or individual supervisor, the instructor makes the final decision.

Clinic Coordinators. The clinic coordinators oversee the day-to-day functioning of the clinic. These individuals assist the instructors in recruiting, screening, and assigning clients, and monitoring timeliness and accuracy of case documentation (including practicum hours), and help with the maintenance and up-keep of the clinic.

Individual / Triadic Supervisor. The instructors assign each student to an individual/triadic clinical supervisor for weekly supervision during the semester. These supervisors include qualified doctoral students, faculty and adjunct faculty within the department of Professional Studies – Counseling Program. Individual/triadic supervisors provide one hour of individual or 1.5 hours of triadic supervision per week to each assigned clinical student. The focus of supervision is case review, clinical documentation, theoretical application, and counselor self-awareness, and knowledge/skill development. *It is the clinical student's responsibility to initiate contact with the supervisor, and to insure that all weekly supervision meetings take place.* In collaboration with the instructors, your supervisor completes an evaluation of your performance at mid-term and upon completion of the clinical course (see the Counseling Skills Evaluation Form in the Appendix). Individual/triadic supervisors taking the supervision class are required to record their supervision sessions with students. These are reviewed in their supervision-of-supervision, where the focus is on the supervisors' work.

Block Supervisor. Each MS Pre-Practicum and Practicum student is assigned to a four hour clinical block time. This is the time each week when these students will see clients, observe their peers, and engage in other activities to enhance their clinical skills and self-awareness. It's wise to plan on being in the clinic at least 10 minutes before your block time starts to be ready, and to plan on staying at least 30 minutes after block to help with tidying the clinic and processing with your group. Block supervisors may include qualified doctoral students, faculty, and adjunct faculty within the department of Professional Studies – Counseling Program. Block supervisors are working to support multiple students, and so it is your job to advocate for your supervision needs within the block, respecting that there will be competing needs and limited supervision resources. Students may not use this block time to work on client documentation, review their own session recordings, or other projects, so long as any clients are being seen. Even if there are not any clients during a block hour, block supervisors will use the time for group supervision, case discussion, and role-plays. If you are unable to attend your scheduled block time on a given week, you must notify your block supervisor and class instructor, and contact your clients to reschedule.

Clinical Students. Your primary responsibilities as clinical students are to provide acceptable services to your clients and to develop your own clinical skills. Additional responsibilities are similar to those of an agency or school counselor, and include: 1) adhering to the ACA and/or ASCA Code of Ethics and Standards of Practice, as well as adhering to all policies and procedures in this manual; 2)

conducting clinical intake interviews; 3) preparing for clinical sessions; 4) maintaining a client caseload; 5) documenting all case information in a timely fashion; 6) attending and participating in all weekly group (class) and individual/triadic supervision; 7) MS Clinical Block members--when not seeing a client him/herself are actively serving on the clinical team by observing other clinical students in session; 8) giving and receiving constructive and challenging feedback to your colleagues; 9) helping maintain a professional and clean clinic setting, and assisting with client recruiting.

As a program, we acknowledge the body of research which continues to support the quality of the therapeutic relationship as the foundation for client growth and healing. Therefore, we strongly emphasize the development of the core skills that help counselors establish this kind of relationship. For MS students, this means that your primary learning responsibility is to cultivate the attitudes and skills for building effective helping relationships with clients, and learning how to blend your unique personhood with the core counseling relationship skills. Only after demonstrating some proficiency in *being with* clients in this way will you have permission (from supervisors and your practicum instructor) to begin incorporating additional techniques and exploring other theoretical ways of working with clients. This usually happens in the spring Practicum course. For Ph.D. students, we will continue to emphasize the importance of effective therapeutic relationships as you continue to refine and strengthen your own theoretical approach for assisting clients.

Students in Pre-Practicum/Practicum and Doctoral Practicum are responsible for obtaining 40 direct client-contact hours during the year-long sequence. Client-contact hour requirements for other clinical courses are set by the individual course instructors. If you are not getting the client contact hours you need, it is your responsibility to speak with the Clinic Coordinators and your instructor, and work out a plan to increase your contact hours. This will likely include helping the Clinic Coordinators with client recruiting activities.

Masters Pre-Practicum and Practicum students: You cannot begin your internship until you have completed this 40 hour requirement. Take advantage of as many opportunities for client contact as you can, while always leaving at least one block hour open each week for observing your peers.

Clinical students in the Doctoral Practicum, Advanced Practice, Child and Adolescent, and Play Therapy classes will schedule their clients around the MS Block times. No one may see a client in a block that is not their own without permission from the block supervisor.

Clients. Clients who receive counseling services through clinical courses are predominately University of Wyoming students. Most clients are self-referred. Common presenting concerns include relationship issues, confusion about the future, personal decisions, family conflicts, adjusting to college, loneliness, etc. Some other clients come from the Lab-School, Wyo Tech, and the community at large. Clients are screened for appropriateness to the training mission of the department. Clients whose needs are judged to be outside the scope of practice of this training facility are referred to other settings (see the section in the Handbook on Making Client Referrals).

Occasionally we see clients who have been referred by the judicial system for counseling services--mainly because of legal concern about substance use. These clients must bring a copy of their court order to the first session, and it helps to call and remind them before their first session. If they don't bring it to the first session, you should reschedule with them. In most cases, the order specifies a requirement for informing the court about the client's participation in counseling (usually by regular letter). This process should be clarified with the client, and the counselor should speak with the clinic coordinator to insure that the requirement is being met in a professional manner.

Clinic Facilities:

Counselor Education faculty are continuously updating equipment and clinic facilities to meet the training needs of both masters and doctoral students. The condition of the clinic communicates to clients how seriously we take their concerns and our work. Please help present a professional and

positive image to clients and prospective students by keeping the clinic clean and by behaving professionally while in the clinic, even if you don't happen to be seeing clients yourself. Each MS block will have weekly cleaning responsibilities in the clinic cleaning, but we expect all of you to take responsibility for any mess you make, and for anything you see that needs to be cleaned or put away. Please don't leave something for others to clean. If there is a regular problem with messes being left, please inform the Clinic Coordinators, and the responsible persons will be held accountable.

We are proud to offer our students and clients the state of the art in digital video recording. We ask for your help in making sure that the equipment stays in good working order for many years. Please don't try to adjust cameras or computers (do not adjust any of the settings on the computer without permission from the Clinic Director or Coordinators), or to turn off any of the clinic computers.

We have in the past had windows left open in some of the rooms, and this can create a huge mess, and may damage furniture and/or equipment. If you use a room, you are responsible to make sure the windows are closed, and the lights are turned off. If you have any doubt about whether another student may use a room again on a given day, assume that you are the last and close things up. Please make sure to keep the workroom door closed at all times, and to make sure external clinic doors are locked closed if you leave the clinic and no-one else is there.

Individual Counseling Rooms. There are several smaller rooms designed to provide a safe and confidential setting for individual and couple counseling.

Expressive Arts Room. The expressive arts room is designed to provide a safe and confidential setting for individual counseling using expressive arts materials. The room and supplies should always be kept organized and tidy, and returned to their clean and organized condition after every session. A photo guide is available to indicate where in the room the different expressive materials should be put away.

Group / Play Therapy Rooms. These rooms are designed to provide a safe and confidential setting for group and family counseling as well as Play Therapy. These rooms are also used for some clinical-course meetings, group supervision and a variety of other meetings within the program. *Play Therapy rooms and their materials should not be used for child-care or to keep a child occupied while a parent is receiving services—they are strictly for use in providing clinical services.* No child should ever be left unsupervised in a clinic room at any time. Toys in the Play rooms are therapeutic tools. Rooms and toys should always be kept organized and tidy, and returned to their clean and organized condition after every session. Photo-guides are available in each of the play rooms to indicate where in the rooms various play materials should be put away.

Observation / Supervision Rooms. There is one main observation room with several stations designated for live observation of counseling sessions. All Pre-Prac and Practicum students should plan on having all clinical sessions observed live. Any exception must be approved by the individual/triadic supervisor *and* the instructor. Play therapy sessions may also be observed live behind the mirror. Sometimes, block supervision might be observed live by the supervision course instructors to provide feedback to the doctoral students conducting block.

Each room with a PC and Monitor may also be used for individual/triadic supervision (they have a computer for observing recorded sessions while the supervisor can also record their supervision session). The main observation room may not be used for individual/triadic supervision because it limits others' access and use of the whole clinic, while also not guarding client/supervisee confidentiality. Please do not enter the Observation room during a block time other than your own. While another block is meeting, that space should be left to them. All of the computers in the clinic proper are to be used

only for observation and review of sessions. Students should not adjust settings or use these computers for any other reason.

Clinic Workroom. This room, adjacent to the main observation room is where all clinical documentation and client communication takes place. Client files, stored in a locked cabinet in the workroom, should be kept in the locked cabinets unless they are being used (in a session, for supervision, or for documentation). This workroom, and the computers and printer located here, are *to be used only for clinic purposes* (not for class or personal use). Please do not adjust computer settings, and for legal and ethical reasons, do not save any item on the computer hard drives. We all share responsibility for answering the phone, checking voice-mail messages, and leaving accurate phone messages. Please make sure that the doors to this room remain closed and locked at all times, and that when you leave the room, the file cabinets are locked, and no client documents are left out (either hard copies, or electronic copies on the PC's). Please help us keep this room clean. Finally, this is a work room – please keep your voices low to protect confidentiality and to respect others who are working in the area.

Preparing for Clinical Courses:

Although your clinical work is part of a class, it takes place within a professional setting with a professional staff and real clients. Therefore, professional and ethical conduct on your part is required for your ongoing participation in any clinical course.

Ethics. Students in clinical courses adhere to the professional ethics of the counseling professions as advocated by the American Counseling Association and the American School Counseling Association. Please familiarize yourself with those standards and consider them binding for your involvement in any clinical course. A copy of the current editions of these codes of ethics and standards of practice can be obtained online at <http://www.counseling.org> and at <http://www.schoolcounseling.org>. Because confidentiality is of paramount importance, the CETC complies with 45 CRF, Part 160 and 164 and the HIPAA legislation (as discussed in the Ethics class, and as you have agreed to observe by signing the Student Confidentiality / Responsibility Form). In addition to the ethical codes and laws protecting clients, clinical students must also observe the following:

1. You have the ethical and professional responsibility to protect the confidentiality of not only your clients, but your peers as well. Personal things shared, or that you observe, in a class, a block, or a triadic supervision session should not be discussed outside of the setting in which it took place, or with anyone other than the person who shared the information. Do not talk with peers about a session you observed, or something that was disclosed in class or supervision. Be respectful and honor your peers as well as your clients by holding such things confidential. Any violations of this ethical responsibility will be dealt with as outlined in the Student Retention and Dismissal policy.
2. Session recordings and materials from client files are never to leave the clinic except as necessary for supervision. *Session recordings and material from client files are never to be discussed or shown to anyone other than your supervisor, instructor, or in class as directed by your instructor.* Other counselors' recordings, client files or live sessions are not to be observed or reviewed by you unless for instructional purposes, and only after the counselor has given you permission. Client's must give written permission for information to be shared outside of these rules (see number 4 below).
3. Reviews of recordings are to be conducted in specifically designated areas, such as the observation room or clinic rooms set up for supervision. Appropriate privacy measures, such as closing doors and/or using headsets, should be taken. Any recordings or client paperwork (paper or electronic) must be returned to the clinic work room file cabinet immediately after

supervision, and must be in the locked cabinet at the end of the day. These guidelines apply to supervisory sessions as well as counseling sessions.

4. Information about clients is never requested or released without the client's specific written consent, a copy of which (Consent to Bilateral Release of Information) must be kept in the client's file. In the case of child clients, a parent or legal guardian must authorize such action. An exception to this rule is made when it is suspected that the client may be a harm to self or others. *The decision to breach the client's confidentiality is never to be made by the counselor alone.* If such need arises, you must discuss it in detail with your clinical supervisor and/or clinical-course instructor. Clients are advised of these limits to confidentiality during the initial session. Clients who are at ongoing risk of harm to self or others are not appropriate for the CETC and need to be referred to more appropriate settings (see the section on Making Client Referrals). Students should be familiar with the regulations on the confidentiality of substance use client records known as 42 CFR Part 2 (and which may be reviewed on the internet).
5. Confidentiality and privacy remain requirements when multiple members of the same family are seen separately in the clinic. Counselors, observers and supervisors should take care not to disclose information that may impact the other counselor's work without appropriate release forms, and then only when necessary.
6. Because counselors are trainees, no documents or correspondence can be sent out under the counselor-in-training's name alone. Letters must be signed by the instructor or clinical supervisor, as well as by the counselor-in-training, and copies of any correspondence must be placed in the client's file. Great care must be taken to insure that addresses or fax numbers are correct before any information is sent, and appropriate follow-up steps should be taken to make sure the information has been received by the intended recipient.
7. Because all clinical students are trainees, *all* sessions *must* be recorded. This is explained to the clients during the intake interview, and they sign their consent to do so at that time on the Information for Clients form. If a client refuses recording, do not record; respectfully, but immediately assist the client in finding another service provider (see section on Making Client Referrals). This is a rare occurrence because it is almost always handled during the screening process by the clinic coordinators.

Professionalism. While it is difficult (and hopefully unnecessary) to define all aspects of professional conduct here, a few specific guidelines are offered because of their importance.

1. Please don't talk about clients in the halls, restroom, waiting area, or elsewhere. *Client information is to remain confidential and is to be discussed in supervision and consultation only.* Please keep your voices low while in the clinic and observation areas since sound carries. Use the white noise machines while in the clinic. Please keep doors to outside halls closed and locked in order to maintain confidentiality, as well as the security of client materials and our equipment.
2. How you dress impacts how clients and the public will perceive you as a counselor, as well as how they will perceive our clinic and the counseling profession. Therefore, we ask that anytime you are likely to interact with clients (any time you are seeing clients yourself, or are observing in the observation room) that you dress professionally. A good generic rule is to dress (including footwear) one level more formally than the clients you are likely to see. In our clinic, the rule is that you avoid wearing *jeans, sport, casual, or provocative clothing.* If your supervisor or instructor feels your dress is unprofessional, you may be asked to change before seeing clients. Repeated problems with unprofessional dress may result in failure to pass the course and loss of

clinical privileges. If you're unsure about what constitutes appropriate dress or how it affects the delivery of effective service, please discuss this with your instructor.

3. Avoid chewing gum during session. When you eat and drink in any parts of the clinic, remember to safeguard the expensive equipment (don't eat or drink near the computers), and remember that clients may be invited back to the observation room to meet the clinical team—keep all spaces in the clinic professional looking at all times.
4. Please familiarize yourself with the recording and other equipment and use it responsibly. The clinic coordinators can help you if you have questions.
5. Please begin and end your sessions on time. Being late reflects poorly on yourself and the clinic, and causes problems for others who may need to use your room. Sessions should only go over 50 minutes in rare cases of emergency.

Prior to your first counseling session, be sure that you have reviewed the Codes of Ethics and Standards of Practice, are familiar with the proper use of clinic equipment, and that you are oriented to the paperwork and other expectations of the clinic. If you have questions, please refer to the appropriate section in this handbook first, and then ask.

Liability Insurance. All students enrolled in clinical courses are *required* to carry current professional liability insurance. Low cost insurance is available to student members of ACA and ASCA, and can be obtained online for ACA members at <http://www.counseling.org>, and for ASCA members at <http://www.schoolcounselor.org>. A current proof of liability insurance document issued by the insurer with your name and the dollar amount for which you are insured is required to be on file with the department office associate prior to meeting with clients each semester.

Supervision:

The purpose of supervision is to provide you (the counselor in training) with ongoing feedback from a variety of perspectives regarding your counseling skills and professional development, as well as to insure that clients are receiving care that meets ethical and professional standards. Your supervisors are part of a supervisory team that includes department faculty, adjunct faculty, and advanced Ph.D. students who have current or prior training in supervision. You will receive three types of supervision while seeing clients in the CETC:

1. Group supervision will be conducted during your clinical class time and will involve reviewing cases and relating class members' counseling experiences to counseling technique and theory;
2. Individual or triadic supervision will be conducted on a weekly basis and will involve a more intensive type of case review, discussion of personal issues, review of documentation, and so forth;
3. Live supervision will be conducted during your weekly clinical block time, and will often include observation by classmates of your live clinical sessions.

The supervisory team meets on a regular basis to share information about each student's progress and needs and to coordinate their work to support your growth and competence. In addition, your block and triadic supervisors will complete a Weekly Supervision Report (see Appendix) each week, noting any concerns and growth. These forms will be shared with the other supervisor and your clinical-course instructor so that all may support your clinical and professional development. Each person who views the form, including the counselor, should initial it to document the review. In situations where one or more supervisors have concerns about a student's clinical work and/or progress, the input of all supervisors will be considered, but ultimately the *department faculty will make decisions about a student's ability to continue seeing clients, and any actions necessary to promote the student's progress and protect both clients and the profession.*

Supervision is most helpful when you do not focus on proving yourself, or sharing only successes, but when you feel free to discuss professional and clinical successes as well as struggles. To do this supervision needs to be a safe place for participants to be vulnerable and share concerns, experiences, and personal information. The confidentiality of supervision should be respected such that what takes place in block or individual/triadic supervision is not be discussed with those who were not there. Supervisors should only discuss with others what happens in the supervision they provide as part of their supervision-of-supervision, or to insure client / program safety. In these meetings, student privacy and confidentiality should be maintained as far as possible.

To prepare for supervision, you must review your session recordings and identify specific supervision needs *prior* to your supervision meetings. Your individual/triadic supervisor or practicum instructor will ask you to bring your client files to supervision and to be ready to show specific segments of session recordings. Meet with your individual/triadic supervisor prior to seeing clients so that you can begin developing a working relationship, set goals, discuss individual styles, needs, preferences, and concerns. Supervision should focus on client care first, and then on student development. Since supervision is an ethical and legal requirement, it is inappropriate to miss or be late for any supervision except in an emergency.

Your individual/triadic supervisor will present you with a disclosure statement about his/her supervision services and your responsibilities as a supervisee that you will both sign prior to beginning actual supervision (similar to the informed consent provided to clients). This important document serves as a contract between the two of you. It is important to remember that supervisors can be held ethically and legally liable for your work as a counselor, and so they have a very personal investment in what you do as a clinician. Supervision works best when both supervisors and supervisees understand their mutual responsibility for client care and trainee development. In addition, supervisors will be documenting what takes place in supervision, noting the clients discussed, client progress, training progress, and any specific actions that need to be taken by counselors-in-training (see the Supervision Note in the appendix). In clinical cases where substance use is a focus (including ASI/ASAM evaluations), the SAMHSA document TAP-21: Addiction Counseling Competencies should serve as a guide (this document is found on the clinic workroom computers and may be copied for your personal use).

Supervisors must review and sign all clinical documentation and have responsibility with the student in making sure that client paperwork is accurate, professional, and up to date. Each case in a student's case load should be reviewed regularly in both individual/triadic and group supervision. Both the supervisor and counselor have an ethical responsibility to insure that each case is reviewed in depth at least once every 30 days (minimum). This should include a careful review of the client's goals as specified on the Service Plan and progress or lack of progress toward those goals. Service strategies, objectives and plans should also be reviewed. The review may lead to amendments in the service plan as well as changes in plans and strategies. For clients who are dealing with substance use issues, ASAM Placement Criteria should also be used in determining ongoing service decisions and strategies.

Personal Issues. Our personal experiences, history, values and beliefs form the foundation for how we experience and make sense of our work with clients. However, we are ethically required to not let our personal issues bias our clinical work. Because of this, clinical work requires the counselor to regularly reflect on how these personal elements are triggered and how they may be impacting the therapeutic relationship and clinical work. Supervision is one important place where this work takes place and is encouraged. Although supervision should not look like personal counseling for the counselor-in-training, when a student's personal life impacts his/her work with clients, it becomes an appropriate topic for supervision. Supervisors are responsible for helping students insure that personal material doesn't negatively impact their clinical work, and so personal material may be explored in a limited way. However, resolution of personal issues should not be a primary focus of supervision, but

should be sought through other means (often personal counseling is critical here). Clinical work is emotionally and personally demanding. All clinical students should develop and use a personal plan for ongoing wellness. This will promote your clinical growth and effective, ethical service delivery, and protects against burn-out. We strongly encourage all students to participate in personal counseling as a way to promote deeper self-understanding and clinical excellence.

Supervisor Styles. Each supervisor functions in his/her own way. It is likely that at times you will receive feedback from different supervisors that is contradictory. It should be only in the extreme cases of client safety, or clinical liability (including the need for meeting standards of quality care) that a supervisor tells you directly what you *have* to do specifically. Failure to follow such specific direction can be grounds for dismissal from the program. If you have disagreements with a supervisor in these cases, please speak immediately with your clinical-course instructor. Outside of these rare cases, supervisors' feedback is intended to provide you with options and ideas for improving your clinical work, and for your own growth as a clinician. At times, this feedback may be challenging to you. While this is part of the growth process, feedback should not feel like criticism of you as a person. You must develop skills for personal reflection and clinical decision making, in conjunction with supervisor input. Using the Reflective Self-Supervision Form (in Appendix) can help. Although we encourage you to develop your own personal style of counseling, the wisdom and experience of your supervisors should not be lightly discarded because you want to follow your own idea or direction. The counselor, the supervisors, and the faculty have a shared responsibility for the care provided to clients. You must have a solid clinical rationale and should discuss it with the supervisor before merely choosing not to follow a supervisor or faculty suggestion.

Each week that you meet together for triadic-supervision, your supervisor will leave a little time at the end to check-in with you about how things are going using the three-item Leeds Alliance in Supervision Scale (see Appendix). After you complete the form, your supervisor will plot the scores and will discuss your ratings and trends, and plan for any needed changes in supervision based on the feedback. If you are in a triadic pair, you will each fill out your own ratings, and you don't have to agree with each other. Doing this will parallel the process you will use to regularly obtain feedback from your clients (see the section below on Session Ratings and Client Progress). Please be as honest and open with your supervisor as possible, so that together you can make sure you are getting the supervision that you need.

When differences or difficulties arise with supervision or supervisors, please keep in mind the following: in many cases both you and your supervisor are fairly new to your respective roles. Both of you bring different world-views, personalities, life-experiences, theoretical approaches, and needs to the table. Some bumps are to be expected in this relationship, and if dealt with correctly, such difficulties can be valuable learning experiences for both you and your supervisor. You will be asked to provide constructive written feedback to your supervisors (see the Counselor Evaluation of the Supervisor form in the Appendix) at both mid-term, and end of each semester.

When difficulties do surface in supervision or in any other program relationships, they should be dealt with respectfully and professionally. Our professional code of ethics stipulates that you address your concerns directly with the person(s) involved. Although it can be tempting to speak to others, it is unprofessional and a violation of professional ethics to simply complain or vent to others, or to seek advice and support from others without also accepting responsibility to speak directly with the people involved. If, after first speaking with the individual(s) involved, you feel the problem is still unresolved, then speak with your course instructor. If this still leaves the issue unresolved, please speak with the Department Head. We are a diverse group and there will naturally be differences in personality, values, and clinical approaches. We expect from ourselves and from you professional respect and mature behavior that respects the dignity of all people in all your relationships.

Evaluations. An evaluation of your clinical skills is conducted both at mid-term and at the end of your clinical courses (see the appropriate Counseling Skills Evaluation Form in the Appendix). The evaluation forms will be completed by yourself, and your supervisor team (your course instructor will work with the block and triadic supervisors). The purpose of the evaluation is to document your performance and to provide direction for your continued professional development. Review the evaluation form and seek clarification as needed so that you understand the skills and practices you need to develop. Each student should expect to find suggested areas for improvement and each is responsible for her/his continued growth. In addition, you will be asked to provide your supervisors with feedback that can help her/him (see the Counselor Evaluation of the Supervisor and Block Feedback forms in the Appendix). You are responsible to complete all evaluations on time.

The Counseling Process:

Request for Services. All requests for services from potential clients go directly to the Clinic Coordinators who, in consultation with course instructors and the Clinic Director, screen them for appropriateness for our clinic. In addition, potential clients are informed of the training nature of the clinic, the requirements of session recording and the preference for at least a four week commitment to attend counseling sessions.

Client Assignment. After review, each case is directed to a specific student or referred elsewhere, based on the nature of the client's presenting concerns, the client's schedule needs, as well as student training needs and schedules. In assigning clients, whenever possible, the Clinic Coordinators will consider both clients' needs and counselors' competency, particularly related to special populations and multicultural competency.

Scheduling. Clinical students receive client assignments directly from the Clinic Coordinators, who will often schedule the first appointment. If this is the case, please contact the client to introduce yourself and confirm the appointment (you may only call clients from the clinic – do not call from your home or cell phone, and do not give those numbers to clients). If an appointment has not been set, it is the counselor's responsibility to initiate contact with the client *within 24 hours of being assigned*. When you are ready to do that, follow these steps:

1. Check the white schedule board in the clinic workroom to find out when a counseling room is available.
2. Obtain the client file from the Clinic Coordinators (it will likely be in the file cabinet).
3. Attempt contact by telephone to either confirm the appointment set by the Clinic Coordinators, or to set an initial appointment. If the client is not present, *do not* identify yourself as a counselor. You *may* say that you are calling from the University of Wyoming and that you will call again. Keep in mind that this is a first impression—professional demeanor and confidentiality is important. All calls to clients should be made from the clinic.
4. After you make or confirm an appointment, enter it on the white board (put one of your magnetic name holders in the room/time-slot) to guarantee a room for your session.
5. Document the phone call for the client file (see Contact Note in the Appendix).
6. Return the client file to the file drawer.
7. Continue to schedule the client. It is often best to try to schedule the same time and same room every week. This can reduce cancellations and "no shows" by helping the client to build their appointments into a routine. However, rooms are assigned on a "first-come, first-served" basis.

Intake. All clients seeking services participate in an initial session intake, which has three purposes. The first is to assess clients' needs and to ensure that their needs can appropriately be served in our clinic. *In general*, clients who are considered to need 24-hour availability of care for any reason

are referred to other settings. The second purpose of the intake is to orient the client to relevant issues such as session recording, the counseling process itself, and to obtain informed consent. The third purpose is to provide a safe foundation for the development of a therapeutic relationship. Building a good, healing relationship occurs as the process of counseling unfolds, not as a prerequisite to counseling. Intakes are conducted by the assigned counselor. See the Intake Interview Guidelines (appendix) for suggestions on successfully sharing and gathering pertinent clinical information during the first session. These will be discussed and practiced in your practicum class, clinical block, and individual/triadic supervision. Refer to the section titled "Clinical Documentation" and to forms in the Appendix for guidance in completing and documenting the intake.

Conducting Sessions. Sessions are 50 minutes long, starting on the hour and ending at 10 minutes before the following hour. Sessions with children may run only 30 minutes, and couple/family sessions may be 1 hour and 20 minutes in length. Courtesy and professionalism dictate that you start and end your appointments on time. Arrange the room and start recording before the client arrives. When setting up the recording, all sessions must be named by your last name, first initial – Client # - Session #. Regardless of when you start, end at 10 minutes before the hour. With some clients, you may find it helpful to start your "wrap up" well in advance of that time. A client's or counselor's difficulty starting or ending a session on time is often indicative of a clinical issue and should be discussed with your supervisor and instructor. Remember to stop recording after each session, or when you determine a client isn't coming.

Mid-Session Consultations. All students will take a short (*5 min max*) mid-session consultation during every session to briefly visit with your supervisor and/or other observer(s). These consultations allow you to collect your thoughts and ideas, receive helpful feedback from your clinical team (supervisor and colleagues observing), and help improve the quality of the session. Let clients know in the first session that our clinic operates with clinical teams, and that you will take a short time each session to consult with the team, and see if they have any helpful comments or questions.

In general, you should try to take these consultations after about 15-25 minutes with the client. This may not make sense in the middle of an intake, and you should not step out while the client is experiencing strong emotions, or is actively processing material. Use natural pauses in the flow of the session to take your consultation. If you are feeling lost, that may also be a good time to step out. Although you should try to take your consultation in the early-middle of a session, if that isn't possible you should still step out—even if there are only 5 minutes left in the session. The team may have a very helpful comment they want you to share with the client. Ultimately, you will need to decide if it is inappropriate to take step out in a given session. Your supervisors can help you develop that awareness. Taking advantage of the consultation improves the services we provide, and will help you to grow as a clinician.

This consultation time is for you and your client, so your supervisor should ask what you want to do with the consult. You may ask specific questions, see if the team has any feedback or ideas for you, see if the team has a message for the client (these should be supportive and/or invite deeper client reflection), or you may choose to have no comments from your team and use the time to just collect your thoughts. In any case, the consultation is not for lengthy processing about the case. Discussion should be very brief (one or two basic ideas or messages), should come from just one person, and should stay focused on helping the counselor and client be successful in the remainder of the session.

Session Interruptions. In some circumstances, usually only in cases of client safety or when the session is not meeting professional standards of care, your supervisor may interrupt the session by either calling in, or knocking on the door. During the first session, let your client know that sometimes the clinical team may call or knock to give you both a message. In extreme cases, the supervisor may enter

the room and help you manage a client in crisis. If any such interruptions take place, be sure to process them with your supervisors and instructor.

Outcome and Session Ratings by Clients: Research has shown that regularly talking with clients about how sessions are going and about how clients are progressing, and then using that feedback to adjust services, leads to better client retention and outcome (see the two editions of the book *The Heart and Soul of Change: What Works in Therapy* for an extensive review of this research). Some of the leaders of this research have developed two simple forms for use in facilitating such conversations with clients, and we have received permission from them to use the forms in our clinic. However, each student must first register with the developers. To do so, go to <http://www.scottdmiller.com/performance-metrics/>, fill in and submit the form. Some classes may do this all together, if not, you must do so on your own. Each student will need to take a printed copy of the e-mail verification to your instructor showing that you have registered before you will be allowed to work in the clinic. You do not need to download the forms themselves as they will be available in the clinic (however, once you have registered, you may download and use the forms for your private work provided you follow the stipulations in the license agreement. All who will be using the clinic (as counselors or supervisors) must register and turn in the e-mail verification no later than the first week of class. You will not need to register more than once during your time at UW (see the forms in the Appendix).

In your first session, tell that one way they can help make sure they are receiving the best services possible is their active collaboration and feedback about how things are going, both in life and in counseling. Let them know that you will be checking in with a brief form and short conversation at the beginning of each session about how they are doing (ORS), and at the end of each session about how your work together is going (SRS). Tell clients that you want them to be honest, and that you won't take offense at anything they have to share – this is a way you can both work together and make adjustments to be sure the client is getting what she/he needs.

After an adult client fills out the rating forms, plot the summed scores for each on the SRS-ORS Scores Plot, and discuss with the client her/his item ratings, seeking understanding about what is working well and could potentially be amplified, as well as what is not working well and which might be modified. Also discuss with the client trends in both scores across sessions. Because the point here is to use these scores as an invitation to discuss ways to improve the therapeutic alliance and client outcomes, if you don't discuss the scores, you are wasting the clients time. Additionally, you should regularly review these scores and client discussions in your supervision, and make plans for any needed adjustments indicated by the feedback you receive from your clients. After you record the scores on the plot in the client file, destroy the original rating forms.

When counseling couples or families, invite them to work together on one form. How the couple/family do this will provide the counselor(s) with important information about patterns and processes in the relationship, in addition to the information on the forms themselves. The forms are available for a variety of age levels, and it is your responsibility to use the most appropriate forms and language for your clients' age and developmental level. When using the child forms, the points on the line correspond to the numbers on the adult forms (so that you can indicate the numbers on the plot). The Young Child SRS-ORS forms do not have corresponding number and are thus not recorded on a plot. These forms should go into the file on the right-hand side on top of the session note for that day.

Cancellations and “No Shows.” Cancellations and “no-shows” should always be followed up. Call the client to reschedule as soon as you can. Cancellations, no-shows, telephone contacts (and attempted contacts) must be documented in the client file (No-shows are documented on Session Notes, cancellations and telephone contacts are recorded on Contact Notes).

Closing / Transfer. When you finish working with a client for any reason, you need to close or transfer the file. Closings and transfers must be discussed ahead of time with your supervisor or instructor. If the client wishes to continue counseling, please let both your instructor and the clinic coordinators know, who will authorize the transfer to an appropriate counselor. This is handled with a Closing/Transfer Summary (See Appendix). This form must be filled out even when clients come for only one session.

If the client wishes to continue counseling but a new counselor is not immediately available, appropriate referrals need to be discussed with the client and documented on the Closing/Transfer Summary. If the client wishes to stop counseling at this time but resume in the future (e.g., next semester) this also needs to be indicated on the Closing/Transfer Summary.

When you close or transfer a file, review the file with your supervisor or instructor, making sure that all forms and notes are complete and have the appropriate signatures, and then let the clinic coordinators know that the file is closed. Please follow this procedure for *all* files assigned to you. Please be mindful that failure to properly close files and insure that all client documentation is completed (including all necessary signatures) is considered poor professional behavior and can put yourself and the clinic in legal jeopardy.

Phone Messages. The Clinic Coordinators and supervisors are responsible for answering the phone and regularly checking for and documenting phone messages. There are instructions by the phone in the clinic coordinators' office for accessing and using the voice mail. *All phone calls that come in to the clinic must be documented.* Incoming calls must all be recorded in the phone log (even if the call is for you) as well as in a contact note for the case file, and outgoing calls should be recorded in Contact Notes (some incoming calls will also require a Contact Note that is placed in the client's file). The phone log is locked in the top drawer of the small black filing cabinet in the Coordinators' office. See the section on Clinical Documentation for specific details about Contact Notes. Block supervisors should check the voice-mail for any messages just before their block time each week, and make sure that messages are documented and passed on to the counselors. The white-copy from the message book is folded, the name of the intended recipient written on the back, and then tacked to the message board in the clinic workroom.

Recording Sessions. Clinic policy is that *all* client sessions conducted in the clinic must be recorded. This will be explained to the client both during the initial screening process and during the intake interview. Name your sessions with your last name first initial - client # - session # (eg. Morgan M – 2 – 1). Recordings are stored on a secure server during the semester. To maintain client confidentiality, do not download recordings to any other device without permission from the clinic coordinator (Dr. Morgan). *All recordings will be erased at the end of each semester.* Any exceptions to this storage rule must be approved by your clinical-course instructor and will require additional client consent.

Clinical Documentation:

Client files form an important record of the client's concerns, your work with the client to address those concerns, and client improvement. While the clinic holds ownership of the files, clients own the information within the files and have a right to view them and to request copies of them. Additionally, your clinical documentation occasionally includes forms sent to other professionals including teachers, lawyers and judges, and in some cases clinical documentation becomes a part of legal proceedings. As such, it is very important that your clinical files be kept accurate and up-to-date, and that they look professional *at all times*.

You are expected to adhere to the following guidelines regarding client files and clinical documentation. Client files are professional records; all of the individual pages and the file as a whole

should look professional at all times (holes punched evenly, no messes, etc.). There should be no loose papers in a client file at any time, and nothing placed in the files that is not discussed below. Do not leave sections of forms blank, but type *None* in any space for which you do not have information. Likewise, cross out any signature lines that aren't necessary. This communicates that there was no information, and not that you missed a section. Additionally, don't leave a page with just signatures on it – if you see that the only thing on a page are signatures, bump some text from the previous page to the top of the next page (leaving enough room for the holes to be punched). After typing a note, print, sign, and place it in the file immediately. *You should not save a copy of the note or any other client paperwork to any computer hard drive—it violates federal privacy laws (HIPAA).* You may save a copy to a USB drive that is to be *stored only in the clinic locked file cabinet* so that any revisions recommended by a supervisor are easier to make, but USB drives with client information may not leave the clinic, must not be shared between clinicians, and must not be kept inside a client file. These will be securely wiped at the end of your work time in the clinic (see below). Once you print a final copy to go in the file, the electronic copy must be erased and previous drafts shredded. Client files are to be kept locked at all times, and should not leave the clinic except if necessary to be taken to supervision.

The documents described below are required for each counseling case. Refer to the Appendix for samples of the forms mentioned. A sample file is kept in the clinic workroom. Templates for many forms are also on the computers in the clinic workroom, and all forms should be typed unless otherwise noted below. Remember that you must take *all* of your client files to your individual/triadic supervision each week for review, and that the condition of your client files reflects your level of professionalism. We expect you to maintain the highest levels of ethical and professional standards in your clinical documentation. All clinical paperwork must be kept accurate and up-to-date. For confidentiality, client documentation should not be completed anywhere but in the clinic workroom.

In general, the information related to your work with the client (intake summary, session notes, closing summary, etc.) is placed on the right-hand side of the file. This side documents the story of your work together. Other information (assessments, letters, surveys, releases, etc.) is placed on the left-hand side – this is the side for information that supports or is related to the story itself. Documentation should be filed in reverse chronological order so that the most recent documents are at the top. Good case documentation is a vital clinical skill that takes practice to develop. Your supervisor will regularly review all your clinical paperwork and make suggestions for improvement. With experience and suggestions from supervisors you will learn how to briefly and professionally summarize important case material. Client case files are regularly reviewed in supervision for compliance and professionalism, and are reviewed a minimum of once every semester in file audits by the Clinic Coordinators. Please know that all client case files are kept in the CETC for seven years from the last date of service, and are then destroyed. See the documentation timeline and layout guides in the Appendix and posted in the clinic workroom for a concise guide for when specific documents should be completed and where in the file they are placed.

Request for Services Form. When clients request services, the Clinic Coordinators complete this brief form to gather basic data about the potential client and to determine the appropriateness of their concerns / situation for services at the CETC. In addition, this form has some important contact information so that the counselor can contact the client to confirm the first appointment, and lay the groundwork for the counseling relationship. This form goes on the left-hand side of the client's file.

Consent to Receive Counseling Services. This form serves as a disclosure statement and informed consent for counseling services. As such, it is a critical document. Prior to beginning counseling, the counselor is required to review the details of this form with the client, respond to all questions, and obtain the signature of the client. This form is to be signed by the client, counselor, and the block supervisor (triadic supervisors sign all other documents). All clinical students must

comprehend and be able to explain any portion of this document. The signed form is placed in the client file on the left-hand side, and a clients should be given a copy. This form must be updated any time that the counselor's supervisor(s) change.

Consent for Minor to Receive Counseling Services. This is the form that must be signed by a legal guardian before a minor can be seen in the clinic. Follow the same procedure as with the consent and place it in the file on the left-hand side. The guardian should also receive a copy.

Child Assent to Receive Counseling Services. This form is to be used with child clients (roughly ages 6-12) in place of having the child sign a Consent form (since only a legal guardian can give consent for a minor). The assent recognizes the child's growing autonomy and invites participation in counseling. Prior to starting counseling, the counselor reviews the details of this form with the child, answers questions, and obtains the child client's signature. The form is also signed by the counselor and block supervisor. The signed form is placed in the client file on the left-hand side just below the guardian consent form, and a copy should be given to the child. With adolescents, both a guardian and the adolescent sign the consent.

Consent for Research Participation. This form is used to get client permission to use their session recordings and other non-identifying information in ongoing research by Counselor Education faculty about the counseling process. Share this form with clients after they have signed the Information for Clients form. This form goes on the left hand of the client file. You will be informed by instructors when it is necessary to complete this form.

Client Information. This questionnaire is a tool used to gather important initial information about the client(s). Students may have clients complete this form either before or during, *but not after* the first session (except in case of emergency). Do not send it home for the client to complete. You must briefly review this form *before beginning the session* (except in emergency situations). The client's responses to items should guide the intake session. In the rare case that the form is not completed prior to the first session, be sure to ask during the first session about any substance use, possible risk factors (harm to self and/or others, current safety), and if the client is taking any medication. A Couple/Family version and a Child/Adolescent version (completed by caregivers) are also available and should be used as appropriate. The Client Information form belongs on the left side of the file.

Mental Status Exam Checklist. The Mental Status Exam Checklist should be completed immediately after all first sessions, and may be completed by hand. You must check either "present" or "absent" for every item on the form. If you check present for an item, *briefly* note what you observed that supports what you checked as "present." For some items you can circle words to clarify, but also jot a few brief notes on the document itself. You will then provide more details on the intake summary. This form provides a snapshot of some critical issues that will affect the course of counseling, and which may necessitate a referral. Be sure to understand each item on the checklist, and how to recognize them before you begin seeing clients. It is filed below the Intake Summary on the right-hand side of the file.

Intake Summary. The intake summary provides an overview and *initial* understanding / explanation of the client's situation and your plans to help the client at the time of the intake. Every client you see must have an Intake Summary, even if the client only comes for one session, or is coming for a substance-use evaluation. A well written intake summary will bring together all of the bio-psycho-social information gained from formal and informal assessments and articulate the relationships among a client's presenting concern, personal history, relational dynamics, diagnostic statement and full DSM

Diagnosis. You will suggest an initial direction for counseling that is consistent with your stated understanding of the client as well as with accepted treatment standards in the field. Use the information in the Appendix (Intake Summary Guidelines) and the sample file in the workroom as a guide. The Intake summary must be completed after the first session (before the second session), and so you will need to be intentional in how you structure the first session to gather the relevant information, while building the therapeutic relationship with your client. For children, you will need additional information from the child's caregiver(s) and possible teacher(s) to complete this form. Some of this information may come from the Client Information questionnaire and Consent forms, but it is considered best practices to visit with caregivers before beginning services with a child. The Intake Summary is signed by both you and your supervisor and belongs on the right-hand side of the file.

Case Notes. The purpose of case notes is to assist in treatment planning and evaluation. They may also be used as a legal record, documenting the content and process of counseling. Therefore, you should record *all* client contacts: counseling sessions and no-shows are recorded in Session Notes, which are placed in reverse chronological order on the right hand side of the file, on top of the Service Plan; telephone contacts (and attempted contacts), cancellations, and consultations with other professionals about the client are recorded on Contact Notes which also go on the right hand side interspersed with the Session Notes,. Any written communication you send to or receive from others about the client goes directly into the file on the left hand side. Someone who looks at the file should have a clear, organized sense of what was done, and when. A good rule to remember is that from a legal standpoint, if you don't document it, it's the same as if it didn't happen at all.

1. **Session Note.** Write a note for each *session* you have with the client (including the first session), or scheduled session that is a no-show. The note should be 6 to 10 sentences long, unless special circumstances dictate documentation that is more detailed. Notes must be written *within 24 hours*, except in rare, extreme situations. In your notes, record the content and process of each session. Record goals, changes in goals, and progress related to goals. Your notes should provide enough detail that another clinician would have a good idea about the course of treatment, without providing unnecessary details.

After filling in the names, date of the session, and session number, fill in the other areas as follows (use the template on the computer). **Subjective.** This section contains *material reported by the client* about presenting issues, current status, compliance and response to homework assignments, progress toward goals. It's *subjective* because they are not things you observe or can verify – things reported to you by the client. **Objective.** This section contains *information that you directly observe*. This should include a *brief* summary of what happened in the session, both the content/focus of the session and process (how things happened), as well as the client's reaction to the session. Include the client's basic way of being during the session. Make note of any dress/grooming, behavior, emotion, and/or cognition that is relevant (similar to the items on the MSE Checklist). **Assessment.** Note in this section *your professional opinion of the client's current level of functioning (including any safety/risk issues), their mental status, and how you feel the client is progressing toward achieving her/his goals, as well as the evidence you have for your assessment*. The evidence of client progress may involve client reports of feelings, thoughts, behaviors along with their frequency, as well as your observations of the client in session, and the client's feedback on the ORS and SRS scales. You should use one of the following classifications: Little Progress (followed by the evidence); Moderate Progress (followed by the evidence); Much Progress: (followed by the evidence). This section would also be where you indicate information about any risk assessment you did during the session. **Plan.** In this final section describe *any homework given, and referrals you made, any action you or the client will take between now and the next session, as well as your plans for the next session(s)*. This may include topics you plan to

address, needed follow-up on safety issues, symptoms that need to be checked, and techniques you may use. You must include a rationale that links your plan to the client's goals, progress and needs. Note the date of the next scheduled session.

Special circumstances that require additional documentation should be discussed and written up with help from your triadic supervisor. Any time there is evidence or suspicion of *at risk* behaviors, including suicidal behavior, self-harm, substance abuse, or physical or sexual abuse, more extensive documentation is needed, but should still follow the above format. Make a careful record of what you observed, what was told to you and by whom (direct quotes are good). Provide details of your assessment of risk, the steps taken and plan for managing the risk, and document any consultation you made with your supervisors or colleagues. In addition, any plan for outside consultation should be reviewed with a supervisor, and carefully documented. In subsequent notes, continue to document how you monitored and appropriately responded to the situation over time (how you provided appropriate follow-up).

Session Note – Play Therapy. This form should be used to document play therapy sessions. It broadly follows the same *Subjective, Objective, Assessment, and Plan* format as the regular Session Note, but with more focus on the objective area and specific prompts for use in documenting play therapy sessions. Play therapy clients aren't likely to present much *Subjective* material. When they do, it can be reported in the section for client verbalizations. Other subjective reports about the client's status and progress are likely to come from caregivers, teachers or others, and should be reported on a contact note.

Using the template on the workroom computers, fill in the client's name, service date, the client's age, your name and the session number. Then fill in the remaining fields to document the play therapy session. **Client's Predominant Emotions.** In this section indicate all emotions expressed by the client during the session, how those emotions were communicated (verbalized, nonverbal facial expressions, behaviors, etc.), and how aware the client was of those emotions. **Session Summary.** Provide here a brief description of the client's play behaviors and toys used, the sequence of her/his play over the session, any significant breaks or shifts in play (in terms of content, focus, intensity, tone, etc.), and any important verbalizations made by the client. Use the check-boxes to indicate any limits that needed to be set or enforced during the session, and provide a very brief explanation of the same. **Clinical Impressions / Understanding.** This is the section for you to report the meaning that you are making from the client's play and your time together. How are you conceptualizing the client's presenting concerns, the meaning of his/her play as reported in the Session Summary, and your estimation of the progress the client is making toward her/his clinical goals, and your rationale for that estimation (what, to you, suggests the progress or lack of progress you are reporting?). Also, use the check boxes to indicate the major play theme(s) that you believe were evidenced in the client's play. **Plan / Recommendations.** Describe your plans for any ongoing work with the client including planned conversations with caregivers or others, any needed follow-up with the client or others, possible referrals, any action you or the client will take between now and the next session, as well as your plans for the next session itself. This should include any techniques you may use. Please include a rationale for how your planned approach fits with the client's presenting concerns and needs. Note the date of the next scheduled session.

- Contact Note.** Documentation of phone or other contacts with clients or other professionals related to a client (or parents of minor clients) should include the date, who was spoken to by whom, a brief summary of the conversation, and any results (such as an appointment date, referral, ect.), along with any need for follow-up. There is a template on the computer for contact notes.

3. **Group Session Note.** The form to use when providing group counseling to document what occurs during each session.

Occasionally children and or adults produce craft or art items during counseling. The general rule is that those belong to the client and should be taken out of the clinic by the client that day. Anything not taken by the client must be considered confidential and carefully destroyed. We do not store any client-produced materials. If you believe an item has clinical documentation value, you must convince your triadic supervisor. Sentimental reasons do not meet this criteria; you must demonstrate a clear therapeutic need to retain the material. Such material that are page sized may be hole-punched, labeled with the client name and date produced and then placed in the file below the session note for the day it was made, with a statement in the session note indicating what the client produced and the clear therapeutic rationale behind it being entered into the client file. Larger items or others must be photographed and then the photograph entered into the file as noted above (see the clinic coordinator for a camera – you may not use your personal phone to photograph confidential client materials). Items that meet the standard to be entered into the file but which require drying may be left in the locked play-therapy observation room to dry (on the racks) but must be placed in the locked work-room file cabinet within 24 hours. Take it to your next supervision session to seek approval for quick entry into the client file. Any other handling or mishandling of client-produced materials that does not follow this procedure will be considered a violation of ethical and professional standards for protecting client confidentiality and privacy.

Service-Plan. The Service-Plan is just that, your collaborative plan with the client for the work you hope to accomplish together. It acts to focus and guide your clinical work together. You should begin to form some goals / desired outcomes for counseling with the client in the first sessions, and discuss these with your supervisors. Client goals should be more than abstract wishes, but relatively concrete, measurable, and as outcome driven as appropriate to the individual client.

This form should be completed by you and the client together in session, and signed by the client and yourself by the end of the third session, and then signed by your supervisor. You should review the Service-Plan at least once every 4 weeks with your client, and in supervision, using a new form. Place the form into the file above the Session Note for that day, and note in the session summary of the Session Note that the service plan was created/reviewed. ASI client files do not need a service plan unless the client chooses to continue services after the ASI.

Indicate if the form represents an initial Service-Plan or a Service-Plan review. List the client's strengths and resources, and then note any case management needs and plans. These are needs that fall outside of normal counseling services, but which impact a client's overall functioning and wellbeing. They may include issues related to food, housing, transportation, education, employment, finances, child-care, legal concerns, medical concerns, and others. Where a client needs case management type services, a referral will be made to a setting which can appropriately provide those services. Such settings may include a community mental health center, vocational support setting, health-care provider, or others, based on the clients' specific needs.

Next, list the client's goals for counseling (two or three is usually enough to focus on at any given time). Indicate if the goal is new or ongoing, and if ongoing, report the progress on goal achievement since the last review (1 = little progress, 2 = moderate progress, 3 = much progress, and 4 = objective achieved). Then indicate if the goal will remain in effect for the next 30 days, and indicate how you and the client will know if the goal has been achieved (achievement criteria).

Closing/Transfer Summary. Closing/Transfer Summaries are used when your work with a client ends. Provide evidence for your conclusions about client progress (ORS scores may be helpful), factors enhancing positive outcome, barriers to positive outcome, and ongoing concerns. Please

complete one for *every* client, even if you only saw the client once. Clients seen briefly will need only a sentence or two; clients seen over a period of time presumably will necessitate more description. At the end of the fall semester, if a client plans to return in January you do not need to complete a Closing/Transfer Summary (similarly for other short breaks less than a month in length). Just document in the last Session note the client's plan to continue counseling after the holiday (break), and set an appointment if possible, or indicate how a next session will be scheduled. If the client chooses not to return, document this and then complete this form. Closing/Transfer Summaries must be reviewed and signed by your individual/triadic supervisor before it is entered in the file, on the right-hand side.

Consent to Bilateral Release of Information. In the course of counseling, it is often helpful or necessary to communicate with other professionals outside the clinic (physicians, former counselors, teachers, judges, etc.) who know or have worked with the client. This can help you better understand the client and better plan services. Because of the legal and ethical rules of confidentiality, you cannot speak to these other professionals, or anyone else outside the clinic (even to confirm that a person is a client), without written permission from the client, or client's legal guardian(s) if the client is a minor. Written consent is obtained using the Consent to Bilateral Release of Information (see Appendix). You must fill in all the blanks on the form in as specific and detailed a manner as possible. Avoid generic titles such as Judge or Teacher; name the specific person and give their title and organization. You must also be specific about what information will be shared, and the reason for the sharing. Please clearly specify if the request is for written records, for a verbal conversation, or both and what information is being requested.

Review the request with the client, explaining what information you want, and how you will use that information. As with any document leaving the clinic, the form must be reviewed and signed by your supervisor before it is used to either obtain or share information about your client. Once the client and your supervisor have signed the release, you must send a copy to the other professional (mail or electronic) before information is exchanged. Be careful about information that you share with the other professional, and do not share any information that the client has not specifically authorized you to share. Written records obtained from others are entered into the file. Conversations should be documented on a contact note which refers to the release, e.g., "Spoke with Dr. Phil after obtaining a release from the client. . ." The consent goes on the left-hand side of the file, as do any records sent by other professionals, while contact notes go on the right.

Other Clinical Forms. There are a few additional forms used in sending letters to clients after repeated no-shows, or when we can't reach a client by phone. Other letters are used to confirm that a person is receiving counseling services, or in making reports to the court system for clients who are mandated to counseling, or for substance use evaluations. Templates for these letters are on the clinic workroom computers. Remember that all letters leaving the clinic must be reviewed and signed by your supervisor. Before you can send a letter to someone other than the client, you must have a Consent to Bilateral Release of Information form signed by the client expressly giving you permission to send a letter to the indicated party, with the information you are sending. Please be timely in drafting any necessary letters, which are mailed by the clinic coordinator.

Occasionally, we may ask clients to fill out other forms about their perception of the counseling process in order to improve the quality of services we provide, and/or as part of our ongoing research into the counseling process. These will be explained and provided as necessary. Copies of any letters sent to or on behalf of clients or other information collected from clients are placed on the left-hand side of the file.

Substance Use Evaluations and Forms (ASI / ASAM):

The CETC has approval from the state to conduct substance use evaluations with adults (18+). Occasionally we receive requests from individuals, the judicial system, the university and other sources to evaluate a person's substance use and make appropriate service recommendations. In such cases, the Clinic Coordinators will inform the student that a substance abuse evaluation (ASI) is the reason for referral, and will make sure that the clinician assigned has had the appropriate training to conduct an evaluation and make service recommendations. The CETC does not test clients at all to monitor substance abuse abstinence, nor are we able to sign off on Department of Transportation (DOT) paperwork. The Clinic Coordinators will let clients know this, but Counselors should be prepared to inform clients as well, and let them know that if they need testing (urine analysis) or DOT forms completed, we can provide a referral. There are additional printed materials about conducting substance use evaluations in the Observation Room (a folder with printed materials), and the SAMHSA document TAP-21: Addiction Counseling Competencies should guide your work with these clients (this document is found on the clinic workroom computers and may be copied for your personal use). A book, *The ASAM Criteria* is in the clinic workroom for your reference.

Be sure in your work with clients who are seeking a substance use evaluation, just as with all your clients, to meet and address them at their level of functioning (cognitive, emotional, motivational, etc.). Since substance use concerns are common among people involved in the criminal justice system, be sure to inquire if this is the case. Treatment Improvement Protocol 44 (<http://www.ncbi.nlm.nih.gov/books/NBK14168/>) contains information and guidelines that should be followed with these clients. Please review and discuss in supervision as needed.

Procedure. When clients call in for a substance use evaluation, the Clinic Coordinators will screen for appropriateness (no need for detox, regular use verification, no need for DOT forms), will let clients know that the evaluation will require one paperwork session, and 3-4 additional sessions with a counselor, and will check for counselor availability. They will set a time for the client to come in and complete some initial paperwork, bring copies of any relevant court orders, and to pay the \$50.00 evaluation fee. During the paperwork session, clients will be given the Information about Substance Use Assessments form that briefly explains the purpose and structure of a substance use assessment, introduces the ASI Substance Use Evaluation – Client Form, the ASAM Adult Placement Criteria, and invites the client to begin considering change options. Clients will also receive and complete the ASI Substance Use Evaluation – Client Form and a Consent to Bilateral Release of Information (if relevant). Once the client has completed the forms and paid the fee, an appointment with a counselor will be set, the forms that the client has filled out will be placed in the file and the counselor informed of a new client for a substance use evaluation. When you are assigned a substance use evaluation, you must call the client to confirm the appointment (as you do with all new clients).

The first session will look much like any other initial session, including the use of the Client Information and Consent forms. The counselor will obtain consent and then begin to gather information as with any other intake session. The client should be given the opportunity to share why she/he is seeking an evaluation, and the counselor will gather pertinent information regarding current issues, background information etc. As with any client, all of the regular CETC paperwork must be completed for clients receiving a substance use evaluation (Intake Summary – complete with clear diagnostic summary and full DSM diagnosis, Session Notes, Closing/Transfer Summary, etc.).

The second and third sessions will be used to clarify and add depth to the information already gathered. Your goal is to achieve a meaningful understanding of the client's substance use, its frequency, duration, history, risk, and the contextual factors related to its use (biological, psychological, and social). Work to understand the potential for the client's ongoing use, negative consequences from that use, and their potential severity. In addition, you need to understand the client's awareness of any problematic substance use and acceptance of responsibility for that use and its negative consequences.

Finally, work to understand the client's willingness to make healthy changes to reduce and if possible eliminate problematic behaviors and consequences of her/his use. Throughout this process, work with your supervisor to use the ASI Substance Use Evaluation – Client Form, the ASAM Assessment Dimensions (see the Appendix), and current DSM to insure that you obtain an adequate breadth and depth of information in order to make level-of-care and service recommendations. You may need to ask more questions to gather this information, but they should be open-ended, and you should avoid any interrogation-like process.

After the three sessions, work with your supervisor to review and evaluate the information obtained from the client. Compare this information to the ASAM Adult Placement Criteria to decide on an appropriate level of care and to make more detailed service recommendations. Complete and review with your supervisor the Closing/Transfer Summary. Under "Ongoing Concerns / Future Recommendations," specify the recommended level of care (number and name), supported by details for each of the six assessment dimensions, and identify service recommendations that fit the level of care specified. Your final session with the client will include a discussion of each element on the Closing/Transfer Summary, and an explanation of your recommendations, along with possible referrals for your client to obtain the recommended services. Where needed, a copy of the Closing/ Transfer Summary will be sent to courts or other organizations to document the client's participation in a substance use evaluation and your professional recommendations.

The results of all pertinent and comprehensive assessment information, screening and other tests are to be placed in the client case file, on the left-hand side of the file.

ASI Fee Policy. Fees collected from ASI evaluations are used to help cover basic clinic operating costs (cleaning materials, tissues, etc.), and we follow generally accepted accounting principles with these fees (as we would if ever other fees were charged for clinic services). Although in most cases the Clinic Coordinators will be the only ones to receive fees, it is critical that everyone follow these procedures in receiving and processing fees from ASI clients. A receipt must be filled out at the time payment is received from the client. The receipt book is locked in the bottom drawer of the small black filing cabinet in the Clinic Coordinators office. The middle (yellow) copy is given to the client and the pink copy goes into the file on the left-hand side. The white copy and money go into an envelope, and into the locked money box in the bottom drawer of the small black filing cabinet. The Coordinators will check the money box at 8:00 each morning. They will verify that money received matches receipts in the envelope and client files, and then take the money upstairs to the department Office Associate, who will sign an additional receipt to verify reception of the money. Failure by anyone to follow this policy is a severe breach of professionalism that will call into question your continuation in the program.

Substance Use Evaluation Progress Letter. On each of the computers in the clinic workroom is a template for this form letter that may be used to confirm that a client is receiving a substance use evaluation, and the status of the client's progress. Be sure you have a Consent to Bilateral Release of Information form signed by the client specifying that you can release this information to the specific individual. Obtain your supervisor's signature on the letter and give it to the Clinic Coordinators, who will mail it. A copy of the signed letter will go into the file on the left-hand side.

Substance Use Evaluation Results Letter. On each of the computers in the clinic workroom is a template for this form letter that is often sent to the court or to an attorney when a person has been ordered or recommended to receive a substance use evaluation. When your client requires that the results of his/her substance use evaluation be sent to someone, you will fill out the letter and send it, along with the Closing/ Transfer Summary detailing the client's participation in the evaluation and your recommendations. Be sure you have a Consent to Bilateral Release of Information form signed by the

client, specifying that you can release the information to the specific individual. Obtain your supervisor's signature on the letter and give it to the Clinic Coordinators, who will mail it. A copy of the signed letter will go into the file on the left-hand side.

Special Circumstances:

Emergency Procedures – Counselor/Client Safety. The safety of clients and counselors is critical. Before you begin seeing clients, consider ways to enhance your own and client safety. Some ideas to consider include never being in the clinic alone with a client – always make sure other students / supervisors will be in the clinic – letting clients know that if they feel a need to leave a session (because they are upset) that you will let them go. If this happens in a session, be sure not to block their path to the door. Get out of the way and let them go, then try to contact them later. It is also wise for you to sit closest to the door so that you too can exit quickly without having to pass by clients who are disruptive or threatening. If you are in the middle of an assessment or safety planning and the client decides to leave before you have finished, let the client know that you will likely contact the police to share your concerns and to request a safety check. Remember, your first priority is to take every reasonable step to insure client safety.

If you suspect a client is under the influence, reschedule with the client (clients are informed of this policy on the “Information for Clients” form), and offer to call Safe-Ride so that they do not have to drive. You may choose to consult with your supervisor first. If a client is behaving violently, or is threatening you or another person, (or if you observe such behavior while watching another counselor) contact the police immediately (911) and end the session. Safety must come first. See the sections on *Client Crisis Protocol* and *Clients with Unusual Presentation of Symptoms* for further guidelines.

In the event that the fire alarm goes off during a session, please leave the building immediately by the nearest unobstructed exit and move away from the building to allow access by emergency responders. If you are with a client, instruct them to leave the building with you and remember to maintain confidentiality once you have left the clinic space.

In a medical emergency, if you are alone, go quickly to the nearest phone to dial 911, and then return to the person in medical need and stay with him/her until emergency personnel arrive. If there are others present, one should go and make the call while at least one other stays with the individual. Supervisors and colleagues observing may also make the call. Do not attempt to move or treat people with a medical emergency unless you are trained, certified, and insured to do so.

Anytime the situations described in this section occur, please report them to your supervisor, instructor, and the Clinic Director. These policies for responding to emergencies will be discussed in greater detail in your clinical courses, and are posted in the observation room.

Clients in Crisis. Our clinic is not prepared to work with all clients. If we become aware that a client is not appropriate for the clinic (either at intake or during the course of counseling), they are referred to agencies more appropriate to their needs. If you suspect that your client needs care beyond our (your) ability to provide in this setting, discuss this with your supervisors and instructor who will help you make appropriate assessments and decisions.

Clients who may not be appropriate for services in the Counselor Education Training Clinic include those who are suspected to be actively suicidal or at high risk for other potentially lethal self-harm, who are homicidal, physically/sexually abusive or violent, severely depressed, experiencing psychotic symptoms, manifest borderline personality characteristics, or are in apparent need of 24-hour availability of care, etc. Clients who are suspected to be suffering from severe eating disorders, tic disorders, organic disorders, psychoactive substance use disorders, schizophrenia, bipolar disorders, dissociative disorders, paraphilias, and impulse control disorders are *in most cases* beyond the scope of

the CETC services. These individuals will be provided with appropriate community referrals as indicated below.

On some occasions, we will agree to provide certain limited services, such as career counseling, to these clients, provided they are receiving services elsewhere for the other concerns. Clients whose involvement in illegal behavior, such as physical or sexual child abuse, has already been reported to proper authorities may, in some instances, also be seen here, under the recommendation of such authorities. *These paragraphs are intended only as general guidelines. Although supervisors and the clinic coordinators / director may be consulted, the final decision about seeing such clients rests with the clinical-course instructors.*

Crisis Intervention. Because we see a restricted range of clients, client emergencies rarely occur at the CETC. Sometimes, however, our clients do experience serious crises and may need immediate, specialized intervention. Check the Counseling Intake Questionnaire before any first session for indicators of possible crisis and/or suicidality. If, during a counseling session, you feel your client may be in crisis, ask enough specific questions to determine the nature of the crisis. If appropriate, assess the client for suicide, using materials below, or as directed by your supervisors. Once you have a sense of the nature of the crisis, work with the client to make plans to promote safety and resolution of the crisis. If you are observing a session and see that the client is in crisis, it is your responsibility to alert the supervisor. In an extreme emergency, when no-one is available or reachable for consultation, call 911.

If your client appears to be suicidal or otherwise in crisis, and you want to consult, you may tell the client you're very concerned about what you're hearing or seeing and would like a second opinion. At this point it is the observer's responsibility to arrange for a supervisor to join the session. If appropriate, the supervisor may contact a faculty member for additional consultation. Avoid leaving a client who is in crisis alone. If a supervisor doesn't join you at this point, have the client go with you to either locate a supervisor in the clinic, or to go use a phone to call one of the faculty. See the section below for client crisis protocol.

Suicide Assessment. While it is not appropriate to provide ongoing services for clients with ongoing suicidal ideation in our clinic, the following information is offered as a guide to the assessment of clients who may be at risk for suicide. *All counselors must familiarize themselves with this material and be prepared to use it at any time.* These materials are derived from the American Association of Suicidology (suicidology.org).

First, understand that suicidal thoughts and feelings are relatively common. They most often occur in the presence of overwhelming psychological pain (often related to severe depression, anxiety, or stress – which is often linked to loss). For many clients, suicide feels like a viable way to end the distress they are experiencing. Hence, it becomes important to understand each clients' level of psychological pain and their ability to cope with that pain. High levels of pain and poor coping strategies indicate a higher level of risk.

You should regularly inquire about suicidal thoughts, feelings and plans with anyone who presents with signs and/or symptoms of depression, or who is otherwise experiencing a high number of stressors or a high level of psychological pain. Be very direct with your questions and conversation (you cannot cause someone to have suicidal thoughts by asking direct questions), and clearly demonstrate empathy for the client regarding the underlying emotions and experiences. You should assess for current stress, risk factors (see below) and protective factors. Your directness and candor will help the client open up and feel confident in your ability to help. Let your client know that suicidal thoughts and feelings are relatively common. Any time a client indicates suicidal ideation or behaviors get a very clear description of them. Have the client relate the experience with enough detail so that you feel like you were seeing it in a video clip of the events and thoughts. You may have to ask specific questions to

get such detail. As you assess, be aware that prolonged stress reduces the positive potential of protective factors.

When you have a client that appears sad/depressed, expresses high psychological distress, has checked suicidal thoughts on the Counseling Intake Information Sheet, or indicates any sense of suicidal thoughts or actions, ask the following types of questions and additional follow-up questions (not an exhaustive list):

- Are you currently having any thoughts about killing yourself?
- How long have you had these thoughts?
- Do you wish you were dead?
- Have you ever tried to kill yourself in the past? (Find out when, means used, and what happened – in video-clip mode)
- Has anyone in your family, or someone you know killed him/herself?
- Do you have a plan for killing yourself? Have you thought about how you would do it? (time, place, method)
- Do you have access to a means for killing yourself?
- Have you said goodbye to anyone, or written a note? Put your “affairs in order”?
- What might prevent you from killing or hurting yourself?
- Who would be hurt if you killed yourself? How would it impact others?
- What could we do today that would help you feel good enough so that you wouldn’t try to kill or hurt yourself?

There are two generally accepted ways to evaluate a person’s risk for suicide, a clinical approach, and an empirical approach (see the Suicide Assessment Worksheet in the Appendix – blank copies should be in each file and in the clinic workroom at all times). The best-practices expectation is that you will consider information from both approaches with any client where an assessment is warranted. Both involve collecting detailed information about risks and protective factors. Risk factors don’t lead to suicide or suicidality, but they increase the likelihood that a client experiencing deep psychological pain will consider suicide as a viable option for dealing with the pain. A greater number of cumulative risk factors represents a higher level of risk. Likewise, protective factors don’t prevent suicide, but indicate that a client has coping skills, connections and resources that provide hope and a better ability to manage crises and psychological pain. During an assessment be sure to listen, show empathy and respect (don’t just get into an interrogation mode). Having someone listen sensitively and be willing to address the underlying pain is a helpful first step.

The Clinical Approach: This approach is a careful consideration of client demographics, current stressors, chronic and acute risk factors and any protective factors. For *demographics*, be aware that risk for suicide goes up with age, that men are more likely than women to die by suicide (possibly because men typically use more lethal means), that Caucasian people are more likely to die by suicide than other ethnicities. Note that Wyoming ranks 4th in the nation for deaths by suicide, and 2nd among people 15-24. *Chronic risk factors* are things from the past that can continue to influence current mental state and functioning. These include things like past trauma, a history of substance abuse, major health concerns, a history of mental health concerns (self and/or family), past suicide attempts, past psychiatric hospitalization, and self-harm behaviors. *Acute risk factors* can be assessed using the acronym “IS PATH WARM.” I = Ideation; S = Substance Abuse; P = Purposelessness; A = Anxiety & Agitation; T = Trapped; H = Hopelessness; W = Withdrawal; A = Anger; R = Recklessness; M = Mood Change. *Protective factors* include evidence of healthy coping skills, optimism / future orientation, supportive social network, strong family connections, cultural or religious beliefs that support self-preservation, access to mental health services, and restricted access to means. Risk level is determined by combining these data obtained through careful questioning. Low risk may include the presence of some chronic risk factors, but no acute risk factors. Moderate risk involves higher chronic risk factors, and some acute

risk factors (a history of prior attempts automatically puts a person at least at a moderate risk). High risk involves many chronic and acute risk factors, and few protective factors.

The Empirical Approach: With this approach, four factors are assessed: suicidal desire, suicidal capability, suicidal intent, and buffers. First, check the client's level of *suicidal desire*. To what extent does the client want to cease living. This may involve things like not having any reason to live; having a wish to die, or not carry on; not caring if death occurred; feeling like a burden to others, or desire to make an attempt. Check for mental health concerns and psychological pain. A client's level of *suicidal capability* includes not only the client's sense of fearlessness and competence to make an attempt (which may involve tendency for impulsive action), but also the availability of means and opportunity, along with the specificity of any plans and any preparations to make an attempt. Level of emotional agitation and turmoil, along with anger are also factors here. A prior attempt is the most important indicator of capability. *Suicidal Intent* includes the client's intention to act on suicidal desire, and is a clear indicator of risk. Intent is present with the client has initiated an attempt or made a plan, has initiated any preparatory behaviors, and expresses an intent to die. *Buffers* against suicidality lower risk when there is desire but neither capability nor intent. When desire is present with either capability or intent, buffers may moderate risk, but buffers diminish in importance if acute risk is high. Buffers include things like a will to life, perceived and immediately available social supports, ambivalence about dying, extensive or meaningful plans for the future (reason for living), a therapeutic alliance with a caregiver, and a sense of purpose.

The questions you ask are to help you determine the level of intervention required, therefore you need to determine the client's intent (how serious are they about actually taking their life – what is the aim or purpose of the suicidal behavior) as well as lethality (the probability of a fatal outcome).

Determining a level of risk helps in managing risk and treatment planning. When risk is high, hospitalization is usually the only acceptable response. When clients are at low or moderate risk, a Safety Plan (see Appendix) is created with the client to help identify specific coping strategies and to foster hope. The supervisor or a peer will bring two copies to your room. Work collaboratively with the client to identify specific activities that will reduce risk, and increase positive experience and connection with others. Both of you sign both copies – one for the client and one for the file. Every session following such an assessment should include careful update to the client's assessment, and follow-up regarding safety and coping. The treatment plan for clients who identify suicidal thoughts/actions should include goals to decrease risks, increase protective factors and relieve the underlying vulnerability (work toward resolution of underlying pain). If a client remains suicidal, a referral to a provider with more experience and 24 hour resources will be required.

We can't emphasize enough the importance of consulting with supervisors and faculty when clients are in crisis. No one should have to make decisions about client safety alone. Also, remember to document everything thoroughly – using client statements as supporting evidence for the clinical decisions and actions taken (review the recording if necessary to get exact client quotes).

Client Crisis Protocol.

- If a client appears to be in imminent danger to self or others, call the UW Police (766-5179) or Laramie Police Department (911), and they will be taken to Behavioral Health Services (the hospital). You may not transport a client to the hospital yourself (an ethical, legal, and safety risk).
- If a UW student client appears to be in a non life-threatening crisis, call the University Counseling Center at 766-2187. You can have the client walk over to the UCC between the hours of 8:00 a.m. and 5:00 p.m., and you could walk them over if another counseling student went with you (do not go alone with a client). If it is after regular office hours, a crisis counselor will be on call at 766-8989 (ask for the on-call counselor). You may also contact the UW Police Department for assistance.

- If a client (not a UW student) is experiencing a non-life-threatening crisis, call Peak Wellness Center at 745-8915. There will be someone on call 24 hours a day.
- Make any referrals as necessary to insure the client receives the care they need.
- If a child client reports suicidal ideation, the parents must be informed – work with your supervisor to do this quickly and in a way that supports both client and parents. If the child is a Lab-school student, you must also share this information with the Principle and Dr. Augustine – they may want to be the ones to inform the parents. Be sure to consult with supervisors and document your actions.

Some Suicide Risk Factors. Important circumstances that clinicians need to be aware of and assess with clients describing passive or active suicidal thoughts and feelings:

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| <ul style="list-style-type: none"> • Crises and/or mounting environmental stress • Mood disturbance: mounting agitation and restlessness, or depression • Symptoms of formal depression: the severity of the depression increases with the number of symptoms and breadth of their impact on the client’s functioning (socially, at work, home) • Loss of interest or pleasure • Decrease or increase in appetite • Insomnia or hypersomnia • Agitation or feeling of being slowed down • Making final plans for suicide: the more specific and plausible, the higher the risk • Identification of the method for self-harm • Method is irreversible (e.g., gun vs. pills) • Client has ready access to method • Giving away prized possessions • Describing "suicide scene" • Planning for or presence of suicide note • Saying good-bye • Has friend or family member who committed suicide • Prior mental health hospitalizations | <ul style="list-style-type: none"> • Fatigue or loss of energy • Feelings of worthlessness or inappropriate feelings of guilt • Indecisiveness or inability to concentrate • Recurrent thoughts of death • Increase in self-destructive behaviors, including risk-taking behaviors • Substance abuse or misuse • Hostility and/or poor impulse-control • Disheveled appearance • Withdrawal or isolation • Either/or thinking; lack of perspective, inability to consider alternative solutions to problems • Suffering from a chronic illness • Aged 14-19 • Lack of social support, contacts, in family, friendships, community. • Feelings of hopelessness • Reduced involvement in normal leisure activities • Reduced involvement in religious life or affiliation • Prior suicide attempts |
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Clients with Unusual Presentations. In the rare case that a client exhibits unusual signs or reports unusual symptoms during a session, the counselor is encouraged to seek consultation from the block supervisor, who can provide direction and support, and can seek additional help as needed.

- Carefully assess the client for danger to self or others, the need for detoxification management, or ability to provide basic self-care and safety.
- The client may be referred to a shelter, either for domestic violence safety, or the local adult shelter, if needed.
- The block supervisor may intervene if necessary (call in, or enter the counseling room), to help assess the client’s status and facilitate appropriate care.
- The block supervisor may contact the counselor-in-training’s individual supervisor immediately after the session to alert them to the situation and decisions made. The block supervisor may also telephone a faculty member at an appropriate time, if it is after business hours.
- Students must call (not e-mail) their individual supervisor to make her/him aware of the situation as well.

Making Client Referrals:

Making appropriate referrals is an important part of providing effective clinical services and insuring a continuum of care, both as an addition to your work, or to transfer services to another provider. It is important that you discuss any possible referrals with your supervisors. They can assist you in making the decision and in finding appropriate referral sources. The following procedure should be generally followed in making referrals, but individual circumstances may require modification, in consultation with your supervisor(s).

1. Discuss with your supervisor making referrals in the following situations: When client's request / need care that the CETC is unable to provide (such as, but not limited to: clients experiencing psychotic symptoms, clients needing detox or other medical care, 24hr care, long-term care, specialized services, etc.), when client progress is minimal and a different provider may be more helpful, when referral is necessary to maintain ethical practice (for example, to avoid dual relationships), and when the clinician will no longer be providing services (such as at the end of the semester) to insure continuing care.
2. Once the decision to make a referral has been made, the counselor should explain to the client the reasons why a referral is being made, and insure the client that she/he will assist the client in making a smooth connection with the other provider.
3. The counselor provides the client with a list of at least 3 possible service providers, including provider name, address, and phone number, and an explanation for why those providers are being suggested (such as low-cost, provision of specialized services, etc.). In addition, the counselor should ask if the client has a preferred provider (such as a family physician, or former counselor) that they wish to approach for services.
4. The counselor reviews with the client how to evaluate and make decisions about selecting a new provider, how to contact and set up an appointment with the new provider, and what the client might expect in transferring services, or seeking adjunct services. In cases where counselor and supervisor deem it appropriate and prudent to insure continuity of care, the counselor may assist the client in making a phone call to the new provider and setting up the appointment from the clinic director office.
5. Where adjunct services are sought, the counselor should discuss the appropriateness of communication between providers for consultation and provision of best practices care. When applicable, a Bilateral Release of Information form should be signed and executed by the counselor in consultation with the supervisor.
6. The counselor should review any other details with the client that are deemed necessary with a given client to promote a positive transfer of services and insure continuity of care (such as ways to obtain transportation to the new provider).
7. Any consultation about referral decisions and procedure should be documented in a contact note, while the conversations with clients about referral decisions and procedure should be carefully documented in a session note.

Potential Providers for Referrals. The following are merely *some* possible good providers to which CETC clients may be referred for continued mental health counseling. This list is not intended to be exhaustive, and any referral decisions should be made according to client needs. Clinicians and supervisors are encouraged to consult the "Referral Agencies" list in the clinic workroom, the phone book, and other sources to identify the best potential providers for each client's unique mental, physical, and other needs.

- Other Counselors within the CETC
- The University Counseling Center
- Peak Wellness Center

Child Clients:

We believe that all clinicians should have some understanding and experience in working with child clients. All MS students take the Play Therapy class in their first fall semester, where you will learn the basics for working with children in the clinic. Ph.D. students may also take this class to improve their understanding of play therapy and work with child clients. If you have not previously worked with children in a clinical setting, please visit with your supervisor(s) and practicum instructor for guidelines. Please remember that to merely play with a child for the hour is not counseling any more than having a random conversation on the bus with an adult is counseling. What you do with younger clients should be theory and research driven and intentionally tailored to each individual child's particular emotional and mental health needs. Those with no prior clinical experience in working with children will draw upon the instruction from the Play Therapy class to guide what they do with child clients in the clinic.

When working with adolescents, take care to let them know that we cannot guarantee their privacy. Their parents/guardians have legal right to the information in their clinical file, and may seek a consultation with you as the counselor. As such, take care in what you document in the clinical record – be accurate, but do not add unnecessary details. Let the adolescent client know that you will take every precaution to protect their privacy, and that if questions arise, you will attempt to meet with caregivers and the client to arrive at an understanding. As always, seek supervision around these issues.

Caregiver Consultations. When counseling a child client, you must have regular visits with the child's caregiver(s). Make every effort to have the *first* caregiver consultation in person prior to the first session with the child. This will allow you to have the Client Information – Child/Adolescent form completed by the caregiver, and for you to gather important information. If not possible, the consultation must take place no later than the third session with the child, and may be done by phone. If doing it by phone, you must have a supervisor in the clinic while you make the phone call, and the Client Information – Child/Adolescent form must still be completed as soon as possible (no later than the third session with the child). For lab-school students, the form will be given to caregivers at the same time that the consent form is shared. For other children, caregivers can come by to pick it up and return it (be sure to let caregivers know that you will need the completed form in order to continue seeing the child).

The meeting allows you to learn about the child and the family needs, build a supportive relationship with caregivers, and help caregiver(s) understand the counseling process. You may wish to use the Dee Ray DVD in the Play Therapy Library to introduce both caregivers and children to play therapy. After the first consult, you should check-in with caregivers at least once per month to see if anything has changed in the family, and to see if caregivers have new questions or concerns. In follow-up consultations, you can share general information about your work with the child, but respect the child's privacy and avoid giving details about your work with the child, or making speculations.

When setting up any consult, let the caregiver know that it would be best to not bring another child. If the caregiver is unable to come alone, do the consult by phone. Another child in the room will be distracting, and we are unable to provide childcare for another child during a consult (a liability issue). All consultations are documented on Contact Notes which are placed on the right-hand side of the file.

Collaboration with the UW Lab-School. Our collaboration with the Lab-School in the Education Building provides opportunities for Counseling Program students to work with both groups and individual children and adolescents, as well as opportunities for students to experience and work with school-family-client systems. At the same time, The Lab-School is able to provide services to their

students, teachers, and families that it might not be able to otherwise. To facilitate clear communication and professional responsibility in this partnership, the following procedures need to be followed:

Communication. The GA Clinic Coordinator(s) will serve as the key contact person for communication with the Lab-School. Our primary contact at the Lab-School is the school counselor, Dr. Sue Augustine. Most communication should funnel between these contacts. Mary Alice, in conjunction with the CETC Clinic Coordinators will keep Dr. Augustine apprised of who is working with each of the clients referred to the clinic. Ideas for additional work with Lab-School (such as setting up groups or in-class visits) must be communicated first to Mary-Alice. If appropriate, Mary Alice will then work with Dr. Augustine to set up new programs. Students should not approach the Lab-School to recruit clients or to suggest new programs without approval from Mary Alice. Likewise, if faculty or staff at the Lab-School approach you to initiate a program, please invite them to contact Mary Alice, who will again coordinate with Dr. Augustine and the Clinic Coordinators to insure that we are proceeding professionally and judiciously.

Protocol. Potential clients from the Lab-School will be referred from Dr. Augustine to the Clinic Coordinator(s) who will make assignments to the appropriate counselor-trainees. Upon receiving each new referral from the Lab-School, please contact Dr. Augustine as soon as possible (721-2155—if she’s not in, leave a message for her), saugustine@acsd1.org, Ed Building room 101), to set up a brief visit. Dr. Augustine will share any important clinical information you need to know about the client, give you the appropriate consent forms, and share how best to contact the student (she may go with you to introduce you to the student, or send another school representative to do so). Please visit with Dr. Augustine before contacting the client / teacher.

When you pick up a client from the lab-school, go first to room 132 (the school office) and fill out the appropriate information on the “Student Checkout Clipboard.” Put your name, the student’s name, and the time. Under *Reason*, please write “Appointment - CETC.” This lets the staff to know that their student is downstairs in the clinic, while still providing some confidentiality about the student’s participation in counseling. Some clients will meet you in the office to be picked up (probably only older children / adolescents) while you will need to pick up younger children from their classroom. When you return the student to the lab-school, you are must fill out the return time on the check-out clipboard.

Any time that you go up to the lab-school, for any reason, you must wear a Counselor Education name-badge (kept in the clinic workroom). This identifies you to the students and staff as having a legitimate reason for being in the school so that you will not be regarded as a threat that triggers their security procedures. While in the school, you must follow any instructions about security that you are given (for example if you are there during a lock-down drill, fire-drill, etc. . .). Remember that you are representing the clinic, the department, and the profession in your work with the Lab-school. Please be professional in your dress, behavior, and communication.

Your professionalism in following all of the procedures here outlined will help insure a continued positive collaboration that benefits both the clients and our current and future student trainees.

Finishing the Semester:

Client Records. As the semester nears an end, determine the status of each client with your individual supervisor and make decisions related to possible referrals. It is your responsibility to insure that all clinical documentation is complete and to secure all appropriate signatures before leaving campus. All client files must have a completed Termination form in them at the semester break (even if clients say they might return). Your instructor will assign a grade to you when she/he determines that you have completed all documentation and procedural requirements for your experience here. Failure to

complete client documentation and/or to appropriately transfer clients in need of ongoing care places in jeopardy your ongoing status in the program.

Confidential Client Data. By the end of the semester you may have accumulated a number of client related materials. These may include some hand-written notes that are not part of the clinical file, photographs or artwork from sessions, and possibly drafts of clinical documentation that you've kept on a USB drive in the locked cabinet. Occasionally there are video-recordings not on the Counselor Ed Server as well. These are confidential – legally and ethically protected materials – and you are responsible to protect them. Before you leave at the end of the semester, *you* must delete and shred all such materials. Confidential electronic files should be more than simply deleted off your USB Drive. Please use the program *ccleaner* (on the computers in the clinic workroom) to wipe the free-space on your USB drive after you have deleted all confidential files in the normal way. This will wipe the space previously occupied by those files in such a way that no one may retrieve them (a regular delete does not do this). Failure to properly take proper care of confidential client data at the end of the semester is a serious ethical violation that may impact your ability to continue your clinical work, and to advance in the program.

In some cases, students may want to save client materials beyond the end of the semester. Before you can save any client materials (tangible or electronic) that do not belong in the client's file, you will need to send a written request to Dr. Morgan. Describe what materials you are wanting to retain, and for what reason (you need a good clinical or educational reason to save them), and where in the clinic you would like to store them that will protect their confidentiality. You retain ethical responsibility for any such held-over materials, and must delete/shred them as soon as you no-longer need to keep them, or *at the very latest*, before you graduate.

As the spring Practicum class ends, consider that you will no longer be employed at the clinic. Think about it like ending a job – you need to have everything wrapped up and cleaned out by your last day. Thus, by the last day of finals week you should have all of your files completed (including all signatures by you and your supervisor), audited, and ready for archiving, your USB Drive securely deleted and removed, anything from the fridge removed, and all personal materials removed, etc. Anything left in the clinic after finals week will count against your professionalism grade and be destroyed or donated.

Documenting Clinical Hours. For MS students, a total minimum of 40 direct client hours are required for the Pre-Practicum / Practicum sequence. A minimum of 60 additional hours, including supervision, preparation, paper work and observation of peers doing counseling are also required. These requirements must be met before a student can advance to internship. Ph.D. students in the Doctoral Practicum need to accumulate a minimum of 40 direct client hours. Other clinical courses will have varying client-contact and supervision requirements and the course syllabi for these courses should be consulted.

You are responsible for keeping track of how many hours you have toward the total you need and advocating for yourself when you need more clients. You are also responsible for keeping the client assignment board in the Clinic Coordinators' office updated with your clients and appointment times. By keeping the Coordinators informed concerning your hours, appointments, and needs, they can more effectively and judiciously assign clients.

All students in clinical courses are required to keep a written record of client contact hours, supervision hours (individual/triadic, class/group, observation), and preparation hours on the Counseling Student's Clinical Log (see Appendix). This form must be signed and turned in to your course instructor at the end of the semester (signed). Direct client-contact hours may be rounded up to the nearest ½ hour (e.g. a 50 minute session = 1 hour). You cannot double count any hours (seeing a client during your

block does not count as direct contact and supervision, just direct contact). Time in class spent discussing clinical cases counts as group supervision).

You may keep track of your clinical hours by hand during the semester, but at the end of the semester should type the form, or rewrite it very neatly. This document will go into your student file and should look professional. Be sure to total all the columns, obtain your supervisor's signature and turn it in to your instructor for her signature. Make a copy of the signed logs for your files, and give a copy to the department office associate. Use the Clinical Log Summary to summarize your clinical hours across your entire tenure in the counseling program.