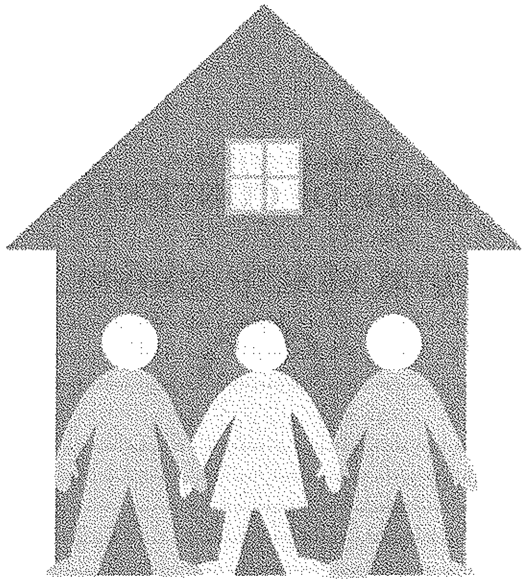

Intern and Clinician Policies and Procedures Manual

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In affiliated with Five Acres

Revised 1/19/11

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Welcome to Pasadena Mental Health Center!

This manual is intended to give you the tools you will need to be successful at Pasadena Mental Health Center. We are happy to be part of your learning and clinical experience.

A Little History...

Pasadena Mental Health Center (PMHC) has provided low cost mental health and social services to adults, children and families since it was founded in 1965 by a group of mental health professionals and concerned community leaders who had a vision and acted upon it. They envisioned a group of volunteers making a difference in the community by providing mental health services in an innovative and non-threatening way. Paraprofessional volunteers received 52 weeks of nationally-recognized training in order to provide crisis intervention and counseling.

In 1999, PMHC expanded its tradition of training and began a clinical intern training program, thereby providing succeeding generations of therapists with practical experience in the counseling field. We have grown from four interns representing three local universities to over 30 interns from 13 different university programs.

The Center today

PMHC serves over 700 adults, children, couples and families each year. Our clients represent a diverse range of cultural and socioeconomic backgrounds in the Pasadena/Altadena area and surrounding communities. Our clients are primarily the working poor - those without any form of mental health insurance - in the Pasadena /Altadena area. Services are provided on a sliding scale basis and most clients enter treatment for mental health needs related to life cycle issues including birth and death, aging, marriage, divorce, parenting; intergenerational conflicts, and adult, child and family relations. The Center does not serve clients with severe mental illness, those who require hospitalization, or are in need of referrals for medication management.

The PMHC team is dedicated to providing the highest quality of service to its clients. Our staff is composed of licensed social workers, licensed marriage and family therapists, interns and trainees (graduate and post graduate students of psychology and clinical social work programs). All interns and clinicians work under the supervision of licensed mental health professionals.

Center Hours of Operation:
Monday – Thursday: 10:00 a.m. to 9:00 p.m.
Fridays: 10:00 a.m. to 5:00 p.m.
Saturday: 10:00 a.m. to 2:00 p.m.

In January of 2007, PMHC affiliated with Five Acres, a child and family services agency that strengthens families and prevents child abuse through treatment and education in community-based and residential programs. Originally founded as an orphanage in 1888, today Five Acres offers an array of services including residential care and education, mental health services in homes and schools, foster care and adoptions, and domestic violence prevention.

All internships for both agencies are now assigned out of PMHC and interns have access to a variety of clinical experiences at Five Acres in addition to PMHC's Center-based and Community Based services. Some interns may be placed solely at Five Acres, but will receive oversight and training through PMHC.

Current Programs offered through PMHC:

Center Services – Groups and Counseling individuals, couples, children and families.

Youth Accountability Program – Serving non-violent youth offenders and their families to provide tools for making healthy life choices. Offered in partnership with the Pasadena Police Department.

Family Preservation – In partnership with Family Preservation Programs in LA County, counseling services are designed to assist families in crisis by improving parenting and family functioning while keeping children safe.

Victims of Crime – Counseling services to minimize the adverse impact of being a victim of crime or witness. This can only be provided by clinicians with a masters degree posted.

Apprentice Preparation Program Case Management – Provide case management to assist adults in the Pasadena/Altadena area to develop skills toward union jobs. Offered in partnership with the Flintridge Foundation.

Current Programs offered through Five Acres:

School Based Programs	Community-Based Programs
Domestic Violence	Deaf Services
Residential Treatment Services	Foster Care/Intensive Treatment Foster Care
Adoptions/APSS	Aftercare
Therapeutic Behavior Services	WrapAround

Who's Who

Chanel Boutakidis, LMFT	Executive Director
Eden Garcia-Balis, M.S., LMFT	Program Supervisor
Nicole Bonassi Shannon, LCSW	Supervisor
Jaydee Tumambing	Supervisor
Alina Sgattoni, M.S., MFTI	Outreach Coordinator
Hectore Escobedo	UNI Case Manager
Gabriela Martinez-Huerta	Office Manager
Kelly Evans, M.A.	Executive Assistant
Estephanie Casas	Evening Receptionist

Chanel Boutakidis LMFT, as Executive Director is responsible for board and fund development and community relations. In addition to her duties here, Chanel is also Director of Permanency Programs at Five Acres.

Go to Chanel for problems related to the physical plant, questions about Five Acres, ideas about funding or community partnerships or any other concerns you may have. She has an open door policy and hopes everyone will stop in and say hello.

Eden Garcia-Balis, LMFT is the Program Supervisor. She is responsible for overseeing all of PMHC's Programs including Five Acre programs. She is responsible for PMHC programming, budgeting, and general oversight of PMHC. This includes the internship program, community programs, and center programs. Additionally, she handles any client concerns or grievances.

Nicole Bonassi Shannon, LCSW is a Clinical Supervisor. She is responsible for providing supervision for trainees in both group and individual sessions. She also assigns cases & coordinates transfers. She is also in charge of the clinical training series.

Go to Nicole for questions concerning supervision and questions about your clients.

Jaydee Tumambing, LMFT is the new supervisor at PMHC who supervises the Family Preservation & Youth Accountability trainees in both group and individual settings.

Go to Jaydee for questions about YAP and Family Pres.

Alina Sgattoni oversees outreach programs including the Youth Accountability Program (YAP) and the Apprenticeship Preparation Program (APP).

Go to Alina if you have any questions about YAP and APP. She's also a great resource for questions about how things operate at the Center, where things can be found, etc.

Hectore Escobedo oversees the UNI program. He is in and out of the office because he works out in the community most of the time. Hectore is very passionate about his role at PMHC and is very dedicated to the youth in the community.

Go to Hectore for questions about the UNI program and UNI clients.

Gabriela Martinez or "Gabby" as she is better known, is our Office Manager who makes sure we're organized and running smoothly. She coordinates all office functions and about a million other things. She is experienced at handling unhappy clients, flustered interns, and overwhelmed administrators with a firm, but calming hand.

Go to Gabby for questions about forms, administrative procedures, and supplies. Gabby is bilingual and a longtime resident of the community, and may be able to help you with clients.

Kelly Evans is Chanel's Executive Assistant. She keeps up with Chanel's busy schedule, communicates with the board members and handles office correspondences at the executive level. She also oversees PR materials including the newsletter, brochures, and website. She is responsible for donations and helping with fundraising events. Additionally, she helps with various administrative projects.

Go to Kelly if you have general questions and concerns regarding office procedures, PR material or fundraising ideas. If you need to contact Chanel go to Kelly first as she is in constant communication with her.

Estephani Casas is our evening receptionist. Her primary role is receiving clients and collecting fees at night. She is popular with interns and clients alike for her smile and warmth.

Go to Estephani for office and procedural information including. She is bilingual and willing to help with any client concerns.

Basic Expectations

Training

At the beginning of your employment or internship/traineeship, you are required to attend 3 days of orientation training.

Each year from September through May every other Friday from 11am to 1pm, our Clinical Training Series occurs and will sometimes include professional clinicians from Five Acres. This is mandatory for students in our internship program and optional for our second tier clinicians and staff.

Be sure to sign in whenever you attend orientation or training. Attendance rates will be reflected in performance evaluations.

Client Caseloads

PMHC requires each therapist to maintain a minimum of ten on-going clients and be at the Center (or a combination of the Center and Five Acres' program) 20 hours per week. The client caseload may be made up of clients both at the Center and at other Five Acres' programs in order to fulfill this expectation. Be advised that your school program may require a higher caseload or hours per week, and it is your responsibility to keep track of this.

The therapist is responsible for filling out a pink Therapist Availability form and placing it in your Supervisor's box when you are in need of new clients. This form verifies your current open times to have new clients scheduled as well as confirming your intake hour at the agency.

Telephone Intake

Each therapist is responsible for providing one hour per week to do telephone intake assessments for callers who are seeking services. In your assigned hour of telephone intake or do a wait list check-in you may also be calling clients to complete an intake or do a follow-up survey or wait list check-in. Lastly, if you want to change your intake hour you must get permission from your supervisor.

Supervision

Each therapist will be assigned a clinical supervisor and will meet weekly with him/her for individual supervision. When an intern is assigned to more than one site, he/she will have an additional supervisor for each setting. Each supervisor of an MFT Trainee or MSW must sign a "Responsibility Statement" as required by the BBS, The supervisee will keep the original and give the supervisor a copy.

It is your responsibility to ensure that all required forms are completed and that hours are signed off weekly by each individual supervisor. Except when covering supervision for a short time (see below), supervisors do not sign off on each other's supervision, so please keep your records current at all times.

If you are unable to keep a supervision appointment, you must notify your supervisor at least 24 hours ahead of time. Supervision missed due to illness, vacation, or any other legitimate reason, cannot be counted as supervised hours and will not be included in the accrual of hours for licensure. If your supervisor is unable to meet due to vacation or illness, you are responsible for arranging supervision with another qualified supervisor, even one from a different discipline. These hours will be signed off by the primary supervisor and do not require a formal supervisor relationship or the paperwork related to that. Keep in mind that according to the Board of Behavioral Sciences and the Board of Psychology, for hours of experience to count within a given week, supervision must occur within the same week that the hours are gained.

Professionalism

PMHC considers the presentation of the staff to be extremely important. It is expected that all students will observe high standards in their personal presentation. This includes dressing in a professional manner or "Casual Business Attire." Always take into consideration who you will be seeing on any given day, and what your attire could communicate. When in doubt, always err on the side of conservatism. See Dress Code Handout.

Presentations

Part of your training experience may involve giving presentations regarding various aspects of mental health treatment. This may include giving a case presentation at one of the trainings, presenting a case description to the PMHC board during a monthly board meeting, or providing community education workshops on a variety of topics. You will routinely present cases during supervision.

Performance Evaluations

All students receive a minimum of two clinical evaluations (forms provided by each school program). Performance evaluations are completed with input from all clinical supervisors, the Youth Accountability Coordinator (if applicable) and the PMHC Program Supervisor. It will reflect your clinical skills as well as how well you have met other expectation such as documentation, attendance at trainings, and completion of your required hours each week.

Vacations and Other Absences

Due to the disruption absences can create in the client-therapist relationship, we ask that vacations are scheduled during normal school holidays, and that no more than 2 weeks are taken at any given time. During the course of your internship period, no more than 14 "client days" should be missed. A client day is defined as any day, Monday through Friday, when you normally have scheduled clients. If clients are willing and able to be rescheduled during the same week, that day may be missed, and not added to the total accrued time off. If you find you must miss more than this, we ask that you arrange to make up these days before you complete your internship. Excessive absences will be reflected on the evaluations we submit to your school.

If you anticipate missing client days for any reason, you are required to give your clients at least two weeks notice and fill out a REQUEST FOR VACATION / LEAVE OF ABSENCE form at least two weeks prior to your absence. All supervisors/preceptors should be notified prior to submitting your request to the Program Supervisor and Supervisor. Vacation requests not occurring on a normal school holiday will be granted on a case-by-case basis. Arranging for client coverage is always the responsibility of the intern.

If you are going to be on vacation or absent and your client appointments will be cancelled, be sure to update the Appointment Book in the front office ahead of time. This will ensure that the room is available while you are gone for someone else's session.

In the event of an unscheduled absence or tardiness, it is your responsibility to notify the front office staff, Program Supervisor and clients regarding your absence or tardiness with as much notice as possible. Except in the event of a sudden crisis, *the notice should be no later than the morning of the date of the unscheduled absence or tardiness.* Appointments with your clients should be rescheduled as quickly as possible.

Required Forms for Student File

See the checklist of required forms below. Please make sure all forms are complete, signed and returned to the Program Supervisor within 2 weeks of your orientation.

Completed Prior to Orientation	**Brought to Orientation**	**Completed during Orientation**
____ Application Form	____ Contact Information Form	____ Student Therapist Agreement
____ Resume	____ Copy of baccalaureate diploma	____ Drug Free Workplace Policy
____ Fingerprints / CAI		____ Confidentiality Policy
____ TB Test or X-Ray		____ Privacy and Security Policy

Client Intake

Telephone Intakes

Each therapist is responsible for providing one hour per week to do telephone intake assessments for callers who are seeking services. You will sign up in advance for a weekly slot that will typically stay the same from week-to-week (to change your hours you must get permission from the program supervisor). When you arrive for your telephone time, please sign the Telephone Intake Schedule in the front office and make sure "In" is beside your name on the board so that front office staff is aware of your intake time.

A blue PHONE INTAKE form will be completed for each person who calls the agency seeking treatment by the therapist covering intake at the time of the call. You must speak directly with the person who is wants treatment (e.g., a wife cannot call for her husband). The only exception to this is if a parent or guardian is calling for a minor. Only make three attempts to call the person. On the 3rd message let them know we have to hear back from them with in a week or we will consider they are no longer interested in our services. **Be sure to get all times the caller is available for an appointment. Also, be sure to get times that the client will be available to receive a return call from their assigned counselor.** All intakes, once processed, go in the bottom inbox on the receptionist's desk.

If the therapist determines that the caller would be an appropriate client for the agency during the course of the call, he/she should let the caller know that they will be contacted within 1 week maximum by their assigned counselor to schedule an appointment. NOTE: There are times when a backlog develops and clients must be put on a waiting list. You will be notified when this occurs, and the approximate length of time before a therapist can be assigned. During these times, we always offer other referrals if the client needs services immediately.

If you are <u>not sure</u> whether or not the client is appropriate for the agency, let the caller know that you will have to check and see whether we have treatment that will meet his/her needs and will get back to them. Discuss any uncertainly with the Program Supervisor.

Clients Who Do Not Meet Criteria for Services

In general, treatment areas which are *not* appropriate for the agency include:

- chronic, severe mental illness AND not stable on medications with regular psychiatric assessment
- severe substance abuse, client is specifically asking for drug/alcohol treatment
- perpetrator of battering/violence/adults court mandated for anger management treatment
- parents court mandated for therapy in a child custody case
- actively suicidal or suicide attempt within the past year
- specialized treatment issues such as specific sexual disorder

If, during a telephone intake or first session, you see that the client could benefit from referrals to other types of treatment or assistance—instead of PMHC or in addition to PMHC services—it is incumbent upon you to do so at that time. These could include hotlines for rape, suicide, or domestic violence, substance abuse treatment, medical services, legal assistance, food and shelter, child abuse, etc. Please document any referrals given on the Phone Intake Form.

Being Assigned a Client

Clients who meet criteria for services will be assigned to a therapist by their supervisor. Clients are assigned based on:

- the time availability of the therapist
- the language needs of client
- the training needs of the therapist (minimum caseload, hours needed, stated preferences or experiential needs in terms of types of client, issue, and modality)

The approved client's intake form will be placed in the therapist's mailbox or given to you during supervision. The therapist is expected to call the client to schedule the initial appointment within **1 week** of being assigned the case. If you must leave a phone message, be specific about the dates and times you want to schedule the appointment. If the client is unable to be reached by phone after one weeks (and you have tried at least three times), place the intake form back in the Program Supervisor's box and note the times and dates you attempted to contact the client and another case will be assigned to you.

Note: If you are scheduling a <u>child or family case</u>, you must schedule the parent (or both parents if possible) alone for at least the first session. Let the parent know that the therapist must first meet with them to get the necessary paperwork signed, background information and conduct an assessment that together they will decide how to structure the treatment from there.

The First Session

Appointment Book / Room Scheduling

As soon as you know you have an appointment time with a client, you must enter it into the Appointment Book in the front office, which is kept on the desk near the mailboxes. **All first sessions with new clients are to be highlighted in yellow**. <u>Enter your name, your client's first name and the initial of last name, and the modality of treatment (individual, family, couple, etc.)</u> The office staff will assign you an appropriate room based on this information.

There are 6 therapy rooms. Some are better suited for different modalities than others.

Beige room	*Individuals and couples*
Taylor room	*Groups and families*
Front porch	*Individuals and couples*
Pink room	*Individuals and couples*
Yellow room	*Children and families*
Back porch	*Individuals and couples*

By the end of the week, all appointments for the following week should be recorded in the book. You can write in appointments up to 4 weeks in advance, which will make it more likely that you are assigned the same room each time. However, be sure to check which rooms have been confirmed for you at the beginning of each week since there may be changes in room assignments from time to time.

REMEMBER: You must write all of your appointments and the modality of treatment in the appointment book by the end of the week for the upcoming week or you will not have a room reserved to see clients. There may be times when there are no rooms available at the Center. Therapists may also consider using one of the four therapy rooms or two group rooms at Five Acres' Lincoln Street office located at 2055 N. Lincoln Street. These rooms are available for evening sessions only and are scheduled through the front office staff.

Notification of Intern Status

As a student, you are required to inform your clients that you are unlicensed and are working under the supervision of an appropriately licensed professional. You should indicate whether you are a MFT trainee, MSW intern, psychology practicum student, etc. and the name of your clinical supervisor. This information should be explained *before* you have the client sign the CONTRACT FOR THERAPEUTIC SERVICES.

You should also inform your clients that your contract is time limited, letting them know the month you anticipate finishing your internship.

Documentation

1. Welcome Packet to New Client:

   Your client is given a welcome packet which includes the following forms:

- What is Psychological Counseling All About? (give to client)
- Client Contact Information
- Client Income Eligibility form (Must be fill out completely)
- Acknowledgement of Receipt of Notice of Privacy Practices

2. Opening Charts

   In preparation for your first PMHC session, get a blank new chart out of the filing cabinet in the front office. Do not, however, complete any documentation on the forms in advance in case your client does not show up. In addition to those explained at length below, these forms should be tended to by the end of the session:

- CONTRACT FOR THERAPEUTIC SERVICES
- CHART ORDER AND CLIENT FILE CHECKLIST (check off as you go)

2. Consent for Services

The CONTRACT FOR THERAPEUTIC SERVICES must be signed at the beginning of the first session with the client. **No services can be rendered until this contract is signed by the therapist and client.**

If the client is a minor, the CONSENT TO TREAT A MINOR form must be signed by the parent or legal guardian before the minor can be seen, *unless* one of the following circumstances apply:

a) the minor is legally emancipated and you have written documentation of this; OR

b) the minor is 12 years of age or older and is the alleged victim of incest or child abuse

c) the minor is 12 years of age or older and both of the following requirements are met

1) The minor, in the opinion of the therapist, is mature enough to participate intelligently in the outpatient services AND

2) The minor would present a danger of serious physical or mental harm to self or to others without the mental health treatment

3. Notice of Privacy Practices

Per HIPAA (Health Insurance Portability and Accountability Act), we are required to provide a copy of our NOTICE OF PRIVACY PRACTICES to all of our clients. The client must sign the ACKNOWLEDGEMENT OF RECEIPT of this notice during the first session. HIPAA Privacy Rules describe the rights each client has in regards to their PHI (Protected Health Information). You should be able to briefly describe each of these to your client.

- The Right to Request Restrictions on Certain Uses and Disclosures of Their Protected Health Information;

Your clients have the right to request restrictions on how you will use their PHI. They also have the right to request restrictions regarding who you will disclose their PHI to for treatment, payment and health care operations purposes. PMHC can decide whether to approve or deny the request for the restriction.

- The Right to Receive Confidential Communications from Health Care Providers;

Clients have the right to request restrictions on how and where you communicate their PHI to them. For instance, a client can request that his PHI be sent to an alternate address, or that you only contact him at home or work.

- The Right to Inspect & Receive a Copy of Their PHI;

Clients have the right to inspect and/or receive a copy of their PHI. Clients must submit in writing a request to inspect and/or receive a copy of their PHI. There are various timelines associated with whether we decide to accept or deny a client's request, so consult immediately with the Clinical Coordinator or Program Director in order to stay in compliance with the regulations.

- The Right to Receive an Accounting of Disclosures of Their PHI;

Clients have the right to receive an accounting of certain, but not all, disclosures you have made of their PHI within six years of the date that the client makes the request for the accounting. This rule *is designed to let clients know who is receiving their health information. Information is 'disclosed' when it goes outside of PMHC.*

- The Right to Amend Their PHI;

Clients have the right to request that you amend their PHI. Once a client has submitted such a request, you then have to decide whether you are going to accept (make the requested change) or deny the request and there are timelines associated with these decisions.

- The Right to Receive a Paper Copy of PMHC's Notice of Privacy Practices.

4. Income Eligibility Form

This form establishes some important demographic on our clients, both for statistical purposes, funding purposes and in order for PMHC to set the appropriate client fee. The following documentation must be brought to the second session in order to verify their income status and residency.

a) proof of income
b) proof of address other than driver's license (ex: utility bill)
c) photo ID

If the client does not bring all necessary documentation with them to the second session, they will not be able to be seen until it is provided. The therapist must turn this form into the front office after the second session. Although we do not limit our services to those who live in Pasadena, much of our funding depends on proof that we are serving the local community; therefore, this document is extremely important to the ongoing mission of PMHC.

5. Contacting previous therapists or other agencies

Sometimes a client may want us to consult with current treatment provider (a medical doctor or psychiatrist, or social worker) or a previous provider (former therapist, etc.). This can be very helpful in understanding the client and coordinating treatment. However, before any contact can be made you must have the client fill out and sign one or both of the following forms: AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION (outgoing information), AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION (incoming information). Make sure that all items are filled out completely and do not have clients sign blank forms. Other providers will most likely have the client sign *their* release forms as well, so this can be a bit cumbersome. However, it is essential before any private information can be discussed.

Setting Fees

The fee will be set by the front office staff. **The therapist is responsible for getting proper documentation (pay stub, etc.) to verify the client's income when the client arrives for the second session and make sure the INCOME ELIGIBILITY FORM has been completed.** Clients who do not provide this documentation by the second session will not be able to be seen until documentation is provided.

Initial Assessment and Treatment Plan

An initial assessment is conducted to elicit strengths, needs and goals of the individual person, couple or family and to develop a treatment plan which effectively meets the person's needs and results in improved mental health outcomes. This assessment looks at not only the client's presenting problem, but at other issues which may be impacting the client such as health, living environment, mental health history, mental status, family situation, drug/alcohol use and, in the case of children, developmental history.

Use of a treatment plan is a traditional part of mental health practice. For example, a therapist providing outpatient psychotherapy to a child usually meets with the child and family to develop a treatment plan. Developing a treatment plan is a mutually defined process between the therapist and client. It is developed with the expectation that the client is capable of positive change, growth, and leading a life of value. In cases of a child client the development of the treatment plan often involves the participation of the child's family as equal partners in the process. As such, the treatment plan provides ethical justification for the entry of professionals into the lives of the child and family to provide mental health treatment for the child. The process of defining goals is a combination of the client's input and the therapist's perception of the client's situation and needs based on a thorough assessment.

The treatment plan, then, is a blueprint for change and a "work plan," identifying the strengths of the client and identifying areas of functioning to be addressed, desired outcomes, and interventions and services to be used to achieve the desired outcomes. Treatment plans should be individualized, strength-based, culturally-appropriate and clinically sound. A treatment plan includes:

- Individualized treatment goals with measurable objectives
- Services that meet the client's needs. In other words, what is the best form of treatment - e.g., evidenced-based - for each treatment goal?
- Type (i.e., individual, couples, family, group) and frequency of services (e.g., weekly, monthly)
- Referrals for outside services and the frequency of those services (e.g., referral to AA)

An effective treatment plan should be both informative and practical. A person reading a treatment plan should be able to grasp the major concerns and how they are being addressed. As a "work plan," the initial treatment plan identifies the work to be done.

Treatment Plan Goals

A goal is a global statement that reflects a positive resolution to the identified need or problem and includes an outcome measure or expectation. An objective (short-term goal) is similar to and directly related to a specified goal but highly specific and reflecting small attainable increments, developmentally appropriate, reflective of cultural strengths and clearly incorporating the desires of the client. In addition, the goal or objective must be measurable, attainable, observable and capable of being evaluated. Goals and objectives must clearly relate to the needs and priorities agreed upon by the client and therapist and identified in the treatment plan.

On-Going Sessions

Clinical Documentation

The therapist is responsible for keeping all documentation in the client's file up-to-date.

Timelines

The following table will help you keep track of time lines related to various pieces of clinical documentation:

Document	***Due***	***Comments***
Initial Assessment and Treatment Plan	*By fourth session*	*Co-signed by clinical supervisor*
Treatment Plan Review	*Every 6 mos.*	***Also collect a Satisfaction Survey at this time.***
Progress Notes	*Within 1 week of session*	*Co-signed by Clinical Supervisor*
Transfer/ Termination Summaries incl. Transfer Checklist	*Within 1 week of last session w/ client*	*Co-signed by Program Supervisor*
Termination Summaries incl. Termination Checklist	*Within 1 week of last session w/ client*	*Date summary* ***with the date of the last secession****, not the date the form was completed*

Each entry must:

- be written in black ink (not felt-tip)
- be dated with the date of the contact / phone call (not the date the progress note was written)
- have the **full signature of the therapist - first and last name - and their complete title (ex: "MFT Trainee"**
- **NEVER** use white-out

All progress notes need to be co-signed by your clinical supervisor within one week of the session.

See "Treatment Plan Goals and Progress Note Protocol" in the Essential Policies and Protocols section of this manual.

Treatment Plan Reviews

Treatment plans must identify what is currently being done and what has recently been achieved, in addition to work and services planned for the future. By defining goals and objectives which can be monitored, the treatment plan becomes an instrument of accountability. Following the initial treatment plan, each subsequent treatment plan needs to describe the client's overall progress and review the goals and objectives of the prior treatment plan, identifying those objectives attained, those not attained, and those still in progress. On the basis of this review, a new treatment plan with appropriate goals, objectives and services can be developed.

Treatment plan goals are formally reviewed every six months and documented on the TREATMENT PLAN REVIEW form. At the same time you are completing a treatment plan review, you should also have the client (either in session or in the waiting room after session) complete a **SATISFACTION SURVEY** and return it to the front office.

Confidentiality & HIPAA

PMHC recognizes and respects the client's personal dignity in the provision of all care and treatment. All students and staff are responsible for safeguarding confidential information regarding clients. Public disclosure of confidential information may constitute a serious breach of the trust that is necessary in any therapeutic relationship. Disclosure of information in the performance of professional duties is, of course, a necessary feature of the helping professions, but is subject to professional standards and legal restrictions. The following statements pertain to all staff members, volunteers and interns:

Details of a client's treatment, past history, current behavior and family history must be regarded as confidential. Generally, this information is shared only with the client's therapist, clinical supervisor and PMHC supervisory staff. There may be times when a client is receiving services from different therapists at PMHC, for instance individual and couples work. Under HIPAA guidelines, the PMHC therapists may discuss the case for purposes of treatment without authorization for release of information.

Non-agency persons with whom information is also shared may include authorized county, funding and peer review representatives. All other Agency staff members who do not work directly with the clients, but who may receive information indirectly (i.e., office staff, maintenance, etc.) are also bound by the constraint of confidentiality within their separate departments.

<u>Students and staff must not discuss any information concerning clients in circumstances where an unauthorized person might overhear, e.g., front office, common areas, public places, etc</u>. The intern room upstairs is available to have such conversations regarding clients. All phone calls to/with clients should also be made in a private area.

No documentation, client charts or confidential information of any kind is to leave the premises of PMHC or other Five Acres setting in which you are working.

No paperwork of any kind can be completed at home or anywhere outside of the agency.

See handout "HIPAA Privacy Overview".

Fees and Other Charges

Collecting Fees

Remember to tell your client the fee when you call to setup the initial appointment. Clients who do not pay for their first session will not be seen. Clients pay their fee to the front office staff at the beginning of each session. They will be given a receipt which will show the current payment and any past due balance. The front office will provide you with a yellow copy of this receipt when you come to pick up your client so that you will know if there are any payment issues you should discuss. **The therapist is responsible for addressing lack of payment or excessive outstanding balances**. Clients who miss payment for two consecutive sessions will not be seen until their balance is paid. Discuss with your supervisor how to address and handle these issues in a therapeutic manner. Your supervisor may decide to involve the Program Supervisor as needed.

See "Fee Collection Protocol" in the Essential Policies and Protocol section at the back of this manual.

No-Shows / Late Charges

Clients who do not show up for their first appointment and do not call the Center automatically forfeit their appointment time. The therapist should make their time available to schedule a new client. The therapist should write "No Show" on the blue telephone intake sheet and put the blue sheet in Estephani's mailbox.

Clients are charged for cancelling a scheduled appointment with less than 24 hours' notice. If a client does not show up for their appointment (assuming they have been seen at least one time), or cancels an appointment *with less than 24 hours' notice*, **the therapist will charge the client for the missed session and document that the client paid for the missed appointment**.

Be sure to log the client's attendance on the RECORD OF CLIENT ATTENDANCE form so that you are accurately able to complete your monthly statistics. Each client will be noted as either:

S	= showed
C	= cancelled with 24 hours notice
LC	= late cancel - cancelled with less than 24 hours notice of (charged full fee)
NS	= no show (charged full fee)

Always let the front desk know if a client has had a Late Cancel or a No Show so that they can charge the client the correct amount the next time they come for an appointment.

Monthly Statistics

Each month you will submit a MONTHLY STATS SHEET by the 5th of the month to front office staff (Gabby's box) which will summarize the clients you have seen during the month. See "Monthly Statistics" in the Essential Policies and Protocol section at the back of this manual.

Family Preservation numbers are due to Kelly by the end of the month. You can get the write-up sheet from the Program Supervisor. The client information can be found in the clients form on the original intake form. If the information is not there let Kelly know. You will indicate that dates you saw the client and the number of hours that should be billed (these two numbers should match). Do NOT include "no shows" or late cancels. We can only bill for hours that you actual saw the client. If you have a after the close date of the case

Correspondence

Correspondence which is sent to the client in writing should be co-signed either by your clinical supervisor (for clinical material) or the Program Supervisor (for administrative material). All correspondence must be approved by the Program Supervisor prior to sending. Please photocopy all correspondence with clients and place in the chart, as well as documenting all phone contacts between client and therapist in the progress notes.

Chart Reviews

Charts are reviewed on a monthly basis for completeness, adherence with timelines, appropriate charting documentation and clinical content. You may also be asked to participate in peer chart reviews once per semester as part of your clinical training in essential standards of clinical care and documentation. Any areas of identified deficit and/or emission will be noted and brought to you and your clinical supervisor's attention for review and correction. The Program Supervisor will review overall chart outcomes for the Center. Any necessary corrections must be complete within 2 weeks. Failure to correct deficiencies or recurrent problematic areas will be addressed with you and will be reflected on your periodic performance evaluations.

Termination of Services

Transfers

Transfers of cases must be approved in advance by your clinical supervisor. The most common type of transfer is when an intern has completed his/her practicum and the client will be transferred to a new practicum student. The TRANSFER SUMMARY and TRANSFER CHECKLIST must be completed within one week of the transfer, signed by your clinical supervisor, and the sheet only turned into your clinical supervisor. (The chart can be returned to the file cabinet.)

When you receive a transferred case you will need to get the following forms re-signed since these documents list the therapist's name.

- Contract for Therapeutic Services
- Consent to Treat a Minor (if applicable)

No Shows

On-going clients who do not show up for three appointments in a row and do not contact the Center should be called to ask if they intend to continue services. If the client cannot be contacted, a form letter is available in the files cabinet in the office which notifies them that that their case will be closed if we do not hear from them immediately. This form is called the THREE MISSED APPOINTMENTS letter. If the client has an unpaid balance, a different letter is sent, advising them of their balance. <u>Clients may not resume therapy until this balance is paid off or arrangements are made through the office.</u>

Closing Cases

The TERMINATION SUMMARY and TERMINATION CHECKLIST must be completed with clinical supervisor's signature within one week of the last session and must be placed on top of the last progress note. After all the paperwork is completed and signed, put the client's chart in the top section of the grey filing cabinet that states "Terminating Charts."

Be sure to hand your client an **EVALUATION OF SERVICES** form (i.e., satisfaction survey) at the completion of services. Your client can take a few minutes to complete the form after their final session and hand it into the front office. Assure the client that the survey is anonymous and their feedback is very important to us.

Special Situations

Clients in Crisis

There may be times when your client is in crisis. If you are in session with your client and become aware of a potential crisis, complete a CLIENT SAFETY PLAN with the client.

In general, critical incidents which should elicit a call to your clinical supervisor include but are not limited to:

- Suspected child, elder, dependent adult abuse
- Property destruction by a client
- Physical aggression by a client against a therapist including threats of aggression
- Potential Tarasoff situations
- Suicidal ideation, threats or behaviors
- Police involvement
- Any other incident which, in the student's professional judgment, cannot safely wait

FAMILERIZE YOURSELF WITH THE EMERGENCY TREE

What constitutes an Emergency/Critical Incident:

- Your client is attempting to inflict serious bodily harm on another
- Gravely disabled: unable to provide for own food/clothing/shelter to the extent that death, bodily injury or physical debilitation might result without treatment.
- Attempting suicide or behaving as though he or she intends to follow through with verbal threats and has the means to do so.
- Mutilating or attempting to mutilate him/herself.
- Acutely distressed by hearing or seeing things which do not exist.
- Expressing serious thoughts about hurting themselves or someone else.

- Experiencing uncontrollable anxiety or anger.
- Having a severe reaction to psychiatric medication.
- Suspected child, elder, dependent adult abuse.
- Physical aggression by a client against a therapist, including threats or aggression.
- Potential Tarasoff situations
- Notice/call regarding subpoena
- Police Involvement

<u>WHEN YOUR DIRECT SUPERVISOR IS ON VACATION OR IF SOMEONE ON THE PHONE TREE IS ON VACATION SKIP TO THE NEXT INDIVIDUAL</u>

<u>IF IT IS A SAFTEY ISSUE CALL 911</u>

If you are presented with one of the above Emergency/Critical Incident, the following phone tree is to be utilized. :

First, call your Direct Supervisor
JayDee Tumambing @ 951-295-7053 or Nicole Shannon @ 626-644-4355
If no response within 15 minutes

Second, call the Program Supervisor, Eden Garcia-Balis @626-379-4448
If no response within 15 minutes

Third, call Outreach Coordinator, Alina Sgattoni @ 310-936-1396
If no response within 15 minutes

Call Executive Director, Chanel Boutakidis @ 626-202-3380

Suicidal Clients

PMHC does not have capacity for walk-in emergencies. However, the following procedures should be followed when confronted with a suicidal client. In all cases, the therapist should attempt to contact his/her clinical supervisor or the Program Supervisor to lend guidance and support while handling the situation.

1. Clients who are threatening suicide will be assessed by the therapist face to face or over the phone. If the threat is imminent, the therapist will call 9-1-1 or advise family members to call 9-1-1.

2. If the client is threatening to harm a specific person and you feel the risk is imminent, notify the intended victim after calling the police.

3. If threat is not imminent but the client still needs to be assessed for hospitalization, determine whether or not the client will voluntarily admit him/herself to the hospital.

If the client will voluntarily admit self,

- contact a friend or family member and explain the emergency situation

- ask the friend/family member to come to the Center in order to transport the client to the hospital
- contact a local hospital (e.g., County USC will accept clients without insurance) and explain that you are sending over a client and ask who the client should ask for upon arrival
- explain to the hospital that you are the treating therapist and would like to be called once the client has been processed

If the client will not voluntarily admit self, call 9-1-1 and keep the client calm and safe while awaiting the police.

4. If the client does not meet criteria for hospitalization and is assessed not to be a threat to self or others, the therapist should complete a CLIENT SAFETY PLAN with the client. The best Safety Plans involve family members or friends as active participants—but be sure to obtain the written authorization of the client if you will be communicating with others about the client within the scope of the Safety Plan.

In such cases where the therapist has needed to take action before receiving consultation, call your clinical supervisor as soon as it is reasonably possible in order to report all actions that have been taken. You should also let the Clinical Coordinator know the next working day. You must speak to an actual *person* by the end of the business day. You should discuss any additional recommendations for intervention(s) and a time frame.

Always be sure to thoroughly document all clinical indicators of risks (e.g., self-report of the client, your assessment of symptoms, other related high-risk behaviors, etc.) and all steps taken in response to the crisis (e.g., calls to the police, completion of Client Safety Plan, calls to clinical supervisor and recommendations from each). Place this in the client's chart. Provide a copy of this documentation to the Program Supervisor and a copy to your clinical supervisor for his/her review and signature.

Confidentiality

All material that a client shares with you, as well as the fact that they are receiving services of any kind is confidential information. If anyone calls seeking information regarding a client, you cannot release any information *including whether or not this person is even a client* unless you have a written release of information from your client to talk to this specific party. This form (AUTHORIZATION FOR RELEASE / EXCHANGE OF INFORMATION) must be completed before you speak to family members who are not participating in treatment as well as other agencies or professionals.

However, confidentiality *must* be breached in specific situations and *may* be breached in others.

MUST BREACH situations:

- known or suspected child abuse
- known or suspected elder or dependent abuse
- a serious threat of physical violence against a reasonably identifiable victim or victims (Tarasoff)

MAY BREACH situations:

- danger to self
- legal proceedings

The therapist may breech confidentiality if s/he has reasonable cause to believe that the client is in such mental or emotional condition as to be dangerous to himself *and* that the disclosure of this information is necessary to prevent the threatened danger.

Privilege refers to the client's legal right to prevent confidential information from being released into a legal proceeding. When records are subpoenaed, you should generally assert therapist-client privilege and refuse to release information unless the client has waived their privilege by providing you with a written authorization to release information. The court may find exceptions to privilege which will require the information to be released. These include: a client who is a danger to him/herself or others, a minor under age 16 is the victim of a crime and it's in their best interest, the services of a therapist are sought to aid in committing a crime (e.g., fraud), sanity proceedings, or proceedings to establish competence.

Mandated Reporting

There will likely be times when you become aware of suspected Child, Dependent Adult or Elderly Abuse while performing in your professional capacity as a therapist. The reporting guidelines differ slightly between each of these. You should always begin by *immediately* discussing your suspicion with your clinical supervisor.

Child Abuse

Legally there is a mandate for therapists to report suspected child abuse or neglect "immediately or as soon as practically possible" by phone and to follow up with a written report within 36 hours to a child protective agency. The law clearly states that your obligation as a mental health professional is to report even the suspicion of child abuse or neglect, without making your own determination as to whether or not it is occurring. Knowing the laws regarding reporting are crucial because you may be mandated to report in a situation where the client does not perceive themselves as abusive.

In the context of domestic violence, a mandated reporter must consider whether there is a risk of physical or emotional harm to the child. The fact that a child's parent or guardian has been the victim of domestic violence is not in and of itself a sufficient basis for reporting suspected child abuse or neglect. A mandated reporter must report suspected abuse or neglect to Child Protective Services in the following domestic violence cases:

1. A domestic violence incident which caused physical injury to the child or created a serious risk of physical injury to the child.
2. A domestic violence incident which caused serious emotional damage to the child or created a substantial risk of serious emotional damage to the child.

One of the best resources to consult for definitions of abuse and for information about the therapeutic implications of making a report, see "The California Child Abuse & Neglect Reporting Law: Issues & Answers for Mandated Reporters" found at http://www.dss.cahwnet.gov/cdssweb/PG20.htm.

Child Abuse Hotline - 1-800-540-4000

Reporting forms can be found in the front office.

Another excellent resource can be found at www.youthlaw.org. Look for the document "Minor Consent, Confidentiality, and Child Abuse Reporting in California" dated October, 2006. A copy of this is available in the Program Director's office.

Adult Dependent or Elder Abuse

A dependent adult is defined as a person between the ages of 18 and 64 who has physical or mental limitations which restrict his/her ability to carry out normal activities (e.g., developmentally disabled, physically disabled). Elders are persons 65 years of age or older. Reports are mandated for these populations under the following circumstances:

- the therapist observes or has knowledge of an incident which reasonably appears to be abuse
- the therapist has observed an injury which indicates physical abuse
- the alleged victim has told the therapist about the abuse

There are seven categories of abuse which the therapist must suspect, witness or hear about from the client including 1) physical , 2) psychological/mental, sexual, 3) neglect, 4) isolation (e.g., preventing the person from receiving mail, phone calls, etc.), 5) abandonment, 6) abduction and 7) fiduciary abuse (taking of money or property without permission).

If you have a suspicion of adult dependent abuse or elder abuse, you are mandated to make a telephone report immediately to Adult Protective Services or the local law enforcement agency followed by a written report within 2 working days. This form, "Report of Suspected Dependent Adult/Elder Abuse" can be found online at http://www.dss.cahwnet.gov/cdssweb/PG20.htm.

Dependent Adult / Elder Abuse Hotline - 1-888-436-3600

Treating Minor Clients

A minor under the age of 12 years old cannot be treated without parental consent. Minors over the age of 12 may be seen under certain circumstances:

a) the minor is legally emancipated and you have written documentation of this; OR

b) the minor is 12 years of age or older and is the alleged victim of incest or child abuse

c) the minor is 12 years of age or older and both of the following requirements are met
1) the minor, in the opinion of the therapist, is mature enough to participate intelligently in the outpatient services AND
2) the minor would present a danger of serious physical or mental harm to self or to others without the mental health treatment

If you decide that the minor is eligible to be seen without parental consent, you must document your reasons in the client's chart.

See "Minor Consent, Confidentiality and Child Abuse Reporting in California" handout for additional information on how consent and confidentiality works with minors.

A minor who is being seen in therapy has the right to a confidential relationship with a therapist. What you can and must share with the parent differs according to who has consented to the treatment. If the *minor* has consented to treatment, you may not share records with the parent unless you have the signed consent of the minor. At the same time, the law states that you must "involve" the parent in the minor's treatment unless you feel that their involvement would be inappropriate. You must document your reasons for this decision in the client's file. "Involving in treatment" is somewhat vaguely defined but may include informing parents about the general progress of treatment and informing the parents of any issues that might endanger the minor.

If the *parent* has consented for the minor's treatment, then the parent generally has a right to control access to the minor's mental health records which includes releasing information about the minor's case.

Legal Obligations

In addition to the above, the following represent standard legal obligations that therapists must adhere to in providing psychological services:

1. <u>Scope of Practice</u>

"Scope of practice" is the definition provided in law that delineates what the profession does and places limits upon or confines the breadth of functions persons within a profession may lawfully perform. Scope of Practice is defined for the profession as a whole. There are different definitions for one's Scope of Practice depending on the specific profession.

MFT: "...the practice of marriage, family and child counseling shall mean that service performed with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of achieving more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and pre-marriage counseling.

The applications of marriage, family, and child counseling principles and methods include but are not limited to, the use of applied psychotherapeutic techniques, to enable individuals to mature and grow within marriage and the family, and the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships."

MSW: " The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate, satisfying, and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counseling and using applied psychotherapy of a nonmedical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping communities to organize, to provide, or to improve social or health services; or doing research related to social work."

Psychotherapy as practiced by an MSW is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation to modify internal and external conditions which affect individuals, groups, or communities in respect to behavior, emotions, and thinking, in respect to their intrapersonal and interpersonal processes.

Psychologists: "The practice of psychology is defined as rendering or offering to render for a fee to individuals, groups, organizations or the public any psychological service involving the application of psychological principles, methods, and procedures of understanding, predicting, and influencing behavior, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counseling, psychotherapy, behavior modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, aptitudes, personality characteristics, emotions, and motivations.

The application of such principles and methods includes, but is not restricted to: diagnosis, prevention, treatment, and amelioration of psychological problems and emotional and mental disorders of individuals and groups.

Psychotherapy within the meaning of this chapter means the use of psychological methods in a professional relationship to assist a person or persons to acquire greater human effectiveness or to modify feelings, conditions, attitudes and behavior which are emotionally, intellectually, or socially ineffectual or maladjustive.

As used in this chapter, "fee" means any charge, monetary or otherwise, whether paid directly or paid on a prepaid or capitation basis by a third party, or a charge assessed by a facility, for services rendered."

2. Scope of Competence

Scope of competence also defines or limits what the individual within the profession may do and is determined by one's education, training and experience. Scope of competence is defined for the individual. As an example, you cannot use EMDR to treat a client if you are not trained in its use, even though the use of EMDR is a technique you would be allowed to use given your profession.

3. Obligation to refrain from unprofessional conduct

Working outside of one's scope of practice and working outside of one's scope of competence are both violations of law. Section 4982 (1) of the Business and Professions Code provides that therapists engage in unprofessional conduct when: "Performing, or holding one's self out as being able to perform, or offering to perform, or permitting any registered trainee or registered intern under supervision to perform, any professional services beyond the scope of the license authorized by this chapter." Also defined as unprofessional conduct in section 1845 (a) of California Code of Regulations: "Performing or holding himself or herself out as able to perform professional services beyond his or her field or fields of competence as established by his or her education, training and/or experience."

Refraining from unprofessional conduct also involves the legal obligation to refrain from intentionally or recklessly cause physical or emotional harm to any client. To maintain *professional* conduct, you must maintain appropriate boundaries and avoid engaging in dual relationships or anything that would involve potential exploitation of the client.

Sexual contact is both a civil and a criminal offense in California. If a client discloses sexual contact with a previous therapist or says that a previous therapist requested sexual contact with the client, you are legally mandated to give the client a brochure that explains the client's rights and options if the client chooses to make a criminal report. A copy of this brochure, entitled "Professional Therapy Never Includes Sex" is located in one of the file cabinets in the front office.

Essential Policies & Protocol

Telephone Assessment & Intake

Protocol Date: 2006 Revisions: December 12, 2010

PURPOSE: The telephone screening for callers is designed to make an initial determination as to whether or not the caller can most likely be served at Pasadena Mental Health Center.

In general, treatment areas which are *not* appropriate for the agency include:

- chronic and severe mental illness
- severe substance abuse
- perpetrator of battering/violence
- court-ordered counseling for issues other than parenting (i.e. anger management, child custody, etc.)
- actively suicidal or in imminent crisis
- specialized treatment issues such as specific sexual disorders, eating disorders, etc.

NECESSARY FORMS TO HAVE AVAILABLE

A blue PHONE INTAKE form will be completed for each person who calls the agency seeking treatment by the therapist covering intake at the time of the call.

If you are assessing a **couple**, you must complete each area of the phone assessment for <u>each person</u> who will be involved in the treatment (this means asking each question more than once, covering each person coming in). It is okay to ask the caller to represent the other member of the couple or family unless they are not able to accurately provide necessary information.

PROCEDURES:

1. <u>Beginning the Conversation</u>

Identify yourself as one of the therapists at the agency. You do not need to bring up the fact that the therapists here are trainees/interns on the phone. This will be addressed in person at the first session. However, if the caller asks, simply acknowledge that our therapists are graduate and post-graduate interns who are supervised by licensed professionals.

Now, to start gathering information prepare the client by saying something like,

"I am going to be asking you some questions to help us determine whether Pasadena Mental Health Center is the best fit for you."

Ask if this is a good time for the caller to spend a few minutes with you on the phone. <u>Explain confidentiality and its limits</u> before you begin to gather information.

2. <u>Identifying Data</u>

Always note the referral source in terms of understanding the diagnostic picture of the caller. If, for example, the caller was referred by a hospital, you would want to understand why they were hospitalized, for what reason. If the caller was referred by the Regional Center, you would know that they most likely have a developmental disability such as mental retardation. You will likely get this information as you continue the screening process, or you can just ask something like, "I see you were referred by Huntington Hospital. Were you in the hospital when they referred you? What was happening at that time?"

3. Presenting Problem

Your initial discussion with the caller about why s/he is calling will begin with an open-ended question such as...

"What were you hoping Pasadena Mental Health Center could help you with?"

This will allow you to get an impression of the client's overall presentation right away as well as some specific information about what they're wanting help with. You may find that you do not need to ask some of the other questions on the form because they have already been answered. Be sure to fill out all areas of the form regardless. If the form is not complete, it will be returned to you.

During caller's initial discussion you can be listening for some of the following:

Affect. Do they sound flat (without emotion) or labile (change their tone and intensity frequently)? Strange or bizarre affect may be indicative of a thought disorder, drug/alcohol use or a more severe personality disorder.

Thought Process. Do they seem tangential, difficult to follow, or incoherent?

Mood and way of relating to you. Are they very angry and hostile? Are they very guarded and unwilling to provide information?

Be sure to clarify ambiguous statements and ask what the caller means when they say, for example, "My husband has temper outbursts." "Tell me what those look like" or "Describe those for me."

Occasionally you may need to either a) set some limits on the phone with callers who go into a great deal of history and/or detail, or b) elicit more information from callers who do not give a full picture of the presenting problem. You can gently interrupt a caller who is going into too much detail and reassure them that what they are discussing sounds very important and can be explored further with their on-going therapist. For clients who make vague statements or are unclear, ask them to give examples, etc.

4. Psychiatric History

Your goal in this section is to determine if the caller has a chronic mental illness such as schizophrenia or bi-polar disorders. This often becomes evident in the question about medications. Clients who have these disorders are typically referred out. Clients who have been hospitalized and/or are taking medications for depression or anxiety *may* be appropriate for the agency. The degree to which their functioning is impaired and whether or not they are suicidal will be major factors in making this judgment.

5. Suicidality

It is very important to ask whether the caller is feeling suicidal even if they do not seem to be depressed (many people will acknowledge passive suicidal ideation but are not actively suicidal). The callers will often times make it clear in describing suicidal feelings that they do not intend to act on their feelings and this type of client is generally appropriate to be seen at the agency, particularly if they have not made prior attempts. (*The number of past attempts and means are an important indicator of chronic, high-risk behavior* and may indicate severe personality disorders or bipolar disorder.) Additionally, callers with a very recent attempt and/or substance abuse issues in combination with suicidal feelings/behavior are at higher risk and may be inappropriate for the agency. **We do not treat clients who have had a suicide attempt within the past year.**

6. Substance Abuse

Callers asking specifically substance abuse treatment, or have a long history of unsuccessful treatment should be referred to a program that specializes in drug and alcohol treatment. This is a highly specialized field and there are many fine agencies that do it well. Clients who are asking for help with other issues, but exhibit signs of addiction or dependence, should be assessed and—if they are otherwise appropriate for PMHC—referred to one of our therapists. The intake clinician can then assess more thoroughly and refer out if the addition seems to be severe enough that it would impede treatment.

It is good to ask the questions about substance abuse with all callers. Begin with questions regarding a family history of substance use. This will allow the caller a relatively non-threatening way to open up on these issues. (There is a high correlation between substance use and family history of substance use). Important questions for the therapist to keep in mind:

- Does the caller currently have some sobriety?
- Does the caller minimize use or do they see it as a problem?
- Have they had multiple inpatient rehabilitation services and been unsuccessful at maintaining sobriety?

If you have any questions about appropriateness for the agency, consult the Clinical Coordinator or Director. Make sure to document your concerns on the intake form.

7. Violence

The greatest predictor of violent behavior is a past history of violence. Also, substance use can greatly increase risk of violence due to decreased inhibition and impaired judgment. Once again, the therapist should ask themselves:

- Is the caller minimizing violent behavior or do they see it as a problem?
- Is there a history of substance use in addition to violence?
- How agitated is the client's demeanor on the phone?

If there has been recent violent behavior, or a history of violence in combination with other risk factors such as drug/alcohol use or agitated presentation, the caller will most likely be referred out.

***Couples with any history of violence in their relationship cannot be scheduled here for couple's therapy.** The person who has been assaulted can be scheduled for individual therapy here. The couple and/or the batterer can be referred to a program which offers specific treatment for this issue. We also refer to the Grace Center, another affiliate of Five Acres.

8. Referred Out

If it is clear to the therapist by the end of the call that the client is not appropriate to be scheduled at PMHC, you will be providing them with resources and referrals and documenting why the caller was referred out and the referrals that were given. Please be mindful of your language when you refer someone elsewhere. It is best to say something like: "Based on what you have said, I think another agency may be able to provide you with services that are best to suit your needs."

COMMON QUESTIONS:

1. Fees: If the caller asks about the fee, simply say that we have a sliding fee scale that is based on ability to pay. Let them know they will bring proof of income to the first session and our office staff will set their fee.

2. Frequent or structure of sessions (ex: "Do I come once a week or can I come in more?"). Let the caller know they can work this out with their therapist when they come in.

3. Specific requests. If you are certain that the caller is appropriate to be seen here and the caller has specific requests such as a female therapist, a certain age, or a certain type of training ("Will they know how to work with anger?"), let them know that the Program Supervisor will call them *only* if the Coordinator is unable to meet the client's specific request. Otherwise, they will be matched with a therapist who will be able to help them. They will learn who their therapist is when the therapist calls to make the first appointment.

Treatment Plan Goals and Progress Notes Guidelines

Protocol Date: 2006 Revisions: December 12, 2010

PURPOSE: The development of a treatment plan is a mutually defined process between the therapist and the client. The process of defining goals is a combination of the client's input and the therapist's assessment of the client's situation based on a thorough assessment.

The process of developing goals is crucial not only in guiding the treatment but in beginning to develop a therapeutic alliance with the client. If the client feels understood in terms of what they're struggling with and feels a sense of confidence in the therapist's ability to help, you have a solid foundation to begin your work and the client is less likely to drop out of treatment in the difficult beginning stages.

NECESSARY FORMS TO HAVE AVAILABLE:

1. Initial Assessment and Treatment Plan

PROCEDURES:

Choosing Treatment Goals

Your initial assessment will give you information about presenting problems, symptoms, diagnostic impressions and psychosocial information. There may be a multitude of areas that might benefit from treatment, but your challenge is to prioritize the top two or three areas to begin with. Choose goals that:

- Relate to why they sought treatment in the first place;
- Address immediate crisis issues;
- Relate to their diagnosis;
- Pose any threat to the safety of self or others;
- Will have the greatest impact;
- Are achievable and allow the client to experience an early success in treatment;
- The client feels motivated to work on

Writing Treatment Goals

A goal reflects the desired *outcome* of a case, something that is observable and measurable. Think of a goal as your road map for treatment. Where does the client want to end up, how do they want their lives to be once therapy has been completed?

Clinicians often confuse goals with process terms that define the means to achieve the goal. For instance:

"Decrease depression" is a goal. *"Explore issues of grief and loss related to childhood neglect"* is a process or intervention that will hopefully decrease the client's depression but is not a goal.

Using the example above, you need to say *how* you would know that the depression was decreasing. How are you going to measure improvement? (And don't just use client self-report). How does depression manifest itself in this client? Does he/she withdraw or isolate? Use a lot of negative self-talk? Cry? You could ask the client, "What would you be doing differently if you weren't depressed?" If the client tells you that they'd be doing more things with friends, you might then write the goal:

"Decrease depression as evidenced by an increase in number of weekly social activities."

Now you have to have some idea of where the client is starting from in relation to that goal. This is called their "baseline." For the goal above, how many weekly social activities is the client currently participating in? This provides your starting point against which to measure improvement.

Treatment Plan

A Treatment Plan shall include:

- Individualized treatment goals with measurable objectives
- Services that meet the client's needs. In other words, what is the best form of treatment - e.g., evidenced-based - for each treatment goal?
- Type (i.e., individual, couples, family, group) and frequency of services (e.g., weekly, monthly)
- Referrals for outside services and the frequency of those services (e.g., referral to AA)

Writing Progress Notes

Each progress note should relate back to your overall treatment goal(s) for the client. For instance, if your goal is to decrease depression you would describe how your intervention that day related to decreasing depression. We use the "GIRP" form of writing progress notes.

G: Goal of Session
I: Intervention
R: Response
P: Plan

G: Goal of Session

The goal of the session needs to relate back to a treatment goal. You wouldn't have "understanding of the grief and loss process" if your treatment goal was to improve social skills. Some examples of goals of a session might include:

- to increase client's adaptive coping skills in stressful situations
- to decrease depressive symptoms
- to increase client's understanding of the grief and loss process
- to explore client's feelings about recent divorce
- to increase positive communication within the family/couple

I: Intervention

Does the intervention match the goal of the session? Examples of interventions might include:

- taught client imagery techniques
- increased client's insight into self-defeating patterns through socratic dialogue
- discussed client's tendency to avoid conflict
- practiced conflict resolution skills
- practiced delay-of-gratification in simulated peer activity

R: Response

- Client reported increase relaxation after practicing imagery techniques.
- Client stated that she could recognize her contribution to a fight with her husband this week.
- Client was able to demonstrate conflict resolution skills effectively during practice.
- Client appeared frustrated with the activity as evidenced by throwing a toy across the room.

P: Plan

Have you given them any homework? What's your plan for your next session?

- Client agrees to journal feelings/automatic thoughts during the week.
- Continue to discuss...
- Continue to practice...
- Introduce additional examples of self-soothing techniques...

SAMPLE 1

Treatment Goal and Measurement: Improve communication skills within family. Measured by frequency of arguments between 2 or more family members that reaches a level of screaming.

Progress Note for Session:
The purpose of this session was to practice communication skills. (G) Therapist described the difference between passive, assertive and aggressive communication and had family members practice in a low-stress conflict situation presented by therapist. (I) Dad and children were able to successfully practice skill; mom was hesitant to express herself even during this role-play conflict and needed considerable prompting to use assertive communication. (R) Family came up with plan for practicing these skills during one discussion this week and chose Wednesday as the time they would try it. Therapist encouraged them to try skills even in 1:1 conversations, not just larger family conversations. (P) Plan next session will be to review each person's success with the new skills and refine as necessary.

SAMPLE 2

Treatment Goal and Measurement: Reduce anxiety in social situations as measured by self-rating of anxiety.

Progress Note for Session: This session dealt with identifying triggers to anxiety. (G). Therapist explored with client situations in the past which had evoked anxiety, looking for patterns in terms of situations or cognitions preceding the anxiety and reviewing any historical variables that may be influencing the anxiety. (I) Client was able to identify that the anxiety began during an incident in which she had embarrassed herself during a large family gathering. (R) Client will track social situations this week and will rate her anxiety on a form provided by therapist. Next week we will begin identifying body cues to anxiety. (P)

On-Going Evaluation of Progress

Evaluating progress toward goals is an on-going process. A treatment plan is always open-ended because new issues and needs arise as you are working with a client. New goals should be defined and documented as your work unfolds.

Fee Collection Protocol

Protocol Date: July 17, 2007 Revisions: December 12, 2010

PURPOSE: PMHC serves the working poor on a sliding fee scale. Clients who pay a fee are more likely to value the services they receive. It enables them to demand quality services. It has also been shown that if a client pays for services, s/he is more likely to use them. While the front office staff will collect fees, discussion about payment problems is the responsibility of the therapist. It is vital that you tell your clients their fee when you call to schedule the first session

PROCEDURES:

Note: Youth Accountability Program clients and their parents receive free services. Family Preservation clients also receive free service. Fees should not be collected from Youth Accountability Program clients or Family Preservation Clients.

1. Client arrives for appointment.

2. Client signs in and the front office staff checks to see what fee the client is supposed to pay.

Note: fees might include more than just the fee for that session. A "late cancel" session (less than 24 hours notice) is charged the full amount for the missed session or there may be a balance from the previous session which must also be paid.

3. Front office staff collects the fee and records the amount on the receipt. The client gets the WHITE copy of the receipt. The therapist gets the YELLOW copy of the receipt. This provides the therapist with feedback about any payment issues which may need to be discussed at that session.

In the Progress Note for that session, the therapist should make a note about the client's fee status,

"Paid in full."
"Owes fee for 1 session. Asked client to make sure to pay balance next session."
"Owes fee for 2 sessions. Explained that he/she cannot be seen until the balance is paid."
"Client called to cancel appointment. Late Cancel. Full fee to be added to client's balance."

The yellow receipt can be discarded once this information is noted in the chart.

5. The front office keeps the PINK copy of the receipt and records the payment in the book.

When a client is unable to pay for his/her session:

The therapist should explain to the client that they will need to pay the balance the next time they come.
If the client is unable to pay the fee *for the second time in a row*, again note "-0-" under Payment" and the carryover balance from the last week plus this week's fee under "Balance."

The therapist must explain to the client in session that they will not be able to be seen for their next session until the balance has been paid off.

When a client has been charged for a "late cancel" session:

Clients who cancel their appointment with less than 24 hours notice are still charged for that session. This is known as a "late cancel."

Therapists must let the front office know when a client has had a 'late cancel' so that they can document it correctly on the client's fee sheet.

When a client requests a fee reduction:

Clients may experience circumstances in their lives (for instance, losing a job, separation from spouse, etc.) which necessitate a reduction in their current fees. This is a discussion the client should have with his/her therapist. If the client begins to explain their change in circumstances to the front office staff, he/she will be encouraged to bring this up with his/her therapist.

All fee reduction requests must go through the Program Supervisor for approval and should be discussed with the client prior to requesting a reduction in fee. See form "Request for Fee Change" located in the small grey filing cabinet in the front office.

Group Therapies

Fees for attendance at group therapies will be collected by the front office staff for most groups. If the group is composed primarily of *paying* individuals, the group facilitators may be asked to collect the fees so as not to interfere with the group starting on time.

Fees for group attendance are $10.00 per group.

MONITORING:

Be sure to log the client's attendance on the "Record of Client Attendance" form (in the small grey filing cabinet in the front office) so that you are accurately able to complete your monthly statistics. Each client will be noted as either:

S	= showed
C	= cancelled with 24 hours notice
LC	= late cancel - cancelled with less than 24 hours notice (charged full fee)
NS	= no show (charged full fee)

Always let the front desk know if a client has had a Late Cancel or a No Show so that they can charge the client the correct amount the next time they come for an appointment.

Monthly Stats

Revised December 12, 2010 and added to the Master Intern Manual 7/1/10 kme

New clients:
Please indicate if a client is a new client of yours by placing an "x" in the "new client column."

Modality:
Indicate the number of individual (I), couple (C), and family (F) sessions conducted for that client that month. If you had a 2 hour session with an individual, couple, or family, please record it as 2 sessions rather than 1.

a) For individual sessions:
-Please distinguish between adult or minor sessions by marking under either "IndAd" or "IndCh"

b) For couples' sessions:
-In the spaces for First and Last Name, indicate the name of both clients in one line (e.g., Mr. and Mrs. Charming, Prince – refer to Stats Example 1).
-If you have individual sessions with each partner in the couple as a part of the coordination plan for the couple, please still indicate the name of both clients in one line. The name listed should reflect what name the client file is opened up in and in this case it's the *couple's* name.
-If you know a partner in the couple is also being seen as an individual at the agency but not as a part of the couple's treatment plan and you are not the therapist, do not indicate it here.

c) For family sessions:
Under the "F" column, indicate the total number of family sessions that were held for that particular client that month.
-When **multiple family sessions** are conducted:
i) Indicate in the "F" column the total number of sessions held for that client that month.
ii) Then, in the following two columns (labeled "# in session – Adult" and "# in session – Child) indicate the number of adults and children (including the client) present in the session.
iii) If a different number of people were present in each session, indicate the different numbers in the rows below. (See example for John Smith below.)

EXAMPLE for how to fill out table for family sessions:

Last Name	First Name	F	# in Session	
			Adult	Child
Smith	John	3	2	1
			3	1
			4	1
Doe	Jane	2	2	2
			2	2

-Parenting sessions are also considered to be family sessions. The difference is that you fill out 2 adults or 1 adult present and no children present since the child is not present.

d) For Groups: Under the "G" column, indicate if that particular client reports having attended a group at the agency (whether or not you facilitated the group) using an "x."

Mini-Group Table (bottom of form)

ONLY complete this table if you facilitated a group this month.

1. Under "Group Name," indicate the name of the group(s) you co-facilitated that month.
2. In the column labeled "Kid Gp?," indicate with the number "Y" if that group is a group for minors. Indicate with a "N" if that group is a group for adults. You **MUST** enter in either "Y" or "N" in order to get credit for that group.
3. In the column labeled "Hr.," indicate the length of the group you facilitated. For example, if the group you facilitated was 1 hour in length, indicate "1." If the group you facilitated was 2 hours in length, indicate "2." Please note that groups that are 1.5 hour in length will be rounded up to 2 hours.
4. Under "W1," "W2," "W3," etc., indicate the number of people participated in that group each week.
5. Under "Total # Clients," sum up the number of clients who attended over the group course of the month.
6. Under "Total # Groups," manually add up the number of groups you facilitated during this month, regardless of the duration of each group session (this will be calculated later). Please distinguish between number of adult groups and number of minor groups.
   -The spreadsheet will automatically turn the totals into corresponding clinical hours.
   -If the form is completed manually, multiply the number of groups facilitated over the month by 2 to get 2 hours credit per group.

EXAMPLE:

		Total # Clients						Total # Groups	
Group Name	Kid Grp	W1	W2	W3	W4	W5	Total Number Clients	Kids	Adult
First Offender	Y	8	8	8	8		8 + 8 + 8 + 8 = 32	4	
Women's Support	N		4	5	4		4 + 5 + 4 = 13		3
							Total Group Credit	4 x 2 = 8	3 x 2 = 6

Attendance rates:
Refer to client fee chart for help.

-Indicate the total number of sessions *scheduled* for that client that month (including individual, couple, and family sessions).
-Indicate the total number of sessions *attended* by that client that month.
-Indicate the total number of sessions *cancelled* by that client that month.
-Indicate the total number of sessions *late cancelled* (not within the 24-hour notice) by that client that month.
-Indicate the total number of sessions *no shows* by that client that month.

Totals:
-All totals will be automatically calculated in Excel so you do not need to fill these in yourself.
-The only exception is that the total number of groups run during the month will need to be inputted manually by you. In such a situation, please enter the totals for that column in the corresponding cell.

Termination date:
Please indicate the termination date for clients who terminate during that month.

Stats are DUE BY THE 5th of the following month.

Handouts

You will receive the following handouts at orientation. It is important that you thoroughly read all the provided material.

1. California Minor Consent Rules for Adolescent Health Care

2. California Child Abuse & Neglect Reporting Law

3. Child Abuse Reporting Guidelines for Sexual Activity between and With Minors

4. Dress Code

5. HIPAA Privacy

6. Setting-up Voice Mail Instructions

7. When Mandated Reporters in CA Must Report Consensual Disparate Age Sexual Activity to Child Abuse Authorities

You should have receive the following handouts in the white envelope you recived at Meet and Greet. If you did not receive these documents please let Nicole know.

8. Confidentiality and Client Information

9. Drug Free Workplace Policy

10. Privacy, Confidentiality and Security Policy

Forms

Below is a list of forms you will need and where you can locate them. The front office staff can assist you if you are unable to find a form. If you take the LAST form please let the front office staff know so more copies can be made.

The following are located in the small gray filing cabinet in the front office:

1. Authorization for Release of Information – outgoing information

2. Client Income Statement

3. Client Letters

4. Three Missed Appointments (English and Spanish)

5. Outstanding Balance

6. Client Request for Fee Change

7. Consent to Treat a Minor

8. Dummy File face sheet (Five Acres clients)

9. Child & Family Initial Assessment and Treatment Plan

10. Couple Initial Assessment and Treatment Plan

11. Phone Intake

12. Request for Vacation / Leave of Absence

13. Student Participation Evaluation

14. Therapist Availability Form

The following forms are included in the *Welcome Packet* that is given to new clients by the front office staff. These packets are located in the bottom drawer of the gray filing cabinet:

15. Client Contact Information

16. Income Eligibility Form

17. Notice of Privacy Practices

18. Acknowledgement of Receipt of Privacy Practices

The following forms are included in the *New Client Files*:

19. Chart Order Checklist

20. Client Safety Plan

21. Client Satisfaction Survey

22. Contract for Therapeutic Services

23. Individual Initial Assessment and Treatment Plan

24. Progess Notes Forms

25. Record of Client Attendance

26. Termination Checklist

27. Termination Summary

28. Transfer Checklist

29. Transfer Summary

30. Treatment Plan Review

Your *Student Therapist Agreement* is in the white envelope you received at the Meet & Greet. You will be signing that during orientation.

Once you have completed your practicum you will be asked to fill out a *Therapist Evaluation of Clinical Supervision/Practicum* form.