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THE CENTER

The Southern California Counseling Center was organized in 1966 by Drs. Benjamin Weininger, psychiatrist and psychoanalyst, and Hans Hoffman, psychologist and teacher. It was their belief that no one should be denied counseling because of limited financial means. Relying as it did on volunteerism, theCenter's approach to mental health was shocking to many in the industry at that time. Volunteer lay counselors were carefully selected and trained to work under the supervision of volunteer professionals. When the California law which created the Marriage and Family Therapy license was enacted in the early 1970s, the Center became a highly respected training site for MFT trainees and interns. As of the Fall of 2001, the Center is also a practicum and internship cite for pre-doctoral students preparing for licensure as clinical psychologists.

As the American economy changed, paraprofessional volunteers gradually came to represent a smaller proportion of the Center's counselors. However, a unique characteristic of the Center is its continuing effort to attract community volunteers (paraprofessionals) with broad life experience as well as trainees and interns.

The Center's mission continues to reflect the philosophy of its founders:

OUR MISSION

We change lives and strengthen communities by providing affordable mental health counseling to people in need.

OUR VISION

We envision and work to create empowered communities where mental health care is a right, not a privilege.

SOUTHERN CALIFORNIA COUNSELING CENTER

OUR VALUES

Respect: We value and respect every person, honoring their history, cultural values and community context.

Volunteerism: Volunteer counselors and supervisors are at the heart of the Southern California Counseling Center; they are the connection to our client communities.

Training: We provide the highest quality training and education for our volunteer counselors and supervisors, other licensed professionals and individuals in other social service organizations.

Welcoming Environment: Our accessible, supportive environment reduces barriers to participation and to receiving care.

Empowerment: We support our clients as they access the resources required to grow, thrive, and make positive changes in their lives and their communities.

Learning: We continuously evaluate and strengthen our programs and services through collaboration among clients, counselors, supervisors, staff and the wider community.

The Center has an extensive counselor training program. Students and interns gain experience applicable to state licensure as LMFTs, LPCCs and LCSWs . Counselors are trained to work with individuals, groups, couples, families andchildren. All counselors work under the supervision of licensed therapists who volunteer their time.

The Southern California Counseling Center has been a model for low cost mental health agencies across the nation attempting to provide affordable mental health treatment. Many public agencies and private psychotherapists, as well as schools, doctors and clergy, refer clients to us. Significantly, more than one-third of all new clients are referred by past and present clients of the Center.
In addition to our sliding scale fees, our evening and weekend hours make us accessible as a supportive community to working people.

The Center has never sought government funding. Rather, a combination of internal and external funding sources keep it self-supporting. Client fees meet more than one-half of the Center's operating expenses. In addition to donating their time, counselors

pay a monthly administrative fee to the Center. The balance of the Center's financial requirements are supplied by corporate grants and the fund-raising efforts of its Board of Directors.

THE STAFF

Each staff member has a specific title, as designated on the front page of your Center roster. However, you will find that there is a great deal of overlap of responsibilities. The Center is a cooperative operation.

The Center staff is always available to assist you with questions, case management issues and spot supervision when your supervisor is unavailable.

THE COUNSELOR

A. Benefits and Opportunities

1. The Center is a learning community. Counselors learn from:

   a. Counseling clients.

   b. Supervision from professionals.

   c. Attendance at in-house training.

   d. Interaction with staff and other counselors. The staff room provides a comfortable place for support from other counselors and consultation with peers.

2. There are many additional opportunities for enhancing personal growth and counseling skills. You may:

   a. Make frequent use of the one-way mirror and video recording of your client sessions. For the use of video recordings or one-way mirrors, the client must sign a release giving the Center and the counselor consent. RECORDINGS MAY LEAVE THE CENTER ONLY UNDER CERTAIN CIRCUMSTANCES. A counselor may be granted permission to take a recording off-site for specific academic or supervision purposes. Discuss with your supervisor and fill out the appropriate form – form #25. For the use of any of this equipment, please check with the front desk to make sure equipment and/or rooms with one-way mirrors are available. You may:

      1) Ask your supervision to observe your session with your client and/or group.

      2) Use recordings for your own reference.

      3) Form a team with other counselors for case conferences.

   b. Sign up for special workshops, seminars and training groups offered by the Center. Sign-up sheets are posted in the staff room and offer a wide range of educational opportunities usually at little or no cost.

   c. Create your own seminars and study groups for Center counselors.

d. Contribute your thoughts in writing to THE SCCC JOURNAL, the Center's periodic newsletter and/or participate in its editing and publication.

e. Read and contribute to the Thursday Bulletin, a newsletter that comes out weekly.

f. Use the lending library. Over the years many of our supervisors and counselors have donated books and tapes which are available for your use. If you use the books, sign them out, enjoy them and RETURN THEM. If you have books to contribute, we would greatly appreciate them.

3. After extensive counseling experience, you may be asked to join the Counselor-Applicant Committee. This group interviews applicants and leads Evaluation Groups.

B. Obligations

1. Maintaining a minimum case load of eight (8) clients per week, if you are gaining hours toward licensure, or four (4) if you are a paraprofessional counselor.

2. Attending group supervision each week. Trainees and interns must also attend an additional hour of one-on-one supervision when their caseloads exceed 5 clients or 8 10? clients, respectively.

3. Attending clinical training classes.

4 Attending monthly Saturday workshops. The specific dates are posted in the staff room. Typically, there are 9 Saturday workshops per year. Counselors are required to attend at least 6 in each year of their 2-year commitment, for a total of 12 workshops, minimum.

5. Being involved in the financial stability of the Center by:

a. Paying a monthly administrative fee. The amount for MFT trainees and interns is $70 per month for the first three years. After that time, the fee is reduced to $35.00 per month. For paraprofessionals, the amount is $35 per month. The laws regulating social workers prohibit the charging of administrative fees to social work interns.

b. Collect established fees with clients consistent with the Center's sliding fee scale to avoid client balances. Be mindful of finances as an integral part of clinical work with clients.

6. Keeping up to date concerning Center activities by:

a. Checking your message box in the Front Office. It contains communications from your clients and other counselors, and communiques from the staff.

b. Reading the bulletin board in the staff room for news of workshops and seminars open to counselors, meetings, events and other opportunities for counselor participation.

c. Attending to monthly announcements in supervision by your supervision rep and the results of the monthly meeting with the supervision reps and Clinical Director after the Saturday Workshops. Keep up to date with your supervision representative concerning the periodic meetings with the Clinical Director after Saturday workshops. Attending to weekly announcements by reading on-line the Thursday Bulletin.

d. Checking your voice mailbox at least twice a day, and always before coming to the Center to see clients. Even if you use our voicemail notification service, it is important to check your voicemails regularly because in the rare case that service doesn't work properly. Client cancellation messages will be left on your Center voice mail.

e. Check your personal e-mail daily.

7. Rotating Assignments

c. Intakes: New counselors are on intake duty approximately once a month. (SEE THE INTAKE) Experienced counselors rotate assignment slightly less frequently.

b. Emergency Phone Duty: All counselors are on

emergency phone duty approximately one night or

weekend day every two to three months. (SEE EMERGENCY PHONE DUTY)

c. If you cannot fulfill your obligation at the assigned time on any of these two rotating assignments, you must find a replacement.

1) Exchange with a fellow counselor.

2) Notify the front desk if the replacement is for Intake Duty. Tell the desk who is replacing you.

3) Notify the telephone exchange if the replacement is for Emergency Telephone Duty. Tell them who is replacing you. The exchange telephone number is at the top of the first page of the roster.

C. Non-Fulfillment of Commitment by Counselors

Counselors can be terminated for non-fulfillment of their duties. If you are having a problem with your obligations the staff is always available to help work out difficulties.

D. Miscellaneous

1. We require one year to elapse before a Center therapy client may begin as a counselor.

2. On completing three years as a Center counselor, the monthly administrative fee is reduced from $70 to $35 for those on a licensure track. It remains $35 for paraprofessionals.

CONFIDENTIALITY

A. Client's Right to Confidentiality

Respect for the client's right to absolute confidentiality is essential to the therapeutic relationship.

The client's right to confidentiality is guaranteed under the law and can only be released with the client's written consent. The Center has forms which must be signed by the client to allow for the release of any information. These forms are:

1. Agreement for Exchange and/or Release of Information (SEE FORM #12). This form is to be used when:

    a. The client requests that the Center release information to an outside agency (such as a hospital) or person (such as a social worker). Before releasing any information, consult with your supervisor.

    b. The Center responds to a request from an outside person or agency, such as a hospital, doctor, therapist, insurance company or attorney (SEE THE SECTION, PROCEDURE FOR HANDLING SUBPOENAS AND RELEASES OF INFORMATION).

2. Observation Consent Form. This form gives consent to allow viewing a session through a one-way mirror (SEE FORM #13).

3. Audio/Visual Consent Form. This form gives consent to record or video-tape a session (SEE FORM #14). PLEASE NOTE THAT ALL AUDIO/VIDEO RECORDINGS ARE TO BE ERASED WITHIN 60 DAYS OF THE DATE OF THE RECORDED SESSION.

4. Recorded Session Release Form. This form is used when a client requests an audio or video recording of his/her/their session. It specifies that the Center releases responsibility for the confidentiality of the recording once it has left the Center and that the Center does not keep copies of recordings released to clients. Note that all client participants in a session must sign the release (SEE FORM #14A). PLEASE NOTE THAT ALL AUDIO/VIDEO RECORDINGS ARE TO BE ERASED WITHIN 60 DAYS OF THE DATE OF THE RECORDED SESSION.

In each case, prior discussion with the client should clarify the purpose and use for each release.

B. Exceptions to Confidentiality

1. The Center releases records only when it is in the best interest of the client and/or absolutely required by law. To protect the client under these circumstances, case notes should conform to the guidelines set forth in the section, CASE NOTES.

2. We are required by law to report cases of child abuse, elder abuse and dependent adult abuse to the appropriate agency. (REFER TO SECTION ON ABUSE REPORTS).

3. We are required by law to report threats to commit bodily harm to both the intended victim and to the appropriate law enforcement agency. (REFER TO SECTION ON HOMICIDAL CLIENT).

Violations of Confidentiality

There are more ways of violating a client's confidentiality than the obvious one of discussing a client with an outside source without permission. Some of these are:

1. Removing material from the Center which identifies a person as a Center client. For example:

   a. a. Video and audio recordings -- the most sensitive of recorded material. They may never be taken out for home viewing. PLEASE NOTE THAT ALL AUDIO/VIDEO RECORDINGS ARE TO BE ERASED WITHIN 60 DAYS OF THE DATE OF THE RECORDED SESSION.

   b. Client files.

   c. Intakes or photocopies of intakes.

   d. Letters or photocopies of letters.

   e. Client names and phone numbers (use first names, initials or file numbers instead of full names for identifying telephone numbers you carry with you).

THESE ITEMS SHOULD NEVER LEAVE THE CENTER.

2. Talking about your client within hearing range of other clients.

3. Allowing unauthorized persons to view one-way mirror sessions.

4. Permitting a client to share personal information, thoughts, etc., outside the therapy room. It is important to set a boundary early on with clients that personal conversation is limited to the session. It should not take place in the hallway.

THE INTAKE

A. General

1. All clients begin counseling at the Center with an intake interview. The intake is the client's initial counseling session. The intent of the intake is to create a non-judgmental, caring atmosphere in which the client can present his/her problems as freely as possible. We want the Center to represent an emotionally safe place so that the client will want to return. Keep in mind that this is a one-time visit and that the client may have to wait for assignment to an ongoing counselor who can follow up.

2. The intake counselor's write-up is the primary source of information about the client and becomes a valuable reference for the Client Coordinator to use in making an assignment to an ongoing counselor. Although it rarely happens, because our files can be subpoenaed, please write the report in a sensitive and non-prejudicial way. (SEE GUIDELINES FOR CASE NOTES)

3. Intake hours are posted in the Front Office (Monday through Thursday 6:00 to 8:00 p.m., Saturday 12:00 to 2:00 p.m.). Individual clients are seen on a first-come first-served basis during intake hours. However, family, couple and child intakes are arranged over the telephone with the Associate Clinical Director. Initial meetings with families, couples, and children are done on a first-come, first served basis during FAM (Family Assessment Meeting) hours (Sunday and Monday from 1:00pm to 3:00pm, Friday from 6:00pm to 8:00pm).

B. Intake Procedure and Forms

1. Client

   a. The client checks in at the Front Desk and is given a one-page form to fill out which asks for basic information (SEE FORM #2).

   b. The completed form is returned to the desk and the client waits to meet with the Fee Setter, who sets the fee for

ongoing counseling and receives payment. The client then meets with the Intake Counselor.

2. Counselor

a. The counselor on intake duty must first check in with the Front Desk.

b. The front desk informs the intake counselor when the client is ready for the interview and assigns a room for fifty (50) minutes. Intake sessions will frequently not start on the hour.

a. The counselor is given:

1) The goldenrod form the client has completed (SEE FORM #2).

2) the Intake Counselor's Form. (SEE FORM #3).

3) two Client Information Sheets (SEE FORM #1): one for Center and a copy for the client. Review this with the client(s) to be certain that they understand Center policy and the exceptions to confidentiality.

4) An instruction sheet regarding the counselor assignment process.

C. Intake Interview

1. Individuals

a. Verify the data provided on the client's intake form. Check that it is readable and that the phone numbers are accurate.

b. The fee for ongoing counseling will have already been set by the Fee Setter.

c. Review the Client Information Sheet (SEE FORM #1) with the client so that all the information is clear. Make it clear to the client that signing this form does not give permission for taping or viewing the client. It merely indicates that the client has read and reviewed the information.

d. Review the client's availability on the Client Intake Form. Be sure that the client understands that the more availability squares checked on the Intake Form, the sooner the client will be assigned.

e. In an informal manner, invite the client to define the presenting problem; encourage the client to explore and focus on the specific incident/s that triggered his/her coming in for counseling now. Discuss the services available here at the Center as they relate to the issues and dynamics that brought the client in (e.g., individual, group, couple, family counseling, The Abuse Prevention Program (TAPP), parenting classes, Rage Resolution, Teen Violence Prevention group, LGBTQ Teen group, Women in Transition group).

f. Explore background of family, social or work relationships.

2. Couples/Families: Because couple and family intakes are arranged through the FAM, you will not see couples or families as an intake counselor.

3. Children: As with families, intakes for children are generally arranged through the FAM process. However, adolescent children may present themselves for an intake during walk-in hours. In that event, your packet of intake forms should include the following forms:

   a. Consent for Treatment for Minor, to be signed by the child's parent(s) or the person(s) who have legal authority to make healthcare decisions for the child. If the person(s) signing the consent is/are either (1) the parent of the child and legally separated or divorced from the child's other parent, or (2) not the parent(s) of the child, a copy of the document, or portion thereof, which authorizes the signing party(ies) to make

healthcare decisions for the child must be attached to the consent form.

In the event that (1) the child appears for intake alone, or (2) the person accompanying the child does not have the authorizing documents with them, or (3) the person accompanying the child is not the person with the necessary legal authority, simply clip the blank consent form to the intake. Either staff or the counselor to whom the adolescent is ultimately assigned will follow through with completing the documentation.

b. Consent by Minor for Treatment, to be signed by the child in lieu of the Consent for Treatment for Minor (above), if one of the legal

exceptions to parental consent listed on the form applies. [See Forms 18 and 19, the section, COUPLES, FAMILIES AND CHILDREN.]

D. The Intake Write-up

1. Intake reports must be written the same day andgiven back to the Front Desk. Intakes on suicidal or homicidal clients, or intakes in which child abuse has been suspected, should be "flagged" so that the Coordinator can spot it for immediate attention. (REFER TO SECTIONS ON SUICIDE, HOMICIDE, AND ABUSE REPORTS.)

2. The "recommendations" section of the intake form should be kept simple,
i.e. male or female counselor, etc. A too specific recommendation will make it difficult to assign the client. Discuss any recommendations with the client.

E. Intake Fee Setting

1. The fee for ongoing counseling will have already been set by the Fee Setter.

2. Fee payment and receipt. (SEE FEE SETTING SECTION OF

PROCEDURE FOR ONGOING COUNSELING.) IF THE CLIENT DID NOT BRING
money with them to pay for the intake s/he should pay the next time s/he
comes to the Center.

F. Clients in Crisis

1. If a client is seriously suicidal or homicidal, the intake counselor is responsible for maintaining phone contact with that client until an ongoing counselor is assigned. New counselor supervision and the clinical training class will provide detailed discussion of related legal and ethical issues. (SEE SECTIONS, SUICIDAL CLIENTS AND HOMICIDAL CLIENTS.)

2. If hospitalization is indicated, the intake counselor should consult with available staff.
3. ALL COUNSELORS are encouraged to ask for help from the Front Desk, from staff, supervisors, and other counselors in the Counselor's Lounge. If the help you need is not readily available, clinical staff and supervisors should be called. Their phone numbers can be found at the Front Desk and on the staff roster.

G. Intake Fee Setting

1. The fee for ongoing counseling will have already been set by the Fee Setter.

2. Fee payment and receipt. (SEE FEE SETTING SECTION OF PROCEDURE FOR ONGOING COUNSELING.) IF THE CLIENT DID NOT BRING
money with them to pay for the intake s/he should pay the next time s/he
comes to the Center.

H. Clients in Crisis

1. If a client is seriously suicidal or homicidal, the intake counselor is responsible for maintaining phone contact with that client until an ongoing counselor is assigned. New counselor supervision and the clinical training class will provide detailed discussion of related legal and ethical issues. (SEE SECTIONS, SUICIDAL CLIENTS AND

HOMICIDAL CLIENTS.)

2. If hospitalization is indicated, the intake counselor should consult with available staff.
3. ALL COUNSELORS are encouraged to ask for help from the Front Desk, from staff, supervisors, and other counselors in the Counselor's Lounge. If the help you need is not readily available, clinical staff and supervisors should be called. Their phone numbers can be found at the Front Desk and on the staff roster.

THE RE-INTAKE

A. Definition

Any unscheduled visit after the initial intake is called a re-intake. Re-intake applies to:

1. Clients not yet assigned to a counselor who need support while they are waiting.

2. Ongoing clients who are in crisis, or clients whose counselors are on vacation, may be encouraged by their counselor(s) to come in for re-intake as a support system. Counselors wanting this for their clients must notify the Front Desk.

3. Former clients returning for a single session or to resume counseling within six months of their last visit.

B. Procedure

1. For unassigned or ongoing clients, write up a brief description of the session on the Re-intake Form (SEE FORM #7) and give it back to the Front Desk. If the re-intake sounds like a crisis, notify the client's counselor immediately.

2. Clients waiting to be assigned pay the fee established at the initial intake.

3. Ongoing clients pay the same fee as for a regular visit.

4. A fee for former clients should be set following the same procedure for new clients.

PROCEDURES FOR ONGOING COUNSELING

A. Taking Individual Clients

1. Unless special arrangements are made with the Client Coordinator, your individual clients will be selected for you by the Client Coordinator.

    a. Notify the Client Coordinator of the days and times you are available to see clients (a form is available for this purpose), and you will be assigned a client(s).

    b. Before requesting a client, secure a room hold by using the CRAWL (Counselor Room Assignment Waiting List) book.

    c. The Associate Clinical Director and Client Coordinator are available to discuss your interests or special needs in client selection.

2. Once a client has been assigned to you, the Client Coordinator will notify you with a voicemail. You will then call the client to set the date of the first session, and then contact the front desk and ask them to put that client into your room hold.

3. Following your first session with a client, please take the Intake Form out of the "Individual Clients" book and give it to the Front Desk so that a file can be created and a file number assigned.

NOTE: There is a separate procedure for taking couples and families, which you will learn about when you begin the Family Therapy portion of the training program (See also COUPLES, FAMILIES AND CHILDREN section).

B. Guidelines for Case Notes (See also CASE NOTES section.)

1. All counselors must keep case notes in the client's file. Notes must be made for each session, dated and signed by the counselor. Client files are randomly checked by staff twice a year.

2. No document of any kind should leave the building which identifies any client of the Center. Any lists of phone numbers or personal notes which you may keep should not contain client names (initials or file numbers can be used instead). Names should be "whited out" of copies of case notes made for supervisors.

C. Room Assignment

1. Rooms are assigned by the Front Desk. Assignments are listed on the large Front Desk calendar and carried over to the same time each week unless a change is communicated to the Front Desk. Please inform the Front Desk of any changes in your schedule.

2. A room is assigned for 50 minutes only. The 10 minutes between sessions eases the transition for the following counselor. Any exception to a 50-minute session must be cleared with the Front Desk. DO NOT USE AN EMPTY ROOM WITHOUT CONSULTING THE FRONT DESK.

3. If the door is closed to a room when it is your hour to use it, KNOCK. Wait for the counselor to acknowledge or vacate the room. If the problem persists, discuss it with the counselor in private and bring it to the attention of the Front Desk.

4. Please make sure that room doors are left open when you leave. A closed door sends a message to the next counselor that the room is still in use.

D. Cancellations and "No Shows"

1. A client is not charged for a cancellation if it is made at least 24 hours ahead of time. When a client cancels 2 hours or less before a session, the Front Desk makes every attempt to notify the counselor.

2. Counselors who cancel an appointment must notify BOTH the client and the Front Desk. A counselor should not consider an

appointment to be cancelled until confirmation from the client has been received.

3. Clients who miss appointments without notifying the Center are listed as "No Show" and are charged for the appointment. Clients who persistently do not show up or cancel frequently should be discussed in supervision.

   After discussing it in supervision, counselors who decide to terminate a client because of lack of attendance should contact the client by mail if the counselor is unable to reach the client by phone.

E. Late clients

1. Clients who consistently arrive late for sessions should be discussed in supervision.

2. Counselors should be prepared to wait the full 50 minutes for a late client.
   It is Center policy that the “hour” belongs to the client. This can be aggravating when the client does not show up at all for a session. Use supervision for support and guidance in addressing the issue with the client.

F. Counselor no-shows.

1. In a perfect world counselors would never miss a scheduled session without the client being informed well in advance. However, once in a great while it does happen despite every effort to avoid it.

2. The client will not be charged for the missed session. If a make-up session can be scheduled during the same week, the client is not charged for that session either. If not, the client is charged for all subsequent sessions as usual.

3. The counselor should provide an opportunity for the client to process their reactions to the counselor’s no-show in session at the first appropriate opportunity. Some clients may be reluctant to express their feelings. The counselor’s non-defensive openness

and acceptance is critical to creating the environment in which disclosure can happen.

4. Use supervision to discuss your own feelings and reactions and to get support with any issues that may have contributed to the no-show.

G. Fee Setting and Follow-up

Collecting fees and inviting meaningful conversations about money with clients is complicated and fraught with political, emotional, psychological, clinical and business implications. The fee schedule used by the Fee Setter is designed to be both reasonable and fair to the clients and practical enough to support the Center. The Center depends on fees for at least half of its operating expenses.

The subject of money usually raises personal issues for both clients and counselors. Supervision should be used to discuss the clinical implications of feelings associated with collecting fees.

1. Ongoing Fee

   a. The ongoing fee is set by the Fee Setter during the intake process. The Fee Review Committee (see below) process is available for clients who believe that they have special circumstances that require a fee adjustment.

   b. Fees are set according to the client's monthly "gross income" and number of dependents. "Gross income" is the client's salary (or other income) before taxes and withholding, plus any additional sources of income or subsidy (e.g., rent or school expenses paid by parents or scholarship, etc.). Savings and other assets are considered as part of income as well, especially if the client is unemployed. Clients whose income varies from month to month are asked to review their income over the past 6-12 months and arrive at an average income.

   c. If and when a client's income changes (either up or

down), the counselor will reset the fee according to the fee schedule and consult with either the Client Coordinator or the Fee Setter to ensure accuracy.

d. The fee for more than one session in a calendar week on an ongoing basis is the usual per-session fee. Any reduction in the fee would need to be requested by application to the Fee Review Committee.

e. Keep in mind that a fee properly set will avoid problems in the future.

f. Ongoing fees are raised on March 1 each year. Clients who pay $30 or less have their fee increased by $1; clients who pay over $30 have their fee increased by $2.

2. Fee Review Committee

Sometimes clients have extenuating circumstances which make it unrealistic to pay the fee determined by the fee schedule. The Fee Review Committee reviews these cases.

a. If a client requests a fee lower than that indicated by the schedule, have the client fill out the "Request for Modified Fee" form. Stress the importance of providing full and accurate answers to all of the questions, including copies of the requested documentation, to expedite consideration by the committee (incomplete forms will be returned). Put the completed form in the “Fee Review” box.

b. Fee Review Committee meetings are held on Thursdays at 3:00 p.m. Counselors who would like to present their client's request to the committee personally are welcome to do so.

c. The committee considers extraordinary expenses such as

major medical and dental bills, student loans, child care, alimony, and child support but usually not things like mortgages, car loans, credit card debts, etc.

NOTE: The Fee Review Committee does not review fees as a result of a change in a client's income. As noted above, the counselor should re-set the client's fee and notify the Client Coordinator or a Fee Setter when the client's income increases or decreases.

H. Fee Payment and Receipt

1. The Center operates on a pay-as-you-go basis. Sessions should be paid for at the beginning or end of each session, unless other arrangements (e.g. monthly payments) are made with the counselor. Clients may pay in cash, by personal check, or by credit card or debit card. There are books of receipts in each room and at the Front Desk.

   Receipts must be prepared for all individual, couple and family sessions whether or not payment is made at the session- even if the client has a credit balance - since receipts are used by the Front Desk to confirm attendance. Receipts should also be prepared when a client no-shows. Check "no-show" on the receipt and place it in the basket on the Front Desk. (Receipts for clients in groups need be given only for actual payment, since each client's attendance is recorded in the group folder by the leaders. SEE GROUPS SECTION.)

   a. The receipt should be filled out completely in each session, with date, client's name (please include last name), how much was paid in cash, check, or credit card, or, if the client does not make payment, a check should be placed above "No money received." Please indicate in the box the number of clients in the session and print your name.

   b. Give the client the carbon (yellow) copy.

   c. Paper clip the cash and/or check to the original (white) receipt and deposit it in the basket on the Front Desk immediately after the session.

d. If the client is paying with credit or debit card, give them both copies of the receipt and have them present it to the Front Desk for payment.

2. The receipts use NCR paper, so the carbon is built into it. The receipt book contains a flap which you need to use to prevent the impression of the pen from running through to other receipts - PLEASE - Do Not Tear This Flap Off For Any Reason - it makes the book useless.

3. Counselors are responsible for making change. Please give any bills you need changed to the Front Desk. Attach the cash payment to the receipt with a paperclip and give your client the change. Please note that SCCC does not take $100 bills.

4. Please do not accept coins. If coins are taken, please change them for dollars using the money from the snack basket.

5. It is good practice to keep your own record of each client's payments in their file. "Fee tracking" forms for this purpose are available behind the front desk on the shelf labeled "Client/File/Counselor". This practice will help you and your client avoid building up a fee balance.

6. Other details of note

a. We can only accept payment in whole dollar amounts (even by check).

b. The above procedure for collecting fees and writing receipts applies to all sessions and counselors.

I. Counselor Vacations/Time away

1. As soon as you know you will be away from the Center, fill out a Vacation Form and put it in the labeled box on the Front Desk.
2. When you will be away from the Center for a

vacation or some other purpose and will be unreachable, ask another counselor (often this is someone in your supervision group) to "cover" your caseload. The covering counselor will be available in case one of your clients has an emergency and needs to meet with a counselor. The option of having a re-intake is also available to your clients while you are away, but their first option is to contact the covering counselor. The purpose of the covering counselor is not to provide regularly scheduled sessions in your absence. Give each of your clients an SCCC business card with the covering counselor's name and extension.

J. Communication with Clients

1. We live in an age of unprecedented ease of communication.

However, strict guidelines govern therapists in the use of electronic communication.

a. Telephones – The Center does not allow counseling by telephone except under certain exceptional circumstances. Permission from a supervisor or staff member is required before conducting a session by telephone. If such a session is conducted, it should be done from the Center if possible. If it is done from an off-site telephone, that telephone number should be blocked.
If your client is outside the State of California, you may only conduct telephone sessions if approved by your supervisor AND the client
remains a resident of California who is temporarily out of state
OR under some emergency circumstances.

i. Cellular Telephones – Personal

cell phone numbers are not to be given to clients. The best policy is to use Center telephones to contact clients; next best is to use an off-site telephone with your telephone number blocked.

b. Use of Email and Text Messaging – Email communication and text messaging with a client is strongly discouraged,. Giving your cell phone number or email address to your clients opens you up to additional boundary issues that need to be carefully considered. If you do communicate by text or email, the communication should be limited to matters of scheduling. Be aware that texting with clients means clients will have your personal cell phone number unless you use a service such as Google Voice. It is important **to avoid conducting therapeutic conversations by email or text. In most circumstances** the confidentiality of email and text communication cannot be guaranteed.

c. Social Networking Websites such as Facebook, Instagram, Twitter, etc. – Be aware that any information about you that is generally available online is also available to your clients. Therefore, you should be sure that your internet presence is restricted to those persons with whom you are personally and ethically comfortable sharing details of your personal life. Discuss with your supervisor any decision to view a client's social networking site.

THE SUICIDAL CLIENT

Regardless of one's own philosophy about suicide, it is assumed that a client who comes to the Center is asking for help NOT to kill him or herself. In all cases of suicidal risk, a clinical staff person and/or your supervisor must be involved. You are encouraged to ask for the help and support of other counselors, staff and supervisors as needed.

A. Definition

1. The term "suicide" encompasses a wide range of self-destructive behavior. It includes non-lethal self-injury, such as accident proneness, withdrawal from friends, quitting a job, severe change in eating patterns, threats and other statements of intention toward self-destruction -- to the final definitive act of self- induced death.

2. Suicidal potential ranges in seriousness from mere thoughts to serious intent, and each person requires individual, careful evaluation to determine their level of risk.

3. The suicidal person is usually in the midst of a crisis. The principal factors are the overwhelming significance of an intolerable situation and feelings of hopelessness and helplessness. The presence of these feelings forces the person toward some action for immediate resolution, such as a suicide attempt.

4. The relationship between and the relative strength of the two opposing impulses to live and to die will vary for each individual. It is the ambivalence which makes suicide prevention possible.

B. Evaluation of Suicidal Potential

1. It is vital to make a clear assessment of risk and lethality. A client is considered suicidal if any of the following are noted in the interview:

   a. The suicidal method is clear and the means are at his/her disposal. The lethality and availability of the chosen suicidal method are probably the most significant criteria of suicide potentiality.

b A definite time for the suicidal act is fixed in the client's mind.

c. The client has already made a recent attempt.

d. The client has taken care of unfinished business, returned borrowed objects, said goodbye to friends.

e. Suicidal themes recur during the interview.

f. The client is unwilling to make a contract not to harm him or herself.

After making an assessment of the probability of risk and lethality. IF THERE IS ANY DOUBT ABOUT THE LEVEL OF RISK OR LETHALITY, ASK FOR HELP!

C. Basic Principles of Suicide Prevention

1. Suicidal clients will arouse feelings of anxiety and self-doubt in the counselor as to their adequacy to handle the critical situation. While a moderate level of anxiety is appropriate, too much may seriously hamper the counselor. FEEL FREE TO CALL ANOTHER COUNSELOR OR STAFF MEMBER INTO THE SESSION!

2. Establish a relationship. Be patient, interested and self-assured. Communicate to the client that coming to the Center was a good step and that his/her presence here indicates a desire to be helped.

NOTE:
If you find yourself becoming overly involved in the client's distress, your first impulse may be to talk the client out of the seriousness of the situation. DON'T! This serves to negate the client's own perceptions.

3. Identify and clarify the problems.

a. The client in crisis often displays disorganized thoughts. The counselor can help the client clarify the problem by:

1) Finding out why now -- what is the precipitating event?

2) Broaden the discussion to include feelings of hurt, anger and resentment, which usually underlie suicidal ideation. Ascertain whether these feelings are directed at a specific person -- this may lead you to the central issue.

3) Get the client to visualize the effect of his/her death on others. A helpful technique is to ask who would attend the funeral and how the people would respond to his/her death, who would miss the client, etc.

4. Assess Strengths and Resources

a. The counselor's connection with the client is an important resource.

b. Determine what outside resources the client has, such as friends, relatives or co-workers, and encourage the client to make contact with them.

5. Educate the client about other available resources such as suicide prevention hotline numbers and voluntary hospitalization. This information is available to you at the front desk and in the resource book in the front office. The Suicide Prevention Center hotline is (877) 727 – 4747.

D. Formulating a Therapeutic Plan

1. Ask for a written or oral contract (SEE FORM #8) which includes:

a. The length of time the client feels confident s/he won't harm him/herself.

b. A commitment to make direct contact with the counselor if the client considers taking harmful action. IT IS THE RESPONSIBILITY OF THE INTAKE COUNSELOR TO MAINTAIN REGULAR CONTACT WITH THE CLIENT UNTIL S/HE IS ASSIGNED TO AN ONGOING COUNSELOR. Insist on a commitment from the client regarding a time and place for telephone contact beginning the next day. The client may welcome and need specific directives because it can help his/her thinking become less disoriented.

c. The client's consent for the counselor to contact persons who may be able to be with the client during this crisis period.

d. The Suicide Prevention Hotline (877-727-4747) and any other appropriate resources.

e. If possible, activities the client can engage in that help them to feel better and people that they can reach out to for support and companionship.

2. If the client has a weapon or medications which he/she is threatening to use, or may be tempted to use to harm him/herself and/or others, deal with them in the contract. Although the contents of the contract will vary with the facts of each case, some possibilities are:

a. A promise not to use the weapon or take the pills for a specified period of time (e.g., before your next appointment with the client, to

be renewed from session to session for as long as needed for the client's safety);

b. If the weapon is a gun, a promise to keep it or the ammunition in an inaccessible location (e.g., a safe deposit box at the bank, or a locked safe or drawer to which someone else, not the client, has the key);

c. If the concern is that the client may overdose on medications, and the medications are not otherwise needed for a serious or life threatening illness or condition, a promise to flush the pills down the toilet;

d. A promise to give the weapon or pills to another person for safekeeping and not to ask for them back until the counselor and client together agree that the client is out of danger. Or, if the pills in question are prescribed by a doctor and are needed for a serious or life threatening illness or condition, a promise to give them to another person who will dispense them to the client as called for in the prescription (e.g., one three times a day) so that the client never has a lethal dose in her/his

possession. Contracts with these provisions could be negotiated with the other person present. I.e., the counselor would ask the client to bring in a friend or relative who is willing to act as custodian and the contract would be agreed to and signed by both the client and the custodian. Never act as custodian for weapons yourself.

NOTE: Bringing in or contacting another person involves breach of confidentiality, and should ordinarily only be done after consulting with your supervisor or a clinical staff member to confirm the appropriateness of the breach. Whenever possible, the client's cooperation in bringing in the person should be enlisted and written consent should be obtained from the client.

3. Notify the Clinical Coordinator of the urgency of this client.

4. It may be helpful to augment the intake counselor's contact with the suicidal client with re-intakes. If necessary, a specific appointment time may be made.

E. If the client refuses to make a non-suicidal commitment, hospitalization -- either voluntary or involuntary -- may be necessary.

1. Voluntary Hospitalization

a. Referral sources are available at the front desk.

b. Enlist the assistance of friends, relatives, etc. If necessary, a taxi may be called. For liability reasons, DO NOT TRAVEL WITH THE CLIENT TO THE HOSPITAL.

Involuntary Hospitalization. Enlist the aid of the Front Desk for appropriate interventions, i.e. police, Psychiatric Emergency Team (PET), etc.

THE HOMICIDAL CLIENT

(the client threatening harm to another)

Center policy: In all cases of homicidal risk, a staff person and your supervisor must be involved in the process. You are encouraged to ask the help and support of other counselors, staff and supervisors as needed.

This section will discuss those clients who have intent to murder or to commit grievous bodily harm. As with suicide, the client who talks about his/her desire to harm another person may have ambivalence about that desire and may want to be influenced away from that action. The counselor's ability to accept the client in spite of their homicidal ideation can facilitate the client's honesty about his/her intention, including any ambivalence. It is crucial that the counselor assess the risk.

A. Assessment.

Angry feelings are human. An assessment is required to determine if risk to another is imminent. The assessment of homicidal risk is, in many ways, similar to that of suicidal risk. Counselors should assess the following:

1. What was the event that precipitated homicidal feelings?

2. Has the client formulated a specific plan to commit murder or harm another person?

3. Has s/he taken any action to implement this plan, such as procuring a weapon?

4. Has s/he had similar feelings in the past, and how were they handled?

5. Is there a family or personal history of murder or violence?

NOTE: A direct question may be included as part of the assessment, i.e., "Are you going to do this?"

B. Response to Imminent Threat

1. For Center policy regarding weapons in the client's possession, see the previous section on THE SUICIDAL CLIENT.
2. Respect the client's physical space.

3. Assure the client of your awareness of his/her ambivalence about controlling the homicidal impulses. For example, tell the client, "I'm concerned about you. At this time you need help in restraining yourself. I believe you want help or you would not have come here and told me."

4. Ask for a non-homicidal contract for the length of time the client feels confident s/he won't harm him/herself or others. (See THE SUICIDAL CLIENT for guidance.)

5. If the client is unwilling to make a non-homicidal commitment, the law requires that potential victims must be warned and the police notified. Hospitalization may also be necessary.

    a. Voluntary Hospitalization

        1) Referral sources are available at the front desk.

        2) If appropriate, enlist the assistance of client's friends, relatives, etc. A taxi may be called.

        3) For liability reasons, DO NOT TRAVEL WITH THE CLIENT TO THE HOSPITAL.

    b. Involuntary Hospitalization. Enlist the aid of the front desk for appropriate interventions, i.e. police, Psychiatric Emergency Team (PET), etc.

6. Notify the Clinical Coordinator of the urgency of this client.

C. Duty to Warn

UNDER ALL CIRCUMSTANCES, the law requires that the potential victim and the police be informed when a life is threatened. Record in detail your compliance with this requirement, including who was warned, what was said, and the specific times involved. Have a staff person sign the documentation which will be kept in the client's file. Send a copy of the documentation to the police department. Once again, involve staff and supervisor.

SOUTHERN CALIFORNIA COUNSELING CENTER

WEAPONS POLICY

The Southern California Counseling Center does not allow weapons of any kind on the premises. If a person brings a weapon into the building they are to be asked to leave the weapon in their car. If they do not have a vehicle or are unwilling to leave the weapon in the vehicle, they will be asked to leave and return without the weapon.

In the State of California, open carry of loaded or unloaded firearms in public is generally prohibited. Personal possession (i.e., carry) of a loaded firearm is prohibited in incorporated areas (such as inside city limits) or prohibited areas of unincorporated territory without a license to carry or other exemption provided for by law.

EMERGENCY TELEPHONE DUTY (ETD)

A. General

The purpose of ETD is to provide a counselor for Center clients who feel some urgent need to talk to someone, after hours, when their own counselor is unavailable.

B. Scheduling

All counselors are scheduled for ETD on a rotating alphabetical basis.

1. The emergency telephone schedule is distributed monthly and a copy is provided to the Center's exchange. The exchange also has a current Center roster which lists counselors' phone numbers.

2. The schedule is in effect at all times when the Center is closed, including Sundays and holidays.

3. It is the responsibility of counselors who are unable to keep their scheduled times to find a substitute and notify the exchange of the substitution. The exchange telephone number and our code are listed on the first page of the Center roster.

4. Counselors who may not be at their home numbers during their scheduled time must notify the exchange of a number where they may be reached.

C. Procedures

1. When the exchange receives a client call they will try to connect the client to their assigned counselor. If the counselor is unavailable and the client wants to talk to someone, they will call the ETD counselor, tell them who is calling, and then connect the caller to the counselor through the switchboard.

    a. When the exchange calls, check to see that they have tried to reach the assigned counselor. If so, proceed with the call. Start by asking the caller to give his or her telephone number and address. For instance, you may say, “I want to make sure that I can reach you in case we get cut off. Where are you now and what is your phone number?” A reasonable amount of time, given the client's needs,

should be spent

on a call but remember, this is an emergency service so use some judgment about the length of the call.

b. If the person is having suicidal thoughts, deal with it as you would an intake. Try to get them to give you a verbal contract not to harm themselves and to contact the Center ASAP during regular business hours. Speak to them about resources they have that will help them develop a safety and support plan. Inform the Front Desk as soon as you can to expect a call from the client.

c. If the danger seems immediate and deadly, try to get an address or telephone number if you have not done so already. Then call 911, identify yourself as a counselor, and give them whatever information you have and your estimate of the urgency.

d. The assigned counselor should be informed of the call as soon as is practical.

e. If the call is from a client who has not yet been assigned, a note should go to the Clinical Coordinator.

2. Sometimes the exchange receives a call from someone who is not a Center client but appears to be in great distress. The exchange may refer them to Suicide Prevention but, more likely, they will refer the call to the ETD counselor.

a. If the person is having suicidal thoughts, deal with it as you would an intake. Try to get them to give you a verbal contract not to harm themselves and to contact the Center ASAP during regular business hours. Speak to them about resources they have that will help them develop a safety and support plan. Inform the Front Desk as soon as you can to expect a call from the client.

b. If the danger seems immediate and deadly, try to get an address or telephone number if you have not already done so. Then call 911, identify yourself as a counselor, and give them

whatever information you have and your estimate of the urgency.

SUPERVISION

A. General

1. Supervision of counselors by licensed professionals is required by law. It is mandatory that counselors attend weekly supervisions. Supervisors volunteer their time unless they are on staff.

2. Supervision is both training and case supervision. Theory and techniques are taught and discussed within the context of the counseling session.

3. Supervision affords counselors the opportunity to explore their reactions to clients and develop an understanding of how this plays a part in the progress of the counseling.

4. Supervision provides an intimate milieu for sharing information, ideas, problems and anxieties with your peers, under professional guidance.

B. Supervision Requirements

1. California law defines supervision requirements for trainees and interns. Trainees and interns share responsibility with the Center for keeping abreast of these legal requirements.

2. All counselors must attend weekly group supervision. Acceptable absences are for illness, personal crisis or vacations about which the supervisor has been notified in advance.

3. There are additional requirements for group and/or individual supervision for counselors who see couples and families, lead groups or carry caseloads larger than 5 for trainees or 10 for interns and paraprofessionals. When adding additional supervision, such as an individual supervisor, the counselor divides his/her caseload between those clients being supervised by the individual supervisor and those being supervised by the group supervisor. Required BBS

paperwork is completed separately for and by each supervisor, including signing for the specific hours supervised by each supervisor.

C. Selection and Rotation of Supervision

It is the Center's intention to expose counselors to a variety of therapeutic orientations and practices. Supervisors bring insights and knowledge from their own particular orientations. Counselors add to their knowledge and understanding and find their own style by participating with a variety of professional practitioners. In order to accomplish this, all counselors change supervisions in the fall of each year.

1. In summer each year, written procedures for indicating supervision preferences for the next supervision year are distributed by the Clinical Director.

New supervision groups are posted in the staff room after the process is complete.

GROUPS

A. Center Requirements for Establishing and Leading Groups

1. The Center encourages counselors to establish and lead groups in areas of interest to them. We ask that each group have two counselors acting as co-leaders . .

2. If a counselor has an idea for a group, we ask that they bring it to the attention of the Clinical Director or Associate Clinical Director, who will request the following:

    a. A written curriculum for the group;
    b. Whether it will be a fixed number of weeks or a drop-in group;
    c. Whether there will be a fee and, if so, how much and how it will be collected;
    d. A screening procedure, if any, for potential group members;
    e. How the the two group leaders will receive supervision for the group;
    f. The day and time of the group, approved by the Front Desk staff.
    g. A plan for publicizing the group: this can include a notice in the Thursday Bulletin and on the bulletin board of the Counselors' Lounge and Clients' Waiting Room, an e-mail blast to Center mailing lists, visits to group supervisions to discuss the new group, postings outside the Center, etc.

3. Group fees for clients whose only form of therapy at the Center is group are set according to the Group Fee Schedule.

4. The group fee for clients who have both individual and group counseling is double the weekly individual fee per month.

COUPLES, FAMILIES AND CHILDREN

A. Center Requirements for Working with Couples, Families and Children

1. In general, enrollment in the Center's Family Therapy Training Program (FTTP) is a pre-requisite to seeing couples, families and children. The program involves a one-year commitment and begins in the Fall of each year. Exceptions to this general rule may be made on a case-by-case basis by the Clinical Director.

2. Counselors working with couples, families and/or children must also attend weekly Family Supervision, which includes supervision of individual cases as well.

B. Procedure for Taking Couple, Family and Child Clients

1. Counselors enrolled in the FTTP can request couples, families, and children using a blue “Counselor Availability” sheet.

2. Most assignments of couples, families, and children will happen during the FAM (Family Assessment Meeting). It is important to keep your availability up-to-date with the Client Coordinator.
3. Clients with availability that matches with a counselor are assigned during the FAM. Counselors are notified by a FAM counselor of the date and time of their first appointment.

C. Procedure for Clients

1. Couples, families, and children come in during our walk-in FAM hours.

2. Individual clients may access couple, child or family counseling through their individual or family counselor. After discussing the client's request in supervision, the counselor fills out the Request for Reassignment or Additional Counseling form and gives it to the Client Coordinator. If an individual client begins couple or family counseling in addition to individual counseling, it is important to consider and discuss in supervision whether individual sessions

should be temporarily discontinued. (SEE also SECTION, PROCEDURE FOR COORDINATION OF MULTIPLE CLIENT SERVICES.)

3. Generally, the consent of the parent(s) or other person(s) having legal authority to have healthcare decisions for the child is required to provide counseling to minors (under 18).

4. Exceptions:

5. A minor who is 12 years of age or older and, in the clinical judgment of the counselor, is mature enough to intelligently participate in the counseling, may consent to outpatient counseling if the therapist determines that there is a good reason not to involve the parents. In such a case, the therapist who decides to treat is required to make a "specified entry" into the treatment record as to why parental involvement or knowledge of the minor's treatment would be inappropriate.

    a. A minor who is "emancipated" may consent to counseling on their own. A minor is emancipated if any of the following apply:
        i. The minor is or has been (now divorced) legally married,
        ii. The minor is on active duty with the U.S. Armed Forces, or
        iii. The minor has been declared emancipated by a court.

    A minor who purports to be emancipated must be able to produce proper documentation (marriage license, divorce decree, court order declaring the minor emancipated, identification from a branch of the armed services, etc.

Minors who meet the requirements for consenting to treatment themselves must sign a "Consent by Minor for Treatment" form.

ABUSE REPORTS

Counselors are mandated by law to make reports in cases of suspected child abuse and elder or dependent adult abuse. Even though confidentiality will be breached, of necessity, in such cases, counselors are protected by law from legal action. The following is intended to be a guideline for abuse reporting; however, we strongly urge you to use good judgment and, if you have any reservations or questions, use staff and supervisors for consultation. An inappropriate report may create severe stress for a struggling family.

A. Child Abuse

1. "Child" is defined as younger than 18 years.

California law requires that known and suspected cases of physical or sexual abuse, severe neglect and emotional abuse be reported when "one acquires knowledge of or observes facts which give rise to a reasonable suspicion." [Penal Code Section 11165 (a)] "Reasonable suspicion" is what a person with your level of training and experience could reasonably be expected to suspect is occurring or did occur under the circumstances. California law also requires mental health workers to report the knowing use or sharing of child pornography.

2. There is no duty to investigate beyond what can be determined in the therapy room. If you are unsure whether something is reportable, call the Child Abuse Hotline (see below) to consult.

3. Suspected cases of child abuse must be reported immediately by phone to the Department of Children and Family Services (800/540-4000) and a written report must be submitted within 36 hours. Forms are located behind the front desk. CONSULT WITH SUPERVISOR OR CLINICAL STAFF BEFORE MAKING REPORT.

4. Adult survivors of childhood abuse: Unless the client is under 18 years, there is no mandate to report. However, the counselor should be alert to the possibility that the abuser may be currently victimizing other children and should enlist the client's aid in gathering information to report that abuse. (Association for Advanced Training, 1989, Law and Ethics).

5. If possible, involve the client in the reporting by making the report during a session with the client. Be aware that a report is likely to increase the client's anxiety, so be prepared to process the client's reactions (anger, betrayal, fear, etc.) and offer whatever support is

needed.

B. Elder and Dependent Adult Abuse

1. An "elder" is anyone 65 years of age and over.

2. A "dependent adult" is anyone 18 to 64 years of age who is dependent upon others due to physical or mental disability, or who resides in a 24-hour health facility.

3. California law requires that known and suspected physical abuse, sexual abuse, abandonment, isolation, abduction, financial abuse, or neglect (including self-neglect) of an elder or dependent adult be reported immediately or as soon as practically possible to the Elder Abuse Hotline (800/992-1660) or police. A written report must also be made within 2 working days.

4. "Suspected" abuse means that a reasonable therapist, under the circumstances known to her/him, would suspect that abuse was occurring. This is the same standard as for child abuse reporting. As with child abuse, there is no obligation to investigate to determine whether abuse is actually occurring.

5. Reports of mental abuse may be reported after conferring with staff or your supervisor. It is empowering to involve the client in the reporting.

NOTE: Reporting instances are stressful for counselors as well as clients. Staff and supervisors must be involved in the reporting process and will support and assist you.

PROCEDURE FOR HANDLING SUBPOENAS AND RELEASES OF INFORMATION

A. Definitions

1. A subpoena is a document issued by the court requesting a) a person's appearance to testify in court or at a deposition, b) documents that are named in the subpoena, or c) both.

2. A release of information is a form requesting information about a client (e.g., copies of notes, information over the phone or at a deposition). You may receive such a release from an attorney, an insurance company, another therapist or a doctor. (This section covers cases where the Center receives a release directly from an outside source, rather than where the client requests the Center to release information.)

B. What to do if you are served with a subpoena in connection with a lawsuit involving a client:

Most subpoenas are served on the Center, as such, and so will not come to you personally. However, a process server may come to the Center and deliver a subpoena to you. If you are served directly, give the subpoena to the Associate Clinical Director. If the Associate Clinical Director is unavailable, give it to the Clinical Director. They will forward it to our attorney who will handle it from there. DO NOT ATTEMPT TO RESPOND TO A SUBPOENA YOURSELF.

C. What to do if you receive a release of information:

1. If the release is sent by an attorney, follow the same procedure as you would with a subpoena, i.e., give it to the Associate Clinical Director or the Clinical Director, in that order, depending on their availability.

2. If the release is sent by anyone other than an attorney, consult with the Associate Clinical Director or the Clinical Director, in that order, as to the next step.

Any phone calls that you may receive concerning a subpoena, a release of

information in connection with a lawsuit, or any other matter having to do with a lawsuit in which a client is involved should be referred to the Assistant Clinical Director or the Clinical Director. DO NOT RESPOND TO THE CALL YOURSELF.

SOUTHERN CALIFORNIA COUNSELING CENTER

PROVIDING REPORTS FOR MANDATED CLIENTS

Mandating agencies (usually a court, school, probation officer or the Department of Children and Family Services ("DCFS")) often want to verify that the client has attended counseling or that the counseling has addressed specific issues. The Center's general policy is to provide attendance reports or letters in accordance with the wishes of the client. This may be the "Client Attendance Report", which reports attendance only, the "Client Participation Report", which includes a checklist of general topics covered in therapy, or a progress letter that summarizes what occurred in therapy. ALL FORMS AND LETTERS MUST BE SIGNED BY BOTH THE COUNSELOR AND A SUPERVISOR,
CLINICAL STAFF MEMBER, OR (in the case of attendance reports)
FRONT DESK STAFFMEMBER.

A. When an agency requests a progress report, it is good practice, after getting a written release from the client, to speak with the social worker, probation officer, etc. to determine exactly what is requested. Often they want written verification that the counseling has addressed certain issues. Sometimes this can be accomplished by providing the "Client Participation Report", which includes a checklist of general topics covered in therapy. More often, a progress letter will be requested.

B. Forms 22 and 23 and progress letters should be co-signed by the client, if feasible. A letter or report can be faxed on short notice, for instance for a court hearing, as long as there is a signed release on file. At the next session, however, it is good practice to have the client sign the form or letter at the bottom of the file copy where it states, "This report was submitted at my request and with my knowledge and consent."

C. In writing a progress letter, you will collaborate with your supervisor and/or clinical staff to provide a letter which addresses 1) attendance, 2) in-session observations and 3) client self- reports, but not evaluations, diagnoses, opinions, predictions or conclusions. (See examples below.) These letters must be reviewed AND SIGNED by your supervisor or a clinical staff person. The letter should also be co-signed by the client following the statement, "This report is/was submitted at my request and with my knowledge and consent." Letters should be prepared on the computer and printed on SCCC stationary.

The following examples will give you a sense of what is permissible to say in progress letters to agencies.

O.K.	NOT O.K.
In session, father responds to the needs expressed by his daughter.	Father is better able to meet his daughter's needs.
Mary reports that her mother spends time with her on weekends.	Mother is spending more time with her children.
Evelyn listens to and answers Jerry's questions in our sessions.	Evelyn and Jerry are communicating more effectively.
Mother reports that she has not had a drink for 6 months and is attending AA meetings weekly.	Mother is no longer drinking and is providing a safer environment for her children.
This couple attends sessions regularly and appears engaged in our work. They report that at home they are better able cooperate in parenting their children.	In my opinion, the work this couple is doing in counseling will enable them to overcome their differences to and be more loving parents.

A REPORT MAY NOT LEAVE THE CENTER UNLESS AN "AGREEMENT FOR EXCHANGE AND/OR RELEASE OF INFORMATION" IS ON FILE SIGNED BY THE CLIENT.

SOUTHERN CALIFORNIA COUNSELING CENTER

POLICY AND PROCEDURE FOR COORDINATION OF MULTIPLE CLIENT SERVICES

Policy:

There are times when a client participates in more than one Center service simultaneously (e.g., individual and family counseling, individual and group counseling, or individual counseling and TAPP services). In such cases it is in the best interests of the client, as well as clinically and ethically advisable, to coordinate the services.

Procedure:

1. To request additional counseling services for a client, use the form, "Request for Reassignment or Additional Counseling". Forms are located behind the front desk.

2. Consult with your supervisor and/or clinical staff on any clinical

issues involved. The Case Conference:

Counselors involved in different aspects of a client's treatment may decide, after consultation with a supervisor or clinical staff, that it is clinically advisable or ethically required to have a case conference. A written release from the client to do so is not required. However, it is respectful of the client, good clinical and ethical practice, and consistent with the philosophy of the Center to inform the client of the consultation and to report the results to her/him. All such consultations should be reported in the client's progress notes.

A case conference may be helpful in coordinating and supporting specific treatment issues. For example, if the TAPP program is working with a client around fee issues, it may be important for the client's individual counselor to be aware of and support that work.

Consultation is sometimes helpful in deciding to make referrals or recommend additional services, either within or outside the Center. If a counselor suggests couples counseling, the other counselors or program coordinators involved in the case should be aware of it. In this way, the client will not receive confusing or conflicting messages from different counselors or staff members.

Exceptions

There are important exceptions where case information is not shared. For instance, a couple may be receiving conjoint counseling while one of its members receives individual counseling. It may be important clinically that the two counselors involved in treatment NOT communicate with each other about the case in order to preserve boundaries between the two therapies. Discuss such issues on a case-by-case basis in your supervision.

SOUTHERN CALIFORNIA COUNSELING CENTER

GRIEVANCE PROCEDURE

1. As much as we might like to think the Center can be all things to all people, there are bound to be times when conflicts or disagreements occur, whether with a supervisor, a staff member or another counselor. When that happens, try first to deal with the situation directly with the other person. Use your clinical skills to support you in being assertive on your own behalf and listening empathically to the other person.

2. If, after doing your best to resolve the issue or conflict with the other person yourself the situation still feels unresolved, the next step is to meet with the Clinical Director or Associate Clinical Director to explore other approaches or solutions.

3. If the issues still cannot be resolved to your satisfaction, arrange for a joint conference between you, the other person and the Clinical Director or Associate Clinical Director.

4. If you believe that the circumstances of a situation are such that it is not possible or appropriate to address it directly with the other person or persons involved, proceed directly to a discussion with the Clinical Director or Associate Clinical Director.

COUNSELOR TERMINATION

1. As much as we hate to lose valued colleagues, there does come a time when most counselors choose to move on to private practice and/or to other settings for continued growth and learning.

2. The termination procedure:

   a. Begin discussing your departure in supervision and with clients well in advance. A termination process with clients of at least 6 weeks is suggested, though this may vary from client to client. Use supervision to work out a timeframe for each client. If there are any outstanding fee balances, develop a plan with the clients to have their balances paid before you leave. Consult with the Client Coordinator to ensure a smooth transition for your clients.

   b. Schedule an "exit interview" with the Clinical Director. This interview will include a review of your plans as well as an opportunity to process and give feedback about your experience at the Center. Pior to the Exit Interview, complete the Exit Interview Form which is available in the Front Office.

   c. If you have an outstanding administrative fee balance, either pay it in full before you leave or develop a plan in the exit interview with the Clinical Director for installment payments.

3. Disposition of clients:

   a. Counselors who leave after fulfilling their commitments to the Center may consider taking some or all of their clients into private practice, depending on client wishes and clinical appropriateness. Use supervision to sort out the clinical considerations. Not all clients are appropriate for private practice and others may wish to remain at the Center.

   b. Clients who wish to remain at the Center:

      (1) Every effort should be made to reassign these clients to another counselor in the same supervision.

      (2) If same-supervision reassignment is not workable, attempt to make a match with another counselor with whose work you are acquainted.

(3) As a last choice, refer the client back to the Associate Clinical Director or the Client Coordinator by means of the Request for Reassignment or Additional Counseling form.

c. Clients who transfer to your private practice must have paid any outstanding balance before terminating at the Center.

For each client, whether they are leaving or staying at the Center, fill out a Counselor Termination Form and have the client complete a Client Termination Form. These forms are to be added to the client's file.

d. Be sure that your case notes are up-to-date and that they reflect the action you and the client have agreed to, be it termination or reassignment. The termination process and all agreements and decisions made with the client should be clearly set forth in the case notes. The final case note will be a termination or transfer summary. Either summary will address the original problems or presenting complaints, the treatment goals, progress on those goals and the client's or your reasons for ending the counseling or making a transfer.

e. Consult with the front desk about closing out the files of clients who are leaving the Center.

4. Incomplete Counselor Commitment

We do not consider counselors to be alumni of the Center until they have completed their agreed-upon commitment, i.e., two years for those on a licensure track and 16 month for paraprofessionals. We recognize that sometimes life intervenes in a way that makes completion of this commitment impossible. Nevertheless, certain consequences flow from an early departure from the program:

1) Counselors may not take clients with them when they leave;
2) Staff members cannot provide recommendations;
3) Until the commitment is completed, they are not considered alumni in good standing and are not included in alumni events and trainings.

The above can be avoided by taking a temporary leave and then returning to complete the commitment, at which point counselors are considered alumni in good standing.

WRITING CASE NOTES

State law and professional ethics require that case notes be prepared and signed for each client session. Case notes serve a variety of important functions:

1. Document client attendance and fee-payment patterns.
2. Provide session-to-session continuity for the therapist..
3. Document the progress/evolution of the therapeutic process.
4. Verify therapist's compliance with legal and ethical requirements in crisis situations.
5. Provide a history for subsequent Center therapists who may work with the client.

The legal and ethical mandate for writing case notes does not include a prescribed format. If there is suicidal/homicidal ideation and/or issues of abuse, be very detailed about the plan, including what you will do if issues escalate, issues to follow up with, telephone numbers, possible referrals, etc.

1. Your signature and the date you wrote the note (may be different than the session date, but hopefully not more than a day or two).
   Your printed name, highest terminal degree & title (counselor).

2. A question often arises as to how much detail to include in a case note when something is reported by a client that might be incriminating in some future legal proceeding, particularly in the case of a client who is mandated. The general guideline is to include enough information so that a future therapist or staff member who consults the notes will have a clear idea of the issues discussed, without including every detail. For instance, if your client is working on issues related to substance abuse, it is important to note that. It is not necessary, however, to report exact quantity or frequency of usage.