Counseling Psychology Practicum Manual

Purdue University Counseling and Guidance Center

Adopted August, 1989; Revisions Approved by CPSY core faculty, December, 2007.

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Counseling Psychology Program On-Site Practicum Introduction

The Counseling Psychology (CPSY) program on-site practicum takes place in the Purdue Counseling and Guidance Center (the Center). The CPSY program, Educational Studies (EDST) department, and College of Education (COE) use the Center for a variety of activities and purposes. The CPSY practicum is only one use, though one that requires confidentiality and privacy for clients. The Center's space (e.g., counseling rooms) can be assigned to CPSY faculty or students, based on approval of a proposal submitted to the counseling psychology faculty and availability of space. Such approval is time-limited and for specific purposes.

Prior to Seeing Clients

Before counselors begin seeing clients, they need to:

1. Clear their schedules, so that they are available during the weekly assigned practicum times. You must also be available for faculty supervision, according to the instructor's supervision procedures.
2. Carefully *read and learn* the CPSY Practicum Manual, along with supporting material (i.e., Tech Room procedures, CPSY Practicum Forms and Examples Manual).
3. Attend the Center orientation session at the time and place announced by the Director.
4. Pay for insurance through the Center Secretary
5. Arrange for a PIN # through the Center Secretary.
6. All practicum counselors are supervised in the Center, typically by a core counseling psychology faculty member. Additional supervision information is detailed later in this manual.
7. The content of the CPSY Practicum Manual is program policy. However, instructors may add additional practicum requirements, including forms that are not documented/included in the companion CPSY Practicum Forms and Examples Manual. Nonetheless, the Appendices in the CPSY Practicum Manual do contain the various forms that different faculty members use for (a) practicum student evaluation, (b) faculty supervision evaluation, and (c) practicum student self-evaluation.

Counselor Room Assignments

During the on-site practicum year, students are, however, assigned specific counseling rooms for counseling sessions. Students may decorate their room so long as:

1. The decoration is professional in style.
2. No other counselor typically uses the same room. If two counselors share the room, they must coordinate any decorating preferences.
3. No furniture can be removed from the room.
4. Any materials (e.g., pictures) removed from the room must be stored with the Center Secretary.
5. The walls may not be marred in any way. Nails and tape may not be used on the walls.
6. At the end of the academic year, the student must remove all personal items and restore the room to its original condition.

Electronic Recording Policy

Each counseling session is electronically recorded. In the Informed Consent Form, clients give their written permission for electronic recording of counseling sessions.

In order to protect client confidentiality, labels on tapes/DVDs should bear no identifying client information. Each videotape/DVD should be labeled with the counselor's and supervisor's name. All tapes (video or audio) and DVDs will be kept locked in the file cabinet in the Tech Room. All tapes/DVDs must remain in the third floor Clinic area.

Viewing or listening to electronic recordings of client sessions must be done in the Center. These tapes must be securely stored when not in use and must not be taken from the Center unless special permission is obtained from the Center Director or a faculty member.

The TECH Room

Counseling sessions are observed, supervised, and recorded. The TECH Room (Room 3114) houses the control panel that directs the observation and electronic recording functions of the Center. In order to protect client confidentiality, access to this room is limited during Counseling Center hours to only Counseling Center staff (i.e., practicum Counselors, Faculty Supervisors, the Center Director, and the Center Secretary), unless authorized by Faculty Supervisors or the Director. A PIN number, obtained from the Center Secretary, is required to enter this room. All counseling center staff will be trained in the operations of the Tech Room. The training materials are located in the Tech Room. Tech room materials and equipment can be signed out for use in the counseling rooms. The materials and equipment cannot, however, be removed from the Tech Room without approval by the CPSY core faculty committee.

Definition of Terms

1. **Blue Book**: Blue 3 ring binder used to reserve rooms. Located at the Center Secretary's desk.
2. **Center**: Refers to the PCGC (Purdue Counseling and Guidance Center)
3. **Client**: Any person seen by the PCGC for counseling services.
4. **Clinic Director**: Responsible for overall administration of the Center.
5. **Computer Sign-Up Book:** Used to reserve computer time. Located in the workroom (3202C).
6. **Counseling Session**: Any counseling conducted after the "intake interview."
7. **Counselor or Student Counselor**: Any counselor-in-training conducting intakes and/or counseling sessions. Usually used in a more restricted sense to mean the "Counselor of Record."
8. **Faculty Supervisor** or **Practicum Instructor**: Conducts practicum class and provides supervision. The supervisor is ultimately responsible for client and counselor welfare.
9. **File Folder (Counselors and Supervisors):** Each counselor and supervisor has a file folder in the client file drawer. The folder is used for case materials (e.g., progress notes) and confidential communication with others and about clients.
10. **Green Folder**: This folder, located at the front of the client file drawer (Room 3202C), contains a form on which counselor's record client case numbers and an ongoing record of counselor case loads.
11. **Intake Interview**: The first interview conducted with a client where background information is gathered. Is different than a "counseling session," and is frequently called an "intake".

12. **Intake Report**: A report generated about a client by the counselor who conducted the intake.
13. **Observation Hall:** Secured area behind the one-way mirrors in the counseling rooms from which client sessions are observed.
14. **Reception Area:** (The secretary’s work space) Staffed by counselors and clinic director during evening hours to greet and check-in clients and to answer the phone.
15. **Sign-In Board:** White board where counselors sign in and out. Located in the workroom (3202).
16. **TECH Room**: Room 3114; Secured location of electronic recording and remote observation equipment.
17. **Test Cabinet:** File cabinet next to the secretary's desk (Room 3202) which contains testing materials.
18. **Testing Session:** Any meeting during which a client completes testing. Cabinet is to remain secured, ask the Center Secretary or Director for tests.
19. **Workroom**: Room 3202C; Work area for counselors. Contains client files, forms, computer, photocopier, mailboxes, sign-in board, and resource materials.

Counseling Process Procedures

Intake Interview Procedures

1. **<u>Scheduling Intakes</u>**
   Potential clients contact the Center by phone or in person. The client is then referred to the Center Director for pre-screening. If the client is appropriate for the Center, the Director will assign the client to a counselor, schedule the appointment in the Blue Book, and complete an **Intake Referral Form**. A copy of the Intake Referral Form will be placed in the file folders of the Counselor, the Faculty Supervisor, and the Clinic Director.

COUNSELOR RESPONSIBILITIES:

Check your file folder and mailbox daily or whenever possible for messages and intake information. When you receive an **Intake Referral Form,** check the name of the client. If you know the client from another context, promptly return the form with an explanatory note to the Center Director, who will re-assign the client to another counselor.

2. **<u>Preparing for the Intake</u>**

COUNSELOR RESPONSIBILITIES:

Prior to the intake, obtain a blank red file folder from the workroom and be sure it contains all the required Counseling Psychology program practicum forms. Note: Some instructors may require additional forms, which they will tell you about in class and on the syllabus.

Be available at least 10 minutes prior to the appointment time and verify the counseling room in which you are scheduled. Make sure your session can be recorded and observed. Check the electronic recording equipment, turn on the room's camera, raise the blinds half-way. Also, check the room for cleanliness and order.

Indicate your room occupancy on the "Sign Up" board.

3. **<u>Conducting the Intake</u>**

All intakes must be supervised. Your Faculty Supervisor and the Director will coordinate this process.

If the client fails to show ("no show") for the intake, immediately return the Intake Referral Form to the Director, with a note indicating that the client did not show. The Director will contact the client.

If the client does show for the intake interview, follow the steps below:

During pre-screening, the client will be instructed to arrive early for the intake to complete paperwork. Upon arrival, the client will receive a clipboard with a **Personal Data Inventory**, a **Policy and Procedures** form, and a **Clinic/Client Agreement** form. Some faculty may require additional forms. The client will complete these forms in the waiting area, prior to the intake. The client will return the forms to the Center Secretary's desk, and the counselor will be notified that the client has finished.

COUNSELOR RESPONSIBILITIES:

Collect the 3 forms from the desk and review them briefly. Place these forms, and any other notes or forms you may need to conduct the intake, in a red file folder. *Leave the folder in the work room while you go to the TECH Room and start your electronic recording*. Pick up your papers from the workroom, greet the client in the waiting room, and escort the client to your counseling room.

Early in the intake, go over the forms. Briefly explain the **Policies and Procedures** form, reiterating that the Center is a training facility, that sessions are electronically recorded, that sessions are observed by supervisors and counseling trainees. Also reiterate the importance of confidentiality and its limitations. (The client has received this information previously; so he or she may seem to dismiss your presentation. Nonetheless, it is important for you to share this information with the client yourself). Check to be sure that the client has read (is able to read) the form, and ask if he/she has any questions. Answer questions, and then ask him/her to sign the form, which you will then sign as a witness. <u>Services cannot be rendered to anyone who refuses to be recorded or observed (i.e., refuses to sign the form)</u>. **A legal parent/guardian must sign for clients under age 18**. Read the note at the bottom of the form about parental custody. This responsibility is an ethical obligation, please be clear and thorough. (See "Written Consent" information in the Ethical Codes for further description.)

Review the **Clinic/Client Agreement**. This form represents a contract between the counselor and the client, with the client committing to attending counseling sessions (and calling if he/she needs to cancel). Please be clear, and give this information adequate attention, because it is intended to help establish boundaries, expectations, and the therapeutic contract. Explain the counseling sessions "no fee" policy and the use of any assessment tools (if needed). Again, be sure the client has read the form, answer any questions, and then both you and the client should sign.

Thoroughly review the **Personal Data Inventory** form, and ask the client to clarify any questions you have about his or her answers.

The primary goal of the interview is to gather information, but you are also beginning to establish a working relationship and therapeutic contract with the client. You may want to explain the function of this intake interview and how its style may differ from ongoing counseling sessions. (Remember that this might be the first time that the client has been in counseling; so he or she may be looking to

<u>you</u> for direction.) Be sure to gather information on all areas that are covered on the intake report. See following sections for a description of these areas.

Explain that the information gained in the intake will be used to make a further assessment of whether the Center can meet the needs of the client.

If the client is currently in counseling elsewhere or has had previous counseling, ask him or her to sign a **Consent for Release of Information** form (you will find this form in the red folder). If the client refuses to sign the form, you and the Center may not be able to render services. You should consult your Faculty Supervisor. If the client is currently being seen by another counselor and the client signs a release form, you (the Center counselor) contact the other counselor to coordinate treatment plans for the client. When contacting the other counselor be sure to discuss the following questions: (a) the reason for the referral, (b) current counseling issues, and (c) an ongoing communication plan between counselors.

Consult your Faculty Supervisor about the client being seen by more than one counselor at a time.

You will also find a **Commitment to Treatment Contract** in the red folder. As will be explained during the orientation, this may be used with a client who is in danger of harming self or others.

4. **<u>Concluding the Intake</u>**

If the client will be continuing counseling with you at the Center, at the end of the intake, you should schedule the client for a second session.

COUNSELOR RESPONSIBILITIES:

Walk the client out to the front desk, and schedule a follow-up appointment, on the hour, in the practicum course time frame, as scheduled by your faculty instructor. On the schedule in the Blue Book, draw a diagonal line through the time block. Write the client's first name in the top part and your first name in the bottom. Give the client a reminder card (attached to the Blue Book).

If consultation with your Faculty Supervisor or the Center Director indicates that the Center cannot meet the client's needs, an appropriate referral should be made. Discuss with your supervisor any specific intake procedures that you should follow.

5. **Immediately following the Intake**.

COUNSELOR RESPONSIBILITIES:

On the **Client Log of Activities**, stapled inside of the back cover of the red client folder, fill in the identifying information. Indicate the intake date, appointment time, time spent (rounded to the nearest quarter hour), and activity code.

Assign a case number to the red client file folder by noting the last number used (in the green folder) and assigning the next consecutive number. The green folder, which contains a form that will track client number sequencing, is kept in the front of the locked file cabinet that contains the client files. Write the case number on both the red client folder and the form in the green folder. Always be careful to monitor the number series so as not to duplicate client numbers or to get the number series out of order. If the client is a continuing client (i.e., seen previously at the Center), DO NOT assign a new case number. Use the already established red folder and DO NOT include the case number on the form. Client numbers consist of the last two digits of the present year, followed by a dash and the next three digits in the sequence order of admittance. (Example: Sally was admitted March 1, 2000 and she was the 49th client that year. Her number would be 00-049.)
Complete an **Abbreviated Intake Report** BEFORE you leave for the evening and put it in the client's folder. This form is necessary so that the Center has information about the client should it be needed before a full intake report is complete.

Store the red client folder in the client file drawer in consecutive order by case number.

6. **Within one week following the intake**:

In most cases, counselors will continue with the clients they saw for intake. In the event that a client is reassigned to another Center counselor, the intake counselor and the new counselor of record may both be present at the second session to explain the procedure and to facilitate the transition. The counselor who conducted the intake is responsible for generating the intake report.

COUNSELOR RESPONSIBILITIES:

Within **one week** of conducting an intake, submit a first draft of the intake report to your Faculty Supervisor. Make two (2) copies of your report: One goes in the client's file, and the other goes in your supervisor's file folder.

Type an Intake Report. There are Intake Report guidelines and examples in the Forms and Examples Manual, though your instructor may have a different preferred format. The report should use the format of the examples (e.g. headings and spacing). Strive to complete the report in two typed pages. Do not put identifying information (e.g., client name, age) on the report until it has been signed and approved by your Faculty Supervisor. Until then, use only the client number for reference on the form. Counselors should use the computer in the workroom to complete the report and also use the intake, planning sheet, and termination templates that are saved on the computer. Access the template and immediately save it to a floppy disk that you will keep in your file folder in the secure filing cabinet. **CLIENT INFORMATION IS NOT TO LEAVE THE CLINIC AREA. DO NOT WORK ON REPORTS OUTSIDE THE CLINIC.**

Remember that your reports are considered professional documents and, therefore, must be written in a professional manner. (See *Helpful Hints* below).

7. **<u>Completing the intake report</u>**

Your supervisor will provide you with feedback on your intake draft and return it to your file folder.

COUNSELOR RESPONSIBILITIES:

In a timely manner, make revisions to the intake report, attach all previously edited versions, and resubmit the materials to your supervisor, in his or her file folder. (You may leave the original intake draft in the client's file until a final version is signed.) You may cycle through this revision process several times. Once a final version is reached and your supervisor has signed it, add the identifying information to the top of the report, sign and date it, and put the final copy in the client's red folder. You may then shred the old drafts.

Helpful Hints for Professional Writing
Your client reports and records are professional documents. Another agency may request the client's records; thus it is important for your reports to be written in a professional manner. The following hints are provided to help you with writing client reports and documentation.

- Use only black ink in the chart.
- Draw a single line through any chart material that you wish to change; then initial and date the change.
- Never use liquid paper (e.g., white out) to make changes. To make a correction, draw a <u>single</u> line through the mistake, write in the correction, and initial and date the change.
- Write in a succinct style; <u>all</u> reports should be only two pages, yet still be comprehensive.
- Reports should be written in terms such that the patient or any non-professional person could read and understand the report. Avoid jargon.
- Use "seemed" and "appeared" rather than absolute or diagnostic terms. The observations reported should be observations and <u>not</u> speculations or demonstrations of the examiner's "insight," clairvoyance, or erudition.

- Be very clear about the source of information: (a) directly from the client, (b) your observation or inference, (c) other documents (e.g., a referral form, previous records). Use “he or she said/stated,” “client reported,” or “client stated” to indicate that the information comes from the client. You may also want to consider quoting client statements, when appropriate, to increase accuracy of description. Your instructor may have a preference for how you indicate client-based information (e.g., there are a variety of ways for stating that everything is from the client’s report).
- Avoid use of an individual’s first name, and instead refer to a person as the “client” (e.g., The client arrived on time for his appointment). Refer to other individuals by relationship rather than name (e.g., parent, brother, roommate)
- Avoid using your name, and instead use “counselor” or “writer” (e.g., The counselor reviewed the intake forms with the client). Although not consistent with APA 5th, this style will provide greater clarity in the records, especially if there should be a subsequent reader.
- Phrase statements in past tense when appropriate.

Refer to your supervisor(s) for other suggestions regarding professional manner of presentation and case documentation.

Be sure to give your supervisor sufficient time to review and suggest revisions.

Referring Clients for Evaluation
Occasionally the clients you see will present with concerns that warrant further evaluation. Recurrent depression, for example, may warrant a psychiatric evaluation. If your client requires further evaluation, that decision will be made by you, the client, and your supervisor and/or the Center Director. Because you are the client’s counselor of record, you will be responsible for corresponding with and coordinating treatment plans with the evaluating psychiatrist, with supervisory support. If this scenario becomes necessary, it will be your responsibility to:

1. Arrange for the client to complete a Consent for Release of Information form that gives you permission to correspond with individuals outside the Center regarding the client.
2. Talk or write a letter to the evaluating psychiatrist or doctor stating client-originated information that supports the need for further evaluation. Be sure your supervisor or the Director reads the letter before it is sent. Be certain that a signed copy of the letter is in the client’s file.
3. Obtain two signed Consent for Release of Information forms. Place one original in the client file. The second, with the client’s signature, will accompany any materials sent to other agencies or individuals. That is, the client signs two forms; one is kept; one is sent.
4. Materials sent to Purdue Counseling and Psychological Services (CAPS) for evaluation must be walked to the CAPS location prior to the evaluation appointment. This material must NOT be sent via campus mail, as confidentiality cannot be assured. The material also cannot be faxed because the Center does not have a secured fax terminal.

Middle Phase – Counseling Procedures

After every counseling session

COUNSELOR RESPONSIBILITIES:

Record the client's next counseling appointment in the Blue Book and provide a reminder slip.

Record the following information on the **Client Log of Activity** sheet that is stapled inside the back cover of the red client folder.

- Session number
- Date
- Time of appointment
- Time spent, rounded to the nearest quarter hour
- Activity, using the abbreviations provided
- Tests Administered, using abbreviations

Counselors must complete a **Student Counselor Planning Sheet** after each session and **before** leaving. All information on the form is part of the client's file and is the Center's property. Writing and comments should be concise and professional, focusing on the client behaviors and the treatment plan. Planning sheets should be neat and orderly, and follow legal documentation standards. Unless your supervisor specifies differently, (a) the Planning sheet may be hand written, legibly please, or typed on the computer using the template provided; and (b) your supervisor does not get a copy of this sheet. Counselors sign the copy that is placed in the client file.

Procedures for No-Shows, Repeated Cancellations, Tardiness

1. Counselors are responsible for setting and maintaining boundaries with clients.
2. In the event of a client's first no-show for an appointment other than the intake, call the client that day/evening to confirm the accuracy of the appointment date and hour. Seek to re-schedule if the client wishes. Discuss this event (i.e., missed appointment) early in your next session with the client. Be aware that client no shows, lateness, and missing appointments may have multiple meanings, some of which can be related to the counseling.

Calling clients:
During the Center's office hours, counselors may use the work room phone to place client-related calls. If the phone call is not local, the Director or the Secretary will approve the long-distance call for the counselor. If someone other than the client answers the phone and the client is not there, simply say that you will call back later. **Remember that counselors must respect the confidentiality of a client. An acceptable response would be to say "I am Laura Wright and I am calling from Purdue. Would you have John Doe return my call." Or inquire as to when would be a good time to call the client back. Try not to leave messages on a client's answering machine unless a client indicates that you can do so. If you're unsure, it's best not to leave more personal information; just leave your name and phone number. Do not identify yourself as a counselor, as working in the clinic, or in any fashion compromise client confidentiality.** Once a session time and date has been set, record the appointment in the Blue Book.

3. After the second or more no-show, do not call. Instead, send a letter to the client. Consult with the Secretary regarding the form letter format, which includes printing the letter on PCGC stationary (letterhead). You may want to indicate at the end of the letter that if you have not heard from the client by a certain date (a good rule of thumb is to allow 1-2 weeks to respond), you will assume that the client no longer wishes to continue counseling at this time. **Ideally the letter should be sent within 48 hours (or 2 business days) of the no-show.** Wait for the client to contact you. If the client wishes to continue, discuss the matter of no-shows immediately in the next interview. Assume that the "no show" is not random behavior and be prepared to see such behavior as metaphorical in regard to something else in the client's life, including (but not necessarily) your relationship. If there is no response to your follow-up letter after two weeks, regard the case as closed, and begin termination procedures.

4. After two or more cancellations, followed by successful re-scheduling, discuss this behavior with the client. This behavior is a treatment issue requiring counselor boundary exploration or responsibility discussion. The counselor is responsible for addressing this behavior pattern and setting and maintaining boundaries and expectations.

5. Consistent tardiness is also non-random behavior that must be acknowledged and discussed. Although tardiness may not be consciously intentional, it is significant. Do not dismiss tardiness, even if you feel neither inconvenienced nor resentful. An attendance and punctuality "contract" or other intervention may be in order. Seek and use advice from your supervisor.

Policies on Assessment Materials

As a part of your practicum experience, you will be asked to do assessments with your clients. You **MUST prepare your clients in advance for taking assessments** (see below).

Who May Use the Assessment Materials
Faculty and practicum students may use the assessment files. Only the Center Secretary, the Director, or Faculty Supervisor may distribute assessment files. To obtain assessments, please follow the procedures detailed below.

Policy on Purchasing/Using Assessment Instruments
The following steps must be followed by all faculty and students using assessment instruments.

1. After consulting with your supervisor about using as assessment tool, inform your client **at least a week** in advance that you want him or her to complete one or more instruments at a scheduled appointment time. With the client, discuss the nature of the test and its purpose in the treatment. Generally, it is best not to use the regularly scheduled counseling session for assessments. Instead, arrange for the client to complete a test before or after the scheduled session time. Be sure you are available to get the client started.

2. Ask the Center Secretary, Director, or Faculty Supervisor to determine the availability of the instruments you wish to use. **Only these individuals may remove assessment materials from the file cabinet.** It is the counselor's responsibility to be sure the assessments are available ahead of time and to reserve them with the Secretary. **Note, the Secretary, Director, or Faculty supervisor will inform you of procedures if the assessment is computer-based.**

3. Put any instruments that need to be scored elsewhere in an envelope and give it to the Secretary to be mailed. Please be aware and inform your client that instruments sent out for scoring often take one to two weeks to be scored and returned. All other instruments need to be scored by the counselor.

Any manuals, templates or other scoring materials you need in order to score and interpret the assessments must be checked out by the Center Secretary, the Director, or Faculty Supervisor, and may be used only in the Center (unless other arrangements have been approved).

Termination Of Counseling
Termination of counseling may occur as a result of the following situations:

a. The client has no-showed or canceled more than twice and failed to reschedule or respond to the counselor's letter. Two weeks have passed.
b. The client and counselor talk together and decide to end counseling. This situation may occur after the intake and before any counseling sessions have taken place or at any time after the first session.
c. The client has been referred for services to another agency/person.
d. The semester is ending and the counselor will be leaving the Center.

Once a client is assigned to a counselor (of record), it is that counselor's responsibility to manage the case and complete the file, including termination and inclusion of the client on the counselor's practicum summary report. This procedure holds true even if no counseling sessions took place.

Termination Procedures

1. If a client was seen for only the intake interview and either wishes to terminate or does not return, complete a **Status Report**, and indicate the specific circumstances on it (e.g., that the client did not continue after the intake). Put one copy in the client's file and one copy in the Director's file folder. You do not need to complete a termination report. If you do not have documentation of termination from a face-to-face session with the client (e.g., the client was scheduled but did not return), you do need to send a Termination Letter.

2. If a client was seen for an intake and at least one actual counseling session during the semester and he or she wishes to terminate, complete both a **Status Report** and a **Termination Report**. The termination report should be prepared in much the same manner as an intake report. Complete a first draft, with one copy in the client's file and one going to your Supervisor. The Termination Report is not considered complete until signed and dated by both the counselor and faculty supervisor, and placed in the client folder. Examples are provided in the Forms and Examples manual, though your supervisor may have a preferred form. If you do not have documentation of termination from a face-to-face session with the client (e.g., the client was scheduled but did not return), you do need to send a Termination Letter.

3. Make sure that the **Client Log of Activities** sheet, on the left hand side of the red file folder, is complete. The number of **Student Counselor Planning Sheets** should correspond in number and date to listings on the Log of Activities. Any telephone contacts to or about the client should be recorded both on the log and on a **Telephone Contact** form. If a letter was sent, it should be noted on the log; and a copy should be in the file. Be sure you have drawn a line through any blank spaces in the Log of Activities sheet.

4. Arrange materials in the client folder according to the order on the **File Checklist**.

5. Put the File Checklist in the front of the client's file. All other paperwork should follow, in the order on the checklist (reverse chronological order).

Guidelines For Practicum Termination

1. All intake reports and termination reports must be signed and dated by both the counselor and his or her faculty supervisor. For each counselor, all paperwork must be completed by the date that the Director scheduled for the end of semester file review. The counselor of record is responsible for securing the supervisor's signature on the intake and termination reports. All practicum paperwork must be satisfactorily completed in order and on time to receive a grade for the course.

2. **All tests that must be sent away for scoring must be administered sufficiently early to allow for mailing, interpretation, and feedback to the client**. Counselors are responsible for debriefing (i.e., providing feedback to) clients on all administered assessments .

3. Clients need to be psychologically prepared for termination *one or more weeks* prior to the end of the semester. *Speak with your supervisor about preparing clients for termination; typically a one-week preparation is not sufficient.* The counselor should explain that the Center is closed over breaks, including the summer. If the client will be continuing, he or she will be contacted around the beginning of the next semester. Clients seen in the fall will be put on a call list and contacted during the first week of spring semester classes. Clients seen in the spring may continue in the fall but need to be informed that the Center is closed for the summer; so they will have about a 3 month wait before services can be resumed. Therefore, other referrals should be considered.
4. Put the client's number and any special instructions about contacting the client on the **Status Report**. Counselors are responsible for completing a **Status Report** for all assigned clients. Make a copy of each complete status report, and put it in the Director's file folder. The original should be placed in the client's file.
5. The **File Checklist** is essential for insuring that client files are complete.
6. A **Practicum Summary Report** is to be completed by the counselor at the end of the semester. This report is used in assigning client, tracking hours, and formulating a Center report for the faculty/COE. The original copy should go to the Center Secretary. Make a copy for the Director and one for your own records.

   a. Complete information requested at the top of page.
   b. List all assigned clients (first name only and case #)
   c. Indicate main presenting client concern, client's age, sex and ethnicity.
   d. Number of Sessions/Cslg" is the total number of **counseling** and intake sessions a client attended (INCLUDE INTAKE SESSION HERE).
   e. Tests administered.
   f. Case Status
   g. Number of Client Contact Hours
   h. Total Hours in Practicum Class.
   i. Total hours of Individual Supervision.

7. At a designated time, usually during finals week, all counselors will schedule a "file review and check out time" with the Center Director. The purpose of this meeting is to double check that all paperwork is completed and that the files are in order.
8. The counselor may find it helpful to begin parts of the termination or summary reports <u>prior to</u> terminating with the client, especially if there are several reports due.
9. Counselors are required to track their practicum hours in the excel spreadsheet provided on the workroom computers. This spreadsheet is consistent with the APPIC internship application's format for reporting hours. **Each semester, all counselors MUST report their total assessment/intervention, supervision, and support hours to the Clinic Secretary. This requirement includes all program-sanctioned hours, including the Center and off-site practicum placement.**

Counseling Session Observations

Recognizing the potential benefits of observation to both observers and counselors being observed, the practice of responsible and respectful observation is important. The following policies will be employed in the observation of all counseling sessions in the counseling psychology practicum at the Purdue Counseling and Guidance Center.

Definitions and Authorization to Observe

- Anyone who watches or listens to all or part of a counseling session as it proceeds is an observer.
- Any faculty member or student in the counseling psychology program, with the Faculty Supervisor's or Director's consent, is authorized to observe a counseling session.
- All observers must sign in on the "sign-in" board when using the Tech Room or Observation Deck

Guidelines for Observation

1. Several observers may be present at any given time for any counseling session; however, priority for seating in the observation deck will be given to the designated supervisors.
2. During observation, observers are strongly encouraged to take notes, including questions, process comments, and other relevant observations. References to specific client and/or counselor behaviors are considered helpful.
3. Observers are encouraged to provide written feedback to the observed counselor. Refer to your supervisor for further instruction.

    - Feedback is provided as handwritten notes on a completed Feedback Form. An example is included in the Forms and Examples Manual.
    - Deliver written feedback as soon as possible after the session.
    - On the written feedback, identify yourself as the observer so the counselor can ask for clarification if needed.
    - Do not include the client’s name or other identifying information. Instead, on the feedback form, indicate the time and date of the session.
    - Hand <u>all</u> written feedback to the counselor directly or place the written feedback in the counselor's file folder.

4. Observers may also provide verbal feedback to the counselor, clarify written feedback, or provide additional information. The counselor is responsible for seeking out such feedback, and the observer is responsible for being available to the counselor.
5. All observers are expected to protect client confidentiality**, always,** as outlined in the current ethical guidelines. Any individual not willing to follow the procedures outlined in this policy statement should discuss his or her concerns with the faculty supervisor.

Making the Most of Observation

Observing refers to watching a counseling session live or via electronic recording. Only authorized persons may observe counseling sessions. If appropriately conducted, observation can be as difficult and as enlightening/educational as counseling itself. Further, the skills gained in observing and giving feedback are extremely valuable in the practice of counseling.

Tips on Observing

Observation may be completed in many ways. For example, you may:

1. Take handwritten notes.
    - Focus on content. Divide the page in half lengthwise. Keep running notes on what the counselor says on one side and what the client says on the other side. In the margins, record your comments regarding themes you see, questions you have, avenues you would like to see explored.
    - Focus on process comments. Pay attention to the interaction between the counselor and client. Note client reactions to counselor responses and vice versa. Watch non-verbal behavior of both. Notice the quality and timing of silences. Pay attention to your own reactions and feelings while observing.
    - Some combination of both or some other system.
2. Use the feedback forms provided.
3. Follow a particular client, noticing changes over time, or a particular counselor, noticing differences across clients. .
4. Be self-aware while in the observation deck. Your voice volume and/or proximity to the mirror/glass could be distracting in sessions.

Tips for Giving Feedback and Taking Notes

1. Be clear and concrete. Provide specific examples; to do so, you must take good notes.
2. Do not overload the counselor. Focus your comments on the most important feedback.
3. Be descriptive rather than evaluative. More information is provided if you say "When you asked the client why she broke up with her boyfriend, she turned red in the face and stammered. . ." than if you say "That was a bad question."

Emergency Procedures

The following procedures should be enacted if:

- a Counselor and Supervisor become concerned about a client's immediate well-being or perceive any sense of urgency regarding treatment
- the client indicates knowledge of a danger to him or her self and/or others
- a client expresses a desire for hospitalization
- there is information or evidence to suggest child or elder abuse

In such cases, the appropriate authorities need to be notified as soon as possible. **The Faculty Supervisor and Director must be notified before any action involving contacting an outside agency is taken.** The Counselor and Supervisor should immediately consult with the Faculty Supervisor or Center Director. Indicate to the client that you wish to consult with your supervisor, and leave the room. Describe the reasons for concern as completely and as succinctly as possible to the supervisors.

If ongoing consultation is occurring, check on your client and inform him or her that you have sought consultation and familiarize the client with the names of those involved. Refer to a faculty member or the Director as "Dr. _______________", *as appropriate to the person's credentials*.

If hospitalization is called for and the client is compliant, follow these procedures:

When immediate hospitalization may be necessary, the following will occur:

After consultation, if there is evidence that immediate hospitalization is needed

1. Refer the client to Home Hospital Emergency Room.
2. Consult with the client and explain the reasons for hospitalization. The counselor will provide as much of this information to the client as possible; the Supervisor or Director will be present (e.g., in the counseling session, observing through the one-way mirror) and will present additional information as needed.
3. If the client agrees to hospitalization, ask him or her to sign a consent form that states agreement with the referral. Also ask the client to sign a Consent for Release of Information form. If the client signs the release form, the Supervisor or Director may call the Home Hospital Emergency Room to inform the psychiatric nurse/social worker that the client is being referred there.
4. The Faculty Supervisor or Director will then call Campus Police, unless the client is accompanied by another responsible adult, and ask for transportation to the hospital.
5. When Campus Police arrive, it is appropriate to show them evidence that the referral is voluntary.
6. Forward copies of client records as soon as they are complete, IF the client signed a Consent for Release the of Information form.

If the client needs to be hospitalized but refuses a voluntary referral, the following will occur:

1. The Faculty Supervisor or Director will contact the Home Hospital emergency room for consultation.
2. Other appropriate persons will be notified according to the situation and its demands.
3. The client will be informed that it will not be possible for counseling to continue at Center.
4. If the client is deemed a danger to the self or others, then the Faculty Supervisor or Director will contact the Purdue University Police so that the client may be transported to the hospital.

When hospitalization is not deemed necessary, but another referral is warranted, the following will occur:

If the client **does not need to be hospitalized, but a referral to PUSH is appropriate** (e.g. the client is a student and is highly depressed, physical symptoms are evident, or medical treatment is necessary):

1. The client will be consulted and reasons for the referral will be explained by the most appropriate person (e.g., the Counselor, Faculty Supervisor, Director).
2. If the client agrees to the referral, (a) he or she should sign a Consent for Release of Information form, and (b) a Center staff member will contact the on-call PUSH staff member to inform him or her of the situation and need for referral, and to schedule an appointment for the client.
3. The client will be informed that the Center continuing with the case will depend on the recommendation of the individual/agency to whom the client is being referred. It is possible that the counselor might continue working with the client, depending on the recommendation.
4. If it seems appropriate (e.g., if the client is very nervous), a Center staff member may accompany the client for the appointment and complete the referral at that time. The Faculty Supervisor or Director should be consulted on this decision. Accompanying the client will also depend on the availability of the PUSH on-call staff member to schedule an immediate appointment.
5. Copies of client records should be forwarded as soon as they are complete, IF the client signed consent to release the information, in a manner that is consistent with HIPAA compliance. NOTE: the Center has no fax capacity.

If the client **does not need hospitalization, but a referral to a community physician or other agency is appropriate**, as in the case of a non-student, the following will occur:

1. The client will be consulted and reasons for the referral will be explained by the most appropriate person.

2. If the client agrees to the referral, the client will be given the contact information for the physician or agency so that the client can make an appointment. If the client would rather his or her physician make a referral to a psychiatrist or if the client already has a psychiatrist, this is also appropriate.

3. The client will be informed that the Center continuing the case will depend on consultation with the physician or agency staff member and his or her recommendation.

4. The client will be asked to sign a Consent for Release of Information form.

5. Copies of client records should be forwarded as soon as they are complete, if the client signed a consent to release the information, in a manner that is consistent with HIPAA compliance.

If, in the opinion of the Faculty Supervisor or Director, the client does not need to be hospitalized but should be referred to a psychiatrist and the client refuses to do so, the client will be informed that it will not be possible for counseling to continue at the Center. Other options for services will be provided to the client.

Important Notes

1. If a police escort to the hospital is needed for a voluntary hospitalization, the Center Staff member is well advised to brief the client on this information and assure him or her that the police escort does not make the referral any less voluntary. The client has the right to change his or her mind at any time.

2. Counselors or supervisors are never to put themselves in any physical danger in working with a client. The procedures listed above assume that no staff member is endangered by following them. Counselors *will not drive clients to the hospital or other referral agency.*

3. In the event that your Faculty Supervisor and the Center Director cannot be reached, call another counseling psychology core faculty member.

4. **Counseling psychology students should not make referrals without first consulting with the Faculty Supervisor and/or the Center Director.*****

Procedures with Suicidal Clients

When a client reports suicidality in a session, a clinician's prudence is paramount in handling the situation. Therefore, the use of appropriate assessment, documentation, and supervisory consultation is important in order to ensure the safety of the clients at the Center.

When meeting with clients, it is important that suicidal ideation/intent is assessed every session. The areas of risk assessment are listed on the following page. This list is not exhaustive; however, it provides a template through which clinicians can better identify when a client is at an increased suicide risk. Other areas to assess are also located on the following pages.

Protocol for Suicidal Clients

If a client expresses suicidal ideation or intent, or through an assessment in session, the client presents information that places him or her at an increased suicidal risk, precautions must be taken in order to ensure the client's safety and well-being.

1. Notify the Faculty Supervisor and/or Director of the client's ideation, intent, or increased suicide risk (if appropriate, client may be referred)

2. Complete a *Commitment to Treatment Form* <u>and</u> a *Crisis Response Plan* on the following pages.

3. Have the Faculty Supervisor and/or Director sign both forms

4. Make copies of signed forms (give original to client and place copy in client's file)

5. Provide clear and thorough documentation of the session, including forms that were signed and implemented as a form of treatment

Ethical and Professional Practice

Counselors must remember that they are expected to act and present themselves in a professional and ethical manner to clients, fellow counselors, clinic staff, and supervisors.

Counselors, and faculty are expected to adhere to relevant Codes of Ethics. Specifically, counseling psychology practicum counselors are expected to adhere to the most recent ethical codes specified by the American Psychological Association. Counseling psychology students are also expected to adhere to the APA Practice Guidelines as well as the Guidelines for Providers of Psychological Studies. Copies of the latest ethical code and the practice guidelines are available on file in the Center.

Counselors are expected to read and use the code and guidelines as part of their counseling training and practice. Feel free to use the Center copies as resources, but please read them in the Center to make sure that they remain accessible and available to others.

All counseling psychology doctoral practicum students should read, sign, and return the Practice Guidelines Verification Form by the third class session.

Guidelines for Ethical Practice

These guidelines address three areas in which ethical dilemmas occasionally arise: records, written consent, oral communication, and supervision. These guidelines include procedural directions and policy statements specific to the Purdue Counseling and Guidance Center, hereafter referred to as the "Center," and are representative of ethical practice as defined by the American Psychological Association.

Records

All records containing client information are confidential and may not leave the Center. These records include the student counselor planning sheets, intake form, personal data inventory, summary/termination report, termination report, schedule form, assessment instruments, log of activities, letters of consultation, and any other materials completed by or about the client.

1. All written information pertaining to a client must be maintained in the client file. Notes or other materials which are no longer pertinent to the client file should be shredded in the Center.
2. All reports, intake information, intake and termination reports, and other correspondence regarding clients will be placed in the respective file folder in the front of the client file drawer.
3. Client file folders and their contents remain in the file drawer, except when being used by a counselor or supervisor. Written material must be in the personal possession of an appropriate staff member at all times and must not be left unattended. After the intake meeting, do not bring client files into sessions.

Written Consent

Those persons who request service from the Center generally do so voluntarily. Even so, certain circumstances warrant the client’s written consent.

Policies and Procedure form. This form records the client's agreement with Center policy relative to electronic recording, observation, written records, consultation, and the like. It also addresses confidentiality and its limits. It must be signed at the very beginning of the intake interview or a counselor cannot proceed. If a potential client disagrees with any statement or wishes to restrict permission in any way, no services may be provided.

The Clinic/Client Agreement Form. This form communicates the expectations of the client and the counselor and solicits agreement from the client for these policies. The agreement not only sets appropriate boundaries for the client session, but ensures the opportunity of services for clients on the wait list.

Release of Information. Written information from a client's file can be released to others when requested in writing by the client. Written information available for release ordinarily includes the Intake, Summary/Termination reports and any test reports/profiles. A request for information from someone other than the client can be honored if authorized by the client. Except as may be required by law, written information about a client is never released without the client's written permission.

Request for Referral and/or Transportation. If it is determined that a client is in crisis and should be referred to a different agency, institution, or person, a written request for referral should be obtained. Also, the client's signature should authorize the provision of transportation for such service, whether transportation is by private auto, University Police, or other vehicle.

Duplication of Service. When a client reports or it is otherwise learned that the client is or probably is receiving service from another mental health agency or private practitioner, several questions must be answered, all of which require that the client immediately provide written authorization to confer with the other agency or person (See **Request for Information Form**) Two principles are to be observed in circumstances of this kind:

1. The Center will not customarily accept as clients those who are receiving mental health service from another source.
2. Concurrent service can be provided when there is agreement among all parties concerned. When either a different agency or practitioner or Center staff believes that concurrent service is inappropriate, it will be necessary for the client to elect a single source of assistance and then terminate contact with the other(s). When all parties agree that concurrent service is justified, care must be exercised in assuring that counseling activities from the two sources are different yet compatible (vs. duplicate or conflicting).

Oral Communication

The primary objective of the Center is the training of counselors, a process which requires extensive observation and consultation. There is need for constant vigilance among all Center staff with regard to oral communication because of the constant, multiple sources of threat to confidentiality and the personal welfare of clientele and staff alike. The following guidelines are to be observed:

1. Conversation about a client occurs only:
   a. when there is a clear purpose, such as service or training,
   b. between those directly involved.
   c. in a location where there is no danger of being overheard.
2. The identity of clients, their family members, and associates shall be protected insofar as possible. For example, in case conferences and supervision sessions, generic terms (e.g., "a local manufacturing firm" vs. "Caterpillar") and titles (e.g., "client's sister" vs. "Jane") are to be used.

Supervision

Extensive counselor supervision is provided in the Center. Counselor supervision may include, but is not limited to, direct observation, case conferences, staff consultation, off-premises consultation with other professionals, evaluations, and review of electronic recordings. The Counseling Psychology Program and the Center expect professionals serving as supervisors to perform several functions, such as:

- promoting client welfare
- ensuring counselor compliance with legal and ethical standards
- serving as teacher and consultant to counselors
- monitoring and evaluating counselor performance
- facilitating counselor self-reflection and self-knowledge as both relate to counseling clients

Effective counseling and supervision require thorough, thoughtful conversation about topics and themes specific to client, counselor, and supervisor, including attitudes, perceptions, emotions, expectations, behaviors, and assumptions. In preserving the personal rights of counselors and supervisors, the following guidelines are to be observed:

1. Immediately upon being assigned, supervisor and counselor pairs should specify the structural characteristics of their association, including time, location, and frequency of meetings.

2. Expectations, goals, and any special circumstances are to be described and understood by both parties. The supervisor may provide instructions relative to unscheduled sessions, how and where to be located, restrictions, and the like.

3. Supervisors may assist in counselor discussions and evaluation of thoughts and feelings, provided that this activity occurs within the context of the counselor's professional performance. Supervisors do not provide personal counseling for those they supervise. A counselor's personal issues are to be addressed in relation to the counselor's work with particular clients or to patterns of behavior having relevance for professional performance. When personal issues appear to be intruding into the students' work, without resolve, a referral for personal counseling is appropriate.

4. All Center staff, faculty and counselors, must be familiar with the Emergency Procedures contained in this document.

Professional Liability

Students engaged in providing service to the public must carry professional liability insurance, either privately through a professional organization or by enrolling for professional liability coverage through the University's Risk Management Office. **The College of Education business office will help counseling psychology students enroll.**