University of Illinois Counseling Center

Therapeutic Services Manual

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Therapeutic Services Structure (revised 2/2004)

Therapeutic Services Coordinator

The Coordinator holds a 4-year term. The Coordinator is responsible for overseeing the Program Chairs in the areas under the auspices of the Therapeutic Services. The Coordinator Chairs the TS Core Committee.

Program Chairs

PC Group Therapy

PC Psychological Emergency Services

PC Trauma Response Team

PC Eating Disorders and Disturbances Treatment Team *

PC Alcohol and Other Drug Treatment Team *

* Only clinically-relevant work done on these teams.

TS Core Committee

Composition

The TS Core Committee will, on average, meet four hours per month, or at the discretion of the TS Coordinator, the Committee may meet bi-weekly. The Committee will be staffed by three counselors (The PC for Group Therapy plus one other Ad-hoc counselor), the Research Data Analyst, the Reception Office Supervisor, and the TS Coordinator.

Where relevant, the TS Core Committee may also meet periodically together with the Ethics Committee to review issues of common concern.

Functions

This Core Committee functions as advisory to the TS Coordinator about on-going TS issues. Proposals for policy additions or changes, recommendations, forms, etc. are generated and/or reviewed by this committee. The committee determines appropriate steps and strategies for presentation of proposed policies/procedures to the Director and/or for clinical staff discussion. If staff discussion is warranted, the item will be brought to a scheduled meeting for that purpose.

TS Planning and Counseling Staff Retreats

All Therapeutic Services Program Chairs will meet in retreat format with the TS Core Committee once a year in time for Fall Contracting and for planning and review of goals/resources. Also, as needed, a full counseling staff Therapeutic Services Working Day Retreat will be scheduled during the Winter or Summer breaks.

Reception Services Office and its Coordinator

The TS Coordinator may meet with the Reception Office Supervisor for scheduled meetings to update and troubleshoot on-going issues as they relate to Reception Office policies and procedures.

Organizational Practices

Scheduling

(Crunch Time) Fall Semester Initial Appointment Policy (approved 8/14/2007; supersedes previous "Algorhythm" policy)

The Counseling Center has experienced a substantial increase in the demand for clinical services during the Fall semester beginning in 2003 and continuing through the past 3 years. These increases in demand have been reported at counseling centers throughout the country and are not expected to decline in the near future. The Therapeutic Services Committee has evaluated changes in demand for clinical services and made several recommendations to the Director that will increase the availability of Initial Appointments to students.

All clinicians are required to reschedule any Initial Appointments missed due to vacation, conferences, sick leave, etc. during the designated "Crunch Time" period;

- The "Crunch Time" period will be determined by the Therapeutic Services Committee every year based on a review of demand data from the past several years. **The "Crunch Time" period for the Fall semester, 2007 is 7 weeks and extends from Monday, October 1st through Friday, November 16th;**
- Clinicians are responsible for rescheduling missed Initial Appointments and informing the Reception Office of schedule changes. It is preferable that Initial Appointments be rescheduled in advance of planned absences or as soon as possible after returning from an absence;
- The Reception Office Supervisor send out an email in early November reminding all clinicians to reschedule any missed Initial Appointments. The Reception Office Supervisor will also review all clinicians' Initial Appointment utilization in mid-November and send a report to the Therapeutic Services Coordinator and the Director;
- If a clinician has not rescheduled Initial Appointments during the "Crunch Time" period, it will be necessary to reschedule them during the last several weeks of the Fall semester;
- If a clinician wants to request an exemption to this policy, s/he should send the request in writing to the Director and the Therapeutic Services Coordinator. Any exceptions to the policy will be made on a case-by-case basis;

The Initial Appointment

Introduction

Underlying Concerns

The client's Initial Appointment at the Counseling Center can greatly affect how well the clinical part of our mission functions as a whole. In the best case scenario, you, the counselor, gather the right information, you are tuned in to the best service options we can offer, you are able to constructively adjust (as needed) the client's expectations to our limitations and boundaries, and then you are able to either provide the service option the client needs or guide him/her to that option. In less happy scenarios, where one or more of these elements is missing, the client can receive inadequate service or additional services that unduly tax the rest of the Center operation. Looked at this way, and multiplying across all of our counselors, our Initial Appointments are pivotal to the functioning and success of our entire clinical mission.

Along with being pivotal, the Initial Appointment can be stressful, not just for the client but for you, the counselor. After all, not all clients can easily and accurately provide you with the information you need, your client may not be able to accept what seems like the best options you can offer, he/she may be in a state of considerable distress and/or vulnerability, you may be limited in both time and control over the client's situation, and still you may have to make a decision and act on it. We try to minimize this stress in various ways, including by encouraging Extended Assessment sessions and consultation, but often your relief will be only partial.

Finally, as with many aspects of clinical counseling, it can be difficult for new staff to learn how to effectively conduct Initial Appointments. Beyond complexities that are implicit in the preceding paragraphs, new people in our Center confront a diverse array of personal philosophies, norms and priorities because our staff is correspondingly diverse. We think our diversity is healthy and conducive to the growth of the Center and everyone in it. However, we also know that this diversity can cause initial confusion for new people who are trying to identify a basic operating structure from which to develop their own individualized styles.

Purposes, Overview, and Acknowledgment

I have intended this Manual to be a teaching aid and reference tool. With it, I hope that new counselors will more easily learn how to conduct Initial Appointments, and to do so with minimal stress and maximal effectiveness.

Keeping in mind our staff's rich diversity of theoretical background and professional style, my goal has been to articulate those perspectives we share in common which seem relevant to an optimal Initial Appointment. First, I describe the Center's over-riding priorities for Initial Appointments. From there, I give guidelines for the main elements of the Initial Appointment (e.g., opening the interview, gathering information, making disposition decisions, etc.). I finish by giving the main elements to consider for the write-up.

This Manual benefits from the experiences and viewpoints of many people who gave me help in writing it and in modifying it. Specifically, however, I want to give special acknowledgment to Dr. Rakhi Sen and Dr. Stephen Wester, who–when I wrote this in 2000–were here in the roles of Therapeutic Services Graduate Assistant and Clinical Intern, respectively. Following a careful review of relevant literature, Rakhi provided most of the assessment items for Charts II-V, addressing the areas of Dangerousness, A.O.D. Use, Medication History, and Trauma History. Stephen researched and provided the first draft of the Documentation/Write-Up section of the Manual. Thank you both, Rakhi and Stephen, and best wishes in your careers.

Finally, unfortunately, I know I have overlooked many important concerns. Thus, please think of the Manual as a work in progress. As you read it and try to use it, please give the Therapeutic Services Committee feedback on how to improve it. Meanwhile, best wishes on this and all other aspects of your Training and Orientation to work at the Counseling Center.

The Initial Appointment's Overriding Priorities

University Mandates to the Counseling Center

It is important to look at our work from the viewpoints of other people in the University (administrators, faculty and advisors) who are not part of the Counseling Center. Many of these people value what we do, but perhaps with less fervor than we have. As humanitarians–but also as very busy people–they are glad to turn over to us students in crises, as well as students with less urgent personal, social and developmental struggles. Going further, many recognize that students' personal problems can detract from the academic process, and that our efforts to resolve or prevent these problems support that process. Most positively, many recognize that we truly are part of the academic process. Thus, in the main, the University supports us–as long as we don't compromise our Mission by over-extending its Boundaries.

Clinically, our Mission from the University emphasizes short-term interventions. The Boundaries tend to address pressures to do long-term counseling. The University simply can't afford to fund all of the long-term counseling we could do and all of the short-term counseling and non-clinical work we "should" do. Stated another way for emphasis, we will never have an excess of resources, and the needs of our client population–in terms of either volume or severity–will often exceed resources we can devote to them.

Currently, as well as historically, four mandates for our clinical work derive from our Mission and Boundary concerns: (1) we must emphasize immediate (same day) student access to Initial Appointments, so as to make timely assessment and disposition decisions possible, (2) we must emphasize crisis intervention (including suicide prevention), (3) we must de-emphasize offering long-term individual counseling (but not its value), and (4) we must emphasize short-term individual counseling, group therapy, referral and other effective alternatives to long-term individual counseling.

Consequent Counseling Center Priorities for the Initial Appointment

Starting with your Initial Appointment with a client, you or I may prefer to gather information with a view toward personally (perhaps immediately) providing an intervention (other than referral) to address

that client's needs. Of course, that preference is shared by many clients. However, while gathering information, if you and all other counselors convey assumed commitments to personally intervene, your individual commitments will add up to eventual over-commitment by the whole Center. Again, note that our client population's needs will always exceed the Center's resources.

Over-commitment has at least three harmful consequences: (1) it leads to an unfair and possibly harmful delay or lack of services for clients who come in later on, (2) it leads to your burn-out, and (3) after you burn out, it leads to you providing inadequate services to clients you've already (over-) committed to.

Thus, for most Initial Appointments, your first priority must not be toward personally providing the intervention. Usually, instead, your first priority must be to gather information with a view toward making an appropriate disposition. That means placing each client as well as you can and helping the client adjust his/her expectations to the potentials and the limitations of that placement.

With the above University mandates in mind, "an appropriate disposition" will include assessing for–and perhaps addressing–any present or likely crisis. Also, however, it usually will consider long-term individual counseling by anyone in the Center as an option of last resort. More positively, it will favor short-term counseling, our other in-house options, or outside referral. We have a strong commitment to serve all clients who are likely to be helped by our alternatives to long-term counseling, when those are available and appropriate. To fulfill that commitment, however, we won't be able to serve all clients beyond the Initial Appointment.

Thus, sometimes your "appropriate disposition" will be to make an outside referral (e.g., to a local clinic or to a local therapist in private practice). As is the case in other professions, an outside referral can be a truly legitimate service and sometimes it is the best option you can offer. When the process of outside referral goes well, you may be perceived by the client as a helpful "messenger" of the Center's limitations and as a helpful "conduit" to an outside service provider. When it goes poorly, you are likely to be perceived more negatively–perhaps as one who "denies" services to the client and then "dumps" him/her on someone else's doorstep. For a variety of reasons, but especially that of wanting good follow-through by the client, it is important that you value this option, yourself, and that you learn how to present it in an informed, positive way that will help the (sometimes reluctant) client value it too.

Some Basic Elements of the Initial Appointment

Advance Preparation

In the course of any day at the Center, you will play a number of roles, each of which requires its own type of mental set and attentional focus. Most days are tightly scheduled, giving you minimal time to shift from one role to another. Clients coming in for their Initial Appointments each carry with them a unique, sometimes conflicting, mixture of motivating pain and inhibitory apprehension with regard to what this Initial Appointment will be like; each also carries an expectation that you will be thoroughly in your "initial appointment role" from the moment you greet them in the waiting room until the moment

you say good-bye. It is important for you to be in the right role from start to finish. You are more likely to be "in role" if you invest a few minutes into some advance preparation.

If you pause and think about some of the things you want to accomplish in your first few minutes with the new client, some practical implications will fall into place. First and foremost, you will want to establish enough rapport that you and the client can work well together. A key requirement for rapport is that you make a genuine "human connection" with the client that is in keeping with your role and with your client's reasons for coming to the Center. It is hard to make any meaningful connection with this new client if your thoughts and emotions are elsewhere, for example, with another client that you just finished seeing. For that matter, stupidly obvious as it may seem, it is hard to make that connection if you are in physiological distress, for example, talking to this new client and regretting that because you were late to start the session you neglected to take a bathroom break. Clearly you should deal with your distractions first–e.g., by jotting down a few key words to "situate" lingering mental or emotional concerns about your previous client and to allow easy retrieval later on . . . and then taking that bathroom break. These few moments are an important investment for the upcoming hour.

On return to your office, invest a few more minutes by previewing the clients' paperwork. Depending on the case, you may go over the paperwork more once you've brought the client in, but get started on this ahead of time. Your training and previous experience will help you use this material to begin generating hypotheses that you will explore as you gather information during the interview. More immediately, however, clues and concerns expressed in the paperwork can help you begin to grasp some of the client's perspective and to identify more accurately what to connect with in him or her.

These same clues and concerns can also help you more effectively address what will be your other immediate task (along with rapport building), namely that of orienting the client to the purposes and nature of the Initial Appointment. Ideally the client's orientation to the initial appointment will have begun already with him/her reading the Counseling Center brochure and/or the "Welcome" flier that comes with the pre-counseling paperwork. Both the brochure and the flier describe our commitment to confidentiality, both refer to a range of Center services, both emphasize the priority toward appropriate disposition during the Initial Appointment, and neither promote an expectation that the Center will offer long-term individual counseling. Of course, for a variety of reasons, these written materials will fail to orient many clients, making it necessary for you to go beyond mere confirmation of the materials and do an actual re-orientation. Again, a preview of the client's paperwork gives you a head start on understanding your "audience" enough to be effective in whatever orientation you find necessary.

The remaining suggestions for advance preparation involve anticipating special steps you may want to take, or special needs you may have to respond to. Again, the paperwork gives you some of the clues on what to anticipate–e.g., to quickly check the meeting times and openings in the Sexual Abuse Survivors Group if the client's paperwork suggests this group as a possible option. Other examples of anticipating special needs might include calling the receptionist, warning him/her that you may be late for your next hour's commitment because of the complexity and urgency that the present paperwork suggests. With less urgent appearing cases, you may still need more time than is left in the Initial Appointment hour, either because of the lateness in getting started or because of the complexity; here remember that you

can schedule the client for a second appointment–an Extended Assessment–and defer your disposition until then. A central benefit to these and many other possible anticipatory steps is that having taken them you can more comfortably and more fully focus on the client, and on your role with that client, once you go to the waiting room and make your introduction.

The Introduction

Thanks in part to your advance preparation, you are mindful of your first tasks with the new client–to establish rapport and to orient him/her to the session. Now you tell the receptionist you are going to take your client–this courtesy on your part helps the receptionist as he/she makes sure everyone is getting taken care of.

Perhaps with some coaching from the receptionist, you spot your client among others in the waiting room, you walk up to him/her, and you say something like,

"Are you Ashley?"

He/she nods in the affirmative, and you continue, with an extended hand and whatever facial expression and tone seems appropriate,

"My name is Pat Doe. I'll be your counselor for this Initial Appointment. My office is back this way."

Note that in your handshake and in your choice of tone and expression, you are already beginning to work on establishing rapport. Also, your choice of words is the beginning of your orienting the client to what this meeting is about: "I'll be your counselor for this Initial Appointment" has a much different meaning than, for example, "I'll be your counselor."

Many clients have misgivings about whether they did the right thing in coming to the Center, and your assurances can be helpful. Thus, once the client is in your office and you are both seated, consider gesturing toward the paperwork you are holding and saying something like,

"I appreciate your having filled out this paper work; it helps point me toward some of the things your are dealing with. You've indicated some issues here that are distressing to many students. I'm glad you've come in, and I'm hoping that by the time we're through today, we can arrive at some directions or services that will help you get these issues resolved."

Note again the emphasis both on rapport (e.g., connection via assurances of normality and legitimacy; expression of concern) and on orienting the client (toward an appropriate disposition).

After assuring the client, if that seems appropriate, the usual next steps in the introduction are to determine whether the client understands the ground rules, perhaps again to articulate the priority on appropriate disposition, and then to structure the rest of the session with a brief overview. You might begin by saying something like,

"Before we go into these issues, I need to clarify several things. O.K.?"

Assuming that the client responds in the affirmative, proceed with something like,

"The first thing I need to be sure of is that you understand our confidentiality rules.

Do you have any questions about the confidentiality form you just signed or the confidentiality guidelines we operate under?"

Help the client on this as needed, especially making sure that he/she understands the main points– i.e., the need for his/her written consent before any disclosure by the Center, and the three conditions for exception to that rule (i.e., imminent threat to life; likely, ongoing child

or elder abuse; or a subpoena signed by a judge in a court of law).

In a similar fashion, if you are required to tape the interview because of your training status, identify that status (e.g., clinical intern), make sure your client understands the uses of the taping (i.e., supervision and/or consultation with colleagues at the Center), and assure him/her of our confidentiality protections concerning taping.

Next, give a more direct articulation of the Initial Appointment's primary goal of arriving at an appropriate disposition. You might say something like:

"As you may have gathered from the materials that the receptionist gave you, our primary focus today will be on exploring the issues that bring you here and to come to a decision as to the best next step. That next step may involve some service we can offer you here at the Counseling Center, or perhaps some service elsewhere. We'll try to figure that out."

Many clients will be comfortable with the prospects that you have just described, and be ready to begin. On the other hand, some clients may need some time to do some processing with you. As with other issues involving informed consent, the time needed for that processing will probably be a worthwhile investment for both of you.

The final aspect of the introduction is to simply give structure to the rest of the session through a brief overview, such as the following:

"O.K., for the rest of the session, here's what I'm hoping we will do. I'll have you describe your issues and related material, and I'll ask questions as we go. Of course, in one session, we won't be able to cover every possible aspect, but hopefully we can get through enough to form some reasonably intelligent conclusions as to what might be your best remedy or approach to a remedy. Then, whether that remedy involves future contact with me or not, I'll try to offer any initial suggestions that might help you get started on your way. Does that format sound O.K. with you?"

Assuming that the client answers in the affirmative, add something like:

"Oh, I should add that we'll come to a stopping spot by ten minutes of the next hour. If we haven't arrived at some conclusions by then, we can always schedule a second meeting to finish up."

Having provided this structure to the client, you are now ready to proceed.

Individualized Information Gathering

The outline provided in Chart I in the Appendix provides a structure you may find useful for gathering information relating to the client's presenting complaint. Whether you follow that structure or some other structure, you will be continually facing the question of "how much information" to gather. Two helpful criteria might be:

1. Do you have a clear idea of the nature of the presenting complaint?

2. Do you have enough clues (from the presenting complaint, the client's history, and his/her ongoing vulnerabilities and resources) to make reasonable hypotheses concerning what he/she needs in order to get on a good trend?

Thinking first about the referral complaint, you may want to begin this part of the discussion with something as simple as,

"Well, why don't I turn the floor over to you, and finally give you a chance to tell me what is bringing you here today?"

Alternatively, you may use something from the client's paperwork as a lead-in.

Don't assume that the client will always have a clear articulation of what the referral complaint is. Indeed, part of your task may be to help him/her make that articulation. The outline in Chart I encourages you to explore along various qualitative and quantitative dimensions and to explore the client's perceptions as to what is causing his/her problem. Going specifically into each of these dimensions and into the client's perceptions increases the likelihood that both of you will end up with a reliable, valid picture of the referral problem. Also, this specificity may reveal important clues as to what has led to the initiation or maintenance of the referral complaint.

Getting this specificity can serve another function for later counseling: it can give the client and any future counselor a baseline from which to evaluate progress, one that is more reliable and valid than if the description was left vague. This can be important. Consider, for example, the therapy situation and the fact that perhaps all of us would have a tendency–on bad days–to say things are terrible and that no intervention is working. But maybe part of the intervention is working. Maybe, for example, I am your client and my "Problem X" used to plague me 90% of the time. Now it only plagues me 10 %–but today is one of those 10% times and I, in my pain, am overgeneralizing and telling you, my counselor for the last four sessions, that our efforts have all been in vain! If, from my Initial Interview on, I had learned to step back and think with more specificity about "Problem X," perhaps I'd have less tendency to catastrophize. I might have been more inclined to ask what else was different when things are bad, and less inclined to throw out what had led to the reduction from 90% to 10%. (Obviously, the Initial Interview can be therapeutic, despite my insistence on "appropriate disposition" being your top priority!)

The outline also encourages you to gather clues from any past occurrences of the referral complaint, from anything in the client's childhood or family history that could be relevant, and from anything in the

client's paperwork that could be of importance. Throughout, it is possible that other issues might come up that you and your client will ultimately assign higher priority to than the referral complaint. Often, however, the outline will provide an efficient order for your exploration, using preceding questions and answers to help you appropriately frame and limit range of the material covered next. As you progress, remember that you are looking for clues with regard to what is going on with this client and his/her referral complaint–e.g., clues from his/her difficult times that may hint at what needs to be altered or deleted; clues from when things have gone "right" that might help you identify what needs to be added; clues from things like onset, pattern, complexity, or durability that might help you predict likely length of counseling, etc.

Finally, throughout the interview, look for ways to estimate the client's strengths and resources. Information on ongoing family support, social support (at home and on campus), and various skills and psychological strengths can help you estimate the range of service options, the urgency with which the options should be exercised, and the prognosis.

Areas to Address for (almost) Any Client

Charts II - V in the Appendix provide "suggested questions" which are designed to facilitate assessment (and documentation!) in four crucial areas: Dangerousness (suicidality/homicidality), use of Alcohol & Other Drugs, Prescribed Medication History, and Trauma History. They cover material not always pertinent to the client in front of you. Often, when an area is not pertinent, the combination of the client's paperwork, his/her presentation of the referral complaint, and his/her answers an area's first one or several questions make that clear and you can decide to omit the rest of that area's questions. However, when in a pertinent area, most or all of the questions in it can be very important, not only for treatment considerations, but sometimes for your protection against legal liabilities.

Concerning how and when to address these four areas, often times you may choose to wait until after covering the presenting complaint. On the other hand, sometimes you may choose to begin all of your information gathering with one of these four areas. (The most clear example of this would be if there is any indication of suicidal concerns in any of your client's paperwork.) Often, however, as you gather information on the client's presenting complaint, issues will emerge which provide helpful segues into at least some of these areas, such that you can go into them without having the interview seem unduly structured or interrogative.

To help you remember the four categories and the questions that fall within them, I've underlined certain letters to encourage your use of mnemonics. (I also did this with the first set of questions, in Chart II, in the Appendix.) For example, to help remember the above four categories, you may find it helpful to combine the above underlined letters to make the quasi-nonsense word, "DAMAT" . . . whatever helps. Obviously, I encourage you, if you prefer, to make your own memory devices, or do without, as best suits you.

Also, with all four sets of questions, you should feel free to "deviate from the script" and fit your own style with the client's needs. Ideally, the content in the questions will guide you to an adequately

complete assessment, and the wordings will help you formulate your best way(s) to address the content.

DANGEROUSNESS. See Chart II for the Suggested Questions for Assessing Dangerousness. Beyond the questions, I would like to offer several other considerations that might help you increase the value of this part of your assessment and related treatment.

First, if you find that the client has made a suicidal threat or attempt in the last 60 - 90 days, he/she is mandated by University policy to have a minimum of four assessment sessions with you. This particular disposition decision is not yours to make; it is automatic. It is based on experiences, here and nationwide, where clients failed to get adequately assessed–sometimes even avoided getting adequately assessed–and remained vulnerable, tragically, to the next set-back or crisis. You'll find that many clients accept the four session requirement in a positive way, especially when they realize that it is intended for their benefit, and that we aren't trying to control them. (Indeed, we're trying to enhance their control, especially concerning the issues to which they are sovulnerable.)

Second, keep in mind the following list of factors widely thought to be important in assessing suicidal risk:

- history of suicide attempts/threats–including recency
- the medical seriousness of previous attempts
- likelihood of being discovered/provision for rescue before actually dying in previous attempts
- acute suicidal ideation
- severe hopelessness
- depression, anxiety, hostility–or possible interactions of these
- psychotic processes
- severe judgment and/or impulse control problems
- health problems
- attraction to death
- family history of suicide
- use/dependence of alcohol or other drugs (including prescription drugs) at a level which may affect judgment and/or impulse control
- recent losses/separations–e.g., concerning significant other, career, status, ability, etc.
- social support system–e.g., does client live alone?
- personal or cultural considerations–e.g., attitudes toward suicide; beliefs about the nature of death, etc.

An implicit concern is the question of what it is that the client is hoping to accomplish by dying. In assessing risk, both the number and the intensities of these factors need to be taken into account on a case-by-case basis.

Third, the earlier comments concerning the importance of making a human connection with the client pertain to the dangerous client too. Your sincere, honest expressions of caring, hope, and willingness to

see the client through this crisis can be very important. Concerning risk factors, your client's failure to do his/her part in establishing that connection between the two of you can be yet another important diagnostic indicator.

Finally, if you determine that the client's risk of imminent danger to self or other is high, among your many consequent steps be sure to include the following three:

(1) openly obtain consultation from another counselor. This is an act of caring on your part, and if you explain that to your client, it is likely to be appreciated.

(2) if hospitalization seems appropriate, consult the "Emergency Hospitalization Kit," available with the Receptionists at the Front Desk.

(3) commit yourself–within safe and legal limits–to reaching a point where physical security is established for the client or whoever is in danger. Whether that commitment involves inpatient or outpatient disposition, law enforcement assistance, etc., it may require a lot of time and probably a lot of energy. Commit yourself to that time and energy, regardless of whatever else you were scheduled to do that day. On a "business as usual" day, you will honor a variety of obligations and priorities, each in its own time slot; when you are working with a dangerous client, things aren't "business as usual" for a while. Ask a receptionist to carry the message, and trust that the next scheduled client(s) or colleague(s) will not fault you for temporarily shifting your priority to this emergency.

ALCOHOL AND OTHER DRUGS. Going again to the Appendix, consult Chart III for some Suggested Questions for Assessing Alcohol and Other Drug Use. The client's paperwork and the client's responses to the first few items from the chart will help you know whether to further pursue AOD-related questions. With clients for whom it is appropriate to go further, the chart's remaining items may give a helpful start. Beyond that, the following paragraphs provide some considerations to guide you toward additional information you may need in order to make an appropriate AOD-related disposition.

It is useful to keep in mind that many clients who abuse AOD are prodded or required to seek help by alarmed family members, friends, University officials, or the law. Ideally, they also come because of their own alarm with problems their substance abuse is causing–problems which can be very tangible, large, and immediate. When other psychological issues seem relatively minor compared to the student's AOD issues, he/she will typically be referred to the University's Alcohol and Other Drug Office for an assessment. When students with significant AOD issues are referred to the Counseling Center (or come here on their own initiative), it is usually because of concern for other psychological issues going on at the same time. Whatever the client's initial presentation, while gathering information on his/her AOD problems, try to gauge the client's concern for the consequent problems as well as the client's awareness of connection between AOD use/abuse and those problems. Both the client's awareness and concern will be pertinent to your disposition decisions. Also, keep the Alcohol and Other Drug Office in mind, possibly for a more in-depth assessment on AOD issues, or for consultation with regard to disposition.

In lieu of other clues for lead-ins on related problems, you may start by asking the client, "Have you ever done anything regrettable while drinking (using drugs)?" This–and similar questions–may lead to descriptions of:

- legal problems your client has had to face (e.g., under-age violations, controlled substance violations, vandalism, etc.),
- harm to him/herself (e.g., over-doses, blackouts, injuries from falls, etc.)
- dangerous and/or anti-social behavior (e.g., driving under the influence, unprotected sex, sex without mutual consent, fighting, emotional abuse, etc.).

Initially clients may be relatively unaware of the impact of the AOD-related behavior on social and financial quality of life. Thus, for example, it may be more difficult to determine whether AOD use/abuse is:

- serving as a replacement for an inadequate social life,
- restricting the client's range or quality of social life,
- compromising the client's financial situation.

Finally, the client may be unaware of the impact of AOD use/abuse on academic problems. For example, while aware of physical discomfort or sluggishness, of problems in initiating or sustaining a focused activity (such as studying), or of drastic disruptions in circadian rhythm (and thus disruptions of any functional routine), the client may not link these problems to AOD use/abuse. Instead, the client simply may have stopped with labels (e.g., "motivation problems," "poor study skills," etc.) or rationalizations (e.g, "these courses are so superficial and irrelevant compared to what I should really be doing at this time in my life").

Looking beyond the above types of problems, try to assess the client's level of ability to resist AOD use/abuse. A client may be physiologically addicted, psychologically addicted, or vulnerable because of a combination of both physiological and psychological factors:

- concerning possible physiological addiction, especially question about any symptoms that develop in periods of abstinence (withdrawal symptoms), and about any need for increased dosages to get the same desired effect as AOD use continued over time (higher tolerance)
- concerning psychological addiction, ask such questions as, "Is AOD use his/her first response to any stress?" and "Is it needed for any activity to be fun?" Perhaps begin by asking, "Have you ever used alcohol/drugs to avoid dealing with problems, concerns, or uncomfortable emotions?"
- concerning vulnerabilities that may involve both physiological and psychological factors, especially ask questions to determine whether:
- the client can stop, once started–or does he/she "have" to continue until unconscious or until the supply of the substance is used up?
- Is the client so sensitive to this substance that a very minimal dosage can have very strong effect?

With all of this information, there are still some things to consider before making an AOD-related disposition. Assuming that you think your client has a significant AOD-related problem, a very important concern is whether your client shares that opinion. More specifically, "Does the client acknowledge his/her AOD problem?" and "Does the client strongly desire to resolve that problem?"

Negative answers to either question do not bode well for the treatment options you have at your disposal. On the other hand, positive answers may come following consultation and possible referral to the Alcohol and Other Drug Office. Whether through following suggestions you receive there, or through a more in-depth AOD assessment that this Office can provide, or through one of its education and awareness programs, the Alcohol and Other Drug Office can help you give your client a helpful, motivational "one-two punch."

Also, of course, keep in mind that the client's positive responses will more likely come via your gentle encouragement and explanations. The emphasis on "gentle" comes from ethics as well as practicality: ethically, a counselor helps the client become aware of beneficial options while respecting client autonomy; practically, an unduly strong sales pitch may interfere with the client eventually "owning" the disposition in question and giving adequate follow-through. Even if your client says "no" to you today, the discussion may help him/her be more readily able to say "yes" later on, possibly after additional psychological development or after additional consequences from his/her AOD-related lifestyle.

Positive answers to the awareness and desire questions improve the prognoses with each of the four main treatment options you have at your disposal at the time of this writing. Those options are inpatient treatment, and outpatient referrals either to Alcoholics/Narcotics Anonymous, to private practitioners in the local community, or to short-term counseling here at the Center. With emphasis on your consultation with the Alcohol and Other Drug Office, considerations for these options include the following:

Often, the first concern with an inpatient referral is to provide a safe detoxification procedure and a controlled, supportive environment for getting past the most basic levels of physiological dependency. Also, for many, this environment is best for establishing (or re-establishing) basic coping mechanisms which will be needed for safe re-entry into the outpatient world. Any treatment plan involving inpatient referral should be followed by regular outpatient treatment, very likely over an extended period of time.

Among the outpatient options, Alcoholics/Narcotics Anonymous (AA/NA) can be especially appropriate where the client is in need of a built-in, strongly supportive, social system. Also, as abstinence-based programs, AA and NA might be considered when a goal of "moderation" is not wise. Here, especially consider the client whose past record shows extreme vulnerability to abuse following any deviation from abstinence, or for whom any instance of abuse leads to especially disastrous consequences. Sometimes, because of age differences, or because of the religious emphasis within AA/ NA "Twelve Step" programs, or because of some AA/NA groups' tendencies toward dichotomous thinking, certain college students do poorly in AA or NA; on the other hand, these groups have had excellent results with other college students.

Factors favoring the other outpatient options—to private practitioners or to the Counseling Center for individual counseling—contrast with some of the above factors for AA/NA groups. For example, the individual counseling options may favor the client who already has a strong, available network of friends who are supportive of therapeutic change. Also, these options can accommodate the client whose goal is moderation, as well as the one for whom abstinence is the goal. Finally, individual counseling approaches can more easily tailor themselves with regard to the client's specific needs and biases. When deciding between a referral to a private practitioner vs. to the Counseling Center, the two major factors are accessibility and likely duration of treatment: depending on timing within the school year, either option may be more accessible than the other; concerning duration, many private practitioners favor long-term counseling whereas the Counseling Center's mission favors short-term counseling.

Finally, whatever treatment option, be sure to emphasize the importance of follow through and to help the client anticipate likely obstacles/detractors to follow through. Clues may come from questions such as, "Have you ever sought counseling to address AOD issues before?"

PRESCRIBED MEDICATION HISTORY. Going once again to the Appendix, consult Chart IV for some Suggested Questions for Assessing Prescribed Medication History. In general, the purposes of these and any related questions are to help assure your appropriate consideration of any medically-related complications that may be pertinent to your client's referral complaint, and to trigger any appropriate consultation with medical professionals. Clearly these questions are NOT meant to imply that you should claim (or offer) medical expertise.

Some of the concerns behind these questions are straight forward. For example, depending on the client's answers, you may want to consult with a general physician as to whether the client's referral complaint is affected by an ongoing physical ailment or perhaps by the medication for that ailment. Also, of course, where answers raise the possibility of a hereditary predisposition to the referral complaint, your likelihood of seeking some type of medical consultation usually increases.

Beyond such concerns, however, the questions in Chart IV can lead to other useful information. For example, the client's past experiences in treatment have relevance to his/her present treatment-related expectations; what did or did not "work" medically may influence everyone's confidence in what will work next; poor compliance with past "doctor's orders" (e.g., the client unilaterally deciding to stop medications) sometimes (not always) reflects more general problems in communicating with a professional or in following through with a commitment to a treatment program; etc. The important point here is that you are not only seeking information for making an appropriate disposition, you are also seeking information on what you can do to make that disposition effective–e.g., will you have to educate (or re-educate) the client concerning certain misconceptions, will you have to address (perhaps contract on) issues of commitment and follow-through, etc.

I hope that the Chart IV questions and this brief, accompanying discussion suggest a strong caution against overlooking a client's medication history, the reasons those medications were prescribed, and the positive and/or negative effects of those medications. On the other side of this caution, the client's presence at this Initial Appointment might also suggest that not all of his/her problems got resolved as a

function of that medication history. You too may have something useful to add (or undo) for this client, either through your own expertise or through the expertise of someone else that you ultimately refer him/her to.

TRAUMA HISTORY. The last set of "suggested" questions, pertain to Trauma History, and are in Chart V, of the Appendix. For our purposes, traumatic incidents can be experienced directly or vicariously, and involve actual or perceived threat or injury to the person you are interviewing (or to someone close to that person). A wide range of incidents can be traumatic, and case-by-case variation in degree of impact must be assumed. Frequently encountered categories of trauma include: abuse (physical, sexual, emotional, psychological); neglect; death of a significant other (family member, friend, a pet); accidents; and substance abuse among family members.

Obviously, material elicited by these questions can be very emotionally charged and painful for the client to disclose. You may feel strong impulses to immediately commit yourself to treating him/her. However, until you get additional information, you can't be sure that such commitment

- would be the appropriate disposition. (Our Center has a policy of providing immediate counseling for survivors of recent sexual assault, but still the appropriate disposition may
- not involve individual counseling with you.) A pre-mature commitment on your part could risk feelings of rejection by the client later, as well as feelings of resentment, especially if the client disclosed more than he/she would have wanted to tell to two counselors.

Perhaps more than usual, in this difficult situation, you have to balance two, somewhat opposite concerns:

- to elicit enough information to make an appropriate referral.
- to avoid eliciting so much information that you make the interview itself unduly traumatic.

Regarding this second concern, remember that the client may experience after-session reactions that you can't yet predict or control–you have known him/her only an hour. Beyond that, of course, you want the client to be able to return for further sessions without undue fear. Ideally, you will be able to achieve the balance between the two concerns, and do so in a way that reinforces the client for having sought help and for having given you the information you needed to identify the next positive step.

Perhaps more than usual, when eliciting trauma-related material, remember the importance of combining support with therapeutic objectivity:

- Opportunities to provide support may occur when the client isn't comfortable answering certain questions: respect a client's right to not disclose; perhaps explain (without browbeating) the reasons you are asking those questions; and support the client's efforts toward self-care, whether that self-care involves disclosing or not disclosing. Support can also occur when you avoid pressing too hard on the client's inconsistencies; part of the client's trauma may have included not being believed by important people in his/her past. Often, on the other hand, it will be appropriately supportive to respectfully disagree with

the familiar, sad distortion of, "I deserved_____(the traumatic incident)."

- Think of therapeutic objectivity as a point along a "passion continuum." The client needs a level of passion in you that makes it apparent that you care and that your expressions of support are not just fluffy techniques that you learned in a psych book On the other hand, if your passion and reactions to his/her trauma are too strong, you will destroy your trustworthiness; the client needs to be able trust your ability to personally handle the painful material he/she presents, as well as to trust your viewpoints–he/she can trust neither if you are a "loose cannon."

As an example of where support and therapeutic objectivity can combine in the Initial Appointment to the client's benefit, consider the situation where a client describes the actions of his/her perpetrator in the client's experience of childhood sexual abuse. The client's mixture of emotions will frequently call for support on your part–behavior on your part that would mean nothing if you lacked any passion for the client. However, if your passion was unduly high, you might globally condemn the perpetrator and inadvertently impede the client's progress. After all, for all you know, despite the client's anger or pain, he/she may have some identification with the perpetrator such that your attack on the perpetrator might come off as an attack on the client. Also, your global condemnation might reinforce a harmful tendency in the client to globally, dichotomously engage in self-condemnation in the face of personal failings, rather than to embrace the complexities of human existence and to address personal behaviors and personal worth as separate entities. As an example of a positive contrast, a stance on your part that could combine support and therapeutic objectivity might have you expressing sadness that the perpetrator's actions occurred and confirming that nothing the client could have done as a child (or as an adult) could have justified this having happened to him/her.

Making the Disposition

The overriding theme of this section is mutuality. Perhaps mutuality should be the over-riding theme of all sections in this Manual, but it is especially true that it has to be the over-riding theme for this section. The reason is that an appropriate disposition requires at least two key elements: (1) exchanges of information between you and the client, and (2) commitment on the client's part to follow-through with whatever disposition the two of you arrive at. Much of the focus so far has been on questions you would ask and considerations you would keep in mind as you got information from the client. At the same time, however, whether you noticed or not, the client has been trying to get information from you. Whether verbalized or not, his/her question has been frequent and consistent, asking something to the following effect: "Are you comprehending what I am saying—at both the factual and emotional levels—and do you care?" If (rightly or wrongly) your client perceives the answer to be a frequent and consistent, "no," he/she will find it difficult to feel interest in disposition options you describe. If, during your descriptions and ensuing discussion, the answer continues to be perceived as "no," your client will also find it hard to feel ownership and commitment to any of those options. In short, mutuality has been important all along, and it remains important in the process of making the disposition.

Ideally, for starters, your acknowledgments and other feedback throughout the Initial Appointment–via non-verbals, clarifying questions, playbacks, etc.–will have given a consistent "yes" to the client's

consistent question. If the client has perceived otherwise, the first step in making the disposition provides you a chance to rectify the situation. That first step is where you play back to the client your version of the client's clinical picture. Part of that picture is based on what you've observed in the client's words and behavior, and part of it–presented in the form of tentative hypotheses–is based on your expertise. In your playback, in your tentative hypotheses, and in your way of inviting feedback, I suggest that you make an important, implicit disclaimer. That is, I suggest that you imply: that human behavior is complex; that despite any appearances to the contrary, you've been trying to get an accurate picture; that you've got the good sense to realize you might have missed something; and that though you'd prefer to not seem stupid, you care even more about making sure you've got things straight. I predict that most clients will appreciate your implicit disclaimer–and not think you are stupid–whether or not some of your clinical picture needs modification.

After comparing clinical pictures, ideally arriving at a mutually shared version, your next step is to describe some of the disposition options that may pertain to this picture. (See Chart VI, in the Appendix for a listing of–and brief comments about–most of the Center's major categories of disposition and referral options.) Continuing on the theme of mutuality, it is crucial that you tailor your selection of disposition options–and your presentation of those options–to the needs and concerns of your client. Like good tailors, good clinicians don't believe that "one size fits all." However, to be effective, we must also make sure that our clients realize that we don't believe "one size fits all." To relieve your client of such a misconception, you usually will need to provide a rationale for the disposition(s) you are offering and a brief description of what is likely to happen during the course of that disposition. Much of the information you will need for doing this is beyond the scope of Chart VI or this Manual, but will be covered during other aspects of your Training and Orientation to the Center.

After you present your disposition options to your client, it is also crucial that you elicit your client's reactions to those options. You may need his/her reactions to guide you in providing further explanations, clarifications, and/or assurances–or in considering additional options. Failing to get the client's reactions runs the risk of getting only a passive agreement to "Do X" (where X equals your preferred disposition). Passive agreements are fine for getting the session done sooner, but they have a lowered probability of active follow-through by the client, which of course is the whole point in making the disposition in the first place.

Finally, you should be prepared for the possibility that you and your client may end the Initial Appointment in disagreement over the question of disposition. The client may reject all of the options that you deem appropriate, perhaps insisting on options that you deem inappropriate. Also, the client may insist that the Center provide him/her with options outside of our available services. In cases like this, avoid letting a power struggle or a stand-off develop, and instead still try to maintain a process of positive mutuality. In the spirit of that mutuality, (1) make sure that you fully understand each other, (2) re-schedule for an Extended Assessment appointment during one of your Follow-up Hours, and (3) assure your client that you will consult with your supervisor or another colleague before that next meeting. Chances are that both you and your client will return for that meeting with additional approaches, information or perspectives that are more conducive to a mutually satisfactory outcome.

Final Touches to the Initial Appointment

Let's assume that you've done a great job of keeping disposition as your top priority for the Initial Appointment and that you've made that disposition. Then what? Whether you have a lot of time left in your 50 minute session or only a minute or two, what else is left for you to try to accomplish?

Perhaps most obvious, especially after you complete the rest of your training and orientation to the Center, there will be some logistical things for you to do. For example, depending on the disposition, you may need to schedule the client for a second session, or have him/her fill out a release of information form to facilitate a referral outside the Counseling Center, or line him/her up for a group screening interview, or complete a schedule card as part of the procedure for putting him/her on the Wait List. At a minimum, you'll probably give the client your business card, shake hands (if that seems appropriate) and wish him/her good luck as you usher him/her out your door. But whatelse?

It might be helpful to ask this question from the client's point of view. Perhaps from your perspective, this client is one of several you'll be seeing this week, presenting challenges that will soon be fairly routine for you. Most likely, from the client's perspective, this interview is a bigger deal. Before the interview, your client may have been building up his/her courage and sense of anticipation for hours or even days. Maybe he/she had misgivings as well as hopes about what might happen. While most won't expect an instant "cure" (actually, a few will), and while many will be able to reduce their expectations down to receiving the "appropriate disposition" I've been talking about so much, still most are going to be very appreciative of any additional gifts you can give them before they leave.

So what are some other possible "gifts?" Looking back at Chart VI, a brief elaboration on some of the items listed under "One-Shots" (A.3.) might provide you with ideas. For example, you may have opportunity to provide new information (e.g., someone on the brink of flunking out might find comfort in knowing that many students who have flunked out have then resolved their problems, recovered, rebuilt their credentials, returned to UIUC and successfully moved forward again). You may introduce a new perspective (e.g., for the test-anxious client who thinks his/her parents only care about G.P.A.'s, it is a pleasant surprise to stop and have to acknowledge that these same parents would fiercely defend him/her against any outside critic, no matter what the client's academic status). Sometimes your very questions introduce new perspectives by helping the client realize previously unnoticed and incongruous assumptions (e.g., highly materialistic assumptions that get exposed in the context of questions about the client's various personal relationships). In light of all of the toxic environments our clients face, you will have many opportunities to validate experiences that have been disconfirmed by others (e.g., "No, it doesn't make you a prude if you don't want to go to bed with this guy you hardly know"). You may also have some fairly quick suggestions that won't solve THE problem, but may still help improve your client's quality of life and long-range ability to solve THE problem (e.g., sleep suggestions for a mildly depressed client whom you are putting on the Wait List for Individual Continuing Counseling). Above all, whatever the disposition, any realistic message of hope from you is likely to be on target. Often, the client's hope is a significant factor in his/her motivation, which in turn is a significant factor in making most interventions successful. The two main caveats with any "gift" are (1) that the client understands that he/she should not substitute the "gift" for follow-through on the disposition, and (2) that you be sure you know enough about the disposition you've made that you

neither introduce false hopes nor any interventions that would run contrary to what will happen in that ensuing disposition.

There is one more "gift" that will seem obvious if you look at the Initial Appointment from many clients' perspectives. Whether they think of it this way or not, many will appreciate anything you can do to make them feel good about themselves as a function of having come to the Counseling Center. In contrast to all of your training and daily experiences which reinforce pro-counseling values, many clients are propagandized with other messages that would make them feel bad about themselves as a function of seeking our counseling. Parts of society still question the legitimacy of counseling and the strength of character of anyone who seeks counseling. These societal doubts have strong impact; if you don't believe me, check your own gut reaction when someone (even jokingly) suggests that YOU need counseling. Thus, throughout the interview, including at the end, look for opportunities to counter these messages. Clients are not "bad" for needing help; they are not "weak" for seeking help; we're glad to be here, helping them briefly as they search for good paths; and we think they show "strength" (as well as intelligence) by countering societal doubts and getting the help they deserve.

Finally, it is often helpful to ask the client if there is anything else he/she would like to say before the two of you close the session. Sometimes, something very important will be revealed at this point, perhaps something that will change the direction of the disposition. If that happens, curb your own needs for closure, realize that the client is doing the best that he/she can do, remember that you can schedule an Extended Assessment session, and remember that your goal is to achieve an appropriate disposition–not to simply rack up another Initial Appointment. More often, the client will have no new information to add, but will register the fact that you cared to ask.

DOCUMENTATION: WRITING YOUR SUMMARY OF THE INITIAL APPOINTMENT

Your written summary of an Initial Appointment is one of the most important pieces of information in a client's file. It may affect subsequent counselor-client match-ups and treatment planning, and it may have ramifications far beyond the client's contact at the Counseling Center. For example, it may be used by an outside referral source or outside consultant (e.g., a psychiatrist at the McKinley Health Center), it may be reviewed by accreditation evaluators, it may be used as a legal document in a legal proceeding–and it may be read by the client, who has legal access to all records in his/her folder. Therefore, while mindful of your time limitations, you will want to write this report carefully, being sensitive to many issues and recognizing that after you are done with it, your summary may continue on with a "life of its own."

This section offers you a framework for writing up the typical Initial Appointment. I hope it will help you avoid accidently omitting information which could be useful to future clinicians. At the same time, however, you should note several points:

- First, the format discussed here is not the only good way to summarize an Initial Appointment. Modify it to suit your needs.

- Especially be ready to modify the structure according to both the type of referral question and the type of audience that will read it. Not all sections suggested here will be relevant for each Initial Appointment. For example, your summary of an Initial Appointment that focuses on substance abuse issues may look quite different than one which focuses on academic difficulties. For another example, an Initial Appointment summarized for a psychiatrist may look different than one summarized for an academic dean.

- Finally, the tone of an Initial Appointment summary is important. Especially avoid value statements, negative evaluations, or an accusatory posture. As some of our clients may present with behaviors which we see as problematic, this is often difficult. However, you must remain objective, and maintain a descriptive tone; do not allow your own socio-cultural assumptions to flavor your summary. Remember, State Law entitles your client to read/obtain copies of his/her files. Also, remember that for a variety of reasons, you could see anything that you write in a Court of Law someday.

With that happy thought, let's consider the possible sections of the Initial Appointment summary. The overall title of each possible section is underlined, and is typically followed by a description of (a) the goals for that section, and (b) typical information contained in that section.

Title and Center Identification

While it may seem simplistic, consider providing a title and identification section. Many times, copies of the Initial Appointment summary are released to outside parties (e.g., academic deans, referral sources). CMIS does not include such identifying information as a rule when printing, so it is helpful if you do so. One example would be:

Initial Appointment Summary

Your name

Counseling Center

University of Illinois at Urbana-Champaign

Client Identification

This information is important to (a) avoid mistakes in client identification, (b) provide a summary of the assessment process, and (c) provide a social and/or cultural backdrop to the information contained in the report. Examples of both headings and materials included are detailed below:

CLIENT NAME. This should include the full name and Social Security Number of the client, to avoid confusion when two clients have the same name and to facilitate any future access to academic and/or medical records. Also, add any nick-name the client may prefer, to help future clinicians as they begin to establish rapport.

APPOINTMENT DATE. All initial assessment interview dates should be included here. The Counseling Center allows for Additional Assessment Interviews, and some types of specialized assessments may

involve multiple follow-up appointments. Further, should multiple dates be noted here, explain (here or later) why this occurred.

REPORT DATE. Many times reports will not be completed immediately after the interview.

DEMOGRAPHIC INFORMATION. Typically, this section includes: client's age, sex, race, marital status, sexual orientation, and his/her academic standing here at UIUC. The nature of the client's living situation should also be detailed, particularly if it is related to his/her current issues.

Presenting Concern

The goal of this section is to detail the client's stated reason for seeking services at this time. Additionally, however, it is not uncommon that this reason differs from that provided by other sources. For example, a client may state that he/she is seeking counseling because of academic difficulties. However, further exploration may reveal his/her Resident Director pushed the referral out of concern for possible alcohol abuse. In cases such as this, both reasons should be noted, and attributed to their respective sources.

Background Information

This section elaborates on the presenting concern at two levels. First, it provides a more specific explanation of why the client is seeking services at this time. For example, under "Presenting Concern" the client may have stated he/she was depressed. In this section, specific symptoms, their severities, and their degrees of impact on the client's life should be noted.

Second, this section serves to detail the explanations(s) behind the client's stated reasons for seeking services. For example, in explaining the depression, a heterosexual male client may offer a description of how he and his girlfriend recently broke up. He may speak of the reasons which led to the breakup, his feelings regarding it, and his attempts to cope with it himself.

Current Functioning

The purpose of this section is to provide readers with specific, select areas of the client's life, including the previously described four areas addressed with almost any client. Remember, not all of these areas will be salient for all clients, and you should modify as you deem appropriate. As noted for the referral problem, above under Background Information, specific symptoms, their severities, and their degrees of impact on the client's life should be noted. Often, you may choose to merely note that the client denied any issues in a given area. This communicates to readers that you considered this area of functioning with the client, and determined its lack of salience. Examples of subheadings under this section are detailed below.

PRESENTATION. In many mental health settings, especially those serving wide ranges of clients with even wider ranges of problems, this section would almost always require in-depth discussion of the client's mental status, his/her physical/ behavioral/interpersonal impacts on you, etc. As a rule, however, the range of clients we serve, as well as their range of referral complaints, is much more narrow. For example, with occasional exception, most of our clients are of high intelligence, in their late teens or in their twenties, single, and not yet parents. Also, most are non-psychotic, and are neither

suffering from significant brain damage nor from any developmental disability. Given this relative homogeneity in our client population, he benefits (in terms of diagnostically useful information) of in-depth "presentation" write-ups would rarely justify their costs (in terms of the time and effort to prepare them). Thus, unless a client provides some unusual "outlier," something in his/her appearance, clothing, manner, or behavior which would clearly and quickly cause many of his/her peers to react to him/her in unusually negatively or avoidant ways, the "presentation" section is quite brief, perhaps commenting only on the nature of your over-all process with this client, the ease with which rapport was established, etc. On those occasions where you deem it appropriate to go into more detail, it is important to remember to keep the tone descriptive rather than evaluative, to focus on the client's presentation rather than your reactions to that presentation, and to give specific examples of the appearances or behaviors in question. Also, be sure to identify possibly relevant cultural contexts, so as to avoid misleading the reader into thinking certain behaviors are pathological when they may be, in fact, an accepted part of the client's normative group.

RISK ASSESSMENT. All readers will wonder about any potential a client may have for self-harm. The way the CMIS format is arranged, you can acknowledge or dismiss this as an issue early on in the "E&A Write-up" section. Alternatively, you can address the issue in the next CMIS section (entitled, "Client's Suicidal/Homicidal Risk Assessment") after making appropriate reference to it in your "E&A Write-up" section.. The previous "Suggested Questions for Assessing Dangerousness" may provide you the structure for writing this section. Also, of course, be sure to connect issues covered here with the client's referral complaint as appropriate, if the two areas do not entirely overlap. As you will learn elsewhere in your Training and Orientation to the Center, certain levels and types of risk-related behavior mandate additional actions on your part that could include writing a Suicide Incident Report, requiring a minimum of four assessment sessions, or even hospitalization.

SUBSTANCE USE/ABUSE. The previous "Suggested Questions for Assessing Alcohol and Other Drug Use" may provide the structure for writing this section. Again, be sure to connect as appropriate, substance abuse issues to the client's referral complaint. Especially include any issues of awareness on the client's part of linkages between the two and any apparent motivational issues that may compromise the effect of future interventions.

MEDICATIONS. Again, you may use the relevant "Suggested Questions" for structuring this section. While you may focus on any psychotropic agents the client is currently taking, be sure to include a description of any/all other medications. This allows future clinicians to get a sense of potential drug interactions, as well as potential side effects which may present in session. Typically, include generic and trade name, dosage information, frequency, and length of prescription. Also discuss the degree to which the client has found the medications effective, as well as an overall side-effect profile.

TRAUMA HISTORY. Again, you may use the previous "Suggested Questions" for structuring this section. As noted earlier, trauma can be defined as either direct or observed experience that involves actual or perceived threat/injury to self or others. Overall, rely less on your definition of what would be traumatic, and more on the client's description. Include such things as: how do they speak of the event? Do they talk of being overwhelmed, terrorized, traumatized, humiliated, or repulsed by the event? Did

they fear that they or someone involved would die? Have they discussed any flashbacks, numbing, intrusive thoughts, or dissociation?

TREATMENT HISTORY. This section addresses previous interactions the client has had with mental health services. This can range from psychological, psychiatric, and medical (e.g., electroconvulsive therapy) treatments to counseling, pastoral interventions, and family therapy. Make sure to cite the nature of such treatment, its length, the issues which it addressed, and the degree to which the client found it helpful. Such information is helpful as it allows future clinicians to establish patterns of distress and coping, as well as rule out potential treatments as unproductive.

MEDICAL/HEALTH ISSUES. This section typically reviews the medical and health concerns which may be impacting on the client's functioning. Not all clients see the back and forth connections between physical and psychological functioning. As important as it may be to address medical conditions, it is just as important to address the client's health behaviors. For example, does the client eat/sleep/exercise regularly? What does the client do to relax and take care of himself/herself? Has the client made any recent changes in any of these areas? Such information can be very useful in charting the course of future interventions.

FAMILY. This section addresses the role the family plays in the client's general life, as well as in the current referral complaint. Typically, you need to present an overview of both the historical and the current family dynamics, as well as a discussion of the relationship between those dynamics and the client's reported issues.

This discussion should be framed within a cultural context, and it should include an exploration of familial history of mental health issues. For example, the client may be the child of an alcoholic parent. How did the family dynamic impact your client's functioning as a child? How does it impact him/her currently? How is it related to the issues he/she is seeking counseling for at this time? How does your client's culture see such behavior? Answering these kinds of questions provides potential insight into the etiology of the referral complaint, and it helps the reader to place reactions in an adaptive, developmental, and cultural context.

LEGAL ISSUES. This section discusses current legal issues impacting on the client's life. Examples include divorce proceedings, abuse charges, substance abuse, violence, and the like. Some clients will present with these issues, others will not, and the importance of this section will vary a great deal from client to client. For example, knowing a client is facing an upcoming court date for underage drinking cues a future clinician to (a) address the client's feelings regarding that event, and to (b) clarify the forces motivating his/her seeking counseling.

ACADEMIC. The purpose of this area is to detail the client's academic functioning. Discussion might include demographics (e.g., year in school, major), as well as a brief history of his/her academic performance. Include a discussion of any impact the client's current distress is having on his/her academic life. Overall, the importance of detail in this section varies. For example, it may be very important to extensively detail the patterns of the client's academic performance, relative to recurring

bouts of depression, or to future ADHD assessments. However, in other cases, detail may be less important (e.g., certain relationship issues).

VOCATIONAL. The purpose here is to detail the client's work life and/or desired work life. As with academic functioning, the importance of this section varies from client to client. For some clients, it may be important to describe the impact of the client's referral complaint on his/her job performance, OR vice versa. For an example of the latter, a client coming in for substance abuse issues may have these issues compounded by working in a bar. In other cases, anticipated career directions may need detailing, for example with certain test anxious clients or clients with certain vocationally related identity problems.

INTERPERSONAL. This section details the extent, nature and content of the client's interpersonal relationships. For example, to what extent does the client have a positive or negative interpersonal history? How does he/she typically interact with others? Does the client feel as if he/she belongs to a social group? Is your client satisfied with his/her interpersonal life? Typically, it is best to include a discussion of the positive and negative aspects of the client's interpersonal functioning. For example, a client may report an adequate social support system, and a strong sense of identification with a group. However, at the same time, this group membership may be allowing the client access to a maladaptive lifestyle. When describing such a paradox, take care that your own values do not bias your report.

Often, this section also addresses the client's romantic and/or intimate relationships, as well as a sexual history. Given the context of our larger society's prejudices against a number of non-mainstream sexual behaviors and relationships, caution needs to be applied with regard to how much detail to include. If such behaviors/relationships are not central to your client's clinical issues, it may be most ethical to limit the depth of your written discussion. As noted earlier, the written summary may take on a future "life of its own"–in this case it could remove too much control of sensitive information from the client.

INTRAPERSONAL. This section summarizes your view of possible dynamics which may underlie the client's issues. Inevitably, the nature of this summary will be driven by your specific theoretical orientation. Realize that jargon-words which for you have lost some of their judgmental connotations still may have quite unproductive impact if read by your client–even words or phrases like "defensiveness," "low self-awareness," or "low level of insight." Thus, try to avoid any jargon that you did not already use in talking to your client, and be sure to aid all of your potential readers through the use of specific examples. Also, remember that the client's strengths, as well as weaknesses, are important to effective treatment planning, and that usually it will be helpful to frame your discussion within a developmental context.

Obviously, after only meeting the client once or twice, it is best to phrase this section as a series of hypotheses. This communicates to readers that while you have ideas about what underlies the client's issues, you realize you may be missing a great deal. You want future clinicians to get whatever benefit is possible from your hypotheses, but to not feel bound by them. After working with the client for some time, totally different hypotheses may have acquired more credibility.

Clinical Impressions

The goal of this section is to capture the essence of the client's situation. While the Counseling Center does not employ formal diagnoses, it may be useful to think in those terms while providing a descriptive impression. Often, this section includes a summary of what distress the client is reporting, as well as your clinical judgment (couched with appropriate qualifications) as to the cause of this distress. Do not be afraid to note an inability to formulate specific impressions of the client; merely note the reasons for this (e.g., the client's articulation difficulties, time constraints, etc.) and state that more investigation seems called for. If needed, consult your supervisor for specific input.

Disposition

Obviously, the main purpose of this section is to identify the main disposition you and your client arrived at, along with any concurrent or sequential dispositions (e.g., referrals to the Career Development Center, etc.). In addition, it is often helpful to describe some of the interactive process that went on when you made the disposition(s). Why was this disposition(s) chosen? Did the client have any hesitations and how were these hesitations addressed? What disposition-related expectations and/or concerns might the next counselor need to be ready to address?

Today's Intervention

Beyond gathering information and arriving at a disposition, often you will have provided an intervention. It is important that you document that intervention, because client's response to it can be of considerable interest to the next counselor. For example, it is of interest in the choosing of future interventions whether this intervention was helpful. If successful application of your intervention required actions by the client in between sessions, it can be of interest whether the client indeed carried out those actions. Further hypotheses and exploration concerning the nature of the referral complaint, the situational context, and any developmental/motivational complexities can be triggered by follow-up on your interventions–if you document them.

A Final Note about Documentation

There was a time when attorneys and other legal experts advised against your documenting certain issues, for fear that you would be held responsible for later related mishaps if it could be proven that you were aware of those issues. The current legal situation is much different: Now absence of your documentation can call into question the quality of care being provided. Going further, now it can be important to note rationales for why certain areas were left unexplored. When in doubt, consult with your supervisor and the Center's Therapeutic Services Coordinator as to what should be considered acceptable practice. . . and do not be afraid to modify the above areas in order to provide the best services possible for your client.

Concluding Observation

When reading about counseling, I tend to form abstractions in my mind about the counseling process and about the clients involved. Later, when I return to the real world, actually providing real, live counseling, with real, live clients, I realize how little overlap many of my abstractions have with reality–

and I feel a bit of pain. For me, some of that pain comes from wondering at some level if I'm failing to measure up–e.g., "If I was competent, this session would be going the way the book said it should go."

I'm concluding with this observation because–if you have similar tendencies–I'd like to spare you some needless pain. As the person who wrote this Manual, let me be the first to assure you concerning the lack of overlap between many of the Manual's abstractions and what you will often experience. I hope the abstractions will provide you with useful guidelines, but at the same time, I hope they won't fill you with needless doubts when your training, intuitions and consultations tell you to depart from those guidelines.

Best wishes through the rest of your Training and Orientation to the Center, and best wishes in your subsequent work!

Ralph W. Trimble, Ph.D.
August, 2000

Prearranged IAs (short version)

Can be made by RSO staff...

- At request of a clinical staff member.
- For student with SIR.
- For student discharged from a hospital.
- For student referred by dean or university staff official.

If fewer than 10 open IAs for a day - RSO will inform the ...

- Triage Caseworker
- Therapeutic Services Coordinator
- Associate Director

If student's schedule prevents scheduling an IA

- RSO staff connect student to Therapeutic Services Coordinator.

If student is unable to schedule an IA after repeated attempts

- RSO staff connect student to Therapeutic Services Coordinator or Triage Caseworker.

When a student has a prearranged IA they need to be told (from ½ green sheet):

- Bring ID & Driver's License to appointment.
- Call by 10:00 AM to confirm appointment.
- Total time will be 90 minutes.

Note: It seems to work best to give the student the time of the appointment as starting 30 minutes before they are actually scheduled to meet with a provider.

Prearranged IAs (long version)

Generally all IAs are scheduled on a "same-day" basis; however there are times when they can be prearranged. The following guidelines are established to help manage the flow of prearranged IAs. Ideally the Center will have at least 10 open IAs at the beginning of a day.

RSO staff may schedule a prearranged IA without consultation under the following circumstances (provided that no less than 10 open IAs remain).

- At the request of a clinical staff member.*
- For a student with an SIR.
- For a student being discharged from a hospital.
- For a student who is walked over by a dean or other university staff official.

If one of these situations occurs, but scheduling the prearranged IA results in there being fewer than 10 open IAs remaining; the prearranged IA may still be scheduled by RSO staff, but they will then alert the Triage Caseworker (TC), Therapeutic Services Coordinator (TSC) and Associate Director via email that fewer than 10 IAs are now available for that particular day.

There may be instances where a student's schedule prevents him or her from scheduling an IA on a same day basis (their available times may not match with ours). When this occurs, RSO staff will connect the student with the TSC who will manage the situation. If the TSC is unavailable that day, the student will be connected to the TC or Associate Director, in that order.

Additionally, there may be times when students explain that they have tried repeatedly to schedule an IA and have been unsuccessful. Some of these situations will be taken care of by the TC as client overflow is managed. Otherwise, RSO staff will connect the student with either the TC or TSC who will manage the situation. If neither of them is available that day, RSO staff will connect with the Associate Director for direction.

*There may be special situations – too varied to address – where clinical staff may decide to prearrange an IA. While approval is not required, it is the clinician's responsibility to assure that the client knows to come in 30 minutes before the appointment is scheduled to complete needed paperwork. This could be done directly with the client or by connecting the client with our RSO staff. In any event, RSO staff will need to know about the pre-arranged IA.

For all prearranged IAs, (except for hospitalization discharges) the client is to be informed to call the Center prior to 10:00 am the day of their IA to confirm their attendance; otherwise their appointment may be made available to another individual. Additionally, when a prearranged IA is made, information on the green half sheet entitled "Pre-Arranged IA" will be relayed to the client by either the clinician setting up the IA or RSO staff. In cases where the client does not confirm their appointment, RSO staff will follow-up by calling the client to clarify their intent.

When a student has a prearranged IA they need to be told (from ½ green sheet):

- Bring ID & Driver's License to appointment
- Call by 10:00 AM to confirm appointment
- Total time will be 90 minutes

Policy on Emergency Coverage (reviewed 7/2003)

I. Scheduled Emergency Coverage (8:00, 12:00, 4:00):

For many years, certainly since the establishment of the semester contracting system, there has been no requirement that academic professionals be here on a strict "eight-to-five" schedule. The priority is on doing mission-relevant work, whether or not "on location" or during regular business hours. For the most part, the mission has benefited from the flexibility which this norm encourages.

The current policy addresses problems regarding predictable emergency coverable, an area where this norm does not seem to serve the Center's mission. Good clinical practice dictates that at least one clinical counselor should be available for emergency requests at all hours of the working week. However, with the above norm, the Center sometimes has not counselor available through the eight o'clock hour, the noon hour or the four o'clock hour.

Emergencies during these hours occur at such low frequencies that it does not make sense to contract for them via the regular contracting system. On the other hand, our clientele and our mission are vulnerable and will continue to be so if we lack a policy that assures coverage during these times.

A. Purpose: The purpose of the present policy is to provide guidelines that assure emergency coverage in a way that minimally violates the norm of flexibility described above.

B. Guidelines:

1. One available counselor or intern should be sufficient to cover emergency requests for any given eight o'clock, noon or four o'clock hour.

2. The emergency coverage counselor or intern should give emergency requests the highest priority during his/her coverage.

3. The definition of emergency is broad, including a practicum student's request for assistance when his/her supervisor is not available.

4. An emergency coverage hour can be compensated by on I.A. if the hour includes:

a. at least one emergency interview lasting 15 minutes or longer, or

b. at least one interview that generates a follow-up session with the same counselor or intern, even if that interview is shorter than 15 minutes in length

5. Over the course of any semester, all counselors and interns should share coverage responsibilities as equitably as possible.

6. Assignments of counselors and interns to the eight o'clock, noon and four o'clock slots for the semester should occur during regular scheduling process for that semester. In making the assignments,

the Therapeutic Services Coordinator should make reasonable attempts to accommodate counselors' and interns schedules and preferences.

7. On a day-to-day basis, the Receptionists should be responsible for linking emergency requests with the assigned emergency coverage person. It is the emergency coverage person's responsibility to inform the Receptionist of their location ifthey are not in their assigned office.

8. Prior to accepting an emergency request, an intern should alert his/her supervisor or supervisor substitute to the possibility that supervisory back-up services may be needed during that hour.

a. It is not to be considered an imposition by an intern to direct such calls to the back-up person's home.

b. Back-up persons may be compensated by I.A. deletions in ways comparable to emergency coverage persons for time/services given.

9. It is expected that the emergency coverage counselor be on-site (within the Student Services Building) during their emergency coverage hour. Cell phone/beeper accessibility is not to be used as a substitute for being on-site.

II. Unscheduled Emergency Coverage (9:00-12:00 and 1:00-4:00)

The following is written so that we are operating with an understanding of how the Reception Office decides who to ask when an unscheduled emergency client appears – either in person, over the phone, or through a referring person.

When a counselor is asked to take an emergency client, an I.A. for that week or the next (or within a reasonable period), can be taken off that counselor's schedule. It is the counselor's responsibility to initiate this with either the Reception Office Supervisor or the TS Coordinator who will see that an I.A. gets dropped on their calendar.

Here is the order of selection of a Clinical Counselor or Intern if an emergency is at hand:

(1) a clinician with nothing scheduled for that hour,

(2) a clinician interrupted during a meeting. Administrative time and DNS time are considered equivalent to meetings unless the clinician has informed the reception office ahead of time that you have compelling reasons for not being interrupted,

(3) a clinician interrupted during a supervision session,

(4) a clinician interrupted during a counseling session (first a continuing, then a follow-up, then an I.A.),

(5) clinicians will be interrupted from a group session only as a last resort.

If there is temporarily no counselor present in the building, reception asks the client to come in, begin to fill out forms and sit in the lobby, reassuring the client that a counselor will be with them ASAP.

If you are asked, counselors should assume that others in this priority system have already been considered, and that you having previously responded to an emergency will be taken into account in this new instance. This doesn't mean that you must say "yes" to such a request (you may be in an emergency with your own client), but it does mean that this request becomes top priority unless there is/are compelling reasons that you cannot take on the responsibility.

If there is more than one counselor available in the "emergency counselor pool" the Reception Office will list these counselors on a sheet and hand that sheet to the first available counselor on that sheet. It will be that counselor's responsibility to confer with the others available to determine who shall be assigned to the emergency/walk-in client. It is NOT the Reception Office who should be left feeling responsible for a clinical emergency, it is the counselors' problem to handle and be available to assist.

Counselors should assume that the emergency was not able to be handled within the normal I.A. system. Let the TS Coordinator know if you feel this needs further discussion or refinement.

III. Accepting/Refusing OFF-HOUR Emergency Appointments

Occasionally students or UIUC employees ask a counselor to take an emergency client at times other than normal Counseling Center business hours. In deciding whether to grant or refuse such requests, important considerations include the welfare of both the client and the counselor. If, in the counselor's judgment, the likely welfare of either person seems at all compromised by surrounding circumstances, the Counseling Center will support that counselor in his/her refusal to grant the appointment. Inadequate back-up staffing is an example of a "surrounding circumstance" which constitutes legitimate grounds for refusal.

Documentation

Policy on Initial Appointment (IA) Documentation (approved January 2004)

IA documentation can serve multiple functions including:

- Descriptive summary of initial appointment;
- Record of treatment planning recommended by the clinician;
- Assessment to be forwarded to an external or internal third party (e.g., psychiatrist, neuropsychologist, primary care physician, etc.).
- Record to be reviewed in an accreditation or quality assurance procedure;
- A legal document used in a court proceeding;
- Documentation provided directly to the client.

The information included in IA documentation will vary somewhat depending on the presenting concerns, the structure of the IA, the referral question and the type of audience that will read it. Whenever a client is experiencing a significant amount of emotional distress, for example, the counselor may elect to focus on clinical issues rather than a thorough assessment. This policy allows for clinical judgment in determining how best to structure a particular IA appointment. There are several clinical issues that always must be assessed and documented—those items marked with an asterisk are required information. If these clinical issues were not assessed, the clinician should document a rationale for not assessing them.

The following is a suggested structure for documenting IAs and it includes clinical information required in all IA documentation:

Client Background Information

*Client name (pronunciation instructions or nicknames where relevant)

*Identifying Information (age, sex, race, marital status, sexual orientation)

Referral Source

*Precipitating Event/Presenting Concern (as reported by client and/or referral sources)

*Current Functioning/Symptoms (global description, subjective level of distress, counselor's perceptions of level of distress, change in functioning, academic status etc.)

Presentation at IA (e.g., dress, affect, mental status, etc.)

Treatment History (nature of such treatment, its length, the issues which it addressed, and the degree to which the client found it helpful. Such information is often helpful in developing treatment recommendations)

Medical/Health Issues

Alcohol (assessment guidelines in IA manual)

Other Drug Use (e.g., club drugs, cigarettes, marijuana, caffeine)

Medication History (assessment guidelines in IA manual)

Family History (e.g., dynamics; mental health history in immediate and extended family; cultural variables)

Legal Issues

Academic Functioning/Career Issues (current and past)

Interpersonal Functioning (e.g., relationships with peers, romantic relationships, conflict with parents, social anxiety, etc.)

Intrapersonal Functioning (e.g., symptoms of depression or anxiety; sleep disturbance, cognitive functioning, self-esteem and self-confidence, etc.)

Trauma (see questions attached)

*Suicidality/Homicidality (assessment guidelines in IA manual)

*Clinical Impression

A descriptive summary of the client's presenting concerns as well as your clinical impressions is required -- this may include a DSM-IV diagnosis and/or a discussion of past diagnoses. Example: "Client has some symptoms of depression and anxiety, but these symptoms seem to have been caused by stressors of bf's arrest and her father's ambiguous but serious health problems. Her symptoms seem best understood as an adjustment disorder rather than a depressive or anxiety disorder. For this reason, a referral for a psychiatric consultation was not made."

*Disposition/Plan

A description of your clinical recommendations, including disposition and why you have made these recommendations. This should also include a description of your clinical recommendations. This should also include a description of any specific actions you are recommending (e.g., "I recommend that client consult with academic advisor regarding late-dropping the physics course").

*Counselor and Agency Identification

Your Name, degree and/or licensure status

Counseling Center

University of Illinois at Urbana-Champaign

Report Date (date documentation was written)

Policy on Consultation Notes (revised Fall 2003)

The Illinois Mental Health and Developmental Disabilities Confidential Act (IMHDDC) requires that disclosures of confidential information (Protected Healthcare Information or PHI in HIPAA) be documented in the record. The Act (740 ILCS 110/5 (7) reads "A copy of the consent and a notation as to any action taken thereon shall be entered in the recipient's record." HIPAA also states that clients "have the right to receive an accounting of disclosures of PHI" in Section IV of the Illinois Notice Form.

The existence of an Authorization to Release Protected Healthcare Information alone does not indicate that a disclosure was made to another provider/agency. It simply indicates that a client provided consent for that disclosure to take place. Because the IMHDDC Act and HIPAA require an "accounting" of disclosures and a notation in the record as to "any action taken," it is necessary for clinicians to document these disclosures in the record.

The following documentation guidelines should be utilized whenever a clinician has disclosed protected healthcare information:

In the "Consultation Notes" section of the record, the following information must be included (at a minimum):

- Date of the consultation;
- Name(s) of the person(s) with whom you consulted;
- A description of the information disclosed to a 3rd party;
- A description of any clinically relevant information provided by the 3rd party;
- Any recommendations you made to a 3rd party;
- A summary of any actions/outcomes to be taken as a result of the consultation

Individual Case Note Policy (approved March 3, 2004)

There have been many attempts by professional organizations and regulatory agencies to define and develop standards for documenting clinical appointments. The Therapeutic Services Committee has utilized these resources to provide some guidance on what types of information should be included in the individual case notes at our agency. Although these guidelines were issued by different professional organizations, the Therapeutic Services Committee believes that they are excellent guidelines for Counseling Center clinical staff, irrespective of professional affiliation.

The literature on mental health records offers a variety of formats for documenting sessions that differ from one another in important respects. The Therapeutic Services Committee determined that a single format was not desirable because it would unduly constrain clinicians who sometimes practice in very different ways. The format that most closely parallels recommendations made in this policy is the STIPS model proposed by Prieto and Scheel (2002) and clinicians may elect to adopt all or parts of this format in their documentation. A summary of the STIPS model is included in an appendix.

The following passages from the HIPAA Privacy Rule, APA Code of Ethics, NASW Code of Ethics and APA "Record Keeping Guidelines" are cited as they were instrumental in developing this policy:

1) The HIPAA privacy rule has provided the following definition on "psychotherapy notes": "[N]otes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record ... These are records that 'capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions'" (cited in APA, 2003; italics added).

2) The American Psychological Association's Ethical Principles of Psychologists and Code of Conduct@ (December, 2002) states that:

   6.01 Documentation of Professional and Scientific Work and Maintenance of Records

   Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work in order to (1) facilitate provision of services later by them or by other professionals ..." (Italics added)

3) The Code of Ethics of the National Association of Social Workers (1999)

   3.04 Client Records

   "(a) Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided" (Italics added)

"(b) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.@ (Italics added)

"(c) Social workers documentation should protect client's privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services"

4) The American Psychological Association has issued a document entitled "Record Keeping Guidelines" drafted by the Committee on Professional Practice and Standards (1993). The guidelines regarding the "Content of Records includes the following:

a. Records include any information (including information stored in a computer) that may be used to document the nature, delivery, progress, or results of psychological services. Records can be reviewed and duplicated.

b. Records of psychological services minimally include (a) identifying data, (b) dates of services, (c) types of services; (d) fees, (e) any assessment, plan for intervention, consultation, summary reports, and/or testing reports and supporting data as may be appropriate, and (f) any release of information obtained.

c. As may be required by their jurisdiction and circumstances, psychologists maintain to a reasonable degree accurate, current and pertinent records of psychological services. The detail is sufficient to permit planning for continuity in the event that another psychologist takes over delivery of services, including, in the event of death, disability, and retirement. In addition, psychologists maintain records in sufficient detail for regulatory and administrative review of psychological service delivery. (Italics added)

The Counseling Center policy on case note documentation focuses on content rather than format or structure. There are many ways to document case notes and clinicians are encouraged to adopt a format or structure which allows them to meet or exceed the professional and ethical standards outlined in this policy.

The Counseling Center policy on documentation of individual appointments does require that the following elements be contained in every case note:

- Every case note must be unique to a specific appointment;
- A brief description of topics addressed in session, including your assessment of any symptoms being monitored or treated such as depressive mood, panic attacks, sleep disturbance, etc.;
- Description of any significant change in symptoms or functioning since last appointment;
- Description of clinician's interventions;
- A description of any new treatment recommendations (e.g., referral to psychiatrist);

- There should be a notation in the clinical record if an appointment was cancelled or not kept;
- Records should be completed in a timely fashion;

Appendix (STIPS Format):

1) Signs and Symptoms
    a. Client's current level of functioning
    b. Changes in behavior or emotional functioning
2) Topics of Discussion
    a. Description of topics addressed in session
3) Interventions
    a. Description of treatment planning, clinician's intervention, recommendations, etc.;
4) Progress and Plan
    a. Brief summary of specific progress toward established treatment goals and/or outcome of interventions
5) Special Issues
    a. Any critical issues being monitored by the clinician should be included in the case note, including suicidal ideation, threats to harm others, concerns regarding response to medications, etc.

References:

The National Association of Social Workers "Code of Ethics" (1999) is available online at http://www.socialworkers.org/pubs/code/code.asp

The American Psychological Association's "Ethical Principles of Psychologists and Code of Conduct 2002 is available online at http://www.apa.org/ethics/code2002.html

Prieto, L. R. & Scheel, K. R. (2002). Using case documentation to strengthen counselor trainee's case conceptualization skills. Journal of Counseling & Development (Winter, 2002), Volume 80, pp. 11-21.

Record Keeping Guidelines. Drafted by the Committee on Professional Practice & Standards, A committee of the Board of Professional Affairs. American Psychologist, September, 1993, pp. 984-986.

HIPAA for Psychologists. CD-ROM published by the American Psychological Association Practice Organization. 2003.

Final Disposition Policy (approved March 17, 2004)

The Counseling Center began utilizing the Client Titanium on January 18, 2000. The system brought all individual and group documentation on-line and it also resulted in substantive changes to the documentation. These changes include the requirement that a "Final Disposition" note be written whenever a client is terminated from individual or group therapy. The development of a "Final Disposition" note has also changed how cases are closed from a record-keeping perspective. In essence, all files remain open until a "Final Disposition" note has been written and printed by the clinician.

The current contracting system provides documentation time for initial appointments, individual and group appointments. In addition, clinicians are provided with "discretionary time" to complete other types of documentation such as letters to third parties. The contracting system does not provide time during the fall and spring academic semesters, however, for writing the "Final Disposition" notes. It is expected that the majority of "Final Disposition" notes will be written during the semester breaks.

While there is an expectation regarding the completion of "Final Disposition" notes and the timely closing of files, there is no system of accountability to monitor individual clinician's progress towards this goal. Therefore, the Therapeutic Services Committee is proposing the following recommendations to provide more guidance and structure to this task:

- That clinicians plan to complete "Final Disposition" notes during the winter break and summer sessions with a goal of closing files for all inactive clients by August 1st every summer. Ideally, clinicians would spread out their work on final dispositions throughout the summer in order to avoid over-loading reception office staff at the end of the summer;
- That clinicians review their "drop down" lists in Titanium in March and develop a rough estimate of the number of "Final Disposition" notes which will need to be written during the summer, including group clients. The reception office should provide clinicians with a printed copy of their "drop down" lists prior to summer contracting to assist with this task;
- That clinicians contract for an appropriate amount of time to complete this task. An informal survey of staff indicates that 15 minutes is a sufficient amount of time for most "Final Disposition" notes, but larger amounts of time can be requested to close complex cases;
- That the Therapeutic Services Coordinator review the number of clients individual counselors have on their "drop down" list prior to summer contracting in order to determine if any counselors have a disproportionately large number of cases needing to be closed and, if appropriate, consult with a particular counselor regarding plans to complete final dispositions and close files.

The Counseling Center has already adopted a policy regarding the content of Final Disposition Notes that requires the following information:

- Client Demographics
- Date of First Individual Counseling Appt.
- Date of Final Individual Counseling Appt.
- Total Number of Individual Counseling Appts.
- Reason for Termination
- Disposition at Termination (with additional recommendations, if appropriate)

Then, a brief summary (a paragraph) of presenting concerns at the Initial Appointment and issues addressed during individual counseling. This summary is not intended to be a treatment plan or a comprehensive summary of the treatment. Rather, the purpose of this summary is to reference the presenting concerns and to identify which issues were the focus of treatment. This summary will allow third parties to more quickly determine what information they may need from the Initial Appointment or case notes in making their own determinations.

Finally, our assumption in adopting this format is that the Initial Appointment write-up and subsequent case notes are complete and comprehensive and provide the additional information that a third party may desire.

Record-Keeping Policy

The Counseling Center requires clinicians to follow the ethical and legal requirements pertaining to record-keeping established by their professional organizations. These include, but are not limited to, the following:

The "Code of Ethics of the National Association of Social Workers" (1999)

3.04 Client Records

"b. Social workers should include sufficient and timely documentation in records to facilitate the delivery of services to ensure continuity of services provided to clients in the future" (Italics added)

The American Psychological Association's "Record Keeping Guidelines" drafted by the Committee on Professional Practice Standards (1993)

"c. As may be required by their jurisdiction and circumstances, psychologists maintain to a reasonable degree accurate, current and pertinent records of psychological services. The detail is sufficient to permit planning for continuity in the event that another psychologist takes over delivery of services ..." (Italics added)

In addition, the Counseling Center has established the following procedures to ensure that clinical records are completed in a timely fashion. These procedures may be less restrictive than those required by a clinician's professional organization. If a more restrictive standard is required by a professional organization, the clinician should follow those procedures.

- Clinicians are encouraged to complete documentation within one week of providing the service. This goal should generally be possible except during periods of exceptionally high demand for clinical services;

- In general, clinicians are required to complete all documentation within two weeks of providing the service. If a clinician makes an exception to this policy, there should be extensive written notes available to ensure the accuracy of the record once it is completed;

- The Therapeutic Services Coordinator will monitor the "Task List" in Titanium for all clinicians at least once per month. If there is any documentation missing for appointments that occurred more than one month ago, the TS Coordinator will draft an email to the clinician requesting that s/he complete the documentation within 72 hours. If the documentation is not completed within the 72 hour time-frame, the TS coordinator will notify the Director via email and copy the clinician.

Policy Pertaining to Electronic Transmissions, Removable Media, and Hard Copy (Fall 2003, Draft)

This policy addresses three of the primary ways that information/data can be managed, stored and transmitted – electronic transmissions, removable media and hard copies. The policy is limited to information/data that is part of the "clinical record" which includes all clinical documentation and records for clients at the Counseling Center. This information is referred to as Protected Healthcare Information (PHI) in the Health Insurance Portability and Accountability Act (HIPAA) and is also regulated by the Illinois Mental Health and Developmental Disabilities Act (IMHDDC).

In addition, the American Psychological Association's "Ethical Principles of Psychologists and Code of Conduct" (December, 2002) and the "Code of Ethics of the National Association of Social Workers" (1999) provide guidance on protecting confidential mental health records:

The Ethical Principles of Psychologists and Code of Conduct states:

4.01 Maintaining Confidentiality

"Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium"

6.01 Documentation of Professional and Scientific Work and Maintenance of Records

"Psychologists create, and to the extent the records are under their control, maintain, disseminate, store, retain, and dispose of records and data relating to their professional and scientific work"

The Code of Ethics of the National Association of Social Workers states:

3.04 Client Records

"(a) Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future."

"(d) Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts."

In order for the Counseling Center to ensure that "reasonable precautions" have been established to protect the confidentiality of the client record, the following policies apply to all clinicians:

- It is not permissible to transmit any part of the record electronically via email, attachment or other means from a computer outside of the Counseling Center. The "reasonable precaution" requirement in not possible given that electronic transmissions can be intercepted en route. In addition, the University of Illinois archives email accounts; therefore, any email or attachment sent to a University email account establishes a copy outside of the client record.

- It is not permissible to remove any portion of the "hard copy" of a client record from Counseling Center property without permission of the Director and the Therapeutic Services Coordinator.

• It is permissible to utilize "removable media" to store records electronically and transfer them to a Counseling Center data base (CMIS). This policy applies to a variety of electronic storage media, including but not limited to floppy disks, Memory Sticks, CD-Rs, Zip Drives, Laptops, PDAs, and JPEGs.

The following conditions apply whenever clinicians are creating a portion of the record off-site and storing/transferring it to a "removable media."

• Any records created outside of the Counseling Center must be stored on a device that is password protected and encrypted as a security precaution. This is important given the potential for electronic devices and storage media to be stolen or lost. In addition, any electronic device can fail and password protection/encryption provides security protection during the repair process.

• Any records created on private equipment should be transferred to the CMIS database promptly and deleted from personal computers and removable media thereafter. It is not permissible to store any portion of the record indefinitely on private equipment because this would undermine the "reasonable precaution" requirement and it creates a separate record.

Policies and Practices on Confidentiality (revised 8/2007)

The following policy and procedures exist regarding confidentiality at the UIUC Counseling Center (CC). These are written in compliance with the APA Ethical Principles of Psychologists and Code of Conduct (December 2002), National Association of Social Workers Code of Ethics (January 1997), Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (August 2002), the APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (January 1993), the APA General Guidelines for Providing Psychological Services (1987), the ACPA Statement of Ethical Principles and Standards (November 1992), and the State of Illinois Mental Health and Developmental Disabilities Confidentiality Act (1979 and as amended through June 1996), the State of Illinois Abused and Neglected Child Reporting Act (March 1992) and the UIUC Student Affairs Mission Statement and Standards of Professional Practice (1993).

These serve as safeguards to insure confidentiality for all service recipients, including those who may be friends, acquaintances, neighbors, family members, fellow students, University staff and/or faculty.

A. Written Consent

1. Written consent of the service recipient is always required before information can be revealed about that recipient. Any written consent forms completed are placed in the recipient's CC record. The only exceptions are those prescribed in the Illinois Mental Health and Developmental Disabilities Confidentiality Act (e.g., life-threatening situations, current child abuse). In these situations, information about a service recipient can be exchanged without the recipient's prior written consent only with those professionals or others necessarily involved.

The only other exception under the Law is a designated administrative clinical team which may exchange client information in the exercise of their assigned administrative responsibility.

2. Written permission to audiotape/videotape client sessions is necessary and is required of all staff at the Center.

a. Clients assigned to the practicum or intern waiting lists will be asked at their first appointment, the "Initial Appointment (I.A.)", if they agree to being taped. Only those who agree will be referred to these wait lists, since all trainees are required to tape all counseling sessions.

b. Upon assignment to the counselor, that counselor will review the taping and use of tapes policy with the client and obtain the client's initials and current date on the already signed "Permission to tape" form if any additional modifications are made. This form is filed in the client record.

c. If any tapes, records or notes are used for any purpose other than consultation or supervision from CC staff members, the purpose, use, location of presentation, and audience must be specified and agreed to by the client in writing.

d. In practicum class group supervision, the instructor is to help students determine whether they should be present for the case if they know the client from other circumstances.

3. In the case where all identifying data has been removed or disguised to insure complete anonymity, materials no longer relate to any individual service recipient and such materials (e.g., personal notes, test reports, written case presentations) can be used without written permission. In any case where there is a question about the complete anonymity, client materials should be treated as client records and individual supervisors, the Therapeutic Services Coordinator, or the Director (in that order as needed) should be consulted to help make this determination. The final decision is made by the Director if disputed at a lower level.

B. Client Records

1. All central client records are kept at the Student Services Building (SSB). The Titanium electronic and paper files currently in use are kept on site. All identifiable electronic client information (Titanium) will be saved in a password protected format on a dedicated server. Electronic backup of clinical records are encrypted and stored in a secured off-site facility.

2. No client records with identifying information (audio/videotapes, computer disks, personal notes, written case presentations, etc.) can be removed from the CC and used in other locations and/or viewed by other than CC counseling staff without the written consent of the client. (Consult with the Therapeutic Services Coordinator or the Director if questions arise as to what constitutes client records).

3. Other than in circumstances specified through a client's written consent, cases are to be discussed only with other Counseling Center staff counselors in private areas under confidential conditions (i.e., behind closed doors – avoid discussing cases in the halls, reception office, restrooms, or anywhere else where the discussion can be overheard). It is not only important to preserve 'real' confidentiality, but also to guard against giving the impression that cases are being discussed openly or in public.

4. In instances where tapes are being played in an office, the counselor in charge must make sure that the tape cannot be heard outside the counselor's office.

5. Counselors and supervisors should view only those files with which they are professionally involved. All paper folders and Titanium records are to be secure from unauthorized persons at all times.

a. To obtain Titanium access to a needed electronic file or paper folder, counselors must ask the Reception staff for it. When possible, requests should be made only at times other than 10 minutes before or after the hour.

b. Folders must be returned to the Reception office by the end of the day and/or locked in the file or desk drawer in the counselor's office.

c. All office doors should be locked even if the counselor leaves the office temporarily since other persons could look at computer records or remove folders, notes, or tapes while the counselor is absent. If the door cannot be conveniently locked, Titanium MUST be exited on the users computer and the user must be LOGGED OUT of the computer. All other related client material must be stored and locked securely away.

d. All client information must be restricted to the Reception area, or in counselor's offices and not distributed via mailboxes with personal mail. Titanium access to electronic clinical records is restricted to the second floor computers in the Center. Titanium cannot be accessed from off-site computers.

6. No client records may be generated outside of the Center except notes which are made in response to emergency telephone calls. In such exceptions, the counselor must assume full responsibility for bringing these notes to the office and inserting them into the file as soon as possible. Care should be taken to insure confidentiality by not including any information through which identification could be inferred until the notes have been brought to the Center.

7. No personal notes are kept outside the Center.

C. Responsibilities of Reception Office Staff

1. Care must be taken that no confidential client information is disclosed through written, verbal or electronic means:

a. Any paper materials that contain confidential client information must be kept in a secured file when not in use, including files, notes, phone messages, etc.

b. Paper materials (excluding client files) no longer in use, such as phone messages and notes, must be shredded in a timely fashion.

c. Confidential client materials must be taken out of counselors clinical boxes and secured in a locked drawer after hours.

d. Receptionists will take precautions to protect clients' confidential in the reception area (e.g., computer monitors shielded from the reception area, confidential papers are not visible to those approaching the Receptionists desk, etc.)

e. Clients full names will not be spoken in a loud voice over the phone or in conversation so as others might overhear.

f. E-mail messages should not containclients' full names. First names or initials should suffice.

D. Responsibilities of Counselors/Supervisors

1. Counselors with training responsibilities (e.g., supervisors) are required to inform their trainees about these policies and procedures and about the ethical and legal standards of the psychology profession as well as monitor their trainees' compliance with them.

2. Supervisors are responsible for monitoring client tapes, and for monitoring their supervisees' use of recorded tape and written material.

E. Multiple Relationships

1. To maintain the integrity of our services, dual or multiple relationships should be avoided. Counselors should exclude themselves from access to related case information and from giving CC services or training to people with whom they have another significant association (e.g., friendship, romantic relationship, other professional or administrative relationship). For example, the CC Director or the Coordinator of Training should not provide therapy services to graduate students who could become trainees at the Center.

2. Conversely, counselors who have or had a professional psychological relationship with someone must adhere to professional ethical guidelines in any future association with that person. Furthermore, multiple roles within the Center should be avoided (e.g., combinations of supervisory, counseling, or administrative roles). Since multiple relationships are not always avoidable, any staff member encountering a potential multiple relationship should seek appropriate consultation with an uninvolved colleague. Issues which should be addressed in the consultation, include: potential for compromising the professional relationship, potential for inappropriate use of one's professional role, and whether the CC Director should be informed in order to maintain the integrity of the agency.

F. Subpoena of Records

The staff of the Counseling Center recognizes that the State of Illinois allows, in certain restricted situations, that client records can be subpoenaed and made public in a court of law. Specifically, Chapter 91 1/2, Section 810 of the Illinois Revised Statutes allows client files to be subpoenaed in 19 different situations, including:

a. If the client raises his or her own mental status in a civil case (e.g. a client's claim of mental anguish following a car accident).

b. A client raises his or her mental status in a criminal case (e.g. not guilty for reasons of insanity).

c. If the client claims diminished capacity in a criminal case (e.g. mental retardation).

d. A client is involved in a competency hearing.

e. A client is involved in a guardianship hearing.

f. A client is involved in a mental commitment hearing.

See Ethics Manual for complete listing of all stipulated situations.

The staff of the Counseling Center also recognizes that subpoenas will originate from a wide range of sources including lawyers, state prosecutors and judges. In particular, the staff recognizes that the Center may receive from lawyers' subpoenas that are neither legitimate nor binding. A subpoena without an attached court order DOES NOT require a release of confidential information. It only requires our response. Our concern with client confidentiality leads us to proceed cautiously before releasing any client's records. The following steps will serve as guidelines in reviewing the legal basis of a subpoena.

1. The Therapeutic Services Coordinator will be responsible for overseeing and monitoring all responses to subpoenas. In consultation with other clinicians, the Center's Director and the Office of the University Counsel, s/he will be the "point person" in responding to subpoenas.

2. Upon receipt of a subpoena, the Therapeutic Services Coordinator, in consultation with the Director, the client's counselor (if available), and the Office of the University Counsel, will review the subpoena and determine the most appropriate response.

3. The staff of the Counseling Center will not make direct contact with any attorney who originates a subpoena (unless the lawyer(s) is the client's attorney see #4 and #5 below), but defer such contacts to the Office of the University Counsel.

4. The Center will make every effort to contact the client and the client's lawyer (if the subpoena originates elsewhere) to determine their interests and wishes.

5. The Center will take every step to insure that the client and the client's lawyer are knowledgeable about the client's right to privilege.

6. The Center, in accordance with Section 810 of the State of Illinois Mental Health and Developmental Disabilities Act, which specifies that the right to privilege lies with both the clinician and the client, will take every step to assert the client's right to privilege as considered appropriate even if the client and/or the client's attorney are either unaware of this right or unwilling to exercise it.

7. In all cases and in accordance with Illinois Statutes, the Counseling Center will take the appropriate protective stance in relation to the client's right to privilege.

8. In cases where the subpoena originates from the University, the counselor may seek appropriate independent counsel at his/her expense as may be necessary to assure himself/herself and the client that there is not a conflict of interest between the Office of the University Counsel and the decision regarding the subpoena.

9. The Reception Office will keep two copies of each subpoena, as well as two copies of all written correspondence related to that subpoena. One copy will be kept in the client's file. The second copy

will be kept in a locked file (labeled "Responses to Subpoenas") at the Reception Desk. This second file will serve to insure consistency of response as well as serve as a base of expertise for current and future Therapeutic Services Coordinators. The Director will designate who has access to this file besides himself/ herself to include, but not be limited to, the Therapeutic Services Coordinator and the Reception Office Supervisor.

G. Release/Exchanges of Confidential Information

1. For all referrals, including administrative, from anyone other than members of legally constituted clinical administrative team (See above.), a signed Authorization to Release Protected Information From Your Clinical Record form (i.e., Release) must be completed before any exchange of client information can occur with the referral source. There is a separate authorization allowing an exchange of information between the Counseling Center and the McKinley Health Center. Ideally, the Release should be completed by the referral source. However, if this is not done, permission should be obtained prior to the beginning of the counseling interview by the counselor so that counselors maintain the ability to report all relevant information.

2. The Release should also be completed each time confidential information is disclosed. A single Release may allow for contact with several people of the same agency, office, or unit and specifies a time period within which the exchange of information is valid. New Releases are completed when additional individuals need to be contacted or an extension of time is necessary. This allows limited permission for exchange of information regarding the appropriateness of the referral and follow-up of the client's disposition.

UNIVERSITY POLICY (per Campus Administrative Manual)

DESTRUCTION OR TRANSFER OF UNIVERSITY RECORDS

Each Unit Should Plan for Orderly Destruction or Archival Transfer of Noncurrent Records within the Definitions Specified by the General Rules.

A records retention program is the key to the efficient management of non-current information and the effective use of filing equipment and data storage space and the office and storage space they occupy. Each university office is requested to include in its normal operating procedures a plan for the orderly destruction or archival transfer of non-current records. The creation and maintenance of records of high quality and small quantity will result in lower office operating costs due to reduction in staff time, space and equipment allocated to records work.

Article VI Section 4 of The General Rules Concerning University Organization and Procedure contains four provisions:

1. Definition of University Records. Records produced or received by any agency or employee of the University in the transaction of University business become University Property. For the purpose of this paragraph, records shall be defined as including all documents, correspondence,

accounts, files, manuscripts, publications, photographs, tapes, drawings, or other material bearing upon the activities and functions of the University or its officers and employees.

2. Records Destruction. No University records shall be discarded or destroyed except upon the prior approval of the Archivist pursuant to a finding and recommendation by the administrative unit involved that such records have no further administrative value.

3. Approvals Required. The Archivist shall withhold the approval of any such action until satisfied that the records involved have no value for other administrative offices and that they need not be retained for legal reasons, as determined by appropriate officers. Pursuant to the State Records Act, Section 43.4 et seq., Chapter 116 of the Illinois Revised Statutes, the university archivist shall forward approved requests for permission to discard or destroy records to the university president and the State Records Commission for their approval.

If you need assistance in inventorying noncurrent records or wish to prepare a Records Disposal Authorization request, please contact the University Archives, 19 Library, 3-0798. The Archives has records inventory worksheets and a model departmental records disposal schedule that may be useful in determining the administrative, financial, legal and research value of records kept in filing cabinets, transfer files and magnetic data storage unit.

Instructions for Requesting Student Data

OAR's (Office of Admissions and Records) data access policy, which is based on FERPA and University policy, is included in the data request form that is required of all requestors. By submitting a request, you agree to be bound by the terms and conditions of that policy. Questions about requesting undergraduate applicant data should be directed to Suzanne Zelle (5-5392); questions about graduate and professional applicant data should be directed to Jose Evans (4-4637); questions about student data should be directed to Michael Miller (4-6170).

Important note: Not all requests can be approved under established policies. If we cannot approve your request, we will provide you with an explanation.

We are required by the campus implementation of FERPA to maintain a file of supporting material on uses made of student data. Therefore, please use the request form to provide the information listed below. Missing or incomplete information will delay processing of your request.

- A statement of how you plan to use the information – e.g., mailing material informing applicants/students of a service you are providing, mailing and checking the return of a research instrument, etc.
- A copy of the material you are mailing, if you are requesting mailing materials. Proposed mailings to students are subject to approval by the Office of the Dean of Students.
- A carefully worded description of the selection criteria identifying the group of applicants/students for whom you are requesting the information – e.g., seniors in LAS whose home address is 61003 through 61008.
- The kind of report format you want – e.g., Mailing Center mailing labels, a list, a dataset for transfer – and the data fields to be displayed on that report. If you need mailing labels, we will coordinate your request with the Department of Printing Services; Printing Services will bill you for this service.
- The order in which you wish the information – e.g., alpha by name, ZIP code.
- The person who will be responsible for the use of the data, if other than you. Faculty and graduate students who are requesting data for research should forward their requests to the Division of Management Information, not to OAR.
- The name and phone number of the person to contact for additional information, if other than you.
- The date when you need the information. Our normal completion time is between 2 and 6 weeks from the receipt of your request; turnaround time depends on the complexity of the request and the volume of requests we are processing.

To expedite processing, please complete the form online; then print and sign it. The signed, completed form can either be mailed or faxed to our office for handling. (Delivery information is provided on the form.)

Recording Permission: Supervision and Training (11/2003)

The Counseling Center staff may consult with one another in order to improve our services. In addition, counselors-in-training regularly discuss their work with their supervisors and each other. The information disclosed remains confidential in all instances. Any exception to this policy requires your written consent.

Permission for Recording of Counseling Sessions

I agree to the recording of my sessions with any modifications specified below. I understand that confidentiality will be maintained and that professional ethical standards will be observed in these processes.

Check one:

( ) No modifications

( ) Modifications are as follows:

_____

Print Name

_____

Student ID Number

_____

Signature

_____

Date

Practicum Consultation Permission Form (1/2004)

As a Clinical Psychology or Counseling Psychology Doctoral student in training, some clinicians at the Counseling Center are providing both counseling services and completing academic requirements for their degrees. Part of this training includes consulting with colleagues and supervisors who may not work directly at the Counseling Center. Consultation may include playing of videotaped material. Anyone not employed by the Counseling Center but providing consultation to one of our counselors in training is required to sign a confidentiality agreement with us.

Permission to Consult

I give permission to my counselor to consult with colleagues and supervisors outside the Counseling Center agency with the understanding that confidentiality will be maintained and that professional ethical standards will be observed in these processes.

Check one:

( ) No modifications

( ) Audiotape only

( ) Modifications are as follows:

_____

Print Name

_____

Student ID Number

_____

Signature

_____

Date

Follow-Up Permission (11/2003)

The Counseling Center routinely evaluates the quality of its services. From time to time, students are mailed a brief follow-up questionnaire. The questionnaire is completely confidential and is mailed in an unmarked envelope. If you are mailed a questionnaire you may decide at that time whether to fill it out or which items you wish to respond to.

Please check all that apply and sign below.

( ) I authorize the Counseling Center to mail a follow-up questionnaire to my CAMPUS ADDRESS.

( ) I authorize the Counseling Center to mail a follow-up questionnaire to my HOME ADDRESS.

( ) I authorize the Counseling Center to send a follow-up questionnaire to me as an EMAIL ATTACHMENT.

If your Home Address is different from your Campus Address, and you would like the questionnaire to be sent to your Home Address, please indicate below:

Street Apt. No. _____

City State Zip _____

( ) I prefer NOT to receive a follow-up questionnaire.

_____
Print Name

_____
Student ID Number

_____
Signature

_____
Date

Referrals and Other Client-Related Issues

Policy Regarding Eligibility for Therapeutic Services (revised 6/2008, draft)

The Counseling Center provides a range of clinical assessment, individual, couples', family and group therapy services in accordance with our mission. The Counseling Center is a fee-supported agency; therefore, our primary obligation is to provide services to fee-paying students. This policy will outline clinical services available to students and what types of services are available to employees of the University and members of the community. This policy establishes guidelines, but it should be emphasized that the Counseling Center values the clinical judgment of staff members. If there are concerns regarding policy or procedures regarding an individual case, it is recommended that counselors consult with the Therapeutic Services Coordinator first, then the Director if need be.

General Eligibility Statement:

- Any student, faculty or staff person is eligible for an Initial Appointment;
- All fee-paying students are eligible for ongoing counseling services (individual, couples', family, group);
- In order to be eligible for couples' or family counseling, one person must be a fee-paying student.

Session Limits by Category:

- Initial Appointments are 1 session;
- Extended IAs are additional assessment appointments prior to disposition. These appointments are scheduled into a counselor's Follow-Up hours;
- Follow-up therapy is generally considered to be 2-5 sessions beyond the IA;
- Continuing therapy is generally considered to be 6-12 sessions beyond the IA;
- Couples' or family counseling can be either Follow-up or Continuing;
- There are no session limits for Group counseling.

Session Limits by Student:

- Students are eligible for up to 12 sessions of individual, family, and/or couples' counseling in any given 12 month period at the Counseling Center. Students are defined as generally ineligible for additional individual, couples' or family counseling if it has been less than 12 months since the date of their last appointment at the Counseling Center. The Therapeutic Services Coordinator can make rare exceptions for training purposes (with either Interns or Practicum counselors) or for Professional Development cases.

- If a student has received previous individual (continuing) counseling at the Center and it has been more than 12 months since the last date of services, they are eligible for:

    - Follow-up Counseling
    - Group Therapy

In general, students should not be referred for continuing counseling more than once, although clinicians should consider the following guidelines when they are referring a student for a second episode of continuing counseling:

- The current presenting concerns are different than past presenting concerns (e.g., depression 1st, sexual assault 2nd) and/or
- Financial resources preclude private therapy (consider agencies such as Family Services in these cases) and
- The services available at the Center are an appropriate form of treatment (the student has not requested long-term therapy and/or the clinician has assessed that long-term treatment is not indicated given the presenting concerns)

Eligibility for concurrent individual and group counseling:

- Students cannot receive individual and group counseling simultaneously except by approval of the Therapeutic Services Coordinator.

Guidelines for Initial Appointments:

• All fee-paying students are eligible for clinical services at the Counseling Center. Individual clinicians determine what services, if any, are most appropriate given a range of factors, including the client concerns, availability of services (e.g., whether wait-list for continuing counseling is open or closed, whether groups are open or closed, etc.), level of urgency, etc.

• The Counseling Center does not provide long-term individual treatment as specified in our mission statement. If students express a preference for long-term therapy or if the individual clinician determines, in their professional judgment, that long-term treatment is necessary, then referrals to the community should be provided to the student;

• The Counseling Center does not provide partial hospitalization or inpatient hospitalization services. If these services are necessary, the individual clinician assists with referrals to the appropriate agencies in the community;

• The Counseling Center does not provide neuropsychological assessment. If these services are necessary, referral to available resources on campus or in the community should be provided;

• The Counseling Center does not refer students to McKinley Mental Health Division (MHD) except in situations where the service is not available here. In general, students can be referred to MHD for psychiatric services and certain group services (e.g., Anxiety Management Workshop);

Policy on Mandated Appointments:

• Students are mandated to attend four sessions of assessment under the University's Suicide Prevention Policy. The individual clinician who first meets with a student who has a Suicide Incident Report (SIR) should do all four mandated assessment appointments as follow-up. Students with SIRs

should not be referred to the community unless it is the student's preference, in which case an individual clinician should coordinate a referral to the community and inform the student that verification of the four mandated appointments is necessary.

Guidelines for Referring to the Community:

- If the client requests a specialized form of treatment not available at the Counseling Center or Mental Health Division (e.g., Biofeedback), referral to the community should be considered;
- If the client wants longer-term individual counseling (more than five sessions) and there is some degree of urgency, but there is a long wait for Continuing Counseling or the Wait List is closed, referral to the community should be considered;
- If the client has been in therapy previously at the Counseling Center and the individual clinician determines that the presenting concerns are related to the prior treatment, referral to the community should be considered;
- If the client has a prior and extensive history of individual psychotherapy and/or psychiatric hospitalizations, referral to the community should be considered. This is particularly true if the client is expecting or wanting a similar intensity of service;
- The Counseling Center has established a policy that referrals must be to licensed practitioners;
- The Counseling Center has established a policy that students be provided with at least three referral options unless the student is requesting a specialized form of treatment and there are not sufficient referral options in the community.
- If the individual clinician makes referrals to Counseling Center staff in private practice, students should be informed that these counselors also work at the Counseling Center. At least two of the referral options must be to practitioners not affiliated with the Counseling Center. The client must be given the "Acknowledgement of Informed Choice" form for their completion.
- Counselors are expected to make arrangements with the client to follow up on the results of the disposition to private practitioners. Counselors may call, write, or have their clients call them regarding the status of the private practice arrangements. Counselors will document that contact in their Final Disposition Note.

Wait List System and Referral Guidelines (approved 2/2012)

The Counseling Center Wait List is a system for reassigning clients to another clinician and/or a different type of clinical service. The Counseling Center offers primarily short-term, individual counseling, and students are generally offered about 12 sessions when they are referred for continuing counseling. This is in contrast to follow-up counseling, where students typically receive 4-5 sessions. The Waitlist also functions as a reservation system meaning there is a commitment to provide continuing counseling to students who are referred to the waitlist. In order to achieve this goal, the waitlist will be closed by the Therapeutic Services Coordinator whenever the Center no longer has capacity to provide more continuing counseling.

There are 3 types of Wait Lists: 1) The General (Intern/Staff) Wait List, 2) The Specific Wait List, and 3) The Practicum Wait List. The procedures related to the Practicum Waitlist are covered in a separate policy. The Therapeutic Services Coordinator, with assistance from the Reception Office Supervisor, takes responsibility for managing the General and Specific Wait Lists.

What follows are the guidelines for referrals to all the Wait Lists:

1. CONTINUING COUNSELING: To offer the Center's version of longer-term counseling (up to 12 sessions) to clients in an equitable and timely manner.
2. REASSIGNMENT: To transfer the client to a different clinician for one of the following reasons:
    a. TRAINING: To distribute cases to interns and practicum students for training purposes;
    b. SUBSPECIALIZATION: To refer clients whenever there are clinician(s) on staff who have expertise in treating a particular condition;
    c. DEMOGRAPHIC REQUEST: To transfer students who have a specific request related to gender, race/ethnicity, religion or sexual orientation;
    d. CLIENT REQUEST: To transfer students who are not willing to be taped, who do not want to see a trainee, who request a different counselor OR for counselors who need to transfer due to ethical/professional conflicts.

The availability of continuing counseling is limited and the Center allocates a relatively small percentage of its overall resources to this service. In general, students should not be referred for continuing counseling more than once during their tenure at the University of Illinois so that the Center can provide this service to as many students as possible.

A student is not eligible for a second course of continuing counseling unless it has been a year since the date of the last individual counseling appointment. In addition, a clinician should consider the following guidelines when they are referring a student for a second episode of continuing counseling:

- The current presenting concerns are different than past presenting concerns (e.g., depression 1st, sexual assault 2nd) and/or;
- Financial resources preclude private therapy (consider agencies such as Family Services, Psychological Services Center, Champaign Mental Health Center in these cases); and
- The services available at the Center are an appropriate form of treatment (the student has not requested long-term therapy and/or the clinician has assessed that long-term treatment is not indicated given the presenting concerns).

Utilization Rates:

The Therapeutic Services Coordinator has responsibility for compiling and distributing utilization rates to clinicians on a weekly basis. All clinicians are responsible for reviewing their utilization rates carefully every week and determining if they have availability to pick up clients from the waitlist. The Therapeutic Services Coordinator will send out an email on a regular basis updating the clinical staff on the status of the waitlist.

Waitlist Assignments:

The Waitlist is a "shared responsibility" meaning that there is an expectation that all clinicians will follow the policies and procedures associated with its use. If clinicians have continuing hours in their contracts, it is necessary for them to pick up clients from the waitlist. It is expected that staff will pick up those clients on the waitlist in the order in which they were referred to the waitlist. A clinician can use his/her discretion in determining that a client's presenting concerns are outside his/her area of expertise and select the next client on the waitlist. Interns have more discretion in selecting cases from the waitlist in accordance with goals related to their training.

A clinician can refer any client seen on Initial Appointment to his/her own "Specific Waitlist". This procedure should be followed whenever a clinician has determined that continued counseling is a more appropriate referral option than follow-up counseling AND the clinician has availability in their continuing caseload. The same review procedures outlined above apply to "Specific Waitlist" referrals. If there are only a few clients on the waitlist AND these clients were referred within the past week, specific waitlist clients can be picked up right away. If there are clients on the waitlist who were referred more than a week ago, specific waitlist clients should be picked up in the order in which they were referred to the waitlist. A clinician should NOT re-code a client from follow-up to continuing in Titanium without referring to their Specific Waitlist.

The Therapeutic Services Coordinator reviews all cases referred to the waitlist and determines the following: Does the client meet the eligibility criteria for referral to the waitlist (e.g., paid the Health Service Fee, can reasonably be expected to benefit from short-term counseling, etc.); does the Initial Appointment report contain a risk assessment; does the Initial Appointment report meet the Counseling Center's documentation guidelines; does the file contain the appropriate consents (e.g., for taping when the referral is to a trainee); does the file contain a schedule card.

The Therapeutic Services Coordinator also has the responsibility for managing the waitlist in situations where clients have waited for more than 3 weeks and/or there are clinicians who are under-utilized in their continuing contracts. The Therapeutic Services Coordinator, at his/her discretion, can consult with clinicians regarding the need to pick up clients in either of these two circumstances.

Professional Development Clients (revised 5/31/2010):

The Counseling Center has a long-standing history of supporting the practice of providing longer-term, individual counseling to some clients. The Counseling Center has a time-limited treatment model and cases that extend beyond these session limits have always been referred to as "professional development" clients.

Guidelines:

- A case is considered "professional development" whenever there have been more than 16 sessions of individual counseling following the most recent Initial Appointment;
- A new code will be added to Titanium termed "professional development" and clients will automatically be re-coded from "follow-up" or "continuing" to "professional development" once there have been 16 appointments following the most recent Initial Appointment;
- Clinicians will be given the opportunity to bid for 1 hour per week of "Professional Development" clients beginning in August, 2010;
- Whenever a clinician exceeds 16 appointments with a continuing client, it is expected that s/he will pick up another client from the waitlist if this re-coding to "professional development" creates availability in their continuing contract;
- Utilization rates will be modified in order to include professional development clients;
- The Therapeutic Services Coordinator will consult with clinicians who have large professional development caseloads that may be affecting their follow-up and/or continuing case-loads. The Director may also be consulted whenever there are concerns regarding professional development caseloads;
- Clinicians are discouraged from carrying a large caseload of professional development clients and to consider various case management options, including referral to group therapy, referral to low cost providers in the community, meeting with clients every other week and/or working with a client for a defined time period (e.g., 6 months to a year);
- Clinicians are advised to inform professional development clients that the Counseling Center has a time-limited treatment model and that they are being offered the opportunity to work longer-term because it is beneficial to the clinician and the client.

Guidelines for Referral to Private Practice for Staff Members of the University of Illinois Counseling Center and McKinley Mental Health Department (revised 9/2006; approved by William Riley, Associate Vice Chancellor for Student Affairs and Gene Barton, Associate Vice Chancellor for Student Affairs)

Overview:

The following guidelines are intended to prevent instances of conflict of interest and/or the perception of conflict of interest that might arise out of the fact that some staff members of the Counseling Center and McKinley Mental Health Department maintain private practices. The guidelines are written with the intent of preventing potential conflicts of interest while at the same time not arbitrarily or unnecessarily restricting students' access to the most appropriate private therapy resources.

The American Psychological Association's "Ethical Principles of Psychologists" (1981 Revision) reads: "When there is a conflict of interest between a client and the psychologist's employing institution, psychologists clarify the nature and direction of their loyalties and responsibilities and keep all parties informed of their commitments." (Principle 6: Welfare of the consumer)

The National Association of Social Workers' "Code of Ethics" (1979) reads: "The social worker should not exploit relationships with clients for personal advantage, or solicit the clients of one's agency for private practice." (Article 11.F.2)

The Counseling Center and McKinley Mental Health Center have chosen to go beyond the ethical guidelines of their professional organizations in advancing the following guidelines. It is understood that these guidelines will be self-monitored in accordance with APA and NASW ethical standards. All clinicians with private practices are also responsible for complying with the University of Illinois' ethical requirements (http://www.ethics.uillinois.edu/training/saeh.html). The most restrictive ethical requirements should apply in any situation.

These guidelines are meant to serve as a flexible framework through which decisions about referral to private therapy can be made in an ethical manner. They are not meant to be exhaustive or applicable in all situations. It is expected that situations will arise that are not covered by these guidelines. In such situations, the staff member should follow the professional guidelines cited above, University ethical guidelines and/or consult with either the Agency Director or Therapeutic Services Coordinator

Informing the Student

Whenever a staff person of the Counseling Center or McKinley Mental Health Center decides to refer a student to a private therapist in the community, he or she should discuss that recommendation with the student. The content of that discussion should include:

a. What the student can expect to gain from private therapy.

b. What alternatives exist on campus to private therapy at this time.

c. Fees for service, including health insurance coverage

The Acknowledgment of Informed Choice Form

In all instances in which a staff member meets with a student in private practice, the staff member should have the student fill out an Acknowledgement of Informed Consent form (see attachment) and retain it in the client's record.

Situation 1: Referral at intake

When it has become clear to a staff member at intake or in the context of an extended assessment, that counseling services at the University are not appropriate and a decision is made to refer the student out, the staff member should:

a. Provide the student with a minimum of three names of private therapists and/or agencies.

b. Only one of these three names can be employed at either the Counseling Center or McKinley Heath Center

c. The staff member should clearly identify to the student the university affiliation, if applicable, of private therapists on the referral list;

d. There should be clinical and/or financial (e.g., sliding fees) reasons why the staff member is being included as a referral option;

e. The staff member should never include his or her own name on the referral list.

Situation 2: Referrals after a course of treatment

In the event that a clinician has been meeting with a student for individual or group counseling and the course of treatment has ended or it becomes clear that the future services of the agency are not appropriate, the following guidelines apply:

a. The clinician should provide the client with the names of at least 3 private practitioners in the community who offer appropriate treatment;

b. The clinician's own name should not be included in this list, but the client can be informed of the clinician's private practice if they make an independent inquiry;

c. Inform the Director of the circumstances under which the student has requested to continue with the staff member in private practice.

d. The staff member should make a note of his/her meeting with the Director and the details discussed and place it in the student's file.

e. In the event that the staff member meets with the student in private therapy, the staff member should have the student fill out a copy of the Acknowledgement of Informed Consent form are retain it in the student's record.

Situation 3: A student contacts the staff member outside of University

In the event that a student independently contacts a staff member outside the agency and in the context of his or her private practice, the staff member should:

a. Determine if the student is appropriate for the primarily short term services of either the Counseling Center or McKinley Mental Health Department.

b. Inform them of the resources that might be available to them at the University and refer where appropriate.

c. If services of the University are not deemed appropriate the staff member may make arrangements to meet with the student privately.

d. If services of the University are deemed appropriate but the student prefers to meet with the staff member privately, the staff member may make arrangements to meet with the student privately without consulting with either the Director or the Therapeutic Services Coordinator.

e. The staff member should have the student fill out a copy of the Acknowledgement of Informed Consent form (attached to guidelines) and retain a copy in the student's record.

Situation 4: A non-student in private practice becomes a student

In the event that a staff member, in the context of his or her private practice, is working with an individual who is not a student, and at some point during therapy the individual becomes a student, the staff member should:

a. Follow the guidelines listed in situation 3 above.

Guidelines Regarding Dual roles and Provision of Clinical Services to Practicum Students, Paraprofessionals, Student Workers, and Graduate Assistants (revised 6/2008)

There are several safeguards in place to ensure the confidentiality of services and to minimize potentially harmful dual roles and/or responsibilities for University of Illinois students who may also work in the Counseling Center. It is the Counseling Center's practice to consider the potentially harmful effects on students who currently work at the Center or may do so in the future and, therefore, the policy includes both professional (administrative, supervisory, therapist) and personal (romantic, friend, social) roles. This policy will focus on the dual professional roles that may be problematic; the specific implications of personal relationships will always be considered, but are not the central concern of this policy.

Confidentiality:

It is Counseling Center policy to maintain an electronic copy of records in the Titanium Schedule Database and a limited paper record which is locked in files in the Reception Office. The APA and NASW Ethical Standards provide guidance to clinicians on access to records. In addition, the Titanium Schedule database allows an administrator to restrict access to an electronic record. In practice, a clinician should consult with the Therapeutic Services Coordinator and request that access to a particular file be restricted to the provider and his/her supervisor (if applicable).

The paper record is kept in the Reception Office and only reception office staff have access to file cabinet keys. All folders (or other client related information) are securely locked after hours. During the day, only those clinicians who have reason to ask for a particular file will be given the file. These practices serve to deter any current practicum student, paraprofessional, graduate assistant, or intern from having access to any clinical records not intended for their professional use. It is possible for an individual clinician to keep this record locked in his/her office. The clinician should inform the Therapeutic Services Coordinator that she/he intends to do this.

Multiple Role Relationships:

If a current, past or future practicum student, paraprofessional, intern, or graduate assistant requests clinical services, several other steps are taken to protect their confidentiality:

Only student workers are permitted to seek therapy at the Center while they are concurrently working at the agency. Paraprofessionals, practicum students, and Graduate Assistants are not permitted to be seen for therapy concurrent with their appointment at the Counseling Center. If they seek such professional assistance, practicum students and Graduate Assistants will be referred to McKinley Mental Health Unit or some other appropriate therapeutic resource. Current interns should utilize staff benefits available to them in arranging clinical services.

The Counseling Center Paraprofessional Program (CCPs) pose some unique challenges regarding dual-roles given the size and complexity of the program. Over the past several years, the Counseling Center Paraprofessionals (CCPs) have become more integrated into the day-to-day functions of the Counseling Center (e.g., treatment teams). Some of these committees, particularly treatments teams, discuss clinical material (perhaps a group under the auspices of the treatment team) or a "formal" case presentation. A CCP may be receiving group services, which are then discussed in the treatment team. Or, a CCP may be assigned a mentor or sit on a committee with a current or former therapist. The therapist would then be in an evaluative role with his/her current or former client. In practice, it is not always possible to know when a multiple role relationship exists or might exist in the future.

The Counseling Center will identify one or more "point persons" each year who is available to meet with the CCPs for Initial Appointments and disposition recommendations. These clinicians should not have involvement with the CCP program (e.g., the Therapeutic Services Coordinator). These clinicians will make decisions regarding access to clinical services on a case-by-case basis with the default assumptions as specified in this policy (e.g., referral elsewhere). The CCP Program Coordinator will inform CCPs of these policies and procedures regarding availability of clinical services at the Counseling Center and provisions for referrals.

No student is assigned a therapist who currently has a supervisory or administrative relationship to the student. Since all dual role relationships are not avoidable in an agency like the Counseling Center, whenever a student is assigned a therapist, great care is taken to see that any dual role which has or might occur will not compromise either of the relationships or roles, and/or represent a problem for the student, the clinician, or the integrity of the agency. It is the responsibility of the clinician, in consultation with the student, and with other professional staff to initiate and follow through on this process. Failure to do so will result in an ethical breach and will be dealt with accordingly.

Any student who has been in therapy previously with a staff member who may also be in the current supervisor pool, should make it known to the respective coordinator that they cannot be supervised by that particular staff member. Or, the clinician must inform the coordinator that they cannot supervise a specific trainee.

It is the responsibility of all clinicians, and especially of the assigned therapist and the Therapeutic Services Coordinator, to channel students who are requesting therapy, and who may be interested in applying for a future CCP, practicum or internship position, to a staff member who is not (or does not expect to be) in a training or administrative role for the respective program. It is also the responsibility of the assigned clinician to encourage such students to seek services elsewhere, either at the McKinley Mental Health Department or another off-campus resource.

If, by chance, a student is assigned at Initial Appointment to someone who is, has been or potentially will be in an administrative (or supervisory) role with them, counselors holding these roles should refer a potential applicant to a counselor not involved in the program to conduct the Initial Appointment. If this is not possible, the counselor should invite the student into their office, discuss these concerns, and offer to pre-arrange another Initial Appointment with another counselor.

If a student's previous therapist is now in an administrative capacity for the program (paraprofessional, practicum, internship) for which they are wishing to apply, it is the therapist's/program administrator's responsibility to inform students that this creates a dual role. It is also the therapist's/program administrators' responsibility to consult with the appropriate Coordinator (Training, Paraprofessional) prior to any assignment, selection, or hiring to review each case on an individual basis. This is to determine if there is any potential for an unethical or otherwise problematic therapeutic relationship. If the Coordinator of Training or the Coordinator of Paraprofessionals is the individual involved, then the case is to be reviewed by an appointed representative from the respective program committee.

If a student's previous therapist is in a position of responsibility for decisions at the program level (e.g., Training Coordinator but not directly coordinating the CC practicum in which their previous client has enrolled), and is called into an evaluative position regarding their previous client, it is the responsibility of the therapist/administrator to consult with the appropriate committee (i.e., Training). This committee consultation will result in an alternative procedure appropriate for evaluative decisions that need to be made about that student so that none of the roles of client/student or therapist/administrator is unduly compromised.

Students may not apply for Graduate Assistantships with their current or previous therapist.

Training committee selection decisions are made only by those who have not had a prior therapy relationship with the applicant. If, for example, a previous therapist is on the training committee for selection of practicum or interns, that therapist would exempt themselves from rating that particular applicant's materials and would not be involved in the interview and final selection process for that applicant.

For the practicum year with us, we discourage those students from also holding graduate assistantships with us. If this is unavoidable, administrative or supervisory roles are arranged such that they do not overlap for that year. If a student wishes to serve in both capacities, they are encouraged to do so in different years.

Acknowledgment of Informed Choice for University of Illinois Students Seeking Private Therapy with Staff Members of the Counseling Center or McKinley Mental Health Department

I,_____, am choosing to see_____

privately for professional mental health services.

I make this decision with full awareness that there may be other resources available to me on a prepaid basis, and because: (check all that apply)

_____ It has been determined that the primarily short-term services of the Counseling Center or McKinley Mental Health Department are not appropriate for the type of service I need.

_____ Of reasons of convenience, and/or privacy.

_____ Other (please specify): _____

_____

Further, I give permission to my private practitioner to keep a copy of this form in my confidential file. This will serve to document that my counselor has acted ethically in this matter. I understand that this form is confidential as covered by the Illinois Mental Health and Developmental Disabilities Confidentiality Act and cannot be released without my written permission. I also understand that this acknowledgment is not binding and I am not giving up my right to receive mental health services at the University as appropriate and available at some time in the future. These policies are also described in the "Guidelines for Referral to Private Practice for Staff Members of the University of Illinois Counseling Center and McKinley Mental Health Department."

Finally, I understand that I have a right to a copy of this form.

Signature: _____

Print Name: _____

Witness: _____

Date: _____

Initial Psychiatric Referral to the McKinley Mental Health Unit (revised 2/2013; short version)

Obtain Consent - Authorization to Release Protected Information (ARPI).

Non-emergency Psychiatric Referrals

1. Call McKinley MHU - 333-2705.
2. Explain need to schedule psychiatric evaluation.
3. Explain that information will be faxed shortly.
4. Schedule appointment.
5. Make sure client knows where to go and time of appointment.
6. Encourage client to arrive 15 minutes early to complete paper work.
7. Fax information (Consent Form (ARPI) along with at least one of the following).

- Recent (within last three months) Initial Assessment.
- Letter or note describing your clients need and condition.
- The Psychiatric Referral Form

8. After reviewing faxed information submit for filing in clients "hard copy" file.

Emergency Psychiatric Referrals

- Obtain consent (ARPI).
- Call the McKinley MHU at 333-2705
- Talk to ET (Emergency Triage) clinician.
- Explain need for emergency psychiatric evaluation.
- Then follow steps 3 through 8 (above) for non-emergency referrals.

(See Long Version for more detailed explanation)

Procedure for making an Initial Psychiatric Referral to the McKinley Mental Health Unit (revised February 2013; long version)

Counseling Center clients can be referred to the Mental Health Unit (MHU) of the McKinley Health Center for a psychiatric evaluation. These referrals are typically made with the intention of having the client evaluated for possible medication. While client concerns vary greatly, the most common reasons for psychiatric referrals are to address conditions related to depression, anxiety, and/or bipolar disorder. Before a referral can be made, a consent form to release information must be obtained.

A specific Authorization to Release Protected Information (ARPI) between the Counseling Center and the McKinley MHU has been created for psychiatric referrals and is to be used in these instances.

This form is stored electronically on the L drive in the "Consent Forms" folder and can be printed and completed by the clinician. (Note: Whoever witnesses the client sign the form is the one to sign on the witness line.)

Referrals are generally made in one of two situations; non-emergency and emergency.

Non-emergency Psychiatric Referrals

Referrals can be made to the MHU psychiatry staff directly by our clinical staff. Depending on the time of the semester the wait time for an appointment can vary between two days and four weeks.

Once the ARPI is obtained the following procedures can be followed.

1. Call the McKinley MHU at 333-2705 with your client in your office (it might be useful to have an idea of when your client is available before hand).

2. Tell the receptionist staff on the MHU who you are and that you would like to schedule your client for a psychiatric evaluation.

3. Explain that you have a consent to release information and will fax the information the psychiatrist will need to them shortly.

4. Schedule your client's appointment for a psychiatric evaluation with the MHU.

5. After finishing the call, make sure that your client knows where to go (3rd floor of the McKinley Health Center) and when their appointment is.

6. Encourage your client to arrive at their appointment 15 minutes before it is scheduled and explain that they will need to complete some paper work there.

7. After you have completed this process and your session has ended, fax (by either clinician, RSO or ASO staff) the information to McKinley's MHU.

Information to be faxed includes a completed Consent Form (ARPI) (required)

Along with at least one of the following.

- Recent (within last three months) Initial Assessment.
- Letter or note describing your clients need and condition.
- The Psychiatric Referral Form

8. If information is faxed by our RSO/ASO staff it will be placed in your mail box in the RSO office.

9. After reviewing the faxed material, submit it to RSO staff for filing in the clients "hard copy" file.

10. For non-emergency referrals the material to be faxed by RSO/ASO staff can be placed in a designated area for them to do later in the day at their convenience.

Note: Document the psychiatrist's name and date of the appointment in the clinical record.

Emergency Psychiatric Referrals

In cases where it is determined that a client's need is urgent and cannot wait the time period for a planned, non-emergency psychiatric evaluation the following procedure is to be used.

Obtain consent (ARPI).

Call the McKinley MHU at 333-2705 with your client in your office and ask to speak to the ET (Emergency Triage) clinician. The ET person should be available unless they are with a client in crisis. If they are unavailable – either leave a message or arrange to call back once they are free.

Once in contact with the ET person, explain who you are and that you have a client who needs to have an emergency psychiatric evaluation. Be prepared to answer questions related to your clients need, condition and why it is an emergency.

Then follow steps 3 through 9 (above) for non-emergency referrals.

Additional Notes

These procedures only apply to making an initial referral to one of the McKinley MHU psychiatrics for a psychiatric evaluation. Initial appointments typically last 50 minutes. Referrals made to the MHU psychiatrics for their active, current clients do not follow these procedures. Those appointments typically last 25 minutes and are routinely made by the client after their most recent session with the psychiatrist. Situations where one of our clinicians wants to expedite a return visit with a MHU psychiatrist for one of our joint clients can be done on a case-by-case basis.

Additionally there are times when Center clinicians might choose to refer a client to a non-psychiatric physician at the McKinley Health Center. This could be for a health related or mild psychiatric concern. These referrals are also managed on a case-by-case basis and do not follow this procedure.

For Non-Emergency Referrals information should be faxed later that day if possible or the next day at the latest. The McKinley MHU will require that the information be available to them at least two days before the scheduled appointment. If they do not have it on time, they will cancel the appointment with your client.

For Emergency Referrals the MHU typically has an emergency psychiatric evaluation slot opened each afternoon (1:00 or 2:00 depending on the day and the provider). They refer to them as PUMAs (Psychiatric Urgent Medical Appointment).

If that slot has been filled already it could be that your client will not be able to be seen until the next day.

During the busiest time of the year, it is possible that your client might have to wait two or more days and you will need to assess if that is soon enough. If you feel that your client cannot wait that long, share your concerns with the ET person. They might tell you that this is the best they can do, or they might ask if they could call you back shortly as they work on a solution. If they are not able to work out a plan to meet your client's needs consult with (in this order), the Therapeutic Services Coordinator, Triage Caseworker, or Associate Director.

Since this is an emergency evaluation you are requesting, the staff at McKinley will assume that your client can make an appointment at the time it is offered.

Given that emergency psychiatric referrals often occur without notice, it might be challenging to complete more involved documents (such as an IA) to make a referral. In those cases the psychiatric referral form can be useful. It will need to be faxed as soon as possible making sure that it arrives before the client's appointment is scheduled. Consent (the ARPI form) will always need to be obtained before a referral can be initiated.

Group Therapy Policies and Issues

Group Screening Note (approved 1/19/2007)

The Counseling Center policy on group screening note documentation focuses on the initial meeting between the group counselor(s) and the prospective group client. There are many ways to document this screening appointment and group counselors are encouraged to adopt a format or structure that allows them to meet or exceed the professional and ethical standards in this policy.

The Counseling Center policy on group screening documentation does require that the following elements be contained in the screening note:

- Group name in which client is being screened for;
- An overview of goals or concerns client would like to address in group;
- Referring counselor;

- Notation of group norms;

- Acceptance of client into group and/or disposition following group screening (i.e., referred back to referring clinician, mentioning of group start date to client);

- Group screening notes should be completed in accordance with the Counseling Center Record-Keeping Policy (11/2005).

Group Case Note Documentation (approved 1/10/2007)

The Counseling Center policy on group case note documentation focuses on content rather than format or structure. There are many ways to document group case notes and group counselors' are encouraged to adopt a format or structure which allows them to meet or exceed the professional and ethical standards outlined in this policy.

The Counseling Center policy on documentation of group appointments requires that the following elements be contained in every group case note:

- Every group case note must uniquely describe a specific group appointment;
- A brief overview of topics addressed in group session;
- A brief description of the level of participation of group clients;
- Description(s) of group intervention(s);
- Group case notes should be completed in accordance with the Counseling Center Record-Keeping Policy (11/2005);
- Group case notes should be distributed to ALL client files regardless of group attendance;
- Group members' initials should be used to identify them.

Group counselors are encouraged to write individual notes for their group client(s) if they are warranted. Examples would include if a group client met with a group counselor individually or an individual note was necessitated given the nature of the presenting issue discussed in a group session (i.e., suicidal ideation). This can be documented as an individual note or an addendum to the group note. Individual notes should follow the policy described for individual case note documentation.

Group Summary and Final Disposition (approved 1/10/2007)

The Counseling Center policy on group summary note documentation focuses on updating the client's record for every semester they have been in group. A group client receives a summary note if they will be continuing with group. Additionally, the group client will receive a summary note if they are being internally transferred to another group or for individual counseling. When a group client has terminated with all services at the center, they will receive a final disposition note. This note could serve as the final group summary note.

There are many ways to summarize a group client's work. Group counselors are encouraged to adopt a format or structure that allows them to meet or exceed the professional and ethical standards outlined in this policy.

The Counseling Center policy on group summary and termination notes requires that the following elements be contained in every note:

- It will be a note that is written for every semester the client is in group;
- A description of their level of participation;
- An overview on the main themes that emerged for the client in group; significant developments or milestones in client's process during the semester;
- Disposition for next semester;
- Number of group sessions attended
- Total number of group sessions attended for a terminating client.
- Group summary notes should be completed in accordance with the Counseling Center Record-Keeping Policy (11/2005);

If the group client is terminating with services at the Counseling Center, the final disposition policy is applied.

Group Evaluation (revised 8/9/2013)

Groups are evaluated each semester, at the end of the semester. All groups are expected to participate in this process, whether they are ongoing, or stop in mid-semester, or conclude at the end of the semester.

The purposes of the evaluation are (1) to give group leaders an alternate source of information about how the group has worked for purposes of professional development, (2) to give the agency a sense of whether there are any ethical or other problems with a group or a leader that need to be corrected, and (3) to give counseling staff in general, and higher administration as appropriate, information about the degree to which clients were satisfied with their group experience and which aspects of the group experience were considered especially helpful or unhelpful, and (4) to give clients an opportunity to give feedback.

Groups are currently evaluated with a questionnaire, consisting of quantitative and qualitative questions, that were compiled by the Center's Assessment and Evaluation Committee in 1995. Sources for the questions included measures in use at other counseling centers, primarily questionnaires from the University of Missouri and the University of Michigan. The questionnaire was piloted in Summer 1995 and instituted officially in Fall 1995.

Development of the evaluation program was begun with a background study. A qualitative study, consisting of interviews with staff who conducted groups, was carried out by a Social Work Field Practicum student in Spring 1993. Group leaders were asked about their attitudes and practices, especially what kind of "informal evaluation" they did, whether these "informal" methods met the needs of leaders and group members for feedback and what alternative evaluation methods could be applied in this setting. Conclusions from this study indicated that while leaders accepted and valued evaluation for the improvement of their clinical skills, there was considerable diversity in leaders' views on appropriate methods and intended audience(s). (See attached "Group Evaluation" report summary.) Two recommendations came from the report. One was to develop one standardized means of group evaluation that would be acceptable and meaningful, that would meet a common need and fit the amount of time staff has to give to evaluation. The second recommendation was to diversify our approaches, given that, for example, the needs of a specific theme group are very different from the needs of a general therapy group. Co-leaders could apply their philosophy of groups in choosing their own evaluation methods. The first recommendation has been followed in that one standardized group evaluation measure has been in use for all groups since Fall 1995. (See attached questionnaire.)

In general, group feedback is handled the same way the individual counseling feedback is handled. Feedback forms are handed out to group members at the end of their last group session or the session prior to the last one. Group members are asked to fill them out before leaving – essentially it is part of the group experience.

Near the end of each semester, a Reception Office staff person provides each group with an envelope of questionnaires, a copy of the administration instructions, and pencils. The group leader explains the task, designates a group member to be in charge of returning questionnaires, hands out the forms and the envelope to collect them in and then leaves the room. (See attached "Group Feedback Procedure" instructions.) Group members are told not to discuss the questions while they are answering them. The envelope should be sealed after the last form is added and turned in to the Reception Office by the designated group member. After hours, the envelope can be shoved under the Reception Office door. If the group meets elsewhere, the sealed envelope can be given to a group leader to turn in. As they are returned, questionnaires are forwarded to the Research Data Analyst. Leaders do not read the questionnaires until data are compiled by the Research Data Analyst (RDA).

The RDA will compile feedback similarly to the individual feedback. Qualitative and quantitative data are compiled by group, then combined across groups. Printed data on their own group is distributed to group leaders, and the combined data with leader identifying information removed and answers scrambled is distributed to all leaders and to other professional staff who request a copy. A summary of the group data is prepared for all permanent staff on a semester or yearly basis.

While the group is identified by code on each form, no client-identifying information is collected. Forms are anonymous in terms of individual group members so we are not able to match group evaluation information with other information we have gathered, e.g., demographics.

For group members who drop out before the end of the group, the leaders can give them the feedback form at the meeting to arrange the drop. Or the form can be mailed if we have a positive blue permission-to-mail slip on file. Ongoing groups can have all group members fill out the forms at a defined ending time, such as the end of the semester, when a number of people drop out. For purposes of group feedback, the ongoing group with new members joining can be looked at as a "new" group.

Process Observer Policy

A process observer is a trained clinician who monitors the group dynamics of a therapy group. The individual reports his or her observations to the facilitators and sometimes to group members. Process observers may be a part of some of our group therapy treatment teams. This practice allows for a training experience for students, while also providing group leaders with assistance in tracking group process.

Role of Process Observer

The process observer is considered a key part of the treatment team. While most process observers do not talk during group, they have an important role in the development of the group. The process observer is as an additional witness to the group experience and provides feedback and impressions to the co-leaders. The process observer utilizes active listening skills in order to develop an understanding of the group process. The process observer will usually attend co-leader meetings in order to give their input on the group process and to receive supervision. It is acceptable for co-leaders to meet separately from the process observer if they find it necessary.

While the process observer is an important part of the group treatment, their experience should also include a training component whenever they are in training. Time should be devoted to assisting the process observer with understanding the group dynamics, writing appropriate notes, and learning more about group therapy. It is recommended that process observers have a group counseling course in their programs as a pre-requisite for this experience.

Group members should be informed about the presence and role of a process observer before they join the group. It would be advisable to introduce the process observer at the screening and at the first group.

Group Notes

Process observers can be involved in clinical record keeping up to and including signing the group note. Each note should include a header with the co-facilitator and process observer names. The co-leader signing the note has legal responsibility for the note. All notes should be written in accordance with the Counseling Center's record keeping policies.

If the process observer has access to Titanium, they should write the note directly into Titanium under their own name. The process observer should sign the note on line 1 and one of the co-facilitators should sign on line 3. It is acceptable for co-facilitators to alternate this responsibility. The process observer should be included as one of the "Attendees and Resources" in the Scheduling field for the group appointment.

Process observers without access to Titanium can write notes, but they need to use a safe and secure way to transfer files from the process observer to the co-leaders. One option is to save it on a shared file via Netfiles. Co-leaders should review the note and then enter into Titanium under their own name. The file should be deleted once it is entered into Titanium.

If process observers are added to groups with interns, the process observer should only have notes signed by the staff co-leader. In order to give both trainees an opportunity to write notes, it would be advisable to have the process observer and intern trade off note-writing responsibilities every other week.

Evaluation

If process observation is part of a student's practicum experience, facilitators will be expected to do formal evaluations after each semester. Consult with the practicum coordinator for more information.

Emergency Policies and Practices

Mandated Assessment Following Suicide Threats and Attempts (August 6, 2004, draft)

The University of Illinois expects and encourages students to maintain a reasonable concern for their own self-welfare. One of the times the University formally requires that such a concern be maintained is in the area of suicide.

In the event that the University is presented with a credible report that a student has threatened or attempted suicide, engaged in efforts to prepare to commit suicide or expressed a preoccupation with suicide, that student will be required to attend four sessions of professional assessment. The purpose of this assessment is to provide the student with resources to adhere to this standard in the future and to monitor the student's willingness and ability to adhere to this standard.

A. Procedures

1. When the Suicide Prevention Team is in receipt of a credible report that a student has threatened or attempted suicide, engaged in efforts to prepare to commit suicide or expressed a preoccupation with suicide, the student will be required to attend four one hour sessions of professional assessment with a licensed mental health professional who agrees to participate in the program's requirement of a comprehensive and in-depth assessment of the precipitating incident, prior attempts and threats, and current suicidal intent. In addition, the professional must be willing and available to engage in counseling and/or therapy, if the student so consents.
2. The first assessment will occur within a week of the incident or release from thehospital.
3. The remaining assessments will ideally occur at weekly intervals.
4. Students are required to participate only in an assessment of their past and current suicidality. Students are not required to engage in counseling or therapy. A student may elect to go beyond the required assessment and participate in counseling or therapy, only after the professional secures the student's permission through verbal consent.
5. Students can obtain the assessments with a private practitioner with comparable credentials at his or her own expense and after signing an authorization allowing that practitioner to communicate with members of the Suicide Prevention Team. All professionals will make the incident, its roots and implications a significant focus of each of the four assessments.
6. Students seeking to obtain the four assessment appointments with a private practitioner must sign a release allowing the practitioner to make contact with a member of the Suicide Prevention Team. As was the case with university professionals, before meeting with the

student, the private practitioner must be provided with independent sources of information regarding the suicidal incident, if such reports exist. These include suicide notes, police reports, emergency room reports and eye witness accounts.

7. Private practitioners will be required, during the period in which the four session assessment occurs, to provide the University with reports of instances in which the student threatened or attempted suicide, engaged in efforts to prepare to commit suicide or expressed a preoccupation with suicide.

8. During the first assessment appointment, the student will sign a release of authorization form allowing the Suicide Prevention Team to communicate with the Dean of Students in the event he or she fails to attend the assessment sessions

9. Failure to adhere to this standard of self-welfare or failure to fulfill the requirements of the assessment following a suicidal incident may result in disciplinary action, academic encumbrance, suspension and/or withdrawal. The disciplinary actions associated with this policy will be made by the Dean of Students.

10. The Dean of Students may take other steps, including contacting the student's parents and/or other significant others in the event of a particularly potentially lethal suicide attempt or in the event of repeated suicide attempts.

B. Confidentiality

1. All records associated with the reported incident are kept separately by the Suicide Prevention Team and do not appear as part of the student's official university record.

2. All records associated with the mandated assessment are protected by state laws regarding confidentiality.

C. Appeals

1. A student may appeal the accuracy of the report to the Suicide Prevention Team. In some instances, in order for the appeal to go forward, a student will be required to sign a release of information authorizing the members of the Suicide Prevention Team to contact and interview witnesses to the incident.

2. The policy of four sessions of professional assessment is applied uniformly to all students who cross the threshold described above. The requirement of four professional assessments is not subject to appeal.

3. If a student disagrees with the decision of the Suicide Prevention Team, he or she can appeal the Suicide Prevention Team's decision to the Dean of Students or designee. The Dean of Students decision is final.

Suicide Incident Report Form

The Counseling Center has a primary role in preventing suicide among University of Illinois students. By filling out this report you will be alerting the Counseling Center to the fact that a particular student was recently, or still is, in a suicidal crisis. The Counseling Center will then review your report and if it seems necessary, will work with you to encourage the student to come in for counseling. The Counseling Center also uses these reports to identify "risk factors" that make certain students more prone to suicide than others.

I. PERSONAL DATA

1. Student's Name: Last: First:
2. Age: Race :
3. Sex: (circle one) Male Female
4. Year in School: (circle one)

1. Freshman 5. Masters
2. Sophomore 6. Doctoral
3. Junior 7. Professional
4. Senior 8. Don't Know

Other (please specify):

5. College:
6. Major:
7. UIN#:

II. INCIDENT INFORMATION

8. Date Incident Occurred:
9. Time Incident Occurred: am / pm (circle one)
10. Location Where Incident Occurred:
11. What was the nature of the incident? (circle one)

a. Was it a threat in which the person expressed an intent to hurt him/herself but took no definite action? (If yes, please go to question 12)

b. Was it a gesture or an attempt in which the person took some definite action? (If yes, please go to question 13)

c. Was it an actual or apparent suicide? (If yes, please go to question 13)

12. Information About Threats: (continue on other side if necessary)

a. Can you briefly describe the events leading up to and surrounding the threat?

b. Was the threat verbal or written? To whom was it made?

c. Did the person have a plan? If so, what was it?

d. Did the person have the means to carry out the threat? Please describe:

(please skip to question 14)

13. Information About Gestures, Attempts and Actual Suicide: (continue on other side)

a. Can you briefly describe what took place?

b. What was the primary means that the person used to hurt him/herself?

c. Were there any secondary means involved (e.g. alcohol, drugs, medication)? If medication was involved, where was it obtained?

d. How did you learn of the incident? Did the person seek help? Did someone discover him/her?

Trauma Response Mission and Protocol

The mission of the Trauma Response is to provide range of easily accessible and professional services to students who are affected by traumatic incidents and/or psychological emergencies.

Priorities:

1. The Team's primary purpose is to provide prompt response to students, faculty, and staff of the university community who are involved in or directly affected by incidents that are of a traumatic or emergency nature. These responses are primarily to address the emotional and psychological needs of those involved.

2. The Team provides preventive services and information to members of the university community who request it. The Team also provides aftercare service for those individuals and groups who are affected by a traumatic incident and would benefit from such services provided by the team.

3. The Team works in collaboration with the Office of the Emergency Dean and other campus agencies and individuals who are involved in a critical incident. The group serves as a part of the information system with others involved in order to maximize the exchange of information and the availability of services without violating the confidentiality of students involved.

Services Provided:

1. Regarding prompt and timely responses, the Counseling Center provides on-the-scene support service to those directly affected by an emergency situation and/or those in positions of making decisions and providing care after the trauma (e.g. RA's, RD's, Greek Peer Advisors, etc.). These services are typically consultation, crisis counseling, debriefing, providing referral information, and arranging for follow-up services.

2. Regarding preventive services, the Counseling Center provides information about the nature of trauma and typical responses to trauma. This information may be requested in the form of a presentation or distribution of materials. (See description of types of meetings provided).

3. Regarding aftercare, the Counseling Center provides follow-up services on a timely basis, typically 1-2 weeks following a trauma, for those who have been affected by the trauma.

4. Trauma Response Committee Co-chairs (or other designated Counseling Center staff member) work in collaboration with the Emergency Dean's office and other involved groups to coordinate prompt and aftercare services to individuals and groups involved in emergency situations and will exchange information necessary to ensure services are or have been provided.

5. Trauma Response Leaders coordinate the response of Counseling Center staff who have expressed a willingness to be on the response team for an individual response and aftercare services.

6. All Counseling Center staff members are expected to participate in at least one Trauma Response during an academic year without compensation. Individuals participating in additional Trauma Responses may be compensated for their time by being relieved of one IA, upon approval of TS coordinator with consideration of current clinical demand.

7. Trauma Response Leaders provide training materials for Counseling Center staff (or other Student Affairs staff) providing such services.

8. Trauma Response Leaders maintain printed materials for the team's use in responding as well as for distribution to those affected by the event and for those in positions of providing on-site care.

Procedures for Accessing Counseling Center Trauma Response:

- The call from Emergency Dean's office or another source would be directed to the Trauma Response Committee Co-chairs.
- If either person cannot be reached, the caller would contact the designated backup clinician.
- It is the responsibility of Trauma Response Co-chairs to coordinate the Trauma Response on behalf of the Counseling Center.

The primary purpose is to make sure someone can provide a timely response in the case of a trauma. It is the initial caller's responsibility to contact someone on the team. Beyond that it is the responsibility of the team member to make sure that they, another team member, or someone else on staff has been informed and has committed themselves to the response

Counseling Center Trauma Response Team

Mission

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Priorities

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Services Provided

1. Regarding prompt and timely responses, the Team provides on-the-scene support service to those directly affected by an emergency situation and/or those in positions of making decisions and providing care after the trauma (e.g. RA's, RD's, Greek Peer Advisors, etc.). These services are typically consultation, crisis counseling, debriefing, providing referral information, and arranging for follow-up services. (See "Critical Incident Debriefing Process").

2. Regarding preventive services, the Team provides information about the nature of trauma and typical responses to trauma. This information may be requested in the form of a presentation or distribution of materials. (See description of types of meetings provided).

3. Regarding aftercare, the Team provides follow-up services on a timely basis, typically 1-2 weeks following a trauma, for those who have been affected by the trauma. (See description of types of meetings provided).

4. The Team works in collaboration with the Emergency Dean's office and other involved groups to coordinate prompt and aftercare services to individuals and groups involved in emergency situations and will exchange information necessary to ensure services are or have been provided.

5. The Team maintains a list of Counseling Center staff who have expressed a willingness to be on the response team as well as a list of staff who are available to work with a team member in providing aftercare services.

6. The Team provides training materials for Counseling Center staff (or other Student Affairs staff) interested in providing such services.

7. The Team maintains printed materials for the team's use in responding as well as for distribution to those affected by the event and for those in positions of providing on-site care.

Procedures for Accessing a Team Member on the Roster

- The call from Emergency Dean's office or another source would be directed to the person whose name appears at the top of the list for that month.
- If that person cannot be reached, the caller would go down the list calling each person until someone is contacted and given the information.
- It is the responsibility of the team member who gets the call to make the response. Or:
- In the event that the team member is unable to make the response, that team member would assume the responsibility for calling down the list until someone is committed to providing a response.

The primary purpose is to make sure someone can provide a timely response in the case of a trauma. It is the initial caller's responsibility to contact someone on the team. Beyond that it is the responsibility of the team member to make sure that they, another team member of someone else on staff has been informed and has committed themselves to the response.

Trauma Response Meetings

There are typically four different kinds of trauma response meetings. Each of these types of meetings has many variations, of course.

One meeting is a **consultation meeting**, conducted with those people who have some leadership role with those involved in the trauma. This is a meeting for determining what steps need to be taken in addressing the trauma, identifying and assigning tasks deal with the immediate needs of those affected, and planning what subsequent meetings or activities need to be take place.

A second type of meeting is a **debriefing meeting**, conducted very shortly after the trauma event with those who have been directly involved with the event. Examples of debriefing meetings include: meeting with the people who were present and witnessed a person being struck by a car, people who were evacuated from a burning building, people who have been held in a hostage situation, people in the room when someone committed suicide. These meetings tend to focus on helping people report and attend to the shock and immediate physical and emotional responses to trauma.

A third type of meeting is a **processing meeting**, conducted within a few days of the trauma, with those who have been clearly affected by the event. Examples of process meetings include: meeting with a group of friends of a person who has recently died, meeting with residents whose living quarters has burned, meeting with people who live with someone who was assaulted, meeting with a group with whom you had a prior debriefing meeting.

The final type of meeting is an **informational meeting**. This is a meeting following a trauma event with people who have not been directly affected by the trauma, but whose sense of well-being or safety has been compromised because of the trauma. Examples of information meetings include: providing emotional and physical safety information to students and staff following a campus assault or murder, meeting with residence hall personnel following a murder in a residence hall on another nearby campus.

Of course, many meetings do not fall neatly into one of these categories. A processing meeting may include people who were present for the trauma and still greatly affected by it in ways that others are not. Informational meetings may trigger thoughts and feelings about past traumas so that it more resembles a processing meeting. However, it is generally helpful to keep in mind the primary nature of the meeting so that as a facilitator you can address issues more relevant to a given stage in the grief process.

Consistent with the models of grieving, the debriefing meeting is more likely to address the initial stage of grief, which is shock, numbness, confusion, etc. The processing meeting is more likely to address the subsequent stages of grief, which include the emotional responses of sadness, longing, anger, fear, guilt, etc. The informational meeting is more likely to address the emotions that accompany grief as well as prevention.

The Critical Incident Stress Debriefing Process

The following six stages in group debriefing are summarized from Mitchell (1983). A fuller description of these stages is on the following pages.

Stages:

1. Introduction

   Introduction of facilitators, overview of the meeting process, setting ground rules and goals, including a discussion of confidentiality.

2. Facts

   Provide or elicit facts, information. Encourage participants to discuss their involvement in the incident.

3. Feelings

   Focus on the feeling states of participants, both currently and at the time of the incident.

4. Symptoms

   Focus on the impact of the incident, the "stress response" symptoms that individuals may be experiencing, focus on how they are handling their current reactions to the incident.

5. Education

   Teaching phase where the leader gives information relevant to the situation. For example, explains how the stress symptoms or grief reactions experienced by the participants are a normal reaction to a traumatic event or loss.

6. Wrap-up

   Identify any specific concerns which warrant follow-up, discuss concerns affecting transition back to "normal life," discuss how to proceed from this point.

7. Follow-up

   Provide follow-up session for group or individuals if needed or requested.

Source: Michell (1983). When Disaster Strikes: The Critical Incident Stress Debriefing Process. Journal of Emergency Medical Services 8(1), 36-39.

Detail: The Critical Incident Stress Debriefing Process

The debriefing meeting has several important purposes included in each of the stages of the meeting. These are delineated below.

1. Introduction of the Meeting and the Facilitators

How the meeting is introduced can be extremely important. Because traumatic events often involve intense personal, even private feelings, a facilitator may be seen as an intruder, an outsider attempting to be a part of a private event. Though this is not usually the case, it is often best if initial introductions of the facilitators are made by someone known to those in attendance (an R.D. for example). Introduce any addition information about yourself that seems appropriate to the situation.

As facilitators, then, your first responsibility is to state the purpose of the meeting, provide an overview of what will happen in the meeting, establish ground rules and goals, and explain the confidential nature of the meeting.

The purposes of the meeting include:

- providing those in attendance updated and accurate information about the trauma event,
- providing those in attendance an opportunity to talk about their own experiences and responses to the event,

- providing information that might be helpful to those in attendance and others they may know who have been affected,
- presenting and discussing some things each person might do in response to the trauma.

Ground rules:

- Participation is voluntary. Each person will have an opportunity to talk if they wish, but no one will be required to talk.
- Information discussed during the meeting is strictly confidential.
- The meeting will last about two hours. There will be no breaks.
- Nothing needs to be said that might incriminate anyone or be part of an investigation.
- Everyone is equal. The focus is on how this event affects us as people.
- This is not counseling.
- Turn off all pagers, cellular phones, and anything else that might distract.
- Identify all individuals who do not belong in the debriefing (reporters, etc.).

2. Providing or Eliciting Facts

It is important that all in attendance have shared knowledge of the traumatic event. Therefore, it is often helpful to have someone present who can best represent accurate, updated information. This includes information about the trauma and what has transpired since then. This may also include information about arrangements being made, such as a funeral, a visitation, etc.

Participants are asked to describe their involvement in the incident or their relationship with any of the victims. For example, "What were you doing when this happened?" "Where were you when you first heard? What was the first thing you did?" "How did you know the person?" Facilitators should not attempt to get participant to describe emotional experiences at this point.

This information and experience shared makes each person's involvement in the event clear to others in attendance. It provides the context for the following stages of the meeting.

3. Focusing on Thoughts and Feelings

In this phase, participants are encouraged to share the thoughts and emotional reactions they had and continue to have. These may include intense feelings associated with shock if the debriefing is held very shortly after the event.

The purpose of this phase is to begin normalizing these thoughts and feelings. By allowing each person to share the range of reactions they have had and by hearing what others have thought and felt, and by having facilitators validate as normal each member's personal reactions, participants can begin to see their reactions as "normal reactions to an abnormal situation."

4. Identifying Symptoms

Facilitators explain to the group that it is common for individual who have been involved in traumatic events to experience physical symptoms as well as emotional reactions. These may include flashbacks, insomnia, anxiety, indigestion, etc. Participants are asked to describe any symptoms they are experiencing. Again the emphasis may be that participants are having "normal reactions to an abnormal situation."

(See handout "Shock and Suffering")

5. Education

This goal of this phase of the meeting is to link what participants have been experiencing with useful information about trauma response. By using handouts and discussion, facilitator gives information relevant to the situation. Sample handouts are available in this packet.

6. Wrap-up and Follow-up

Identify any specific concerns which warrant follow-up, discuss concerns affecting transition back to "normal life," discuss how to proceed from this point. It is generally desirable to arrange a follow-up meeting approximately two weeks after this meeting to discuss the ways participants have reacted and adjusted to the situation.

Skills for Facilitators

Given your role in the University system, you may be called on to help people in the midst of a trauma. It is normal to feel helpless and to think that you lack the knowledge or skills for helping others in such a situation. However, you are probably a more capable helper than you realize. Many of the skills you use in your counseling are directly applicable to a trauma situation. Remember that there is no single correct response to make when someone needs support. You cannot eliminate their pain, but you have knowledge and skills that can help them through the situation. This handout will provide you with some ideas for helping others cope with the trauma.

General Skills for Helping

- Listen
- Provide compassionate support
- Provide information and suggestions for coping

Specific Suggestions for Helping

Although there are some common ways people react to extreme stress or trauma, everyone is unique. These suggestions may not fit for every person who turns to you for support, but they may be helpful guidelines.

Helping People to Express Themselves:

- Don't be afraid to ask questions.

- Listen emphatically. Invite people to talk, help them to summarize their thoughts and feelings, and communicate their concerns. Giving people a chance to express themselves is important. Some may need to tell their stories many times. Allow them to do so.

- Normalize people's reactions. Trauma survivors are having normal reactions to abnormal circumstances. Many times, because of the intensity of their reactions, they may assume they are feeling or thinking things that are not normal. Inform them that what may seem an excessive or bizarre reaction at other times is normal now.

- Let people know that it's OK to feel bad, to be confused, etc. and it's OK to express those feelings with others.

- Help people identify sympathetic others such as friends and family members. Encourage people to talk to people in their natural support systems.

Helping People with Healthy Coping:

- Ask people what they have been doing to cope. Help them see that they have some good coping skill which they are already using. Encourage them to continue using those skills that are working. Help them brainstorm other actions they can take.

- Encourage people to spend time with others, even if they don't feel like talking. It is the tendency of many to isolate themselves following a trauma, and just finding ways to "hang out" with friends can be comforting.

- Talk with people about small ways they can take care of themselves. Ask them what they find comforting or relaxing (e.g. going to a movie, listening to music, exercising).

- Help people think of ways to keep their daily routines as normal as possible. Maintaining basic activities, such as regular meals, sleeping, exercise; and making as many small daily decisions as possible will help them gradually re-establish a sense of control and normalcy.

- Help people set priorities. This may not be the best time for them to make major decisions. However, recovering from trauma does require time and some relief from significant demands. Therefore it may be important to find ways to step back from major commitments and allow time to reflect and heal.

- Caution people not to "numb" the pain with alcohol or other drugs.

Helping Them with Resources:

- Provide people with information about professional help and resources.

- Provide people with information about administrative help (e.g. Emergency Dean).

Helping Yourself:

- Remember that responding to people in distress is stressful for the helper. Know when you need to take a break. Talk to a friend or colleague. Take care of yourself.

Suggestions for Planning an Intervention / Debriefing

There may be occasions when you are "thrust" into a trauma situation without time to prepare. Hopefully, this will be the exception. When the situation permits, planning can be crucial to an effective intervention. This handout provides some general guidelines and suggestions for preparing for an intervention.

The Consultation meeting is important in planning an effective debriefing meeting. Meet with leadership personnel to secure the following information as much as possible.

- Determine likely attendance
- Get as much information about the group and individuals as you can.
- Identify individuals who are likely to be particularly affected by the trauma (roommates, closest friends, etc.)
- Secure information about the event and designate an information person to share that information at the outset of the meeting (see Debriefing outline)
- Brainstorm support networks and individuals
- Determine setting. Secure setting that is private, comfortable, and will allow interaction if at all possible.
- Inform them that you will be assuming leadership of the meeting.

The Debriefing Meeting is described in detail on a separate sheet.

- Have at least 2 counselors at the meeting if at all possible. They can share leadership or one can be a backup person. This not only provides emotional support for each person, but it also provides a person who can address the needs of individuals who may be particularly upset while the other attends to the group.
- Rely on the Outline/Agenda to guide the process of the meeting.
- Rely on the "Skills for Facilitators" to guide your words and actions.

After the Debriefing Meeting

- Take time to debrief with each other. Talk over what seemed to go well, what you might do differently if given another opportunity, how you can follow-up with the group or the leadership.
- Fill out a report form. Give the original to Ann Jolly, give a copy to John Powell

- Provide John with any information, feedback, suggestions about the intervention that will benefit subsequent interventions.

Surviving the First Five Minutes of the Debriefing Meeting

"I wouldn't know how to get things started."

From my experience and from reports of others, concerns about how to begin a debriefing meeting are enough to keep someone from getting involved at all. Below are some important principles and specific suggestions.

Principle: Your concern, as evidenced by your willingness to show up, conveys a great deal to people who are confused, grieving, fearful, bewildered, and looking for something to help them make sense of the situation.

Principle: The skills that allow to you deal with ambiguous situations in individual or group therapy will also serve you well in a debriefing meeting. You don't have to lead the charge all the time. Much of the time you follow what is being said.

Principle: Providing something is almost always better than providing nothing. Even if what you say is not the best you have to offer, many who are there are simply looking for a way to express themselves and receive some kind of support.

You will generally not be the person to start the meeting (see handout on debriefing process). Usually someone known by the students is the first to talk. They will update students on the latest information about the situation, arrangements that have been made, etc. You will then be introduced as someone who is there to help people talk about the situation, address feelings, or give information about resources.

Now Comes the Five Minutes You Need to Survive

Give an introduction.

Introduce yourself and give a 2-3 minute introduction that may include a few main ideas such as:

- this has been a tragic accident (or whatever is appropriate to the situation)
- people react to these kinds of situations differently
- it's important to pay attention to what's happening inside you; your thoughts, feelings, unique reactions
- it's important to get support from people who care about you.

I might expand on any one of these a bit, depending on how receptive the group appears to be.

Invite them to talk.

Every group is different, so it is helpful to be ready with different approaches. I have found two basic approaches helpful at different times.

1. Invite people to talk about their personal reactions to what has happened.

   If I take this approach, I begin with a general, open question, such as "Would someone be willing to identify what thoughts or feelings you have had since you first got the news?"

   If no one responds to that after a short time, I ask a more specific question that requires less disclosure on their part, such as, "Where were you/what were you doing when you first heard the news?" This is often enough to get things going.

   If still no response, I get even more specific. I may say something like, "It's very common for people, when they get the news of a tragedy to first of all experience shock, or disbelief. Did anyone react like that?"

   Often if you can get a few people to identify with shock, you are on your way. Almost everyone will identify with some form of shock, disbelief, numbness, etc.

   From there, if the group begins to open up, you can go back to the more general questions and observations. There may be some groups, however, where it will be necessary to remain specific and concrete. For example, "After the shock, it's not unusual for people to feel some guilt (or whatever other feelings seem appropriate). Has anyone had that thought or feeling?"

2. Invite people to talk about the person who has died or been involved in the trauma.

   This second approach was a gift given to me by a debriefing participant. He saved me from a deadly silent meeting by asking the question I had not thought to ask, "I didn't know him very well. Could someone tell me something about him?"

   Asking the group to talk about their individual relationships with the person, their fondest memories, their last encounters, or other kinds of stories can pave the way to talking about their thoughts and feelings related to grief.

Trauma Response General Procedures (7/2007)

Occurrence of Critical Incident

Emergency Dean (ODOS)
University Police Department
Housing/Res Life Staff
Hospitals

Counseling Center
(First name on the list and go down on the order)

Providing Appropriate Response
(Briefing, Debriefing, Follow-Up Counseling)

Update the CC Staff for the Incident When Necessary

Submit a brief Write-Up to the Team Chair

Record of Trauma Response

Date/Time of Occurrence:

Reason for Trauma Response:

Location:

Number of Deaths, Injuries, Other (specify):

Students of Concern:

Date/Time of Responses(s) Provided:

Total Number of People who Attended:

Services Requested by:

Services Provided by:

Summary of Incident(s)
(briefly describe the nature of the incident, critical information, and who are/were affected)

Actions Taken
(types of crisis interventions provided, names of providers, who are the recipients, etc.)

Follow-up Recommendations / Plans

Large Scale Event Response Protocol (approved 1/2009)

Purpose

Due to the potential impact of a Large Scale Event (LSE) on campus or in our community, it is the Counseling Center's responsibility to develop a plan to prepare and respond to any incident related to the threat that may occur.

Applicability

The Large Scale Event Response Protocol is designed to illustrate the procedures that the Counseling Center will adopt in the event of an LSE such as a campus shooting, an act of terrorism, a large scale natural disaster, or another such event that results in multiple fatalities, injuries, or widespread loss of safety within the community.

This plan will be implemented upon the occurrence of any incident related to an LSE and at the discretion of the Director. All Counseling Center Full Time Employees (FTEs) at the University of Illinois at Urbana-Champaign are included in this plan. The mobilization of this protocol will be activated by the Director based on the extent of the incident.

Limitation

The Counseling Center LSE Response Protocol will be superseded by any direct response made by another organization with administrative oversight to the Counseling Center, up to and including the Incident Command Post Commander designated by the National Incident Management System.

The Counseling Center will coordinate and support all efforts to respond to an LSE in good faith without violating any ethical principles applicable to mental health care and trauma response.

Response Plan

Phase I - Acute Crisis Phase

The Director, upon being notified and briefed on the nature of incident, will make a decision to activate an LSE Response based on the extent of the incident.

Tasks of this phase include but are not limited to:

- Participating in the campus-wide evacuation plan
- Responding to requests given by local authorities, Office of Dean of Students, Emergency Dean program, the offices of the Provost, Chancellor, or President of the University of Illinois at Urbana-Champaign, or any other agency involved in the University's response to an LSE
- Responding to the Incident Command Post Commander, local law enforcement, local, state, or federal government, or other organizations with an administrative or organizational response to a local LSE

- Providing psychological clinical services to any identified individuals/groups in distress in a setting where safety is assured
- Other duties assigned

Notification

In the event of an LSE, the Counseling Center will adopt the following phone tree as the method of notification for the incident and activation of the Counseling Center's response:

Primary notification: Carla McCowan, Director, Counseling Center

Secondary notification:
TS Coordinator
Trauma Response Co-chair: Group 1
Trauma Response Co-chair: Group 2
Assistant Director (first available): Group 3

Tertiary notification:

Group 1	Group 2	Group 3
Clinicians	Clinicians	All Civil Service staff
Last name A – L	Last name M - Z	& EPI personnel

Mobilization

The Director will designate three Team Leaders. Team Leaders will then meet and designate Counseling Center staff to Teams 1, 2, and 3. Staff will then report to Team Leaders as outlined in the LSE Reporting Structure outlined below.

Counseling Center Reporting Structure

The Counseling Center will adopt a temporary reporting structure for the duration of an LSE.

The Director will designate an LSE Response Coordinator to serve as the primary liaison between the Director and all personnel and activities included in the LSE Response. Team Leaders will report to the LSE Response Coordinator and be the liaisons to all Counseling Center staff and LSE activities. The Director will designate an External Agency Liaison during the LSE, and this individual will report directly to the Director. All other Counseling Center staff will report directly to Team Leaders as designated.

LSE Reporting Structure

Counseling Center Director

↑ ↑

LSE Response Coordinator & External Agency Liaison (as assigned by Director)

↑

Team Leaders 1, 2, & 3 (as assigned by Director)

↑

All Counseling Center Staff

The Director has the sole discretion to add, delete, or amend the above hierarchy during an LSE Response. Additional Teams can be created in order to serve any predictable or unforeseen needs (such as logistical coordination of services with external counseling centers, local mental health counselors, community volunteers, food and beverage needs of the staff, etc.). If Additional Teams are created by the Director they will report to the LSE Coordinator throughout the response.

Counseling Center Activities during LSE

In an off-campus or after-hours LSE that calls for a response requiring the physical presence of the staff, all available personnel will then serve as responders and be directed to report to a safe location. A meeting will be held and the responders will be briefed on the incident and assigned duties.

In all instances, if the provision of clinical services is appropriate, responders will be briefed with basic procedures, expectations, and any materials that may be helpful or required.

Teams 1 and 2 will be designated as clinical teams and be prepared to offer psychological services both on-site (the Counseling Center or another designated clinical center) or as mobile responders. One of these teams will have a priority of providing on-site clinical services and the other team will have a priority of providing mobile trauma response services to the campus and community as needed. However, either team may be called upon to provide any service deemed necessary by the Director, and teams will report to the appropriate Team Leader.

Team 3 will be a support unit ready to provide any service assigned by the Director and will report to the Team Leader.

Counseling Center interns, practicum students, GAs, and other personnel connected with the Counseling Center will be involved with an LSE Response as appropriate and as designated by the Director, the LSE Response Coordinator, or the Team Leaders at the time of LSE activation and determination of personnel needs and availability.

The Director has the discretion to determine the termination of Phase I Acute Crisis Phase activities.

Phase II Post-Acute Crisis Phase

The Director has the discretion to designate the initiation of Phase II Post-Acute Crisis Phase activities.

In this phase, the focus is to continue providing campus-wide clinical services as needed pursuant to the general operation of the Trauma Response Team.

The Director has the discretion to determine the termination of Phase II Post-Acute Crisis Phase activities.

Phase III - Deactivation of LSE Response

The Director has the discretion to designate the deactivation of the LSE Response Protocol.

Upon the deactivation of the Counseling Center LSE Response, the Director of the Counseling Center and Team Leaders will coordinate an all-staff debriefing. The extent and time allotment of the debriefing will be determined by the Director.

University of Illinois at Urbana-Champaign
Counseling Center
Emergency Services – Triage Form

For Office Use Only:
Date:
Time In:

Student Information

Last:_____Mi:____First:_____Date of Birth: ___/___/___
UIN:_____Local #: (____)_____Cell #: (____)_____
Local Address:_____City/State:_____
Zip:_____
Email Address: _____
Emergency Contact/Relationship:_____Phone: (____)_____

The Counseling Center has permission to contact you or your emergency contact (please initial all that apply):

Phone: Y N **Mail:** Y N **Email:** Y N **Emergency Contact:** Y N

Were you referred today by someone? Y N

If so, by Whom? _____

Have you been to the Counseling Center in the past?

Y N

If so, when?_____Who did you see? _____

Have you ever attended counseling for mental health reasons?

Current Academic Status:

____ Freshman ____Sophomore

____ Junior ____ Senior

____ Grad/Professional ____Other

Gender:

____ Male

____ Female

Sexual Orientation:

____ Bisexual

____ Gay

Reason for your visit (check all that apply):

1. ____ I witnessed or was in close proximity to a traumatic event.
2. ____ I have a friend who witnessed or was in close proximity to a traumatic event.
3. ____ I am unable to contact an important person who may have been involved in a traumatic event.
4. ____ I am considering or fear suicide or seriously harming myself.
5. ____ I am considering or fear doing serious harm to someone else.
6. ____ I believe my life is in danger.
7. ____ I would like to receive immediate counseling.

Psychological Services Agreement

Your signature below indicates that you have read the Counseling Center's Psychological Services Agreement and agree to its terms. Your signature also serves as an acknowledgement that you have been offered a copy of the HIPAA Notice Form.

Print Name

University of Illinois at Urbana-Champaign
Counseling Center
Emergency Services – Triage Form

8. ____ I would like to receive medication and counseling.

9. ____ I would like to receive medication only.

10. ____ Other: _____

_____

Threat Response Protocol: Responding to students who make threats or who engage in significant homicidal ideation with a protocol of engagement and progressive limit-setting (May 15, 2007, draft)

Introduction

Recognizing the lack of scientific support for the prediction of future acts of violence on the part of law enforcement and mental health professionals and recognizing the need for the campus to respond systematically and comprehensively to students who make threats to harm others, the following protocol is being implemented.

Primary Goal

The goal of the Threat Response Protocol is to guide university professionals though a series of engagements with students who have made threats to harm others and to challenge them with a set of comprehensive limits and requirements. The intent of the Threat Response Protocol is to lead a student to desist from engaging in threatening behavior and failing that, lead to a series of increasingly restrictive limits up to and including his or her formal separation from the university.

Additional Goals

- The Threat Response Protocol is intended to counter the unrealistic desire on the part of university personnel to predict future acts of violence.
- The Threat Response Protocol is intended to counter the natural tendency on the part of university staff to withdraw from students who are disruptive or who make threats and to insure that administrators engage with students making threats personally and promptly.
- The Threat Response Protocol is intended to counter the tendency of university personnel to be indirect with either their concerns or expectations and to insure that students who make threats are given explicit feedback about their behavior and detailed expectations about future behavior.
- The Threat Response Protocol is intended to counter the tendency to make assumptions about the presence of underlying mental health conditions and to insure a consistent focus on conduct.
- The Threat Response Protocol is intended to counter the tendency to respond informally to students who make threats and without clear standards by providing a clear set of guidelines for university staff.

Triggering Events

The Threat Response Protocol will be initiated by any one of four events. First, the student makes a threat of violence towards a specified person(s) or to the community as a whole. The threat might be direct or indirect, implicit or explicit, veiled or outright, but leaves a reasonable observer in fear of his or her safety. The threat might take the form of verbal or written statements and/or might occur through various electronic media. Second, the student engages in "significant homicidal ideation" that is alarming and disturbing to a reasonable observer and is divorced from any significant artistic intent. Third, a student assumes a stance of being substantially "in charge" of processes or outcomes, or decisions and movements of another person that is inappropriate given his or her standing or position. Fourth, a student persists in pursuing options and outcomes that do not reasonably exist and after being instructed to cease pursuing them.

Suicide threats, attempts and significant suicidal ideation. In accordance with existing university policy, students who make threats to commit suicide, make attempts to commit suicide or who report a pattern ~~of~~ significant suicide ideation are required to attend four sessions of professional assessment (see policy: "Mandated assessment following suicide threats and attempts," December 10, 2004). In the event that a student makes a threat to harm others as well as himself/herself or to the extent that a student engages in both suicidal and homicidal ideation, reports will be made simultaneously to both the Suicide Prevention Team and the Threat Response Team. The two Teams will work together to coordinate their response.

Covered individuals. The Threat Response Protocol covers enrolled students, former students, alumni, individuals who are applying for admission and members of the general public. It does not apply to faculty and staff, who are covered by the Incident Review Committee, which is facilitated by the Division of Public Safety.

Threat Response Team. A report that a student has engaged in one of the triggering events will be made in writing to the Threat Response Team. The Team will consist of assigned representatives from Public Safety, Office for Student Conflict Resolution, Office of the Dean of Students, Housing Division, Legal Counsel, Graduate College, Office of the Provost, Office o the Chancellor and the Counseling Center. The Threat Response Team will meet on a regular basis, as well as on a case-by-case basis as needed.

Case Coordinator. A member of the Threat Response Team will be assigned to each student who crosses one of the threshold events. The Coordinator might or might not meet with the student, but he or she would communicate with the administrators who will, both before and after their meetings. The Coordinator will also track the student's response to these meetings and to the behavioral expectations that have been established. Coordinator assignments will be transferred temporarily during vacations and other absences or permanently to another member of the Team.

Team Facilitator. Both the regularly scheduled and ad hoc meetings of the Threat Response Team will be led by a Facilitator. The Facilitator will maintain a roster of active cases along with a roster of

assigned Coordinators. At each regularly scheduled meeting, the Facilitator will invite a discussion of new incidents that have occurred since the last meeting. Once a review of new incidents has been completed, the Facilitator will invite a discussion of existing cases.

Active and inactive Cases. The submission of a report will serve to activate a case. Only after a sufficient period of inactivity and only after a simple majority of the Threat Response Team voting to deactivate a case, will the student's status become inactive.

Listserv and database. Each member of the Threat Response Team will have access to a secure listserv. Reports of new threats will be posted on the listserv and members of the Team will be invited to comment and discuss. In addition to the listserv, the Team will maintain a secure database that will log student under active consideration, the initial report and actions taken to date.

Face-to-face engagement. On the basis of the submitted report, the Threat Response Team will initiate a series of separate face-to-face meetings with the student. At a minimum, the student will have one or more separate meetings with each of two administrators. Ideally, the student will have one or more meetings with each of three administrators. If the student's behavior could be considered to be a violation of the Student Code, one of these meetings will occur with a staff member of the Office for Student Conflict Resolution. The pool of potential candidates for the remaining meetings include faculty, the student's academic department head, an Associate Dean of Students, an RD/AC or other Housing administrator, a U of I police officer, a Dean in the Graduate College, and a mental health professional specializing in the Threat Response Protocol. As appropriate, the student might meet with more than one administrator simultaneously, e.g., the department head and the director of graduate studies.

Timeliness expectations. Ideally, these meetings will occur as soon as reasonably possible--that day or the day after. Ideally, the first round of meetings with each administrator will occur within three business days of the receipt of the report and no later than one calendar week.

Written expectations. One of the goals of the Threat Response Protocol is to provide students who make threats with clear and explicit expectations regarding future behavior. The members of the Team, working through regularly scheduled meetings, ad hoc meetings and/or the listserv, will draft a letter of expectations. In the context of one of the meetings with the student or shortly after, the student will be provided with a letter outlining the reported behavior, the university's concern, the university's expectations regarding future behavior, and the consequences of future occurrences of similar behavior.

Purposes of the meetings. There are six primary purposes to the meetings. First, to present the student with information about the reported incident and allow him or her the opportunity to provide additional and/or contradictory information. Second, to express concern about the reported behavior and its impact on others. Third, to direct the student to appropriate resources such as the Counseling Center and academic counseling. Fourth, to introduce a set of common sense limits, requirements and behavioral expectations. Fifth, to inform the student of the sanctions and consequences that might result in the event that the student fails to adhere to these limits, requirements and expectations. Sixth, to gauge the student's willingness and ability to adhere to these limits, requirements and expectations.

Nature of the limits. In response to each reported incident, the administrators comprising the Threat Response Team will adapt a set of limits that are appropriate to the situation and proportionate to the reported behavior. In many instances the limits will represent a reiteration of the Student Code of Conduct (e.g., "Do not threaten or intimidate other students."). In other instances, the limits will represent additional restrictions on a student's conduct (e.g., "You are not allowed to make contact with specified individuals" (Order of No Contact), or, "You are to direct all future correspondence about this matter to a specified administrator" (Point of Contact Designation), or, "You are not allowed to enter Trelease Hall" (No Trespass Order)).

Progressive limit-setting. To the extent that the student adheres to the specified limits, the university's response remains stable. In the event that a student violates the limits, it will result in further reports, additional sanctions and/or increasingly restrictive limits. Ultimately, if a student is unable to adhere to the specified limits, he or she might have his or her housing contract revoked, might be arrested by the police for violating a No Trespass Order or the matter may be referred to the student discipline system.

Meetings with a mental health professional. All reports will be reviewed by the mental health representative of the Threat Response Team. As standard practice, all students who make threats or engage in significant homicidal ideation will be made aware of the campus's mental health resources and encouraged to make use of them. However, only the Dean of Students, after being petitioned by the Threat Response Team, can require a student to meet with a mental health professional as part of the Threat Response Protocol. In general, every effort will be made to address a student's behavior in conduct terms and without making assumptions about the presence of underlying mental health conditions.

Authority of the Threat Response Team. The Threat Response Team has no authority beyond that which is housed within the units that comprise it. For example, Housing Division has the authority to revoke a student's housing contract, the Office for Student Conflict Resolution has the authority to issue an Order of No Contact, and the Division of Public Safety has the authority to issue an Order of No Trespass for the entire campus.

Due process. Since the official sanctions of the Threat Response Protocol occur within the context of the practices of the Office for Student Conflict Resolution, Housing Division, the student's academic department, etc., the student is afforded the due process provisions accorded by these units. Under these provisions the student has the right to appeal the accuracy of any report made regarding his or her behavior and the right to appeal any restriction imposed by these units.

University, local, state and federal statutes. The Threat Response Protocol will be adhere to all university, local, state and federal statutes, including the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1 et. seq.), FERPA, and the Americans with Disabilities Act of 1990 (ADA)..

Record-keeping. Through the use of the listserv and database the Facilitator of the Threat Response Team will maintain a roster of active cases, a roster of case Coordinators, and a chronology of actions taken. Formal records will be kept of all threats received and housed in the Division of Public Safety and the Office of Conflict Resolution. Each unit will be responsible for maintaining formal records of the incident, meetings and other documents in accordance with their established practices.

Assessment factors. The Threat Response Team will assess the student's behavior in light of the following 10 factors.

Factor 1: Does the student recognize the existence of the legitimate authority as vested in university administrators and university policies?

Factor 2: Does the student accept the authority of university administrators and university policies and allow it guide his/her behavior?

Factor 3: Does the student recognize the legitimate and essential interests of other members of the university community?

Factor 4: Does the student value the importance of the interests and concerns of others as equal to, and at times exceeding, the interests and concerns of his or her own?

Factor 5: Where appropriate, does the student subordinate his/her interests and concerns to the interests and concerns of other members of the community? (E.g., in the context of an Order of No Contact, does the student subordinate his/her interest in making contact to the other student's interest in not having contact?)

Factor 6: Does the student have the capacity to enter into a contract with a university administrator and adhere to the terms of that contract?

Factor 7: Does the student recognize standards of conduct as specified either by the Campus Code of Student Conduct or as specified by university administrators and adhere to those standards?

Factor 8: Does the student refrain from engaging in freedoms of action, movement and speech when they are at odds with explicit standards and expectations?

Factor 9: Does the student take charge of domains (possessions, proposals, personal space, choices and decisions) appropriate to himself/herself while at the same time abdicating being in charge of domains that appropriately belong to others? (For example, in the context of making a dating proposal, can the student limit himself/herself to being in charge of his/her proposal and not take charge of another person's response to his/her proposal?)

Factor 10: Does the student limit himself or herself to a restricted set of options that are either appropriate to the situation or which have been imposed by an administrator, instead of

pursuing inappropriate options? (e.g., if the student is restricted to a point of contact, can he or she limit his or her contact to this person or does he or she contact university administrators other than the point of contact?)

Networking and Training. The members of the Team, in collaboration with other units on campus, will develop materials, workshops and other means to train relevant constituencies on campus regarding how to identify and report students who have made threats or are engaging in significant homicidal ideation.

Critical Incident Stress Debriefing

Introduction

- Introduce team members and have group members introduce themselves.
- Set up rationale for session. Example below:
    - This has been a tragic event.
    - People react to these kinds of situations differently.
    - It's important to pay attention to what is happening inside you; your thoughts, feelings, unique reactions.
    - It's important to get support from people who care about you.
- Set expectations.
    - 1-2 hours where you will have time to discuss how you were impacted by this event, to provide each other with support, and to celebrate your resilience in the face of this event.
    - Not therapy or substitution for treatment.
    - Participation in the discussion in VOLUNTARY.
    - Ground Rules – What do you need from each other to feel safe in this space?

      e.g., confidentiality; respect for each other / not appropriate to blame in this session; if need a break, feel free to leave the room; not a problem solving process; in this case, can someone follow to check-in
- Preview structure.

Fact

- Tell us how you knew (name). Or tell us about (name) you knew.

Thought

- There's was a lot in the news about (name), and I know that this does not necessarily map onto the (name) you knew. Can you share with us about (name) you knew?

Reaction

- What have been your reactions about this event?
- What was the worst part of the event for you?

Symptom

- What signals of distress have you noticed in yourself since this happened?
- In other words, how did you mind, your emotions, your body, or behaviors react or change as a result of this traumatic event?

Teaching

- Normalize reactions; discuss stress management; describe resources; pass out materials.
- Can anyone share coping techniques that have been useful for them in the past?

Re-Entry

- What's it going to be like for you tomorrow or after we leave here?
- Summarize key points/lessons learned.
- Offer cognitive reframe if useful to facilitate closure.
- Foster group cohesion.

University of Illinois (UIUC) Psychological Emergency Service Guidelines and Instructions (effective July 1, 2007 to December 31, 2007)

In the Event of a Psychological Emergency,
Call 244-P911

The Counseling Center and McKinley Mental Health Department collaborate with the Champaign County Mental Health Center to provide students with Psychological Emergency Services. The services are available 24-hours a day, 365 days a year, and focus on problems that need to be addressed immediately.

If the emergency occurs during the day and the student is available and willing to meet with a counselor, call the Counseling Center (333-3704) or McKinley Mental Health Department (333-2705) and set up an initial appointment. When contacting one of these two units, it will help to declare that this is an emergency and the student needs to be seen today or right away (whichever is appropriate).

If the emergency occurs after normal business hours or if the student won't see a counselor, can't be found, won't answer his or her phone, then the situation is more complex. Call the Psychological Emergency Service at 244-P911 (the acronym is 4-P911 -"For Psychological Emergencies") to consult with a mental health professional. You and the mental health professional can strategize about the best way to make contact with the student and see that he or she gets help. If some cases, a counselor may be able to visit the student at his or her residence and conduct the assessment there.

After Hours Resources

(Weekdays 5:00 p.m. - 8:00 a.m., weekends, holidays)

1. Crisis Line

Purpose	Crisis Line is a 24-hour telephone counseling service for individuals who are experiencing crisis. Appropriate calls include students who are in crisis and who are seeking counseling, support and/or referral for additional services. Crisis Line is also appropriate for individuals who are called on behalf of other parties who may be experiencing life crisis and need information about how they might be able to help.
Staffing	Crisis Line is staffed by trained volunteers and backed by the professional staff of the Mental Health Center.
Availability	Crisis Line is available 24 hours a day, 365 days a year.
Access	Instruct the student to call 359-4141. An operator will take the caller's name and phone number and a volunteer will call back.

2. Crisis Team

Purpose	Crisis Team is a primary resource for the professional staff of the University wanting to consult with a mental health professional about a student. This consultation may occur over the phone and might lead to a formal face-to-face evaluation of the student regarding the need for psychiatric hospitalization. Crisis Team is under contract with the University to conduct assessments of students in the residence halls and other University facilities as well as off-campus apartments and houses and other locations in Champaign County.

Staffing	Crisis Team is staffed by the professional staff of the Mental Health Center.
Availability	While the Crisis Team is available 24 hours a day, 365 days a year, we will direct calls to them only after hours. Emergencies occurring during business hours will be directed to the Counseling Center (333-3704) and McKinley Mental Health Department (333-2705).
Emergency Professional Access:	The Crisis Team is accessed by dialing 244-P911.

3. Trauma Response Team

Purpose	The Trauma Response Team is a resource for students, faculty and staff following an accident, death or other traumatic event. Typically two members of the Team will go to a residence hall, apartment complex, or departmental meeting and facilitate a group discussion to address feelings and issues that significant others may have regarding the person or event. Members of the Team might also meet individually with students before or after the discussion.
Staffing	The Trauma Response Team is staffed by professionals of the Counseling Center.
Availability	The Team is available both during and after-hours.
Emergency Professional Access	Emergency Deans can access the Trauma Response Team by consulting Attachment 2. All other Emergency Professionals can access the Team by contacting the Emergency Dean on duty.

4. Campus Safe House

Purpose	The Campus Safe House is a temporary housing resource for students, faculty and staff who have reason to fear for their safety in their personal relationships.
Staffing	The Campus Safe House is administered by Jeannette Weider (333-5656).
Availability	The Campus Safe House is available both during and after-hours.
Emergency Access	Contact 840-2232. Call 333-5656 for backup during normal business hours.

Daytime Resources

(Monday through Friday: 8:00 a.m. to 12:00 a.m., 1:00 p.m. to 5:00 p.m.)

In addition to the 25 social workers, psychologists and psychiatrists employed at the Counseling Center and McKinley Mental Health Department, there are a number of daytime teams devoted to addressing some of the long term issues that are often present in emergency situations.

1. Suicide Prevention Team

Purpose	Suicidal students are especially at risk of attempting suicide again in the weeks and months following their original attempt or threat. The University has addressed this increased risk by mandating that all students who have attempted or threatened suicide receive four sessions of professional assessment/counseling starting within a week of the threat or attempt. The Suicide Prevention Team administers this policy by receiving reports on suicide incidents and working discretely but firmly to get suicidal students to meet with a mental health professional.

Staffing	The Suicide Prevention Team is staffed by professionals from the Counseling Center and McKinley Mental Health Department.
Availability	The Team is available during normal business hours.
Access	Phone: Paul Joffe, Counseling Center (333-3704) Douglas Bennett, Counseling Center (333-3704) Bill Roberts, McKinley Mental Health (333-2705)

2. Sexual Assault Victim's Advocate

Purpose	Women who have been sexually violated often have emotional and legal needs that continue long after the assault. The staff of the Office of Women's Programs provide support, intervention and advocacy. A support group is available each semester.
Staffing	Office of Women's Programs.
Availability	The Office of Women's Programs is open during normal business hours
Access	Phone: Pat Morey, Office of Women's Programs (333-3137) Ross Wantland, Office of Women's Programs (333-3137)

3. Interpersonal Violence Working Group

Purpose	Victims of Interpersonal violence (stalking, battering, assault, etc.) often need long term assistance and support. The members of the working group are available to take statements from victims, consult.
Staffing	The Interpersonal Violence Working Group is a campus-wide group of professionals who have the day-to-day responsibility of addressing the problem of interpersonal violence on campus.
Availability	The members of the working group are available during normal business hours.
Access	Phone: Sergeant Tony Brown, Division of Public Safety (333-1216) Brian Farber, Office of Student Judicial Affairs (333-3680) Pat Morey, Office of Women's Programs (333-3137) Paul Joffe, Counseling Center (333-3704) Bob Wilczynski, Housing, Student Relations and Conduct (333-0770) Ruth McCauley, Associate Dean of Students (333-0050)

4. Dating Abuse Project

Purpose	Violence may and does occur in the context of dating relationships. Dating relationships are defined as expected, established or former romantic relationships. These include traditional heterosexual relationships as well as gay, lesbian and bisexual relationships. Violence might include physical abuse, assault, restraint, emotional abuse and stalking. The Dating Abuse Project offers victims of violence individual counseling and advocacy and support groups. For perpetrators it offers a structured group and a process for change.
Staffing	The Dating Abuse Project is a joint program of various units of Student Affairs, the Office of Women's Programs, the Counseling Center, Residential Life (Student Affairs) and a Woman's Place.
Availability	The members of the Dating Abuse Project are available during normal business hours. For 24-hour assistance, call A Woman's Place at 384-4390.
Access	Phone: Pat Morey, Office of Women's Programs (333-3137) Connie Maske, McKinley Health Center (333-7724) Julie Misa, International Student and Scholar Program (333-1303) Jeannette Weider, Family Housing (333-5656) Sergeant Tony Brown, Division of Public Safety (333-1216)

Non-Clinical Communications with External Agencies

Private Therapy for UIUC Students: How to get it, How to pay for it (revised Spring 2007)

How to Find a Therapist:

It is not uncommon for students to want or need more therapy than the primarily short-term services the University can provide. Private resources in the community are an alternative, but with more than 100 therapists in the Champaign-Urbana area, choosing one can be a bewildering process. Here are some helpful hints:

Word of Mouth: Probably the best way to find a therapist is by word of mouth. Perhaps a friend has seen a therapist, or has heard about a therapist that he or she can recommend.

Consultation: Another good option is to make an appointment at either the Counseling Center (3-3701) or McKinley Mental Health Department (3-2705) and talk to a counselor about choosing a therapist. The staffs at both agencies are familiar with many of the private therapists in the community and can help in terms of finding the style, expertise, and fee you want.

Yellow Pages: A third way to find a therapist is to look in the phone book under "Counselors," "Marriage and Family Therapists," or "Psychologists."

Contacting Potential Therapists:

The first step is to contact the therapist(s) of your choice and ask about the following:

Availability: Do they have any openings? When could you begin? What times would be available?

Training: What kind of training do they have? What is their experience with your area of concern? Briefly describe what you are looking for; pay attention to how comfortable you feel with the responses you receive.

Fees: What is the charge per visit? Do they have a sliding fee, and how does that work? (A "sliding fee" means that some therapists reduce their fees for a certain percentage of clients who would have trouble paying the full fee) Is the therapist eligible for payment under your insurance plan?

How to Pay for It:

Most Psychologists (Ph.D., PsyD.), Social Workers (MSW, LCSW) and Professional Counselors (M.A., LCPC) charge between $75 – 110 per session. Some therapists have sliding fees, but these openings tend to fill up quickly. The staffs of the Counseling Center and McKinley Mental Health can help steer you towards therapists who may have sliding fee openings, but there is not a guarantee that one will be available.

With vacations and class schedules, the average student can expect to have about 40 weekly therapy sessions in a given academic year (including the summer). At $75 per session this comes to $3000 a year, at $100 per session it increases to $4000 per year. For most students, this is a large sum of money. How can a student pay for it?

Insurance: For students covered by the Student Health Insurance plan, the policy covers part of the cost of private therapy. The coverage for undergraduates is 50%, up to $35 per session. There is a limit of 45 sessions for a single year. For graduate students the coverage is 50%, up to $50 per session with a limit of 52 sessions per year. Claim forms can be picked up in the Student Insurance Office, 807 S. Wright Street, 4th floor. Expect to wait 6-8 weeks for claims to be processed.

Students covered by other private insurance will need to contact their insurance provider to determine their coverage.

Parents: Some students find that their parents are more than willing to help cover the costs of being in therapy. Of course, many adult or graduate students may not consider this to be an option. But, for a variety of valid reasons, they may be unwilling to ask their parents to help, or even tell them they are seeing a therapist.

Loans: The Office of Student Financial Aid makes loan money available to students to pay for the cost of private therapy. Students who are interested in this option must first meet with a counselor from the Counseling Center or McKinley Mental Health and have their counselor formally recommend that he or she needs to be in private therapy. This counselor can also provide information on therapists in the community. Once recommended, the Office of Student Financial Aid will process the loan as if it were any other educational expense, with the same eligibility requirements and limits.

Supplemental Financial Assistance for Private Therapy

Budget Worksheet

Dear Student:

A recommendation has been made to the Office of Student Financial Aid to consider adjusting your yearly budget to take into account the costs of private therapy. To help the Office of Student Financial Aid calculate this adjustment, please fill in the budget worksheet to the right.

To best determine the therapist's hourly rate, it is advised that you phone the therapist(s) of your choice and establish their hourly rate, and their eligibility for insurance. You will need to consult your health insurance provider to determine your mental health coverage. For those students covered by the student health insurance plan, the policy covers part of the cost of private therapy. The coverage for undergraduates is 50%, up to $35 per session. There is a limit of 45 sessions for a single year. For graduate students the coverage is 50%, up to $50 per session with a limit of 52 sessions per year.

You may not have some or all of this information available to you before your meeting with the Office of Student Financial Aid. Please do the best you can with what information is available. A counselor at the Counseling Center or McKinley Mental Health may also be able to assist with parts of this worksheet.

Instructions for Counselors: Give students this form at intake and ask or help them to prepare it for their meeting with the Office of Student Financial Aid.

Worksheet

Student's Name (please print): _____

UIN: _____

Date: _____

.....

Therapist's Name: _____

Therapist's Signature: _____

Therapist's Hourly Rate: _____.____

Less Amount Covered by Insurance: _____.____

Actual Cost Per Session (rate minus insurance): _____.____

.....

Estimated Number of Visits During the Academic Year (August-May): _____

Estimated Total Cost _____
(actual cost times number of visits):

Note: With 14 weeks per semester, you can expect to have 28 weekly sessions across two semesters. Additional weeks should be added if you plan to have sessions during finals week, winter break, etc. Subtract weeks if you plan to begin therapy mid-semester. If you plan to continue therapy over the summer, a separate application covering that period must be filed with the Office of Student Financial Aid.

Supplemental Financial Assistance for Private Therapy

Loan Recommendation Form

Victor Martinez
Office of Student Financial Aid
Arcade Building – 620 E. John Street
University of Illinois
333-0100

Dear Mr. Martinez:

It is my professional opinion that_____needs long term therapy to either remain in school or to take full advantage of the University's academic and social opportunities. It is also my opinion that he or she is not eligible for the primarily short-term services of the Counseling Center and/or McKinley Mental Health Department. I would appreciate it if you would determine if this student is eligible for supplemental loan funds for private therapy.

Counselor's
Signature: _____

Name (print): _____

Agency: _____

Date: _____

Student's UIN: _____

Instructions for Counselors:

- Fill out both forms

- Make 2 copies (one to Reception Office and one in file)

- Give the student the original, or send it directly to the Office of Student Financial Aid.

Authorization to Exchange Information

I authorize the Counseling Center and/or McKinley Mental Health Department to exchange information with Victor Martinez, Susan Dickey or_____in the Office of Student Financial Aid. This information will be used to help arrange supplemental loan funds for private therapy.

This consent will remain valid for a period of one year or until_____.

I understand that:

1. I can inspect and copy the information that is being exchanged.

2. In the case of oral information, I have the right to be told what was exchanged.

3. Information exchanged cannot be redisclosed outside of the Office of Student Financial aid.

4. I may refuse or revoke my consent at any time.

5. There will be no consequences for not consenting.

Signature: _____

Name (print): _____

Address: _____

_____

Phone: _____

Witness sign: _____

Date: _____

Private Practitioner Referral Information

Name:

Practice Address

Street Address, Suite No.:

City: Postal code:

Practice Telephone Number :

Practice Fax Number :

Accessible by Bus?

( ) Yes If yes, name of closest Bus Route:

Professional Email:

Professional Website:

Practice Information

Degree and License

Fee/Minutes

$_____for_____min

Do you accept the University of Illinois' Student Health Insurance Policy?

Do you accept other insurance plans? (Please name them.)

Are you an "In Network" provider for any insurance plans? (Please name them.)

Are there any insurance plans you don't accept?

Accessibility

My practice is accessible to individuals with:

Regular Practice Hours:

Special Practice Hours:

Practice Modality

Individual – Adults:

Individual – Children:

Couples:

Family:

Group (please describe):

EMDR:

Other (please describe):

Primary Theoretical Orientation (please describe):

Specialty Areas:

Academic:

ADHD:

Alcohol and Other Drugs:

Anxiety:

Couples:

Eating Disorders:

Depression:

Forensic Assessment:

Perpetrators:

Personality Disorders:

Sexuality:

Trauma Survivors:

Other:

Are there any client issues that you will NOT work with?

Please specify:

Therapy Loan Program (revised 7/2003)

Overview

This document is intended as an update to the Counseling Center and Office of Student Financial Aid (OSFA) policy for students who seek financial assistance for therapy from private sources. Of particular interest, this program may provide loans to supplement what is covered by Student Health Insurance or other private health insurance. This program was piloted in 1989, and has generally proven successful. The program is outlined below, and includes some changes that have been made from the original policy.

In general, this program is designed to help a small but significant number of students who are not eligible for the therapeutic services of the Counseling Center or McKinley Mental Health Department. Utilizing these organizations may place some students in a dual-role situation, especially graduate students or student employees. Other students may need long-term therapy, beyond the services offered through the University.

The program works as follows: The staffs of the Counseling Center and McKinley Mental Health will identify students who need long-term or non-UIUC therapy, but who lack sufficient funds to cover the expense. If the student wishes to explore the possibility of financial assistance, the staff member will fill out the attached referral form and help the student make an appointment with the Office of Student Financial Aid. Maureen Crump-Hamblin (333-0100) will serve as the contact person. At this time the counselor may also provide the student with referrals and resources for private therapists. Note: To prevent actual and/or perceived conflicts of interest, the staff of the Counseling Center and McKinley Mental Health will adhere to the guidelines governing referral to private practice (included in the CC Therapeutic Services Manual).

In general, the Office of Student Financial Aid gives the clinician broad latitude in determining whether a student is an appropriate clinical referral to the Therapy Loan Program. To help expedite the referral or to clarify doubts the student may have concerning his/her financial aid eligibility, the counselor may obtain an Authorization to Exchange Information from the student and contact Maureen by phone. Maureen will review the student's current financial aid file (if one exists), and make a determination. Maureen will schedule a meeting with the student and advise him/her of the loan application process. Note: A student in need of therapeutic services is almost never denied loans for this purpose.

The Office of Student Financial Aid strongly advises students to explore all possible options for funding their private therapy, including their health insurance provider, whether that be the Student Health Insurance Plan or other private insurance plan, parental assistance, and personal funds. Students will need to consult their own health insurance plans to determine the coverage for outpatient mental health coverage.

The current Student Health Insurance Policy reimburses undergraduate students for 50% of the cost of therapy, up to $35.00 per session. This policy is good for up to 45 sessions per year. Graduate students are reimbursed 50% of the cost of therapy, up to $50 with a maximum of 52 days per year. Again, students seek therapy loans to cover the cost of therapy not covered by student insurance. Specific questions about Student Health Insurance, including exclusionary criteria and pre-existing condition clauses, and requests for claims forms should be referred to the Student Insurance Office, at: 807 S. Wright St., 4th Floor, Champaign 333-0165.

Helpful Information for the Counselor

The student may have many specific questions about therapy loans (i.e. interest rates, payment dates, etc.) that will need to be addressed by Maureen Crump-Hamblin. However, you may find the following general information helpful:

The Office of Student Financial Aid

The Office of Student Financial Aid has a set of policies and procedures that it uses to determine eligibility and allocate loan monies. These policies and procedures are based on the assumption that parents and students have a responsibility to finance postsecondary education to the extent they are able.

Accordingly, the Office of Student Financial Aid conducts a "needs analysis" to measure an individual's and/or family's financial strength, and their capacity to contribute towards college costs. Specifically, the needs analysis works as follows: Each year the Office of Student Financial Aid establishes a student's educational budget, which includes fees, room and board, allowances for books, supplies, transportation, and personal expenditures. The budget covers a period of 9 months, corresponding to fall and spring semesters. The family's combined income is then determined and the student's eligibility is calculated using a formula provided by the U.S. Congress.

The Office of Student Financial Aid has the authority to add special items to the student's budget that are deemed necessary under the "medical necessity" clause. Upon recommendation from a mental health professional, costs of long-term therapy can be added in.

In general, the Office of Student Financial Aid feels that parents have a responsibility to help finance their dependent children's undergraduate education. An unwillingness on the part of the parents to do so, estrangement between parents and children, or conflicts in values are not considered sufficient grounds to disallow the parents' contribution in the needs analysis. There are, however, situations in which parental contributions are not required. Requests by undergraduates to not require parental contributions will be reviewed carefully on a case by case basis; although considered exceptions to the rule, such requests may be granted.

Many students (e.g. married, veterans, most graduate, professional, or older undergraduates) are considered to be financially independent of their parents. In these cases, parental support is usually not

taken into account during a needs analysis. Therefore, most of these students will be eligible for therapy loans, provided that they have not already exceeded loan ceilings (next section).

Loan Ceilings

The student is subject to the same yearly and aggregate loan ceilings that normally apply. Loan ceilings vary by depending on year in school and student status. Maureen Crump-Hamblin can provide further information and answer specific questions regarding current loan ceilings.

Alternate Sources of Funds

If a student has reached the maximum loan amount for the Direct Student Loan, there may be other funds available. Financial Aid can discuss these options with students at their meeting. Dependent students who have previously exhausted their eligibility for Direct Student Loans may wish to consider asking their parents to borrow from the Parents Loan for Undergraduate Students (PLUS) program. Maureen Crump-Hamblin can discuss these options with students at their meeting.

Wait Period

Once eligibility has been determined, and the loan application has been submitted, a student can expect to wait 3-4 weeks before the funds are available. Students who don't already have an existing file with the Office of Student Financial Aid can expect to wait up to 8 weeks.

Emergency Situations

If a student needs to begin therapy immediately and cannot wait for the loan to be processed, there are two options. He or she can ask the private therapist to delay payment until the funds become available (the Office of Student Financial Aid can provide documentation that a loan has been approved and is being processed). Or he or she can apply for an emergency loan to carry him/her through this period.

Mental Health Acts and Laws

HIPAA (Federal)

Uses and Disclosures for Treatment and Health Care Operations

The Counseling Center may use or disclose your protected health information for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- "Protected heath information" or PHI refers to information in your health record that could identify you.
- "Treatment and Health Care Operations"
    - Treatment is when the Counseling Center provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when your counselor consults with another health care provider, such as a psychiatrist or another counselor.
    - Health Care Operations are activities that relate to the performance and operation of the Counseling Center. Examples of health care operations are quality assessment and improvement activities, business-related matters such as administrative services, and case management and care coordination.
- "Use" applies only to activities within the Counseling Center such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of the Counseling Center such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

Other Uses and Disclosures Requiring Authorization

The Counseling Center may use or disclose protected health information for purposes outside of treatment or health care operations when your appropriate authorization is obtained. In those instances when the Counseling Center is asked for information for purposes outside of treatment or health care operations, the counselor will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that the Counseling Center has relied on that authorization.

Uses and Disclosures without Authorization

The Counseling Center may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If your counselor has reasonable cause to believe a child known to him/her in his/her professional capacity may be an abused child or a neglected child, they must report this belief to the appropriate authorities.
- Adult and Domestic Abuse – If your counselor has reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, he/she must report this belief to the appropriate authorities.
- Serious Threat to Health or Safety – If your counselor believes that you present an imminent, serious risk of physical or mental injury or death to yourself, he/she may make disclosures he/she considers necessary to protect you from harm. If you communicate to your counselor a specific threat of imminent harm against another individual or if he/she believes that there is clear, imminent risk of physical or mental injury being inflicted against another individual, he/she may make disclosures that he/she believes are necessary to protect that individual from harm.

Patient's Rights and Counseling Center's Duties

Patient's Rights:

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – We will accommodate reasonable requests. We will ask you for specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Officer.
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI maintained in the Counseling Center's records and your counselor's Psychotherapy Notes. Certain information may not be inspected or copied including the following: information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; protected health information that is subject to law that prohibits access to protected health information; a counselor's personal notes. Please contact our Privacy Officer if you have questions about access to your personal record.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Amendments to records will be made only in the instance where it is determined the information was created by the Counseling Center and is not accurate or complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. Requests for amendment of PHI must be submitted in writing to our Privacy Officer.

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of PHI. However, the Counseling Center is not required to agree to a restriction you request.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Counseling Center's Duties:

- The Counseling Center is required by law to maintain the privacy of PHI and to provide you with a notice of its legal duties and privacy practices with respect to PHI.
- The Counseling Center reserves the right to change the privacy policies and practices described in this notice. Unless the Counseling Center notifies you of such changes, however, the Center is required to abide by the terms currently in effect.

If the Counseling Center revises its policies and procedures, the Center will provide this information to you in your next appointment or as the occasion demands if you are no longer a client.

"E. Electronic Signature Standard

[Please label written comments or e-mailed comments about this section with the subject: ELECTRONIC SIGNATURE STANDARD]

HIPAA directs the Secretary of the Department of Health and Human Services to coordinate with the Secretary of the Department of Commerce in adopting standards for the electronic transmission and authentication of signatures with respect to the transactions referred to in the law. This rule was developed in coordination with the Department of Commerce's National Institute of Standards and Technology. We propose to adopt a cryptographically based digital signature as the standard.

Whenever a HIPAA specified transaction requires the use of an electronic signature, the standard must be used. It should be noted that an electronic signature is not required for any of the currently proposed standard transactions.

In the electronic environment, the same legal weight associated with an original signature on a paper document may be needed for electronic data. Use of an electronic signature refers to the act of attaching a signature by electronic means. The electronic signature process involves authentication of the signer's identity, a signature process according to system design and software instructions, binding of the signature to the document and non-alterability after the signature has been affixed to the document. The generation of electronic signatures requires the successful identification and authentication of the signer at the time of the signature.

The proposed standard for electronic signature is presented at § 142.310 and would be digital.

The following matrix depicts the requirement and implementation features for electronic signatures. Following the matrix is a discussion of the electronic signature requirement.

ELECTRONIC SIGNATURE

REQUIREMENT: IMPLEMENTATION:

Digital signature (If digital signature is employed, the following three implementation features must be implemented: Message integrity, Non-repudiation, User authentication. Other implementation features are optional.) Ability to add attributes.

Continuity of signature capability.

Countersignatures.

Independent verifiability.

Interoperability.

Message integrity.

Multiple Signatures.

Non-repudiation.

Transportability.

User authentication.

Various technologies may fulfill one or more of the requirements specified in the matrix. Authentication systems (passwords, biometrics, physical feature authentication, behavioral actions and token-based authentication) can be combined with cryptographic techniques to form an electronic signature. However, a complete electronic signature system may require more than one of the technologies mentioned above. If electronic signatures would be used, certain implementation features must be included, specifically:

- Message integrity.
- Nonrepudiation.
- User authentication.

Currently there are no technically mature techniques that provide the security service of nonrepudiation in an open network environment, in the absence of trusted third parties, other than digital signature-based techniques. Therefore, if electronic signatures are employed, we would require that digital signature technology be used. A digital signature is formed by applying a mathematical function to the electronic document. This process yields a unique bit string, referred to as a message digest. The digest (only) is encrypted using the originator's private key and the resulting bit stream is appended to the electronic document. The recipient of the transmitted document decrypts the message digest with the originator's public key, applies the same message hash function to the document, then compares the resulting digest with the transmitted version. If they are identical, then the recipient is assured that the message is unaltered and the identity of the signer is proven. Since only the signatory authority can hold the Private Key used to digitally sign the document, the critical feature of nonrepudiation is enforced. Other electronic signature implementation features that may be used follow:

- Ability to add attributes.
- Continuity of signature capability.
- Countersignatures capability.
- Independent verifiability.
- Interoperability.
- Multiple signatures.

- Transportability.

This standard is described in greater detail in § 142.310 of the regulation text and is depicted in tabular form along with the security standard in a combined matrix located at Addendum 1. We have not included the matrix in the proposed regulation text. We invite your comments concerning the appropriateness and usefulness of including the matrix in the final regulation text. We have also provided a glossary of terms to facilitate a common understanding of the matrix entries. The glossary can be found at Addendum 2. Finally, we have included currently existing standards and guidelines mapped to the proposed electronic signature standard. This mapping is not all inclusive and is located at Addendum 3."

APPENDIX I

Chart I: A Possible Structure for Gathering Information on the Referral Complaint

1. Have client describe referral complaint
    - A. Qualitative description, e.g.
        1. What happens
        2. Emotional impact
        3. Impact of the referral complaint on other parts of client's life
    - B. Quantitative description, e.g.,
        1. Frequencies, Durations, Intensities
        2. Situations of highest probability (e.g., time, place, social circumstances)
        3. Situations of lowest probability
        4. Distress Rating (1-10)
    - C. Causal factors the client may be aware of
        1. Triggers
        2. Situational factors/context
        3. Client's interpretations/construals
        4. Have client describe any previous episode(s) of the referral complaint
        5. Possibly recycle above lines of questioning
        6. Seek to identify factor(s) that helped alleviate previous episode(s)
2. Have client describe any related childhood/familial/cultural information
    - A. Childhood experiences, teachings, family themes
    - B. Relevant problems experienced by family members
3. Have client summarize other issues/problems indicated in paperwork ("brown card," etc.)
    - A. Possibly repeat above steps for some issues
    - B. Look for co-morbidity, themes w/re triggers, situations, construals, etc.

4. Returning to referral complaint, further explore themes, with benefit of information gathered from all steps above.

5. Assess client's ongoing supports and strengths (or lack thereof), e.g.:

   A. Family support

   B. Other social support systems

   C. Social Skills

   D. Present and past achievements; sources of meaning, positive striving

   E. Basic ego strength

Chart II: Suggested Questions for Assessing Dangerousness

Ever Considered?

1. Have you ever considered harming/hurting yourself/anyone else?

Last Time?

2. When was the last time you had thoughts of harming/hurting yourself/anyone else? What was going on?
3. How would/did you do it? Do/did you have a plan? (Plan)
4. What means would/did you use? (Means)
5. Do/did you have access to those means? (Access) =>PMAS
6. What stopped you? (Stopped)

Other Times?

7. Have you ever made any prior attempts to harm yourself/anyone else? When? What was going on?
8. How did you do it? Did you have a plan? (Plan)
9. What means did you use? (Means)
10. Do you have access to those means now? (Access) =>PMAS
11. What stopped you then? (Stopped)

Now?

12. Do you really want to die? / Do you really want the other person dead?=>W/D
13. Would you carry it out? When?
14. What would push you to do it? (or other questions aimed at determining impulse control) =>WWW
15. What would stop you now? =>STOP!

Understand: Sometimes, during or after questions about suicide, it is helpful to say something like,

"Lots of times, when people are considering suicide, it isn't that they think death per se is all that desirable. Instead, what they really want is some way to deal with whatever pain they are going through, and they wonder if killing themselves is the only way to reduce or eliminate that pain. Does that seem to describe your situation?"

(Then, if the client answers in the affirmative:)

Well, when that's the case, we put our focus on helping the people find those other ways. Once they've found good alternatives, they find they're not thinking about suicide any more, and they're pretty glad

they stuck around. So we won't be giving you lectures about why you shouldn't kill yourself; instead, we'll be working with you on how to reduce or eliminate the pain. O.K.?"

With underlining near the left margin, you get the mnemonic, E-LOT, NOW; UNDERSTAND.

Chart III: Suggested Questions for Assessing Alcohol and Other Drug Use

1. How often do you drink/use drugs? How much do you consume? (Per month, per week, per evening or session)
2. How often do you have six or more drinks in one session?
3. Under what circumstances do you usually drink/use drugs? (Alone, socially, what's going on at the time?)
4. What drinks/drugs do you currently use? (If the answer points to medications, include psychopharmacology assessment)
5. When was the last time you drank/took drugs?
6. Under what circumstances? (When, why, where)
7. How much did you consume?
8. When was the last time you drank to get drunk? When was the first time?
9. When did you first use alcohol/drugs?
10. What drinks/drugs did you use?
11. Could you list the types of drugs you have ever experimentally tried or used regularly, including sharing of someone else's prescription?
12. Are you concerned about your alcohol/drug usage?
13. Are others concerned about it?

Chart IV: Suggested Questions for Assessing Prescribed Medication History

1. Physical examinations:
   A. When was the most recent time you had a physical examination?
   B. Have you ever consulted a medical doctor for_____(referral complaint)?
2. Are you currently taking any medications? If "yes,"
   A. When did you start taking the medications?
   B. Who prescribed the medications?
   C. Do you know what diagnosis your physician made?
   D. What dosage(s) are you taking?
   E. What symptoms were these medication(s) prescribed to treat?
   F. Has the medication been effective in treating your symptoms?
   G. Are you experiencing any side effects?
   H. Have you been using alcohol or other substances while taking the medications(s)?
3. Before now:
   A. Have you taken any other medications to treat these symptoms or a different condition?
   If "yes,"
      1. What were the symptom(s)/condition(s) being treated?
      2. What medications were prescribed for these symptom(s)/conditions(s).
      3. When and for how long were you taking this medication?
   B. Do you know if anyone in your family has ever taken medications to treat psychological symptoms? If "yes,"
      1. What were the symptoms(s)/conditions(s) being treated?
      2. What medications were prescribed for these symptom(s)/condition(s)?
      3. When and for how long was he/she/they taking this medication?
      4. Would you be willing for me to consult with your physician/a physician?

Chart V: Suggested Questions for Assessing Trauma History

1. Have you had a past experience that felt overwhelming, unmanageable, terrorizing, or traumatic?

2. Could you tell me about it? e.g.:

   A. How old were you?

   B. Where were you?

   C. What happened?

   D. Who was involved? How were they related to you?

   E. How many times did it happen?

3. (If sexual abuse is reported:)

   It is certainly ok if you don't wish to go into detail about what happened, but it would be helpful if you could answer a couple of questions:

   A. First, can you tell me what type of sexual abuse was involved?

   (e.g., leering, making comments, touching, fondling, kissing, penetration [vaginal, oral, anal], coerced watching of sexual acts, etc.)

   B. My other question tries to identify any things that increased your vulnerability to the perpetrator. What sorts of things are you currently aware of that increased your vulnerability?

   (Common examples include: age at the time of the incident, psychological dependence on the perpetrator, being intoxicated, being physically over-powered, or some type of verbal or physical threat or coercion.)

4. A lot of feelings would be possible when the traumatic incident happened. What were your feelings?

   (Examples may include fear, shame, self-blame, terror, revulsion, anger, helplessness, humiliation).

5. How did you react to the experience:

   A. At the time?

   B. Since then?

   (Examples may include cutting, disordered eating, suicidality, substance use/abuse)

6. Have you experienced any of the following (PTSD) symptoms?

   A. Re-experiencing through intrusive thoughts, nightmares or flashbacks?

B. Loss of any normal physical or emotional responses? (numbing and dissociation)

7. On a scale of 1–10, how much distress do you still feel as a result of the traumatic incident(s)?

Chart VI: Major Dispositions

A. Major "In-House" Dispositions

1. Additional Assessment Interview–use this option when you have run out of time in an Initial Appointment and–for whatever reason–are not ready to make a disposition.

2. Group Counseling–options here vary from semester to semester. Whatever their themes, most groups emphasize the opportunity to gain supportive, interpersonal feedback, and to gain interpersonal skills. Consult (and share with appropriate clients) the Center's excellent brochure, entitled Group Psychotherapy, which can both inform and assure the hesitant client.

3. "One Shots"–a wide range of needs can be met adequately in the Initial Appointment, after (and during) the process of arriving at a disposition. Those needs include: certain outside referrals (see below); provision of new information, perspectives, concepts, approaches, or confirmations with which the client can resume moving forward; provisions of certain administratively mandated assessments; and/or provision of advocacy letters (to be covered in your Counseling Center Training and Orientation).

4. Individual Follow-up Counseling–this is counseling where you and the client agree to begin meeting regularly (without delays imposed by a wait list) to address goals which you predict can and will be attained within the next two-to-five sessions.

5. Individual Continuing Counseling/Wait List–this is counseling where you and the client agree on goals which you predict can and will be attained within a range of five-to-sixteen sessions. In most cases, this disposition will require putting the client on a wait list and him/her waiting his/her turn before being "picked up" by you or some other counselor, intern or practicum student for regularly scheduled counseling sessions. (Information on appropriate match-ups, exceptions and procedures will be provided in your Counseling Center training and orientation.)

6. Mandated Assessment–typically this involves suicidal clients. University policy requires any student who has made a suicidal threat or attempt within the last 90 days to have a minimum of four sessions of assessment. Depending on the circumstances, this minimum number can be increased. Those sessions must be focused on suicide-relevant issues and be conducted by a mental health practitioner from the Counseling Center or the McKinley Mental Health Division or by a licensed mental health provider in the local community. Typically, unless the client requests a referral, you will conduct the mandated sessions, rather than refer the client to someone else. More details on the University's Suicide Prevention Policy and the Center's Suicide Prevention Team will be provided during your Counseling Center Training and Orientation.)

7. Professional Development Case–typically, these are cases where the counselor is able to predict ahead of time that the clients' needs and goals exceed the Center's normal resources (e.g., needing more than 16 sessions), but treatment is offered, nevertheless, because the nature of the client's case

will provide the potential for mutual benefit–therapeutic benefit for the client and an important growth-producing experience for the counselor. Such cases can be thought of as investments of time, with the idea of "pay-off" later on in terms of greater counselor productivity with future, similar, but less severe cases.

B. Major Referrals beyond Our Counseling

1. Referrals within the University

A. McKinley Mental Health Division (MHD)–typically, when you refer to MHD, you are seeking a psychiatric consultation that provides diagnostic impressions and/or treatment recommendations, especially on whether your client might benefit from some form of psychotropic medication. In most cases, when medication is indicated, the psychiatrist will give the client a prescription, and the client will get the medication free at the McKinley pharmacy. While MHD will provide follow-through monitoring concerning the medications, any counseling will usually occur back at the Counseling Center. During the regular school year, a psychiatrist from MHD works on-site here at the Counseling Center for a half-day each week; compared to a similar visit to MHD this service option is quicker and more convenient for many clients. Phone: 333-2705.

B. The Psychological Services Center (PSC)–operated by the Department of Psychology, the PSC is the primary service and training site for doctoral candidates in clinical-community and counseling psychology. Services are offered through Specialty Clinics, each headed by a faculty member. In most cases, client care will come from advanced doctoral students, working together with experienced faculty members. The Clinics most pertinent to our referral needs focus on couples therapy, stress and anxiety management, general adult psychotherapy issues (e.g., depression, anxiety, low self-esteem, interpersonal issues, etc.), neuropsychological assessment, and legally relevant (forensic) psychological assessments. For UIUC students on student insurance, there is a $25 co-pay; in cases of financial hardship, students can petition to reduce that fee via a sliding scale accommodation. Phone: 333-0041.

C. Career Development Center (CDC)–both the CDC and the Counseling Center address career issues, but with differing emphases. The CDC emphasizes career-related interests, and information on options, opportunities, job search preparation, and placement; the Counseling Center's emphasizes interactions of career choice with the client's identity, social pressures, and various psychological conflicts. Often, when you refer to CDC, it is for consultations and/or workshops that will occur concurrently with other services the student receives at the Counseling Center. Phone: 333-0820.

D. Reading and Study Skills Program(R&SSP)–the R&SSP is funded and run by the Counseling Center. It specializes in helping improve the student's study effectiveness and efficiency, especially regarding reading speed & comprehension, time management, note taking skills, and test preparation. The R&SSP provides non-credit courses (for $35) and individual consultations (free). Problems in academic functioning can be exacerbated by–or independent of–other personal problems, such that referrals for R&SSP services often run concurrently with counseling at the Counseling Center. Phone: 333-3728.

E. Division of Rehabilitation and Educational Services (DRES)–DRES provides evaluative and therapeutic services for a wide range of physical, cognitive, and psychiatric disabilities. Typically, when you refer a client to DRES, you are seeking consultation that provides treatment suggestions or that provides an evaluation aimed at certifying a disability that is interfering with the client's academic functioning (e.g., Attention Deficit Disorder). Such certification can be very important, both in helping the client understand why certain academic difficulties are occurring and/or in obtaining "reasonable academic accommodations" (e.g., altered exam-taking conditions) for which he/she may be eligible under the American Disabilities Act. These evaluations are time consuming and expensive, so we typically have the client go through a screening interview here to determine whether a referral to DRES would be worthwhile. Thus, your first referral in these cases would be to one of our counselors who has developed additional expertise in the area of disabilities. In most cases, following the DRES consultation, the client will continue to receive his/her main counseling services here at the Counseling Center. Phone: 333-1970.

2. Outpatient Referrals to Local Practitioners and Local Clinics

Many students need services that we cannot provide; reasons include the likely length of individual treatment (>16 sessions), problems needing specializations which we lack, preferences by the student for a non-University provider, and conflicts of interest (e.g., a grad student in clinical or counseling psychology who will be applying here for internship later on–see your Staff Manual for our policies concerning conflicts of interest). To aid you in your referrals, the Center will provide you with information on local practitioners or clinics in whom we have some level of confidence. You will also receive information on practical issues such as how to help such students apply for insurance reimbursements, "therapy loans," etc.

3. Inpatient Referral–i.e., Hospitalization

Most of our client population will benefit most from outpatient services. Inpatient referrals do occur, however, usually when a student is experiencing a psychotic episode or when his/her condition represents an imminent threat to life (to self or other). Voluntary hospitalizations are usually preferable over involuntary ones, both in ease and in regard to therapeutic concerns. However, State Law does empower mental health providers to initiate involuntary hospitalizations in cases where we deem there to be an imminent threat to life. You will receive materials and training in how to effect hospitalizations. Also, be sure to always consult the "Emergency Hospitalization Kit," available with the Receptionists at the Front Desk.

Meanwhile, let me emphasize that if you hospitalize someone, you should do it in consultation with colleagues, and with enough assistance from others that they can handle various logistics while you focus on one role–that of making the hospitalization process as therapeutic and non-traumatic for the student as possible. Please anticipate that no matter how non-traumatic you can make the process is for the client, you (like any of us) are going to find this experience draining of both time and emotions. Thus, please also give yourself time to debrief and recover afterwards. It is not helping yourself or the Center's mission to return to work wounded or exhausted.

Appendix II

Authorization to Release Protected Information from Your Clinical Record To The Person You Designate

University of Illinois - Counseling Center
206 Student Services, 610 E. John Street
Champaign, IL 61820 (217) 333-3704

I authorize_____to release (specific nature of information to be released) :

_____

about (Client's Name):

_____

to (Receiving Agency/Person's Name and Address): _____

The information requested above is being released for the purpose of ("at the request of the individual" is all that is required if you are my client and you do not desire to state a specific purpose.)

[ ] Whether or not I arrived at the agency noted above to which I am referred, and what counseling arrangements have been made for me, if any.

[ ] Information and recommendations which will help in arranging the most appropriate counseling services for me.

[ ] Opinions and recommendations regarding decisions the above-named faculty or staff must make about my situation at the University.

[ ]

_____

This consent is to remain valid until: _____
(date)

I understand that:

[1] I have the right to copy and inspect the information being disclosed;

[2] I have the right to revoke this authorization, in writing, at any time by sending written notification to the Counseling Center;

[3] I may not revoke an authorization if the Counseling Center has relied on that authorization in providing services on my behalf;

[4] My counselor may not condition psychological services upon my signing an authorization.

It has been explained to me that if I refuse to consent to this release of information the following are the consequences (or indicate "none")

_____

Signature_____Student ID # _____

Date_____Witness _____

The statutes that govern this Authorization include but are not limited to:

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), 735 ILCS 5/8 2001 (inspection and copying of hospital records), and any relevant confidentiality code of any state, and the Employee Personnel Records Act, 820 ILCS 40/0.01.

Notice to Receiving Agency/Facility/Person: Under the provision of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, (740 ILCS 110/1 et.seq.) You may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.

Under Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorizations for such redisclosure.

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McKINLEY HEALTH CENTER
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN

Medical Records Department
1109 South Lincoln Avenue
Urbana, IL 61801
Phone (217) 333-2720 Fax (217) 244-6495

Counseling Center
206 Student Services, 610 E. John street
Champaign, IL 61820
Phone (217) 333-3704 Fax (217) 244-9645

Authorizing for Disclosure of Confidential Mental Health Referral Information

- **Name (Please Print)**_____ **UIN**_____

Date of Birth_____ **Current Phone No**_____ **Date of Request**_____

- **I authorize** the Counseling Center and McKinley Health Center to **release and receive** information from my patient records as described below:
- **Specific Records to be Disclosed:** ☐ Mental Health Notes and Verbal Communication
  ☐ Other: Specify_____
- **Approximate date(s) of treatment:**_____
- **Purpose of Disclosure:** Referral/Continuing Treatment
- **By checking the box or boxes below, you are authorizing the release of the following information:**
  - ☐ Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations –
    will not be released unless specifically indicated.
  - ☐ Mental Health records (as defined by Illinois Mental Health and Developmental Disabilities Confidentiality Act) –
    will not be released unless specifically indicated.
- **This authorization expires 90 calendar days after it is signed** or upon the following specific date, event or condition:
  _____
- **I acknowledge that I have read the following statement:** I understand that in order to provide coordinated and continuous care as part of my referral, the University of Illinois Counseling Center and McKinley Health Center must share information related to my health status, treatment and other related issues while I am undergoing treatment at the University of Illinois at Urbana-Champaign.

  I also understand that this bilateral sharing of information could include verbal communication as well as release of copies of my health records in accordance with the Illinois Mental Health and Developmental Disabilities Confidentiality Act and that information will flow back and forth between the two departments.
- **I UNDERSTAND THE FOLLOWING PROVISIONS:**
  I have the right to inspect and receive copies of information to be disclosed. I have the right to revoke this consent at any time. Revoking this consent shall have no effect on disclosures made before the revocation of consent. Any revocation of consent must be submitted in writing to both the Medical Records Unit at McKinley Health Center and the Counseling Center and signed by the person who gave the consent.

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, any records disclosed pursuant to said Act may not be re-disclosed unless the person who consented to this disclosure specifically consents to such re-disclosure.

It has been explained to me that ***if I refuse to consent to this disclosure of information,*** the following are the consequences: Possible lapse in coordination of care potentially resulting in harm.

- Signature of Patient or Consenting Individual_____Date___

_____

If signature is not of Patient, indicate relationship_____

Signature of Witness **(required)**_____Date___

_____

For Office Use Only ☐ **Mail** ☐ **Pick-up (date_____)** ☐ **Fax** ☐ **RUSH** **Appt Date____**

_____

Method of release = 1) Mailed 2) Hand Carried 3) Faxed 4) Courier

# pages	Date	Method	Init	Documents Released

Confidentiality Agreement

This is to certify that I have read and agree to abide by the documents and policies regarding confidentiality and professional ethics. If I have questions related to the implementation of these policies, I will consult with my supervisor. The documents are:

1. Policy and Procedures on Confidentiality Counseling Center document dated August, 2007

2. Listing of confidentiality and security requirements for Counseling Center records as found in APA's and ACPA's Ethical Principles and Standards Code, Illinois State Statute, University Policy, UIUC Student Affairs Standards and Counseling Center policy

Name: _____

Job Title: _____

Supervisor: _____

Date: _____

Signature: _____

E-Mail Communication and Client Confidentiality
Informed Consent

The Counseling Center complies with the University of Illinois' POLICY ON APPROPRIATE USE OF COMPUTERS AND NETWORK SYSTEMS and clients are referred to this policy for information on the privacy of email communications. The Counseling Center cannot guarantee that your email will remain confidential, although we will take all reasonable precautions to keep your communications private. There are several ways that an email message can be intercepted and the University of Illinois retains ownership of staff accounts and archives these accounts. Therefore, if you are concerned in any way about the content of your email being read by someone other than the person you are contacting, you should rely on alternate ways of communicating with us. If you elect to use email as a way of communicating with your counselor, you will be asked to acknowledge with your signature that you have been informed of the limits of confidentiality pertaining to its use.

I have read and understand the limits of client confidentiality and the use of e-mail as noted above and I have been informed of The University of Illinois Policy on Appropriate Use of Computers and Network Systems. I DO NOT want the Counseling Center to contact me for any purpose.

_____ _____

Signed Date

I have read and understand the limits of client confidentiality and the use of e-mail as noted above and I have been informed of The University of Illinois Policy on Appropriate Use of Computers and Network Systems. I DO want the Counseling Center to contact me by e-mail for scheduling purposes ONLY.

_____ _____

Signed Date

I have read and understand the limits of client confidentiality and the use of email as noted above and I have been informed of The University of Illinois Policy on Appropriate Use of Computers and Network Systems. I Do want to communicate with my counselor via email and I am authorizing my counselor to respond via email to me communications.

_____ _____

Signed Date