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Department of Family Relations and Applied Nutrition

Couple and Family Therapy Centre POLICIES and PROCEDURES MANUAL

2017

This document is under review and has been changed significantly over previous versions.

Please review it carefully as policies and procedures have been changed and updated.

Introduction

How to use this manual

The CFT Centre, Policies and Procedures Manual (the Manual) is intended to:

- absent other factors, be a user friendly and informative reference and resource guide for therapist interns, clinical supervisors and staff
- outline best practices that will support meeting the obligations and responsibilities associated with the clinical work provided at the Centre
- be resource for handling high risk clinical matters
- absent other factors, serve as a general guide to navigating the administrative responsibilities associated with clinical work.
- serve as a complement to on-going supervision, consultation and administrative file meetings

The Manual is not intended to provide an answer for every client situation or clinical event.

If, after consulting with the Manual you remain unsure about what to do, consult with the Director of Clinical Training, Clinical Supervisor or Client Services Coordinator - *before* proceeding. While it can sometimes be helpful and often seems easier to seek the help of a cohort colleague or a second year Therapist Intern we strongly advise that you consult with the Director of Clinical Training, Clinical Supervisor or Client Services Coordinator first.

Please note this manual has undergone a significant update and re-writing and it continues to be reviewed and tweaked to ensure clarity and consistency. This version has been deliberately written using gender neutral terminology and is designed to be used as a web based resource with imbedded links, while also function well asa printed document. Should you note contradictions, discrepancies, missing items or have any suggestions please do not hesitate to bring them to the attention of the Director of Clinical Training.

Manual Organization

The Manual is divided into 18 sections. Each section is intended to cover a specific policy or procedure area relevant to clinical training and client work.

Forms identified in this manual can be found separately on the One Drive folder.

Each section is divided into subsections and numbered for ease of reference and to help organize the information in a clear manner. For example:

Some sections (eg: supervision) provide a general over view and less procedural detail because there may be greater variance in how the information will be applied over the course of the program, or in case of supervision from one practicum to another or from one supervisor to another.

Other sections (eg: assessing risk) provide more information and greater procedural detail because the way the information is applied will vary less from practicum to practicum.

Boxes highlight prominent points or to make some items stand out for punctuation or for ease of reference.

- Lists with "dots" are provided in no particular order, and can be considered a menu of options from which to consider. Some items may apply while others may not.

1. Lists with numbers are intended to be followed in chronological order.

Information about a given item (eg consent; clients under the age of 12 etc.) is generally only provided in detail in one section. However, that item may be mentioned in several places and sections in which case the section and/or page number where it is detailed is provided for ease of reference.

Links: this version of the manual is designed for access on line. As such many sections make reference to various documents housed on a third party website (eg: CRPO or AAMFT). When you click on the link a new browser should open to allow you access to the referenced material while also staying connected to the section of the manual you are reading.

Glossary of Terms

MSc:CFT Emphasis – is the official name of the training program, it is colloquially know as the CFT Program and will, for ease of language, be referred to in this Manual as "CFTP" or "The Program".

CS – Clinical Supervisor

PI – Practicum Instructor

P-I – Practicum Number (I, II, III, IV, V)

CSC – Client Services Coordinator

DCT – Director of Clinical Training

APD- Academic Program Director

AAMFT – American Association for Marriage and Family Therapy

CRPO – College of Registered Psychotherapists of Ontario.

CFTC – Couple and Family Therapy Centre

F&CS – Family and Children's Services (Children's Aid Society of Ontario)

FROSS/FROCS - First Response on Site Supervisor / First Response on Call Supervisor.

IPV – Intimate Partner Violence Assessment.

Clinical File – refers to the paper or electronic collection of notes, reports and documentation maintained on all clients.

Linked file –

No case made – is a term used when an Intake is prepared and file or enrollment is opened for a potential client, however the client does not actually attend a session.

Yellow File – the yellow file refers to the hard copy, paper copy or physical copy of the clinical record, which are bound in yellow file folders and are similar to yet distinct from the electronic file.

Electronical file – is the electronic version of the clinical record that is stored on Caseworks and is similar to yet distinct from the Yellow file.

Digital recording – refers to all audio or "video" recording made using the V-Cap digital recording system.

1 Mandate and Mission

Background

The Couple & Family Therapy Centre is a distinct training facility that offers among the highest academic, professional and ethical standards of clinical training, supervised practice and clinical care in Canada. Our approach is unique in that we think about clients in the context of their relationships (partners, families, friends, work) as well as the wider communities in which they live. We apply this "relationship" focus to all of our client work, even when working with individuals. Our approach to therapy is also collaborative, strength-based and evidence-supported, and we are committed to addressing the effects of injustice and marginalization.

1.1 Recognized and Accredited Training Program

The Masters of Science emphasis in Couple and Family Therapy Program is a Recognized Education and Training Program with the College of Registered Psychotherapists of Ontario (CRPO) and accredited by the American Association for Marriage and Family Therapy (AAMFT) Commission for Marriage and Family Therapy Education (COAMFTE). We are bound:

- by the Professional Practice Standards set out by the College of Registered Psychotherapists of Ontario (CRPO).
- additional and relevant provincial and federal laws and legislation (eg: RHPA; PHIPA: HCCAO)
- the Code of Ethics set out by the American Association for Marriage and Family Therapy (AAMFT).

Watch Video: Understanding the Benefits of Marriage and Family Therapy
https://www.youtube.com/watch?v=31EgvvbXS6M

The CRPO Code of Ethics serves is an inspirational document intended to set standards for which its members aspire. While Therapist Interns are not eligible to become registered with the College until the program has been substantially completed, the CRPO Code of Ethics serves as a valuable reminder of the principles you as future members will be expected to uphold.

As a member of the College of Registered Psychotherapists of Ontario, I strive to practise safely, effectively and ethically, and to uphold the following principles:

Autonomy & Dignity of All Persons: To respect the privacy, rights and diversity of all persons; to reject all forms of harassment and abuse; and to maintain appropriate therapeutic boundaries at all times.
Excellence in Professional Practice: To work in the best interests of clients; to work within my skills and competencies; maintain awareness of best practices; and to pursue professional and personal growth throughout my career.
Integrity: To openly inform clients about options, limitations on professional services, potential risks and benefits; to recognize and strive to challenge my own professional and personal biases; and to consult on ethical dilemmas.
Justice: To strive to support justice and fairness in my professional and personal dealings, and stand against oppression and discrimination.
Responsible Citizenship: To participate in my community as a responsible citizen, always mindful of my role as a trusted professional; and to consult on potential conflicts-of-interest and other personal-professional challenges.
Responsible Research: To conduct only basic and applied research that potentially benefits society, and to do so safely, ethically and with the informed consent of all participants.
Support for Colleagues: To respect colleagues, co-workers, students, and members of other disciplines; to supervise responsibly; to work collaboratively; and to inspire others to excellence.

Approved at Council November 16, 2011.

It should be noted that there are significant differences between a Professional Association (AAMFT/OAMFT) and a Regulatory College (CRPO). Similarly the meaning and purpose of AAMFT's Code of Ethics versus the Code of Ethics for the College can be confusing however, are important to understand. These concepts will be discussed and explained in varying degrees during 6160 Introduction to Systemic Practice in Couple and Family Therapy.

1.2 Dual Mandate: Therapy Training and Therapy Services

The Couple & Family Therapy Centre houses both a Master's level Professional Training Program and community styled agency, and as such has a dual mandate to:

1. provide a training context for the MSc-CFT emphasis graduate students. Therapist Interns will work directly with clients while obtaining on-going instruction and supervision in couple and family therapy.
2. provide accessible, high quality therapy services to people in the Guelph and surrounding communities.

1.3 Therapy Training

Our training mandate includes theory, research, and practical application and clinical skill development, grounded in relational and systemic ideas. We concentrate the skill development on selected models in the couple and family therapy field. We foster a life-long learning approach and establish the foundational skills in critical thinking and conceptualization necessary to be an effective life-long learner. The models of therapy we feature are considered applicable to a wide range of clinical practice in couple and family therapy. The training program is intended to provide therapist interns with a solid foundation on which they can pursue further development and training in more specialized areas post-graduation.

> CFT Program Mission: to promote excellence in educating and training students in the specialty mental health profession of couple and family therapy: by embracing multi-dimensional diversity; by integrating theoretical and research knowledge with systemic clinical practice; by fostering high standards of professionalism and ethical conduct; by addressing issues of marginalization and discrimination throughout the program

Please see the CFT Student Handbook for a complete list of Program Goals, Educational Goals and Expected Student Learning Outcomes.

Therapy Services

The Couple and Family Therapy Centre is dedicated to providing affordable, effective, helpful and accessible therapy services to a diversity of people in Guelph and the surrounding area.

LINK Brochure

CFTC Mission: Our mission is to provide high quality relationship focused therapy services to people living in Guelph and the surrounding area by:

- Striving for excellence in service and training
- Fostering change collaboratively and respectfully
- Ensuring accessibility
- Valuing diversity
- Being accountable to clients, the university, the community and the profession of Couple & Family Therapy
- Maintaining high standards for ethical practice

2 Therapy Services and Limitations

Background

Given the CFTC dual mandate referred to in Section 1 and that the Centre operates as a unique teaching facility, care is taken to consider what therapy services we can provide and what therapy services can and cannot be equipped to provide.

The nature of clinical work is such that situations present themselves that do not always or should not always fit within the services or limitations that we have set. Sometimes, clinical situations need to be considered on a case by case basis, and always in consultation with a Clinical Supervisor and the Director of Clinical Training.

This section broadly outlines the therapy services provided and identifies some key services which we do not provide.

2.1 Therapy Services provided

Couple and Family Therapy is about people and their relationships with themselves, their families, their friends, their work, their school, and in their community. In general the Couple and Family Therapy Centre will:

- work with people of all ages (adults, adolescents, children), as well as people from diverse cultural, ethnic, economic, religious backgrounds, with diverse sexual and gender identities, and family configurations.

- work with couples, families, and individuals to help them better understand and find new ways of dealing with difficulties, challenges, and transitions they may be experiencing in their lives and relationships. This includes such things as social location, social influences and expectations, culture, or things that can make a person feel marginalized.

- collaborate with people to help them better understand and manage these influences and strengthen the relationships that are important to them. We build on clients existing skills, help develop new ones and work with people to explore and consider new ideas and possibilities for change.

- support clients by providing resources, making recommendations, co-ordinating with other health care professionals or community agencies as needed or making referrals when necessary.

We help clients to:

- Consider alternative ways of managing, coping and dealing with problems;
- Generate possible solutions and implement constructive change;
- Enhance current strengths, skills and personal resources;
- Build communities of support and concern.

The following is a sample of the types of presenting issues or problems we have experience working with:

- Family, couple, workplace and school challenges, conflicts and communication.
- Life transition and change
- Intimacy and sexuality
- Anxiety, stress and depression
- Grief, loss, loneliness and feelings of isolation
- Disability, illness or enduring pain
- Parenting or blended family challenges
- Trauma, unexpected crises and intimate partner violence
- Diverse genders, sexualities and orientations.
- Transnational families and adapting to a new home

Co-ordination of care

We also provide on-going complementary support to people with an established mental health diagnosis or addiction who are also receiving care from a qualified medical professional.

2.2 Service Limitations

The following is a list of services not currently offered by the Centre. Requests for any of the following services should be discussed with a clinical supervisor or the Director of Clinical Training.

2.2.1 Clients in Crisis

The CFT Centre is not a crisis centre and is not equipped to provide crisis services to clients. The CFTC is constrained by its hours of operation, and the fact that we do not have the necessary onsite supports (eg: medical; legal; critical incident team etc) to competently attend to crisis situations. The CFTC does not provide crisis or emergency counselling or telephone support to clients.

We will refer clients in crisis to relevant and available community resources and assist clients to consider who in their personal lives may be of support to them between sessions.

2.2.2 Diagnosis and Formal Assessments

Diagnosing or conducting formal or standardized assessments is a specialized service and requires specific training and competence which we do not provide. In addition, conveying a diagnosis as a Controlled Act in Ontario and only professionals who have access to that controlled act may perform it.

Therefore, the CFT Centre does not provide diagnosis, formal or standardized assessment services. This includes, but is not limited to:

- Mental health or addiction assessments
- Psycho-educational assessments for schools,
- Child custody and access assessments
- Probation and parole, or pre-sentencing dispositions.
- Other assessments used for legal purposes or court proceedings.

- *See Procedures for Requesting Psychiatric or Addictions Assessments below in this section* ***link and section***
- *See Procedures for Legal and Court Related Communications below in this section* ***link and section***

2.2.3 Mediation

Mediation requires formal training and competence to perform and is a service we don't provide. A referral to a mediation service can be provided upon client request.

2.2.4 Advocacy

The CFTC does not provide direct advocacy to a third party on a client's behalf. We will however support a client to consider ways to self-advocate or access resources to assist them in direct advocacy.

2.2.5 Supervised Access

Providing and facilitating supervised access is a specialized service requiring specific training and competence which we do not offer. As such, the CFT Centre does not provide nor facilitate supervision for supervised parental access.

2.2.6 Home Visits

Asa general rule we do not provide home visits as part of our regular services. While there may be an extraordinary situation where a home visit may be considered (e.g., a dying or palliative client) that decision would be made in close consultation with the Clinical Supervisor and Director of Clinical Training.

2.2.7 Sessions off site

As a general rule all clinical sessions are held within the CFTC building. Requests to hold sessions outside the premises (eg: outside on a fine day) must be discussed with a Clinical Supervisor or the Director of Clinical Training and must have clear therapeutic merit.

2.2.8 Electronic Practice

While the CRPO has developed some standards for the electronic practice and communication technologies, virtually all services provided at the CFT are face to face. The centre does not use technology to communicate with clients; this includes but may not be limited to e-mail, text, skype, or social media. The CRPO standard can be found by clicking here.

2.2.9 Medication Use by Clients

Clients who come to therapy are sometimes taking prescription medication for issues they would also like to work on in therapy (ex. Antidepressant medication for depression).

At other times clients may experience the effects of serious medical/mental health conditions for which they have not yet consulted a medical professional.

If the Therapist Intern has a concern about a client's medical condition or about prescribed medication the client is taking/not taking, the Therapist Intern consults with the Clinical Supervisor to determine the best course of action.

2.2 REFERRALS

Background

This section details how to make specific referrals for clients for clinical issues that we do not provide or sit outside of our areas of competence or mandate. Sometimes, clients will request or it is appropriate to provide a client with a referral to a therapist outside of the CFTC. In such situations, and wherever possible, CRPO Professional Practice Standards require that a minimum of three referral names are provided to clients.

2.2.1 Requesting Psychiatric or Addictions Assessments

Clients sometimes come to therapy dealing with serious mental illness, or other serious issues that require more ongoing support than we, at the CFTC are able to solely provide. It is particularly important in these cases that the Therapist Intern works in collaboration with the psychiatrist or other mental health professional that is caring for the client to ensure a coordinated approach to the client's care. If the client has not seen a psychiatrist or other mental health professional and the Therapist Intern have questions or concerns about what type of service would most closely meet the client's needs, a consultation with the Clinical Supervisor to ascertain whether a referral to another professional is in order.

Procedures for Requesting a Psychiatric Assessment

In non-crisis/emergency situations with clients where the Therapist Intern believes a psychiatric assessment would be helpful for the client, the procedure is as follows:

1. **Consult and obtain prior approval from the Clinical Supervisor**.
2. Obtain an Authorization for Release of Information from the client before contacting any professional.
3. After consultation, and approval from the Clinical Supervisor, the Therapist Intern requests a psychiatric assessment by calling:

Central Intake provided by Here 24/7 for the Canadian Mental Health Association Waterloo Wellington Dufferin (CMHAWWD) at 1-844-437-3247.

If appropriate, the Therapist Intern may request that the client be seen in the First Episode Psychosis Clinic at Community Mental Health Association Waterloo Wellington Dufferin (CMHAWWD).

Wait times for psychiatric assessments vary.

Procedures for Requesting an Addictions Assessment

During Intake or ongoing therapy session's clients may disclose or suggest a substance abuse or other addiction problem that may need to be addressed before therapy can be helpful. Since the assessment of addictions is outside our scope of practice at the CFT Centre, when a Therapist Intern learns that a client may be living with an untreated addiction the procedure is as follows:

1. **Consult and obtain prior approval from the Clinical Supervisor**
2. Obtain an Authorization for Release of Information from the client before contacting any professional.
3. After consultation and approval from the Clinical Supervisor, the Therapist Intern requests an addictions assessment by calling:

Central Intake provided by Here 24/7 for the Homewood Community Addictions Service (CADS).

Alternately, walk in appointments with CADS are conducted at 147 Delhi Street, Guelph between 9:00am and 4:30pm, Monday to Friday.

Wait times for addictions assessment vary and can take several weeks.

3 Professional Responsibility and Conduct

Background

Working as a Couple and Family Therapist and acquiring the knowledge skill and judgement to become a Registered Psychotherapist, requires understanding and developing some core aspects of professional conduct specific to the field. Given our training mandate, some time and attention will be placed on helping Therapist Interns strengthen professional conduct and foster professional responsibilities.

Therapist Interns nots only have a responsibility to how they conduct themselves in front of clients but also with regard to indirect service (documentation etc).

The following is a list of the main core aspects of professionalism you will be expected to foster over the next two years.

3.1 Confidentiality,

The CRPO Practice standards state that confidentiality is the cornerstone of the profession and in some situations holds its members to a higher standard of confidentiality than required by other professions. The Centre holds a commitment to work toward and maintain a high standard of confidentiality in all aspects of client care. As explained in Section 4 “Consent and Confidentiality”, understanding how to apply confidentiality can be complex and cans sometimes require careful consideration and planning.

- You will be expected to understand, apply and adhere to the high standards of confidentiality as set forth by the CRPO; AAMFT and Centre policy.

3.2 Ethics and Best Practice

The CFTC is dedicated to providing a strong foundation of understanding and practice in ethical decision making fundamental to best practice and solid client care.

- You will be expected to develop a strong sense of ethical practice a strong entry to practice ability to discern the ethical implications of and best practices required in a variety of clinical and collegial situations.

While both the CRPO and AAMFT set forth standards for the profession, the vast majority of professional practice standards are unwritten.

- You will be expected to understand and apply the written standards and develop a strong awareness and application of those that are unwritten or simply industry standards.

3.3 Collaborative Team Approach

The CFTC emphasizes a collaborative and Team Approach to clinical work. Decisions about the therapy services for any client are made in collaboration with members of the clinical team (Director of Clinical Training; Practicum Instructor, Clinical Supervisors, Client Services Co-coordinator etc.). Therapist Interns work on a variety of teams including in supervision, practicum, and use of clinical teams to work with clients etc. Working collaboratively and in a team approach is viewed as strength and a rich learning opportunity for Therapist Interns. It also helps foster consideration and application of best practice, while striving to ensure the best possible provision of service to clients.

- You will be expected to work collaboratively and in a team approach in an open and engaged manner.

3.4 Best Interests of Clients

We believe that our clinical team approach to service provision and clinical decision making helps ensure we are working in the best interests of clients. Best interest of the client is not just following what the client wants, but also includes input from the Therapist Intern who in turn has had input from a clinical supervisor to help determine what approach or direction may be the best fit for the client and the clients presenting problems. Best interest of clients also means working collaboratively with the clients "circle of care" - other professionals in the community who are involved in the client's life (family doctor; F&CS; psychiatrist etc.) to help ensure coordinated care is provided.

- You will be expected to always be working in the best interest of the client and to engage with community partners or the client's circle of care as required.

3.5 Availability and Presence

The CFT Centre is open for clients most days of the week and is staffed 5 days a week. While the actual days the Center is open varies from semester to semester, the Centre is generally open most days of the week and some evenings to see clients. The Director of Clinical Training and or Client Services Co-coordinator are on site Monday to Friday. The Centre is closed for two

weeks following the end of each semester. The Centre also operates a University of Guelph Student Walk-in Clinic, generally held on Fridays from 10AM-3PM (see section 18 for more detail) . With the exception of the Walk-in clinic, all client work is booked by appointment only. All administrative tasks associated with clinical work (supervision, file meetings, documentation writing, timely client contact) is completed on site only.

- Therapist Interns are expected to be onsite, on-time, ready and available to work with clients when the Centre is open, including several evenings each week.
- Therapist Interns are expected to be on time and prepared for all clinical appointments, supervision and Centre related meetings.
- Therapist Interns are also expected to be present and on site to undertake administrative tasks associated with clinical work (supervision, file meetings, documentation writing, timely client contact).
- Therapist Interns are expected to take vacation and holiday time during the three two week periods the Centre is closed (see student handbook).

3.6 When you are sick

The CFT Centre serves a vulnerable population and close to 600 clients annually. The CFT Centre is housed in an old building with close quarters that is also the work place for about 25 people. While colds and flus are common life occurrences, they are often far too easily spread and not always conducive to providing good therapy. Therapist Interns who get sick are asked to take care of themselves and take measures that will reduce the spread of colds and flus to clients and colleagues. If you get sick and are unsure whether to come into the Centre please call and check in with a clinical supervisor, Director of Clinical Training or the Client Services Coordinator. If you are sick, staff will gladly assist you in ensuring clients are cancelled.

- Therapist interns are expected to monitor their health and balance the need to be at work with the need to get well and reduce the spread of colds and flus.

3.7 Appearance

CFTC Intern Therapists are unique in that they are both students of the university and providing a public service in a professional training program. The CFT is a public building that is visited by clients, students, staff, faculty and other people from the greater university and Guelph communities. A wide range of people from all walks of life come to our centre for work or to access clinical services. Given the diversity of clients how come to the Centre, it may seem complex to determine the best appearance that helps all visitors feel welcome and that is reflective of the profession. Appearance of Therapist Interns, staff and faculty is important as it serves as a reflection of our centre and the work that we provide. Therapist Interns are

encouraged to engage with supervisors and colleagues about ways to approach appearance.

- Therapist Interns are expected to present themselves with respect to dress and hygiene in a manner that is reflective of their professional role and conducive to conducting clinical work with a diversity of clients.
- Therapist Interns are also expected to present themselves in this way *regardless* of whether they are clients that day or not.

3.8 Direct and Indirect Service

The standards for direct and indirect service are presented in some detail throughout this manual and adhere to those set forth by the CRPO and the AAMFT. In general, Therapist Interns are responsible for all aspects of their clinical work with clients both direct contact (eg: sessions; scheduling) and indirect service (eg: documentation writing etc). Ensuring clients are contacted promptly to schedule a first session or to follow up on missed appointments and maintaining accurate, complete and timely clinical records are fundamental aspects of professionalism in this field.

- Therapist Interns are expected to learn and apply the standards of the profession and those set forth in this manual and as they apply to direct and indirect service.

3.9 Diversity of Clients and Breadth of Clinical Issues.

The CFT Centre is committed to training therapist Interns to work with a broad range of people and presenting problems. The CFT Centre offers services to services adults, adolescents, children, as well as people of diverse cultural, ethnic, economic, religious backgrounds, sexual identities/orientations, and family configurations. In addition, the Centre works with a vulnerable population and people seeking therapy for a wide range of presenting issues, with some bringing highly complex issues requiring careful consideration. Therapist Intern could be asked to see any person who seeks the services the CFT Centre offers. Some Intern Therapists may be challenged by an aspect of client diversity or the issues a client may talk about in therapy. Some situations may feel or be beyond the therapist Interns current level of competence.

- Therapist Interns are expected to work with clients from diverse backgrounds and with a range of presenting problems.
- Therapist Interns are expected to monitor the impact that working with clients may have on them professionally or personally, and to raise questions or concerns as a result with a clinical supervisor.

3.10 Consultation and Supervision

The fields of Family Therapy and Psychotherapy place high value on clinician's willingness and ability to consult regularly about clinical work. Consultation in these fields is viewed as both accountable ethical practice and as strength. One of the most valuable resources available to a therapist Intern is access to clinical supervision and or consultation. The CFT Centre closely supervises the direct clinical work of Therapist Interns. Clinical supervision serves a dual function: (a) contributing to the development of the Therapist Intern's skill, and (b) ensuring clients receive the best service we can offer. Working collaboratively, the supervisor and the Therapist Intern will make decisions about which client issues are being addressed in the therapy. Considerations of current areas of Therapist Intern competence will be a part of the decision-making process.

- Therapist Interns are expected to keep their supervisors fully informed when client work moves in a different direction than originally indicated.
- If, at any time, the Therapist Intern has concerns about the direction therapy is going and his/her competence to deal with the situation, consultation with the supervisor responsible for the particular client(s) is required.
- If the Therapist Intern is uncertain or experiences discomfort regarding a situation, she/he is to seek consultation with the supervisor responsible for the particular client(s) immediately.

4 Consent and Confidentiality

Background

Consent and Confidentiality are two of the most important and complex concepts to understand and apply in a clinical setting. This section reviews both the legal obligations and Centre specific policies with regard to consent and confidentiality.

4.1 – CONSENT

Consent is a complex and very important concept which is foundational to how we engage with clients. In general terms Therapist Interns must ensure that clients receive sufficient and relevant information about the service they are about to receive including possible risks, in order for consent to be considered informed. Obtaining informed consent prior to beginning therapy is required. Informed consent is best obtained through discussion and wherever possible in written form (eg: client's signature). In order for consent to be valid it must be informed, voluntary, specific (sufficient information was provided) and not be a misrepresentation of services to follow.

Relevant resources to review:

- CRPO Professional Practice Standards section 1.2. http://www.crpo.ca/wp-content/uploads/2014/11/CRPO-Professional-Practice-Standards.pdf
- The *Health Care Consent Act* (1996) https://www.ontario.ca/laws/statute/96h02/v15
- Child and Family Services Act (1990) https://www.ontario.ca/laws/statute/90c11/v38

Consent in Ontario is based upon the "Capacity" clause in the *Health Care Consent Act*. The capacity to consent means an individual understands the information relevant to making a decision about participating in Therapy Services ad appreciates the reasonably foreseeable consequences of participating in Therapy Services. As such consent is based more on a person's "capacity" - than it is based on age. Having said this, the younger a person is the more difficult it will be to ensure that a person has the capacity to make that decision.

The Child and Family Services Act (1990) states that: "[a] service provider may provide a counselling service to a child who is 12 years of age or older with the child's consent, and no other person's consent is required." However, The Child and Family Services Act further states that "…if the child is less than 16 years of age the service provider shall discuss with the child at the earliest appropriate opportunity the desirability of involving the child's parent [in therapy]."

Clients who do not have capacity (regardless of age) or are under the age of 12 years old cannot provide consent and as such must have another person (substitute decision maker) give or refuse consent in accordance with the Health Care Consent Act.

The following is the hierarchy of substitute decision makers:

- A guardian, power of attorney (for personal care), children's aid society or representative appointed under the *Health Consent Act* with authority to give or refuse consent to the treatment
- Client's spouse or partner
- Client's parent. **If there is a custodial agreement or order, a copy may be requested by the CFTC**. Parents with only a right of access can give or refuse consent only if the custodial parent is unavailable
- Client's brother or sister
- Client's relative

The substitute decision maker must:

- have Capacity
- be at least 16 years old, (unless the substitute decision maker is less than 16 years old and the parent of the minor (parents are exempted from the age requirement)
- not prohibited by court order or separation agreement from having access to the Client or giving or refusing consent on the Client's behalf
- willing to assume the responsibility of giving or refusing consent.

The CFTC, in consultation with university legal counsel has established the following policies with respect to consent for therapy services:

- Absent other factors, individuals who are twelve (12) years of age or older are presumed capable of consenting to receive Therapy Services.
- Individuals who are under the age of twelve (12) years of age are not presumed capable of consenting to receive Therapy Services and therefore normally require consent from a substitute decision maker (eg: parent Guardian etc).
- Individual Therapy is not provided nor offered to clients under the age of 12.
- Given that we are relational and systemically focused training centre, we prefer, wherever possible, reasonable and safe, to engage with parent(s) and/or a substitute decision maker involved in the client's life.
- In some situations we will provide individual therapy to clients aged 12-15. However we request that a parent or substitute decision maker minimally participates in the first session.

Consult with a clinical supervisor prior to agreeing to see or seeing a client aged 12-15 individually.

Process for obtaining consent for therapy services: Clients will read and/or be explained the Terms of Service (form F-1) which includes a discussion about the digital recording of sessions. Clients who are able to consent to therapy on their own will complete and sign the General Consent form (F-2). Clients who are unable to consent (lack capacity) or are under the age of 12 years old will have a substitute decision maker consent on their behalf using form F-3.

Consent to the release of information

The Personal Health Information and Protection Act (2004) outlines the rules for collecting, storing and releasing clients personal health information.

- See PHIPA - https://www.ontario.ca/laws/statute/04p03

While there are some exceptions under which PHIPA allows for the disclosure or release of personal health information without a client's consent, the general rule is that a client's

personal health information is kept confidential and can only be disclosed to a third party with the clients consent or consent of a substitute decision maker. The exceptions will be discussed below under confidentiality.

Clients maybe involved in a number of helping systems (Family Physician; Children's Aid Worker, Psychiatrist etc.) and it may be appropriate or necessary to speak with one or more of these helping professionals. In order to do so, a client must provide consent for a therapist Intern to speak with and obtain and or provide Personal Health Information. The CFTC requires that Therapist Interns obtain written consent (Form C-2) from clients in advance of speaking with another helping professional or third party.

A consultation with the clinical supervisor is required before obtaining consent and before contact with the third party is made in order to determine:

- the purpose and intent for making contact,
- hat if any information can or should be provided
- what information would be helpful to obtain
- how best to inform the client of the conversation with the helping professional.

4.2 CONFIDENTIALITY

Background

Client confidentiality is a cornerstone of the profession and core ethical value of marriage and family therapy (see CRPO Professional Practice Standards and AAMFT Code of Ethics, 2015). Maintaining client confidentiality is a central focus of the procedures and practices at the Couple & Family Therapy Centre. Given that we work as a clinical team with a training mandate, procedures and practices regarding client confidentiality are often more complex and nuanced than initially expected.

General confidentiality guidelines governing our practice are summarized below, followed by some specific considerations associated with our training centre.

4.2.1 General Confidentiality Guidelines

As the AAMFT Code of Ethics (2015) states, "marriage and family therapists have unique confidentiality concerns because the client in a therapeutic relationship may be more than one person. Therapists respect and guard confidences of each individual [in the] client [system]".

Everything that is said in the context of the conversations between therapist and client is kept confidential. This includes all written notes about a client, formal and informal. Since we work as a team, what is said may be shared with clinical supervisors, the client services coordinator, with other Centre Therapist Interns when appropriate and, occasionally, with therapists who are consultants to the Centre.

The following exceptions to confidentiality are outlined in the Terms of Service which all clients must understand and agree to before they begin therapy at the CFTC. Therapist Interns must also explain the limits to confidentiality verbally to clients before therapeutic conversations can begin.

Confidentiality:

1. Subject to section 7 below, a client's personal health information is kept confidential and can be disclosed to a third party only with the client's consent or the consent of a substitute decision maker in accordance with PHIPA.

2. Disclosure of personal health information is considered in accordance with PHIPA and includes but is not limited to the following circumstances:

    a. in response to a court order or as otherwise required by law;
    b. to report a child in need of protection in accordance with the *Child and Family Services Act (1990);*
    c. to eliminate or reduce a significant risk of serious bodily harm to a person or group of persons;
    d. for the provision of emergency healthcare in circumstances where it is not possible to obtain the client's consent in a timely manner and the client has not prohibited such disclosure; or
    e. to report a client who is a member of a regulated health profession and where mandatory reporting under the *Regulated Health Professions Act 1991* applies.

4.2.2 Required Disclosure of Client Information

In any one of the situations listed above, the Therapist Intern may be required to disclose client information. The Therapist Intern **must consult immediately with the clinical supervisor** and **before** any disclosure of client information is made.

ALL consultations, disclosures and actions must be documented in the clinical record.

- See Section 5: Consultation Notes
- See also Section 12 – Assessing Risk Part II – Children

In response to a court order or as otherwise required by law:
All court orders or requests for information from a client lawyer are handled by the Director of Clinical Training. In situations where a Therapist Intern believes that a disclosure may be necessary in law, the situation must be immediately discussed with the Director of Clinical Training or Clinical Supervisor.

- See Section 15 Legal Issues and Ethical Slips and Professional Misconduct.

To report a child in need of protection in accordance with the *Child and Family Services Act (1990).*

Therapist Intern MUST consult with a clinical supervisor and may need to make a report to Family and Children's Services when:

- a client discloses that a child under age 16 has been sexually or physically abused, or neglected. This also includes when domestic violence or ongoing verbal abuse between family members is reported and there is a child (or children) in the home.

- a client discloses that a child is at risk of abuse or neglect as determined by the therapist. This includes when a client reports that a child is not adequately supervised and is at risk of harm.

- a client discloses that he/she was abused in childhood and there is a possibility that the person who was abusive towards them may be a danger to other children now.

- See Section 12 Assessing Risk Part II: Children for detailed instructions.
- See Child and Family Services Act (1990) https://www.ontario.ca/laws/statute/90c11

To eliminate or reduce a significant risk of serious bodily harm to a person or group of persons

A Therapist Intern MUST consult with a clinical supervisor when:

- a client is clearly at risk to hurt self (including but not limited to suicide)
- a client is clearly at risk to hurt someone else (including but not limited to homicide)
- a client reports that someone else is or may clearly be at risk to hurt self or hurt another person.

In any one of these situations other resources (hospital, ambulance, police) may need to be brought in to provide support or protection.

Bodily harm includes physical and emotional harm. HPRAC amended the RHPA in 2007 through Bill 171 that changed the old serious physical harm to the current serious bodily harm (sec. 30(1)). The change was in direct response to a 1991 Supreme Court of Canada Ruling (McCraw (1991)) and makes the definition of serious bodily harm definition align with the same in the criminal code of Canada 264.1(1)(*a*) which states "any hurt or injury, whether physical or psychological, that interferes in a substantial way with the integrity, health or well-being of a victim".

- See Supreme Court Ruling: https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/790/index.do

f**or the provision of emergency healthcare in circumstances where it is not possible to obtain the client's consent in a timely manner and the client has not prohibited such disclosure**

to report a client who is a member of a regulated health profession and where mandatory reporting under the *Regulated Health Professions Act 1991* applies.

4.2.3 Individual Sessions with Members of a Relational Enrolment

CRPO Professional Practices Standards state that when a couple or family attends part or all of a session sessions in different combinations a separate or "linked file" must be created.

Example:

- If one member of a couple attends a session individually, a file for that individual file is created and maintained separately from the couple file.
- If one child and one parent in a family of four attends a session together without the other two family members a separate file is created and maintained.

The individual files will contain notes for the individual sessions; the couple file will contain notes for the sessions attended by both members of the couple; and the family file will contain notes for sessions attended by the family together. More than one family file may be required if family members come in different constellations.

- See Section 7 "Multiple Files – Client Relational System" for further information

4.2.4 Seeing clients aged 12-15

In this first session, rights and exceptions to confidentiality must be explained clearly to the client and parent/guardian*. This includes informing them we may be compelled to disclose client information (with or without the client's consent) by informing parents or legal guardians if the therapist learns that the client is engaging in serious risk-taking behavior (drug/alcohol misuse, unprotected or risky sexual activity, self-harming behaviour).* Therapist Interns **must** consult with a Clinical Supervisor before informing a parent or guardian about information disclosed by the client.

4.4 CFTC Guidelines for Team Confidentiality

The CFTC Terms of Service and confidentiality practices are vested in the Centre and members of the clinical team as opposed to individual Therapist Interns. When discussing the terms of service with clients before they sign the consent for therapy services, how we work as a team should be verbally explained. Clients should be informed that information disclosed in sessions and digital recordings is shared with Clinical Supervisors and Therapist Interns as appropriate.

4.4.1 Intentional and Respectful Discussion

Most consultation conversations should be conducted with a clinical supervisor, since the clinical supervisors have ultimate responsibility for ensuring the best interest of the client and for providing the clinical training to interns. Client or client related conversations between Therapist Interns and colleagues must be conducted in an intentional and respectful manner. A good and general rule is to imagine that the client is listening and consider how the conversation might be understand or interpreted by the client. Therapist Interns should be able to:

- Ensure they have the authority (and consent) to have such a conversation
- Clearly articulate the purpose of the conversation
- What made having the conversation necessary and appropriate
- Ensure the conversation is held in private where other colleagues or clients are unable to hear

Appropriate purposes include:

- Broadening the resource base available to enhance client service

- Generating resources to enhance therapist skill development
- Consultation to help the therapist discern the appropriateness of an particular interpretive frame being held
- Session planning and de-briefing when working as co-therapists
- Particularly salient professional and/or personal reactions following a meeting with clients.

It is *not* appropriate to talk with Therapist Intern colleagues without a particular intent to enhance clinical competency or improve the service to the client.

Therapist interns should not be engaging in general ongoing conversations about clients.

Engaging in client gossip may be considered Professional Misconduct.

4.4.2 Multiple Therapists in the System

When more than one Therapist Intern is involved in working separately with various members of a family system (e.g., two different therapists working separately in individual therapy with, for example, two members of a couple, or a parent and adult child, etc), the interns are not to discuss the work with each other, or use each other as consultants in the work unless those discussions are held with a clinical supervisor. Similarly, when more than one Therapist Intern is involved in working separately with the same client (for example, different therapists working with the person in individual and couples therapy) the interns are not to discuss the work with each other, or use each other as consultants in the work unless those discussions are held with a clinical supervisor.

In some situations, it may be important or prudent to obtain prior and written consent form clients before engaging in conversations with other Therapist Interns involved in the same system.

- See form A-26b.

This form allows clients to provide the required consent for the client's individual therapist to share information with their couples or family therapist. Again, any discussions in these circumstances must be held with a clinical supervisor.

4.4.3 Prior Knowledge

When a client situation is being discussed and a Therapist Intern becomes aware s/he has some recognition of the client or client situation from a context outside of the CFT Centre, the Therapist Intern immediately declares s/he has reason to believe s/he has some prior knowledge. In this situation, the discussion/consultation must be discontinued. If the discussion/consultation involves a group of Therapist Interns, the individual with prior knowledge must excuse her/him-self from the conversation, before further discussion continues. The Therapist Intern should consult with a supervisor before further participation in any discussions pertaining to this client or client situation.

4.5 Client Access to Digital Recorded Clinical Material

Our "open file" policy at the CFT Centre includes client access to digitally-recorded material of their therapy sessions. This access is limited to viewing on-site at the CFT Centre (i.e., clients are not allowed to take recordings of their therapy sessions home). It is good therapeutic practice for the Therapist Intern to work with the client(s) wishing to view segments, or the whole recording of a session in a way that increases the therapeutic value of viewing this material. The therapist needs to have clear therapeutic goals regarding how the viewing of recorded material of previous therapy meetings will be helpful to the client(s). The relevant supervisor must be consulted and give approval to this practice.

Clients may also, on occasion, view selected professional tapes from our clinical resource library. These tapes are to be viewed on-site at the CFT Centre (i.e., these professional resource tapes cannot be taken home by clients). Therapist Interns must consult with the appropriate clinical supervisor regarding which professional resource tapes are appropriate for client viewing prior to sharing these resources with clients. These resources are to be used with clear therapeutic goals and plans are to be made for adequate debriefing with the clients following viewing. These same guidelines apply to referring clients to specific written resources.

Any and all request for clients to view digital recordings must be discussed in advance with the Director of Clinical Training.

4.6 Electronic Communication with Clients

Electronic communication is a very sensitive matter given the inability to ensure confidentiality. As a general rule Therapist Interns are not permitted to use any form of

electronic communication with clients. In consultation with the clinical supervisor the Therapist Intern may send appropriate information (e.g. signed Consent for Release of Information) via facsimile to coordinate services with relevant community partners. In some rare circumstances e-mail communication for the sole purpose of scheduling appointments may be permitted using a designated e-mail. NO email communication will occur with clients without the prior consent of the Director of Clinical Training.

4.7 Client Rights

Clients have the right to view a copy of the AAMFT Code of Ethics at any time, as well as the right to ask any questions they wish about the therapy process and the specific course of their therapy. They have the right to review the records of their therapy sessions (see Section 7, pg. 21, Client Request to View His/Her Enrolment file), as well as the right to request correction of inaccurate information. Corrections are to be made in consultation with the supervisor. Minor corrections may be made directly on the report other corrections may require an addendum to the original file. All corrections must be initialed by the supervisor of record and the client. They have a right to complain about any aspect of the service they are receiving when they consider it to be unsatisfactory. They have a right to confidentiality except when the client has given a specific signed consent or when there is a legal requirement to release information. They also have the right to be informed of these rights. Clients are free to leave therapy whenever it makes sense to them to do so. These rights are outlined in the Terms of Service Document that the therapist reviews with the client(s) at the first session.

5 Supervision and Consultation

Background

Supervision and consultation are the backbone of a clinical training program. Both the CRPO Professional Practice Standards and the AAMFT Code of Ethics require that members work within their areas of competence. Competence is defined by the CRPO as having the "knowledge skill and judgement" to work with particular clients or clinical issues. Both the CRPO and AAMFT have developed comprehensive Competency Profiles. These along with two comprehensive sets of expected learning outcomes (ESLO and EMLO) are integral parts of assessing the competency development of Therapist Interns.

An important step in competency development is to be able to self-assess whether there is sufficient knowledge skill and judgment to work with a particular client or clinical issue. Given that this is a training facility, Therapist Interns are not expected to enter the program being able to meet competency expectations. Therapist Interns are however expected to actively work at learning and developing the entry to practice competency standards set forth by the program as noted above.

Don't know?
Not sure?
Unclear?

When in doubt – consult.

To assist in competency development and to help ensure delivery of helpful, effective and ethical clinical work, a strong commitment is made to providing therapist Interns with frequent and on-going supervision and consultation opportunities.

The CRPO outlines the following as purpose of supervision.

- promote the professional growth of the supervisee
- enhance the supervisee's safe and effective use of self in the therapeutic relationship
- discuss the direction of therapy, or
- safeguard the well-being of the client.

This section will provide a brief overview of supervision requirements, different ways supervision can be accessed, different methods of providing supervision, and how to best prepare for supervision.

4.1 Overview of Supervision Requirements

4.1.1 CRPO Supervision Requirements

The CRPO legislation requires a minimum completion of 100 hours of clinical supervision over 450 direct client contact hours to become an RP – Registered Psychotherapist. CRPO Members who want to practice "independently" - that is without formal supervision - must complete an additional 50 hours of supervision and 550 direct client contact hours.

For more detail on CRPO Supervision requirements click here

4.1.2 COAAMFT Supervision Requirements

COAMFTE Standards of Accreditation require all Therapist Interns receive at least one hour of clinical supervision during every week when they are seeing clients. Clinical supervision must be provided in a ratio of 1:5 with direct client service (i.e., one hour of supervision for every 5 hours of client service). COAMFT requires 100 hours of supervision over 500 hours of direct client contact.

For more detail on COAMFTE Supervision requirements click here

Therapist Interns will receive at least 100 hours of supervision during their training in the CFT Program, exceeding the requirements for both the CRPO and AAMFT.

4.1.3 Reliance on "raw data" in supervision

A unique aspect of the clinical training provided is the value and importance placed on the use of "raw data" to strengthen competency development and enrich the supervision learning. Examples of raw data include reviewing digital recordings of client sessions and live observation of clinical work. COAMFTE requires that supervision include access to raw data.

4.2 Supervision formats and methods and mode

Supervision is provided in three different formats:

- **Individual Supervision** occurs when a Therapist Intern meets individually with a clinical supervisor.
- **Paired Supervision** occurs when two Therapist Intern's, co-therapists or supervision partners meet with a clinical supervisor.

- **Group Supervision** occurs when 3-8 Therapist Interns meet with a Clinical Supervisor. Group supervision includes:
    - part of a practicum class when leaning a particular model of therapy
    - when working with clinical teams
    - to discuss on-going clinical work.

4.3 There are three modes of supervision:

4.3.1 Digital Recordings (Video/Audio).

Clinical supervision conversations are usually based on access to "raw data," meaning the clinical supervisor listens to or observes the Therapist-intern's therapeutic work using audio or video digital-recording. Asa condition of service, all therapy sessions at the CFT Centre are digitally recorded. Typically individual and paired supervision and, on occasion, group supervision are based on the review of recorded session material. Each Therapist-intern must bring recorded material to every weekly supervision.

A clinical supervisor has access to all digital recordings and may view any recording at any time.

4.3.2 Case Report. When clinical supervision conversations are based on case notes and verbal or written description of the therapeutic work to date, it is considered "case report." This format is occasionally used in individual or paired supervision, infrequently it is used for group supervision.

4.3.3 Live Observation. Live observation occurs when a Clinical Supervisor observes one or more Therapist Interns conducting a session in real time (with or without a clinical team). Live observation is a component of every practica and can be arranged on an ad-hoc basis.

The format for live observation varies from practica to practica depending on the model of focus.

4.4 Types of Supervision

Supervision and consultation are generally accessed in the following ways:

- Scheduled Supervision
- Adhoc supervision
- FROSS/FROCS
- File Meetings

4.4.1 Scheduled Supervision

Therapist Interns will participate in separately scheduled supervision sessions with both the practicum instructor and the Director of Clinical Training. The format and frequency of this supervision varies between practicum and will be explained in detail in the practicum course outline. In general each Therapist Intern will attend weekly scheduled supervision. The Practicum Supervisor and Director of Clinical Training will be each responsible for supervising one half of the Intern Therapist clinical case load.

Therapist Interns participate in the following regularly scheduled supervision:

- individual or paired supervision with the Practicum supervisor for the duration of the semester
- group supervision with the Practicum supervisor as part of the Practicum course.
- individual, paired and group supervision with the Director of Clinical Training. This ongoing supervision begins in first Practicum and continues through to the end of Fourth Practicum.

4.4.2 Ad Hoc Supervision or consultation

A Therapist Intern or Clinical Supervisor may request an additional meeting to discuss or consult about a specific clinical issue or client situation. These ad hoc supervision meetings are to be used when there was insufficient time in scheduled supervision to cover off all

necessary items or when a non-emergency clinical issue arises that needs to be discussed prior to the next scheduled supervision. Different Clinical Supervisors use ad hoc supervision in different ways, please consult with each supervisor about how they use ad-hoc supervision.

When co-therapy clients are discussed in supervision or on an ad-hoc basis both therapist interns should be present. This helps to ensure that both therapist interns and the supervisor are on the same page with regard to suggestion or direction for therapy with the clients.

4.4.3 On Call or Emergency consultation (FROSS/FROCS)

In case of a clinical emergency a supervisor is always available in person or by telephone. All on call supervisors carry pagers so that they can be easily reached. An on call schedule is created each semester, which lists the supervisors on call and pager contact information. Whenever a Therapist Intern encounters a *clinical crisis or emergency* situation with a client they should contact the designated first response on-site supervisor (FROSS) or the first response on call supervisor.

First Response On-Site Supervision (FROSS) 8:3O am- 4:30 pm

Whenever a Therapist Intern encounters a *clinical crisis or emergency* situation with a client during Centre daytime hours between 8:30 AM and 4:30 PM, they will immediately contact the designated FROSS. Daytime FROSS is generally the responsibility of the Director of Clinical Training. Back up is generally the responsibility of the Practicum Instructor.

The FROSS can be reached by:

1. **Calling the designated pager number.**
2. **Checking to see if they are in their office or a meeting.** The Therapist Intern is to knock on their door regardless of whether the "In Session" sign is showing or not.
3. **Calling their office extension**

First Response On-call Supervision (FROCS) 4:30pm-9:00pm

Whenever a Therapist Intern encounters a *clinical crisis or emergency* situation with a client during Centre evening hours 4:30-9:00 PM they will immediately contact the designated FROCS. Responsibility for crisis supervision in the evening: is shared between the Practicum Instructor and the Director of Clinical Training.

The FROCS can be reached by:

1. **Calling the designated pager number.**
2. **Checking to see if they are in their office or a meeting.** The Therapist Intern is to knock on their door regardless of whether the "In Session" sign is showing or not.
3. **Calling their office extension**

When to call FROSS/FROCS Over the course of the Program students will become more competent at discerning the ethical nuances and levels of risk associated with various clinical issues or client situations. Developing this competence will be a key part of practicum and supervision learning. There are a number of situations which require notification of a clinical supervisor. There are also a number of situations where a Therapist Intern may require supervision while in a session in order to safely complete the clients session.

As a general rule Therapist Intern will **immediately** contact a clinical supervisor (FROSS or FROCS) during the following situations:

(a) when there is strong or **imminent danger or risk to anyone** connected to the clinical work, including the client, the Therapist Intern, or any other person.

(b) when a client **discloses an incident of child abuse**, **child neglect, or child witness to violence** whether recent or not.

(c) when the therapy demands are, for any reason, **beyond the Therapist Intern's competence or ability** to reasonably meet them.

(d) whenever the Therapist Intern has breached or feels they may be at risk of breaching the CRPO Professional Practice Standards or AAMFT Code of Ethics.

(e) When clients arrive for sessions in constellations that are unfamiliar or in a condition that may jeopardize the therapeutic integrity of the clinical work

Therapist Interns are strongly advised to discuss when and how to use FROSS/FROCS with <u>each</u> clinical supervisor they begin working with.

In all emergency or risky clinical situations, Therapist Interns are only to seek supervision from a clinical supervisor. Please do not attempt to resolve the issues with a Therapist Intern colleague.

See also: use of panic buttons in Emergency situations section 8

4.4 File Meetings

Therapist Interns meet with the Client Services Coordinator regularly to review their clinical documentation and file work. In the first practicum these meetings are held weekly. In the second practicum these meetings shift to bi-weekly. By the beginning of the third practicum, these meetings shift to monthly. There are some situations in which it may be helpful for a Therapist Intern to meet more regularly with the Client Services Coordinator throughout the practica. This decision is usually made collaboratively with the Therapist Intern and the Client Services Coordinator.

The Client Services Coordinator prints a number of reports to help the Therapist-interns prepare and maintain organization of their client files. These reports include:

(1) Case Detail Carried Forward Report: This is a list of clients with their enrollment number.
(2) Service Event Report
(3) Scheduled Missing Items Report: This report informs the therapist of any outstanding service events, attendance, or session notes that need to be completed.
(4) Intern Accumulated Hours Report: This report provides a summary of total clinical hours as well as information about client caseloads.

After the Therapist Interns receive these reports, it is their responsibility to review them for accuracy. At each file meeting, the Therapist-Interns pull all of their client files and review each one with the Client Services Coordinator to review documentation and ask any questions that they may have.

4.4.1 File Day

The course outline for practicum each semester will stipulate the date by which all clinical files are to be up-to-date and complete. All client files must be in good order for the Therapist Intern to receive a passing mark (satisfactory) in the Practicum course.

File Day Preparations (1 week before File Day)

One week before "File Day" each Therapist-intern must thoroughly review all their files – both hard copy and Caseworks enrolments to ensure:

(1) Session Notes - All session notes must be reviewed to ensure that dates, session numbers, session lengths, client names (first and last), therapist names (first and last), therapist signature and page numbers are accurately completed.

(2) Initial Paperwork Forms – All initial paperwork must be reviewed to ensure these forms are all complete and up to date. Check to make sure all the proper signatures, file numbers, and dates are present on each form.

(3) Clinical Maps – Any active enrolments where there has been at least one session must have a completed clinical map.

(4) Reports: Any enrollments where there have been 2 sessions or more require a completed and signed Initial Therapy Agreement (ITA). Any enrollment where the second session has been attended within the last week of practicum requires an ITA to be ready by the 3rd session. This means the therapist-intern may need to prepare the ITA before leaving for their end of semester break depending on when the client's next appointment is after the break.

(5) Inactive Files- Any enrolments where there has been no activity within the preceding month and the client does not intend to book an appointment must be closed by File Day.

(6) Client Billing – Each therapist-Intern must review their client billing for each client(s) using Caseworks. Any clients with outstanding fees should be noted to the Client Services Coordinator with a plan of how the client intends to pay their outstanding fees.

(7) New Files – Any new client(s) should be called to book an appointment.

(8) Clinical Hours – Each Therapist-intern is responsible for verifying that the clinical hours are up-to-date and accurate. It becomes increasingly difficult to correct errors in this area once a new semester begins.

Each Therapist Intern arranges a meeting with the Client Services Coordinator on File Day. The Therapist Intern brings all their hard copy files to this meeting. They show the Client Services Coordinator all of the work that was to be completed for File Day. Once the Client Services Coordinator is satisfied that all files are complete, s/he will notify the Practicum Instructor that all clinical documentation requirements have been met for that Practicum.

4.5 Preparing for supervision

Supervision may focus on:

- a review of specific clinical work
- specific clinical issues
- emerging themes in the clinical work
- application of model and theory
- the interface between the personal and the professional and the safe and effective use of self.
- addressing therapist interns concerns, questions or areas of "stuckness" or challenge.
- Intersections of social location, power and diversity in clinical work

4.5.1 Arrive Prepared

Therapist Interns are expected to take time to prepare for supervision by reviewing digital recordings, reflecting on clinical work and skill development; model application and systemic thinking. Therapist Interns are expected to come to supervision ready and prepared to discuss their clinical work – progress and areas for continued development.

Supervision focus and practice will vary depending on the Practicum level and the Practicum Supervisor. It is important to know and understand the exceptions and particular focus of each practicum supervisor. Each Clinical Supervisor will outline specific practices required for supervision materials/documents for the semester materials

4.5.2 Standard expectations for supervision

Selecting tape: previewing and selecting relevant segments of digital recordings and developing questions to focus the supervision discussion

- **Supervision Form:** Therapist Interns fill out a "supervision form" for each clinical file discussed in scheduled supervision. This form is intended to help focus and guide

the supervision conversation. The Therapist Intern makes two copies of the completed supervision form (one for the supervisor and one of the supervision partner) and brings these to scheduled supervision. Note that the supervision form used by the Practicum Instructor and the Director of Clinical Training may be different. Be sure to use the form that corresponds with the appropriate supervisor. Note: the supervision form is NOT part of the Clinical Record. However given it holds client identifying and confidential information, the forms must be kept in accordance with the safe storage of files and must be shredded when no longer required.

- **Client Supervision Form** (*Form A-32)*

Each client file must be discussed at least once per semester with the clinical supervisor. Each time a client file is discussed in any form of supervision (scheduled; ad-hoc or FTROCS/FROSS) an A-32 form must be signed by the supervisor. Therapist Interns are responsible for ensuring an A-32 form is filled out for each client file and ensuring that it is signed by the appropriate clinical supervisor. For how to complete the A-32 form click here

- **"Map" of Clinical System** (*Form A-19A)*

Interns must bring a clinical "map" to all regularly scheduled supervision session and whenever possible for ad-hoc supervision. The Clinical Map for A-19A is a part of the Clinical Record. For how to complete the A-19A click here

4.6 Safe and Effective Use of Self

The CRPO recognizes that the Safe and Effective Use of Self (SEUS) is a defining competency in clinical practice. Click here for CRPO definition. Therapist Interns are required to inform the Director of Clinical Training and Clinical Supervisor whenever events occur in their lives that might interfere with their abilities to work ethically and professionally with clients. These include, though are not limited to, times when the Therapist Intern is:

- experiencing high levels of stress,
- expected or unexpected losses,
- expected or unexpected difficult transitions in personal circumstances or family-life,
- the experience of traumatic events,
- unexpected disruptions in support networks or community of concern

- feeling significantly impacted by or a parallel in clients presenting problems or challenges.

The Director of Clinical Training and/or the Clinical Supervisor will work with the Therapist Intern to either:

- help monitor the concern and consider how the therapist Intern can best continue to serve clients safely, effectively and with competence.
- Develop a plan with the therapist Intern to take the time needed to deal with life's circumstance, while ensuring continued service to clients in their best interest.

4.7 Supervisors' Consultation Meetings

Each term the Director of Clinical Training, Practicum Supervisor, CSCC, and available clinical supervisors meet for bi-weekly to consult about various aspects of clinical work and practice. The meetings include

- Review of clinical and supervision hours accumulated by therapist Interns.
- Discussion of on-going clinical work, particularly complex situations or ones that may involve risk, reporting obligations or have legal implications.
- Consultation and discussion about supervision decisions that may require multiple perspectives and to help ensure best practice.
- Review of Therapist Intern progress toward meeting learning outcomes, professionalism as well as any other issue or concern that may constrain a therapist intern from providing ethical, safe and effective service.

In addition, the Practicum Instructor Supervisor and the Director of Clinical Training consult regularly about specific clinical files or to discuss Therapist Intern's clinical work, learning progress and to coordinate application of the model into supervision practices.

4.8 Procedures for Addressing Difficulties between Therapist Intern and a Clinical Supervisor

CFT supervisors will always work with a Therapist Intern to ensure adequate supervision is available for all the clinical work being done by the intern. This is essential to ensure the best possible services to our clients.

In the event that a Therapist-intern experiences difficulties in a particular practicum with a the clinical supervisors, the following procedures apply:

1. Attempt to raise the difficulties with the Clinical Supervisor.

2. If the difficulties are not redressed and difficulties continue, or if the Therapist-Intern does not feel comfortable raising the difficulties directly with the clinical supervisor, the intern can bring the difficulties to the attention of the Director of Clinical Training, Academic Program Director or another CFT supervisor.

3. Once the difficulties have been raised with a third party, that person will meet with the Therapist-intern to discuss the difficulties and determine what course of action is feasible or options available. A meeting may be arranged where the three people will discuss the difficulties and explore possible alternatives to resolve the difficulties.

6 Using V-Cap and Caseworks

Background

Digital recordings of client sessions are a condition of service for clients and a mandatory component of clinical training for therapist interns. All client sessions are recorded in the digital system using V-CAP (Video Capture System). Audio-recording is acceptable in rare circumstances, but needs **prior approval from the clinical supervisor.**

In accordance with CRPO standards, all electronic records containing a client's personal health information are protected by a user ID and password and stored in a secure and confidential manner.

Tampering, unauthorized use or off site access of a client's personal health information (including digital recordings) is a serious breach of professional conduct and Centre policy. Therapist Interns may only access V-cap and caseworks onsite and must maintain records in accordance with Centre policy which reflects CRP professional practice standards and the AAMFT Code of Ethics.

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6.1 V-CAP

All therapy rooms are equipped with cameras and microphones that when activated, record therapy. All client therapy sessions are recorded and the Therapist Intern is responsible for activating the recording on the web-based V-CAP system.

- V-Cap requires each user to log in with their U of G Central Log-In ID.

Once a client session has been recorded on V-Cap it is stored on a secure server where it is "processed" overnight and uploaded the next day to a unique network folder.

- Client Video network folders require each user to log in with their U of G Central Log-In ID.
- Each Therapist Intern has a folder on the network in which they view their client videos.

- Clinical Supervisors have access to all of the Therapist Interns folders and may view client sessions at any time.

DO NOT GIVE YOUR CENTRAL LOG IN TO ANY OTHER PERSON!

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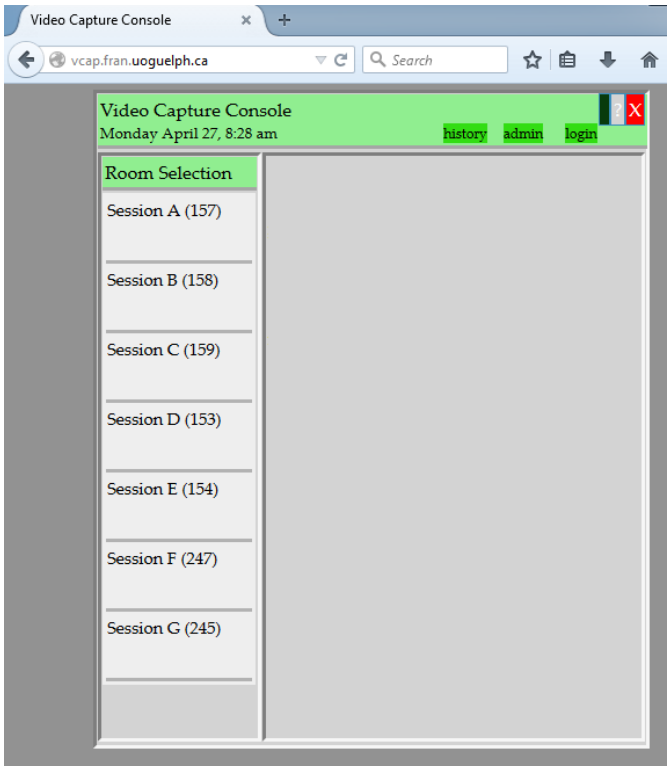
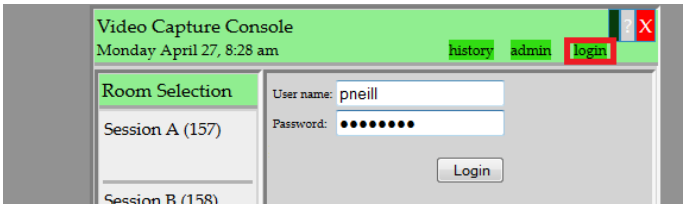
Procedures for use of the V-CAP digital recording system.

6.1.1 Creating a Session and Recording a Video

In your web browser (Firefox recommended) Browse to http://vcap.fran.uoguelph.ca click the **login** link in the upper-right of the page

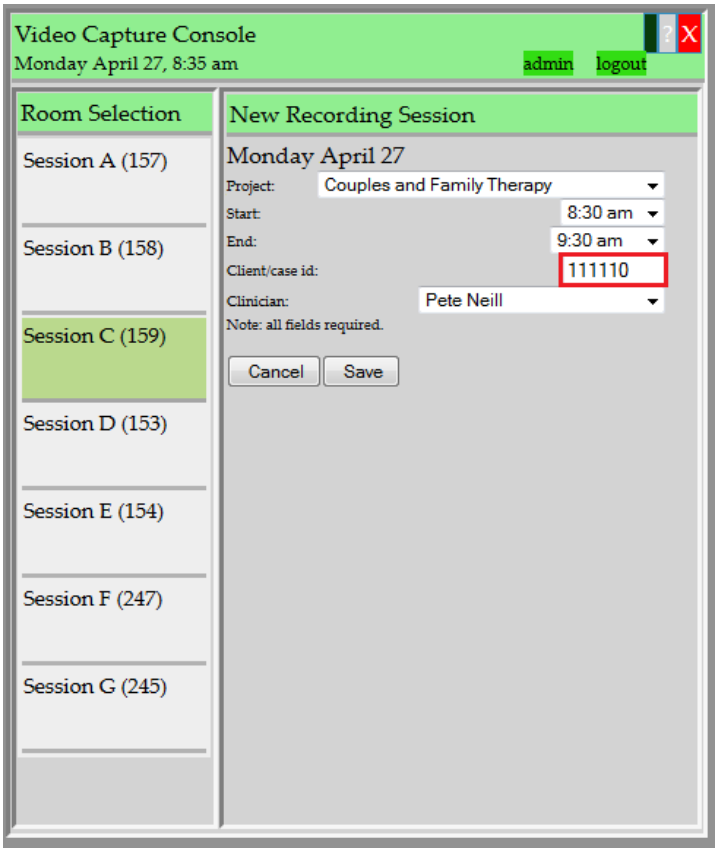


Enter your Central ID username and password

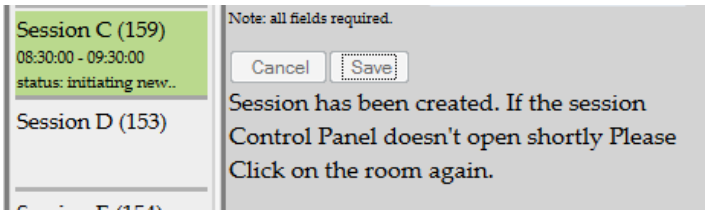


A "New Recording Session" screen will appear. Under the project dropdown, select "Couples and Family Therapy" for a typical therapy session or "Couples and Family Therapy Research" for a session that will be recorded for research and therapy.

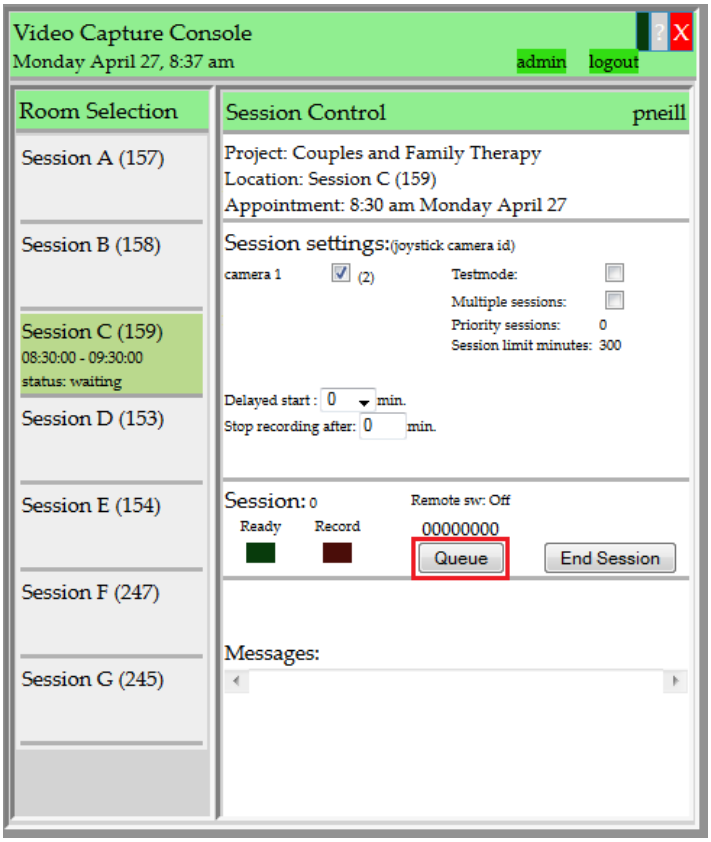
Select an approximate start and end time and enter a case id (typically the client #). Make sure the correct clinician is listed in the dropdown menu, then click **save**.



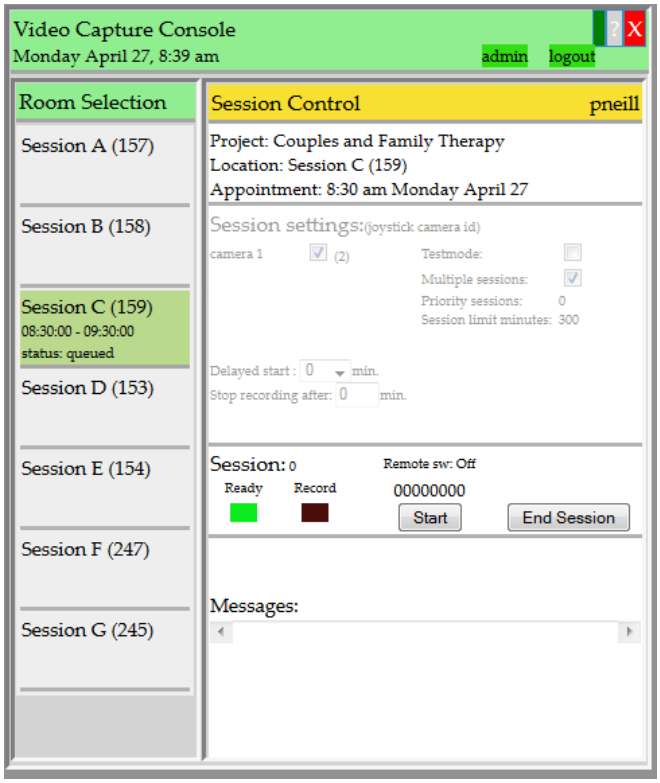
It will then take a few seconds to initialize the recording, while it is initializing, you will see this message



Once it is initialized, you will see the **Session Control** screen. Clicking the Queue button will tell the service that a recording is ready to start.



Once it is queued, the green ready light on both the web console and the physical panel in the Session room will be lit, indicating that it is ready to start. You can now log out of the web console.



When the switch is moved from the **Off** (down) position to the **On** (up) position, the red **record** light will turn on, indicating that it is now recording.

If the switch was already up before queueing the session, flip the switch down, wait at least 2 seconds for it to register the change, then flip the switch back up, it will then begin recording.

Once the therapy session is complete, be sure to stop the recording, otherwise it will continue recording on its own. Just flip the switch back down and the recording will stop, indicated by the red **record** light turning off. The video will appear in your network drive by the following morning, when it is finished being processed.

6.1.2 Accessing the videos

Windows

In the header bar in Windows Explorer, type (or copy/paste) the following:

\\cft1.fran.uoguelph.ca\homes or \\cft1.fran.uoguelph.ca

After several seconds, a prompt will show, asking for a username and password

Enter cft1\[your central id] for the username and your central account password. It will then open a folder where your videos will be stored.

Viewing Client Videos

Client video is viewed in the Computer Room (161) using headphones.

Copying, downloading or showing video to anyone not assigned to the file is strictly prohibited. Such actions constitute a breach of professional conduct and to client confidentiality and will be dealt with according to policies outlined in this manual.

Videos are automatically deleted from your folder after 15 days.

Equipment Malfunction

Any AV equipment problems must be reported immediately to the Client Services Coordinator. It is most effective to do this by sending an email that copies the rest of the staff, faculty and Therapist Interns so that everyone is aware that the problem has been reported. The Client Services Coordinator will keep everyone up-to-date on plans to repair malfunctioning equipment.

6.2 CASEWORKS

6.2.1 Client Database Management System

Caseworks is an electronic web-based client data management program that is the secondary method of storing client information (Yellow physical file is the primary method).

Caseworks Log In

Caseworks is password protected with a unique Log in ID and password for each user.

DO NOT GIVE YOUR CASEWORKS LOG IN TO ANY OTHER PERSON!

Commented [KS3]: Box this

Caseworks is used for: Scheduling client appointments, storing client information and running statistical reports by the Administrative Team.

6.2.2 Client Information in Caseworks

Caseworks contains information not found in the yellow client file: a record of scheduled sessions, client attendance (including cancellations and no-shows) and client billing information.

In addition, the electronic record contains contact information, scanned copies of hand-written session notes, scanned copies of any clinical maps, out-of-session notes, consultation decision records, client summary reports, records of ancillary contacts with other professionals on behalf of the clients, letters sent to clients, a record of referrals made by the Therapist Intern.

All documents created in Caseworks are printed off and put in the yellow physical file.

6.2.3 How to use Caseworks

During Practicum I, Therapist Interns receive training on how to use Caseworks. The Client Services Coordinator is responsible for the administration and training on Caseworks. A Caseworks Training Site is used for this purpose.

6.2.4 Caseworks Malfunction

Any Caseworks problems should be reported to the CSC right away via email, copying your colleagues. CSC will report back progress on resolutions to the issue.

7 Seeing Clients and Documentation: The First Session

Before reading this section, please ensure that you have read and understand Section 4 on Confidentiality and Consent.

Remember information in this manual referenced across sections, it is not repeated in each section.

Background

The overall responsibility for the appropriate maintenance of client files and documentation is shared by the Client Services Coordinator, Director of Clinical Training and Clinical Supervisors. However, given that this is a training centre there is a clear expectation that Therapist Interns will take on increasingly more responsibility for the appropriate maintenance of client files and documentation. As always, if you are unsure about what to do - **CONSULT**.

This section provides a detailed description of the Therapist Intern's responsibilities regarding clinical documentation file maintenance and as quick reference guide for on-going work with clients.

7.1 FILE FUNDAMENTALS

7.1.1 Maintaining Clinical Records

The CRPO Professional Practice Standards states that "secure and appropriate record keeping is essential to good client care". [1] Maintaining good, clear and complete clinical records is a fundamental aspect of a Couple and Family Therapists Professional Practice. Clinical records include:

- Documentation of all client contact (session notes; phone calls; reports; administrative forms; etc).
- Documentation of discussions or decisions made about the client (relevant FROSS/FROSC calls; Consultation Decision Record (CDR); conversations with

[1] http://www.crpo.ca/home/professional-practice/standards-regulations/#Professional Practice Standards for RPs

allied professionals or circle of care* (eg: FCS, family doctor etc)
- Appointment records
- Financial records

Given the complexities of electronic filing the CFTC is not currently able to maintain a complete electronic file. As a result the CTFC maintains both an electronic and paper copy of the clinical file (yellow) for EACH client constellation. Given that the yellow file holds all original copies clinical documents (reports, session notes, consent forms etc) the yellow file is considered the primary file or clinical record. However, both yellow and electronic files are susceptible to a request for review by a client, court subpoena, accreditation review, or College investigation.

As noted in Section 4, we have a legal and ethical obligation to protect both the confidentiality and privacy of client files.

- Resource: Section 4 Consent and Confidentiality

7.1.2 Yellow File

The yellow file is maintained in accordance with Centre Policy, AAMFT code of ethics and meets the record keeping standards set by the CRPO. The yellow file contains:

- all original documentation signed by the client(s) and Therapist Intern,
- client contact, attendance and payment information as recorded in Caseworks,
- original hand-written session notes
- printed copies of the Clinical Decision Record (CDR) and the rarely used out-of-session note or consultation note
- clinical maps
- printed copies of (non draft) client summary reports created in Caseworks and signed by the Therapist Intern(s) and Clinical Supervisor.
- any record of ancillary contact with other professionals on behalf of the clients
- correspondence sent to or received from the client or on behalf a client (legal request).

Since 1979, the CFTC has used Yellow or Orange file folders to house the Physical file. Given our strict adherence to confidential and the protection of client information, these colours are used exclusively for Centre Clinical Files. Yellow or Orange file folders **may not** be used within the Centre for any other purpose (personal, professional or academic).

The Yellow file is considered the PRIMARY client record, and the Electronic file the secondary one.

- See CRPO standard 5.0 on Record Keeping and Documentation http://www.crpo.ca/wp-content/uploads/2014/11/CRPO-Professional-Practice-Standards.pdf

7.1.3 Caseworks - Client Database Management System

Each enrolment record in Caseworks contains basic client contact information including:

- a record of scheduled sessions,
- client attendance (including cancellations and no-shows),
- client reports (ITA, RTA, FTR),
- scanned copies of any clinical maps included in the hard copy file,
- scanned copies of hand-written session notes,
- Clinical Decision Record (CDR) and the rarely used out-of-session note or consultation note
- records of ancillary contacts with other professionals on behalf of the clients, letters sent to clients,
- documentation of referrals not noted elsewhere
- record of fees and payments.

7.1.4 Confidentiality of Files

As noted, confidentiality is the corner stone of the profession and central to the record keep practices of the Centre. While we do work as a team and client information can be shared among team members it is only shared when it is clinically or operationally relevant to do so. The following people hold varying degrees of access to clinical records:

Client Services Coordinator – can access to any file
Director of Clinical Training – can access any file
Clinical Supervisors - generally has access to files under their supervision though may have access to files not under their supervision on an as need basis
Reception Staff – has access to all clinical files for administrative purposes only
Intern Therapists – has access to the enrolment files of their own clients (or clients they share in co-therapy).

Therapist Interns are **prohibited** from having access to any file (electronic or yellow) for any client not assigned to them, without the express consent of a clinical supervisor. Doing so is considered a violation of confidentiality.

7.1.5 Storage

The yellow file for each client enrolment is kept in a locked file drawer in the Client Services Coordinator's locked office at the CFT Centre. All files must be returned to the CSC's cabinet after two days. Files not stored in the CSCS office must be stored in the students' confidential storage closet.

Clinical documentation that identifies clients must never to be left unattended on desks, in the lounge, computer room desks or desk drawers - not even locked desk drawers. Doing so is a breach of confidentiality and may constitute professional misconduct.

- It is the responsibility of the Therapist Intern to ensure all draft or final copies of reports are kept confidential while in preparation.
- Under no circumstances are clinical documents to be saved to the hard-drive of the computers in the CFT Centre, a student's portable computer or USB drive, or distributed by e-mail. Doing sis a breach of confidentiality and may constitute professional misconduct.
- In the event that Caseworks is not functioning, Therapist Interns will not be able to work on clinical documentation.

7.2 NEW FILE ASSIGNMENTS AND CO-THERAPY

7.2.1 Distribution of New Client Enrolments

The Director of Clinical Training reviews and assigns new client enrolments to Therapist Interns. New client files are distributed based upon:

- the overall work-load of each Therapist Intern
- where a Therapist Inter is in relation to target hours
- equity of opportunity (different configurations, diversity, clinical issues etc.).
- skill and competency needs and abilities of the therapist Intern.

The DTC consults regularly with the other Clinical Supervisors and with Therapist Interns to inform this decision making.

7.2.2 New Client Enrolments

1. New file assignments are placed in the administrative Therapist Intern's mail folder once the file has been assigned by the DCT.
2. If the Therapist Intern has a conflict of interest that prevents them from working with the clients or has another reason that they believe prevents them from working with the

newly assigned clients, the therapist Intern must speak with the Director of Clinical Training.

3. **Declined Enrolments must be returned immediately** to avoid unnecessary delay in providing the client with service.
4. **Clients are to be contacted within 24 hours of receiving a file.**
5. After a review of the file and the client has been contacted, the file is returned to the Files for Filing folder in the mail cabinet. **The file should be submitted within 24 hours**. The client information needed to contact the client can be accessed in Caseworks.

7.2.3 Co-therapy

Two Therapist Interns working with a couple or family system is a common CFTC practice. The Director of Clinical Training assigns co-therapy files and identifies one of the Therapist Interns as the file "Administrator".

The Administrator of the File is responsible for:

- Reviewing the file with the co-Therapist Intern and organize mutually agreeable appointment times to offer the potential client(s)
- Organizing any needed or required consultations with the assigned supervisor.
- The initial and subsequent telephone contact with the client(s).
- All file documentation.
- Both Therapist Interns sign session notes, formal reports and other relevant documents.
- When the file is discussed in supervision or on an ad-hoc basis both therapist interns should be present. This helps to ensure that both therapist interns and the supervisor are on the same page with any suggestion or direction for therapy with the clients.

7.2.4 Family & Children's Services Involvement

Family and Children's Services (F&CS) are often involved with clients (individuals, couples or families) and it is most often helpful to have contact with the F&CS worker. Whenever F&CS is actively involved in the life of a client the therapist Intern must obtain written consent to have contact with the F&CS worker.

Contact could include:

- Confirmation of an open file with F&CS
- A telephone conversation with the F&CS worker regarding coordination of services
- An F&CS worker attending a session with a client to better understand the agencies concerns as well as its goals and hopes for therapy.

- In this situation it is generally best for the F&CS worker to attend within the first 3 sessions.
- An F&CS worker should attend the first or second session whenever a client has been mandated by the agency to attend therapy.

Therapist Interns must notify the clinical supervisor whenever F&CS is currently involved or has recently been involved with a client. Decisions on which contact option is best will be made in consultation with the clinical supervisor.

7.2.5 Initial Phone call to client after receiving file

- Check enrollment to see if F&CS is involved, if so see above procedure
- Check enrollment to see if you need to consult with a Clinical Supervisor before calling
- If it's a co-therapy session, get available appointment times from your co-therapist
- Call the client using the phone number recorded in the Caseworks enrollment in the yellow client file
- Remember the "Phone Call Fundamentals" from FRAN 6160!
- As soon as the client agrees to the appointment, book it in the Caseworks Schedule. First sessions are 90 minutes, follow up sessions are typically 50-60 minutes
- Remind the client of the cancellation policy, and to call x56426 in order to cancel
- You're ready to go!
- If you didn't get a hold of the client, record the phone call in your Telephone Log and try again at another time. Remember, it's OK to leave a message for the client unless otherwise directed in the enrollment.

7.3 PREPARATION FOR THE FIRST SESSION – BEFORE THE CLIENT ARRIVES

7.3.1 Required Documents to take into the Therapy Room:

- Mandatory Consent Forms (see below)
- Supplementary Forms if required (see below)
- Session Notes (see below)

7.3.2 Mandatory Consent Forms

- Pull all of the relevant consent forms for each client. Below is a primer on the consent forms that are required and the supplementary used depending on the enrollment detail.

All Clients over the age of 12 and who are deemed to have capacity must Consent to receiving Therapy Services as outlined in the Terms of Service by signing a Consent Form C-2.

Terms of Service (Form C-1 2016)

Consent Forms must be signed before any discussion with clients about the concerns that brought them to therapy.

Fee Agreement (*Form A-2)*

Supplementary Forms, Unique to each clinical situation

Consent to Contact Referral Source (*Form C-5)*
The client may consent to having a thank you letter sent to the referral source and, if they wish, to having their Final Report sent at the end of therapy.

Session Notes (excluding Walk-In Clinic - see section 18)
Session notes are found in the therapy rooms, and are an integral part of the therapeutic process. The session notes are hand-written at the end of the session and copied for the client.

- **Session Notes have to be written in black ink!**

All session notes will include:

Item	Description of Item
Enrolment #	• Write the client's enrolment number
Session Number	• Write the session number
Session Duration	• Initial sessions are 1.5 hrs • Other sessions are 1.0 hrs • Hours are calculated in 15 minute intervals (i.e. 0.25)
Client Name	• First and last names of everyone present
Therapist Name(s)	• First and Last Names
Team Members	• To be included when conducting reflecting teams
Date	• Date of session
Date of next Session	• Include the date of the next session or TBA if not finalized
Session Summary	• Main themes discussed • Client's preferred direction, plan of treatment

	• Commitment to statement of purpose/goals re:therapy • Future possibilities for therapy • Contact with others (family members, community, other professionals)
Client Comments	• How was the session "helpful" • Unique outcomes/exceptions & their meanings • Noted changes (beliefs, attitudes, behaviors, interactions)
Therapist Comments	• Main themes discussed • Unique outcomes/exceptions noted • New information regarding resources and/or risks • In cases of co-therapy, both therapists offer their own comments for the note.
Therapist Signature	• Therapists sign the bottom of the session note
Page Numbers	• At the bottom right hand side of the page

After you've pulled all forms the following steps are recommended:

- Scan your booked therapy room to ensure there is enough seating, a clipboard, session notes, and adjust the temperature etc.
- Turn on V-CAP, greet you client and begin!

After the First Session Ends

- Client pays the agreed fee at the Front Reception Desk.

  CRPO standards request compliance for Therapist Interns to issue invoices, bills and receipts that are accurate[2].

Therefore it is IMPERATIVE to not process a payment before client has handed you the payment, and to change the default name on the receipt from RECEPTION to the name of the Therapist Intern.

Two copies of the receipt will automatically be printed.

One copy will be given to the client. Because printing errors have been known to occur (i.e. reprinting of the receipt for the previous client), **it is imperative that the Therapist Intern verify that the name on the receipt they hand out is correct.**

See Section 17 Accounts Receivable Process for detail.

[2] CRPO Professional Practice Standards for Registered Psychotherapists

Re-negotiating Fees

There may be times when clients request their fee be changed as a result of a change in their financial situation. Therapist Interns have the ability to lower a client's set fee by $10.00; larger reductions are submitted to a Clinical Supervisor on the Fee Reduction (A8a) form. Once approved please submit the form to the CSC.

If the Client Does Not Pay

Clients may not be able to pay for the session at the time it occurs (forgot money, etc.). If a client does not pay for two sessions in a row they are asked to settle their account **before** another session is scheduled. When a client has not paid for two consecutive sessions, it may mean that a fee reduction in in order. The Therapist Intern **must discuss any outstanding fees for two consecutive sessions with the relevant supervisor.** Whenever a client does not pay for a session, a notation must be made in the Caseworks billing.

- Another appointment is booked and recorded on the Session Note
- The agreed upon appointment is recorded on the appointment card and handed to the client
- The session note is immediately scanned at the scanner, an copied on the photocopier for the client

8 Seeing Clients and Documentation: Sessions 2-4

Background

All Therapist Interns are expected to adhere to professional best practices outlined by the CRPO and AAMFT with respect to record keeping.

Hardcopy files (yellow files) each sheet of paper should include the client's name or enrollment number, date of entry, and signature of the Therapist Intern. [1]

Electronic files (Caseworks) each entry includes the client's name or enrollment number, date and Therapist Intern's initials.

- See CRPO standard 5.0 on Record Keeping and Documentation http://www.crpo.ca/wp-content/uploads/2014/11/CRPO-Professional-Practice-Standards.pdf

8.1 MAP OF A CLINICAL SYSTEM (*Form CD-01)*

- The clinical map is a systemic tool that is created after the first session and completed no later than the third session.
- Each file requires a map, even if the clients only attended one therapy session. The map is useful for in the event the client returns to therapy.
- It is not usually shared with clients but is used primarily for supervision meetings.
- The original is to be placed in client's enrolment file. A copy of the map is also scanned and uploaded into Caseworks and a copy is provided for the relevant supervisor at the first supervision for the client system.

[1] CRPO Professional Practice Standards for Registered Psychotherapists.

8.2 INITIAL THERAPY AGREEMENT (*Form CD-02*) AND REVISED THERAPY AGREEMENT *(Form CD-03)*

New client(s) and returning clients over six months since last session: The Initial Therapy Agreement (ITA) is prepared for each client file.

Returning clients within six months of last session: Revised Therapy Agreement (RTA) is prepared.

Linked files with less than 3 sessions: The Initial Therapy Agreement is NOT required.

Linked files with 3 or more sessions: The Initial Therapy Agreement is prepared.

The Initial Therapy Agreement is ready to share with the client(s) by no later than **at the third session**.

This document is always prepared and saved in Caseworks. The first and subsequent drafts must be submitted to the clinical supervisor on plain paper for review along with the previous draft(s) showing the supervisor's notes.

The final draft is submitted on letterhead for the supervisor's signature, together with the last draft. All Initial Therapy Agreements must be signed by the Therapist Intern and Co-Therapist (if applicable) who wrote the document as well as the Clinical Supervisor.

The hard copy for the client is then printed on CFT Centre Letterhead and photocopied for the physical file.

Session 3, the client(s) review the ITA. There are two possible outcomes:

1. If the client accepts the document "as is" and no changes are required the client(s) initial the Change Goals section. A copy is made for the client after the session and the original is submitted for filing.

   The Therapist Intern "signs" the ITA on Caseworks by pressing the "Lock" button in the ITA.

2. If there are changes required the Therapist Intern will take the ITA back (no copy provided to client) to make changes. Changes are completed for client review at the

next session (session 4)

Changes are made and the ITA is returned to the Clinical Supervisor along with the client marked up copy for review.

Session 4 the client accepts the changes, follow the above instructions for client accepts "as is" and no changes are required.

If the client has a copy of the ITA and it's been "signed" in Caseworks and changes need to be made, the changes take place in an Out of Session Note and labelled "ITA Amendment"

The Initial Therapy Agreement includes:

- Identification of the clients, their ages, their relationship to each other, and, for couples, the length of their relationship.
- Background Information (family, school, work, relationships, medical / developmental histories, and other significant/related information including cultural /ethnic, and/or religious background and values).
- Issue(s) of Concern: all clients' perceptions of the problem or other basis of need
- Change Goal(s) (short and long term created in collaboration with the client(s). Include here what the client is committed to doing in order to resolve the problem.
- Stressors and Possible Risks (Include information regarding all pertinent "risk " factors such as significant episodes of mental health/illness, recent deaths in family, incidents of violence, or abuse, child abuse or neglect, alcohol and drug misuse, relevant hospitalizations, prescription drugs taken for mental health, prior suicide ideation and/or suicide attempts, self-harming or other risky behaviours, current and/or prior criminal record, etc.)
- Resources and Supports: Include client's internal strengths and resources as well as information regarding current involvement with other mental health or social service professionals and informal supports, and how they might be used. Known previous relevant services received by the client within the previous two years should also be documented here.
- Therapist Comments is the section of the Initial Therapy Agreement where the Therapist-intern is required to use professional judgment and offer recommendations as appropriate. In the case of co-therapy comments from both therapists separately are included. The comments must include:

    - Areas of strength, resources, resilience
    - Areas of challenge and/or struggle

- Growing edges and new strategies to be considered
- Balance of risk and resources, and whether there is a high level of concern.

While these comments clearly reflect the therapists' views/opinions, they are centered on the client(s), not on the therapist-intern.

- Therapy Plan: Include:
    - the frequency of sessions [weekly, bi-monthly, etc]
    - that the therapy work will be reviewed prior to the 10th session to determine next steps
    - any plans for contacting and liaising with other professionals who are already involved (e.g. Family Physician, F&CS, CMHA, substitute decision maker, priest, etc.)
    - which persons/agencies the clients have given their consent for the therapist to communicate with.
    - recommendations made for the client to access additional resources (e.g. an addictions assessment at CADS, a psychiatric or psychological assessment, etc.)

Initial Therapy Agreements are to be **brief**, usually 3 pages. The client enrolment number is required on every page.

8.3 ADDITIONAL DOCUMENTS

8.3.1 Suicide Risk Documentation CD-10

- Completed by hand by the Therapist Intern, submitted for signature by the consulting Clinical Supervisor and client constellation Clinical Supervisor (if not the same)
- Scanned for uploading into Caseworks and submitted into Scanned Documents Folder

8.3.2 Safety Plan CD-11]

- Completed by hand by the Therapist Intern and client in session
- Photocopy of signed plan is provided to the client after the session
- Scanned for uploading into Caseworks and submitted into Scanned Documents Folder

8.3.3 Out of Session Note CD-08

- Completed by the Therapist Intern directly in Caseworks
- Electronically "signed" in Caseworks and prints a hardcopy
- Submitted into the Scanned Documents Folder for filing

8.3.4 Consultation Decision Record (CDR) CD-12

- Completed collaboratively with the Clinical Supervisor directly in Caseworks
- Dynamic document may have multiple entries
- All persons (therapist Interns and supervisors) entering information must date and type initials after their entry. This constitutes an electronic signature.
- Upon file closing, the Therapist Intern electronically "signs" in Caseworks and prints a hardcopy
- Submitted with yellow file upon file closing

8.3.5 Letters to Clients or other Professionals

- Completed by the Therapist Intern directly in Caseworks
- Drafts are sent to Clinical Supervisor for edits, once complete all Therapist Interns and Clinical Supervisor sign the hard copy
- A photocopy of the letter with signatures is copied for the yellow file
- The electronic document is electronically signed in Caseworks by the Therapist Intern
- Therapist Intern requests an envelope for mailing letter from Reception, places letter in outgoing mail tray

9 Seeing Clients and Documentation: Sessions 5 to File Closing

9.1 CONTINUATION OF THERAPY BEYOND 10TH SESSION

Although this kind of review of goals and client change happens throughout the therapeutic process, it is conducted in a more formal and focused way as clients approach their 10th session.

If therapy beyond 10 sessions is indicated in order for the client to achieve or continue working to achieve goals the Therapist Intern discusses this with the Clinical Supervisor **before** the 10th session. It is ideal to raise discussion in supervision when the client has had the 8th session.

- In the discussion with the Clinical Supervisor prior to the 10th session, the Therapist Intern talks about the therapy with the client to date.
- The Clinical Supervisor will approve sessions or provide guidance on how to end therapy with the client.

Reviewing goals in this way provides opportunity to reflect on the clinical work to date and consider ways to clarify goals, refocus or adjust the direction of therapy.

Session 10 the Therapist Intern discussed future therapy plans with the client and documents the goals in the Therapy Session Note. The client initials the goals on the session note.

Session 20 follows the same procedure as Session 10.

9.2 FILE CLOSING

Decisions about when the therapy work with any particular client will end are usually made through a collaborative process.

9.2.1 Client has been Attending: Planned Ending

- The appropriate closing report is written. See below for guidelines on Closing Reports.

- The file is audited by the Therapist Intern for completeness. All documents have been printed off (CDR, Out of Session Notes, Letters, Consultation Notes) and "Signed" in

Caseworks. Service Events are accurate, payment is up to date.

- The Closing File Checklist (*Form A-25*) is completed by the Therapist Intern and enclosed in the physical file. The file is placed in the Files Closing folder in the mail cabinet.

- In special circumstances (Therapist Intern on leave, or going to Externship) the client is transferred to a new Therapist Intern. This is considered on a case-by-case basis in consultation with the Clinical Supervisor or Director of Clinical Training. The procedure for the transfer will be communicated by the Clinical Supervisor or Director of Clinical Training to the Therapist Interns at that time.

9.2.2 Client has been Attending: Unexpected Ending

In cases where there is **no clear ending session,** but the client does not book a subsequent session or misses the subsequent booked session resulting in the possibility that a file will become inactive (no sessions for 4 weeks) the procedure is as follows:

- The Therapist Intern attempts to make contact with the client (either by telephone or by mail) to inquire about the client's intention to return for further therapy sessions.

- If the client does not respond or responds but does not wish to book an appointment for several weeks, a closing report (Final, Initial Final or Closing Summary) is prepared **within 4 weeks** and the enrolment is closed. The client is invited to return to therapy at any time.

- The Closing File Checklist (*Form A-25*) is completed by the Therapist Intern and enclosed in the physical file. The file is placed in the Files Closing folder in the mail cabinet.

9.2.3 Client does not Attend Initial Appointment

Occasionally a client does not follow through after intake. In this event, over the next 10 business days, the procedure is as follows:

- The Therapist Intern tries to contact the client on two occasions, leaving messages requesting that the client return the call.

- A third and final message is left indicating that the file will be closed if the client does not contact the Therapist Intern within the next week.

- If the Therapist Intern is unable to leave messages or speak to the client after three

attempts, an “Unable to Connect” letter is generated in Caseworks and mailed to the client. This letter is to be signed the Therapist Intern and the Clinical Supervisor.

- If the client fails to contact the Therapist Intern by the stipulated date, the Therapist Intern documents all phone calls and messages left for the client as indirect service events in Caseworks

- An out of session note is prepared in Caseworks explaining the No Case Made and printed off for the physical file.

- The Closing File Checklist (*Form A-25*) is completed by the Therapist Intern and enclosed in the physical file. The file is placed in the Files Closing folder in the mail cabinet.

9.2.4 Closing Linked Enrolments

When an enrolment is linked to an existing file and has <u>two or fewer sessions</u>, the procedure is as follows:

- Review consents, any session notes and documents, service entries and payments to ensure they are accurate

- No reports, clinical maps, or supervision forms are needed

- Complete a Closing File Checklist (Form A-25)

- Submit the enrolment for closing to the CSC with an explanatory note.

When an enrolment is linked to an existing enrolment and has <u>three or more sessions</u>, the Therapist Intern follows the regular guidelines for closing the enrolment.

9.3 TRANSFER PROTOCOL – WINTER SEMETSER

The following are procedures for transferring active clients from second year Therapist Interns to first year Therapist Interns.

Second Year Therapist Intern Ending with Client

1. The second year Therapist Intern consults the supervisor of record for the file about the suitability of a transfer.

2. Once a decision to transfer has been made an email is sent to the Director of Clinical Training with the client file number and any relevant information to assist in reassigning the file. The DCT will re-assign the file and let the second year Therapist Intern know who the new therapist will be.
3. The second year Therapist intern should discuss the transfer process with the client and can let them know who their new therapist will be and that that person will be in contact with them shortly. The second year Therapist Intern also completes a Final Report.
4. The second year Therapist Intern conducts a final session with the client.

First Year Therapist Intern Contacts with Client

1. The first year Therapist Intern makes contact with the client to schedule a first appointment BEFORE the end of the term. The appointment time needs to be coordinated with the second year Therapist Intern so that they can attend mid-way through the session for about 15 minutes. The first year therapist Intern should explain to the client the process for that first session.

The Transfer Session

2. The first year Therapist Intern and client begin the session alone. This is opportunity to begin to establish rapport, and hear a bit about the client's hopes/goals for continuing therapy. As the file is being transferred no new paper work needs to be completed nor signed by the client– however the Therapist intern should obtain informed consent from the client by reviewing the terms of service lending particular attention to fee schedule, cancellation policy, confidentiality and limits to confidentiality.
3. The second year Therapist Intern is invited to attend the session after about 20 minutes. This is opportunity for the first year Therapist Intern to interview both therapist and client about their work together. The following are some possible questions to ask:
    a. Tell me about some of the changes or gains that "client name" has made during your work together?
    b. What are some of the strengths you have noticed in "client name" over the course of your work together?
    c. What are some things about "client name" that stand out for you as they worked toward meeting their goals for therapy?
    d. What are some things you have appreciated about your work with "therapist intern?"
    e. What are some of the ways "therapist intern" has worked that you found most helpful?
    f. Is there anything you (client/therapist Intern) would like to add about your work together that you think will be helpful for "client name" and me to know?

4. Once the Interview is completed (10-15 minutes) Second Year Therapist Intern leaves the session.
5. Client and First Year Therapist Intern reflect on the conversation just held, consider next steps for therapy, write a collaborative session note and book a next appointment.

The first year Therapist Intern writes a "Revised Therapy Agreement"

9.4 CLOSING REPORTS

Final Report: Client has a copy of the ITA and has been seen for two or more sessions after receiving the ITA

Initial Final Report: Client did not view or receive a copy of the ITA

Closing Summary: Client received a copy of the ITA in their last session attended, and didn't return for anymore sessions. (No new information has been gathered)

Out of Session Note: Only used in a No Case Made closing (client never attended therapy) or closing a linked file with three or fewer sessions.

Mailing of Closing Reports to Clients
If a Therapist Intern would like the client to received copies of closing reports, upon closing a photocopy of the report with a sticky note indicating "Mail to Client" is put in the yellow file. CSC and Reception will mail the report out to the client. If no copy is made, the report will not be mailed.

The above procedure only applies to clients who have provided consent for mailing on the A-11.

Unpaid Fees at Closing
If a client has an outstanding balance upon file closing, note this on the A-25. The CSC and Reception will prepare a closing letter requesting payment of the balance and mail this to the client.

10 Client Cancellations and Phone Calls

Background

Is there any?

10.1 CLIENT CANCELLATIONS

At times clients may need to cancel a session. We ask clients to give 24-hours' notice of a cancellation to avoid being charged for the session. The procedure for receiving and processing client cancellations is as follows:

> Remember: that the telephone or in person are the only permitted methods of communication with clients.
>
> E-mail, text, skype, on line communication are not permitted.

If CFT Centre staff takes a message about a cancellation, a note will be placed in the Therapist Intern's mail folder.

> The Therapist Intern immediately removes the client appointment from the scheduler in Caseworks.

The Therapist Intern will then determine whether/when it is appropriate to call and re-schedule the appointment.

Less than 24-hours' notice: the cancellation is considered a late cancellation**.** The Centre does not bill for late cancellations if the client(s) has (have) not had an initial session. Clients aren't billed in the event of illness or emergency.

More than 24-hours' notice: the cancellation is considered a "Cancellation" and the client is not charged.

No Show: Sometimes clients miss an appointment without giving notice. As with late cancellations, with the exception of first sessions, "no shows" are billed. In cases where there are several "no shows" and "cancellations" interspersed throughout the work, the Therapist Intern should consult with the clinical Supervisor to determine how this issue should be addressed with the client.

Therapist Intern initiated cancellations: This is only done in special circumstances, such as illness, a family crisis, or the CFT Centre has been closed due to poor weather.

The following procedures are to be followed when canceling appointments with clients:

- The Therapist Intern contacts the clients directly to notify them of the need to cancel. Please make repeated attempts to contact the client to speak directly with the client rather than leave a message.

    - When calling clients from home use the *67 feature to mask your phone number, or #31# if calling from a mobile phone.

    - Therapist Interns should keep a list of client phone numbers with them. The list should only have client first names. It should not identify the clients as CFT Centre clients in any way.

    - If, after repeated attempts to speak directly with the client, a message has been left (on an answering machine or with other family members) the Therapist Intern should request that the client call the CFT Centre to confirm the cancellation.

- **The CFT Centre staff (Receptionist and Client Services Coordinator) must be notified whenever appointments are cancelled**.
- If not on campus, the Therapist Intern will ask CFT Centre staff to cancel all relevant appointments in the Caseworks Scheduler so others will be able to use the room if needed.
- The cancellation must be documented with a Service Event in Caseworks.
- Only in unusual circumstances, and with the approval of the Clinical Supervisor, will CFT Centre staff (Receptionist or Client Services Coordinator) be involved in arranging cancellations.

Cancellations Due to Centre Closure: At times, the University of Guelph may close the campus because of poor weather conditions or in cases of widespread influenza. When the university administration makes a decision to shut down, they post a notice on the University of Guelph web homepage. This information is also relayed to Guelph radio stations to release. Whenever the CFT Centre is closed during a business day, the following procedure is to be followed:

- **Closure before 8:30am announced:**
    - Therapist Interns, staff and faculty are to check the University of Guelph homepage to keep up to date on U of G closures
    - Once the Director of Clinical Training and Client Services Coordinator are notified, they will make sure all Therapist Interns, staff and faculty are aware that the university will be closing via email
    - Therapist Interns will contact their clients directly to notify them of the need to cancel appointments set for that day. The Therapist Intern must make repeated attempts to contact the client in order to speak directly with him/her rather than leave a message.

- **Closure during the business day announced:**
    - Once the Director of Clinical Training and Client Services Coordinator are notified, they will make sure all Therapist Interns, staff and faculty are aware that the university will be closing via email
    - Therapist Interns will contact their clients directly to notify them of the need to cancel appointments set for that day. The Therapist Intern must make repeated attempts to contact the client in order to speak directly with him/her rather than leave a message.
    - If a Therapist Intern is not on campus, but has clients scheduled in Caseworks for that day, the Client Services Coordinator will call the Therapist Intern and request their clients are called and notified.
    - If the Therapist Intern cannot be reached, the Client Services Coordinator or other staff member will attempt to call the clients.
    - Therapist Interns will report back to the Director of Clinical Training once they have attempted to reach their clients to let them know of any clients where contact was not possible.
    - Once all clients have been contacted (or wherever necessary, messages left) the Centre staff may leave the building.
    - The Client Services Coordinator and reception voicemail will be changed to announce that the Centre is closed due to poor weather conditions.
    - The Client Services Coordinator will put a sign on the door of the Centre to announce the Centre closure.

10.2 KEEPING TRACK OF CLIENT PHONE CALLS

Due to the need to follow best practice legal and ethical guidelines, certain phone calls will need to be noted as service events.

Times when Phone Calls will be recorded as Service Events:

- Unable to make client contact to schedule an initial appointment. These dates must also be included in your Out of Session Note in the case of a file closure and as such must be documented within Caseworks
- Unsuccessful attempts to reschedule a client
- Unable to make client contact regarding a consultation with a community professional.

Documentation of these attempted calls need to be recorded as a way of documenting our continuity of care with our clients.

11 Assessing Risk - Part 1: Suicide and Homicide

Background

The CFTC serves a vulnerable population whose life circumstances are often complex and multi stressed. Clients often attend therapy feeling the real effects of that complexity and stress with increased anxiety, depression, and sadness. Clients also often express a loss of personal agency or sense of control over life and a reduced ability to cope and manage complexity and stress.

A critical aspect of Therapist Interns training is developing the knowledge, skill and judgement necessary to assess a client's level of risk, including:

- (suicide and suicidal ideation; self -harm; substance misuse[1]; risky sexual activity etc.).
- Risk to children (includes physical, verbal and sexual abuse; neglect etc).
- Risk to others (includes homicidal ideation, intimate partner violence –IPV etc).

Therapist Interns and supervisors have legal and ethical obligations to take action ensure the safety of clients and protection of children or others at risk of harm by a client. The application of these legal and ethical obligations can be complex, and shall be made in consultation with a clinical supervisor.

Therapist Interns MUST consult with a clinical supervisor immediately when they learn that a client may be at risk – see section XX for more detail.

This section focusses on Risks to self for suicide, self-harm or homicidal thoughts.

[1] includes, alcohol, street and pharmaceutical drugs

11.1 RISK TO SELF – SUICIDE, SUICIDAL IDEATION, AND SELF-HARM

Developing knowledge, skill and judgment to assess suicide and suicidal ideation are of critical importance. When a client talks about suicidal ideation or presents as suicidal, or is feeling or presenting as particularly low, down or depressed) it is important to engage in a thorough conversation or "assessment" about this with the client. The intention in this assessment is to begin to determine the client's level of risk, paying close attention to the warning signs that may suggest a risk for suicide. The level of risk presented is one important factor that will help determine what course of action to take.

WHEN TO CONSULT WITH A SUPERVISOR

When a client talks about suicide or suicidal ideation and cannot state with a degree of certainty that they will not act upon the suicidal thoughts, the Therapist Intern **MUST** consult with a clinical supervisor **- immediately** and before the session ends.

When a Therapist Intern is uncertain how to interpret, understand or what to do next when a client talks about suicide or suicidal ideation, the therapist Intern **MUST** consult with a clinical supervisor **- immediately** and before the session ends.

When a client talks about suicide or suicidal ideation and ***is*** able to state with a degree of certainty that they will not act upon the suicidal thoughts, the therapist Intern **MUST** consult with a clinical supervisor at the next and earliest opportunity.

When a client informs the therapist intern that someone they know is or maybe in imminent risk of suicide, the Therapist Intern **MUST** consult with a clinical supervisor **- immediately** and before the session ends.

When a Therapist Intern is unsure or in doubt about a client's safety or is receiving mixed messages from a client about the clients safety the therapist Intern **MUST** consult with a clinical supervisor **- immediately** and before the session ends.

The need to engage in a thorough conversation and assessment of a client's risk to self could occur during a session or between sessions if speaking with the client on the phone. In the

event that the discussion occurs while on the phone it is critical to get the geographical location of the client. This is important in case:

- the call is disconnected for whatever reason and the client cannot be reached on recall
- the Therapist Intern receives information to warrant calling 911 and dispatching police or ambulance.

11.1.1 Assessing Suicide Risk

> In reviewing the procedures for assessing risk in this section, Therapist Interns should refer to the suicide risk assessment form CD-10.

The information provided here is intended as a supportive resource to information and practices learned in Practicum or Supervision. It is important to have on going discussions with clinical supervisors about different ways to assess, explore, and ask questions about both depression and suicidal ideation. Asking questions or gathering more information about risk or suicidal ideation or planning is always an iterative process. That is, a process of asking, re-asking or asking questions differently in order to gather sufficient information for the Therapist Intern and Clinical Supervisor to adequately assess risk or factors that may contribute to risk.

11.1.2 Warning signs of potential Suicidal Ideation or intent

While these warning signs do not necessarily indicate suicidal ideation or intent, and conversely, their absence does not necessarily indicate that the person is safe from suicide. All responses need to be taken in context of the client's current circumstances, presenting problems, resources, and family history and always in consultation with a clinical supervisor.

(Warning signs are listed in no particular order)

- Serious mental illness
- Serious addiction
- Family or friend group history of suicide
- Previous suicide attempts
- Serious chronic or life threatening physical illness, especially if it involves serious chronic pain or loss of daily functioning
- Impulsive behavior
- Lack of family or other social supports
- Withdrawal from family, friends or interests

- Access to weapons, medications or other means of suicide
- Direct and indirect expressions to self-harm
- Expressions of hopelessness, helplessness, or purposelessness
- Intense feelings of feelings of shame, embarrassment, guilt or remorse
- Neglecting self-care
- Giving away prized possessions and/or making a will out of context

General questions to ask to help assist suicide risk assessment: (Note: These would need to be revised for work with children and adolescents).

When assessing risk of suicide the following is a non exhaustive list of important areas to as questions about that will help determine the course of action to take and help aid in consultation with a clinical supervisor.

- Current circumstances that lead to feelings of helplessness or hopelessness
- Whether a person is having suicidal or self-harm thoughts
- What is the severity, intensity, and frequency of those thoughts
- What is the likelihood the client plans on acting on the suicidal thoughts today or in the next few days
- Does a person have a plan and the means to carry out the plan
- What or who are the resources in the client's life and what is their willingness and ability to access those resources.
- What if any non suicidal future planning does the client have and or is looking forward to (Im going to a friend's cottage this weekend; a particularly event that is forthcoming they want to be at etc).

A non-exhaustive list of question to ask to help access suicidal thinking:

- Sometimes when people feel really down (get into difficult situations) they think of not wanting to live. Have you had any thoughts like that?
- When you say that you can't handle this anymore, what do you mean by that? Have you had thoughts about hurting yourself or suicide?
- (If yes) when was the last time you had those thoughts?
- (If within the past weeks) How often have those thoughts been on your mind in the past weeks? When was the last time you had those thoughts?

- Is there any kind of plan in those thoughts about wanting to die?
- In thinking about suicide do you have a plan for how you would do it? What is the plan? (Follow up with questions of clarification)
- Have you been influenced by those thoughts to begin to act on the plan?
- Do you have the means to act on the plan. For example if a person said they were going to shoot themselves it would make sense to ask if they had access to a weapon.
- If you were to act on this plan when do you think or imagine you would do that?
- What other thoughts do you have that would tell you not to act on the plan?
- Who or what helps you to want to live?
- If you compare the part of you that wants to live with the part that wants to die, which part is strongest now?
- Does the want-to-live part of you have a plan that has kept you safe from killing yourself?
- What are you going to do when you leave here? What plans do you have for tomorrow, the weekend etc?
- You knows about these suicidal thoughts? Who are the people you can turn to help you?

Sometimes clients talk in less direct ways or speak in metaphor or riddle. While it is often best to clarify the meaning of what is being said, this is particularly true when working with clients who are affected by depression or may be at risk for suicide or self-harm.

If a client makes statements that allude to suicide, regardless of how vague or indirect they maybe, *always* **ask more questions and gather more information.**

Examples of statements that may allude to suicide:

- "I feel like going off into the night to find peace"
- "I feel like not wanting to live
- "there's nothing left to live for"
- "If I had a gun, I might not be here"
- "If a truck ran into me, it would not matter"
- "[People] would be better off without me"
- "Wish I lived on the 10th floor, it would be a longer fall"

11.2 SAFETY PLANNING

Safety planning is an important part of helping reduce client's level of risk. Safety planning is used with clients who:

- Are currently having suicidal thoughts
- Have had previous suicide attempts or plans, and when there is a reasonable risk the thoughts may return.
- Is not at risk for suicide per se, however is at risk for other types of self-injury including cutting, misuse of alcohol, street or prescription drugs; risky sexual behavior.

See forms CD -10 assessment form and CD 11 safety plan

Examples of some question to ask why creating a safety plan

- What is the safety plan you have for yourself that has kept the suicide thoughts under control so far?

- If you wanted to improve that safety plan, what would you need to do, what resources might you tap into? (E.g., call a friend/relative – make a list of these people, call the crisis line – give the number, journal, go to emergency at the hospital) [Note: As we are not a crisis centre, do not arrange for the person to contact you in the event of a crisis.].

- Let's write down that plan. I am on the side of the want-to-live part of you. I am worried that the part of you that wants to die will overpower the life-seeking part before we can have time to understand better the part that wants to die.

- If the thoughts about suicide were to return what kind of safety plan might we come up with now to keep you safe if you were to experience a crisis?

As a general rule, clients should sign any safety plan created; particularly those created using the safety plan form (CD-11). Clients should be provided a legible copy to take home. Safety plans may also be documented in session notes and initial or final reports.

When a client is at risk for suicide, the Therapist Intern completes a safety plan with the client using form CD-11. The client must sign the CD-11 form, committing to following the plan as outlined. The plan must include reference to the client one or more of the following actions in

the event that they feel suicidal:

- Call the mental health crisis/distress line HERE 24/7 at **1 844 437 3247** and openly discuss the suicidal feelings and thoughts

OR

- Inform a family member or friend about the suicidal feelings and ask them to stay until the client feels more stable

OR

- Proceed to the nearest local hospital emergency department either with a friend, family member or by calling 911 and inform them of the suicidal thoughts and that there is a risk of acting on those thoughts.

If the client is unable or unwilling to commit to this plan, the Therapist Intern *in consultation with a clinical supervisor* must decide whether it is safe for the client to leave the Centre.

11.3 STEPS TO DEALING WITH IMMINENT RISK OF SUICIDE

- ALWAYS CONSULT WITH A CLINICAL SUPERVISOR

Involuntary transportation to hospital: If the client is unwilling to be taken to the hospital the Therapist Intern in consultation with a clinical supervisor will call campus Police at extension 2000 and request assistance with a client who is suicidal an unwilling to voluntarily attend to the hospital.

Voluntary transportation to hospital: When a client states or when the Intern Therapist and Clinical Supervisor have determined that the client is at **imminent risk of suicide**, steps must be taken to ensure the clients safety and is taken to the Emergency Department at The Guelph General Hospital (519) 837-6438.

If the client voluntarily agrees to be taken to the hospital, one of the following steps is taken:

A: If the client has a trusted family member or supportive friend other who is willing able to assist the client in getting to the hospital:

1. At any time of day or night, instruct the support person to contact or to help the client in contacting the **Emergency Mental Health Services** at Guelph General Hospital to let them know that s/he will be bringing the client to the hospital for an emergency assessment due to an immanent risk of suicide.

2. The Therapist Intern will also instruct the support person that the client's Family Physician should be contacted so that s/he is aware of the situation in order to be able to offer assistance in the process.

3. The family member or friend must come to the Centre to pick the client up for transport to the hospital. The Therapist Intern will stay with the client until the person has been picked up.

B: In the event that the client does not have or does not wish to contact a supportive friend or family member the following procedures apply:

1. At any time of day or night the Therapist Intern will contact the **Emergency Mental Health Services** at Guelph General Hospital (519) 837-6438 to let them know the concerns and that the client will be coming to the hospital for an emergency assessment and possible admission due to an immanent risk of suicide.

2. Contact and inform the client's Family of the situation in order to be able to offer assistance in the process.

3. Accompany the client to the hospital and communicate concerns to the mental health triage nurse/mental health crisis worker who will assume responsibility for the client from that point.

The therapist Intern must accompany the client to the hospital by Taxi. The CFTC will provide or reimburse the taxi expense. For liability and insurance reasons, Therapist Interns are not permitted to use their own vehicles. The therapist Intern may ask a colleague to co-transport the client to hospital.

11.3.1 University of Guelph Students – suicidal

When seeing clients who are students and who are acutely suicidal and you feel require additional intervention that is beyond the scope of your service.
In those cases, it is best if you can get them to Health Service. They can be seen by our Mental Health Care Coordinator Kelli Corrigan, who can further assess, assist with care planning, case management or if need be referral to the physician for assessment of a Form 1. It is best if you can contact Kelli prior to bringing the student over. If Kellie is unavailable then Colleen Comerford (HS Clinic manager) is also available to assist. You may also contact myself or our front desk and speak with Monika Noble who can also assist in ensuring the student is seen. Here are all the contact information

Kelli Corrigan, MHCC ext 53497
Colleen Comerford, Clinic Manager, ext 58050
Alison Burenett, Director Student Wellness, ext 54333
Monika Noble, Reception SHS ext 52131 (if it is not answered, you can select 1 to get through the urgent line)

11.3.2 Using the CD-10 form

NB: consult with a clinical supervisor for most current direction on using this form.

The Therapist Intern must document all pertinent information using the Suicide Risk documentation form.

This form *(CD-10)* is used to document any conversation the therapist has with a client when the potential for suicide is a concern. This form is to be completed immediately following the session. A copy is made for the supervisor who provided the consultation as well as for the supervisor of record on the enrolment. This form is NOT to be taken into the session with the client, but rather to be completed after the session. The therapist completes all relevant parts of the form. The therapist signs and dates the form once completed, and the supervisor who provided the crisis consultation reviews and signs the document. If the supervisor who provided the consultation is not the supervisor of record, the supervisor of record also signs the document. The original signed document is then scanned for uploading into the client's Caseworks file and the hardcopy is placed in the filing drawer to be filed into the client's hard copy file. The supervisors' copies are to be placed in their mail slots immediately after completion.

11.3.3 Medication Use by Clients

Clients who come to therapy are sometimes taking prescription medication for issues they would also like to work on in therapy (ex. Antidepressant medication for depression).
At other times clients may experience the effects of serious medical/mental health conditions for which they have not yet consulted a medical professional.

If the Therapist Intern has a concern about a client's medical condition or about prescribed medication the client is taking/not taking, the Therapist Intern consults with the Clinical Supervisor to determine the best course of action.

11.4 CREATING AN INDIVIDUAL SAFETY PLAN

11.4.1 Background

Therapists should work with clients individually to create their own unique action plan for increasing their safety when there is on-going abuse or violence in the home. The Safety Plan should be documented in the client's individual file.

11.4.2 Individual Safety Plan: Possible Actions to Include

- List the behaviors that tend to precede abuse and violence and watch for these.
- Move to safer, larger place in the house when an argument begins or there is any threat.
- Plan an exit route or way out of the house that cannot be easily blocked.
- Plan where to go (friend, family, neighbour) if deciding to leave. Let these people know that you may need their help.
- Have phone numbers of support people in wallet.
- Leave if the conflict begins to escalate. Do not wait.
- Call 911 if anyone is in imminent danger.
- Have some money set aside in wallet for emergencies.
- Do not return until it is clearly safe to do so.

You can also refer to or refer clients who are being abused to this webpage for access to a helpful safety planning booklet: http://www.pcawa.org/rp1.php

11.4.3 Depression

While depression or feeling down or low are not automatic determiners of suicide or suicidal ideation, they may be important warning signs, and as such is important to explore with clients.

The following is a list of signs of depression. If a client talks about any one of these items therapist Intern should explore all the other items on the list with the client. Items should be explored until it is clear that the client is at risk of suicide or that the client is not at risk of suicide**.**

Depression warning signs

1. Depressed mood or general feeling of irritability.
2. Loss of interest in doing things and isolation form others.
3. Significant weight loss or gain, or decrease/increase in appetite.
4. Insomnia or hypersomnia.
5. Feeing restless or lethargic in day to day activities.
6. Fatigue, tired or loss of energy.
7. Feelings of worthlessness or excessive guilt.
8. Diminished ability to think or concentrate and difficulty making decisions
9. Recurring thoughts of death
10. A previous attempt or current plan for suicide.

12 Assessing Risk - Part 2: Children at Risk

Background

The CFTC serves a vulnerable population whose life circumstances are often complex and multi stressed. Clients often attend therapy feeling the real effects of that complexity and stress with increased anxiety, depression, and sadness. Clients also often express a loss of personal agency or sense of control over life and a reduced ability to cope and manage complexity and stress.

A critical aspect of Therapist Interns training is developing the knowledge, skill and judgement necessary to assess a client's level of risk, including:

- (suicide and suicidal ideation; self -harm; substance misuse[1]; risky sexual activity etc.).
- Risk to children (includes physical, verbal and sexual abuse; neglect etc).
- Risk to others (includes homicidal ideation, intimate partner violence –IPV etc).

Therapist Interns and supervisors have legal and ethical obligations to take action ensure the safety of clients and protection of children or others at risk of harm by a client. The application of these legal and ethical obligations can be complex, and shall be made in consultation with a clinical supervisor.

Therapist Interns MUST consult with a clinical supervisor immediately when they learn that a client may be at risk – see section XX for more detail.

This section focusses on Children at Risk.

[1] includes, alcohol, street and pharmaceutical drugs

Child and Family Services Act

The *Child and Family Services Act* mandates that every Ontarian shares a responsibility for the protection of children stating that "[a]nyone who has reasonable grounds to suspect that a child is or may be in need of protection must promptly report the suspicion and the information upon which it is based to a CAS" [Children's Aid Society, also known as Child and Family Services]. As providers of mental health services in Ontario, we have a legal obligation and "duty to report" known and suspected instances of a child or children who are, or may be, in need of protection.

According to the Act reasonable grounds is defined as "information that an average person, using normal and honest judgment, would need in order to decide to report".

The duty to report applies to any child who is or appears to be under the age of 16 years, or any child 16-17 years of age who is already under the protection of the CAS.

This section outlines the steps to take when an Intern-Therapist or supervisor suspect on reasonable grounds that a child is in need of protection.

> In this section and for simplicity of writing, the term "child" is intended to refer to one or more children.

It is important to note that when reporting information we are providing information that has been disclosed to us. In the vast majority of situations we only know the information as told to us by a client – we are not in position, nor is it our role to determine whether or not the information is factually accurate. This is particularly true when it comes to claims or allegations made about other people with whom we do not have contact.

12.1 CHILDREN AT RISK

Step 1 - Consult

When a Therapist-intern suspects, or has concern about the possibility that a child has suffered or is at risk of suffering physical harm, emotional harm, sexual abuse or neglect a **clinical supervisor must be informed IMMEDIATELY**. This includes but is not limited to:

- When a child is a witness (can see or hear) to violence (eg: between parents).
- Is witness to (can see or hear) ongoing verbal abuse between family members

- when a client reports that a child is not adequately supervised, and is at risk of harm
- When a client discloses abuse they experienced in childhood and there is possibility that the person who was alleged to be abusive may currently pose a risk to children.
- When in doubt consult.

Should there be doubts about the duty to report, a consultation with the F&CS can be made by relating the concerns without giving identifying information about the client(s). The F&CS intake worker will then determine whether there is a duty to report. If there is a duty to report the therapist intern will immediately report the identifying information.

If a report is to be made, the Therapist Intern(s) and Clinical Supervisor will determine how best to approach the call and whether a direct reporting or consultation is warranted.

Step 2 - Making a Report to Family and Children's Services

If the situation is to be reported, the therapist intern will make the report to the Family and Children's Services office which has jurisdiction over the child's area of residence. It is essential that the person who acquired the reportable information is also the person who calls to make the report.

- Guelph 519-824-2410
- Fergus 519-843-6191
- K-W 519-576-0540
- Cambridge 519-623-6970

When making a call to F&CS, the he Therapist-intern will document in writing the following:

- The name of the F&CS worker they are speaking with.
- The time and date the call (and subsequent contacts if any).
- Information or direction provided by the F&CS worker.
- Questions the F&CS worker asked that the Therapist Intern was unable to answer or provide information about.
- What action F&CS will/may take.

When making the report to F&CS the following information can/should be disclosed:

- Name of client disclosing the information and the relationship to the child (if the child is not the client);
- The child's name and age
- Nature and known details of the allegations
- Alleged perpetrator's name or identity
- Response of other caregiver(s)
- Assessment of current risk
- Content and outcome of discussion with client
- Date and time of report
- Name and contact information of making report
- Name and telephone number of the F&CS person who received the report
- F&CS response and follow-up to the report
- Revised case plan, if any, withdrawal of client from service if such is the case and other further follow up by F&CS
- Further action or contact stemming from the reporting

1. The Therapist-intern will report the information from the F&CS worker to the clinical supervisor, **immediately.**

2. The Therapist Intern must discuss with the clinical supervisor how/when/whether to inform the client that a report has been made.

3. If the client has provided consent, the Therapist Intern may request that Family & Children's Services give notification as soon as a follow-up investigation has been completed. This allows for possible exploration of the matter in the therapeutic process.

These procedures are based on **Bill 6**, of the Ontario Legislature. Bill 6 amended the **Child & Family Services Act**, and became effective on March 31, 2000. It is incumbent on all Therapist Interns at the CFT Centre to be familiar with the **Act** as it pertains to professionals who are not Child Protection Workers. The duty to report can be summarized as follows:

Single Duty to Report for the Public and Professionals. Under the amendments, all persons, including professionals, are included in one clause which states that they must report circumstances where there are "reasonable grounds **to suspect**" protection issues. Suspicion alone, even without evidence, provides grounds for a therapist to make a report.

Ongoing Duty to Report. If there are protection concerns, each and every incident, must be reported, even if a previous report has been made. Therapists must report **every single incident** that they become aware of, it is not sufficient to call once and assume that Family & Children's Services are addressing the concerns.

Duty to Report Directly. The person who acquires the information that is reportable "shall report **directly** to the society and shall not rely on any other person to report on his or her behalf".

Expanded Penalty for Professionals for Failure to Report. A professional who fails to report is subject to a fine of not more than one thousand dollars, BUT that person is subject to this fine for failing to report any of the child protection concerns as amended by Bill 6: Thus it applies to cases of **abuse** AND also to suspicion of **protection** issues. Bill 6 defines more extensively what is considered reportable to Family and Children's Services. The following points serve only as a summary:

1. The paramount purpose of the Act is to promote the best interest, protection and well-being of children: thus the needs of the child are put ahead of the needs of the family or parents. This may lead to issues in the therapeutic relationship, but reporting is **a legal obligation and is not optional.**

2. In addition to reporting cases where a child may be physically, sexually, or emotionally abused, there is also a responsibility to report children who may be in need of protection due to poor supervision, inadequate care, neglect, or failure to ensure the child's safety. (For example: a severely depressed parent who is unable to focus on the needs of a child.) There is an obligation to report patterns of neglect in caring for a child.

3. Only the **concern or suspicion of risk** needs to exist before a report **must** be made. It is the responsibility of the local Family and Children's Services to determine whether the case needs investigation: The therapist's responsibility is to report any concerns that a child **may** be in need of protection.

4. The definition of emotional abuse has been expanded to include the risk that the child is likely to suffer emotional harm resulting from the actions, or failure to act, on the part of the parent. This includes domestic violence, which is known to put children at significantly increased risk of abuse and to have an emotional impact on them. There is, thus, a responsibility to report any cases where there is a pattern of partner violence when there are children in the home. In some jurisdictions, the police are now reporting all cases of domestic dispute calls when there are children residing in the home. However, this does not release therapists from their own duty to report.

5. All concerns raised with respect to child protection must be documented in writing and made part of the clinical file.

6. It is the obligation of Family and Children's Services to inform a parent of any referral made to the society. Informing a parent of the therapist's intent to report may seriously jeopardize the investigation and may interfere with the protection of the child. Remember that reporting is **a legal obligation and is not optional**.

12.1.1 Prior F&CS Involvement

If it is indicated in the file that there is an "open or active file" with Family and Children's Services, the Therapist Intern asks the client to arrange for the F&CS worker to participate in the *first* session, except in the case that an assessment for intimate partner violence is being conducted in the first session. In this case the supervisor may advise the Therapist-Intern to ask the client(s) to invite the F&CS worker to attend a subsequent session. *Form A-26* is signed in that session so that the intern is able to liaise with F&CS. (See Section 5 for further information).

12.1.2 Information about Children in Danger or Witnesses to Violence/Abuse

If information emerges that there has been physical violence and/or extensive and serious verbal abuse and there are children under age 16 in the home, the therapists are required to ask whether the children have witnessed the violence/abuse. If the client says they are "usually asleep" the therapists need to ask further questions about times the children might have been awake or present. If the client discloses that children have been witness to the abuse or are themselves in any danger the therapists must **consult with a clinical supervisor immediately after the meeting with the clients regarding the need to report to F&CS.**

12.1.3 Children's Safety Plan: Possible Actions to Include

If there are children present in the home where violence or abuse is taking place the parent who is fearful about safety should create a plan with them.

- Children should get out of the room where abuse or violence is occurring.
- A safe place/room in the house should be identified for them.
- Children should be told that it is not their responsibility to make sure that adults are safe.
- Teach the child how to call 911 for help.
- Teach children where to go outside the house if they feel unsafe or a caretaking adult tells them to leave the house in order to be safe (neighbour's house, friend).

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13 Assessing Risk 3: Intimate Partner Violence (IPV)

Background

The CFTC serves a vulnerable population whose life circumstances are often complex and multi stressed. Clients often attend therapy feeling the real effects of that complexity and stress with increased anxiety, depression, and sadness. Clients also often express a loss of personal agency or sense of control over life and a reduced ability to cope and manage complexity and stress.

A critical aspect of Therapist Interns training is developing the knowledge, skill and judgement necessary to assess a client's level of risk, including:

- (suicide and suicidal ideation; self -harm; substance misuse[1]; risky sexual activity etc.).
- Risk to children (includes physical, verbal and sexual abuse; neglect etc).
- Risk to others (includes homicidal ideation, intimate partner violence –IPV etc).

Therapist Interns and supervisors have legal and ethical obligations to take action ensure the safety of clients and protection of children or others at risk of harm by a client. The application of these legal and ethical obligations can be complex, and shall be made in consultation with a clinical supervisor.

Therapist Interns MUST consult with a clinical supervisor immediately when they learn that a client may be at risk – see section XX for more detail.

This section focusses on intimate partner violence.

[1] includes, alcohol, street and pharmaceutical drugs

Section Overview

The purpose of this section is to provide some guidelines for Therapist Interns when faced with clinical work related to violence and abuse between adults, particularly intimate partner violence. The guidelines are stated in generic terms as they are intended to provide an overview and basic orientation to the topic. Therapist Interns are required to consult with a Clinical Supervisor whenever intimate partner violence or violence between adults is disclosed. The guidelines are broad and cover the following:

- Various forms of violence and abuse. These may include: economic abuse, physical violence, sexual abuse (forced or unwanted sexual activity), verbal and emotional abuse (e.g., disrespectful, prejudicial or degrading comments, harassment).
- A range of situations. These may include: relationship where there is a history of abuse or violence; there is on-going abuse or violence in the relationship; or there has not been any relationship abuse or violence but clients might be at risk.
- A diversity of adult relationships. Violence or abuse might occur between partners in a couple (heterosexual, GBLT, polyamorous), or between adult family members (e.g., parent, adult children, siblings, extended family).

These guidelines are based on a current reading of the literature and a review of *Best Practice Guidelines for Family Counselling Services* (Family Service Ontario, 2009). The CFTC takes an anti-violence, anti-abuse and anti-oppression approach to all clinical work and seeks to promote realistic hope about change and acknowledgement of how people are resilient in the face of oppression and abuse

13.1 CENTRE STANDPOINT ON VIOLENCE AND ABUSE: FIVE COMMITMENTS

The goal is to provide therapy services that enhance the possibility that:

- The violence and/or abuse will end;
- Those who acted abusively to take responsibility for their actions and acknowledge the effects;
- The relationships will improve.

13.1.1 The Five Commitments

1. **SAFETY**. For therapy to be helpful everyone in the room (including the therapist) needs to be and to feel safe enough to engage in a relatively open and therefore generative therapeutic conversation. It is the therapist's responsibility (in consultation with a

supervisor) to determine whether it is possible to facilitate a sufficiently safe therapeutic context. If there is a history of violence/abuse or current signs of risk, the question of safety in the therapy room and safety following the therapy session needs to be addressed before the session can proceed.

2. **COMPLEXITY**. Whenever there is a history of violence or abuse and/or a current risk, the situation is complex and requires a complex approach. Decisions about what kind of therapy to provide or recommend (couple, family, individual, group) are usually based not only on discernment of the risk for (further) violence/abuse but also an assessment of the connection between the partners or family members and of the resources available to them. The therapist must take into consideration:

- Cultural/ethnic differences between clients, and/or between the therapist and the client(s), and
- The fact that clients who act abusively (and who experience abuse) may be affected by oppressive and violent circumstances that they are currently experiencing or have experienced in the past (e.g., racism, ethnocentrism, anti-immigrant sentiment, and homophobia).

3. **COMPASSION AND ACCOUNTABILITY**. The therapist's compassion towards the persons who have acted violently/abusively and those they have oppressed is important in preventing unhelpful shame and self-judgment. Compassion is promoted when the therapist is able to view everyone as human rather than inhuman, multi-dimensional rather than uni-dimensional, and people with values rather than people who are amoral. In situations of violence and abuse of power, compassion needs to be combined with accountability. Those who engage in violence or abuse must be accountable for the effects of their actions.

4. **CONSULTATION**. Therapist Interns are always required to consult frequently and on an on-going basis with the clinical supervisor regarding situations where there is a history of violence or abuse, or current signs of risk.

5. **CONSTANT DISCERNMENT**. In all their clinical work Therapist Interns should maintain a continual awareness of the possibility of danger or risk of violence, abuse and mis-use of power. When there are signs of risk the therapist-intern should consult with the supervisor.

13.2 SECRECY AND ABUSE OF POWER

People often do not disclose violent incidents. They also remain silent about other forms of abuse that then fail to be identified and named and actively resisted. Without disclosure and identification, violence and abuse in relationships are likely to continue. Often the silence is the

result of fear and shame held by both victims and perpetrators. Therapists, therefore, should expect clients to be cautious about breaking the silence and sharing information. Some of the fear is about what will happen once the secret has been disclosed. Clients may be concerned about breaching loyalty to family members. They may also fear reprisal (more abuse) and loss of connection or access to resources.

Therapist Interns might hesitate to consult with their supervisor when a client has disclosed information about their experience with abuse of power (as victim or perpetrator). Therapists may also fear reprisal and/or loss of a trusting connection with the clients. They might also be at risk for personal re-traumatization if they, themselves, have experienced violence and/or abuse of power. Overcoming these barriers to disclosure is not easy. At the Centre, supervisors are aware of how strong the silencing can be. Therefore, they welcome a discussion of the therapist's experience. They recognize that it is more important than ever to work closely together as a supervisor-therapist team when abuse of power is disclosed or when the therapist discerns that there might be someone at risk. Information about violence and abuse might come to the therapist-intern in several ways.

13.3 DISCLOSURE OF RELATIONSHIP VIOLENCE/ABUSE AT INTAKE

In some cases the client who first contacted the Centre will have disclosed to the Client Services Coordinator that there has been violence or abuse between themselves and their intimate partner or between adult family members (e.g., parent and grown son or daughter). The CSC will have asked several questions and, if some disclosure is made, she will provide brief information on the data management intake sheet that is placed inside the front cover of the file. Due to fear and silencing, in many more instances there will be no information when the therapist-intern receives the file even though some kind of abuse has taken place or there is current risk. Also, sometimes people do not think of behaviors they use or even behavior they are subject to as violent or abusive, even when it is clear that violence has been used. It is important, therefore to ask about specific behaviours (hitting, pushing, restraining) rather than categories (abuse, violence) of behaviour.

13.4 CONSTANT DISCERNMENT

Therapist Interns are expected to uphold the Centre commitment to "Constant Discernment" by being attuned, on an ongoing basis, to the possibility of abuses of power. The therapist is expected to be watchful for signs of risk that there has been, there is currently, or there might in the future be violence or abuse. This watchfulness is continual; the therapist maintains awareness regarding danger and risk during all kinds of therapy (individual, couple and family) and across all sessions from the beginning to the end of the course of therapy.

13.5 SIGNS OF POSSIBLE DANGER OF RISK

The following signs during a therapy session, either a first meeting or a later one, may indicate risk and the need for consultation. Some of these signs would pertain only to conjoint sessions (couple or family), others relate to what might be observed during a session with an individual.

- Therapist senses that there is something not being said by client(s); notices hesitation to speak; careful choosing of words.
- Before speaking, the client frequently checks with other family member or partner who is present.
- Client reveals emotional distress, fragmented thinking, and/or anxiety and cannot say why.
- Client reveals little or no emotion (positive or negative), especially with respect to topics that would usually evoke emotion.
- Raised eyebrows, rolling eyes, and other expressions of contempt when the partner or other family member speaks during the session.
- Frequent interruptions by one family member of another or by one partner in couple of the other; interruptions that prevent an open kind of conversation.
- Attempts by one family member or one partner in couple to humiliate, disrespect or shame another.
- Intimidating or threatening looks between family members or partners.
- Depreciating comments by one family member or partner in couple.
- Differences or disagreements between family members or partners are met with irritation and defensiveness.
- Hints about violence or abuse (e.g., “I was so angry I could have hit the wall.”)
- Clients report violence against objects (throwing objects, smashing or breaking objects, punching walls, etc.)
- General lack of goodwill and humour towards partner or another adult family member.
- A general feeling of fear or tension in the room that is difficult for the therapist to explain.
- Therapist-intern feels scared, confused, intimidated or overwhelmed either during or after the therapy session.

13.6 WHAT TO DO WHEN ABUSE HAS BEEN DISCLOSED OR SIGNS OF RISK OBSERVED

In the following situations Therapist Interns must consult with their supervisor BEFORE scheduling a meeting with clients:

- If the disclosure is at intake and the clients are seeking conjoint therapy (couple or family) then the therapist-intern must consult BEFORE calling the clients to schedule a first meeting.

- If the disclosure is later in therapy, the consultation must happen as soon as possible and definitely BEFORE the next session.

- During conjoint therapy (couple or family) if the intern has discerned signs of possible violence or abuse (see above list), consult BEFORE the next session.

- During individual therapy if the intern has discerned signs of possible violence or abuse or if the client discloses that they are either a victim or perpetrator of abuse, consult BEFORE the next session.

13.6.1 Talking About Safety

During their meeting the intern and supervisor will first address the question of whether the therapist-intern feels comfortable and safe enough to be working with the client(s). If not, alternatives are considered (e.g., adding a co-therapist, making a referral).

The second question relates to safety of the clients and others. If the client is seeking, or involved in, individual therapy the intern-supervisor team will discuss helping the client to create safety plans for him or herself and any children who might be in the home.

If the clients are seeking or already involved in couple or family therapy (e.g., adult siblings, parent-adult child), the supervisor and Therapist-intern will discuss whether it is safe for the couple or adult family members to meet for conjoint therapy. This question about safety is usually answered by engaging in a process designed to gather more information while remaining therapeutic. With new clients requesting conjoint therapy this information is often obtained through a series of "client consultation" interviews. These are described below.

13.6.2 Talking About Trauma

The Therapist-intern and supervisor will address the question as to whether the client(s) might have experienced trauma as a result of the violence and/or abuse. When the therapist-intern carries out the "client consultation" and asks the questions that are suggested below they should be prepared to adapt their interview so that the client(s) are not re-traumatized. This work must also take into account the Therapist-intern's past experiences and ensure that there is some prevention of them also be re-traumatized.

13.6.3 The Initial Consultation with New Clients Where Abuse Has Been Disclosed at Intake and Clients Are Requesting Conjoint Therapy

NOTE: The following protocol has been created as a generic guideline. It relates specifically to couples who are seeking conjoint therapy. In the pre-session supervision meeting (see above), the Therapist-intern and supervisor will revise this consultation process to accommodate the unique and complex situation of each client system. Revisions would also need to be made for situations where adult family members are seeking conjoint therapy and violence or abuse is disclosed at intake.

Until safety is assured, conjoint meetings with clients where there has been violence or abuse are not referred to as "couple therapy" or "family therapy". Therapists will refer to these meetings as "consultation" with respect to the issues of violence. Clients then are clear that the "couple or relationship therapy" will begin only when everyone agrees that there is sufficient safety.

The first meeting with clients when there has been disclosure of violence or abuse is often booked for two to two and a half hours. Alternatively two to three consultation meetings are set up. The therapist-intern informs the clients in the initial phone contact that the first meeting(s) will be a "consultation" in which the clients will be heard and the therapists and clients will work together to gather information about their situation. The Intern makes it clear that booking this longer consultation session is the usual Centre practice in situations where there has been some kind of serious conflict between adult clients who are seeking conjoint therapy. The fee for the consultation will be the same as for usual therapy sessions. The intern informs the clients that the meeting will have the following format:

1. An Initial Interview with the Couple or Adult Family Members Together
2. Separate Interviews with Each Client
3. A Final Discussion Meeting with the Couple or Family Members Together

The therapist-intern who makes the phone call will also tell clients that after this first consultation meeting (or set of meetings) the therapist will be reviewing the situation with the clinical supervisor before setting up any subsequent sessions. Clients should be told that once the consultation with the clinical supervisor has taken place, they will then be contacted as soon as possible to discuss the next step.

Part I. Initial Engagement, Issues of Concern and Information Regarding Relationship Attachment

This part of the Consultation involves the following four activities:

1. Carry out the usual signing of documents, consents, etc.

2. Explain why it is important to gather more information when there has been serious conflict, abuse or violence between members of a couple. The clients may minimize the violent and abusive incidents. It is helpful to make clear that understanding the violence is one of the primary goals of this initial consultation session. The therapists would explain that, without an initial direct focus on ending the conflict, there is a risk that the therapy itself will lead to an escalation and greater danger. They should also remark that in therapy the clients will be talking openly about difficult topics that could increase anger and frustration.

3. Engage in a discussion regarding the most important concerns that each partner of the couple (member of the family) is bringing as their preferred focus for the therapy.

4. Assess the nature and degree of attachment or connection between partners. The reasons for asking about attachment near the beginning of the consultation are to establish the therapeutic relationship, to respect the couple's caring for each other despite the conflict, to validate their decision to seek some kind of help, to take a strength-based approach, and to reduce the risk of unhelpful shaming with respect to violence/abuse. There is some research evidence to suggest that such shaming is linked to an increase in conflict and violence. The level of bonding between the couple also predicts whether they will be able to work together to end the violence and improve their relationship.

After an initial discussion of the primary concerns the clients are bringing to therapy, the following kinds of relationship questions might be asked. Attempt to obtain responses from both partners.

NOTE: All of the questions below are meant to be a *guide to the kind* of respectful conversation that conveys to clients that you are interested in their experience and at the same time, you need to get a very clear picture of their relationship. They are not to be asked in a way that might suggest to clients that you are merely "ticking off boxes" on a form. Rather, the Therapist-intern should see these specific questions as cues to the kind of information that is needed to assessing safety, yet should be asked in a way that feels natural to the Therapist-Intern and to the client in the context of any first therapy meeting.

For example, the questions would be revised if the client system is composed of adult family members. In addition questions would be re-phrased taking into account the clients' age, gender, ethnicity/culture, etc.

Attachment and Connection Questions

- How long have you been together?
- What attracted you initially to each other that you still value?
- What has kept you together with your partner, despite any struggles you might have had?
- What do you appreciate most about your partner?
- What do you know you can count on him/her for?
- Compared to other couples you know, how strong is the bond between you (ask for a rating)?
- What are your dreams for the future as a couple?
- What are the values that you share about being a couple?
- (if children) What do you hope your children to learn about relationships from you?

It is important to be alert to the following positive signs during this line of questioning:

1. The overlap and differences between partners in their responses
2. Non-verbal interaction including for example: eye contact, smiling, nodding agreement, leaning towards each other, touching, taking turns to speak.
3. Signs of respect between the partners
4. Spontaneous expressions of caring
5. Handling disagreements with humour and good will

Part II. Separate Interviews with Each Member of the Couple (Family)

The objective of these separate interviews is to gain some understanding of (a) the current risk for violence or abuse between the couple and (b) the level of responsibility-taking that the partner who has acted violently takes for his/her actions and their ability to empathize with how their partner was affected. This information gathering is done in separate interviews to increase the safety for each partner to talk openly about their possible fears related to violence and abuse without risking reprisal from the other partner.

Prior to the separate interviews the therapist asks the members of the couple to agree that they will not interrogate each other about what is said in the separate interviews. The therapist also needs to assure each member of the couple that, at the Centre, information shared in

individual interviews is **kept confidential**. Notes taken at the end of this interview are kept in a separate client file. There will be three files: one for each member of the couple and one couple file. When working as co-therapists, both of the interns meet together with each partner while the other client waits. This co-interviewing increases the ability to assess the appropriateness of conjoint therapy.

In the separate interviews the therapist would usually ask some of the following kinds of questions. It is important to **ask each partner** about their participation in the violence or abuse since violence is more likely reciprocal than not. It is also very important to be complimentary about any positive and hopeful information and to be non-shaming but straightforward about any signs of risk.

13.7 DESCRIPTION OF RECENT INCIDENT OF VIOLENCE OR ABUSE

It is important to note that people sometimes do not label what we might define as forms of abuse or violence as such. Sometimes the intern will need to define abuse for the client in order to elicit recounting of an incident and to understand what kind of abuse has taken place. At other times it may be preferable to ask about the nature of the conflicts they have in a more open-ended way in order to gain a clear description.

Questions such as the following can be helpful in eliciting a description

- Do you ever feel intimidated by your partner's behavior? What happens at those times?
- Has there ever been a time where you touched you partner or been touched by your partner in a way that might be described as less than kind? What happened?
- If I was a fly on the wall at your house during your last serious conflict, what would I have observed?
- Have there been times in the past that were worse than that? Can you describe what happened?
- Are there ways that your partner talks to you that feel demeaning or hurtful? What kinds of things are said?

Once the behavior has been defined as violence or abuse you can ask more directly about it:

- Has there been an incident of violence and/or physical or verbal abuse between you and your partner in the last six months? Before that?
- Describe the most recent incident in detail; who did what to whom and what happened next, and who did what after that?
- Is this a usual type of incident that has happened between you? What would be a more usually incident? (It is important to understand whether, and to what extent, the violence/abuse was reciprocal and, if so, whether it is equally reciprocal or whether one partner is only attempting to defend him/her against an initial physical or verbal attack by the other).

Empathy re Impact of Violence/Abuse on Each Partner

- What have you realized about the impact of your actions on your partner? Your children?*
- How well do you think your partner understands your experience of the incident and how you were affected?
- If you could change one thing about how you have acted (re-acted) what would you change? What would you need in order to take one small step toward this change?*

History of Violence (in or outside relationship)

- Have you been involved in this kind of situation before? As a victim? As the one who acted violently? Have either you or your partner ever been charged by the police for violence?
- When did the violence/abuse begin in your relationship? Do you see the risk of violence/abuse as increasing or decreasing? Why?
- Have there been times when you were about to act in an abusive way and stopped
- (if has been violent) How ready are you to make a commitment to yourself to stop

Stress

- How much stress have you been under (ask on 10-point scale)? What is the stress most related to?*
- How much stress has your partner been under (10-point scale)? What is her/his stress related to?
- Have there been times when you have been treated abusively, or discriminated against by some agency, on the job, or in some other situation? (e.g., racism, sexism, homophobia, anti-immigrant sentiment, etc.).

Alcohol, Drugs, Mental Health, Physical Health issues

- Sometimes people deal with stress by using drugs and alcohol. To what extent have drugs or alcohol been present in any of the recent violent/abusive incidents? Is treatment of addiction being carried out?
- Are you or your partner in treatment for depression or other mental health concerns (bi-polar, delusions, paranoia, anxiety attacks, etc.)?
- Do you or your partner have any serious health problems?

Degree of Fear, Safety Plans

- How safe do you feel in this relationship (use scale: 1=absolutely not safe and 10=completely safe and absolutely sure you will not be hurt again)?*
- What is your plan next time you feel yourself getting worked up?* (if the client has used abuse or violence)?
- What kind of plan do you have to ensure that you are safe should there be a risk of another incident?
- (if there are children) How have you tried to protect your children?* What kind of plan do you have to ensure the children are safe?
- Did you come willingly to the meeting today or did you feel coerced or threatened to come?
- How safe do you feel in talking about issues of violence and safety with your partner? How ready do you think your partner is to make non-violence commitment to her/himself?

Resources

- Who is most supporting you? Who can you talk with?*
- Do you have enough support? What other kind of support do you need?*
- What strengths do you have that have helped you through?
- What gives you hope?*

It is important to observe the following during this part of the Initial Consultation.

1. Hesitancy to speak; signs of fear to disclose or difficulty in recounting a coherent story of an abusive incident
2. Appropriate presence of remorse and accountability
3. The person who was hurt denies or diminishes the severity of the abuse and its impact on them (and children, if witness to the abuse)
4. The person who acted abusively denies or diminishes the severity of the abuse and its impact on their partner
5. Incongruence between the partners' individual descriptions of the recent incident or other information
6. Discordance between the description of painful events and the person's emotional tone (e.g., laughter when recounting sad events, numbness/lack of any emotion)
7. Signs of despair and sense of helplessness

At the end of this second part of the Initial Consultation, the therapist writes brief notes documenting the process, signs of hope, safety plans, and any recommendations or resources provided regarding safety. A copy of these notes is offered to the client. These notes are kept in that person's individual clinical file.

Part III. Final Conjoint Discussion

In this part of the Initial Consultation the therapist meets again with the couple. The objective is for clients to add any information and for the therapist to ask any questions that are remaining. It is essential not to disclose information obtained in the separate interviews. The therapist ends the initial consultation by writing the Session Notes with the clients' participation. These notes are based only on information obtained in the parts of the meeting when both partners were present (Parts I and III). These session notes are placed in the couple file.

13.8 AFTER THE INITIAL CONSULTATION MEETING(S)

If, at any point in the Consultation meeting(s), the therapist is concerned that anyone is at imminent risk they **immediately consult with their supervisor**. If this is not the case, as soon as possible after the Consultation (or each separate meeting if there is more than one) the therapist makes notes regarding their observations. These notes are for supervision/consultation use only. At the next supervision meeting the therapist reviews the initial consultation information with their clinical supervisor. If there are co-therapists they need to meet with the supervisor together for this review in order to utilize everyone's observations in deciding whether conjoint therapy is appropriate

13.8.1 Discerning When Conjoint Therapy is Appropriate

The current literature draws a distinction between two types of situations where violence or abuse has occurred, one much more common than the other. At the Centre these two types are conceptualized more as points at opposite ends of a continuum of risk. North American national surveys indicate that in most situations both partners are involved in violence/abuse and the violence is mild to moderate (not life threatening). In these circumstances the violence/abuse occurs in particular situations where members of the couple are fighting with each other about an issue and, as part of their conflict, occasional minor physical aggression and some verbal abuse occurs. There is no intent to coerce the partner or to instill fear although either partner may feel scared. This pole on the violence/abuse continuum is usually termed "common or situational couple violence".

Situational couple violence is distinguished from situations which are much more serious and involve greater risk of psychological and physical harm/assault. This less common situation involves circumstances where the person who acts violently is motivated by a wish to exert general on-going control over her/his partner. To exert control the partner who is acting violently uses various tactics of domination, intimidation and fear induction fairly continuously over a period of time against the other person. The violence in this circumstance is not reciprocal although the victimized partner may sometimes defend her/himself or "resist" in some other way. This end of the violence continuum is usually termed "intimate terrorism". An important concern for therapists is that, in situations at this end of the continuum, risk of imminent harm is greatly increased when relationship problems are discussed. Couple therapy is **definitely contra-indicated** in this circumstance.

It is not very likely that couples would be requesting services at the CFT Centre when there is high risk of imminent serious harm. However, it is possible and, therefore, the therapists should know about "intimate terrorism". It is important to note that even some signs of coercion are sufficient to question whether conjoint therapy is appropriate.

13.8.2 Inappropriate: Unsafe and High Risk Signs for Conjoint Therapy

The first task of the therapists and their clinical supervisor is to discern, using the information and observations from the initial consultation interview, for signs of "intimate terrorism" and impending life-threatening risk. These signs include the following four factor sets:

1. **Pattern of Coercive Control**
    - Threats and intimidation
    - Surveillance (stalking, monitoring)
    - Inhibiting ability to resist by restricting psychological, economic, social influence
    - Extreme jealousy
    - Multiple tactics

2. **Pattern of Severe Physical Assault**
    - Frequency, range, severity of physical assault increasing over time (more than two acts in past 12 months)
    - Injury requiring medical care

3. **Lethality**
    - Unresolved substance abuse
    - History of violence inside and outside the home
    - Unresolved or on-going child custody issues,
    - Availability of weapons
    - Threats to retaliate, hurt, kill self or partner
    - Obsession with partner (jealousy, stalking)
    - Bizarre forms of violence (sadism, torture, starvation, etc.)
    - Abusing or killing pets

4. **Other Potential Risk Factors**
    - Low anger and remorse in the abused person
    - High hostility
    - Externalization of blame
    - Unresolved psychopathology
    - Depression, PTSD, psychotic breaks, bi-polar symptoms in one or both partners
    - Fear of partner or belief of imminent harm by partner

13.8.3 Appropriate: Safe Signs to Proceed With Conjoint Therapy

Even when there is no imminent risk, the question remains as to whether conjoint therapy is appropriate. Therapists should always be cautious about moving too quickly to deal with contentious relationship issues as this can lead to exacerbation of violence/abuse. Therefore the next task of the Therapist-Intern and supervisor is to discern whether the clients are able to establish sufficient safety for "conjoint therapy" to begin. This decision is made based on information from the Initial Consultation interview(s) with the couple. Signs of sufficient safety include the following:

1. There is reduced concern of escalation, retaliation, or harm
2. Both partners freely (without coercion) agree to couple therapy; couples therapy is not mandated by court or F&CS.
3. Both partners show respect for partner's feelings, boundaries
4. Neither partner is afraid to express their views with the other present
5. The partner who acted violently can tolerate hearing the other partner's description of what happened
6. The partner who acted violently shows awareness of escalation process
7. The partner who acted violently is able to manage anger and conflict without becoming violent
8. The partner who acted violently is committed to stopping all violence and abuse
9. The partner who acted violently extends empathy to the other partner and acknowledges the effects of the violence.

Until these conditions are met, at least to some degree, the therapist should ensure that the primary focus of any conjoint meetings is on eliminating the violence and developing effective safety plans.

13.9 OPTIONS TO CONSIDER AFTER THE CLIENT CONSULTATION MEETINGS

The therapist and supervisor will determine the next step by carefully considering the information and observations gathered in the Client Consultation interview(s). This includes the seriousness of the violence/abuse risk, the viability of the clients' safety plans, the responsibility-taking by partners, and the nature of the attachment bond (and desire for conjoint therapy). The Therapist Interns' skill level will also be taken into account. There are various possibilities for next steps:

1. Proceed with conjoint therapy. The Therapist-intern and supervisor may decide the situation is safe enough to begin couple therapy to address the clients' relationship concerns. The only requirement is that each member of the couple has an individual safety plan for

his/herself and that there is one for any children that might be in the home. Once therapy has begun the therapist-intern should check regarding the presence of violence/abuse by meeting with members of the couple or family separately from time to time. The frequency of these separate meetings will depend on the seriousness and chronicity of the initial violence/abuse and on discernment regarding whether both members of the couple (family) appear to freely express their views in conjoint sessions. At any point where it seems appropriate the Therapist-intern and supervisor might decide that there is need for the "Safety Plan" consultation meetings and documentation as described below.

2. Continue safety consultation meetings and create "Safety Plan" documentation. The Therapist-intern and supervisor may decide that it is best to meet again with the couple to continue to monitor together the risk of violence/abuse and to work toward establishing sufficient safety. In this case the therapist would postpone attention to relationship concerns that the couple might have raised **until** sufficient safety is established and the three documents noted below have been completed. It may take more than one additional consultation meeting for this to be accomplished:

- A "No-Violence Commitment to Self" in which each member of the couple makes a commitment to himself or herself that s/he will not engage in violent/abusive behaviour. This No-Violence Commitment to Self should be written into the Session Notes that are placed in the couple file.
- A "Negotiated Time-Out Plan" in which the couple specifies the conditions under which they will agree to take a break and calm down when there is a disagreement. This Plan should also be written into the Session Notes that are placed in the couple file.
- "Individual Safety Plans" developed by each member of the couple with the support of the therapist. These should be created in individual sessions and written into the individual files for each partner. Safety Plans for any children who may be in the home would also be required. See section below for what might be included in these plans.

3. Provide both clients with individual therapy. The Therapist-intern and supervisor may decide to recommend individual therapy for each partner provided by two different Therapist Interns as the safest way to work until criteria for appropriateness of couple therapy are met. The Therapist Interns working with each member of the couple (family) would need to have signed consent (Form A-26b) from each partner to consult with each other. The focus of individual therapy for each partner would be to: develop responsibility-taking for her/his actions, create the safety plan documents; and clarify her/his values and personals goals regarding the kind of person s/he wishes to become in the relationship. Usually this would include strengthening a sense of personal agency. Following this individual work the couple

(family members) might then be met with for conjoint therapy as a second step, once sufficient safety is established.

4. Provide individual therapy for one person and refer the other to another agency. If there is risk of serious imminent violence, partners who have acted violently may be referred to a specialized group program at another agency (e.g., PAR – Partner Assault Response program[2], available for both men and women). If drugs or alcohol misuse is present then a referral might also be made for addictions assessment and treatment (CADS – Homewood Community Addiction Services). If one partner has mainly been the victim of abuse/violence that person might be seen for individual therapy at the CFT Centre. This partner should be informed that his/her partner is acting dangerously and provided with information about community resources (shelters). The violence/abuse should be labeled and defined. It is essential that the therapist work with this partner to create a safety plan for him or herself (and for any children). This plan would be documented in the individual file. The therapist-intern should consult with the appropriate supervisor for more information about safety planning. Depending on the circumstances this plan might or might not be shared with the partner who has been violent.

13.10 ABUSE, VIOLENT ACTS, OR THREATS OF VIOLENCE DURING A CONSULTATION OR THERAPY SESSION

If the therapist discerns that there are minor signs of violence/abuse/coercion or risk for violence/abuse during the initial consultation or in on-going couple therapy sessions s/he takes steps to create more safety by first providing greater structure. This might include:

1. The intern requests that the clients take a "time out" from their discussion. S/he asks the person who is abusive or threatening to leave the room to "take a break" for 10-15 minutes. S/he might also suggest "grounding" techniques and/or deep breathing. The therapist would not continue the session with the other client until the person who had left returned.

2. After the "time out" or break when the client is ready to return, the intern makes clear to everyone that the Centre is committed to an anti-abuse and anti-violence policy. S/he asks that all the clients agree to interact safely; that is, without engaging in verbal abuse, intimidation, or verbal threat of violent action. If all the clients cannot agree to this, then the therapist ends the meeting. If one or both of the clients could be in any danger after the meeting then a consultation with the clinical supervisor is required **before** the clients leave the building.

[2] **The PAR program is a 16-week group offered by Family Counselling and Support Services "to assist men in addressing issues of domestic violence. The group is divided into 2 parts: the first 4-week "open" group is an introduction to such issues as power/control, "what is abuse", and how to keep intimate relationships safe and healthy. This is followed by a 12-week "closed" group which builds and expands upon these themes. Participants must complete the 4-week group before proceeding to the 12-week program." Source: FCSS website**

3. If the structuring interventions described in (1) and (2) are not effective and/or the clients cannot agree to interact safely, the following actions should be taken:

- The therapist should indicate to the clients that there is a need for immediate consultation with a supervisor.
- S/he then requests that the partner who is least at risk to act violently or engage in abuse accompany him/her to the reception desk. The intern then asks the receptionist to contact the clinical supervisor immediately.
- The intern consults with the supervisor to formulate a plan for how to ensure safety for everyone involved.

NOTE: If, at any point, the Therapist-intern observes a threatening physical gesture or witnesses actual violent action that suggests there is imminent danger s/he should immediately seek safety and then press the nearest "Panic Button" which connects to the Campus Police.

13.11 PROCEDURES FOR DEALING WITH CRITICAL INCIDENTS

A **critical incident** is an event, which causes **extreme distress** to a client, therapist, clinical supervisor or CFT Centre staff. This may be the suicide of a client, a death or injury caused by a client, death or serious injury of a client or therapist, threats made by a client against a therapist, staff or other persons. The Director of Clinical Training, or a clinical supervisor, may declare a situation "critical".

Safety of all Centre staff (Therapist Interns, faculty and staff) and clients is of **paramount concern** in these situations:

1. Any staff member with a concern may notify a Supervisor or the Director of Clinical Training who will determine whether the situation is critical.

2. All CFT Centre personnel will be informed of the existence of a critical incident and will be assigned roles as appropriate.

3. Confidentiality will be maintained as a primary principle. However, in cases where there is significant risk of harm to anyone, confidentiality may need to be breached, at the discretion of the Director of Clinical Training, or designate.

4. Outside service providers, such as the police, hospitals, crisis centers may be involved. It will be the responsibility of the Director, or Supervisor or therapist (in that order) to bring in such agencies.

5. Should a critical incident occur at the CFT Centre, the Director of Clinical Training or designate may bring in an outside professional to facilitate a critical incident stress debriefing.

6. Should a critical incident involving a therapist have potentially critical consequences for his/her clients, the Director of Clinical Training, clinical supervisor, and possibly an outside professional will develop a plan of action for responding appropriately, considering the needs of the therapist and his/her clients.

7. All decisions taken will be clearly recorded and placed in the file of any clients involved in the incident.

8. The Director of Clinical Training will maintain a file noting the date, time, and pertinent particulars of all critical incidents, as well as documenting the steps taken to address the incident.

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*Source: Anna Toth, Safer Families Project of Peel, Ontario, 2004.

14 CFT Centre Security, Safety, and Hours of Operation

Background

The CFT Centre is located in one of the historical buildings (designated "building #2) on the University of Guelph campus. Its historical architecture adds to the sense of character, and it creates some challenges when considering use of space.

CFT Centre is also a multi-purpose building. We have several multi-purpose rooms which we use for class meetings, as well as for CFT Program meetings of students, staff, and faculty. Along with the dedicated therapy rooms, we sometimes also use these multi-purpose rooms as therapy rooms. Students, staff and faculty have offices in the building. The CFT Centre is open to the public, and we have a regular flow of people coming to their therapy appointments.

Creating and maintaining safety in the building is a shared responsibility. We believe that safety is enhanced when we all take responsibility for our own safety and the safety of each other.

14.1 CENTRE HOURS OF OPERATION

The CFTC is in operation all year round. While the CFTC is staffed (CSC and DCT) and open as a building five days a week from 8:30AM-4:30PM, the Centre's hours to see clients vary from semester to semester. As a general rule the centre is open for clients minimally four (4) days and three (3) evenings a week. Evening hours are 4:30-8:30 and a staff receptionist is always present. The Centre is closed to clients and all clinical work the two weeks following each semester. The Director of Clinical Training will determine the Centres hours for each semester and these are made known at the end of each semester. The hours are also posted on the front entrance to the centre. Client work (including telephone calls) may only occur during hours the Centre is open and Reception or Administrative Staff is present.

14.2 SECURITY SYSTEM

The CFT Centre is equipped with an electronic security system which is directly linked to the University of Guelph Police Department. Security push buttons are located throughout the Centre. Portable security necklaces are also available for use from Reception. The security buttons and necklaces sound an alarm at Campus Police and an officer is immediately dispatched to the Centre.

14.2.1 Door Locks

The entry doors to the three floors of the CFT Centre have secure locks; with interior escape bars (panic bars).

Basement door - is always kept locked. Basement is currently out of use.

First floor door - is left unlocked during the daytime Centre hours when a receptionist is present. During evening Centre hours (4:30 – 8:30 p.m.) and when the Centre Receptionist is away from the office during the day, the outside door may be locked. Clients will use the buzzer to notify the Evening Receptionist of their arrival. The Evening Receptionist or the therapist-intern will let the clients into the building.

Second floor door - is unlocked during the day and locked at the end of the evening by the Evening Receptionist except on days when there is a practicum class. On those days the supervisor locks the second floor door (see below).

14.2.2 Weekends

The CFT Centre outside and inner doors are always kept locked on weekends. If any arrives and finds a door unlocked, they must report this to Campus Police immediately.

14.2.3 Evening Appointments

Evening appointments are allowed with some restrictions:

- There must be a Receptionist present in the Centre.
- The last evening appointment is to finish **by 8:25 p.m.**
- Clients are to be out of the CFT Centre **by 8:30 p.m**.

14.3 PRACTICUM EVENINGS

On evenings practicum class is in session, no appointments are to be booked following the class. If there is no class scheduled for an evening when class is normally scheduled; Therapist-Interns are not to schedule clients unless a Receptionist has been scheduled in advance.

Therapist Interns must verify with the Client Services Coordinator that a Receptionist has been scheduled.

The afternoon receptionist is responsible for locking the outside door upon leaving however, the Practicum Instructor is responsible for ensuring that the classroom lights, upstairs hall and the 2nd floor and main floor inside doors are locked after class.

In the winter semester when both cohorts are working with clients and practicum classes take place on two evenings, the Centre is usually open and a receptionist available four evenings: Monday through Thursday so that when one cohort is in class or participating on therapeutic teams, the other cohort can schedule clients.

14.4 PROCEDURES FOR EVENING LOCK-UP

The Therapist Interns are responsible for checking to ensure all necessary equipment (kettles, toasters, etc.) is unplugged in the Grad Lounge (Room 154) at the end of each day.

Any lamps, heaters, fans or other equipment is turned off.

The **last person out is responsible** for turning off all the lights and doing a final check to make sure everything is secure.

14.5 FIRE SAFETY

The University maintains Fire Safety Plans for all of its buildings. Emergency evacuation maps are posted on the backs of doors throughout the CFT Centre. Students should familiarize themselves with the floor plan of the building and in particular the location of the stairwells and exits from the building so that they will know how to evacuate in the event of a fire or a fire drill. The following are procedures to follow in the event of an emergency evacuation:

1. Leave the building as quickly and as safely as possible if able to do so safely.

2. Walk, do not run.
3. Advise the Fire Warden (TBA) at the building entrance of any individuals having difficulties evacuating or if you notice signs of fire.
4. Do not ether the building until the "all clear" has been given by the Guelph Fire Department, Campus Community Police, University Fire Prevention, or the Fire Warden.

Evacuation training and fire drills are conducted every September.

14.6 MAINTENANCE OF THERAPY ROOMS & OBSERVATION ROOMS

The therapy rooms are pleasant, but they need "TLC" to remain that way. It is the responsibility of each of us to maintain this atmosphere.

Therefore, each therapist is required to **straighten the therapy room after they have used it (e.g.,** straighten chairs, replenish Kleenex supplies, put toys away). If the therapist brought in extra chairs for a session, they are required to remove them after the session.

Toys in Therapy Rooms

Toys are stored in the Observation room on the main floor in the large grey cabinets. There are plastic baskets also located there with covers. Therapist Interns can select the toys they wish and carry them to the therapy room. This helps to facilitate the intern's work with children and not overwhelm them with stimuli. It is important to make an appropriate selection of toys to take into a therapy room when working with a family with small children. There is also a large doll house and sand tray in Room "D".

All toys are to be **returned** to the cabinet.

Toys and games are very expensive. Interns are to make sure all parts are put back in the appropriate box and cupboard. If any toys are broken during a session, they should not be returned to the cabinet, please let a member of the Administrative Team know.

14.7 PETS IN THERAPY ROOMS

Service Animals assisting persons with disabilities are not considered pets, and are therefore allowed in the Centre. University of Guelph policy does not, however, allow pets of any variety in buildings on campus. Given the unique nature of the work we do at the CFT Centre, however, the Department has recognized that there may be some need for exceptions to this policy.

In rare circumstances, there may be legitimate and strong therapeutic reasons for the client to bring a pet with them to the therapy session. If a Therapist Intern thinks this is a good idea for one of their clients, they must obtain prior approval from the supervisor before inviting the client to bring his/her pet.

When animals are brought to the Centre, it is very important that they not disturb other clients and that the therapy room is left without signs of the pet's presence.

Remember other clients may be allergic to animals or may be frightened by animals. When having a pet or a service animal accompany the client in therapy, the Therapist Intern is to book the appointment in Room "D". The window should be opened at the end of the session to air out the room after the animal has left.

14.8 GENERAL CENTRE MAINTENANCE

The Director of Clinical Training is responsible for overseeing the general maintenance of the building. Please report all maintenance problems (lights, washrooms, broken chairs, etc.) or maintenance questions to the Director of Clinical Training.

If an urgent maintenance problem arises after hours or on the weekend, call the Director of Clinical Training's cell number (519.767.6581) or campus emergency at 2000.

15 Legal Issues, Ethical Slips and Professional Misconduct

Background

This section is provided primarily as information. All client related legal issues (request by a client lawyer; consultations with university legal counsel; subpoenas) are handled by the Director of Clinical Training.

15.1 LEGAL REQUESTS FOR INFORMATION

15.1.1 Client Requested Documents

Any letter or report requested by the client for their lawyer, insurance companies, and other service providers and/or to be presented in court, the procedure is as follows:

1. Consult with the Director of Clinical Training regarding the request, nature and intentions of the document.

2. If the client file has a different Clinical Supervisor other than the Director of Clinical Training assigned to it, the Therapist Intern notifies the assigned Clinical Supervisor that the request has been made to the Director of Clinical Training.

3. A letter or report is addressed to the client who may use it or provide it to whomever; a Release of Information consent form is not required.

4. The document must be reviewed and co-signed by the Director of Clinical Training before being reviewed by the client.

5. A collaborative approach that involves the client is recommended. Therefore, a copy of the document is to be **reviewed by the client, before it is released**.

6. Changes to the document, determined by the client's review, is provided to and signed off by the Director of Clinical Training before releasing the document to the client.

15.1.2 Lawyer Requested Documents

When a lawyer requests client documents, the procedure is as follows:

1. Consult with the Director of Clinical Training regarding the request, nature and intentions of the document. The Director of Clinical Training may decide to consult with the Clinical Supervisors team, The University Legal Counsel.

2. If the client file has a different Clinical Supervisor other than the Director of Clinical Training assigned to it, the Therapist Intern notifies the assigned Clinical Supervisor that the request has been made to the Director of Clinical Training.

3. A client signed Release of Information consent form is mandatory before releasing any client information. If the documents pertain to a relational file, all clients over the age of 12 have to sign a Release of Information before proceeding.

4. The Director of Clinical Training views the provided Release of Information document(s) before proceeding with the request.

5. The documents are addressed to the lawyer, and an invoice is enclosed billing the lawyer for the CFTC administrative time. The fee is calculated by either the Director of Clinical Training or Client Services Coordinator using a set fee schedule.
6. The document must be reviewed and co-signed by the Director of Clinical Training.

15.1.3 Subpoenaed Court Documents

Any subpoena, notice of motion, or any other means through which the Therapist Intern files are directed to appear in court is received, the procedure is as follows:

1. The **Director of Clinical Training is notified immediately** upon receipt of notice.

2. Before accepting a subpoena, verify that it is properly issued; it should name the clinician and/or the Director of Clinical Training, as well as the full name of the Couple and Family Therapy Centre.

3. Only the person who is named in the subpoena should accept it.

4. If the person named on the subpoena is not available, request that the police officer

return at a later time to issue it.

5. Request identification of the person delivering the subpoena.

6. The Director of Clinical Training will consult the Clinical Supervisors team, the University Legal Counsel to determine the appropriate course of action. An attempt will be made to preserve the confidentiality of the files and arrangements for legal representation will be made if this is deemed necessary.

The following **may be considered** in the legal consultations:

1. The client is informed about the subpoena and is given the opportunity to see a copy of the file. This is documented.

2. The file is not copied to Lawyers prior to court in any case, unless the client signs an authorized consent form.

3. Should the client not wish the file to be disclosed in court, a written notice to this effect is placed in the client's file prior to it being sent to the judge.

4. Should the file inadvertently contain information about others that is not relevant to the court case, the copied record may have this information redacted. An affidavit is written by the Therapist Intern and/or Clinical Director stating that the information redacted pertained to others and not the identified client.

15.2 ETHICAL SLIPS AND PROFESSIONAL MISCONDUCT

Background

Therapist Interns are required to bring all ethical questions and any ethical slips, violations or acts of Professional Misconduct to the Director of Clinical Training or Clinical Supervisor or both *before* making decisions or taking action.

Therapist Interns are exposed to many new, complex and sometimes subtle client situations that require careful thought, understanding and application of ethical judgement. Clinical Supervisors are important resources for Therapist Interns in learning to:

- developing good ethical judgment
- making appropriate ethical decisions

- better understanding the nuances and complexities of ethical and legal decision making
- better understanding the impact of subtle and often complex interactions with clients and their relational systems can have on ethical decision making.

15.2.1 Ethical or Professional Practice Violations

An ethical or Professional Practice violation (sometimes referred to as a "slip") occurs when a Therapist Intern makes a decision (or series of decisions) that in some way violates anyone of the:

- CRPO Professional Misconduct Regulations https://www.ontario.ca/laws/regulation/120317
- CRPO Professional Practice Standards http://www.crpo.ca/wp-content/uploads/2014/11/CRPO-Professional-Practice-Standards.pdf
- AAMFT Code of Ethics http://www.aamft.org/iMIS15/AAMFT/Content/Legal_Ethics/Code_of_Ethics.aspx
- Policies or Procedures as set forth in in this manual.

In the context of a Training Program, it may not be unusual for a Therapist Intern to be faced with a minor ethical or professional practice violation or slip. However, and while rare, it is possible that a Therapist Intern may make a serious ethical or professional practice violation. Regardless, **ALL** ethical or professional practice violations or slips must be taken seriously and addressed with a clinical supervisor immediately in order to safe guard clients.

Given that this is a Training Program, having open conversations about ethical violations and slips or concerns that one may occur is critical to both the development of solid ethical practice and safeguarding clients from harm. Clinical supervisors are invested in creating an environment that is both supportive and serves as opportunity to learn and grow as a therapist when faced with an ethical violation or slip. Having open conversations about ethical violations, slips, practice and boundaries can be challenging and sometimes hard to do. However, doing so provides an invaluable opportunity to explore our decision making process and strength our abilities to not only make better ethical decisions but to better predict situations that may put us at ethical risk. The CFT Faculty members view this open, supportive, and analytical process as a valuable aspect of the overall training in ethical and professional practice.

When and ethical violation or slip occurs a, regardless of its nature, a Therapist Intern must:

- **Immediately consult with a clinical supervisor**
- Take responsibility for the violation or slip
- Work with the clinical supervisor to redress as is possible the situation
- Work with the clinical supervisor to mitigate further harm to the client.
- Inform the Director of Clinical Training

The following are guidelines for addressing:

- **General practice slips** related to the procedures outlined in the CFT Centre Policies and Procedures Manual and/or the practicum course outline.
- **Ethical practice slips or violations** as set by the AAMFT Code of Ethics.
- **Confidentiality violations or slips as set by the CRPO, AAMFT or this Manual.**

15.2.2 General Practice Procedures Slips

1. The Therapist Intern discusses concern about possible slip with the Director of Clinical Training and or relevant Clinical Supervisor and/or:

2. The Therapist Intern is informed by the Clinical Supervisor that a specific aspect or set of aspects, of his/her clinical practice has fallen outside of the expected standards as set out in the CFT Centre Operations Policies & Procedures Manual.

3. The Clinical Supervisor and the Therapist Intern review the expectations and identify a plan to bring the Therapist Intern's clinical practice into line with expectations. The plan includes a time-frame, a review date, and probable next steps and/or consequences if follow-through on the plan is lacking.

4. The Therapist Intern may be required to participate in extra supervision as part of the plan.

5. The plan is documented with the Director of Clinical Training for this Therapist Intern; the Therapist Intern is given a copy of the plan.

6. The Clinical Supervisor supports the Therapist Intern in following through on the plan and monitors progress.

7. If the Therapist Intern is not following through, he/she is reminded of the plan and the probable next steps and/or consequences. The Clinical Supervisor informs the Therapist Intern that the supervisors' consultation group will be informed of the situation.

8. At the plan review date, the Clinical Supervisor and Therapist Intern discuss an evaluation of progress toward meeting the professional practice expectations of the CFT area of study. If progress has been satisfactory, this is noted in the Therapist Intern's file for the semester. If the progress is not satisfactory, the Clinical Supervisor will consult with supervisors' consultation group. The Therapist Intern will be informed of this in advance and be invited to make a statement of her/his case in writing. The Therapist Intern may be invited to attend a portion of the consultation meeting to represent her/his case.

9. The Therapist Intern is informed of the next steps and the process of implementing the consequences.

15.2.3 Ethical Practice Violations or Slips

Slips in ethical practice vary across the Principles in the AAMFT Code of Ethics. The type of ethical slip (i.e., which Principle is involved and/or whether multiple Principles are involved) and the severity of the slip are considered. The following outlines a typical process for handling ethical violations that would be assessed by the clinical supervision team as minor to moderately severe.

1. The Therapist Intern discusses concern about possible slip with Clinical Supervisor and/or:

2. The practicum instructor/Clinical Supervisor inform the Therapist Intern that some part of her/his practice with a client (or across clients) may be in violation of the AAMFT Code of Ethics.

3. The Therapist Intern and the Clinical Supervisor discuss the context of the situation. The Clinical Supervisor identifies which Principle(s) of the AAMFT Code of Ethics may be involved.

4. The Therapist Intern is informed that this situation will be discussed with the supervisors' consultation group immediately.5. The supervisors' consultation group discusses whether the AAMFT Code of Ethics has been breached. If so, they discuss a plan to deal with the potential impact on the client(s) and how to assess the severity of the slip. If they also determine the Therapist Intern needs to participate in **required extra learning activities**, they recommend a plan to be reviewed with the supervisors' consultation group. The plan may include a cessation of client work until it is

determined by the supervisors' consultation group that it is safe for client work to resume.

6. The Therapist Intern may be requested, and/or request, to meet with the supervisors' consultation group that consulted on the issue. The Therapist Intern is reminded of the procedures for "appeal".

7. The Therapist Intern and the Clinical Supervisor review the recommended plan for "required extra learning activities"; the plan outlines all required activities, probable next steps and/or consequences if progress is insufficient, and a time-frame for completion, as well as dates for review of progress and evaluation/re-assessment.

8. The Clinical Supervisor supports the Therapist Intern in the required extra learning activities and follows through with re-assessment/review dates.

9. The Clinical Supervisor keeps the supervisors' consultation group informed of the Therapist Intern's progress and makes recommendations for next steps.

10. If the Therapist Intern involved agrees, the supervisors' consultation group discusses how and when to share this situation with others at the CFT Centre as part of the commitment to create a broader "community of learning and support". This involves sharing information about "slips" so that everyone is aware of how it is determined that a slip has occurred, what the process is for taking responsibility for attempting to redress any damage to clients, and what the process is regarding prevention of a future occurrence (including the types of "extra learning activities"). An important feature of this environment is that compassion, respect, and understanding are extended to the person(s) who made the slip.

11. The Director of Clinical Training documents the process/procedures and outcome in the Directors' files.

Once the Therapist Intern has graduated, only the general information in the Director's files documenting that a slip has occurred, the process and the outcome are maintained. No identifying information on either the Therapist Intern or the client will be retained in this general file. For accreditation purposes, COAMFTE personnel may have access to this general file during site visits.

For ethical violations that the clinical supervision team assesses to pose a significant or severe

risk to client(s), or violations that involve a serious lack of judgment on the part of the Therapist Intern, it is most likely the Therapist Intern will be required to cease client work until it is determined that it is safe to resume. The procedures listed above may also be more strictly prescribed and could include the involvement of the Department Chair, the Dean of the College and/or the Office of Graduate Studies. In these cases the "extra learning activities" mentioned above may be part of a formalized remediation plan. In some situations, externship supervisors may have access to a remediation plan. The remediation plan may require the Therapist Intern to work with special outside consultants to help the student to actualize the plan, and/or for additional assessments of readiness to return to clinical work. Once the therapist is deemed ready to continue with clinical work, the Clinical Supervision team will consult with respect to the timing and the manner in which the Therapist Intern returns. If, after the completion of the remediation plan, the Supervision team concludes that it is not appropriate for the Therapist Intern to return to clinical work, the Therapist Intern will not be allowed to continue in the CFT Program. Options for completing the Master's degree outside the CFT Program will be explored with the student.

15.2.4 Confidentiality Violations or Slips

The most common ethical slip involves Principle II - Confidentiality of the AAMFT Code of Ethics. After consultation with the AAMFT Ethics Consultant, we developed the following practice to address minor slips in confidentiality. The most common minor slip in confidentiality usually has the Therapist Intern breaking confidentiality practices with a member of the client's family (who is not attending therapy).

The "confidentiality slip" may have been, for example, the result of the Therapist Intern's attempt to call and leave a telephone message, or to contact a family member to attend a therapy appointment based only on verbal consent from the client.

Procedure:

1. The Clinical Supervisor advises the Therapist Intern that her/his actions have resulted in a "confidentiality slip".

2. The Therapist Intern and Clinical Supervisor review Principle II - Confidentiality section of the Code of Ethics.

3. The Clinical Supervisor notifies the supervisors' consultation group of the violation in confidentiality.

4. The Therapist Intern is required to contact the client and notify the person that he/she has made a slip in confidentiality and to advise the client of her/his right to report this slip to the AAMFT Ethics Committee. The Therapist Intern provides the client (either in person at the next session or by mail) with a copy of the AAMFT Code of Ethics, with the pertinent section highlighted; the Therapist Intern also notes the address for filing a written complaint to the AAMFT Ethics Committee.

5. The Therapist Intern notifies the client that he/she may talk to the student's Clinical Supervisor and/or the Director of Clinical Training; names and telephone numbers are provided.

6. The Therapist Intern invites the client to explore the consequences, in the client's life, of this ethical slip in confidentiality.

7. The Therapist Intern is to take responsibility for the slip and apologize to the client.

8. The client is advised that, if he/she chooses, we can make a referral to another Therapist, either at the CFT Centre or to another agency in the community.

9. The Therapist Intern reviews the client's view/reaction with the Clinical Supervisor; the Therapist Intern and Clinical Supervisor review and follow-through on issues the client has raised about the situation/process.

10. The Clinical Supervisor and Therapist Intern discuss the steps necessary to minimize the chance of an occurrence of a similar slip in future.

16 Training Portfolio

As students in an accredited program with COAMFTE, each Therapist Intern is required to accumulate 500 hours of direct client contact/experience prior to qualifying for graduation.

Each Therapist Intern is responsible for accurately reporting his/her therapy hours (in the service event section of Caseworks and on each Session Note), as well as to maintain his/her own records of therapy and supervision hours. The Client Services Coordinator or designate will verify therapy hours for accuracy.

16.1 DEFINING THERAPY HOURS FOR RECORD KEEPING

All clinical contact time with clients is **counted on the quarter hour**. Thus if a therapist meets with a client for 50 minutes s/he gets one hour of client contact time. If s/he meets with the client for 80 minutes s/he would get one hour and a half hours contact time (1.5 hours).

Only time spent in **direct face-to-face contact with the client** (couple, family, or individual) is counted as client contact time.

Frequently the intern will take time to gather information from clients by telephone before seeing them, or may need to handle crisis situations with clients via the telephone. This time is **not counted** as clinical contact time.

16.1.2 Categories of Client Contact

"INDIVIDUAL" contact time is counted when the client is coming as an individual and other family members are not involved.

"COUPLE" contact time is counted when the client is a couple.

"FAMILY" contact time is counted when the client is a family, parent/child, extended family. Friends are also included in this category.

16.1.3 Tracking Hours for Linked Enrolments

When an existing individual client chooses to bring another person to join them in therapy, a separate couple or family enrolment is created. When tracking service events in this new enrolment, these sessions are considered couple or family therapy sessions.

When a member of a couple or family therapy system comes to a session alone, an individual enrolment is created. When the work being done is in the service of the relational work, the sessions can be considered couple/family therapy sessions, however, if the focus of the therapy shifts more exclusively to individual work, the hours must be counted as individual therapy hours. The Therapist Intern must consult with the appropriate supervisor about how best to track the "linked file" therapy hours.

16.1.4 Relational Hours

It is important to remember that for COAMFTE/AAMFT purposes, at least 250 hours of client contact time must be "relational contact time". By the time the Therapist Intern graduates from the CFT Program, s/he must have accumulated at least 250 hours of relational therapy work. Couple and family contact time are added together to provide the relational contact time total.

16.1.5 Therapeutic Team

When the intern is serving as a therapeutic team member s/he may count the time as **team hours** when working jointly with other interns as a member of a therapeutic team. Therapeutic team hours refer to those hours when interns are members of a team during a "live session". These hours may be individual, couple or family hours, based on the clients present during the session. The Therapist Intern in the therapy room meeting with the client counts this as direct client contact hours in Caseworks. This service event is attached to the appropriate client enrolment. All of the other interns on the team count this time as therapeutic team hours. These hours are recorded as service events in Caseworks and are not attached to the client enrolment.

To ensure consistency and accuracy, at the end of each team session the team, in conjunction with the supervisor, an intern should clarify the amount of time to be recorded for that session. Therapeutic team hours will be added to each intern's direct therapy hours, as "alternative hours" at the end of the program, and reported to COAMFTE.

It is important to note that the CRPO Registration Guidelines state that direct clinical contact

with clients is required in order for hours to be counted toward the 450 need for application. Direct Clinical contact includes reflecting in front of clients as a team member but may not include therapeutic letter writing or behind the scenes developing SFT tasks

16.1.6 Group Hours

In the event that an intern is involved in providing group therapy, group contact time is recorded separately on the Group Hours Log. All group hours are added to the Annual Report submitted to COAMFTE. Group contact time usually takes the form of groups of individuals, couples or families at the externship placement. For AAMFT purposes, group hours are counted as individual hours, unless there are 2 or more members of the same family in the group.

16.1.7 Documenting Hours

The Client Services Coordinator maintains a record of therapy hours for each Therapist Intern recorded in Caseworks and checked against Therapy Session Notes.

It is required that each Therapist Intern also keeps a record of his/her therapy hours (according to each category above). **It is important that weekly Caseworks print-outs, provided by the CFT Client Services Coordinator, are verified by interns to confirm that both records agree.** If there is a discrepancy, it should be reported to the Client Services Coordinator immediately.

When on **Externship,** each Therapist Intern is to **keep a monthly log of all therapy hours and supervision hours** (*Form A-33*) signed by the External Supervisor. The Client Services Coordinator e-mails each extern a copy of the Excel version of this form prior to the beginning of the externship. The intern records his/her hours, prints it and has the Externship Supervisor sign it before submitting it to the Client Services Coordinator. These monthly logs for direct therapy hours and supervision hours are **due at the end of each month while at Externship placements.**

16.1.8 Target Clinical Contact Hours by Semester

During each clinical practicum semester every Therapist Intern is expected to maintain active contact with clients. The following targets represent expectations based on maintaining an average of 7 - 8 hours per week of direct client contact. Five hundred (500) clinical hours are required to complete the program.

Clinical Semester (15 weeks)	**Average Clinical Hours Per Week**	**Total Hours Per Semester**	**Total Accumulated Clinical Hours**
Practicum I (Winter -semester 2)	Start in Week 3; gradually increase to 7-8 per week	55 – 60	55 - 60
Practicum II (Spring -semester 3)	Average 7 - 8 per week	110 – 125	165 - 185
Practicum III (Fall - semester 4)	Average 7 - 8 per week	115 – 125	280 - 310
Practicum IV (Winter - semester 5)	Average 7 - 8 per week (9 - 10 weeks on campus, then transition to community agency)	80 – 90	360 - 405
Externship (Spring - semester 6)	Minimum 3 days per week. Average 10 - 15 per week (with slow start-up and a phase down period - 15 to 18 weeks)	95 - 140	500

Interns are required to plan their work so that they are within close range of these targets for each practicum. They must discuss with the supervisor how to stay within the range, as it is problematic if they are significantly under or over the targets in any given semester.
It is anticipated that Therapist Interns can meet the above targets by maintaining a case load of no more than **25-30 open and active client enrolments (includes linked files)**. Inactive enrolments are to be **closed** as soon as it becomes clear that the client is not returning.

Sometimes Therapist Interns are working under a special plan for completion of their clinical hours. This plan is created in consultation and coordination with their advisor and practicum supervisor. A minimum of 3 hours of clinical work per week throughout the semester is required for participation in a Practicum course, and participation in a Practicum course is required for working with clients at the Centre. Therapist Interns following a special plan must complete a minimum of 40 clinical hours in the first practicum, and a minimum of 70 hours each in each of the 2nd,3rd and 4th practica, so as to have completed a minimum of 250 clinical hours prior to proceeding to Externship.

In situations where interns have followed a special plan, they will often make up their missed hours while at their externship thus may stay an extra semester in order to complete the clinical hour requirement.

16.2 SUPERVISION HOURS

16.2.1 Video/Audio-recording

Clinical supervision conversations are usually based on access to "raw data," meaning the Clinical Supervisor listens to or observes the Therapist Intern's therapeutic work using audio or video-recording. All therapy sessions at the CFT Centre are recorded digitally. A Clinical Supervisor can request to view any recording at any time. Typically individual and paired supervision and, on occasion, group supervision are based on the review of recorded session material. The Therapist Interns can count this as "audio" or "video"

16.2.2 Group Supervision- Live

When the Clinical Supervisor is present for a Therapeutic Team, all Therapist Interns participating in the Therapeutic Team receive "group supervision" hours.

All Therapist-interns on the therapeutic team receive the same number of group supervision hours for the session. This is to be agreed upon before the end of the group supervision session. Typically, this is three (3) hours; ½ to 1 hour of "pre-session"; 1 - 1.5 hours of the session with the client, and 1 hour "post-session" discussion.

Everyone involved in the meeting receives Group Supervision (pre and post session time) and Therapeutic Team hours except the active Therapist who receives Group Supervision and Client Contact hours. The Therapist Intern working directly with the clients and the Therapeutic Team, receive credit for direct clinical hours for the amount of time the clients were actually present.

16.2.3 Individual Supervision- Live

If no more than two Therapist Interns are involved (either as co-therapists or one as therapist and the other as an observing team member) then the Therapist Interns may count this as "live observation - individual supervision".

16.2.4 Case Report

When clinical supervision conversations are based on case notes and verbal or written description of the therapeutic work to date, it is considered "case report." This format is used in individual or paired supervision, infrequently it is used for group supervision.

16.2.5 Ad-Hoc Supervision

When this occurs it is considered “ad hoc supervision,” but is counted in the same manner as regular supervision.

17 Accounts Receivable Process

Background

This process was developed in response to consistent challenges reconciling daily receivables and maintaining an adequate supply of change. The process is intended to facilitate the process of payments, reduce accounting errors and meet the CRPO standards for marinating financial records.

The process outlines:

17.1 Reception Desk Float

During client hours of operation and when a receptionist is on duty, a cash box with a float of $300.00 is kept under lock and key in an exclusive drawer at reception.

Rules:

- The primary float must remain locked at all times.
- This primary float is to be counted at the beginning and end of each individual shift and **must always** total $300.00.
- This primary float is **ONLY** to be used to “make change” - dollar for dollar. That is, a receptionist receives a $20 bill and provides back an equal amount in change: eg: 2 X $5 and 1 X $10.
- Only the receptionist on duty may go into the primary float to make change or otherwise come in contact with the money.
- No one else (including therapist interns, staff, or faculty) are permitted access without the clear and express permission of the receptionist.
- When the float is short on change, it may be exchanged with a secondary float stored in the safe in the CSC office. Only the CSC and the DCT have access to that safe and only they can make the exchange.
- The primary float is locked in the in filing cabinet in the CSC office at the end of the days shift.

17. 2 Processing Client Payments.

1. Therapist Intern accepts payment from client – if it is cash that needs to be changed, first make change with the receptionist.

2. Therapist Intern generates receipt to be given to client and then transaction receipt is attached to the client payment. (Be sure to check the appropriate payment method – cash or cheque)

3. Therapist Intern places client payment (must be the exact amount) and transaction receipt into deposit envelope and seals it closed with tape.

4. Ensures the label on the front of the deposit envelope is filled in completely including:
    a. Date
    b. Enrollment Number
    c. Therapist Intern Initials
    d. Today's payment
    e. Arrears payment
    f. Total Enclosed
    g. Payment type: cash or cheque.

5. The envelope is then placed into the deposit slot on the CSC door.

17.2.1 When a client requires change the therapist Intern will:

a. Take the money and ask the receptionist to make change.
    - Change is always made dollar for dollar. That is, a receptionist receives a $20 bill and provides back an equal amount in change: eg: 2 X $5 and 1 X $10.

b. Under no circumstances may a Therapist Intern or anyone other than the receptionist make change from the reception desk float.

c. The therapist Intern then takes the change and provides the client with the correct amount
d. and proceeds with steps 1-4 above.

17.2.2 When a client pays for the current session and pays an arrears amount the Therapist Intern will:

a. Process the payment and make change as necessary and following the steps noted above.
b. Record on the transaction receipt and the deposit envelope the amount the client paid for the day's session AND the amount paid in arrears and for what date.
c. If the client is paying for the day's session for one enrollment (eg individual therapy session) and also paying an arrears for a previously held couples session.
    i. For example $40 for session October 2, 2020 enrollment number 1234 and $20 owing for September 25th, 2020, enrollment number 6789

BOTH **payments must be processed separately** and placed into TWO DIFFERENT envelopes.

    ii. Both payments must be processed in Caseworks, under the appropriate enrollment numbers for each payment received.

17.3 Reconciliation of Daily Receivables

Reception:

- Prints Payment Received Report from Caseworks for the previous day.
- Collects all the previous days envelopes from the box on CSC door
- Reconciles the amounts on each envelope with the amount listed on the Payment Received Report (PRR) - the amounts should be exact.
- DO NOT OPEN THE ENVELOPES
- Notes any discrepancies
- Gathers the PPR and the payment envelopes, placing everything into an inter university envelope and hands it to the CSC. If the CSC is away it is handed to the DCT if both are away it is stored back into the steel box on the back of the CSC door.

17.4 CSC Cash Safe

The following items are stored in the CSC office

- Secondary float (safe)

- Daily receivables envelopes
- Weekly deposits (safe)
- Petty Cash (safe)
- Centre keys (filing cabinet at the end of the day)

18 Walk-in Clinic

Background

In the fall of 2016, the University of Guelph's Counselling Services for students was overwhelmed by the demand for services. By mid-October Counselling Services was running a 5 week waiting list. The CFTC and Psychological Services were asked to lend support to help manage the immediate crisis and long term how complimentary services on campus could be better coordinated.

One outcome was the establishment of a walk-in clinic for university students operated by CFTC and currently held Friday's from 10AM-3PM.

18.1 Walk in Clinic Process

18.1.1 Staffing

- The walk in operates on an as need basis September to April
- In the fall the walk in is staffed by second year Therapist Interns
- First year Therapist Interns are provided opportunity to see clients through the walk-in as part of FRAN 6160.
- Both first and second year therapist Interns will staff the walk in during the winter semester.
- Therapist Interns are asked to sign up to see clients during walk in.

18.1.2 Booking Clients

The majority of University of Guelph students who come to walk in are referred to the CFTC by Counselling Services. There are two ways that students can access CFTC Walk-in Clinic 1) physically walking in on the day the clinic is open 2) calling ahead an booking a walk in appointment time with the CSC Intake. The majority of CFTC walk-in sessions are pre booked. Clients are generally booked r seen for a 30-40 minute session. After which they are placed on a waiting list, however have the opportunity to:

- Book a follow up 30-40 minute session with the therapist they saw a walk-in.
- Return on a subsequent Friday to access walk in services with a therapist on duty at the time.

18.1.3 Arrival Process

When a student arrives to the walk in the receptionist on duty provides them with a clip board with the following documents attached:

- Walk-in Information Sheet
- CFTC Terms of Service
- Consent Form

Each student is asked to complete the Walk-in information sheet and review both the Terms of Service and Consent Form. Once completed all forms are handed bac to the receptionist who adds these to the file.

18.1.4. Seeing a Walk-in Client

The Therapist Intern collects the file from the receptionist and greets the client for the session. The Therapist:

- Reviews the Terms of Service and signing of the Consent form *regardless* of whether the client signed the consent form in the waiting room.
- Reviews the walk-in information sheet with the client
- Uses the Walk-in Note as a work sheet. This note can become the note for the session and a copy can be given to the client if legible and appropriate.
- Consults the supervisor on call/site as necessary

- Reception will assign the file to the Therapist Intern seeing the client on walk-in. The Supervisor is listed as the Supervisor responsible for that walk in (usually the Director of Clinical Training).

19 Miscellaneous Items

Background

These policy notes or other relevant items do not clearly fit in any other section, however are important to document here. They may also be located in other manuals (eg: administration) or on the Website.

19.1 Portability

The practice of psychotherapy is regulated in Ontario by the College of Registered Psychotherapists of Ontario (CRPO). Two other provinces (Quebec and Nova Scotia) also regulate the practice of psychotherapy and three more (BC, New Brunswick, and PEI) are in the process of developing regulations (see https://www.ccpa-accp.ca/profession/regulation-across-canada/). The Federal Governments Agreement on Internal Trade (1994) and Ontario's Labour Mobility Act (2009) allow those regulated as psychotherapists in one province to transfer their certificate of registration to another equally regulated province (see https://www.ontario.ca/laws/statute/09o24). The CRPO does not have a residence requirement to become a member, meaning anyone in the world who meets the registration requirements for the College may make application to become a member.

19.1 Client Satisfaction Survey

Client Satisfaction Surveys will be undertaken once per calendar year. The process for doing so will be as follows:

- The survey will be made available in the waiting room and both therapist interns and reception staff will actively encourage clients attending the Centre for sessions to take part.
- Client Satisfaction Surveys are anonymous and should only be completed once per year per visiting client.
- The surveys will be available for no less than 4 weeks and no more than 6 weeks starting in February.
- The survey results are tabulated and discussed during a Curriculum and Admin meeting in March or April, to determine what if any accountability practices need to be developed and how they will be implemented.

A-1 *Revised 02/2017* INTAKE DATE: _____

INITIALS OF INTAKE PERSON: _____ PREVIOUS ENROLLMENT: _____

ENROLLMENT TYPE: INDIVIDUAL COUPLE FAMILY

CALLER INFORMATION:

Salutation: First Name: _____ Last Name: _____ DOB: _____

Primary Address:

Street Address: _____

City: _____

Postal Code: _____

Alerts: _____

Primary Phone: _____ □ Cell □ Home

Secondary Phone: _____ □ Cell □ Home

Secondary Address:

Street Address: _____

City: _____

Postal Code: _____

Alerts: _____

Primary Phone: _____ □ Cell □ Home

Secondary Phone: _____ □ Cell □ Home

EMAIL ADDRESS: _____

COUPLE AND FAMILY ASSOCIATIONS

Attending First Session: _____

ASSOCIATION NAME	ROLE	NAME	D.O.B.
	_____	_____	_____
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
_____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

CONTACT ASSOCIATIONS (ie. Family Doctor, Caseworks, F&CS, Other Therapists etc)

ASSOCIATION NAME	NAME OF CONTACT	ROLE	CLIENTS ASSOCIATED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

USER DEFINED – ENROLMENT SPECIFIC DATA: Circle appropriate answer

Permission to leave message on primary phone: Yes No

Permission to leave message on secondary phone: Yes No

Permission to mail to primary address: Yes No

Best time to call: AM PM EVE DAY ANY

Client will be called by: _____

Previous Therapy: CFTC EAP FCSS Private Practice CMHA Other:_____

F&CS Involvement: Yes No

Current Open File with F&CS: Yes No

Custody Arrangement: Full – Copy of Agreement Required Shared- Both Parents Attending Shared- C-3 required

IPV Reported: Yes No

Severity of Concern at Intake: _____

Research Participation Agreement: Yes No

Permission to leave message with others in the home: Yes No

Permission to leave message with others in the home: Yes No

Permission to mail to secondary address: Yes No

Appointment Time Requested: AM PM EVE DAY ANY

Session Frequency: Weekly Bi-Weekly Other: _____

Date of F&CS Involvement: _____

F&CS Worker Name: _____

Date of Last IPV Incident: _____

Team Approach Informed: Yes No

REFERRAL SOURCE:

Referral Source: _____ **University of Guelph Student – Insert Payor** ☐

FEE: (sliding scale, cash or cheque only – due at each session)

Income Source: Employment Ontario Works ODSP CPP Family Other: _____

Wage Earner Name: _____Occupation: _____ Income: $_____

Fee Per Session: $_____

Issues/Diagnosis	***Addictions***	***Couple***	***Trauma***
Anger Issues	Couple	Couple Communication	ASCA
Anti-Social Behaviour	Individual	Couple Conflict	Child Witness Other
Abuse/Violence/Perpetrator	Family	Trust Issue	Child Witness IPV
Disability Issues	Gambling		IPV
Grief/Loss		***Family***	Political
Harassment/Discrimination	***Contextual Issues***	Blended Family Issues	Other
Individuation/Differentiation	Crisis	Child/Adolescent Behaviour	
Loneliness/Isolation	Cross Cultural Adaptation	Custody/Access Issues	***Work***
Life Transition	Financial Issues	Extended Family Issues	Career/Employment
Personal Adjustment	Faith/Religious Issue	Elder Care Issues	Work/Life Balance
Physical Health/Illness	Housing Issues	Family Conflict	Workplace Issues
Sadness	Poverty	Family Communication	
School Problems	Systemic Oppression	Parenting	***Mental Health***
Separation/Divorce			Anxiety
Self-Care	***Crisis***		Depression
Self-Esteem	Self-Harm		Eating Disorder
Sexuality	Suicidal Ideation		Mental Health - Other
Sexual Diversity			
Stress			
Time Management			

STATEMENT OF CONCERNS/INTENT FOR THERAPY: When did concerns begin? _____

GOAL:

ADDITIONAL STRESSORS AFFECTING THE SITUATION (i.e. poverty, recent losses, illnesses, addictions etc)

COUPLE AND FAMILY THERAPY CENTRE
FEE SCHEDULE

OUR FULL FEE IS $100.00 PER (50- 60 Minutes)
THE FEE PAID IS PRORATED FOR LONGER SESSIONS

GROSS ANNUAL HOUSEHOLD INCOME	NUMBER OF HOUSEHOLD MEMBERS AND FEE PER SESSION		
	1	**2**	**3-5**
100,000+	100	100	100
90,000-99,000	90	90	90
80,000-89,000	80	80	80
75,000-79,000	75	75	75
61,000 – 74,000	70	65	60
56,000 – 60,000	65	60	55
51,000 - 55,000	60	55	50
46,000 - 50,000	55	50	45
41,000 - 45,000	40	35	30
36,000 - 40,000	35	30	25
30,000 - 35,000	30	25	20
26,000 - 29,000	20	15	15
21,000 - 25,000	15	10	10
16,000 - 20,000	10	10	Negotiable
10,000 - 15,000	10	Negotiable	
0 - 9,000	Negotiable		
ODSP	5 FLAT FEE		
STUDENTS	15 FLAT FEE		

INTRODUCTORY LETTER TO CLIENT

January 1, 2025

Jane Doe
123 University Ave.
Whoville, ON
N1G 1N2

Dear Jane Doe:

Thank you for calling for an appointment at the University of Guelph Couple and Family Therapy Centre. Please find enclosed a brief description of some of our services, terms of service, fees, parking and other important information.

The Couple and Family Therapy Centre is located at the University of Guelph. It is staffed by a team of Therapist Interns specializing in Couple and Family Therapy. The team is dedicated to providing high quality professional services. All the Therapist Interns are supervised by Approved Supervisors or Supervisor Candidates of the American Association for Marriage and Family Therapy. The Centre utilizes established and progressive therapeutic techniques.

The services offered by our Therapist Interns are confidential, except in situations where someone is in danger of being harmed or when the law explicitly states that confidentiality provisions do not apply as outlined in the terms of service. Please feel free to ask your Therapist any questions you might have in this regard.

Please find enclosed a copy of our "Terms of Service". Prior to your first meeting please review this information. The therapist will review these details in full with you at your first meeting.

We charge a fee for service that is not covered by OHIP. Our fees are on a "sliding scale", based on family income and number of persons in the household. The fee is due at each session and can be paid by cheque or cash.

The University of Guelph now has a scent free policy. Please do not wear cologne or perfume when visiting the Couple and Family Therapy Centre.

A map providing directions to the Centre is enclosed. Parking is available at meters in several locations near the Centre on Lennox Lane, or on College Ave. in Parking Lot 23. Parking costs $2.50 per hour on campus. Remember to bring enough change. Meter parking is free after 5:00 p.m. Parking Lot 44, in front of Johnston Hall, is an attendant lot which requires a deposit fee of $16.00 in the morning or $8.00 from 12:00 noon. Upon exiting the lot your deposit is refunded minus $2.50 for each hour you have parked in the lot. Please note that the attendant leaves at 3:45 p.m. No refunds are possible beyond 3:45 p.m.

We look forward to working with you, and hope that you find the experience helpful. If you have any questions at this point, please feel free to call me at (519) 824-4120, Ext. 56335.

Sincerely,

Client Services Coordinator

Encls.

CASEWORKS RECEIPT

PURPOSE:

The University of Guelph requires that a receipt be issued for any and all monies received, whether in the form of cash or cheque.

INSTRUCTIONS:

1. In Caseworks, open the scheduled appointment. Select “Make Payment.”

2. Ensure the date and Enrolment are correct.

3. Select the payee. The billing address will then fill in appropriately.

4. Select “Insert Payment ” Select payment method (cash, cheque), reference number (i.e. cheque numbers where relevant), and the amount being paid.

5. In the comments section, enter what the client is paying for (i.e. 1 session, missed session etc).

6. Save and Print the Receipt. Two receipts are printed. One copy is for the client and one is attached to the payment and submitted to the Client Services Coordinator.

Fee Reduction Tracking Form

Client Enrollment #: _____

Client Name(s): _____

Therapist Intern(s): _____

Fee Reduction # 1 **Date: _____**

Current Client Fee: $_____

Reduction: $_____

Reason for reduction:_____

New Client Fee: $_____

Approved By: _____

SAMPLE LETTER TO REFERRAL SOURCE

July 27, 2005

Dr. Sample
1234 College Ave E.
Guelph, ON
N1G 3P8

Dear Dr. Sample:

I am writing to thank you for referring **Client** to the Couple and Family Therapy Centre. Client met with Therapist Intern on July 22.

We appreciate your consideration of our services and look forward to any future referrals that you deem appropriate.

I am enclosing two copies of the CFT Centre brochure for your use.

Sincerely,

Kevin VanDerZwet Stafford, M.Sc, RP, RMFT.
Director of Clinical Training

Encl.

Enrollment #: 10733

SAMPLE LETTER TO CLIENT: INQUIRING REGARDING CLIENT'S STATUS

March 12, 2011

Harry Pother
89 Privet Dr.
Guelph, ON
N1R 4H3

Dear Mr. Potter:

I am writing this letter to find out if you are still wishing to come to the Centre for therapy. We have not met since February 14, 2011 or (the last appointment(s) we scheduled did not take place). I would appreciate you contacting me at Ext. 56426 or our Client Services Coordinator at Ext. 56335 to let us know your plans.

If we do not hear from you before March 31, 2011, we will close your file. We would open it again if you called back some time in the future.

Sincerely,

Ron Wemsley, B.Sc.
Therapist Intern

Samuel Snape, Ph.D.
Therapy Supervisor

Enrollment #: 10706

SAMPLE COVER LETTER FOR FINAL REPORTS

July 27, 2005

Max Slyde
89 Hoover St
Guelph, ON
N4F 3J8

Dear Mr. Slyde:

Your file at the Centre has recently been closed. Enclosed you will find a copy of the (Final Report, Closing Summary, Initial/Final Report).

If you have any questions, wish to seek services again at any time in the future, or would like information about other services or agencies, please feel free to contact me at (519) 824 - 4120 Ext. 56335.

OR

Your file at the Centre has recently been closed. If you wish to receive a copy of the Final Report, have any questions, wish to seek services again at any time in the future, or would like information about other services or agencies, please feel free to contact me at (519) 824-4120 Ext. 56335.

Sincerely,

Amanda Buda
Client Services Coordinator

Encl.

A-6C

SAMPLE COVER LETTER FOR FINAL REPORTS WITH UNPAID FEES

(date)

(full address of client)

Dear (Mr., Ms. Client):

Your file at the centre has recently been closed. Enclosed you will find a copy of the (Final Report, Closing Summary, Initial/Final Report).

At closing, your account has an outstanding balance of **$ _____** for **(# sessions/no shows/missed)**. We would appreciate payment of this outstanding balance within 30 days of receiving this letter.

Please send a cheque or money order for the outstanding amount along with the bottom portion of this letter in the self addressed envelope that we have enclosed. Cheques should be made payable to the "University of Guelph". We will send you a receipt by return mail. If you have any concerns about being able to complete your payment by the specified date, please contact the Client Services Coordinator.

If you have any questions, wish to seek services again at any time in the future, or would like information about other services or agencies, please feel free to contact the Client Services Coordinator at (519) 824-4120, Extension 56335.

Sincerely,

Amanda Buda
Client Services Coordinator

The Couple and Family Therapy Centre

*Please make cheques payable to the University of Guelph

Enrollment # _____ **Balance Owing: _____**

SAMPLE COVER LETTER WITH NO REPORTS WITH UNPAID FEES

(date)

(full address of client)

Dear (Mr., Ms. Client):

Your file at the Centre has recently been closed. At closing, your account has an outstanding balance of **$ _____** for (**# of sessions/no shows/missed)**. We would appreciate payment of this outstanding balance within 30 days of receiving this letter.

Please send a cheque or money order for the outstanding amount along with the bottom portion of this letter in the self addressed envelope that we have enclosed. Cheques should be made payable to the "University of Guelph". We will send you a receipt by return mail. If you have any concerns about being able to complete your payment by the specified date, please contact the Client Services Coordinator.

If you wish to receive a copy of you (Final Report, Closing Summary, Initial/Final Report) you may do so by contacting the Client Services Coordinator.

If you have any questions, wish to seek services again at any time in the future, or would like information about other services or agencies, please feel free to contact the Client Services Coordinator at (519) 824-4120, Extension 56335.

Sincerely,

Amanda Buda
Client Services Coordinator

The Couple and Family Therapy Centre

*Please make cheques payable to the University of Guelph

File # _____ **Balance Owing _____**

LETTER TO CLIENT CONFIRMING ATTENDENCE

[Date]

[First and Last name]
[Address]
[Address]
[Address]

Dear [client name]:

I am providing this letter in response to your recent request. To date you have attended [number of sessions] sessions ([number] hours) of [individual couple family] therapy at the Couple and Family Therapy Centre at the University of Guelph with therapist intern [intern first and last name] at a rate of [$] per session for a total of [$] to date. [Intern] is in her second year of the two-year Master's of Science with an emphasis on Couple and Family Therapy in the Department of Family Relations and Applied Nutrition. [Intern] is student member of the American Association for Marriage and Family Therapy (AAMFT)

[Intern]'s therapy work is closely supervised by [supervisor] who is a Registered Marriage and Family Therapist and an Approved Supervisor with the AAMFT.

If you would like additional information about the program of study, please visit http://www.uoguelph.ca/family/graduate/couple-and-family-therapy-msc/about-cft-program.

If you have any further questions please do not hesitate to contact [supervisor] at 519-821-4120 ext. 56426.

Sincerely,

_____
[Name, Degree]
Therapist Intern

_____
[Supervisor, Degree]
Therapy Supervisor

LETTER TO CLIENT CONFIRMING ATTENDENCE

PURPOSE:

This is a form letter to be provided to clients requesting confirmation of attendance at therapy and fees paid, usually for insurance coverage purposes.

INSTRUCTIONS:

The template for this letter is saved in Caseworks. The therapist should fill in the appropriate information. This letter is to be addressed only to the client and must be signed by the therapist and the supervisor.

A-6F

COUPLE AND FAMILY THERAPY CENTRE
Department of Family Relations and Applied Nutrition
College of Social and Applied Human Sciences

[Date]

[First and Last name]
[Address]
[Address]
[Address]

Dear [client name]:

I am providing this letter in response to your recent request. To date you have attended [number of sessions] sessions ([number] hours) of [individual couple family] therapy at the Couple and Family Therapy Centre at the University of Guelph with therapist intern [intern first and last name] at a rate of [$] per session for a total of [$] to date. [Intern] is a graduate student in the two-year Master's of Science degree program with an emphasis on Couple and Family Therapy in the Department of Family Relations and Applied Nutrition. [Intern] is student member of the American Association for Marriage and Family Therapy (AAMFT).

[Intern]'s therapy work is supervised by [supervisor] who is a Registered Psychotherapist with The College of Registered Psychotherapists of Ontario – Registration # [Registration Number]. [Supervisor] is also a Clinical Fellow and Approved Supervisor with the AAMFT.

If you would like additional information about the program of study, please visit http://www.uoguelph.ca/family/graduate/couple-and-family-therapy-msc/about-cft-program.

If you have any further questions please do not hesitate to contact [supervisor] at 519-821-4120 ext. 56426.

Sincerely,

_____
[Name, Degree]
Therapist Intern

_____
[Supervisor, Degree]
Therapy Supervisor
[Registration #]

SAMPLE LETTER TO CLIENT: UNABLE TO CONNECT

date

Joan Smith
564 Woodlawn Rd.
Guelph, ON
N1P 4H3

Dear Ms. Smith:

I called [insert date] to set up an appointment with you to come to the Centre. Unfortunately, I was unable to connect with you because [insert reason] I am writing this letter to find out if you are still wishing to come to the Centre for therapy. I would appreciate your calling me at Ext. 56426, or our Client Services Coordinator at Ext. 56335 to let us know your plans. If we have not heard from you by [insert date - two weeks from date of letter], we will close your file. We would open it again if you called back some time in the future.

Sincerely,

Name.
Therapist Intern

Name
Therapy Supervisor

Enrollment #: 10706

A-7A

INITIAL SESSION CHECK-LIST

The following is a checklist for the documentation which should be completed in the **first session**. This checklist is for Therapist-intern and **needs to be initialed**.

Enrollment #: _____

Before First Initial Session:

- ☐ Terms of Service: C-1
- ☐ Fee inserted into Terms of Service
- ☐ Consent Form I - General: C-2 (one per client)
- ☐ Consent Form II – clients under 12 or who do not have capacity: C-3 (if applicable, one per client).
- ☐ Consent to Contact Referral Source: C-5
- ☐ Consent to Release information (if applicable) C4A-4D
- ☐ Confirmed and initialed contact details on enrollment print out (left side of file)

After Initial Session:

- ☐ Photocopy the Session Note for the client(s).
- ☐ Enter your attendance and service event in Caseworks.
- ☐ Collect the Payment from client(s). Ensure any outstanding billing is up to date.
- ☐ Schedule your next appointment with client in Caseworks.
- ☐ Photocopy the Session Note for the supervisor. File copy in the supervisors' hanging folder for session notes in the bottom drawer of the mail cabinet.
- ☐ Scan the terms of service, consent, checklists, and the session note (to be uploaded by Reception staff into Caseworks)
- ☐ Paperclip all scanned documentation and place it in the correct file in bottom drawer of the cabinet.
- ☐ Complete your clinical map. Make a copy for your supervision binder. Scan a copy. Place the original for filing.
- ☐ Begin drafting the Initial Therapy Agreement

NOTES:

Walk In Checklist

Enrollment #: _____

Opening of Walk-In Session:

- ☐ Gather info sheet and other forms from reception
- ☐ Terms of Service (if not already completed)
- ☐ Consent (if not already completed)
- ☐ Verify the personal information on the walk in Sheet **and** enrollment detail
- ☐ Complete walk in session

End of Walk-In Session

- ☐ Referral/Resource Sheet
- ☐ Offer to reschedule another walk in session
- ☐ Complete walk in Session Note
- ☐ Upload documents: Session Note and Info Sheet together, Walk In Checklist. (Terms of Service and Consent if applicable)
- ☐ Place uploaded documents in the Session Notes file in the filing cabinet
- ☐ Place yellow file in the Files for filing folder in the filing cabinet

University of Guelph
Department of Family Relations & Applied Nutrition
Couple & Family Therapy Centre

CLOSING ENROLLMENT - CHECK-LIST

Enrollment # _____

Therapist Intern: _____
Co-Therapist: _____
Supervisor: _____

Indicate with a check-mark that all required documentation is complete in Caseworks:

- ☐ Service Events have been entered (incl. appointments, cancellations, and any relevant phone calls)
- ☐ All documents are up-to-date (session notes, reports, consultation notes, out-of-session notes, letters, risk assessment)
- ☐ CDR's completed and signed by supervisor. CDR's signed in Caseworks
- ☐ All client billing is up-to-date if not, Outstanding Balance $_____ Reason: _____

Indicated with a check-mark that all required documentation is complete in the physical file:

- ☐ Terms of Service (C-1)
- ☐ Consent Form I – General (C-2)
- ☐ Consent Form II – Under 12/No Capacity (C-3)
- ☐ Consent to Release Information (if clinical work involved any correspondence, any consultation, or any conversation with individuals or agency personnel outside CFT Centre) (C-4A, C-4B, C-4C, C-4D)
- ☐ Consent to Contact Referral Source (Authorization Form required) and ☐ completed (C-5)
- ☐ **CONSENT TO SEND MAIL**
- ☐ Initial Session Checklist
- ☐ Initial Therapy Agreement (initialed by client) or Revised Therapy Agreement (initialed by client) (CD-2, CD-3)
- ☐ "Map" of Clinical System (CD-1)
- ☐ Session Notes (complete for every session)
- ☐ Final Report (Initial/Final Closing Summary or Final Report) (CD-4)
- ☐ Linked File, no maps or closing report necessary
- ☐ Client Supervision Form (A-32)
- ☐ Letter to referral source Final Report/Closing Summary (Authorization Form required)

Indicate with a check-mark that the following have been completed

- ☐ File Tape from VCAP has been deleted from archive
- ☐ Copy of Final Report has been made and enclosed for mailing

Client Services Coordinator _____ Date: _____

University of Guelph

Department of Family Relations and Applied Nutrition

Couple and Family Therapy Program

MONTHLY LOG OF SUPERVISON HOURS

Month / Year: _____ Therapist: _____

Supervisor: _____

	Individual/Partnered Supervision				**Group Supervision**			
DATE	Case Report	Live Observ.	Video Observ.	Audio Observ.	Case Report	Live Observ.	Video Observ.	Audio Observ.
TOTAL								

_____ _____

Supervisor's Signature Date

Record all data in increments of ¼ hours.

On letter head

This letter is written at the request of XXXX.

XXX has attended (number of sessions) on the following dates :

July 15, 2015 1 hour $35.00

All of these sessions were conducted by a Therapist Intern in the Couple and Family Therapy Training Program whose work was supervised by Kevin VanDerZwet Stafford, a Registered Psychotherapist with the College of Registered Psychotherapists of Ontario - registration number 1005.

Sincerely,

_____
Katarina Kovacevic, BA
Therapist Intern

_____
Kevin VanDerZwet Stafford, MSc. RP. RMFT
Therapy Supervisor
CRPO Registration Number 1005

Couple and Family Therapy Centre
Department of Family Relations and Applied Nutrition

"MAP" OF CLINICAL SYSTEM

Enrollment #: _____ **Date:**_____

Client Name(s): _____ **Therapist(s):** _____

_____ _____

Important Events, including both positive and problematic

Strengths, Resiliences, Solutions Already Created

INITIAL THERAPY AGREEMENT

Enrollment #:

Client Name (s):

Date(s) of Birth:

Date(s) Seen:

Date of Report:

Therapist(s):

Referral:

Note: This report is based on the author's understanding of information which emerged in the context of NUMBER OF SESSIONS meeting (s). It should be considered selective and partial.

Background Information (documented or reported facts only)

Family History

Cultural / Ethnic / Religious

School / Work / Relationship History

Issue(s) of Concern:

Change Goal(s):

Stressors and Possible Risks:

Resources and Supports:

Therapist's Comments:

Plan for Therapy:

Note: Clinical supervision of this client system was provided by: [list all names of Practicum Supervisors with time frames for supervision].

_____

Name – Therapist Intern

_____

Name – Therapy Supervisor

Report Given to Client ____

Enrollment #_____

REVISED THERAPY AGREEMENT

Enrollment #:

Client Name(s):

Date(s) of Birth:

Date(s) Seen:

Date of Report:

Therapist(s):

Referral:

Note: This report is based on the author's understanding of information which emerged in the context of [NUMBER OF SESSIONS] meeting(s). It should be considered selective and partial.

Updated background Information (documented or reported facts only):
- to be included only where pertinent

Updated Concerns:
- to be included only where pertinent

Change Goals:

Therapist's Comments:

Plan for Therapy:

Note: Clinical supervision of this client system was provided by: [list of all names of Practicum Supervisors with time frame for supervision]

_____
[Name, Degree]
Therapist Intern

_____
[Name, Degree]
Therapy Supervisor

Report Given to Client ____
Enrollment #:

INITIAL/FINAL REPORT

Enrollment #:

Client Name (s):

Date (s) of Birth:

Date Seen:

Date of Report:

Therapist (s):

Note: This report is based on the author's understanding of information which emerged in the context of a single meeting. It should be considered selective and partial.

Background Information:

Issue(s) of Concern:

Stressors and Possible Risks:

Resources and Supports:

Therapist's comments:

Reasons for Ending Therapy:

Recommendations/Referrals:

Note: Clinical supervision of this client system was provided by:
[list all names of Practicum Supervisors with time frames for supervision].

John Doe, B.Sc.	Ann Smith, Ph.D.
Therapist Intern	Therapy Supervisor

A copy of this report was (was not) sent to _____
Enrollment #:

CLOSING SUMMARY

Client File #:

Client Name (s):

Date (s) of Birth:

Dates Seen:

Number of Sessions:

Date of Report:

Therapist (s):

Note: This report is based on the author's understanding of information which emerged in the context of NUMBER meeting (s). It should be considered selective and partial.

Reasons for Ending Therapy:
[include dates of contact and attempts and what messages were left, if any].

Changes Noted:

Current Risks:
[if any, otherwise put "none noted"]

Recommendations/Referrals
[if any, otherwise put "none noted"]

Note: Clinical supervision of this client system was provided by:
[list all names of Practicum Supervisors with time frames for supervision].

_____	_____
John Doe, B.Sc.	Ann Smith, Ph.D.
Therapist Intern	Therapy Supervisor

A copy of this report was (was not) sent to
Enrollment #:

TRANSFER REPORT

Enrollment #:

Client Name(s):

Date(s) of Birth:

Dates Seen: [list dates. If more than 10 list only first and last date, indicating this in brackets]

Number of Sessions:

Date of Report:

Therapist (s):

Note: This report is based on the author's understanding of information which emerged in the context of several meetings. It should be considered selective and partial.

Background Information
[Taken from Initial Therapy Agreement and updated with relevant new information related over the course of therapy]

Summary of Concerns (or Issues) Addressed Over the Course of Therapy:
[three or four sentences briefly identifying chief concern(s); point form is recommended]

Changes Noted:
[include both positive and less positive developments; one sentence for each idea, strategy, solution, etc. discussed; point form is recommended]

Current Risks:
[if any, otherwise put "None noted."]

Reasons for Ending Therapy:
[briefly and specifically identify reason for ending and, if applicable, what clients are planning as their next steps around their concerns]

Note: Clinical supervision of this client system was provided by:
[List all names of Practicum Supervisors with time frames for supervision.]

_____	_____
Name, degree	Name, degree
Therapist Intern	Therapy Supervisor

A Copy of this Report was (or was not) sent to:
Enrollment #:

Couple and Family Therapy Centre, University of Guelph

THERAPY SESSION NOTES

Enrollment # _____ Clients Present _____

Session Number_____ Therapist(s) _____

Session Duration_____ Team Members_____

Date _____ Date of Next Session _____

Session Summary: _____

Client's Comments: _____

Therapist's Comments: _____

Page ____ of _____

☐ ORS completed ☐ SRS completed

_____

Therapist's Signature

CD-7B

Couple & Family Therapy Centre, University of Guelph

THERAPY SESSION NOTES- DIAGRAMS

Enrollment # _____ Clients Present _____
Session # _____ Therapist (s) _____
Session Duration _____ Team _____

Date of Session _____ Date of Next Session _____

Page ___ of _____

☐ ORS completed _____ _____

☐ SRS completed Therapist's Signature Therapist's Signature

OUT OF SESSION NOTES

Enrollment #:_____
Client(s):_____
Date _____
Therapist/s:_____

Notes:

CONSULTATION NOTE

Enrollment #_____
Client(s)_____
Date_____
Therapist Intern(s) _____

Notes:

University of Guelph
Department of Family Relations and Applied Nutrition
Couple and Family Therapy Centre

SUICIDE RISK DOCUMENTATION

Client's Name: _____

Enrollment # _____

Therapist Intern Name: _____

Interview time and date: (from - to): _____

Doctor Name: _____ Doctor's Phone #:_____
Client Age: _____
Thoughts: ❒ Suicidal ❒ Suicidal and Homicidal
Client defined frequency: (e.g., hourly, weekly) _____
Client defined intensity: (e,g., 1= low, 10=high) _____
Does the client live alone? ❒ No ❒Yes
Client has given away prized possessions: ❒ No ❒ Yes
History of suicide - family members/close friends: ❒ No ❒ Yes
When:_____
Perceived Social Supports: 1 2 3 4 5 6 7 8 9 10
(1= feels well supported; 10 = feels very alone)
Client reports feeling indifferent and apathetic: 1 2 3 4 5 6 7 8 9 10
(1= not at all; 10 = very apathetic)
Client reports being angry with others: 1 2 3 4 5 6 7 8 9 10
(1= not angry at all; 10 =very angry)
Hopefulness (1= very hopeful; 10 = very hopeless) 1 2 3 4 5 6 7 8 9 10

Prior history of suicidal ideation in client: ❒ No ❒ Yes
If yes, give details:
_____
_____
_____

Prior history of suicidal attempt in client: ❒ No ❒ Yes If yes, give details:
_____
_____
_____

Current Plan: ❒ Suicidal ❒ Suicidal and Homicidal Specifics:
_____
_____
_____

Preparations made to act on suicide plan (availability of means):

_____
_____
_____

Mental health concerns (recent or historical): ☐No ☐Yes If yes, give specifics (e.g., medications, psychiatrist):

_____
_____
_____

Substance use/abuse: ❒ No ❒ Yes If yes, give specifics:

_____
_____
_____

Family/social support: ❒ No ❒ Yes If yes, give specifics:

_____
_____
_____

Degree of the client's sense of social isolation:

_____
_____
_____

Recent and/or significant loss(es):

_____
_____
_____

Critical event/trigger:

_____
_____
_____

Availability of other resources:

_____
_____
_____

Action taken/arrangements agreed to:

- ❒ Referred to CMHA HERE 24/7 Crisis service
  (Therapist Intern must follow-up with client at next session)
- ❒ Immediate appointment at CMHA Date: ___/____/___ Time:_____
  (day/month/year)
- ❒ Psychiatric assessment (CMHA) appointment
  Date: ___/____/___Time:_____
  (day/month/year)
- ❒ Safety plan enacted, see attached
- ❒ Referred to emergency department.
- ❒ Intern called police
- ❒ Intern called Crisis team
- ❒ Intern called ambulance
- ❒ Intern accompanied client to Emergency Department
- ❒ Client to contact family physician/psychiatrist
- ❒ Intern called family physician/psychiatrist
- ❒ Client to contact relative/friend - Name of friend: _____
- ❒ Intern called relative/friend
- ❒ Other Please specify: _____
- ❒ Name of supervisor providing consultation_____

Details of Conversation with Supervisor:

_____
_____
_____

Details of conversations with other professionals such as physicians, psychiatrists, etc.

_____
_____

Details of information exchanged with any other person, such as family members, etc.

_____
_____
_____

_____/___/____
Signed (Therapist-intern) Date *(day/month/year)*

_____/___/_____
Signed (consulting Supervisor) Date: *(day/month/year)*

_____/___/_____
Signed (Supervisor of record) Date: *(day/month/year)*

Couple and Family Therapy Centre
Department of Family Relations and Applied Nutrition
University of Guelph

SAFETY PLAN

I am aware that the Couple and Family Therapy Centre is not a crisis service and my Therapist Intern is not available to provide immediate assistance in a crisis situation. Therefore, I agree that, if I am having suicidal thoughts, including thoughts about how I might take my own life, and I believe that I might act on these thoughts, I am committed to doing one or more of the following:

- Call the Crisis Line HERE 24/7 1-844-437-3247 and openly discuss my suicidal feelings and thoughts.
- Inform a family member or friend that I am feeling suicidal and ask them to stay with me until I feel more stable

_____
(name) *(telephone number)*

_____
(name) *(telephone number)*

- Proceed to the nearest local hospital emergency department either with a friend, family member or by calling 911 and inform them that I am experiencing suicidal thoughts and am afraid that I might act on these thoughts.

Additional activities that I can do that may help minimize the risk of suicide (eg: removing access to items of risk from home) and alleviate some feelings associated with suicidal thoughts (eg: helplessness, overwhelm, anxiety, etc.) include:

_____/___/___
Client Name DOB *(day/month/year)*

_____ Date_____ Enrollment #: _____
Client Signature

_____
Therapist Name(s) and Signature Date

_____
Therapist Name(s) and Signature Date

REQUEST FOR A LINKED FILE

Administrative Therapist: _____

Co-Therapist: _____

Current Client Name(s):

_____

_____

Current enrolment # _____

New File Request: **INDIVIDUAL** **COUPLE** **FAMILY**

Client(s) of New File:

Client Name: _____ Date of Birth: _____

Client Name: _____ Date of Birth: _____

Client Name: _____ Date of Birth: _____

Client Name: _____ Date of Birth: _____

Address (if new):

_____

Phone Number(s) (if new):

_____

Supervisors' Signature: _____

Brief Intake Notes (i.e. purpose of file):

University of Guelph
Department of Family Relations and Applied Nutrition
Couple and Family Therapy Centre

CLIENT SUPERVISION FORM

Therapist: _____

Co-Therapist: _____

Therapy: I C F

Client #: _____

Date of First Session: _____

Date of Last Session: _____

Names	**Ages**	**Therapy focus/goals**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dates Reviewed in Supervision (Initialled by Supervisor)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CONSULTATION DECISIONS RECORD

Client Name (s):

Enrollment #:

Therapist Intern(s):

Supervisor of Record:

Consulting FROSS or FROCS Supervisor:

Date of Initial Consultation:

Choose one of the following issues and identify it in the "Issue for Consultation"

RISK/SAFETY ASSESSMENT
SUICIDE ASSESSMENT
SAFETY PLAN
FAMILY & CHILDREN'S SERVICE REPORT
IPV ASSESSMENT RECOMMENDATION
LEGAL CONSULTATION (NAME)
CHANGE IN CLINICAL CONSTELLATION
ETHICAL CONSIDERATIONS or CONSULTATIONS
PROFESSIONAL REPORTING
OTHER (Specify)

Hypothetical
Individual Therapy

Report Made
Couple's Therapy

Issue for Consultation:

Notes on Issue:

Recommendations/Directives (brief summary below)

Follow up by Supervisor of Record:

Additional Issue for Consultation: **DATE:**

Notes on Issue:

Recommendations/Directives (brief summary below)

Follow up by Supervisor of Record:

_____

Additional Issue for Consultation: **Date:**

Notes on Issue:

Recommendations/Directives (brief summary below)

Follow up by Supervisor of Record:

_____

CD-W1 2016 Date: _____

Walk – In information sheet: Couple and Family Therapy Centre

Enrollment # : _____ **First Name:** _____ **Last Name:** _____

1 **What concern/problem brings you into Couple and Family Therapy walk-in services today? What do you hope to address or come out of today's 20-30 minute session?**

_____
_____
_____
_____
_____
_____
_____

2 **How much are you concerns impacting your life? (1=lowest and 10 = highest impact)**

1 2 3 4 6 7 8 9 10

3

I am experiencing difficulties with: (check all that apply)

General Concerns

- ☐ Depression
- ☐ Anxiety/stress
- ☐ Loss/grief
- ☐ Sleep
- ☐ Sex/sexuality
- ☐ Suicidal thoughts
- ☐ Alcohol/drug/gaming/porn use
- ☐ Emotional regulation (anger/frustration)
- ☐ Assault/violence/abuse (emotional, physical or sexual)
- ☐ Harassment/Discrimination

School

- ☐ Academic performance

Relationships

- ☐ Dating/Marital
- ☐ Family Relationships
- ☐ Living Arrangements/house, mate conflict
- ☐ Social Relationships

☐ Other: _____

And this is causing me to: (check all that apply)

- ☐ Feel concerned enough that I want to speak with a therapist/counsellor.
- ☐ Be at risk for failing a course or dropping out of school.
- ☐ Feel concerned for my own, or someone else's safety or well-being.
- ☐ Have strong suicide thoughts and a plan.

4

Date of Birth (D/M/Y) _____ Gender: ☐ Female ☐ Male ☐ Transgender

U of G Email: _____ @mail.uoguelph.ca

Best Contact #:_____ Is it okay to leave messages ☐ Yes ☐ No

Residence / Local Address: _____ City: _____

Program: _____ Current # of Courses: _____ Semester #:_____ ☐ Undergraduate ☐ Graduate

Have you seen a counsellor at UofG before (including groups?) ☐ Yes ☐ No **If yes,** approximately how long ago? _____

Walk-In Session Note

Enrollment #: _____ Date: _____

Client's Name: _____ Therapist(s): _____

Issues of Concern/Problem:

Strengths & Skills:

Resources:

Exceptions to Problem:

Next Steps (Concrete):

Therapist Signature: _____

COUPLE AND FAMILY THERAPY CENTRE
Department of Family Relations and Applied Nutrition
College of Social and Applied Human Services

TERMS OF SERVICE

General:
The Couple & Family Therapy Centre (CFTC) is a teaching facility within the University of Guelph's Master's of Science Couple and Family Therapy Program (MSc.CFT). Our Therapist Interns are graduate students and provide therapy services under the supervision of clinical supervisors. CFTC's teaching and training program is recognized by the *College of Registered Psychotherapists of Ontario* (CRPO) and accredited by the American Association for Marriage and Family Therapy (AAMFT). The CFTC may amend these Terms of Service from time to time without notice. In the event of a discrepancy between a print version (downloaded) and the Web version, the Web version will apply.

Therapy Services:
1. CFTC provides individual, couple and family therapy services ("Therapy Services").
2. Absent other factors, individuals who are twelve (12) years of age or older are presumed capable of consenting to receive Therapy Services.
3. Individuals who are under the age of twelve (12) years of age are not presumed capable of consenting to receive Therapy services and therefore normally require consent from the custodial parent(s) or substitute decision maker).
4. Therapy Services do not include:
    a. assessments required for court proceedings (eg: child custody and access; parental competence; child abuse; pre-trial disposition reports; probation assessments, etc) or.
    b. crisis support or after hours contact;
    c. intervention services to individuals experiencing active and/or acute episodes of a psychiatric illness, or to clients in acute crisis situations.

Electronic Record:
5. In-centre Therapy Services are recorded ("Electronic Recording"). Electronic Recordings do not replace the written clinical notes which are part of the clinical record. Electronic Recordings are used to support the training function of the CFTC, so that Therapist Interns can evaluate their own work and have it reviewed by a clinical supervisor ("Purpose"). Once the Purpose has been satisfied (normally within two weeks), the Electronic Recording is destroyed.

Confidentiality:
6. Subject to section 7 below, a client's personal health information is kept confidential and can be disclosed to a third party only with the client's consent or the consent of a substitute decision maker in accordance with PHIPA - *Personal Health Information Protection Act* (Ontario).

7. Disclosure of personal health information is considered in accordance with PHIPA and includes but is not limited to the following circumstances:

    a. in response to a court order or as otherwise required by law;
    b. to report a child in need of protection in accordance with the *Child and Family Services Act (1990);*
    c. to eliminate or reduce a significant risk of serious bodily harm to a person or group of persons;

d. for the provision of emergency healthcare in circumstances where it is not possible to obtain the client's consent in a timely manner and the client has not prohibited such disclosure; or
e. to report a client who is a member of a regulated health profession and where mandatory reporting under the *Regulated Health Professions Act 1991* applies.

Fees & Cancellation Policy:

8. The CFTC operates on a cost recovery basis. Fees for Therapy Services are based upon a number of factors including household income, number of dependents and length of session (60 or 90 minutes). In addition to in-person appointments, fees will be charged for telephone calls longer than 15 minutes at the same rate, pro-rated.
9. Fees are to be paid in full at each session and receipts issued. Receipts should be kept for taxation or insurance reimbursement purposes.
10. Clients are required to provide twenty-four (24) hours' notice for cancellation except in the case of emergency or illness. No-shows and cancellations without twenty-four hours' notice are subject to the full session fee. Chronic lateness and missed appointments may be subject to additional charges or be grounds for termination of service.

Established Fee:_____ per hour. Enrollment #: _____

Records:

11. Clinical records which include personal health information are subject to PHIPA and the Professional Practice Standards of the CRPO.
12. Clinical records are kept for a period of 10 years after the date of last contact with the client or in the case of family counselling, for a period of 10 years after the eighteenth birthday of the youngest person to attend the Therapy Session, whichever is longer.
13. Requests for access to or copies of clinical records must be made in writing. Copying fees may apply.

Concerns:

14. Any concerns regarding Therapy Services can be raised directly with Therapist Interns or with the Director of Clinical Training.

COUPLE AND FAMILY THERAPY CENTRE
Department of Family Relations and Applied Nutrition
College of Social and Applied Human Services

TERMS OF SERVICE – ELECTRONIC PRACTICE

General:
The Couple & Family Therapy Centre (CFTC) is a teaching facility within the University of Guelph's Master of Science Couple and Family Therapy Program (MSc.CFT). Our Therapist Interns are graduate students and provide therapy services under the supervision of clinical supervisors. CFTC's teaching and training program is recognized by the *College of Registered Psychotherapists of Ontario* (CRPO) and accredited by the American Association for Marriage and Family Therapy (AAMFT). The CFTC may amend these Terms of Service from time to time without notice. In the event of a discrepancy between a print version (downloaded) and the Web version, the Web version will apply.

Electronic Therapy Services:

1. The Terms of Service – Electronic Practice is an addition to the general Terms of Service and for which consent was previously provided.
2. Electronic therapy services are used to support and enhance face to face therapy, they are not intended to replace face to face contact.
3. The CFTC will take reasonable steps to ensure that the electronic communication technology (eg: video conferencing portal) is secure, confidential and appropriate.
4. Clients recognize that electronic communication technology *is not* a secure mode of communication and confidentiality cannot be ensured.
5. Clients must physically be in the province of Ontario to receive electronic therapy services.
6. Clients will ensure the therapist has updated contact information (address telephone numbers) on file.
7. Clients will report their geographic location (eg: at home; at office) to the therapist at the beginning of the call.

Concerns:

8. Any concerns regarding Therapy Services can be raised directly with Therapist Interns or with the Director of Clinical Training.

COUPLE AND FAMILY THERAPY CENTRE
Department of Family Relations and Applied Nutrition
College of Social and Applied Human Sciences

Consent Form I - General

Enrollment #:_____

Client Name:_____ DOB: (MM)_____, (DD)_____, (YYYY)_____

Address: _____

_____

Consent requirements

The capacity to consent means an individual understands the information relevant to making a decision about participating in Therapy Services and appreciate the reasonably foreseeable consequences of participating in Therapy services. ("Capacity").

Clients who are 12 years and older can consent to Therapy services unless it is the opinion of the Therapist that the Client lacks Capacity.

Clients who are 12-15 years of age can consent to Therapy Services unless it is the opinion of the Therapist that the Client lacks Capacity. Prior to commencing Therapy Services, a discussion regarding the desirability of the parent(s)/guardian involvement will be discussed.

Consent

I understand and agree to the CFTC's "Terms of Service" for Therapy Services available on the CFTC's website. I voluntarily consent to receive Therapy Services in accordance with the Terms of Service.

_____ _____

Client's signature Date

_____ _____

Date Therapist Intern's signature

_____ _____

Date Therapist Intern's signature

A SEPARATE CONSENT FORM MUST BE COMPLETED FOR EACH CLIENT

COUPLE AND FAMILY THERAPY CENTRE
Department of Family Relations and Applied Nutrition
College of Social and Applied Human Sciences

Consent Form II
(clients under the age of 12 or who do not have "capacity" to consent)

One person per form

Enrollment #:_____

Client Name:_____Client DOB:(M)_____, (D)_____, (Y)_____

Address:_____

A. Consent requirements

The capacity to consent means an individual understands the information relevant to making a decision about participating in Therapy Services and appreciates the reasonably foreseeable consequences of participating in Therapy services. ("**Capacity**").

Clients who do not have Capacity or who are under the age of 12 years old cannot provide consent. In these circumstances, another individual can give or refuse consent in accordance with the *Health Care Consent Act* ("**Substitute Decision Maker**").

B. Substitute Decision Maker

Under the *Health Care Consent Act*, an individual may act as a Substitute Decision Maker if he or she qualifies under one of the following categories. If one or more individuals are involved, precedence is given based on the ranking of the categories which applies in descending order. For example, #1 (authorized guardian) has precedence over #4 (spouse or partner).

I / We, _____ am / are:

1. ☐ guardian with authority to give or refuse consent to the treatment;
2. ☐ power of attorney for personal care, with authority to give or refuse consent to the treatment;
3. ☐ representative appointed by the Consent and Capacity Board, with authority to give or refuse consent to the treatment;
4. ☐ Client's spouse or partner;
5. ☐ Client's parent
    - ☐ *not* separated from Client's other parent – one parent's consent is required
    - ☐ separated from Client's other parent without custody agreement or order in place **both parents must consent.**

- ☐ Separated from Client's other parent with custody agreement or order in place – **COPY OF CUSTODY AGREEMENT OR ORDER MUST BE PROVIDED AND RETAINED.**

5. ☐ Client's parent
   - ☐ joint custody – **both** parents must consent **unless a court order indicates otherwise**
   - ☐ sole custody – custodial parent's consent sufficient

6. ☐ Client's parent with only a right of access **when** custodial parent is unavailable ***(reasonable efforts must have been made to reach the custodial parent);***

7. ☐ Client's brother or sister; or

8. ☐ Client's other relative.

C. Requirements

I/We also acknowledge and agree that I/we:

- ☐ have/each have Capacity
- ☐ am/are at least 16 years old, (parents are exempted from the age requirement);
- ☐ am/are each not prohibited by court order or separation agreement from having access to the Client or giving or refusing consent on the Client's behalf; and
- ☐ am/are willing to assume the responsibility of giving or refusing consent.

I/We have read, understand and agree to the CFTC's "Terms of Service" for Therapy Services available on the CFTC's website. I/We voluntarily consent on behalf of the Client, to receive Therapy Services in accordance with the Terms of Service.

_____ _____

Substitute Decision Maker's signature Date

IF TWO SIGNATURES REQUIRED:

_____ _____

Substitute Decision Maker's signature Date

_____ _____

Therapist Intern's signature Date

_____ _____

Therapist Intern's signature Date

C-4A *revised 11/2016*

COUPLE AND FAMILY THERAPY CENTRE
Department of Family Relations and Applied Nutrition
College of Social and Applied Human Sciences

CONSENT TO RELEASE INFORMATION - FORM I
General – *one form per client*

Enrollment # _____Client's Name: _____

Address: _____

_____Date of Birth: _____/_____/_____
(day/month/year)

I _____, consent to have the **Couple & Family Therapy Centre** to release to
(client's name)

_____, information contained in my Clinical Record as follows
(agency, organization, school, hospital, professional)

_____
(state type of information)

for the purpose of:_____

I _____, consent to _____ releasing
(client's name) *(agency, organization, school, hospital, professional)*

information contained in my Clinical Record as follows to the **Couple & Family Therapy Centre**

_____
(state type of information)

for the purpose of:_____

I consent to release information: ❑ verbally ❑ in writing ❑ via facsimile
❑ by email (understanding that email may not be a secure mode of communication)

I consent for this release to remain inforce until _____ unless I revoke it in writing prior to that date.
(date – Max. 1 year)

_____ _____
Client Signature Date

_____ _____
Therapist Intern Signature Date

_____ _____
Therapist Intern Signature Date

C-4B revised 11/16

UNIVERSITY of GUELPH

COUPLE AND FAMILY THERAPY CENTRE
Department of Family Relations and Applied Nutrition
College of Social and Applied Human Sciences

CONSENT TO RELEASE INFORMATION - FORM II
(clients under the age of 12 or who do not have "capacity" to consent)
one form per client

Enrollment # _____Client's Name: _____

Address: _____

_____Date of Birth: _____/_____/_____
(day/month/year)

I, _____am the substitute decision maker of
(substitute decision maker name and relationship eg: parent, guardian etc))

_____ and consent to the **Couple & Family Therapy Centre** to release to
(name)

_____, information contained in _____ Clinical Record as follows
(professional organization, school, hospital, etc)

_____
(state type of information)

for the purpose of: _____

I, _____, also consent to _____ releasing
(professional organization, school, hospital, etc)

information contained in _____ Clinical Record to the **Couple & Family Therapy Centre,** as follows

_____
(state type of information)

For the purpose of: _____ .

I consent to release information: ❑ verbally ❑ in writing ❑ via facsimile
❑ by email (understanding that email may not be a secure mode of communication)

I consent for this release to remain inforce until _____ unless I revoke it in writing prior to that date.
(date – max. 1 year)

_____ _____
Substitute decision maker Signature Date

_____ _____
Therapist Intern Signature Date

_____ _____
Therapist Intern Signature Date

C-4C

COUPLE AND FAMILY THERAPY CENTRE
Department of Family Relations and Applied Nutrition
College of Social and Applied Human Sciences

CONSENT TO RELEASE INFORMATION – FORM III
Internal to CFTC

Enrollment # _____Client's Name: _____

Address: _____

_____Date of Birth: _____/_____/_____
(day/month/year)

I_____ , consent to my couples/family therapist(s) at the **Couple & Family Therapy Centre** to release information contained in my couples therapy clinical record, to my individual therapist at the **Couple & Family Therapy Centre.**

I_____ , consent to my individual therapist at the **Couple & Family Therapy Centre** to release information contained in my individual therapy clinical record to my couples therapist(s) at the **Couple & Family Therapy Centre**.

I consent to releasing information: ❑ verbally ❑ in writing ❑ via facsimile
❑ by email (understanding that email may not be a secure mode of communication)

I consent for this release to remain inforce until _____ unless I revoke it in writing prior to that date. (date – Max. 1 year)

_____ _____
Client Signature Date

_____ _____
Therapist Intern Signature Date

_____ _____
Therapist Intern Signature Date

C-4D *revised 11/2016*

COUPLE AND FAMILY THERAPY CENTRE
Department of Family Relations and Applied Nutrition
College of Social and Applied Human Sciences

CONSENT TO RELEASE INFORMATION – FORM IV
FAMILY MEMBERS

Enrollment #: _____

For the purpose of sharing among other members of the relational system, information garnered in individual conversations between one member of the system and the therapist, or in sessions where all members of the relational system were not present

I_____ , consent to the **Couple & Family Therapy Centre** to release to

_____ information discussed in individual conversations with our Therapist
(name(s) of family/system member(s)

Intern, or in sessions where all members of the enrollment numbered below were not present for the purpose of:

_____

I consent to release information: ❑ verbally ❑ in writing ❑ via facsimile
❑ by email (understanding that email may not be a secure mode of communication)

I consent for this release to remain inforce until _____ unless I revoke it in writing prior to that date. (date – Max. 1 year)

I consent for this release to remain inforce until therapy is finished unless I revoke it in writing prior to then.

_____ _____
Client's Signature Date

_____ _____
Therapist Intern Signature Date

_____ _____
Therapist Intern Signature Date

C-5 *Revised 11/2016*

UNIVERSITY of GUELPH

COUPLE AND FAMILY THERAPY CENTRE
Department of Family Relations and Applied Nutrition
College of Social and Applied Human Sciences

CONSENT TO CONTACT REFERRAL SOURCE

Enrollment # _____Client's Name: _____

Address: _____

_____Date of Birth: _____/_____/_____
(day/month/year)

I _____ consent to the CFT Centre contacting the following referral source for the sole purpose of acknowledging this referral for therapy services:

I consent for you to release information: ❑ verbally ❑ in writing ❑ via facsimile
❑ by email (understanding that email may not be a secure mode of communication)

Referral Information (Please Print):

Title:_____ First Name: _____ Last Name:_____

_____ _____ _____
(Referral - Address) (City) (Postal Code)

_____
(Referral - Phone)

_____ _____
Client Signature Date

_____ _____
Therapist signature Date

_____ _____
Therapist signature Date

COUPLE AND FAMILY THERAPY CENTRE
Department of Family Relations and Applied Nutrition
College of Social and Applied Human Sciences

Consent Form - Electronic Practice

Enrollment #:_____

Client Name:_____ DOB: (MM)_____, (DD)_____, (YYYY)_____

Address: _____

_____

Consent requirements

The capacity to consent means an individual understands the information relevant to making a decision about participating in Therapy Services and appreciate the reasonably foreseeable consequences of participating in Therapy services. ("Capacity").

Clients who are 12 years and older can consent to Therapy Services unless it is the opinion of the Therapist that the Client lacks Capacity.

Clients who are 12-15 years of age can consent to Therapy Services unless it is the opinion of the Therapist that the Client lacks Capacity. Prior to commencing Therapy Services, a discussion regarding the desirability of the parent(s)/guardian involvement will be discussed.

Consent

I understand and agree to the CFTC's "Terms of Service -Electronic Practice" for Therapy Services to be provided via video conferencing, available on the CFTC's website. I voluntarily consent to receive Therapy Services via video conferencing in accordance with the Terms of Service – Electronic Practice.

_____ _____

Client's signature Date

_____ _____

Date Therapist Intern's signature

_____ _____

Date Therapist Intern's signature

A SEPARATE CONSENT FORM MUST BE COMPLETED FOR EACH CLIENT

CONFIDENTIALITY AGREEMENT

TO: University of Guelph ("University")

In my capacity as a MSc. student in the Couple and Family Therapy program ("Program"), I acknowledge that I will be involved in **confidential** discussions, have access to, and may receive client **confidential** personal health information ("PHI"). "**PHI**" means identifying personal health information about an individual whether visual, written, electronic or oral, in accordance with the *Personal Health Information Protection Act*. ("PHIPA"). I further acknowledge and agree that PHI includes but is not limited to the information in the client clinical record. PHI does not necessarily include the client's name. If a client can be recognized, the information is considered PHI.

I acknowledge and agree that subject to applicable legislation and standards set by the College of Registered Psychotherapists of Ontario and the American Association for Marriage and Family Therapy, I agree at all times to keep PHI, **confidential** and not to disclose any **confidential** PHI to any third party.

I acknowledge and agree that the collection, use, storage and disclosure of PHI is subject to PHIPA as well as such policies of the University of Guelph and the Couple and Family Therapy Centre as may exist from time to time. I also agree that, upon receiving a written request from the University, I will return to the University all PHI provided to me in written or electronic form, and all originals and copies thereof in any form.

I acknowledge and agree that should I breach this Agreement for any reason, I have a positive duty to notify the Director of Clinical Training immediately.

I also acknowledge and agree that should I breach this Agreement, I may be subject to academic restrictions with respect to participation in the Program.

_____ _____

Print name Date

_____ _____

Signature student number

CONFIDENTIALITY AGREEMENT

TO: University of Guelph ("University")

In my capacity a University of Guelph employee in the Couple and Family Therapy program ("Program"), I acknowledge that I may be involved in **confidential** discussions, have access to, and may receive confidential Information. "Information" means all information, whether visual, written, electronic or oral, related to the personnel, the students, clients and the business, financial and other affairs of the University. All Information shall be considered **confidential** Information: (a) if it is marked confidential; (b) if it is identified in writing as confidential within thirty (30) days after non-written disclosure; (c) or if I ought reasonably to have determined that the University would consider it confidential.

I agree at all times to keep **confidential** Information, **confidential** and not to disclose any **confidential** Information to any third party without the prior written consent of the University. I also agree not to use any of the Information, confidential or not, for any purposes other than to further the interests of the University.

I further agree that, on receiving a written request from the University, that I will return to the University all Information provided to me in written or electronic form, and all originals and copies thereof in any form.

I acknowledge that the disclosure of Information to me shall not be construed as granting to me (or to any third party) any right, title or interest in or to the Information. I agree that I will abide by this Agreement, applicable law and all relevant University policies with respect to the collection, use and disclosure of all Information.

I acknowledge that the University would be irreparably injured by a breach of this Agreement by me and that the University shall be entitled to equitable relief, including injunctive relief and specific performance, in the event of any breach of the provisions of this Agreement by me (such remedies not being deemed to be the exclusive remedies for a breach of this Agreement, but to be in addition to all other remedies available at law or equity). No failure or delay by the University in exercising any right, power or privilege under this Agreement shall operate as a waiver thereof, nor shall any single or partial exercise thereof preclude any other or further exercise of any right, power or privilege hereunder.

_____ _____

Print name Date

_____

Signature