OPC COLLEGE CLINICAL PRACTICUM MANUAL

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POLICIES:

General Supervision Policies

1. Minimum Client contact hours for OPC: Students will need to carry approximately 3-4 regular clients to meet minimum graduation requirements and so that faculty may adequately evaluate clinical competency. Students who require accommodations regarding carrying fewer clients must submit an accommodation form. **Minimum Required Hours for graduation:** Students must complete a minimum of 300 hours of client contact. **Students will complete 21 hours of Supervision in Y4 and Y5 for a total of 42 hours needed to graduate.**

2. Cost of extra clinical supervision at the request of students:
OPCC clinical supervisors can provide extra dyad supervision at a cost and duration to be determined by the supervisee and supervisor. Optional 2-hour group supervision is possible when available for a cost determined by the supervisor and the supervisees. Requested extra clinical supervision is contracted directly with the clinical supervisor.

Please speak to your supervisor about extra supervision if:

*In Y4 Supervision your total CCH exceeds 75 hours at the end of January and/or your total CCH exceeds 150 hours at the end of June.

*In Y5 Supervision your total CCH exceeds 175 hours at the beginning of September and/or your total CCH exceeds 225 hours at the end of January.

**Your supervisor will determine if extra supervision is required based on the ratio of CCH to Supervision hours. Please speak to them for more details.*

3. Professional Membership and Insurance

Once a student receives approval for supervision, then a student must apply and receive malpractice and general liability insurance (minimum for malpractice is 1 million) within the first month. You are free to explore any options for your malpractice insurance as long as it meets the minimum requirement stated above.

OPCC suggests that students contact the CAPT website to initiate a student membership through which students can easily access insurance coverage through CAPT membership. Scott Petrie is the contact person if you have questions and for letters of confirmation of enrollment. (Scott sends these through to CAPT prior to Orientation. If you are not sure if yours has gone

through once you reach out to CAPT or if you go through another membership, reach out to Scott.)

4. Clients of Students in Clinical Practicum

A student can only see their assigned OPCCclients in a sanctioned office or online and in consultation with clinical supervisors to ensure appropriate professional practice standards are maintained and followed when conducting their practice. Students can make themselves available for in-person practice (when it is safe to do so) to a maximum of 2 of their clients.

If a student leaves the program either by withdrawing, taking **a leave of absence (LOA)** or due to a decision for withdrawal made by OPCCFaculty, the student must be engaged with their clinical supervisor for the process of closure and referral. A student will need to completely finish their clinical practicum and graduate in order to receive credit and/or clinical hours for any part of the 2-year minimum clinical practicum. OPCCwill not support/supervise or give credited clinical hours to students who deliver health care services to clients who are not referred by the OPCC clinical practicum supervisors.

If a student has not fully completed the OPCCCollege, OPCCcannot provide a completion reference for clinical practicum. We do not offer a certificate of studies for the three academic foundational pre-clinical years. Transcripts will be provided upon request for completed studies, excluding a clinical practicum that is not complete.

Case Note Policies and Procedures

Case Notes Requirements:

A) Students in clinical practicum are required to maintain appropriate case notes and client documentation for every client that they see. And post all of their notes in the Jane app.

B) Supervision students will complete the OPCC assessment forms for each initial consultation and SOAP notes for every regular session. And post them all to the Jane app.

C) Supervisors will review 2 case notes a week through the Jane app (as soon as the student has the client numbers to support this).
D) Once a student has posted 150 case notes on the Jane app. Your supervisors may stop reviewing your notes unless your supervisor determines that your notes need further refinement/development.

E) Students will be required to maintain a log of clinical hours: a running total of CCH, along with

a running number of active clients and their scheduling etc. This will be posted to a Sync folder each week by Friday at 5pm.

F) All in-person client sessions must be booked through the Jane app.

G) Clinical Supervisors can and may request all Case notes at any time and thus, students must ensure that their case notes are complete and up-to-date on all clients and provide the requested notes within a 3-day period.

H) Students are not to use AI to record/transcribe or write Casenotes. In Y5, a student may request to do this. Ultimately this will be decided by the Clinical Supervisor.

Room booking client contact hours and practicum tuition:

OPCC students can see OPCCclients (clients that have been given to the training therapist through the OPCCdirectory and are under the supervision of an OPCCFaculty) in OPCCStudent office space or an approved office elsewhere.

Tuition and Student Fees

The additional tuition fees of your clinical practicum cover the costs associated with the administration of the clinical practicum aspect of the program. Often these costs can be offset by the minimal fees that student therapists are permitted to charge the clients that they see. A student in clinical practicum offers their client a sliding scale from **$25.00 to $55.00.** Please clarify the fee in the same order **($25 to $55)** in the first session.

Students book client sessions through the Jane app. Each Supervision student may see a maximum of 2 of their clients in-person. Booking through the Jane app is required (whether online or in person) and assists in securing in-person session times and is also a method through which OPCCfaculty can verify in-person and online client contact numbers.

Once you exceed 300 CCH, any room bookings above 16 hours a month requires the payment of room rental fees at the cost of $25.00 per hour (50 minutes). Rental fees can be etransfered to opcfinance@opcprogram.ca

Students with their own, approved-by-your-supervisor office space or seeing clients virtually are still required to maintain appropriate records of all client contact.

Room Booking Policies

Room Bookings & Offices Available

Student offices at 43 are room 101,102, 103,104 and room 105.

There is a white cabinet at 43 in the waiting room which contains a sand table as well as many objects for creative activities. Please feel free to use it and to top up any supplies that you may use on a regular basis.

A student can only book **two weeks ahead and cannot block book, (unless given permission by supervisors if students are from out of town) . In other words they must see a client and then book after they see them.** A student books only **on the hour** and not the half hour. A student ends their session at **ten to the hour** and leaves the office at **five to the hour.** A student cannot occupy the offices if they haven't been booked. There are sound machines outside of each office and these must be turned on when you begin a session and turned off when you leave the office.

To book a room on the Jane app, first sign in at https://opcprogram.janeapp.com/, then in Schedule (on the top), select the hour that you would like to book your session at. A menu will appear on the right side. Click on the drop-down menu Session and choose either In-person Initial Consultation or In-person Session.

When you see your clients at 43 Madison, please let them know to come to the back deck, lower level so they don't knock on the front door. There is street parking available for a cost.

Internet Access:

This is available for student therapists for case notes and room bookings only. Please do not give out the security key to anyone unless you run it by Amy McGrath.

Wi-Fi: 43Madison

Password: airplane

There is one desktop computer (in room 104), which is only used for room bookings and library bookings. If there are no other student therapists in the building when you leave, then shut the computer off. If you want to use the desktop computers for any other reason, then run it by Amy McGrath at 1-905-932-7898.

The desktop will be password protected and the password should not be given to anyone who is not a student of OPCC.

Password is: Harry Potter

Security:

Please let your clients know that there is no parking or drop off in the parking lot. A student will be given a key to the building. **You must try your key on both doors as soon as you get them.**

Never lock the following rooms: **101, 102, 103, 104, Room 105.**

There is a lock box attached to the pipes at 43 Madison located by the garbage cans. It is the first box and the combination is **1390**. Line up the numbers in the middle to open. There is an extra set of keys there. Please return the keys immediately once you open your doors and ensure that the box is closed. You must practice opening the lock box before you see clients.

Maintain a respectful quite decorum at all times while in the building.

43: Make sure that you put the "in session" sign on if in room 101, 102, 103, 104 or 105. Once you finish please change the sign to indicate that the room is free.

Before you leave, make sure that everyone has left the building by looking at the "in-session" signs and listening in case someone forgot to change their sign-in and/or change the sign on their door. Please turn off all the lights. (The switches are located in the little office outside the furnace room, across from Room 105, and outside the door at the bottom of the stairs.)

There is to be no loud physical work in the office, which is not soundproof. Students may book Room 105 for this kind of session.

Supplies:

At 43 Madison you will find all these supplies in the furnace room opposite the waiting room or in the "cubby hole" in the stairwell coming down to the offices at 43.

Cleaning:

Ask your clients to take off their boots in wet weather. Boundaries are good for all of us. Please empty garbage cans as needed. In winter, we all work together on snow removal. If you know you might be the last one out of any of the student offices, please empty garbage cans. Just empty and reuse the bag that is in the garbage can.

In the washrooms, replace toilet paper and paper towels as needed, refill the hand cleaner as needed and empty the garbage can. Again, supplies are in the furnace room.

You are able to use OPCCoffice space to do online sessions if needed, in a very limited capacity. If using OPCC office space to conduct in-person or virtual sessions, please practice appropriate precautions - hand washing and disinfecting door handles, doors, light switches and armrests. If you plan to use OPCCoffice space to see clients or for virtual sessions please contact Scott and

Eva at least a week in advance to arrange to pick up your keys and for a tour of the offices.

If there are any problems in the building, call **Amy McGrath at 905-932-7898**

Student Fees and Client Receipts

A student in clinical practicum offers their client a sliding scale from **$25.00** to **$55.00.** Please clarify the fee in the same order (25 to 55) in the first session.

Student receipts for your clients will be produced by Jane. These can be downloaded or sent to the client directly.

Directory Policies

The Referral Coordinators (Eva Moran & Tierney Race) make the initial client referral decisions and then an assigned volunteer will follow through with you to make the referral. The student therapist can make the first contact with the referred client. The initial consultation, first session and third session must be marked by specific dates **(not day of week but calendar date).** Please post your client log to Eva and Tierney each week by Friday at 5pm.

On or before the first assessment meeting, a student asks the client to fill out the OPCC client information form along with the Teletherapy Form or the Client Confidentiality Form (for in person), all of which can be found in Jane.

A student therapist has to keep an updated client contact list which includes: name, phone, email and frequency. This will be part of the Jane app but should be maintained in your own records and your Client Updates to Sync.

Vacation Notice:

The school is closed every August and through the first week of September. As such, it is recommended that each supervision student take at least two weeks of vacation during that time—to be discussed and determined in conversation with your supervisor.

Faculty/Supervisors will be on call. Speak to your Supervisor to determine who you can call. We will also create on-call schedules for questions and crisis/emergency supervision coverage. OPCCwill provide the schedule for the on-call supervisors for the month of August before the end of July each year.

While on any vacation during the year:

A student needs to be sure to record a vacation notice on their voicemail and also set a vacation notice on their email and text messages so that referrals and clients are aware of their vacation

(if a client reaches out to the student therapist).

A vacation notice on your email can look something like this:
Vacation Alert- I am on vacation and will not be returning until [insert date]. Please note I am not checking emails. I will respond to your emails the week of [insert date] during business hours.

Please note If you are experiencing a crisis please phone the Distress Centre Helpline at 1.416.408.HELP (4357) or text 45645, or call or text 988 (nationwide). In the case of an emergency, please call 911 or proceed to your nearest hospital emergency department.

Students must also consult with their clinical supervisor about who they intend to have as a back-up therapist, typically this ought to be another student. Students will be responsible for making these arrangements and **clarifying them with their clinical supervisor**.

Leave of absence (LOA) Policies

A leave-of-absence (LOA) may be granted to a student in good standing. All requests must be made in writing and submitted on a LOA APPLICATION form.

Students who are on leave of absence do not have access to OPCC resources and faculty time and are not required to pay for continuous enrollment during the period that the leave of absence is in effect.

Students on leave of absence are not enrolled at OPCC and must return to the Program by the date specified on the leave of absence contract. Otherwise, they will be dropped from student status and will have to reapply for readmission. The registrar reserves the right to verify all information provided on the leave of absence contract. Contact the registrar's office if you have any questions or have a change of contact information.

The actual length of time permitted for the leave of absence is one school year (including summer).

Students who plan to return to OPCC must notify the Assistant E.D. & Registrar by the date determined at the time the leave of absence was granted. The faculty must approve the return before the registrar permits the student to register. If the student does not notify the Faculty by the agreed date, the student will be automatically dropped from student status and will have to reapply for readmission.

A student may request a leave and it must be 1 year in length. If unable to return after the requested leave, the student will need to reapply to the OPC College and will be processed by faculty like all new students. Students on a LOA will not have access to the password protected student site nor to any student services.

A student in supervision will need to work with their supervisor about how to ethically pass their clients to another therapist. A student will also be withdrawn from their concentrated study.

Additional considerations for student leave-of-absence policy:

• personal objectives (travel, time off, etc.) shall not be grounds for a leave-of-absence

• financial matters shall not be grounds for a leave-of-absence

• Normally, a student shall be in satisfactory standing when requesting a LOA; exceptions may apply and shall be determined by the faculty.

• The student therapist in clinical practicum should inform their supervisor in writing as soon as they are aware that they will require pregnancy/parental leave. The written notice should include the date of expected leave and the date of expected return. Considering the arrangements that will need to be made on the part of the supervisor, students are encouraged to give as much advance notice as possible, with no less than 1 month.

• The student therapist, in collaboration with their clinical supervisor, will develop a transition plan to refer the student therapist's clients onto another therapist. The purpose for this transition is for the well-being of clients who have not been in a long-term therapeutic relationship with the student therapist and thus for the sake of continuity and therapeutic efficacy for the client the transition is necessary. The transition should include no less than 90 days' notice for the clients – so that an effective closure and re-referral process through the OPCC Directory can be completed.

Family Leave/LOA may be granted to OPCCstudents for the following reasons: maternity or parenting reasons, or family health reasons. Such a leave must be requested on a yearly basis. A Family Leave request shall be submitted to the Assistant E.D. & Registrar of the Program in writing.

During a family leave, as above, no tuition fees will be charged for the duration of the authorized leave. During a leave of absence, a student may attend lectures and workshops at cost for professional development purposes; although these hours will not be applicable towards the student's diploma.

Students who enroll at another college or university while on a leave of absence are considered withdrawn from the OPC College and must apply for readmission before being permitted to re-enroll at OPCC. If official withdrawal paperwork is not received, the student is considered

unofficially withdrawn.

Full Auditing Status is a student who attends all learning units except course work, supervision and concentrated study. The advantage of this choice is to continue professional development in the field of psychotherapy or for personal growth. Modules and activities attended while auditing must be paid for. The student will not receive credit toward the OPCC Diploma while in full auditing status. Nor do these activities qualify a student to practice psychotherapy or apply to the CRPO.

A student who audits the OPC College will have to re-apply to the OPC College once they decide to resume coursework.

EXAMPLE FORMS & TEMPLATES:

*All of the following forms can be located on the Jane app, Google Classroom.

Casenotes

Initial Assessment

Student Therapist:
Supervisor:
Date of Session:
Time of Session:
In-Person Teletherapy
No fee charged

Client:
Age:
Email:
Phone:

Consent for treatment: Verbal Written

Length of sessions

Fees

Informed consent
Frequency of sessions Confidentiality
Supervision
Cancellation policy
Privacy
Roles/responsibilities of client/therapist

Explained qualifications/education and how you work: *(what psychotherapy and psychodynamic therapy is, benefits, advantages, disadvantages, ethics, goals, therapeutic relationship/alliance, communications, techniques and approaches)*

A future appointment has been arranged.

Assessment:

1. Information provided by client about medications and/or diagnoses:

2. Cultural Awareness: Psycho-social-cultural view of assessment: *Age and stage of lifespan, place, class, race, family, community, country, ethnic group, religion, gender and political climate.*

Please put psycho-social-cultural assessment information here:

3. Assessment of Risk: *(self-harm, suicide plans, IPV/Abuse [self/child/other], violent plans if required: safety plan, report to authorities, monitoring and follow-up)*

4. P- Axis – Client's Description

1. Describe your client's presenting narrative and data about the significant people in their lives. 2. How does your client describe their level of functioning (ego and other) or the characteristic ways they engage with the world?

5. **M-Axis - Therapist's Assessment:** *Describe your assessment of capacities: (Determine level) Rate on scale of 1-10 (10 being optimal functioning)*

1. Overall rating of capacity for affect tolerance. [ ]
2. Capacity for relationships (depth, range, consistency) ability to sustain relationships. [ ]
3. Capacity to see self and other in stable/accurate ways
4. Level of confidence and self-regard. [ ]
5. Capacity for affective experience, expression, and communication. [ ]
6. Level of healthy defensive patterns or ability to cope and adapt. [ ]
7. Capacity to appreciate what is realistic. [ ]
8. Self-observing capacities (psychological-mindedness). [ ]

9. Capacity for internal standards and ideals that is a sense of morality. [ ]
10. Ego strength [ ]

6. **S Axis – Client's Assessment -** Client's subjective experience of symptom patterns or presenting problems

Treatment plan and formulation of goals for the therapy discussed and developed with client: *What does the client present as their problem? Discuss some treatment plans as agreed upon by both the client and therapist. Examples of treatment plans are: Psychodynamic therapy (uncovering /supportive interventions), talk therapy, CBT. Explain to the client that treatment modalities, approaches and techniques can change and adjust over time depending upon the needs of the client. Psychodynamic therapeutic techniques of talking, free association, dealing with conflict, resistance, feelings, thoughts, dreams, the unconscious and memories will be worked out in the therapeutic relationship and communications with the therapist in the sessions.*

Treatment plan and goals: *provide a bullet-point list of 1 -2 goals that the client has brought in to work on and 1-2 goals that you feel support their intended growth, for example: *client wants to work on their marriage which is high conflict *client wants to explore depression related to relationship *work on building affect tolerance and communication skills.*

Signature

OCC SOAP Case Note Template

OPCC SOAP REGULAR CASENOTE

SEUS: Subjective experiences of the psychotherapist: (What do you think your feelings/ experiences/ behaviours are that will affect the therapeutic process?):

CLINICAL RECORD:

Therapist:

Date: **Phone number:**

Duration: 50 minutes

Fee: $0.00 **Method:** Face-to-Face

Client Name: Age:

Client contact Hours:

Signature:

Typed name of therapist indicates signature

Case Notes

S: <u>Subjective:</u> How does the client describe their problem? This is usually a quote or statement from the client describing their subjective description of the problem.

O: <u>Objective:</u> What did you observe about this client? These are written as factual notations. Verbal and nonverbal, including eye contact, voice – tone and volume, body posture. Especially note any changes and when they occur.

A: <u>Assessment:</u> What is your impression about/of this client? Hypothesis of what is happening (is it an ego issue, self esteem, attachment, object relations, id issue?)

Consent Implicit**:**

P: <u>Plan:</u> What is your plan with this client? Short and/or long-term goals. How do you want to interact with this client; what you may plan to respond to in the next session (follow-up). Do you plan to help client focus on thoughts, feelings or behaviors?

**Incident reports are separate narrative notes that record any negative outcomes or mandatory*

reporting issues. **Consent:** Implicit

Risk Assessment: Low Risk*

Protective Factors: no plan, no intent, no behavior. Strong social supports, no history. Risk: Some passive ideation,

**Any assessment above No Risk (Low, Medium, or High) needs to have an outline in bullet points on how you arrived at this assessment.* It should include:

Protective Factors: *list*

Risk Factors: *list*

Risk assessments need to be completed each session - more often than not the risk will be 'No Risk'

X

Psychotherapist

SOAP Note Samples

Therapist: Lisa-Marie Presley

Date: Oct 10th, 2017

Phone number: 555-321-7894

Duration: 50 minutes

Fee: $45.00 **Method:** Face-to-Face

Client Name: Harold D Age: 61

Client contact Hours: 25

S: He shared his reflections on the dynamics with J and how angry she made him. As he was processing the dynamics we explored and named the feelings of 'not being heard' and feeling like he had to be like her. He shared how he feels like his 'relationship picker' is broken. He realized with the help of his friend D, that it was a big deal for him to actually get angry with a woman; as he typically either feels guilty or that he must 'save her'.

O: Again, H seemed mildly to moderately distressed. He seemed to be reflective and grounded.

A: Overall, H seemed to be experiencing a moderate level of difficulty with feelings connected to relational functioning. We continued to emphasize his process around sorting through his feelings connected to the breakdown of his relationship and his internal object relations connected to relational dynamics. H continues to develop his self-awareness and capacity for emotional awareness and expression as well as insight into his internal psychological patterns.

Consent Implicit**:**

P: Continue to support his exploration of relational dynamics and dating.

Consent: Implicit

Risk Assessment: No Risk

X

Student Name
Student Therapist

Therapist: Lisa-Marie Presley

Date: June 15, 2020

Phone number: 555-987-1234

Duration: 50 minutes

Fee: $20.00 **Method:** Teletherapy Client Name: Molly J Age: 45

Client contact Hours: 30

S: She had been reflecting on our last session and the idea that her response to W is informed by her early childhood experiences of her angry dad – as she shared more of her reflections she was able to express the complexity of being afraid of her dad's anger and also afraid of his fragility because of his health issue. She shared how she can see this dynamic affect all her relations with the men in her life, including her husband.

O: M seemed moderately distressed and emotional and also quite reflective and grounded.

A: Overall, M seemed to suggest moderate emotional difficulties relating to relational dynamics. We especially emphasized how current difficulties are connected to earlier relational patterns and experiences. M continues to develop in her awareness, understanding and expression of underlying feelings and beliefs.

Consent Implicit**:**

P: Continue to support and work with her relational dynamics and challenges with occupational functioning. Support ego development and adaptive strategies.

Consent: Implicit

Risk Assessment: No Risk

X

Student Name
Student Therapist

Third party letters

Therapy versification with treatment plan template letter

This letter is in regard to [insert name]. I began seeing [] on [date] and saw her on a weekly basis until. She came to see me because she had been experiencing feelings of [insert – anxiety/depression/stress] related to [insert context].

[insert name] and I worked with the emotional impact and response to this event in her life. Additionally, we worked on strategies to assist her in managing environmental stress and coming to understand the sources of her [insert anxiety/depression/stress].

Our strategies have included:

Learning cognitive techniques in order to cope with stress/anxiety.

• Breathing techniques.

• Deep relaxation.

• Changing mental thought processes.

Using psychotherapy modalities in order to address the deeper issues attached to anxiety and

depression. • Active listening.

• Regressive work with his family of origin.

• Learning personal reflective skills for insight and change.

The cognitive program has given [insert name] short-term solutions and has been assisting her in her capacity to tolerate and manage her sources of stress.

The psychotherapy modalities provide longer-term treatments for addressing the meanings of her grief

and depression. Please feel free to contact me if you have any further questions,

[Student name]

Training Therapist in Supervision with Ontario Psychotherapy and Counselling College Member CAPT

Therapy verification template letter

Dear , Click here to enter a date.

My name is [student name] and I am a senior student in supervision with the Ontario Psychotherapy and Counselling College. This letter is in regards to Click here to enter text. And confirms that I have been

seeing her/him since Click here to enter a date. on a weekly [change to suit appointment frequency] basis for psychotherapy sessions.

Should you have any questions, please feel free to me at

Sincerely,

[Student name]

Training Therapist in Supervision with Ontario Psychotherapy and Counselling College Member CAPT

Consent to disclose personal health information form

Consent to Disclose Personal Health Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, {name} **authorize**
(Print your name) (Print name of health information custodian)
to disclose
□ my personal health information consisting of:

(Describe the personal health information to be disclosed)
or
□ the personal health information of
(Name of person for whom you are the substitute decision-maker)*
consisting of: _

(Describe the personal health information to be disclosed)
to
(Print name and address of person requiring the information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

My Name: Address:

Home Tel.: Work Tel.:

Signature: Date:

Witness Name: Address:

Home Tel.: Work Tel.:

Signature: Date:

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**

Receipt for Treatment Payment template

Receipt #:

RECEIPT FOR PAYMENT

Payment From:

Address:

Date: Duration: 50 min. Amount: $

For: Therapy Sessions

Receipt Issued by:

Jane Smith
Student in Clinical Practicum
Ontario Psychotherapy and
Counselling College

How to do a Case Presentation

Come to supervision prepared to share. Please spend some time before your session to reflect on the following questions.

The following is a guide when you present your cases to your supervisor. Be sure to share honestly about these areas and make your supervisor aware of any special concerns – areas where you are struggling, feel like you are unfamiliar or raise concerns about client safety.

Once you have covered some of the areas below, be prepared to share what the 'problem' is that you wish to discuss. Is it a transference/counter-transference bind, is it a question of interventions? Are you struggling to conceptualize the client case and therefore are unsure of goals and directions with the client?

Demographics:

Demographics are the facts, the nuts and bolts about the client. Demographics include the client's name, age, gender, relationship status, ethnicity, occupation, length of employment, age and gender of any children.

Example: *Mary T. is a 25-year-old married bi-racial female who has worked for City Savings and Loan as a teller for the last 2 years. She has been married to her husband for 4 years. They have no children and no previous marriages.*

Presenting Problem:

The presenting problem is the reason why the person is receiving your services. The presenting problem can also be called the client's chief complaint.

Example: *Mary presents with multiple concerns related to an unfulfilling marriage, potential loss of employment, and concerns over her husband's gambling.*

Goal:

Clients come to therapists to accomplish something. I think it is a good idea to find out what the client's goal is. **What do they want to get out of their therapy?**

Example: *Mary would like to first focus on concerns related to her husband's gambling. Mary states that her husband told her last week that he is approximately $45,000 in debt. Mary is also worried about her job security.*

Legal/ethical

This is one of the most critical categories. Not addressing your legal and ethical responsibilities can be a show stopper. For your career, I mean.

Make sure you know what your legal and ethical responsibilities are at all times. If you have any questions, please ask your supervisor.

Crisis/Safety:

Is the client in crisis? If so, describe the type and severity of the crisis and your interventions to address this concern. You must be exact.

Example: *While her situation is difficult, Mary does not appear to be in crisis at this time. She denied any thoughts or feelings related to self-harm. She denied any past history of self-harm. There are no reporting responsibilities present. She seems to have an active and extended support system.*

Diversity:

What are the differences between you and the client? These differences can be about age, gender, education, socioeconomic status, sexual orientation, marital status, religion, stage of life, and should be noted.

The concern is whether or not these differences pose a difficulty for the therapist to remain objective and focused on the client's concerns. **If the differences between the client and therapist are too great for the therapist, it should be noted how the therapist will handle this problem.**

General Overview:

The first meeting:

The following is a brief outline of the things that should be covered in the first meeting with a new client as part of informed consent*:

* *Informed consent is an on-going process throughout the entire therapy relationship. Therapists must always ask the client permission to use a new technique, to change something in the therapy relationship, etc.* ***Please review CRPO Professional Practice Standards***

a) It is very important to be clear about your expectation around the fee: the amount which is outlined in the policy section of this handbook; adjustments over time and your cancellation policy.

b) Confidentiality should be confirmed, as well as that you are a training therapist and that you are in clinical supervision. You will not share identifying details with your supervisor and that your supervisor is also held to the ethic of confidentiality. There are limits to confidentiality – self-harm, abuse and imminent threat of harm to others.

c) You should encourage them to ask you questions. "How do you work?" is frequently asked, so it's a good idea to think about that one ahead of time. You might say something like: "I work with your current patterns and we explore how they may be connected to other times in your life. And I also have knowledge of a number of different ways of working so I will work to figure out your world or inner map and go from there."

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d) We do not charge for the first meeting (the initial interview), and it is good to encourage them to see how they feel about the "fit" between you and them.

e) It is often better to let the person speak first and this shows them that you will be respectful of their story.

f) At the end of the first session you should make an appointment for the next session, often the client will know by that time whether they are comfortable in working with you and this shows

your interest in working with them.

Informed Consent & Confidentiality Letter:

It is important in that first session to also go over the limits of confidentiality and have clients read over and sign the following form. A Copy of this form will be provided in the resources on your google drive.

I, , understand that I am agreeing to see an OPCC student therapist in training who is under the clinical supervision of an OPCC faculty member.

Please read the following guidelines pertaining to confidentiality and its limits.

Confidentiality

An OPC College therapist does not collect or use information about a client without the informed consent of the client or the client's authorized representative, nor disclose information about a client to anyone other than the client or the client's authorized representative without the written informed consent of the client or the client's authorized representative, except where the collection, use or disclosure is permitted or required by law.

OPCC Therapists in training are under the clinical supervision of a Clinical Supervisor and Faculty member of OPCC who is also a Registered Psychotherapist and therefore from time to time, will share clinically relevant information with their supervisor for appropriate training and responsible professional practice.

In case discussions, no identifying details are shared. The clinical Supervisor and the training therapist are bound by the Professional Practice Standards of confidentiality as outlined by the CRPO below.

Confidentiality is considered a cornerstone of the profession of psychotherapy and is embedded in its core values. Individuals come to therapists with sensitive, personal information, and confidentiality is required to build trust in the therapeutic relationship.

Confidentiality is also an important legal concept that applies to all regulated health professionals, including Registered Psychotherapists. The Personal Health Information Protection Act, 2004 (PHIPA) establishes the rules relating to confidentiality and privacy of personal health information in Ontario. PHIPA requires that personal health information be kept confidential and secure.

It is a fundamental responsibility of Members to maintain client confidentiality at all times. In compliance with PHIPA, Members must ensure that the professional relationship with the client and the client's personal information are kept confidential, within legal limitations.

Limits to confidentiality

Normally, a Member may only disclose personal health information with the consent of the client or his/her authorized representative. However, in law, there are a limited number of circumstances where disclosure of personal health information is required without consent. Notable limits to confidentiality include:

1. where the Member believes on reasonable grounds that disclosure is necessary to eliminate or reduce significant, imminent risk of serious bodily harm (includes physical or psychological harm) to the client or anyone else, e.g. suicide, homicide;

Note: If the Member believes a significant, imminent risk of serious bodily harm exists (this includes physical or psychological harm), there may be a professional and legal duty to warn the intended victim, to contact relevant authorities such as the police, or to inform a physician who is involved in the care of the client.

2. where disclosure is required under the Child and Family Services Act, for example, where the Member has reasonable grounds to suspect that a child is in need of protection due to physical harm, neglect or sexual abuse by a person having charge of the child;

3. where necessary for particular legal proceedings (e.g. when the Member is subpoenaed);

4. to facilitate an investigation or inspection if authorized by warrant or by any provincial or federal law (e.g. a criminal investigation against the Member, his or her staff, or a client);

5. for the purpose of contacting a relative, friend or potential substitute decision-maker of the individual, if the individual is injured, incapacitated or ill and unable to give consent personally; and

6. to a College for the purpose of administration or enforcement of the Regulated Health Professions Act, 1991 (RHPA) (e.g. assessment of the Member's practice as part of the quality assurance program; mandatory reporting where the Member's client is a regulated health professional and the Member has reasonable grounds to believe that the client has sexually abused their patient/client).

I have read and understood the conditions of confidentiality and its limitations and agree to the psychotherapeutic treatment with,

Therapists Name:

Client Signature Date

Overview of Assessment process:

Are clinical assessments ever complete? Yes and no. Yes, the clinician will finish any one assessment, but as changes are made by the client(s), so will changes be made in the assessing of the client or system. **Assessment is best seen as a continual process.**

Please refer to the OPCC Case Note Assessment Form as you review this section, as these questions are just examples of the kinds of ways to guide the assessment process and thus act as supplemental to that form.

Versions of these questions of areas for inquiry may be done over numerous sessions in the beginning. However long an assessment takes, it must be started somewhere. Let's start with the questions listed below as guiding principles to think about during the assessment phase.

You will likely not ask all the following questions in this manner, but you will want to explore each of the areas: **Problem identification, symptoms & goals**

Problem identification:

• What is the presenting problem?

• What brings you here today?

• How long has this been a problem?

• Have you noticed times when the problem isn't as bad?

• Has anything like this happened before?

• If so, how? How did you try to resolve this problem the last time?

• How often has this problem occurred?

• Who is involved or affected by this current problem/situation?

Goals:

1. What is your goal in coming to counseling?

2. What would you like to get out of this appointment time?

3. What changes would you like to see happen?

4. What are some things in your current situation you would like to keep or stay the same?

5. How will you know (what will you be thinking and doing differently) such that you won't need to come back to a place like this anymore?

Symptoms:

• Have you experienced any recent changes in eating, sleeping, mood or concentrating? • Have

you gained or lost any weight recently?

• What is your level of alcohol or drug use? See C/D Assessment.

• Have you had any thoughts currently, or in the past, of wanting to do anything to hurt yourself or someone else? See *Safety Assessment.*

• Has your current problem or difficulty been affecting your health?

• Has your current concern(s) affected your ability to perform your duties at work, school or home?

Other clinical assessment questions:

1. Do you have important people in your life to talk to, or do you tend to keep your problems to yourself?

2. Have you had any recent problems with the police?

3. When was your last physical exam? Any concerns?

4. Are you taking any medications?

5. Have you had any recent hospitalizations?

6. Do you have any history of physical or sexual abuse?

7. Do you see or hear things others might not?

8. Have you ever been in therapy before?

I hope you find these clinical assessment questions useful. **Please know that if you are presented with a situation in which you are unsure what to do, or if you have any question of your client's safety, then you need to contact your supervisor. Please do so immediately if your client's safety is at risk.**

Risk Assessments:

1. Suicidality

Conducting a Safety Assessment

Few things are more nerve racking than conducting a safety assessment when a client is threatening to kill themselves or harm another. It takes courage for the therapist to ask direct

questions about the client's thoughts or actions intending to hurt himself or someone else. This type of courage is a required skill if you are to work successfully in this field.

Can a therapist prevent someone from hurting himself or another? No.

What then, is the responsibility of the therapist? To conduct a clinically competent safety assessment and, based on that assessment, act in a way showing a standard of care similarly trained persons would do, in a similar situation, given the information received.

The therapist **is not** ultimately responsible for the safety of another. However, she is responsible for asking the direct questions and formulating, then delivering, an appropriate set of interventions.

A therapist **is** required to break confidentiality if a person is determined to be a threat to another, identified victim. This is a legal requirement on the part of the therapist, who is required to inform both the police and the intended victim.

If the person is a danger to herself/himself the therapist does not bear a legal requirement to break confidentiality, but therapists are generally permitted, if the situation requires, to break confidentiality in order to maintain client safety.

Not all individuals who think of hurting themselves require involuntary hospitalization. A sound safety assessment will look at:

• The level of risk from low to high*

• An assessment of the client's social supports

• Possible removal of weapons

• Increased level of contact with the therapist

• A formal safety assessment (see the questions below)

Safe-T Quick Evaluation

RESOURCES

- Download this card and additional resources at http://www.sprc.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide http://www.sprc.org/library/jcsafetygoals.pdf
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline

1-800-273-TALK (8255)

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

HHS Publication No. (SMA) 09-4432 • CMHS-NSP-0193
Printed 2009

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personali disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis I psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g. loss of relationship, financial or health status or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolati
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live
- * *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition
- * *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significa change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/cri numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determ

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with signific others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

The therapist should formulate interventions following the idea of **least restrictive measures**.
The therapist should seek to maintain a person's safety that is least restrictive of the client's

civil rights.

A progression of restrictive measures may look like: verbal no-harm contract, written no-harm contract, voluntary hospital admission, involuntary hospital admission.

A No Harm Contract/or Safety Plan is not a contract nor a legal document, but an agreement that cannot promise a person's safety. These agreements outline what a person needs to do if he or she becomes suicidal. They are best thought of as strategies that can help form your assessment of a person's ability to maintain their own safety and also provide a framework for the client to utilize when feeling unsafe.

Client Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing: 1.
2.
3.

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):
1.
2.
3.

Step 3: People and social settings that provide distraction:
1. Name
Phone
2. Name
Phone
3. Place
4. Place

Step 4: People whom I can ask for help:
1. Name
Phone
2. Name
Phone
3. Name
Phone

Step 5: Professionals or agencies can contact during a crisis:
1. Clinician Name
Phone
2. Emergency Contact #

3. Local Urgent Care

Services
Urgent Care Services
Address

4. Urgent Care Services
Phone

5. Suicide Prevention Lifeline Phone: Line: 416-408-4357

Step 6: Making the environment safe:
1.
2.

The one thing that is most important to me and worth living for is:

If a **health and safety check** is to be conducted, either the police or, a psychiatric emergency team can provide the needed assessment and invoke a Form 1

Documentation of the clinical course of action is extremely important in all cases where safety is of concern. The purpose of documentation is to protect the therapist, indicating the results of the safety assessment and the actions taken to competently and appropriately address the client's safety. Documentation helps the clinician's self-supervision in not overlooking important clinical standards.

While there are many types of clinical charting, in many crisis/safety situations narrative charting is preferred.

Narrative charting is time-based, where the clinical actions and/or information received are noted in chronological order and the information is written in paragraph form.

In Ontario, a Form 1 means the involuntary holding of an individual for 72 hours for evaluation and treatment if the person is found to be a danger to themselves, a danger to another or gravely disabled due to a mental disorder. Gravely disabled generally means the person is unable to provide for their own food, clothing or shelter.

Once a person has been brought to a psychiatric facility to be assessed, the physician may hold them there for up to 72 hours on an *application for psychiatric assessment* (Form 1). This form allows the person to be held at a psychiatric facility for assessment, but does not itself permit any treatment without the person's consent.

Consent to treatment is not covered under the *Mental Health Act* but rather the Health Care Consent Act. The physician must also fill out a **Form 42** to notify the person and inform them of why they're being held.

At the end of the 72 hours permitted by a Form 1, the person must either be released, be admitted as a voluntary patient, or continue to be held as an involuntary patient with a *certificate of involuntary admission* (Form 3).

The physician who signs the Form 3 must be different than the physician who signed the initial Form 1. A Form 3 allows the patient to be held for two weeks, and the patient must be notified with a Form 30.

At the end of the two weeks, if the facility is to continue to keep the patient on an involuntary basis, a *certificate of renewal* (Form 4) must be filled out. The first time a Form 4 is filled out, it is valid for one month, the second time it is filled out it is valid for two months; each time after that it is valid for three months. Each time a Form 4 is filled out, another Form 30 must be filled out, notifying the patient.

It cannot be stressed enough that if you are concerned for a client's safety, or the safety of another, always contact your supervisor.

The following are just guidelines for the kinds of information you may need/want to gather when you suspect there is risk for the client.

Safety Assessment Questions

Danger to Self

1. Have you had any thoughts or actions, now or in the past, to do anything to hurt yourself? 2. Are you concerned about your ability to maintain your own safety?

3. Is anyone else concerned about your ability to maintain your safety?

4. What, exactly, are any thoughts you have had or are having to hurt yourself? 5. Do you have a plan on what you would actually do to hurt yourself?

6. Have you ever acted on these thoughts? What did you do?

7. Regarding any past actions to hurt yourself, was your intention to…hurt yourself, die, let someone know how bad things are?

8. What were you trying to get away from or are you trying to get away from, by doing something to hurt yourself?

9. How are you hoping hurting yourself/killing yourself will solve your problems?

10. Do you have the means to hurt yourself? Do you have access to weapons or drugs?

11. Has anyone in your family ever hurt themselves/committed suicide?

12. What level of support do you have in your life?

13. Are you willing to make a no-harm contract with me?

Danger to Others

1. Have you had any thoughts or actions, now or in the past, to do anything to hurt someone else?

2. Have you ever acted on these thoughts? What did you do?

3. Regarding any past actions to hurt someone else, was your intention to…(a) get them to stop doing something, (b) make them start doing something, (c) intimidate them, (d)let them know how bad you feel?

4. You mentioned being angry with. Is this the person you are thinking about hurting?

5. What, exactly, are any thoughts you have had or are having to hurt? 6. Do you have a plan on what you would actually do to hurt him/her?

6. Do you have the means to hurt others or the intended victim? Do you have access to weapons?

7. Are you concerned about your ability to control your impulses and not hurt someone else or?

8. Is anyone else concerned about your ability to control your actions?

9. How are you hoping hurting others or will solve your problems? 11. Is there any history of violence within your family?

10. What level of support do you have in your life?

11. When you have acted out with anger in the past have you been under the influence of alcohol or drugs?

12. Are you willing to make a no-harm contract with me?

Additional Risk Assessment Tools:

There are 5 documents in the Google drive that will assist with understanding the assessment process when the risk involves adults and children. Please be sure to read through these documents and be prepared to discuss them with your clinical supervisor as part of ongoing learning regarding assessing risk.

The documents that you need to review are:

1. Ontario Domestic Assault Risk Assessment (ODARA)
2. ODARA Fact sheet
3. Ontario Child Protection Tools Manual
4. Short-Term Assessment of Risk and Treatability: Adolescent Version (START: AV) 5. START Summary sheet

PLEASE NOTE: The ODARA Tool is heteronormative in its languaging; however, the tool has been validated for female-to male violence prediction accuracy, and we include this link to recent research on same-sex intimate partner violence for your awareness. https://www150.statcan.gc.ca/n1/pub/85-002-x/2019001/article/00005-eng.htm

We are also including an article about its usefulness and history that can be found with the forms as well.

RESPECT Handout

Handout 20.1

Description of the RESPECTFUL Counseling Model

Becoming a culturally competent counsellor fundamentally requires individuals to become aware of their clients and their own multiple identities. By presenting the RESPECTFUL counseling framework in these materials, we hope to stimulate your thinking about the multidimensional nature of your clients' and your own development. We also hope the RESPECTFUL counseling model will enhance your understanding of the various factors counselors need to consider when planning helping interventions that are aimed at promoting the mental health and psychological well-being of clients who are different from you.

The RESPECTFUL counseling framework (Cartwright & D'Andrea, 2004; D'Andrea & Daniels, 2001) stresses the importance of incorporating a comprehensive model of human diversity into the work mental health practitioners do. This theoretical framework

• is composed of 10 factors that represent vital considerations to keep in mind when working with persons from different cultural groups and backgrounds;

• emphasizes the need to incorporate one's understanding of these cultural factors in multicultural counseling situations; and

• stresses the need for mental health practitioners to exhibit a high level of respect when working with

persons whose psychological development is significantly affected by the various factors outlined in this theoretical framework.

It is important to point out that the components contained in the RESPECTFUL counseling model do not represent an exhaustive listing of all the factors that affect human development. Rather, the factors that comprise this framework have been selected because they are known to affect clients' psychological development and sense of personal well-being in many important ways. The specific issues that the RESPECTFUL framework directs particular attention include a person's

R—religious/spiritual identity,

E—economic class background,

S—sexual identity, **P**—

psychological maturity,

E— ethnic/racial identity,

C—chronological challenges and identity,

T—traumatic experiences and other threats to one's well-being,

F—family identity and history,

U—unique physical characteristics and

L—language preference and location of residence.

Not only do all of these factors influence the way that people learn to view themselves and others, but each factor frequently affects the way clients and mental health practitioners construct meaning of the different strengths, challenges, and problems individuals present in counseling. By briefly describing these vital dimensions of human development below, we hope to (a) increase your knowledge of what are thought to be important cultural variables that influence your clients' and your own development, (b) underscore the need to think more comprehensively and holistically when working with clients from diverse groups and backgrounds, and (c) promote an increased awareness of the different counseling interventions that may more effectively address your clients' multidimensional nature.

Religious/Spiritual Identity

The first component in the RESPECTFUL model focuses on the manner in which individuals personally identify with established religions or hold beliefs about extraordinary experiences that go beyond the boundaries of what is thought to be the strictly objective, empirically perceived world that characterizes Western, modern, psychological thought (D'Andrea & Daniels, 2001). Kelly (1995) noted that the terms *religion* and *spirituality* are grounded in an affirmation of transcendental experiences that are typically manifested in religious forms extending beyond the boundaries of ordinary and tangible life experience. As used in the RESPECTFUL counseling framework, *religion* and *spirituality* refer to a person's belief in a

reality that transcends physical nature and provides individuals with an extraordinary meaning of life in general and human existence in particular.

Because clients' religious/spiritual identity may play a vital role in the way they construct meaning-of-life experiences, it is important that counselors take time early in the helping process to assess the degree to which this factor affects an individual's psychological development. It is equally important that mental health practitioners take time to consider how their own religious/spiritual identity and beliefs may positively or negatively affect the work they do with clients who embrace perspectives different from their own in this cultural domain.

Economic Class Background

Numerous researchers have explained how a person's attitudes, values, worldview, and behaviors are all affected by that person's economic class standing, background, and identity (Liu, 2001). Given the influence that this aspect of clients' multidimensionality has on their psychological development, practitioners would do well to be attentive to the ways in which this cultural consideration contributes to their clients' identified strengths and expressed problems during counseling.

Many counselors may have developed inaccurate and negative views and prejudices about persons from economic backgrounds that are different from their own. For this reason, it is also important that mental health professionals evaluate their own class-based assumptions, biases, and stereotypes when working with individuals from diverse economic class groups.

It is particularly important for counselors to examine closely how economic factors affect the psychological health and personal well-being of poor clients. In doing so, it is useful to keep in mind that traditional theories of counseling and psychotherapy have largely been developed by middle-class individuals who did not direct much attention to the ways that poverty affects poor people's psychological development and sense of personal well-being.

Sexual Identity

One of the most complex, though often understudied, aspects of human development involves the sexual identity development of persons from diverse groups and backgrounds. As used in the RESPECTFUL counseling model, the term *sexual identity* relates to a person's gender identity, gender roles, and sexual orientation.

The term *gender identity* relates to an individual's subjective sense of what it means to be male or female. A person's gender identity is clearly affected by the different roles men and women are expected to play within different cultural/ ethnic/racial contexts.

A person's sexual identity is also influenced by one's sexual orientation. There are a number of ways to conceptualize this dimension of human development. Generally speaking, sexual orientation includes such concepts as bisexuality, heterosexuality, and homosexuality.

Bisexuality refers to individuals who demonstrate a sexual interest in both males and females. *Heterosexuality,* in contrast, refers to individuals whose sexual interests are directed toward persons of the opposite sex. A third way of viewing this dimension of one's sexual orientation involves the concept of *homosexuality,* which is a term that has been used to identify individuals whose sexual orientation involves persons of the same sex. However, in light of the negative stereotypes that have historically been associated with the term *homosexuality,* terms such as *gay males* and *lesbians* are considered

more acceptable and respectful in describing this dimension of a person's sexual orientation (D'Andrea & Daniels, 2001).

Psychological Maturity

Counsellors often work with clients who share common demographic characteristics (e.g., age, gender, socioeconomic identity) and cultural/racial backgrounds but appear to be very different psychologically. In these situations, we might refer to one client as being "more or less psychologically mature" than another person who is the same age, identifies with the same cultural/racial reference group, and shares a similar sexual identity.

Some descriptors that are commonly used to describe "immature" clients include statements such as, "He demonstrates limited impulse control in social interactions" or "She has a low capacity for self awareness." When describing "more mature" clients, we may say that "He is able to discuss his problems with much insight"; "She is highly self-aware"; and "She has developed a much broader range of interpersonal and perspective-taking skills than many of my other clients." Cognitive–developmental theories view psychological development as a process in which individuals move from simple to more complex ways of thinking about themselves and their life experiences. This movement can be traced along a set of invariant, hierarchical stages that reflect qualitatively different ways of thinking, feeling, and acting in the world (Sprinthall et al., 2001).

By assessing clients' levels of psychological maturity, counselors are better positioned to design more effective interventions that respectfully meet their clients' unique psychological strengths and needs. It is also important that counselors take time to reflect on their own level of psychological development, as the therapeutic process can easily be undermined when practitioners are matched with persons who are functioning at a higher level of psychological development than they are themselves.

Ethnic/Racial Identity

Clearly, tremendous psychological differences exist among persons who come from the same ethnic/racial groups in our society. This variation is commonly referred to as *within-group differences*. Given the within-group variation that is manifested among persons from the same ethnic/racial groups, it is important that counselors develop the knowledge and skills necessary to accurately assess these important differences and respond to them in effective and respectful ways in counseling. It is also very important that counselors understand how their own ethnic/racial experiences have affected their psychological development, the way they construct meaning of the world, and the types of biases they may have acquired toward others in the process.

Chronological Developmental Challenges

In the RESPECTFUL counseling model, we refer to age-related developmental changes as *chronological challenges*. Mental health practitioners are familiar with many of these challenges as they represent characteristics normally associated with infancy, childhood, adolescence, and adulthood. The normal age-related developmental changes that people predictably
manifest from infancy through adulthood include physical growth (e.g., bodily changes and the sequencing of motor skills), the emergence of different cognitive competencies (e.g., the development of perceptual, language, learning, memory, and thinking skills), and the manifestation of a variety of psychosocial skills (e.g., the ability to manage one's emotions and demonstrate more effective interpersonal competencies over time).

Human development researchers have greatly helped counsellors refine their thinking about the unique challenges clients face at different points across their lifespans. Practically speaking, this knowledge enables practitioners to use age appropriate intervention strategies in counseling to work more effectively with persons who face difficult chronological challenges.

These considerations also allow practitioners to be mindful of the unique challenges they are likely to encounter when significant chronological differences exist between themselves and their clients. D'Andrea and Daniels (2001) suggested that many young practitioners are likely to encounter major challenges in gaining a high level of trust, respect, and professional legitimacy when working with some clients who are much older than themselves.

Trauma and Other Threats to One's Well-Being

Trauma and threats to one's well-being are included in the RESPECTFUL counseling model to emphasize the complex ways that stressful situations put people at risk of psychological harm. Such harm typically occurs when the stressors individuals experience exceed their ability to cope with them in constructive and effective ways. An individual's personal resources (e.g., coping skills, self-esteem, social support, and the personal power derived from one's cultural group) may be overtaxed when that person is subjected to ongoing environmental stressors. People who experience stressors for extended periods of time are commonly referred to as being *vulnerable* or *at risk* for future mental health problems (Lewis et al., 2003).

Counselors are frequently called on to work with persons in various at-risk groups, including poor, homeless, and unemployed people; adults and children in families undergoing divorce; pregnant teenagers; traumatized war veterans; individuals with HIV or AIDS; persons with cancer; and individuals who are victimized by various forms of ageism, racism, sexism, and other forms of cultural oppression. Heightened, prolonged, and historical stressors often result in more severe and adverse psychological outcomes for many persons from oppressed cultural/ethnic/racial groups in our contemporary society.

To be effective in their work, counselors need to be able to (a) accurately assess the different ways that environmental and historic stressors contribute to the onset and perpetuation of various forms of psychological and spiritual trauma in the lives of clients who come from diverse cultural/racial groups and (b) develop intervention strategies intentionally aimed at effectively ameliorating these problems.

It is equally important that counselors become knowledgeable of the ways that intergenerational trauma may contribute to the adverse psychological problems many persons from diverse cultural/racial groups experience in their lives. Duran and Duran (1995) wrote extensively about the adverse impact of this sort of trauma, referring to it as an intergenerational "soul wound" that significantly contributes to the complex psychological and spiritual problems many Native American Indians experience today. The negative effect of the soul wound is also thought to adversely affect the lives of other individuals in our nation, including many persons of African descent as well as women, children, and gay/lesbian/ bisexual persons who have been subjected to various forms of abuse and violence in their lives (Lewis et al., 37 2003).

With this knowledge in mind, mental health professionals are better able to develop and implement helping strategies that are deliberately aimed at addressing the negative psychological and spiritual ramifications of such complex forms of trauma. It is also important for mental health practitioners to

consider how various life stressors and traumatic events may have a lasting impact on their own psychological development as such experiences can influence the way mental health professionals work with their clients.

Family Background and History

The rapid cultural diversification of the United States includes an increasing number of families that are very different from the traditional notion of *family* many counselors have historically used as a standard for determining *normal family life* and *healthy family functioning*. The different types of families (e.g., single-female-headed families, blended families, extended families, families headed by gay and lesbian parents) that counselors increasingly encounter in their work challenge practitioners to reassess the traditional concept of the nuclear family that has been used as a standard against which all types of other families have been compared.

As a result of these changes in our society, counselors will be increasingly pressed to (a) understand the unique strengths clients derive from these different family systems and (b) implement counseling strategies that effectively foster the healthy development of these diverse familial units. In addition to learning about the personal strengths individuals derive from such diverse family systems, mental health practitioners are encouraged to assess the biases and assumptions they may have developed about family life as a result of their own familial history and experiences. If left unexamined, these biases and assumptions may adversely affect the counseling relationship mental health practitioners have with clients who come from families that are very different from their own.

Unique Physical Characteristics

The RESPECTFUL counseling framework emphasizes the importance of being sensitive to the ways that society's idealized images of physical beauty negatively affect the psychological development of many persons whose physical nature does not fit the narrow view of beauty that is fostered by our contemporary culture. When working with clients whose unique physical characteristics may be a source of stress and dissatisfaction, it is important for counselors to reflect on the ways that the idealized myth of physical beauty may have led such clients to internalize negative views and stereotypes about persons who do not fit this culturally biased perspective.

Also, when working with women and men whose psychological development has been negatively affected by some aspect of their unique physical nature, practitioners need to be able to assist them in understanding the ways in which being socialized into a society that adheres to myopic views of beauty contribute to irrational thinking about some clients' sense of self-worth (Worrell & Remer, 2003).

Counselors need to also be sensitive to and knowledgeable of issues related to various physical disabilities when working with persons who experience these personal challenges. To respectfully assist these clients, practitioners are encouraged to help them identify and build on the unique personal strengths they bring to counseling (Cartwright & D'Andrea, 2004).

Location of Residence and Language Differences

The location of one's residence refers to the geographic region and setting where one resides. D'Andrea and Daniels (2001) identified six major geographic areas in the United States: the northeastern, southeastern, midwestern, southwestern, northwestern, and far western regions. These geographical

areas are distinguished by the types of persons who reside there. They also differ in terms of climate patterns, geological terrain, and the types of occupations and industries commonly available to workers who reside in these locations.

When mental health practitioners work with persons from geographical regions or residential settings that are different from their own, practitioners should reflect on the possible stereotypes and biases they may have developed about such individuals and regions. This introspection is particularly important when working with persons who use a different dialect or language in interpersonal interactions. As is the case with the other components of the RESPECTFUL counseling model, this self-assessment is very important because stereotypes and biases counselors may have developed about persons whose residential background and language dialect is different from their own may lead to inaccurate assumptions and clinical interpretations within the helping setting.

As has been repeatedly emphasized in the above discussion, it is important that counselors take time to assess the ways that each component of the RESPECTFUL Counseling framework affects their clients as well as their own personal and psychological development. The RESPECTFUL Counseling Self-Assessment Activity Form that is included with these materials is designed to assist you in formally conducting this sort of self assessment. More specifically, this activity is provided to assist you in gaining (a) new insights into some of your own cultural/contextual preferences, biases, and values; (b) a greater understanding of the complex and multidimensional nature of your own personal and professional development; and (c) greater clarity about the types of clients you are likely to be more or less effective working with in the future.

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Handout 20.2

The RESPECTFUL Counseling Self-Assessment Activity Form

Instructions. We are all "multidimensional" beings who are affected by the various factors that make up the RESPECTFUL counseling model. As repeatedly stated in the materials you have read that describe the RESPECTFUL counseling model, it is vital for counselors to become aware of any assumptions, stereotypes, and biases they may have about clients who are different from themselves in terms of their religious/spiritual identity, economic class background, sexual identity, ethnicity/race, and the other dimensions of the RESPECTFUL framework. As you think about the clients you are working with or are likely to work with in the future, it is useful to reflect on the RESPECTFUL model and (a) consider the impact diversity issues may have in the here and now of every interview you have with your clients as well as (b) understand how these issues affect your own view of the clients you serve.

Now that you have had an opportunity to learn about the RESPECTFUL counseling model, please take a few minutes to reflect on the ways in which each factor that makes up this theoretical framework affects your own life and worldview. In doing so it is helpful to write a short description of yourself as it relates to each component of this model in the space provided below or on a separate piece of paper. Then briefly state how your understanding of these components and their impact on your development may affect the work you do with clients from different groups and backgrounds you may work with in the future.

Religious/spiritual identity

Economic class background and identity

Sexual identity

Psychological maturity

Ethnic/racial identity

Chronological challenges and identity

Trauma and threats to well-being

Family history and experiences

Unique physical characteristics

Language preference and location of residence

Note. From M. D'Andrea and J. Daniels, "RESPECTFUL Counseling and Development," in D. Pope-Davis & H. Coleman (Eds.), *The Interface of Class, Culture and Gender in Counseling* (Thousand et al.: Sage, 2005). Training materials developed in the Department of Counselor Education at the University of Hawaii, Honolulu. Reprinted by permission.

Links for community resources:

CAMH:

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in the area of addiction and mental health. CAMH combines clinical care, research, education, policy development and health promotion to help transform the lives of people affected by mental health and addiction issues.

CAMH provides high-quality, client-centred care to meet the diverse needs of people facing addiction and mental health challenges at different stages of their lives and illnesses-- from children to adults to seniors. Clinical services include assessment, brief interventions, inpatient/ residential programs, day hospital services, continuing care, outpatient/ambulatory services, and family support.

If you have a question about CAMH's treatment programs call ACCESS CAMH at **(416) 535-8501 press 2** or **1 800 463-2338 (toll free)** Mon-Fri 8:30 a.m. - 4:30 p.m.

http://www.camh.ca/en/hospital/care_program_and_services/Pages/care_program_and_services.aspx

CHECKPOINT:

CheckPoint is a charity that connects mental health resources with video games and technology. **What Do We Do, And How Do We Do It?**

CheckPoint provides resources to improve the well-being of those who play games: • **GamerMates:** A pro-mental health gaming community.

• **The CheckPoint Series**: A 16-part web series tackling mental health issues using the power of video games. • **Mental Health Resources**: Our site is full of tailor-made articles, courses and downloads to educate and teach self-care.

CheckPoint supports the use of video games for positive well-being, boosting resilience, and even to treat mental illness:

• **Mental Health for Game Dev**: A collection of online resources for teams to support wellbeing, improve engagement, and maintain productivity.

• **CheckPoint's Checklist**: Guidelines for representing or tackling mental health issues in games.

• **Clinical Research**: Real medical research about the benefits of games.

• **Development**: Watch this space…

Because CheckPoint is run by both mental health and games industry professionals, our reach spans across both industries and ensures the information we provide is **accurate, relevant** and **implementable**.

We are passionate that what we do will **change the face of mental healthcare and video game culture forever**.

https://checkpoint.org.au/about-us/

Gerstein Centre:

Is a 24-hour community based mental health crisis service.

For over 25 years, Gerstein Crisis Centre has been working with adults 16+ in the city of Toronto experiencing mental health crises. Gerstein Crisis Centre is a voluntary, non-medical service, and we work with our clients to address their needs and find solutions, and tools to proactively avoid future crises.

We offer 24-hour telephone crisis intervention, mobile crisis visits and short-term residential beds. We also provide integrated services for individuals with complex needs which can include mental health and justice, concurrent and serious substance use, homelessness and dual diagnosis.

Our experienced staff works with a wide range of community groups to educate on mental health awareness, suicide and crisis intervention. Training initiatives offer practical work experience to individuals with lived experience and newcomers to Canada to assist in finding employment in the mental health field.

Our wellness and recovery services provide training and mentoring to those with lived experience using evidenced-based models to support individual recovery and overall well-being.

http://gersteincentre.org/

Toronto Distress Centre:

Callers' issues include problems related to domestic violence, social isolation, suicide, addictions, and mental and physical health concerns. The Distress Centre offers, as appropriate: emotional support, crisis intervention, suicide prevention, and linkage to emergency help when necessary.

https://www.torontodistresscentre.com/

Assaulted Women's Helpline:

GTA: 416-863-0511, 1-866-863-0511, We provide crisis counselling, safety planning, emotional support, information and referrals accessible 7 days a week, 365 days a year. We work in tandem with community partners and sister agencies towards bridging gaps in service and identifying emerging issues or trends relevant to the women we work with

Toronto Withdrawal Management System Central Access (detox placement)

1-866-366-9513, 24 hrs/7days

Help for seniors:

Toronto Seniors helpline 416 -217-2077
Senior Safety Line - 1-866-299-1011, 24 hrs/7days