The Gestalt Center for Growth and Training, LLC ("TGC")
Internship Manual v. 12.22.2024

Introduction

Introductions {Name, How you are doing in this moment}
Burning Questions
Online resources: TGC Drive, Gmail, Calendar, Website, and Therapy Notes Home Page
Office locks and record storage (lock codes, laptop passwords)
Dani and Eligibility Checks and Client Payment (danicrawford@boulderemotionalwellness.org)
Office Etiquette/ Chore List
Safety
Teletherapy Etiquette
Camera/ Video (Recording session)
Calendar (Link TN to Calendar)
Phone System and Voicemailing
Phone Screen (review online form)
Client Assignment
Mandatory Disclosure
Getting Started With a Client
Termination

Medicaid Guardrails - Clinical Audit Sheet, Billing Audit Sheet
Golden Thread of Documentation: Phone Screen -> Consult -> Intake Assessment -> Tx Plan -> Sessions -> Termination
Assessments (PHQ 9, GAD 7, Columbia Scale from within TherapyNotes)
Progress Notes introduction

Intro {Name, life context, important for people to know about me}
Self-care {things I do for self-care}
Check-in {typical 2 minute}
Discuss phone screen and first session (90791 practice)

Office Etiquette

- When arriving at the office please turn on all lights in the waiting room.
- Please do not hang out in the waiting room. This is to minimize running into known clients and giving them space to be in a place where they bring their vulnerabilities.
- Restrict cellphone and laptop use during meetings.
- Arrange the counseling room when done. This includes emptying the trash bin, making sure there are tissues, arranging pillows, blankets, furniture, etc. back to the way it was.
- Follow office procedures thoroughly. Make sure all lights, and heaters/fans are off; all blinds open. Make sure the staff door is locked; the front door is locked.
- Minimize conversations in the waiting area. They can be heard in the counseling rooms and we ant to increase client safety by not having to hear other conversations and support clients in knowing they have confidentiality when speaking in the counseling rooms.
- Be on time. This applies to meetings and client sessions. Please show up ahead of time to make sure the counseling room is ready, and so you have time to read over the file, etc.
- Keep counseling room doors open when not in use.
- Schedule room(s) in TherapyNotes; update immediately if something changes (i.e. cancellation). This includes removing them from the calendar when a client cancels at the last minute, as well

as if you know you'll be out of town, or there will be a missed appointment for some reason. File a missed appointment note ASAP.
- Discuss use of intern room.
- Make copies when using the last form.
- Keep the playroom clean and the sand tray empty with the lid on after use.

Office Dog Policy
- To be discussed on a case-by-case basis.

Chore List
- See posted chore list. Will discuss during onboarding.

Safety

General

An awareness of safety issues is encouraged at all times for staff and interns. Use your common sense, intuition, and best judgment in situations where safety might be an issue. Your safety concerns could be either physical or emotional. If you have safety concerns with a client, please talk to your supervisor.

Counseling Alone in the Building

When client appointments are outside of usual business hours (8am to 8pm), discuss directly with supervisor.

Unsupervised Children

Children under the age of 10 are not allowed to be anywhere at The Gestalt Center for Growth and Training without adult supervision. This includes the waiting room and counseling rooms. Children 10 and older may sit quietly in the waiting room (they may not be in a counseling room, including the play room) during a session. A client may bring another adult or older child to sit with the younger one. However, if any disruption or questionable situation occurs, the counseling session will be interrupted and the child will be returned to the supervision of the parent/guardian.

If a client brings a child/children unexpectedly to a session:

Reschedule the session when childcare can be arranged or include the child(ren) in the session if appropriate and adjust the session plan accordingly

Teletherapy Etiquette

<u>You must get your client's signature on the Telehealth Authorization through the TherapyNotes portal.</u>
- **Be Early Enough**
- When doing teletherapy, please be ready for the request from the client. This may mean ending an earlier session so that there's enough time.
- Assure Confidentiality for both the counselor and the client's environment. For children clients, understand who is in the room.
- Be Aware of Your Background
- Take time to arrange your space and lighting.
- The Client Can See When You RECORD. <u>Do not record without client permission.</u> Share the "Authorization to Record" with your client through the TherapyNotes portal.
- Prepare to Dial with Cell Phone or Landline

Video Recording on TherapyNotes

You are required to record one session per semester.

Calendars

To be discussed during onboarding.

Phone System

To be discussed during onboarding.

Calling Clients From Your Personal Phone

We require when calling clients from your personal phone you take steps to block your number. The easiest way to do this is by entering *67 and then the phone number you want to dial. However, many people have services that will not allow blocked numbers to be received. If this is the case, Google Voice is a good second option. Download the Google Voice app on to your phone, and follow the on-screen prompts to get started.

Getting Started with A Client

- Schedule a session and meet with the client. Listen for goals and working diagnosis.
- Provide proper forms for signature through the Portal.
- Produce a 90837 Consultation Note within 48 hours.
- Meet for 90 minutes and produce a Therapy Intake Note (90791)
- Draft a Treatment Plan, submit, Supervisor will share with the client through the portal.
- Meet and review the treatment plan with the client, discuss, and get the client's signature.

Treatment Plans must be reviewed by the client within 14 days of the first session. So generally there is a consult session (day 0), a history taking session (day 7), and a treatment plan gets discussed in the third session (day 14).

CLIENT FORMS AT FIRST SESSION
Please share these documents with clients on the TherapyNotes portal as soon as possible:

- Your mandated disclosure statement "Disclosure - {Initials}"
- TGC Policies Statement
- (if telehealth) TGC Teletherapy Consent

For Medicaid :

- Medicaid Rights-AdvDir-ChildWellness
- Medicaid Notice of Patient Privacy

For private pay : TGC Private Pay Fee and Cancellation Policy
For child clients: TGC Auth - One Parent, or TGC Auth - Two Parents

ONGOING PROCEDURES EACH SESSION
Write a Missed Appointment note immediately.
Write a Progress Note within 48 hours.

Medicaid Intake Assessment

The Intake is a structured, 90-minute session in which you will use a biopsychosocial format to gain a thorough understanding of your client's history. The intake form in TherapyNotes will guide you on what questions to ask, however here are some additional considerations for some fields in the form:

The Presenting Problem MUST be related to symptom criteria from the diagnosis.

Additional fields:
Document as "Client did not disclose perpetration of sexual or physical assault."

< 12 y.o.: Please add narrative about contacting CPS if physical/sexual abuse is noted in history.
for example “Contacted CPS on this date to fulfill mandated reporting requirement. Shared __ with CPS.”

Medical Conditions & History:
> 65 y.o.: ask about elder issues: vision loss, hearing loss, mobility issues
< 15 y.o.: Ask about growth and development issues

Other Information
Note the client’s capacity for Activities of Daily Living (ADLs): sleeping, eating, exercise
Note cultural factors that may impact treatment, particularly differences in social location between ct and thx.

Note: If you do not manage to finish the intake questions in your scheduled 90-minute intake session, that’s okay; finish them up in the following session and save your intake note as a draft until then. Fill out a progress session note for that following session as usual.

Termination
"Records shall contain a written discharge summary to include, but not limited to, the following information, where applicable:

- Reason for admission.
- Reason for discharge.
- Primary and significant issues identified during the course of services.
- Diagnoses.
- Summary of services, progress made, and outstanding concerns.
- Coordination of care with other service providers.
- Advance directives developed or initiated during the course of services.
- Summary of medications prescribed during treatment, including the individual's responses to medications.
- Medications recommended and prescribed at discharge.
- Summary of legal status throughout the course of services and at time of discharge.
- Documentation of referrals and recommendations for follow up care.
- Documentation of the individual's and/or family's response and attitude regarding discharge.
- Information regarding the death of the individual.

Discharge Summary Example:

Clients were seen for 28 sessions of therapy. Clients were referred by their attorney in the court system for concerns with establishing a new family system, healing abandonment and neglect issues, and maintaining stability during a custody dispute. Initial treatment plan focused on uniting a new family, healing wounds and stabilizing the inner systems while the external often remained in chaos. Treatment began with relationship development and continued through the implementation of strength-based approaches. Course of treatment included creative arts (poetry, art, music, sand tray), somatic interventions (breathing techniques, body scans, relaxation exercises), genogram processing, psycho-education, honest communication (including code words, skills, and resources), trust building, use of humor and contact, and normalizing. Thirteen of the 28 sessions were 2 hours long and most sessions included the entire family, although some separating out did occur (i.e., just the girls, just the aunt/uncle, etc.). Clients attended their sessions regularly and appeared strongly motivated. Clients made excellent progress during therapy. Termination occurred when their goals had been reached.

Medicaid Guardrails and Audits
Medicaid audits are done once a month. To be discussed during onboarding.

Golden Thread of Documentation
Phone Screen -> Consult -> Intake Assessment -> Tx Plan -> Sessions -> Termination

Video (55 minutes) discusses "the golden thread of documentation." Password is "bew." https://vimeo.com/246901215

Assessments
PHQ 9, GAD 7, Columbia Scale from within TherapyNotes

https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures

https://psychology-tools.com/?fbclid=IwAR3qqHui2Yp7qb-tYnYtbtBZQ7gfkwM3EYKJHevgd61t6l1O4bTQz3W-Z3k

Progress Notes Introduction

How to Write Efficient and Ethical Progress Notes

See resources on **TherapyNotes**; we will discuss during onboarding. (TherapyNotes has excellent 24-hour support. Feel free to conatact them if you have ANY questions. Call: (215) 658-4550.

Important Notes About Progress Notes

- SPELLING MISTAKES ARE DELAYS. PLEASE USE THE ABC BUTTON and proofread.
- When you are quoting a client, use quotation marks.
- Symptom Description field MUST include something related to the dx symptoms. If the client has a depression dx, ask about depression symptoms, etc. You can have the session happen, listen for statements by the client that relate to the dx, and put the quote in the Symptom Description box.
- If you change frequency, please update the dropdown widget at the bottom of the progress note with the new frequency.
- Please ask about sharing dx and tx plan with PCP. PLEASE edit the box in Patient Info that deals with this. (Lower Right).

TherapyNotes Progress Note Fields

In Therapy Notes there are two areas in which you will write content:
"Symptom Description and Subjective Report" and "Objective Content"

Generally, the client's subjective report, including direct quotes, will go into the first "Symptom Description and Subjective Report" area, and content of the session, your interventions, and how the client responded, go in the "Relevant Content" section.

Symptom Description
a. What is the client describing to you? What "symptoms" justify their presence in therapy? What are some direct quotes from the client?

Symptom Description and Subjective Report
Write 2-3 sentences including quotes from the client around progress related to their goals (i.e. "I'm not doing great at all on practicing my pause response… I did pretty well noticing in the moment when I felt anger this past week"). It can be helpful to start a session by checking in on this explicitly.

Objective Content
a. What are the most important issues that were discussed?
b. Describe at least four interventions you employed, and how the client responded.

Additional Notes / Assessment
Provide an assessment of how the client is responding to treatment, progress toward goals, changes in symptoms, patterns observed, hypotheses, and changes in diagnosis. This part connects the data from the session and informs future treatment adjustments.

1. Date of birth (it's helpful for supervisors to be reminded of the client's age).
2. If the client is enrolled in Medicaid, the client's ID will appear here.
3. These fields must be accurate. These are federal compliance requirements.
    1. Edit Date, Time, and Duration.

Service Code must be accurate.

- 90837 is a typical consultation session.
- 90837 is a typical therapy session.
- 90791 is "Therapy Intake Session".
- 90847 if Family Therapy (couple therapy).
- 90486 is a collateral phone call, typically to a parent.

1. Location is teletherapy.
2. Participants includes who participated.

1. "AEB" is an acronym for "as evidenced by" and is standard.
2. Clicking "All Normal" automatically fills the Mini Mental Status Exam.
3. If this box is checked, additional fields appear to guide and document a safety check.

1. Click "History" to recall entry from previous notes.
2. What did the client come in with? What did they report related to their symptoms and objectives? "How was your week…"
3. What happened in session. What was taught, experienced, attempted?
4. Customize your intervention list. Discuss new entries with supervisors.

Note "Review of Treatment Plan" to be checked when relevant.

1. Select an accurate assessment of progress toward the objective from the drop down list.
2. There must be a plan. "Continue insight oriented therapy", "Explore relationship with FoC" (father of client)
3. Usually "Continue…"
4. Frequency of treatment may change without new treatment plan. Please explain reason for change in "Additional Notes…"

Example phrases for "Therapist Intervention"
Cognitive Behavioral Therapy:
Coached use of X, Y, Z technique during session.
Practiced progressive muscle relaxation, deep breathing, etc.
Used role-play to practice assertiveness, focusing on "I" statements and pro-social expression of emotion.
Facilitated identification of behaviors related to positive mood, explaining use of behavior activation and creating behavior activation plan.

Engaged client in resource activation, facilitating identification of external resources and people to support client in the change process.
Explored core beliefs, identifying….
Facilitated identification of cognitive distortions.
Challenged cognitive distortions.
Caught and reframed thoughts.
Identified alternative interpretations.
Explained cognitive model of emotion, using A-activating event, B-Beliefs, and C-consequences from client's life.
Used ladder method to identify significant values.
Assisted client in identifying strongest, positively emotionally engaged moments and strategies to elicit these in the future.
Explored meaning client made in relation to previous schemas and beliefs, focusing on inconsistencies and emotional reaction to inconsistencies.
Assisted client in finding alternative meaning in significant negative experience by finding positive outcomes and moments of learning.
Explored identity, focusing on contrasts with others and understanding of self in emotionally strong moments.
Assisted in identifying happy place and discussed application of this skill to X problem.
Facilitated practice of mindfulness with X activity…
Practiced guided meditation.
Facilitated client's exploration of alternative interpretations of situations, focusing on the use of radical acceptance.
Used behavioral chaining to explore cause and effect relationships between behaviors and current situation.

Motivational Interviewing:
Steadied ambivalence.
Rolled with resistance.
Facilitated identification of client's stage of change, providing psychoeducation on stage of change model.
Facilitated pro/con list, exploring cost-benefits of behaviors.
Assisted in identification of barriers to change, identifying….
Explored rationale for treatment and others' views regarding need to change behaviors, assisting client identify discrepancies.
Facilitated exploration of reasons for and against change with client.
Reflected change talk while discussing client's……

Person-centered:
Used reflections to empower client and facilitate personal problem-solving.
Provided positive feedback regarding "X" behavior discussing impact on current functioning and goals.
Reflected and summarized feelings.
Provided unconditional positive regard to build alliance and rapport.
Validated strong emotions.
Assisted in emotional identification and expression of emotions.

Play therapy:
Assessed themes, identifying…..
Facilitated practices of social skills through the use of play, specifically practicing "X" behavior and providing feedback.
Used reflection and tracking during session, in order to…
Using sand tray, reflected…(ex: behaviors, consequences of behaviors, themes, emotions, thoughts).

Used play to facilitate re-telling of stories, focusing on facilitating changing themes of "X" to "Y."
Engaged in limit-setting to reinforce boundaries and create structure.
Used play to model appropriate social interactions.
Empowered client by giving appropriate challenges and encouraging independent accomplishments.
Observed behavior, reinforcing "X" behavior when observed.

Interpersonal/Process:
Identified and explored value-congruent boundaries.
Used immediacy, genuineness, and authenticity to build therapeutic alliances.
Used active-listening skills to validate and express empathy.
Used reflection and active-listening to facilitate self-awareness.
Normalized client experience by…

Systemic/Family Systems:
Explored relationship dynamics with family members, identifying….
Used narrative interventions to externalize family problems.
Created a genogram with family to visualize family of origin structure and relationship to current relationship dynamics.
Identified family roles and responsibilities in order to better define family structure.
Facilitated the creation of a relational focus
Reframed X experience and reflected to client
Assessed for hierarchy
Assessed parenting styles
Engaged clients in behavior sequencing
Used role play to….
Assisted clients in identifying appropriate expectations (i.e., rules/consequences)
Provided psychoeducation around conflict resolution skills and observed demonstration of skills, while providing coaching.
Walked clients through process of creating shared meaning in their experiences.
Developed strategies for turning toward one another and reinforcing bids for connection
Focused on building fondness and awareness with couple by….
Engaged couple in friendship strengthening activity by….
Identified and discussed complimentary roles of partners (and/or family members).
Assessed commitment level with couple, recognizing that…
Explored values among couple, focusing on identifying differences and similarities.

Solutions-focused/Brief Therapy:
Engaged in scaling and identifying exceptions, recognizing that…..
Used miracle question, identifying….
Reviewed long and short-term goals, recognizing….
Used cost-benefit analysis to facilitate problem-solving.
Examined consequences of behaviors, focusing on pros/cons and goal movement.
Assisted client in externalizing problems.
Identified skeleton key to address multiple concerns, including…
Identified passed successes.
Highlighted discrepancies between behaviors and goals.

Psychodynamic:
Connected present maladaptive behavior to past experience.
Explored subjective experience of inner-child and behaviors related to inner child's unmet needs.
Identified "X" theme from childhood, providing interpretation of how this may be influencing current relationships.

Utilized dream imagery to access unconscious content.

Psychosocial rehab/Community psych. support:
Taught & observed independent living skills, providing feedback and coaching.
Modeled appropriate interpersonal interactions.
Assisted client in practicing X coping skill, using coaching to….
Empowered client by assisting in problem-solving worksheet around maintaining a safe home environment and reminding client of previous successes.
Practiced X money management strategy, assisting client in becoming independent by teaching and having client demonstrate skills.
Used Role-play to practice assertiveness skills.
Observed and assessed functioning within social skills, redirecting and providing suggestions regarding current behaviors.

Treatment Plans
Treatment plans describe general goals and specific objectives for treatment.

Goals are the accomplishments or larger ways in which a client wants to make progress in their life.
Goals should be:

- Collaborative between you and the client
- Informed by the intake and assessment processes
- Prioritized in a few key areas
- Cognizant of underlying causes. We need to practice more than symptom reduction.

Tips for helping a client identify goals:

- Focus on areas that are strengths for the client
- Ask your client to visualize an "ideal day." What would this look like? What would they be doing? Who would they be with?
- Ask your client to imagine that their current challenges have magically disappeared. What would this be like? What would they be doing and feeling?
- If your client focuses on symptoms, help them identify how their life would look without the symptoms. For example, if your client states, "I want to feel less depressed," ask them, "If you were less depressed, what would you be doing? How would you spend your time? How would life be different for you?"

Goals can be thought of as three concentric circles where the inner is emotional regulation, the middle is ADLs, and the outer is social interaction:

- Intrapersonal goals: Mood, regulation, behaviors
- Activities of daily living (ADLs) goals
- Interpersonal goals: Relationships/ways of relating to others
- also include a goal related to social location differences between therapist and client

For example, "Therapist will address with C the differences in social location between thx and ct, within four weeks of onset of treatment, to discuss possible impacts on treatment."

Objectives:
Objectives are the ways in which a client meets their overall goals.

Objectives should be SMART:

- Specific
- Measurable

- Attainable
- Realistic
- Time-framed

Interventions:
Interventions are the skills and/or behaviors that a client practices as part of the objective.

Tips for developing interventions:
• Who is providing the intervention?
Include the name of the person providing the intervention and his or her relationship to the person.

• What is the modality that will be used?
Individual therapy? Mindfulness skills? Journaling? etc.

• Where will the intervention take place?
In session? In daily life? With their partner?

• When will the intervention be provided?
Include both the frequency and the duration of the intervention, i.e., weekly for three months.

• Why is the intervention being provided?
What is the purpose for providing the intervention? What mental health barrier is being addressed?

Documenting the Treatment Plan in TherapyNotes
The Presenting Problem MUST be related to symptom criteria from the diagnosis.
Please work with the client so that that client contributes at least one objective to the treatment plan, and indicate in the tx plan that the objective was contributed by the client.
There must be one or more objectives related DIRECTLY to reducing diagnosis symptoms.
Please make sure clients sign treatment plans (out of 10 records that were audited, ZERO had signed plans.)

Notes from the Office of Behavioral Health Audit (5/21/22)
“Service plans shall: Contain specific, measurable, attainable objectives that relate to the goals and have realistic expected date(s) of achievement.” A majority of service plan goals reviewed lacked one or more SMART components, most often specific and time-bound.

Examples:
"Client will increase behaviors that demonstrate self love 1x/day as evidenced by client report"
Lacks specificity, Lacks target date

"Client will improve self esteem by creating healthy boundaries within her relationships that support actualizing her highest potential aeb the client's report in therapy"
Lacks specificity, Lacks target date

"The client will review and reinforce the positive steps necessary to deal with her stressors"
Lacks specificity, Lacks measurability, Lacks target date

"There was little evidence found in charts reviewed that the client contributed a goal/objective and/or participated in the development of the plan. Most agencies demonstrate this by either including client generated goals or utilizing client quotes."

Notes from the Office of Behavioral Health Audit (5/17/23)

Records for Educational or Psychotherapy Groups

90853 "Group Therapy 45+ minutes"

Please create a scheduled 90853 session in TherapyNotes calendar for any clients that are attending the group. The session should be at the actual time that the group happened. Then you can write a note and we can bill.

Below is the service description from the state manual:
https://hcpf.colorado.gov/sites/hcpf/files/SBHS%20Billing%20Manual%20January%202024.pdf

Please align your note writing to what the state is asking for.

Colorado's manual says:
Service Description: (Including example activities)
Facilitating emotional and rational cognitive interactions in a group setting with 2/more members (other than a family therapy session) in an effort to change the individual behavior of each person in the group through interpersonal exchanges. The group may include members with separate, distinct, maladaptive disorders, or share some facet of a disorder with other people in the group (e.g., drug abuse, victims of violence). Goals relate to BH treatment, including the development of insight/affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality/any combination thereof to provide therapeutic change.
● Serving special member populations with a particular theoretical framework/addressing a specific problem, such as low self-esteem, poor impulse control, depression, etc., through cognitive behavioral therapy (CBT), motivational enhancement therapy, trauma counseling, anger management, and/or sexual offender (SO) treatment
● Personal dynamics of a member may be discussed by group and dynamics of group may be explored at same time
● Interpersonal interactions, support, emotional catharsis, and reminiscing

Notes: (Including specific documentation and/or diagnosis requirements)
90853 is used for group psychotherapy involving members other than the members' families. 90853 does not include socialization, music therapy, recreational activities, art classes, excursions, group meals, or sensory stimulation. If only one group member is present, document as individual therapy. While group psychotherapy is not a time-based service, the average session length is 1.5 hours. Recommended minimum is 45 minutes for adults and 30 minutes for children/youth. Document and report 90853 for each identified member within the group.
All providers, licensed or unlicensed, are required to practice

psychotherapy only within their areas of competency, in accordance with State rules and regulations.

https://myclientsplus.com/how-to-write-group-therapy-notes/

Elements of a Group Therapy Note

While writing an individualized group therapy note for everyone in your group may feel daunting, you can streamline the process. You'll follow your preferred format for individual therapy note-taking. Here's what you'll need for each component.

Summary of the Group

As stated, the group summary includes basic information on the group. List the group name, main topic(s) covered during the session, interventions you implemented, and the schedule. Since this section will be the same for each client, you can copy and paste this into everyone's individualized note.

How the Client Interacted with the Group

In the individualized portions, it's important to document how the client engaged within the group. Include information like their level of active engagement, contributions, and reactions. For example, are they seen as a leader, or do they assume a more passive role in the group's dynamics?

How the Group Reacted to and Interacted with the Client

In this section, detail how the group reacted to the client. Were they welcoming and receptive, or did the group struggle to accept and integrate the client into the discussion?

How the Client Influenced the Group

Each group has its own unique dynamics. And each member exerts an influence on how the group functions as a whole. Detail how the client influenced the group. Did they have a significant pull on the direction of the discussions, affecting the tone of the interactions in a marked way?

How the Group Influenced the Client

Group dynamics work both ways. In this section, you'll note how the group affected the client. Did the group's consensus on a particular topic seem to hit home and exert a noticeable change in the client's way of thinking about the issue? Were they more excited about the possibility of change due to the encouragement they received from the group?

How to Write More Effective Group Therapy Notes

1. Stay Objective

Some clients make this easier than others. If you have a client in a group with a strong personality or difficult demeanor, seeing them through an objective lens can be challenging. After all, you're human. But as you're describing a client's interactions within the group, be careful to avoid any language that may come across as judgemental. Report just on what's objectively observable, avoiding recording any opinions or feelings that aren't rooted in fact. Be mindful of any biases you may have towards certain clients and take extra precautions to stay objective as you write their summaries.

2. Maintain Client Confidentiality

Individualized group therapy notes should only include identifiable information for the client you're writing about. As you're describing group dynamics and how the client interacted with and was influenced by others, be careful not to include any identifiable information about other group members. If you're documenting an interaction the client had with another group member, never use names, even first name. Describe the other individual in generic terms to ensure you protect their confidentiality.

3. Be Clear and Precise

Best practice for every progress note is to write it so that another therapist has enough information to pick up right where you left off. Therapy notes are useful for documenting current progress and planning for future interventions. They also form a historical record of the client's therapy experiences over time. As you write group notes, be as detailed and explicit as possible. Remember that although you know important details and background on the client, valuable insight will be lost if you don't put it down on paper. As a secondary benefit, the more clear and concise your progress notes are, the less likely your billing claims will be denied or delayed over an insurer's request for additional information. And if you're audited, well-written progress notes are your best friend.

4. Describe Methods and Interventions Used in the Session
A group session usually focuses on a single theme. For example, a session for a group of clients struggling with substance abuse disorder may focus on identifying triggers that increase the likelihood of experiencing a relapse. After discussing potential triggers, you present a general plan for avoiding relapse, and each group member crafts a plan unique to their needs. As a general rule, clearly state your actions and guidance as the group leader and any therapeutic interventions you provided during the session in every individualized group therapy note.

https://www.icanotes.com/2018/04/25/how-to-create-a-group-therapy-note/#element

1. Group Summary
Each note for individual clients should begin with a group synopsis. You might include the following details:
The group's name
The discussion topic
The session's date
The session's start and stop time
The session's schedule
The counselor's name
The number of clients in attendance
The interventions used
You can use the same group summary for each client. If you do so, make sure it does not include individual client names. You might create an attendance list and file it in a separate folder.

2. Identifying Information
Ensure each note includes accurate identifying information such as:

The client's full name
The client's identification number
The client's date of birth
Your organization's name
Depending on your practice, you may need to include a few other details, such as the client's gender or contact information.

3. Mood and Appearance
Include the client's observed or reported mood. Also, note the client's overall appearance and anything that stands out. You might use a mental status exam checklist to help you describe a client's mood and appearance.

4. Behavior
Behavior

Did the client participate in the group discussion? Did they share their feelings with others or offer their insights? Note observations you made of each client and how they behaved in group therapy, including their response to other group members and any personal experiences they shared.

5. Issues and Events
Describe any new issues the client presented during the session or problems they had with another group member. For example, if a client becomes angry and argues with another group member, describe how you intervened and helped them identify the source of their anger.

6. Patient-Group Interactions and Reactions
In each group member's individual notes, you'll want to describe how they interacted with the group and how the group reacted or interacted with them. Discuss how they engaged with the group and the contributions they made. Do they assume the role of the group leader or are they more passive and timid? Is the group receptive and welcoming to the individual or do they have difficulties integrating and accepting them into the discussion?

7. Patient-Group Influences
Next, report on the patient-group dynamics in terms of influence. Every individual member will play a different role in how the group functions as a whole. Detail how each of your patients contributed or influenced the group. For instance, did they have a significant effect on the direction of the conversations or topic? Did they have a heavy influence on the tone of the overall interaction?

As you should describe how each client influenced the group, you should also explain how the group influenced each client. Describe the nature of how the group did this and the effect it had. Did the group's support positively influence the client and make them feel encouraged about the possibility of change? Did the group's agreement or disagreement on a particular topic affect the client or make them feel excluded? Was the group able to change the patient's mind about a specific issue?

8. Goals and Objectives
Document the goals and objectives in each client's treatment plan that you addressed during the group therapy session. For instance, imagine a client's goal is to stop abusing alcohol. They have several objectives in their treatment plan to help them achieve this, such as identifying triggers that lead to their alcohol use. Include this specific objective if the group therapy session focuses on identifying substance use triggers.

9. Therapeutic Intervention
List the interventions you used during the session to target a client's goals and objectives. For example, you might write that you taught the group a breathing exercise to help members reach their goal of feeling less anxious.

10. Response or Progress
Write how the client responded to the session and whether it helped them get closer to their goals. Include if the session moved the client away from their objectives or made no impact. For example, you might add that a client listened to the group's feedback but did not seem interested in applying their suggestions. If the client does not eventually make progress, you may want to include how you will change your strategy.

11. Plan and Additional Information
Describe the client's plan for future sessions and homework you assigned. Use this section to mention if a client will miss the next session and explain why. Include any strategies the client learned during group therapy that they plan to apply while they're absent.

12. Signature and Date
Include your signature, credentials, time and date. If needed, get your supervisor's signature as well. You might also add the time and date of the next group therapy session.

Medicaid Dismissal Policy

https://s18637.pcdn.co/wp-content/uploads/sites/26/PRCO-001-Member-Dismissal-Policy.pdf

A. The provider may dismiss a Health First Colorado Member from their practice for cause at any time. Cause is defined as any of the following:

1. A documented, ongoing pattern of failure on the part of the Member to keep scheduled appointments or meet any other Member responsibilities.
2. The Member fails to follow the recommended treatment plan or medical instructions.
3. The provider cannot provide the level of care necessary to meet the Member's needs.
4. The provider moves out of the service area.
5. If the provider and/or practice staff perceives the Member and/or Member's family is abusive to the provider and/or practice staff or poses a serious threat of harm to the provider, staff, and/or other patients.
6. Other reasons satisfactory to the Department.

Supervision

1. **For your individual supervision, please come prepared.** Think about what you want help with. Bring client files of specific clients and spend some time focusing your questions. These may include issues of transference/countertransference issues or personal issues that you think may impact your professional work.
2. Be professional and conscientious about your paperwork at TGC. You are required to have all case notes completed within 48 hours of completing a session.
3. Once you have a caseload, we expect that you will record and review at least 1 session each semester. Listening to or watching your sessions will dramatically increase your learning as a therapist. Your supervisor will review your taped sessions with you and give you feedback at that time. This feedback is designed to help you identify and work on your areas of strengths and weaknesses.You will have the opportunity to do two formal case presentations during group supervision. Please use our Case Presentation Form as a guide. Please bring questions or concerns to the supervision group along with ideas about what feedback you are seeking from the group and supervisors.

Boundaries with Supervisors

Interns in their relationship with supervisors, are also accorded special protection in the eyes of the law and in our professional code of ethics.

1. Sexual and social conduct between clinical supervisors and supervisees is prohibited. This prohibition extends for the duration of the supervisees' services at TGC.

1. Dual relationships (that is, professional and social) between clinical supervisors and supervisees are restricted by Colorado law. This prohibition applies to all supervisory relationships, both individual and group. In cases where a potential dual relationship cannot be avoided, counselor and supervisor will discuss appropriate behaviors and boundaries. In some cases a counselor may need to be transferred to another supervisor.

1. Supervisory and other meetings should take place at TGC or in other business settings (schools, health care facilities, judicial or agency settings, etc.).

Setting and maintaining appropriate boundaries is the responsibility of the supervisor, not the supervisee.

Requirements Before Seeing Clients

In order to begin seeing clients at TGC, the following must be completed:

- Completed orientation with Dan
- Internship Contract signed through digital document system.
- Disclosure statement approved by supervisor
- Cover page of liability insurance to TGC Drive (share with Dan)
- Phone screen role play
- First session role play
- Set up voicemail
- Scheduled weekly individual supervision
- In TherapyNotes; created practice client record, shared documents through portal with client, created practice treatment plan, created practice intake record, created practice progress note

Internship Agreement
Expectations For Interns:

1. Provide 20 hours per week to the TGC internship. Build and maintain a caseload of 8-12 clients.
2. For private pay, cash only, handle client fees ethically, including collecting, recording and turning in fees on the day of the session (if the session is in-person).
3. Understand and comply with the agency's policies and procedures.
4. Maintain professional, ethical boundaries at all times while at or representing TGC (please refer to the ACA professional code of ethics: https://www.counseling.org/resources/ethics
5. Understand and comply with the the State of Colorado reporting codes for child abuse and neglect or threat to self or others.
6. Understand and respect the nature of the supervisory relationship (i.e. the supervisor has final say if a question/conflict arises).
7. Contact a supervisor when a child abuse or neglect report is necessary or if a client is in a life-threatening situation (suicidal threat or threat to harm another).
8. Keep your supervisor informed of all necessary school requirements, meetings with school liaisons, student evaluations needed and any other pertinent information.
9. Complete client records and required paperwork in an appropriate and timely manner.
10. Wear appropriate dress while at or representing TGC.
11. Participate in the chores required for a functional office (20 minutes a week).

Program Requirements:

1. Eleven-month commitment
2. Background check clearance from the Colorado Bureau of Investigation. A previous background check (within the past two years) could be accepted. TGC will pay the check fee.
3. Up to one hour of individual and one hour of group supervision each week and attendance at agency orientation, agency meetings and site meetings. (To be discussed during onboarding.)
4. Two case/topic presentations during the internship year and at least two audio or videotaped client sessions to be reviewed in supervision. Release forms from clients must be obtained.
5. Phone screens as needed.
6. Registration in the Colorado Department of Regulatory Agencies databases as an LPCC by the time of graduation.

7. Complete and pass the jurisprudence exam before April of internship year.

Vacation Policy

Predetermined vacation periods for TGC interns and staff:

- The week of Christmas/New Year's Day (one week)
- Naropa Spring Break (one week)

(you may choose to see clients during these weeks at your own discretion)

In addition, interns may take an additional week (5 business days) of vacation during their internship year at TGC. In the interest of client care and continuity, please consider taking one week at a time if possible.

Vacation time may not be taken during the following periods:

- Orientation period (Thursday - Thursday). Exceptions to this include births, deaths, and weddings or funerals in your immediate family.
- During the final three weeks of your internship.
- Vacation time cannot be used to leave your internship early.

Rescheduling clients to a different day of the same week is not considered to be taking a vacation day.

Weekly Meetings:

To be discussed during onboarding. Missing a meeting for an unexcused reason will be considered the use of a vacation day. Excused reasons include:

- Attending a relevant workshop approved by your supervisor
- Working off site on TGC business
- illness

Arc of Internship

Naropa requirements:

1. Initial meeting with faculty supervisor and myself (Initial Goals)
2. 1 case presentation
3. 1 in-service, "topic" or "content" presentation (+ In-service form)
4. 2 recorded sessions (1 each semester) (+ A/V Form)
5. Mid-term meeting and PCCE (+ PCCE Form)
6. Final PCCE
7. Final Hours Form

also… group experience.

Balancing school and internship

There are times throughout the academic year when your obligations for Naropa will increase, and other times when they will be negligible. Please be proactive and plan for when your workload may increase so that you can remain present for your clients and also maintain your self-care. Some of these times include the end of semesters and mid - to late-April of second semester, when capstone presentations are due and you will be required to wrap up all of your internship requirements. Poor planning and overwhelm are not allowable reasons to cancel client sessions or supervision sessions.

Take some time at the beginning of each semester to organize your due dates for school and map a plan for when you'll be able to get these done while maintaining your weekly caseload and supervision requirements.

Self-care
Being a therapist can be hard work! We will offer consistent support to you as you grow into this role at TGC, knowing that there will be cases you take on that are higher acuity, activate your countertransference, and/or are simply challenging. With this said, you have a personal responsibility to also consistently support yourself. It may take some time to find the practices and resources that truly work for you, and once you find these we expect that you will prioritize them in your daily and/or weekly life. **You must show up for yourself first and foremost!**

Professional Boundaries with Clients
Setting and maintaining professional boundaries in the relationships between counselors and their clients is a major topic in the counseling profession. Counseling relationships can, by their nature, be intimate and include a power differential. The issues discussed are often very personal, and the setting is usually private. Therefore, it is especially important to set clear boundaries and to be ethical and respectful in all our interactions with each other, both in counseling sessions and in more casual encounters.

Boundaries with Clients
Psychotherapy clients are accorded special protection in the eyes of the law and in our professional code of ethics. TGC operates in accordance with all laws of conduct and with the highest standards of professional ethics.

1. Sexual or social conduct of any kind with clients is prohibited. This prohibition extends from the first client contact, through the duration of client services, until at least 2 years after official termination.
2. Physical contact with clients as part of therapeutic technique is prohibited at TGC. Physical contact as human connection, compassion and encouragement (i.e. handshakes, pats on the back, touches on the arm, hugs when initiated by the client) is allowed. Be aware that for some clients that have been abused, touch can be extremely threatening and/or re-traumatizing. If you have concerns or questions about what is appropriate, talk to your supervisor.
3. Alcohol & Drugs if there is any alcohol or substance intoxication at the time of a scheduled session, the session will be canceled and private pay clients will be responsible for the session fee.
4. Dual relationships (that is, professional and social) between counseling interns and clients are restricted by Colorado law. In cases where a potential dual relationship cannot be avoided, counselor and client will discuss appropriate behaviors and boundaries. In some cases a client may need to be transferred to another counselor.
5. Trade for counseling services by clients is not accepted. Gifts from clients should not be accepted unless there is therapeutic value or cultural considerations in receiving a gift. Any gift accepted should be of no or minimal monetary value.
6. Setting and maintaining appropriate boundaries is the responsibility of the counselor, not the client.

Confidentiality

All interns, volunteers, and staff at TGC are bound by the laws of client confidentiality. We cannot discuss client confidences to anyone except: a) as mandated by law; b) to prevent a clear and immediate danger to self or others; c) where the counselor is a defendant in a civil, criminal, or disciplinary action arising from the counseling or the information has been subpoenaed by the court.; or d) if there is a release of information signed (by the client(s), or parent/guardian of the client involved in the case of clients 12 and under) in order to communicate with another person or agency as designated on the release of information. In the case of more than one person receiving counseling together, confidentiality may be released only by the signature of all members of the system aged 12 and older.

If you have any questions about confidentiality please speak to your supervisor or your site director.

Client Confidentiality Within TGC
It is important to remember and communicate to the clients that this is done for the coordination of treatment. As such it is best to share goals of the treatment, the themes and issues being addressed by each counselor, and any suggestions may help the counselors work together. Try to avoid the details of the client sessions or personal details of the clients themselves that are not relevant to the overall treatment plan.

Procedure for Addressing Significant Problems with an Intern

1. The primary supervisor meets with the intern to discuss concerns.

2. Supervisors meet to discuss suspected problems and share observations.

3. If the problem involves counseling with the clients the intern may be required to audio or videotape counseling sessions for 2 to 6 weeks for the supervisor to review with the intern. Some transcription of the tapes by the intern may also be required.

4. The supervisors (and the executive director if indicated) meet again to discuss the severity of the issue/problem.

5. If significant deficiencies are noted, both supervisors will call a meeting with the intern and the intern's school supervisor(s) to devise a plan to address the issues and problems of concern. If it is felt that the problem is severe enough, the intern may be asked to leave the internship at that time. If it is felt that the issue or problem can be addressed, there will be a probationary period of no less than one month in which the plan will be in effect.

6. At the end of the designated probationary period or at the end of one month's time, another meeting including all the supervisors (school and site) and the intern will be called. At this time: a) the probationary period may be continued/extended if some but not adequate progress is being made on the part of the intern; b) the probationary status of the intern is terminated due to satisfactory progress made by the intern on the identified issues/problems; or c) the intern may be asked to leave the internship.

Client Screening Guidelines
These are guidelines to help determine if client(s) are appropriate for the early intervention counseling services that TGC offers or if another agency or type of service might be more appropriate to meet their needs.

- Cutoff age to be seen without parental permission: 12 years and older
https://celaw.com/colorado-lowers-the-age-of-consent-for-outpatient-psychotherapy-services/

- Children in Joint Custody Situations: Children/teens under 15 who are in joint custody following their parents' separation or divorce cannot be seen for counseling without the signed and dated written permission of the parent who is not initiating the counseling. TGC policy.

- Crisis: If the person is currently at risk for harming themselves or others (suicidal, homicidal, needing hospitalization or medication) we will refer them to the Mental Health Partners crisis line (303 447 1665), or we will contact the police.

- Physical fighting in the family:
    - DOMESTIC VIOLENCE If severe active battering or any kind of physical violence is currently occurring within the couple or family, or if it has occurred within the past year and is an ongoing problem, and the client wants couples/family therapy, provide a referral to an appropriate agency. If it appears to be an isolated incident of a non-severe nature, the supervisors will consider if our services would be appropriate.
    - SEXUAL/PHYSICAL ABUSE OR NEGLECT If at any time issues of abuse or neglect are revealed, we will comply with the Department of Social Services reporting requirements. If abuse or neglect of children is currently occurring we will report to the Department of Social Services. If abuse or neglect has occurred in the past and the child/individual is no longer at risk, the supervisor will determine whether our services are appropriate.

- Drug or alcohol abuse issues: If alcohol or substance abuse is a primary issue, we will assist the client with a referral to an appropriate agency, which deals with these issues directly. If alcohol or substance abuse is a factor but not the primary issue the supervisor will determine whether the case is appropriate for our services.

- Suicide attempts: If there has been a suicide attempt by the individual seeking services or within the family in the past year, and no follow-up treatment has occurred, or if the supervisors determine that a particular situation requires more extensive or specialized services than the scope that our agency provides we will refer to the Mental Health Partners.

- People with mental health or medical issues and/or have been hospitalized for psychiatric or other reasons will be assessed for appropriateness. Clients with a history of seeking help unsatisfactorily with a series of agencies, the chronically mentally ill, people needing 24 hour back-up services, people needing medical or psychological evaluation or testing, people needing supervision of medication or specialized services will not be a good fit for services at TGC. If the supervisors determine that a particular situation is outside the scope of services that our agency provides we will provide a referral.

Case Presentation Format

Please select a client or a relationship to present. This should be someone, or a relationship, that you have worked with for more than four sessions, where there is already a treatment plan, and where interventions have already been attempted. Please include a vignette.

Presenting about interventions that have been attempted and how the client responded is the core of the case presentation.

Format

1. Introduction
    1. Reflect on what kind of support/feedback you would like to receive from the group when presenting your case and let us know when introducing the case.
    2. Age, gender orientation, family context, school/work/living context, sexual orientation, etc.
2. Sketch of client
    1. Body-Speech-Mind description (below)
    2. Coping behaviors; healthy and unhealthy
    3. Brief trauma & loss history or summary
    4. Strengths and resources/supports
    5. Any transference and/or countertransference that has come up; what do you notice internally when in session with this client?

6. What interventions/resourcing have you tried and how did they go/how did the client respond; what has been helpful?
3. Conclusions
4. Questions for the group

The Body-Speech-Mind Discipline and Questions to Consider

Body

- Physical description of client (coloring, size, styles of dress, grooming, movement, posture, overall health and appearance)
- How does the client hold themself? How do they meet the world? Are they fragile, collapsible, sturdy?
- What do you notice about this person?
- How do you hold yourself when with this person?
- Include the client's physical environs: do they live alone or with people? What kind of car do they drive (if you know)? Is their schedule filled or spacious? Do they engage in physical activity? What do they eat?
- How does the client relate to wakefulness? Body disciplines can contribute to this aspect of a person's life and so may be worth exploring.

Speech

- Metaphor = Breath = a continuous medium of exchange between the person and their world; the client's feeling of being alive and which qualities are connected to this (liveliness, deadness, fear, anxiety, insecurity, etc.)
- How the client speaks: tone, modulation, prosody, accent, speed (an indication of what the mind process is like).
- Does the client use particular phrases often? Gestures? Pauses?
- Are they direct in their speech? Do they stick to the point?
- Are they quiet or verbose?
- Does the client speak in metaphors? Stories?
- Does the client know how he sounds to others?
- Does the client talk at you? Through you? Beyond you? With you?
- Other exchanges with the environment: emotions, reactions, relationships.
    - How do they relate to other individuals? To groups? To animals? To money? To dreams and images?
    - How do they express their feelings? When do certain moods arise?
    - Who are significant people in their life and how do they talk about them?
    - Is the client in integrity with their speech? Do they mean what they say?
- What kinds of communication from you are invited when you're with this person?
- What does it feel like for you to be with this person?
- How the client interacts with their world represents their experience of compassion, and ability for it, and this can be used to understand the client's current relationships including their relationship with you.

Mind

- Mind is revealed through body and speech. Focus is the client's relationship to their own mind.
- Often we can uncover underlying patterns or obsessions within the client.
- How does the client think?
- What does the client think about?
- What is their relationship with their mind like?
- Are they analytical?
- Are they intuitive?
- Do they think in concrete terms? In imagery?

- How is their concentration?
- Do they get stuck in repetitive thought patterns?
- Are they distractible?
- How do they relate to surprise? Pain?
- What makes them light up?
- How do they relate with honesty? With humor?
- What is their mind-landscape like?
- How do they work with doubt? Curiosity?
- What happens to your mind when you're with this person?
- Be aware of your impulse to problem-solve, categorize, or judge this person (a function of your mind process)

Content Presentation Format

Content Presentation Guidelines for Psychotherapy Interns

Objective:
To deliver a comprehensive, graduate-level presentation on a topic relevant to psychotherapy practice, demonstrating your ability to synthesize and communicate advanced concepts to fellow professionals.

Topic Selection:
- Choose a subject that is current, evidence-based, and applicable to psychotherapy practice.
- Topics may include emerging therapeutic modalities, specialized interventions, or contemporary issues in mental health.
- Ensure the topic is sufficiently complex to warrant a graduate-level discussion.

Presentation Format:
- Duration: 30-40 minutes, with 10-15 minutes for Q&A.
- Use visual aids (e.g., PowerPoint, handouts) to support your presentation.

Content Requirements:
1. Introduction:
  - Clearly state the topic and its relevance to psychotherapy.
  - Provide a brief overview of what will be covered.

2. Theoretical Background:
  - Present the theoretical foundations of your topic.
  - Discuss relevant research and empirical evidence.

3. Practical Applications:
  - Explain how the topic applies to clinical practice.
  - Provide concrete examples or case vignettes (anonymized).

4. Critical Analysis:
  - Discuss strengths and limitations of the approach/topic.
  - Compare and contrast with other relevant theories or methods.

5. Ethical Considerations:
  - Address any ethical implications or challenges related to the topic.

6. Future Directions:
  - Discuss potential areas for further research or development.

7. Conclusion:
  - Summarize key points and their significance for psychotherapy practice.

Evaluation Criteria:
- Depth and accuracy of content
- Critical thinking and analysis
- Clarity of presentation and communication skills
- Engagement with current research and literature
- Ability to answer questions and facilitate discussion

Preparation:
- Conduct a thorough literature review, including peer-reviewed journals and reputable sources.
- Consult with your supervisor to refine your topic and approach.
- Practice your presentation to ensure smooth delivery within the time limit.

Final Note:
This presentation is an opportunity to demonstrate your expertise and contribute to the professional development of your peers. Approach it with enthusiasm and a commitment to excellence.

Documentation
A malpractice judgment can seriously harm your personal and professional life. And your case documentation may be the only thing between your word and that of a client's. Often your documentation may be the sole item of evidence in a case.

Proper documentation is a key element in avoiding adverse legal action. Legally credible documentation involves an accurate record of the care your client received, and your competence in providing appropriate counseling. The file notes should be contemporaneous, accurate, honest, and appropriate. Notes should avoid adverse comments about the client.

Ensuring Proper Documentation
Here are some common sense steps to take to ensure proper documentation:

- Document care when it's provided. Be sure to always note the time and date. This is especially important during an emergency, such as when a client expresses a desire to harm themselves or others. *Please always adjust start time and duration.*
- Be sure you indicate accurately what you did. Inaccurate statements are not helpful.
- Avoid exaggeration or untruthful comments.
- Remember that file documentation may be subject to a subpoena. You must be comfortable in the knowledge that someone could be reading your notes. View your client as a unique individual with a distinct set of cultural values, beliefs, and attitudes.
- Document emergencies. Include a follow-up plan. State what's important for the client to do. If consultation or a referral is needed, that should be indicated. Be sure to make an appropriate referral if the notes indicate this.
- Ask yourself these questions in emergency cases:
    - When did the intervention begin?
    - When were family and authorities notified?
    - How did the client respond?

- Never alter a client's records. Altering records is a criminal act. It can be especially devastating if any alteration is done after a civil action is filed.

Records Required To Be Kept
From CCHA Provider Manual (Medicaid payer) - Properly used, TherapyNotes covers all of this.
At a minimum, every medical record must include the following:

- The patient's name or identification (ID) number on each page in the record
- Personal biographical data, including home address, employer, emergency contact name and phone number, home and work phone numbers and marital status
- Entries dated with month, day and year
- Entries documented with the author's identification and title. For example, handwritten signature, unique electronic identifier or initials
- Identification of all providers participating in the member's care
- Information on the services furnished by these providers
- List of problems, including significant illnesses, medical conditions, and psychological conditions
- Presenting complaints, diagnoses and treatment plans, including the services to be delivered
- Physical findings relevant to the visit, including vital signs, normal and abnormal findings, and appropriate subjective and objective information
- Information on allergies and adverse reactions, or a notation that the patient has no known allergies or history of adverse reactions
- Information on advance directives
- Past medical history, including serious accidents, operations and illnesses.
- For patients 14 years old and older, the record must include information about substance abuse
- For children and adolescents, the record must include past medical history as relates to prenatal care, birth, operations, and childhood illnesses
- Notations concerning the use of cigarettes, alcohol and substance abuse for patients 14 years and older, including anticipatory guidance and health education
- Physical examinations, treatment necessary and possible risk factors relevant to the particular treatment
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information about the individuals to be instructed in assisting the patient
- Medical records must be legible, dated and signed by the provider, physician assistant, nurse practitioner, or nurse midwife providing patient care
- Up-to-date immunization record for children, or an appropriate history for adults

From Colorado State Board of Licensed Professional Counselor Examiners Rules:
RULE 16 -- RECORDS REQUIRED TO BE KEPT AND RECORD RETENTION (C.R.S. §§ 12-43-203(3), 12-43-222(1)(u))

(a) General. Every licensed professional counselor shall create and shall maintain a record as defined in subsection (b) of this rule for each client, this record shall be retained for a period of seven (7) years, commencing on either the termination of professional counseling services or the date of last contact with the client, whichever is later. Exception. When the client is a child, the record shall be retained for a period of seven (7) years commencing either upon the last day of treatment or when the child reaches eighteen (18) years of age, whichever comes later, but in no event shall records be kept for more than twelve (12) years.

(b) The record shall contain, as applicable to the mental health services rendered, the following information:
(1) Name of treating therapist;
(2) Client's identifying data to include name, address, telephone number, gender, date of birth, and if applicable the name of the parent or guardian. If the client is an organization, the name of the organization, telephone number and name of the principal authorizing the mental health provider's services or treatment;

(3) Reason(s) for the psychotherapy services;
(4) Mandatory disclosure statement(s);
(5) Dates of service including, but not limited to the date of each contact with client, the date on which services began, and the date of last contact with client;
(6) Types of service;
(7) Fees;
(8) Any release of information;
(9) The record shall justify and describe the assessment, diagnosis and therapy/treatment administered in a legible document. The records must be prepared in a manner that allows any subsequent provider to yield a comprehensive conclusion as to what occurred;
(10) Name of any test administered, each date on which the test was administered, and the name(s) of the person(s) administering the test;
(11) A final closing statement (if services are over).

(d) Record Storage. Every professional counselor shall keep and store client records in a secure place and in a manner that both assures that only authorized persons have access to the records and protects the confidentiality of the records and of the information contained of the records.

(e) Transfer of Records. Whenever a professional counselor deems it necessary to transfer her/his records to another professional counselor or other health care provider, the professional counselor making the transfer shall obtain the client's consent to transfer (when possible).

(f) Disposition of Records. If the professional counselor is not available to handle her/his own records, the professional counselor and /or his estate shall designate an appropriate person to handle the disposition of records. A plan for the disposition of records shall be in place for all professional counselors for the following conditions:
(1) Disability, illness or death of the professional counselor.
(2) Termination of the professional counselor's practice.
(3) Sale or transfer of a practice.

(g) Record destruction. Every professional counselor shall dispose of client records in a manner or by a process that destroys or obliterates all client identifying data. However, records cannot be destroyed until after seven (7) years or as otherwise provided in these rules or any other applicable statutes or rules.

(h) Record Keeping in agency/institutional setting. A professional counselor need not create and maintain client records if the professional counselor practices in an agency or institution and if the professional counselor:
(1) Sees the client in the usual course of that practice;
(2) Keeps client records as required by the agency or institution, and;
(3) The agency or institution maintains client records.

Transfer Clients
If you are taking on a transfer client from an intern or extern who is leaving, please do the following:

- Give them a new disclosure form with your information.
- Notify staff that you are now on the case so you can be added as a therapist to their record. You will be able to read the previous therapist's notes, so you must get authorization from the client to release this information to you.
- Ideally, a transfer session including both the old and new therapists with the client(s) can occur.

Definition of Legal Ages

Child: A person under the age of 18 years old.
Adult: A person 18 years and older.
Minor: A person under 18 except if living on their own or married.
Consent to treatment without parental permission: 12 years and older.
Emancipation: Flexible; child must petition court and be employed.
Drinking and Gun Purchase: 21
Smoking: 18
Driving: Learner's permit at 15 years with a Driver's Ed. class; license at 16 years.
GED: 16
Voting: 18
Military Service: 17
Consensual Sex:

- If 12 and under, legal consent is not possible.
- At 13 and 14, consensual sex means 4 years or less of age difference.
- At 15 and 16, consensual sex means 10 years or less of age difference.

At 17, consensual sex means anyone except a "person in trust," i.e., a teacher, coach, minister, etc.

Child Abuse & Neglect Resources

Please participate in this training as soon as possible:
https://coloradocwts.com/public-training/mandated-reporter-training/

Child Protective Services
Boulder County Child Abuse & Neglect Hotline 303-442-1000
Longmont Child Protection 303-678-6000

Colorado Statutes Regarding Child Abuse
Definitions of Child Abuse and Neglect

Physical Abuse Citation: Rev. Stat. § 19-1-103
Abuse or child abuse or neglect means an act or omission in one of the following categories that threatens the welfare of the child:

- Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death and either:
- Such condition or death is not justifiably explained
- The history given concerning such condition is at variance with the degree or type of such condition
- The circumstances indicate that such condition may not be the product of an accidental occurrence

Neglect Citation: Rev. Stat. §§ 19-1-103; 19-3-102
Child abuse or neglect includes any case in which a child is a child in need of services because the child's parent has failed to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take. A child is neglected or dependent if:

- A parent, guardian, or legal custodian has subjected the child to mistreatment or abuse or has allowed another to mistreat or abuse the child without taking lawful means to stop such mistreatment or abuse and prevent it from recurring.
- The child lacks proper parental care through the actions or omissions of the parent, guardian, or legal custodian.
- The child's environment is injurious to his or her welfare

- A parent, guardian, or legal custodian fails or refuses to provide the child with proper or necessary subsistence, education, medical care, or any other necessary care
- The child is homeless, without proper care, or not domiciled with his or her parent, guardian, or legal custodian through no fault of such parent, guardian, or legal custodian
- The child has run away from home or is otherwise beyond the control of his or her parent, guardian, or legal custodian

Sexual Abuse Citation: Rev. Stat. § 19-1-103
Abuse or child abuse or neglect means any case in which a child is subjected to sexual assault or molestation, sexual exploitation, or prostitution. Sexual conduct means any of the following:

- Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex or between humans and animals
- Penetration of the vagina or rectum by any object
- Masturbation
- Sexual sadomasochistic abuse

Emotional Abuse Citation: Rev. Stat. § 19-1-103
Abuse or child abuse or neglect means any case in which a child is subjected to emotional abuse. Emotional abuse means an identifiable and substantial impairment or a substantial risk of impairment of the child's intellectual or psychological functioning or development.

Abandonment Citation: Rev. Stat. § 19-3-102
A child is neglected or dependent if a parent, guardian, or legal custodian has abandoned the child.

Domestic Violence As Child Abuse Citation: Rev. Stat. § 18-6-402 (7)(e)(IV)
A pattern of witnessing domestic violence is child abuse.

Parental Drug Use As Child Abuse Citation: Colo. Rev. Stat. Ann. § 19-103(1)(a)
"Abuse" or "child abuse or neglect" means an act or omission in one of the following categories that threatens the health or the welfare of the child:

- Any case in which, in the presence of a child, or on the premises where a child is found, or where a child resides, a controlled substance, as defined in § 18-18-205(5), is manufactured
- Any case in which a child tests positive at birth for either a schedule-I controlled substance, as defined in § 18-18-203, or a schedule-II controlled substance, as defined in § 18-18-204, unless the child tests positive for a schedule-II as a result of the mother's lawful intake of such a substance as prescribed

Standards for Reporting Citation: Rev. Stat. § 19-1-103
A report is required when a responsible person's acts or omissions threaten the child's health or welfare.

Persons Responsible for the Child Citation: Rev. Stat. § 19-1-103
Responsible person meaning a child's parent, legal guardian, custodian, or any other person responsible for the child's health and welfare.

Spousal equivalent meaning a person who is in the family-type living arrangement with a parent and who would be a step-parent if married to that parent.

Exceptions Citation: Rev. Stat. §§ 19-1-103; 19-3-103
Those investigating cases of child abuse shall take into account child-rearing practices of the culture in which the child participates, including the work-related practices of agricultural communities. The reasonable exercise of parental discipline is not considered abuse.

Mandatory Reporters of Child Abuse and Neglect

Professionals Required to Report Citation: Rev. Stat. § 19-3-304

Persons required to report include:

- Physicians, surgeons, physicians in training, child health associates, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, nurses, hospital, personnel, dental hygienists, physical therapists, pharmacists, registered dieticians
- Public or private school officials or employees
- Social workers, Christian Science practitioners, mental health professionals, psychologists, professional counselors, marriage and family therapists
- Veterinarians, peace officers, firefighters, or victim's advocates
- Commercial film and photographic print processors
- Counselors, marriage and family therapists, or psychotherapists
- Clergy members, including priests, rabbis, duly ordained, commissioned, or licensed ministers of a church, members of religious orders, or recognized leaders of any religious bodies
- Workers in the State Department of Human Services
- Juvenile parole and probation officers
- Child and family investigators
- Officers and agents of the State Bureau of Animal Protection and animal control officers

Reporting by Other Persons Citation: Rev. Stat. § 19-3-304

Any other person may report known or suspected child abuse or neglect.

Standards for Making a Report Citation: Rev. Stat. § 19-3-304

A report is required when:

- A mandated reporter has reasonable cause to know or suspect child abuse or neglect.
- A reporter has observed a child being subjected to circumstances or conditions that would reasonably result in abuse or neglect.
- Commercial film and photographic print processors have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child engaged in an act of sexual conduct.

Privileged Communications Citation: Rev. Stat. § 19-3-304; 19-3-311

The clergy-penitent privilege is permitted.

The physician-patient, psychologist client, and husband-wife privileges are not allowed as grounds for failing to report.

Inclusion of Reporter's Name in Report Citation: Rev. Stat. § 19-3-307

The report shall include the name, address, and occupation of the person making the report.

Disclosure of Reporter Identity Citation: Rev. Stat. § 19-3-307

The identity of the reporter shall be protected.

Making and Screening Reports of Child Abuse and Neglect

Individual Responsibility Citation: Rev. Stat. § 19-3-304; 19-3-307

A mandated reporter who has reasonable cause to know or suspect that a child has been subjected to abuse or neglect shall report immediately to the Department of Human Services or a law enforcement agency. The reporter shall promptly follow up with a written report.

Content of Reports Citation: Rev. Stat. § 19-3-307

The department's report, when possible, shall include the following information:

- The name, address, age, sex, and race of the child
- The name and address of the person alleged responsible for the suspected abuse

- The nature and extent of the child's injuries, including any evidence of previous cases of abuse or neglect of the child or the child's siblings
- Family composition
- The source of the report, including name, address, and occupation of the person making the report
- Any action taken by the reporting source
- Any other information that might be helpful

Penalties for Failure to Report and False Reporting of Child Abuse and Neglect
Failure to Report Rev. Stat. § 19-3-304(4)
Any mandatory reporter who willfully fails to report as required by § 19-3-304(1):

- Commits a Class 3 misdemeanor and shall be punished as provided by law
- Shall be liable for damages proximately caused

False Reporting Rev. Stat. § 19-3-304(3.5), (4)
No person, including a mandatory reporter, shall knowingly make a false report of abuse or neglect to a county department or local law enforcement agency. Any person who violates this provision:

- Commits a Class 3 misdemeanor and shall be punished as provided by law
- Shall be liable for damages proximately caused

Procedures For Suicidal Clients

1. Assess the suicide risk

- Suicidal Ideation (to be discussed during onboarding)
- Suicide Plan
- Lethality of plan
- Availability of weapons, drugs, etc.
- Isolation
- History of suicide (self or family)
- Bipolar Diagnosis
- Caucasian male 65+
- Chronic pain
- Recent severe life stressor

Administer Columbia protocol through TherapyNotes (Library > Outcome Measures)

(Telehealth) If they call and have a plan and it is lethal and currently available, and they are isolated and they sound serious about following through with it: put them on hold for a minute, call your supervisor, and call 911. Give 911 the caller's name and number (or they can trace the call). 911 will first ask “where is your emergency?”

Then return to talking with the person and attempt to keep them on the line until the police arrive. Another option is to convince them to go to a hospital emergency room for assessment.

If they have suicide ideation and no plan:

- Ask for a verbal commitment that they will stay safe until you can meet with them.
- Ask who they can go to for support – friends, family, support groups, church members – and encourage them to talk about their feelings with someone they can trust. If they can't think of anyone be sure to give them the Mental Health Partners crisis line number (988 is the crisis phone number)
- Ask how they have handled these kinds of feelings before (feeling hopeless, helpless, lonely, overwhelmed, in despair). Help them identify ways to take care of themselves and self-regulate.

- As soon as you can get them to come in for a session.
- Help the client make a plan for daily support.
- You may want to set up a plan for daily check in with you either via TGC phone mailbox or your initiating a call to them at a specified time. If they do not follow through and you are concerned for their safety you may call the police and initiate a well-check.

1. Call your supervisor to notify them and discuss the situation

Life threatening events override client confidentiality. This is to be stated verbally as a part of the disclosure form they sign at their first counseling session.

MENTAL HEALTH PARTNERS CRISIS LINE 303-447-1665

Suicide Assessment

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change.

RISK FACTORS

Suicidal behavior:
☐ History of prior suicide attempts
☐ Aborted suicide attempts
☐ Self-injurious behavior
Current/past psychiatric disorders:
☐ Especially mood disorders
☐ Psychotic disorders
☐ Alcohol/substance abuse
☐ ADHD
☐ TBI
☐ PTSD
☐ Cluster B personality 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
☐ Axis 1 psychiatric disorders requiring hospitalization
Precipitants/stressors/Interpersonal:
☐ Triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated)
☐ Ongoing medical illness (esp. CNS disorders, pain)
☐ Intoxication
☐ Family turmoil/chaos
☐ History of physical or sexual abuse
☐ Social isolation
Change in treatment:
☐ Discharge from psychiatric hospital
☐ Provider or treatment change

Access to firearms:
☐ Gun in the home
☐ Knows someone with a gun

Notes:

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 pets

☐ Positive therapeutic relationships

☐ Social supports

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

Ideation:
Frequency: How often do you think about suicide/dying/killing yourself?

Intensity:
How strong are your thoughts and urges? Do you find them hard to control?

Duration:
In last 48 hours, past month, and worst ever: In the last 48 hours, how long have your thoughts about suicide lasted? In the past month? When your feelings were the worst ever, how long did your thoughts about suicide last?

Plan:
Timing: Do you think about when you would complete suicide? What time of day? Day of the week?

Location:
Do you think about where you would complete suicide?

Lethality:
Do you think about what means you would use to complete suicide?

Availability:
Do you have access to these means?

Preparatory acts:
What have you done to prepare?

Behaviors:
Past attempts: Have you attempted suicide before? How?

Aborted attempts:
Have you attempted recently without success?

Rehearsals (tying noose, loading gun) vs. non-suicidal self-injurious actions:
Have you taken steps towards your plan, such as keeping a loaded gun near you, a bottle of pills with you, or tying a noose? Or have you engaged in self-harming activities such as cutting or burning yourself?

Intent:
Extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal (a suicide) or self-injurious (not suicidal self-injury).

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

RISK LEVEL/INTERVENTION
Assessment of risk level is based on clinical judgment, after completing steps 1–3.
Reassess as patient or environmental circumstances change.

High:
Psychiatric diagnoses with severe symptoms or acute precipitating events; protective factors not relevant. Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal. Admission generally indicated unless a significant 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 a crisis plan. Give emergency/crisis numbers.

Low:
Modifiable risk factors, strong protective factors. Thoughts of death, no plan, intent, or behavior. Outpatient referral, symptom reduction. Give emergency/crisis numbers.

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

Domestic Violence

Disclosure During Phone Screens
If a phone screen is done with one partner and domestic violence is indicated, discuss with staff and possibly do an additional screen with the other partner to assess safety concerns and whether we can consider taking the case or will need to provide referrals.

The top two considerations for accepting cases:

1. The safety of the victim (i.e. a low risk situation).
2. The perpetrator takes responsibility for his/her actions and is willing to be accountable.

Conditions indicating a Low Risk Situation (potential for couples counseling):

1. The therapy is not court mandated and the perpetrator demonstrates an ongoing commitment to containing explosive feelings without acting them out or blaming others
2. A couples safety contract is signed by both clients
3. Both partners want to do the work
4. the couple's history is limited to a few incidents of minor physical violence, and use of psychological abuse is infrequent and mild
5. No risk factors for lethality are present (see below)

Risk Factors for Lethality (couples counseling would be contraindicated):

1. The victim has a sense that his/her partner will seriously injure or kill him/her
2. Alcohol/Substance Abuse is present
3. There is history of domestic violence, there have been two or more incidents within the last year, or there are previous violations of restraining orders
4. There is a history of violence or violent crimes
5. There is a history of weapon use or weapons are available
6. Threats are made to the victim of future intent to hurt him/her or any children , or retaliate
7. There is an obsession with the partner (intense jealousy, unfounded accusations, controlling and isolating behavior, stalking and harassment)
8. History of bizarre forms of violence (sadism, torture) or sexual violence

Err on the side of caution

Couples counseling can create a false sense of security, with the risk for violence still present. Many states have public policy regulations that delay couples counseling for perpetrators until:

1. Participation in a specialized program is completed by the perpetrator
2. A six-month period of non-violence has occurred
3. The victim's full consent and willingness to be seen in couples counseling is present

At Risk Adult Abuse & Neglect Reporting

Adult Protective Services
303-441-1441

Boulder County Adult Protective Services (APS) staff investigates reports of abuse, neglect (including self-neglect) or financial exploitation of at-risk adults who are unable to protect themselves due to a physical or mental limitation. APS staff assesses the need for protective services and provides services to reduce the identified risk to the adult. These services may include case coordination, short-term case management, guardianship or representative payee, and information referral.

Adults who may receive Protective Services are defined in the state law as: “At-risk Adult” means a person eighteen (18) years of age or older who because of mental or physical dysfunction or advanced age is unable to manage such person's own resources, carry out the activities of daily living, or protect such person from neglect, hazardous or abusive situations without assistance from others and who has no available, willing, and responsibly able person for assistance and who may be in need of protective services.

What allegations will APS investigate?

1. Physical Abuse

Physical abuse is intentional infliction of injury or physical mistreatment, including: Slapping, pinching, choking, kicking, shoving, inappropriate use of drugs or physical restraints.

1. Sexual Abuse

Sexual abuse is any non-consensual sexual contact. (Note: Any sexual contact between a facility staff person (such as a nursing home, adult family home, boarding home, or supportive living) and a vulnerable adult is considered non-consensual). Sexual abuse includes: Unwanted touching, rape, sodomy, coerced nudity, sexually explicit photographing.

1. Mental or Emotional Abuse

Mental (or emotional) abuse is the intentional action or inaction of mental or verbal abuse. Mental abuse includes: Intimidation, coercion, ridicule, harassment; treating an adult like a child; isolating an adult from family, friends, or regular activity; use of silence to control behavior; yelling or swearing resulting in mental distress.

1. Neglect or Self-Neglect

Neglect or self-neglect means that, through action or inaction, by themselves or someone else, a vulnerable adult is deprived of care needed to maintain physical or mental health. This does not include a competent person who decides to live in a way that may threaten their safety or well-being. Neglect or self-neglect includes: Untreated or improperly attended medical conditions, poor personal hygiene; unsafe living conditions (for instance, no heat); unsanitary living quarters (for instance, no toilet); lack of appropriate clothing; lack of necessary medical aids; failure to take medications as prescribed.

1. Exploitation or Financial Exploitation

Exploitation is exerting undue influence or forcing a vulnerable adult to perform services for the benefit of others. Financial exploitation is the illegal or improper use of the property, resources or income of a vulnerable adult for another person's profit or gain. Examples of exploitation include: An adult relative living in the home of a vulnerable adult without contributing to the household. An unexplained sudden transfer of assets to a family member or someone outside the family.

1. Abandonment

Abandonment is leaving a vulnerable adult without the ability to get necessary food, clothing, shelter, or health care. An example of abandonment includes a caregiver deserting the individual in a public place or their own home.

Medicaid Overview

Medicaid is a federal and state funded program, which therefore includes various anti-discrimination statutes, where states are awarded money to supplement their programs. Colorado calls its Medicaid program “Health First Colorado”. Colorado has expanded Medicaid coverage from children under 6 years old to include all people with low incomes. Note that eligibility is based on income, not assets, so a person who is “land rich” or paid off their home a long time ago may qualify based on low income.

Here are some sites to explore coverage in Colorado :

https://www.coloradohealthinstitute.org/research/colorado-health-access-survey

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html

https://spotlightonpoverty.org/states/colorado/

To learn more about Medicaid in Boulder County, see:

https://www.bouldercounty.org/families/medical/health-first-colorado/

https://www.bouldercounty.org/departments/public-health/health-data-resources/

https://www.colorado.gov/pacific/hcpf/county-fact-sheets (click “Boulder”)

Paying for emotional wellness for Coloradans is a complicated project. For a glimpse, see:

http://leg.colorado.gov/sites/default/files/fy2019-20_hcpbrf2.pdf

The state of Colorado is divided into 7 “Regional Accountability Entities” aka RAEs, with boundaries coincident to county lines. These RAEs administrate Medicaid services on a county level.

Boulder is in RAE 6. Currently Colorado Community Health Alliance (CCHA) is the “payer” for Medicaid here in Boulder. See https://www.cchacares.com/

TGC has contracts with all the RAEs. This is necessary because of this:

The RAE that a member is enrolled in is determined by the physical location of their medical health provider.

This rule means that two clients living next to each other can be enrolled in two different RAEs. So TGC must contract with all the RAEs.

For a client to enroll in medicaid, direct them to https://www.healthfirstcolorado.com/apply-now/

Or “To apply by phone call 1-800-221-3943”

Colorado allows members to switch RAEs with some ease, depending on their situation.
The client must call (the therapist cannot do this for the client).
The number to give to the client to call is : **(303) 839-2120**

Medical Necessity
Definition of Medical Necessity (Beacon 2020)

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (current ICD or DSM) that threatens life, causes pain or suffering, or results in illness or infirmity.
- Expected to improve an individual’s condition or level of functioning (or preclude deterioration).
- Individualized, specific and consistent with symptoms and diagnosis, and not in excess of the patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative and less costly treatment is available.
- Not primarily intended for the convenience of the recipient, caretaker or provider/participating provider.
- No more intensive or restrictive therapy than necessary to balance safety, effectiveness, and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

Definition by Colorado Law
“(c) "MEDICAL NECESSITY" MEANS

A DETERMINATION BY THE CARRIER THAT A PRUDENT PROVIDER WOULD PROVIDE A PARTICULAR COVERED HEALTH CARE SERVICE TO A PATIENT FOR THE PURPOSE OF PREVENTING, DIAGNOSING, OR TREATING AN ILLNESS, INJURY, DISEASE, OR SYMPTOM IN A MANNER THAT IS:

(I) IN ACCORDANCE WITH GENERALLY ACCEPTED STANDARDS OF MEDICAL PRACTICE AND APPROVED BY THE FEDERAL FOOD AND DRUG ADMINISTRATION OR OTHER REQUIRED AGENCY;

(II) CLINICALLY APPROPRIATE IN TERMS OF TYPE, FREQUENCY, EXTENT, SERVICE SITE, AND LEVEL AND DURATION OF SERVICE;

(III) KNOWN TO BE EFFECTIVE IN IMPROVING HEALTH, AS PROVEN BY SCIENTIFIC EVIDENCE;

(IV) THE MOST APPROPRIATE SUPPLY, SETTING, OR LEVEL OF SERVICE THAT CAN BE SAFELY PROVIDED GIVEN THE PATIENT'S CONDITION AND THAT CANNOT BE OMITTED;

(V) NOT EXPERIMENTAL OR INVESTIGATIONAL;"

Proving <u>Medical Necessity</u> in Your Documentation

Use items from the Assessment/ Intake/ Mental Health Status Exams:
"Based on assessment and need...",
"as evidenced by..."

Speak to the impairments in daily living
relationships, work, school, home, leisure, medical, etc

Speak to how the presenting diagnosis is continuing to provide instability
Mention the risks associated with identified areas being left unaddressed

Vocabulary suggestions:
labile, flooding, externalized locus of control, reactivity, tangential, denial

Angela Lee

> If they originally had criteria to meet DSM Dx then you document that you're doing maintenance sessions to prevent and help clients maintain their mental health. Explain what you're doing to help the client not have a relapse. Obviously, these sessions would decrease in frequency, so you document the necessity for fewer appointments. I've had some want to continue to come forever. And others feel fine, and request to be terminated. So I do both.

Danielle Kepler Lapidus

If they no longer meet criteria, you discuss their progress and terminate or reduce frequency. I would talk about how it's benefitting aka what symptoms it's reducing, etc. to explore medical necessity.

> "All plans should have a document clarifying their medical necessity criteria. This is from Cigna: 'individual therapy is indicated when: The individual is experiencing symptoms or impairments that are impacting their day-to-day functioning, relationships, work or school performance. The individual has been unable to alleviate their symptoms on their own and/or is in need of additional assistance to relieve their symptoms."

Nancy Burke

> Actually, the standards of care outlined in the Wit v UBH decision specify that therapy is justified to treat not only symptoms but underlying problems.

"This is from Magellan, might also be good to consider:
"Services by a provider to identify or treat an illness that has been diagnosed or suspected. The services are:
1. consistent with:
    a. the diagnosis and treatment of a condition; and
    b. the standards of good medical practice;
2. required for other than convenience; and
3. the most appropriate supply or level of service

Client Options at Close of Internship
For continuity of counseling, clients have options. Discuss:

- Termination of counseling
- Follow current counselor into private practice
- Continuation of counseling with another counselor at TGC
- Referral to an outside therapist or agency

Structuring a Good Final Session

1. Have the client review their counseling experience. Invite them to review goals and any progress towards those goals. Have them look at how they are different now than when they started therapy, in terms of feelings, thoughts and behaviors.
2. Review with the clients your views of what has changed and what has been accomplished. Many times the therapist sees improvement that the client has overlooked.
3. Mutually identify the strengths and coping skills that the client has found or developed to handle their problems.
4. Remind them of how they plan to continue to practice and experience what they have learned here about themselves, their thoughts, emotions and behaviors. Identify situations, thoughts and feelings that may be difficult for the client in the future. Reinforce their intentions to change, their successful experiences and their new coping skills.
5. Invite them to see how they can continue to improve their ability to deal with and enjoy life and relate well with others. Encourage them to persist in examining their life, finding resources and support, and setting goals for future progress.
6. If appropriate, encourage them to let you know at time how they are doing and return to you and/or TGC when further help is needed.

Boulder County Mental Health Resources
Boulder Alcohol Education Center……...(303) 444-6142
Alcohol education
Boulder Bridge House……..(303) 442-8300
Day shelter and resources for the homeless and working poor
Boulder County AA……...(303) 447-8201
AA meetings
Boulder County Legal Services…….(303) 449-7575
Low-income legal services
Out Boulder County……..(303) 499-5777
LGBTQIIPA resource center for Boulder County
Boulder Senior Center……..(303) 441-3148
Programs and services for Boulder County residents 65+
Boulder Shelter for the Homeless……(303) 442-4646
Food and shelter
CDR Associates…….(303) 442-7367
Mediation services

Children's Alley……..(303) 449-1951
Emergency child care
Emergency Psychiatric Services……...(303) 447-1665
Crisis hotline
TruCare Hospice……...(303) 449-7740
Grief and loss support free of charge
La Luna……..(720) 470-0010
Eating disorder treatment center
Mental Health Partners……...(303) 443-8500
Intake and information
Moving to End Sexual Assault (MESA).....(303) 443-7300
Bilingual crisis hotline
National Alliance on Mental Illness……(303) 443-4591
Mental illness support
People's Clinic……...(303) 449-6050
Low-income medical care

Autobiography in Five Short Chapters

I walk, down the street.
There is a deep hole in the sidewalk.
I fall in.
I am lost … I am hopeless.
It isn't my fault.
It takes forever to find a way out.

I walk down the same street.
There is a deep hole in the sidewalk.
I pretend I don't see it.
I fall in again.
I can't believe I am in the same place.
But, it isn't my fault.
It still takes a long time to get out.

I walk down the same street.
There is a deep hole in the sidewalk.
I see it is there.
I still fall in … it's a habit.
My eyes are open.
I know where I am.
It is my fault.
I get out immediately.

I walk down the same street.
There is a deep hole in the sidewalk.
I walk around it.

I walk down another street.

From The Child Within

Finally

We are here to listen, not to work miracles.
We are here to assist people to discover what they are feeling,
not to make feelings go away.
We are here to assist people to identify their options,
not decide what they should do.
We are here to discuss steps with people,
not to take steps for them.
We are here to assist people to discover their strengths,
not to rescue them and leave them still vulnerable.
We are here to assist people to discover that they can help themselves,
not to take responsibility for them.
We are here to assist people to learn to choose,
not to make it unnecessary for them to make difficult choices.
We are here to provide support for change.