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CU DENVER COUNSELING CENTER

MISSION STATEMENT

Service to CU Denver Students, Faculty, and Staff - We, at the UCD Student and Community Counseling Center, (hereafter referred to as "the Center"), believe that students' successes are dependent on their emergence as whole human beings, and dedicate ourselves to delivering the best possible help and guidance. We act in partnership with the Mission of this University to enhance students' optimal educational experiences. We help students to establish themselves as contributing individuals responding to "the challenges of an urban environment". The staff of the Center serve as experts and consultants to CU Denver faculty, staff and parents regarding the mental health needs of students. All students receive a service benefit of an intake session, counseling sessions at no cost, and access to walk-in crisis services during normal business hours. Students have the option of being seen by one of our licensed professional staff or one of our student counselors as determined to be clinically appropriate.

The Center staff is available to help with campus mental health emergencies, and to provide consultation for troubled students and staff. Staff is also available upon request for classroom and departmental in-services on a variety of topics related to college students and mental health. Further, the staff will provide a one-time mental health consultation for any UCD faculty or staff upon request.

Service to the Denver Area Community - The Center provides low cost or no cost mental health and counseling services to students and families in a partnership with the Denver Public Schools. We also provide low cost services to any community member who qualifies for our services. Many of our clients would otherwise go without the benefit of mental health services. Several private and public community agencies refer clients to our Center.

Service to the Counseling Program student training - The Center is part of the professional training program in the Division of Counseling Psychology and Counselor Education at UCD. The Center serves as the “in house” clinical training site and research center. As a clinical training site, the Center provides opportunities for Master’s level Practicum and Internship students to provide quality services through different modes of treatment such as individual, couple, family and group counseling under the supervision of qualified clinicians and faculty members. As a research center, this site provides opportunities for research that can improve our understanding of human coping mechanisms and how clinicians can be trained to better serve the needs of a diverse community population.

PHILOSOPHY

The staff at the Center believes in a health-oriented model and values an integration of diverse theoretical modalities. Our staff also responds to the developmental challenges individuals and their families may be facing.

Increasingly, counseling psychology is moving toward a strength perspective in both philosophy and counseling practice. To quote Martin Seligman, Counseling “... is not just the study of weakness and damage; it is also the study of strength and virtue". The University of Colorado Denver Student and Community Counseling Center has practiced a strength-based approach to helping our clients for several years. Our current logo, Support, Growth, Solutions, embodies our focus on support for clients as they learn to optimize
their skills and inner resources in order to grow, see possibilities, find solutions and overcome barriers to their academic and personal success.

In order to increase our efficacy, the Center practices a multimodal, strength-based, short-term (6-12 sessions), wellness approach. At intake all individual UCD student needs are assessed and a resource action plan (Wellness Resources Action Plan) is collaboratively constructed between client and counselor. Center resources include individual, couple, family counseling; group counseling; workshops, testing, biofeedback, crisis intervention as well as on campus and community resources as appropriate. Details about how to access each resource are outlined. Our goal is that each client will utilize all the recommended resources in order to maximize their potential for success and optimal well being.

**STRENGTH BASED CORE COUNSELING SERVICE MODEL**

What follows is a description of the strength-based counseling model which is infused in all Center services. The model is trans-theoretical; therefore, it can be integrated with a variety of theoretical orientations and interventions. We are indebted to Dr. Elsie J Smith who authored a major contribution article in *The Counseling Psychologist*, Vol 34 No. 1 January 2006. Much of the model she outlined in that paper has been adapted for use at the UCD Counseling Center.

**Definitions**

**Strengths**

Strengths are that which helps a person to cope with life or that which make life more fulfilling for oneself and others. Strengths are not fixed personality traits. They develop from a dynamic, contextual process rooted deeply in one’s culture. Strengths can be learned or taught. Strengths are incremental: one strength provides the foundation for achieving another.

Strengths can be classified as:

- Biological - rest, nutrition, compliance with medication, exercise, health status, leisure time
- Psychological
  - Cognitive - intelligence, problem-solving abilities and knowledge
  - Emotional - self esteem, stable mood, optimism, good coping skills, self-reliance, self-discipline
  - Social - belonging and support, friends, family and mentors
  - Cultural - beliefs, values, traditions, stories, strong positive ethnic identity, sense of community and bicultural identity
  - Economic - being employed, having sufficient money, and adequate housing
  - Political - equal opportunity and having a voice in decisions
  - Spiritual - religious tradition, faith, meaning or life purpose beyond the material world

Further, strengths have the following characteristics. They are:

- Culturally bound - Characteristics regarded as strengths in one culture may be viewed as weaknesses in another culture. An example of this is individualistic autonomy.
- Contextual - Strengths are developed within a given situation containing certain characteristics that may either promote or retard human strengths.
• Developmental and lifespan oriented - Some strengths require a certain level of cognitive, physical or experiential development.
• Adaptable and functional - These are core strengths. They reflect a person’s ability to apply as many different resources and skills as necessary to solve a problem or to achieve a goals
• Transcend personal, environmental and societal circumstances - Strengths enable resilience.

Categories of Strengths have been identified in the literature:
• Wisdom- the ability to integrate logic and emotion; to take the long view
• Emotional Strengths - insight, optimism, perseverance, putting troubles in perspective
• Character Strengths - honesty, discipline, courage, integrity, perseverance
• Relational and nurturing strengths
• Educational strengths

Holistic
Holistic refers to a wellness approach that addresses the body, mind and spirit (the physical, emotional/mental and spiritual aspects of an individual).

Strength-Based Counseling
An approach to counseling which stresses developing assets, seeks to understand human virtues and to answer the question, “What strengths does a person have to deal effectively with life?” It is a corrective paradigm that allows counselors to see the glass as half full rather than half empty. The perspective maintains that humans have a self-righting tendency that allows them to grow and develop even under persistent, adverse life circumstances.

Core Assumptions of the UCD counseling approach
• Integrative, collaborative and multimodal
• Respectful of clients including their readiness for change
• A collaborative process between counselor and client
• Short-term, flexible model (6-12 sessions)
• All people have strengths, resilience, innate competence, resourcefulness and unique motivations which can be identified and amplified
• Client directed, non-pathologizing
• Conversations are possibility focused; counseling is infused with hope and optimism
• Empathy and the ability to step into clients’s world views are essential to all successful client interactions
• We seek to amplify client’s agency and sense of control
• Culture has a major impact on how people view and evaluate human strengths. Counseling focuses on the clients’ cultural and individual strengths while understanding and acknowledging the reality of the victimizing effects of racial, ethnic and other forms of discrimination and oppression.
CENTER ADMINISTRATIVE POLICIES

SICK TIME
The Staff of the UCD Student and Community Counseling Center and Practicum Training Clinic recognize that we as professionals are committed to our work life as well as to our personal relationships including the care and welfare of our children. At times, we recognize that parenting responsibilities will trump our professional commitments. When children are ill, in need of home care, and other childcare arrangements are not viable, we encourage and support both staff and trainees staying home even if that means rescheduling clients. We do not support bringing sick children and/or children who are in need of childcare to the Center. For several reasons, sick children and/or young children need to be cared for at home, not at work. If on occasion, staff or trainees need to stop by the Center for a few minutes, children may accompany them.

DRESS CODE
You are required to wear professional dress while in the clinic. Items such as; short skirts, leggings and short tops, lower cut sweaters, athletic attire, flip flops, clothing with holes or stains are not considered professional. If the staff notices inappropriate clothing they (with another staff member) will privately let you know.

GIFT GIVING POLICY
The giving and/or receiving of gifts can be a very important task in the termination process with clients. However it is very important that it is done with therapeutic consideration and with consultation with one’s supervisor. As a counselor is considering whether or not to give a gift, the following items should be thought about and discussed in supervision.

1. Is the counselor trying to find a way to “make-up” for insecurity about his or her own qualities as a therapist?
2. Is the gift attached to the therapy/relationship?
3. Will the gift make the client feel obligated to the therapist?
4. What is the monetary cost of the gift?* Is it excessive?
5. How do I define excessive?

Generally it is not recommended that therapists give gifts to clients who may have a personality disorder due to high potential for the client misunderstanding the meaning behind the gift (Pipes & Davenport, 1990).

*In general, we encourage giving gifts that are symbolic rather than monetary. Any gift of monetary value must be approved by the supervisor before being given to the client.

Ideas for quality gift-giving with clients: (Again, remember to discuss these with your supervisor and consider the client in their cultural context)

1. Remember to customize the gift to your client. Think about what would be memorable about the unique relationship you have had with this particular client and what he/she worked on in counseling. (Such things as a copy of a writing or poem that fits the client)
2. Often a ‘symbolic’ gift is memorable. (Such things as articles from nature, “this sprig of lavender is meant to remind you to soothe yourself. . .” etc. etc)
3. Compose a letter and read it slowly in session to the client. You can address such things as their growth, strengths, and/or your appreciations and what you have gained through knowing the client.
4. Provide a tray of various items from nature and ask the client to choose something that would be a helpful reminder of their counseling process.

As the counselor is considering receiving a gift from the client, the counselor should ask his or herself the following questions and discuss in the next supervision.

1. Is the gift excessive? (How am I defining excessive?)
2. What appears to be the client’s motives for giving the gift?
3. Is it culturally respectful to accept the gift?
4. Do I feel comfortable accepting the gift?

**EMAIL CORRESPONDANCE POLICY**

It has been approved that the staff of the CU Denver Student and Community Counseling Center (including clinicians and graduate students/interns) may utilize email to correspond with clients about scheduling appointments. This is a privilege, and not an expectation to use. If you elect to email clients regarding scheduling, the following restrictions must be adhered to in order to use this privilege:

1. The client consented to email correspondence regarding appointment scheduling in the Center disclosure form.
2. The Center staff member is emailing from a secure location (a computer at the Center or on a personal computer in a residence that is password protected) and in a private location.
3. The Center staff member has the following disclaimer as an auto-signature on every email:

   CONFIDENTIALITY NOTICE: If you are not the intended recipient of this electronic message, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this document is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of this document. This email correspondence does not serve as counseling. Thank you.

4. The content of the email is strictly contained to information regarding scheduling appointments, and does not intrude into the contents of the client’s counseling work at the Center. Any other content is considered a HIPAA violation.
5. CU Denver Counseling Center employees will utilize their CU Denver email address only for correspondence with clients.
6. Graduate students, interns and externs at the Center will utilize a gmail account, provided by the Center that is used solely for the purposes of scheduling emails with clients. At the end of the semester, the account will be reset and used for an incoming practicum student/intern/extern at the Center.
7. Email correspondence will be printed out at the Center added to the client chart.

By signing this policy, you agree to the following terms. If these conditions are not met, it is considered a breach of confidentiality, and appropriate corrective action will occur. (actual document found in student room)

CONFIDENTIALITY
All information obtained is confidential and can only be released with the client's written consent. The exceptions to the right to confidentiality are when disclosure of records is mandated by federal and state laws such as court order, risk of harm to self or others, and child or elder abuse.

CLIENT RECORD KEEPING PROCEDURES
In order to comply In keeping with ethical standards of mental health professionals (American Counseling Association, American Psychological Association, and American Association for Marriage and Family Therapy), all counseling services will be confidential. The Center's ethical, professional, and legal responsibility to maintain records on behalf of past, present, and potential clients in a confidential manner, a professional file will be developed on each client containing: a) initial assessment interview notes, b) intake summary and case treatment plan, c) case progress notes, d) termination summary, e) client consent documents, e) assessment reports, and f) any other documents appropriate to the treatment of the client. This professional client file will be maintained in a secured room for 5 years beyond termination of client services.

A client who asks to see his/her/their record may receive a (verbal) summary from any counselor involved or from the Clinic Director/supervisor if the counselor is no longer on the clinic staff.

In accordance with applicable federal and state laws, the requirement for written release is waived in a health or safety emergency for the duration of the emergency. The following must be considered in determining whether disclosure without prior written consent may take place:

1. The seriousness of the threat to the health and safety of the student or other individuals
2. The need for the information to meet the emergency
3. Whether the parties to whom the information is being disclosed are in a position to deal with the emergency
4. The extent to which time is of the essence in dealing with the emergency

The counselor acknowledges the responsibility in making decisions regarding disclosure of information and to whom such information may be disclosed. Consultation with a Clinical Supervisor or the Clinic Director should be sought. In some cases, it may be appropriate for the information to be communicated through the Clinical Supervisor or Clinic Director if direct contact between the counselor and the recipient would be inappropriate.

DISCLOSURE OF CONFIDENTIAL INFORMATION
Client Access to Records - Access to records and copies of records will be provided when requested by competent clients, their legal representatives or parents/legal guardians of minors, unless the records contain information that may be misleading and detrimental to the client. When records contain such information, the counselor or agency may provide a report of examination and treatment in lieu of copies of records. Upon a client’s written request, complete copies of the client’s records will be provided directly to a subsequent
treating mental health professional. In situations involving multiple clients, access to records is limited to those parts of records that do not include confidential information related to another client.

**Disclosure of Confidential Information to Third Parties** - A client may request that information regarding assessment data, test interpretations, or other information gathered in the course of counseling be released to other appropriate mental health professionals. These requests must be in written form through the completion of an Information Release Form, which can be obtained from the counselor-in-training or the clinical supervisor. Telephone requests will not be honored, but the Information Release Form can be mailed to the caller. The form includes: a) the individual or agency to whom the information is to be released; b) the kind of information to be released; c) the reason for requesting the release; d) the client's date of birth; e) the client's signature; and f) the signature of a witness.

**Disclosure of Confidential Information Prior to Consent** - (i.e., disclosure due to health and safety emergencies) Information may be released from client records to appropriate persons in connection with an emergency if the knowledge of such information is deemed necessary to protect the welfare of a client or other persons. A counselor has a legal responsibility to follow procedures for dealing with potentially violent clients when he or she becomes aware of potential violent behavior on the part of the client. Counselors have an ethical responsibility to follow procedures for dealing with potentially suicidal behavior on the part of the client. Counselors have a legal responsibility to report to the local police authority or to the local child protection services any instance of suspected or reported child abuse.

**Disclosure Pursuant to Requirements of Law** - Confidential information will be released if so ordered by a court of competent jurisdiction or otherwise as the law requires. In such a case, an attempt will be made to notify the client prior to the compliance.

**Disclosure for Research Purposes** - Clients participating in research studies conducted by the UCD Student and Community Counseling Center will be informed of the safeguards against disclosure in the research design. Research studies of this nature demand prior client knowledge and consent. All research studies will have obtained permission from the Human Subjects Board prior to the collection of data.

**Research Projects Involving Clinic Records and Clients** - Due to the need for confidentiality of client records and the requirements for the protection of human subjects, it is necessary for all proposed research projects to be reviewed and approved by the Human Research Committee, the clinical faculty, and the Division Director prior to implementation.

**TAPE RECORDING AND OBSERVATION**

**Informed Consent for Recording and Observing Sessions** - Clients will be first informed of The Center's policy on recording and observation of counseling sessions when they call to obtain information or to make an appointment at The Center. Additionally, they will receive written information about taping and observation of sessions. This information packet will inform potential clients of The Center’s requirement that all clinic sessions be observed.

**Consent for Recording** - Clients are to be informed that their sessions' audio or video tape will be used for training and supervision purposes and that the information is kept confidential as is all client information (as is set forth on the section on confidentiality). A signed consent form indicating their agreement to the taping
and observation of session requirements must be completed before the first session. If a community client refuses to be taped or observed, the counselor-in-training will provide referrals to other counseling agencies.

**EMERGENCY PROCEDURES**
The center takes the safety of its clients, staff, and the community seriously. At times, clients may be in need of a higher level of care to ensure the safety of themselves and others. Below are the procedures for handling emergency procedures. All staff at the center is expected to know these procedures.

**LIMITATIONS OF SERVICES**
The Center uses a short-term, goal-directed counseling model. The Center is not able to provide 24-hour care; therefore, the Center provides appropriate referrals to individuals (e.g., in-patient substance abuse, acutely suicidal, homicidal, or psychotic) in need of more intensive treatment and continuity of care. In these cases, supervisors will collaborate with the appropriate agencies in order to assure client safety. Some services may be requested that are beyond the scope of our competencies such as forensic assessments or child custody evaluations. In these cases referrals will be made to other agencies.

**SCREENING QUESTIONS**
1. Is client currently receiving counseling services elsewhere?
2. Is client interested in an evaluation for medication instead of counseling services?
3. Is counseling ordered by the court system or social services, and do they require an evaluation, recommendation, or testimony?
4. Has client been hospitalized for mental health reasons in the past three months?
5. Have you made any attempts to physically harm yourself or others in the last three months?
6. Has there been any active domestic violence going on in your relationship in the past three months?
7. Have you been charged with or convicted of a felony involving a violent crime within the last 2 years?
8. Does client need higher level of care or more specialized care?
9. Does client have an active addiction?
10. Is there a reason other than those listed above that renders this person a poor match for our Center?

**FLAGS**
In order to make sure clients who have elevated risk factors are monitored carefully, a flag system is used in the center’s electronic record keeping system, titanium.

**PROCESS FOR FLAGGING IN TITANIUM**
Types of Flags
a. Banned from Campus
   i. Report received and LeThi will flag in titanium
b. CARE report
   i. Report received and Amanda will flag in titanium
   ii. Amanda gives verbal notification to; Pat, Counselor, and Supervisor (if applicable)
   iii. Note: clinician/supervisor does NOT share information with client
   iv. Amanda will add follow up flag
1. CARE report + follow flag = clinician has acknowledged and is aware of the contents of the care report

c. Reviewed in Staff Meeting
   i. Names received in staff meeting and Amanda will flag in titanium
   ii. Amanda will add follow up flag
      1. Reviewed in Staff Meeting flag + follow flag = recommended action from staff meeting taken

d. Safety Plan
   i. BTG supervisor, staff or interns will fill out ‘flags’ form and submit to LeThi
   ii. LeThi will flag in titanium
   iii. LeThi will add follow up flag
      1. Safety Plan flag + follow flag = reviewed by supervisor (in supervision) and assigned counselor follows up in next session

e. Abuse Report
   i. BTG supervisor, staff or interns will fill out ‘flags’ form and submit to LeThi
   ii. LeThi will flag in titanium
   iii. LeThi will add follow up flag
      1. Abuse Report flag + follow flag = reviewed by supervisor (in supervision) and assigned counselor follows up in next session

f. Hospitalization
   i. BTG supervisor, staff or interns will fill out ‘flags’ form and submit to Amanda
   ii. Amanda will flag in titanium and let Jenny-Lynn and Pat know
   iii. Amanda will add follow up flag
      1. Hospitalization flag + follow flag = Jenny-Lynn will take the following actions steps
         a. Notify; Kushnur D, Kristin K, Emergency Contact
         b. Call to arrange discharge plan
         c. Discuss in staff meeting

g. CCAPs >2 (#25, #29, #34)
   i. Name will come from intake
   ii. LeThi will review CCAPs and flag in titanium
   iii. LeThi will add follow up flag
      1. CCAPs flag + follow flag = reviewed by supervisor (in supervision) and assigned counselor follows up in first session. If client doesn’t come to first session, counselor will
         a. Notify the Director/Pat
            i. Pat will review the file and determine (based on NaBita tool) if risk is elevated.
               1. If yes, Pat will call the client to check in or emergency contact will be notified
h. Follow up
   i. These flags will only be removed by Amanda after appropriate action has been taken
   ii. Amanda will pull a weekly report during the staff meeting

Follow Up Flag Action Steps
   1. Click on clients flagged tab
   2. Edit/View Edit
   3. Click on the follow up flag
      a. In the description area indicate date of follow up action

WALK IN PROCEDURES
Walk in sessions are available to CU Denver students only who are in crisis. If a non UCD student comes in for an emergency appointment the counselor on call should quickly assess for safety and refer appropriately.

WALK IN EMERGENCY/CRISIS PROCEDURES FOR CLINICIANS
1. Client fills out walk in paperwork and CCAPs
   a. Front desk identifies the client as high risk (answered yes to high risk questions and/or indicated on CCAPs)
2. Front desk gives the walk in paperwork and CCAPs to On Call Counselor
3. On Call Counselor on call reviews paperwork and determines if they want to involve an intern the following ways:
   a. On call counselor or intern remind front desk to turn off video camera
   b. On call counselor and intern meets with the client for initial screening/assessment. If on call counselor determines the intern is competent to handle the scenario; the following may occur:
      i. Intern conducts session, taking a midsession break, and consulting with On Call counselor midsession and before the walk in leaves.
      ii. On Call Counselor and intern co facilitate the session
      iii. On Call Counselor allows intern to watch behind the glass
   c. Intern will write up the note and the on call counselor will sign off on the note
4. On Call counselor may opt to see client alone. Counselor will give client personal disclosure statement to scan into the system.

ESSENTIAL TOPICS FOR CLINICIANS TO COVER IN A CRISIS/WALK IN SESSION
1. Why now?
2. Review CCAPS together
3. Assess risk to self or others  Assess both current and past functioning, support system, reasons to live, means, self soothing/cop ing skills
4. If appropriate, label the client’s current state as “in crisis”. Help them make short term plan of action and normalize “you may feel like you have the emotional flu”, instill hope.”
5. Create a safety plan if appropriate
6. Consider suitability for clinic
7. If seems suitable, help client, if new to the Center, schedule an intake (consult with counselor on call first)/ or shift to intake right then and complete with walk in after explaining the purpose of the intake
8. Supply intake with follow up resources, Metro Crisis Line, workshops, psychiatrist, other resources in WRAP or community as appropriate/ walk in again if needed before first session occurs
9. Document walk-in session. Include substantial detail if risk of safety is present

Consult! Consult! Consult!

**REFERRING TO HEALTH CENTER AT AURARIA**

For Emergency/Urgent Referral (requiring urgent medication evaluation but not hospitalization), the Counselor calls Health Center at Auraria front desk: 303-556-2525. Request to speak to or page psychiatrist regarding urgent psychiatric referral. During phone consultation Psychiatrist/Physician will arrange for client to be seen. The Counselor escorts patient to Health Center at Auraria, faxes referral form to Health Center at Auraria: 303-556-3881. If after business hours page the on call psychiatrist at 303-352-4455.

For standard referrals. The counselor gives client Health Center at Auraria number: 303-556-2525. The counselor and client sign UCD Referral form (located in student room) and faxes referral form to Health Center at Auraria: 303-556-3881.

The level of care is dependent on how the client is presenting. If client is presenting with routine Depression and/or Anxiety refer to the Primary Care Medical Provider or Psychiatrist. If client is presenting with complex Depression, complex Anxiety, any other challenging diagnoses refer to the Psychiatrist.

To see a primary care medical provider, the Initial visit (1 hour) is $65-100, then the follow up (1/2 hour) - $40-55. They will be seen at least 2-3 times for follow up visits over the next several months. The Psychiatrist’s initial visit (1 hour) is $200, a follow up (1/2 hour) is $105. Frequency varies on condition and patient progress.

If the client has student health insurance the health Center at Auraria will bill insurance. Medication requires a $20 co-payment at time of service. If the client has health insurance not accepted by Health Center at Auraria, the client must pay in full at time of service. The Health Center at Auraria will provide a “super bill” that the client can submit to insurance company. If the client has no health insurance they must pay in full at time of service.

**HOSPITALIZATION PROTOCOL**

Protocol - If a client is assessed as a danger to himself or others and is need of hospitalization

**Uninsured clients**

1. If client is willing to go to hospital voluntarily
   - i. Help client decide on plan for transportation
   - ii. Follow up with hospital to make sure client followed through
   - iii. Document assessment and plan in chart
2. If client refuses voluntary hospitalization
   - i. Complete 72 hour involuntary hospitalization form
   - ii. Call Campus Police
   - iii. Call ambulance to arrange hospitalization (company/phone number obtained from campus police)
iv. Client may be transported to any hospital

**UCD clients with Student Health Insurance**
Procedure is the same as above with one additional step.

1. Health Center at Auraria must be notified so they can generate a referral
   a. Two hospitals covered by UCD insurance
      i. University Hospital 720-848-9111
      ii. Presbyterian/St Lukes 303-839-6000
      iii. If both are filled send the client to any hospital emergency room
   b. After hours Psychiatric Pager 303-352-4455
   c. Health Center at Auraria 303-556-2525

**Private insured clients (other than UCD insurance)**
Procedure is same as uninsured clients with one additional step

1. Call clients insurance company to determine if they require admission at a specific hospital

Hospitalizations are the responsibility of the supervisors and professional staff. Students may participate and observe as a learning experience, if appropriate

**GUIDELINES FOR DEALING WITH CENTER CRISIS**
Clinical staff does not leave the clinic. If a client leaves the clinic and is believed to be putting him or herself in danger outside the clinic, the supervisor and therapist will call campus police.

Clinician’s safety comes first, even before your client. If you believe you are in danger, excuse yourself and get a supervisor. If the danger is immediate leave the room. If a clinician is in eminent danger and is unable to leave the room, he/she should push the panic button in the room.

Suicidal/homicidal ideation contact on-call supervisor. Complete a lethality assessment with the assistance of the on-call supervisor. If you are in session when a lethality issue emerges, gather as much information as you can. Then, excuse yourself for a consultation. You may have to inform the supervisor of the emergent crisis as he or she may not have been watching your session. Be assertive about letting the supervisor know.

**Role of Supervisor**
The supervisor and you will decide how to continue with the assessment. The supervisor will make the final decisions about the plan of action. The supervisor will contact Pat Larsen in person or by phone for a consult if hospitalization is needed. In the event that Pat cannot be reached, supervisor will consult with another supervisor before deciding to hospitalize. Supervisor will complete 27-10 hospitalization criteria. Supervisor will contact campus police if hospitalization is necessary and they are to arrange transportation. In the case of a voluntary hospitalization, we sometimes help arrange a taxi or friend to transport. In the case of an involuntary hospitalization the campus police are always to be called. They will transport client to Denver General or call an ambulance to do so.
All dispositions will be determined on a case by case basis. A follow-up plan will also be devised on a case by case basis.

Students must inform their individual supervisor of any lethality concerns or actions taken within a day.

**Phone contacts from campus personnel regarding mental health crisis elsewhere on campus**

Calls of this nature should be routed to a supervisor on call or administrative assistant.

If a high level of danger is present to self or other, offer to call the police for the caller.

Obtain the location, name of caller, phone number, and name of dangerous individual if possible. Hang up and dial 911 for campus police. Be aware that faculty and staff are sometimes reluctant to involve the police, so emphasize safety. For lower levels of danger to self or others or questions of competence, the caller should be informed that they can escort the client to the clinic or the health center for evaluation. Callers will need support and guidance about how to talk to the individual about their concerns. Inform callers that they should not hesitate to call the police if safety or ability to care for oneself is a concern.

Unfortunately, we do not have the resources to have clinicians or supervisors leave the clinic to do assessments at this time.

**GUIDELINES FOR DEALING WITH POTENTIALLY VIOLENT CLIENTS**

A counselor in the UCD Student and Community Counseling Center has a legal responsibility to follow certain procedures when he/she becomes aware of potentially violent behavior on the part of the client.

**A. Evidence of Potentially Violent Behavior**

The following criteria is sufficient cause for notification to the intended (identifiable) victim and for the invocation of these procedures:

1. When there is a clear and immediate probability of physical harm to the client.
2. When there is a clear and immediate probability of danger to other individuals.
3. When there is a clear and immediate probability of danger to an entity or location where people could be harmed.

**B. Procedures to Follow**

1. Evaluation and Documentation--As part of the process of identifying the intended violent action (threatened violence towards a specific victim), the counselor should immediately:
   a. Notify their clinical supervisor or other clinical faculty designated in the Counseling Center (This conversation should be noted in writing and signed by both parties).
   b. Assess the potential for violence

2. Based upon consultation, a mutual decision will be made with respect to the level of danger and whether to begin crisis management procedures.
   a. It is recommended that the supervising faculty consult at least one other clinical faculty to assess danger and determine a course of action.
   b. In cases where there appears to be no real danger, in the opinion of at least two clinical faculty members, a decision may be made to proceed no further in the evaluation at that time.
c. In cases where there appears to be reasonable concern for danger, a decision may be made to undertake further evaluation. In those instances, the following steps 3 through 8 may be initiated so long as there remains reasonable concern.

3. The clinical faculty will meet to determine a treatment plan, intervention strategies, or to consider options such as further psychological assessment, referral to an outside professional, or other appropriate medical/psychiatric collaboration.

4. Continual contact with the Clinic Director and other supervising faculty.

In cases involving UCD students, appropriate University officials will be notified.

NOTIFICATION OF CLIENT, POLICE AND INTENDED VICTIM

1. Notify the client at the time of disclosure that you have a duty to warn the intended victim and the local police.
2. Notify the police, or other appropriate agencies. This should include the police in the community of the intended victim. Be specific about the threat and the nature of the assistance required.
3. Notify the intended victim. Be specific regarding the nature of the threat and other steps in process or steps intended (i.e., phone call, certified mail)

EMERGENCY RESPONSE GUIDELINES FOR HIGH RISK STUDENTS

These guideline are to assist SCCC staff in a difficult decision making process that occurs with high risk students who are in need of intervention but who do not meet the criteria for involuntary hospitalization. All crisis situations are different and involve clinical judgement; therefore, this is a set of guidelines rather than an official protocol.

Examples/Situations that may trigger use of guidelines.

- Has scored 2 or higher score on any of the critical items on the CCAPs and verbally confirms accuracy of score.
- Verbal confirmation of risk - has endorsed current thoughts of suicide or violence towards others and although does not plan to take action imminently, is unwilling or unable to confidently endorse an ability to refrain from acting on above thoughts.
- Denies a current plan to take action but may have rehearsed a plan in the past.
- Supervisors Clinical Judgement has determined that client is high risk or impaired.

Guidelines

1. Always involve supervisor and plan for crisis response to situation
2. Construct a signed and witnessed safety plan (copy to client and copy scanned into chart)
3. Secure ROI for emergency contact as well as any other persons or entities. Verbally remind client that their signed disclosure at time of intake outlines exceptions to confidentiality including emergency contact, dean of students, campus police.
4. Set a follow up appointment in the next few days. Inform that client that failure to attend the follow up appointment and/or call in (depending on the plan) may result in the following SCCC responses
   i. Contact client and remind them that if we don’t hear from them we will...
      1. Call to emergency contact
2. Welfare check by campus police or Denver PD
3. Notification to Dean of Students office
5. Document details of risk assessment and staff consultation in Titanium including the fact that information about possible next steps discussed with client.
6. Set a date/time and responsible person for after action steps to be executed if student fails to comply with follow up emergency plan.
7. If possible, leave a message for client that SCCC is moving forward with safety/notification actions outlined in safety plan and follow up.
8. Execute and document safety/follow up notification and document actions in titanium

EMERGENCY RESPONSE PLAN FOR HIGH RISK STUDENTS WHO DISAPPEAR
These guidelines are to assist SCCC staff in a difficult decision making process that occurs with high risk students who are in need of intervention but who do not meet the criteria for involuntary hospitalization. All crisis situations are different and involve clinical judgment; therefore, this is a set of guidelines rather than an official protocol.

The guidelines are meant to be followed when a student:
- Has scored 2 or higher score on any of the critical items on the CCAPs
- Has endorsed current thoughts of suicide or violence towards others and although does not plan to take action imminently, is unwilling or unable to confidently endorse an ability to refrain from acting on above thoughts.
- (Other descriptors?)

GUIDELINES
1. Involve a supervisor in emergency plan
2. Construct a signed and witnessed safety plan (copy to client and copy scanned into chart)
3. Secure ROI for emergency contact as well as any other persons or entities. Verbally remind client that their signed disclosure at time of intake outlines exceptions to confidentiality including emergency contact, dean of students, campus police.
4. Set a follow up appointment in the next few days. Inform that client that failure to attend the follow up appointment and/ or call in (depending on the plan) may result in the following SCCC responses:
   a. Call to emergency contact
   b. Welfare check by campus police or Denver PD
   c. Notification to Dean of Students office
5. Document details of risk assessment in Titanium including the fact that information about possible next steps discussed with client.
6. Set a date/time for after action steps to be executed if student fails to comply with follow up emergency plan.
7. If possible, leave a message for client that SCCC is moving forward with safety/notification actions outlined in safety plan and follow up.
8. Execute and document safety/follow up notification and document actions in titanium

MEDICAL REDUCED COURSE LOAD INFORMATION
Immigration law requires that international students admitted to the U.S. on a student visa pursue a full-time course of study during every academic session or semester except during official school breaks, or unless
approved under a specific exception, in advance. Under some circumstances, medical conditions can qualify a student for a reduced course load.

**Medical Conditions**, as defined in 8 CFR 214.2 (f)(6)(iii) (B) and 22 C.F.R. § 62.23(e)(2). A Designated School Official (DSO) may authorize a reduced course load due to a student’s temporary illness or medical condition for a period of time not to exceed an aggregate of 12 months while the student is pursuing a course of study. The student will need to submit a written statement from a licensed medical doctor, a doctor of osteopathy, or a licensed clinical psychologist requiring the reduction in studies and recommending how many credits the student should be able to take. A student may be authorized for a reduced course load for a reason of illness or medical condition on more than one occasion while pursuing a course of study at the same program level so long as the aggregate period does not exceed 12 months.

Students should not drop below full time before getting approval from a DSO in International Student & Scholar Services.

Example:
Sample wording to be placed on an official signed letter from doctor or clinical psychologist:

(student name) is undergoing treatment for an illness or medical condition....

Due to the condition for which I am treating (student name), it is my professional recommendation that (student name) take a reduced course load...

I understand that (student name) is in the U.S. on a student visa, and as such is required to be a full-time student. I understand that the normal full-time course load is 12 credits, but because of this medical condition, I recommend that (student name) take only _______ credits this semester.

**SAMPLE LETTER WORDING ONLY. DO NOT SIGN THIS SHEET.**

____________________________
Letter signed by a
Licensed medical doctor Colorado License Number DR..._________ or
Doctor of osteopathy Colorado License Number DR..._________ or
Licensed clinical psychologist, Colorado License Number PSY..._________
(other practitioners do not meet Immigration’s regulatory requirements to make the recommendation)

**CLIENT**

**MODALITIES**

Individual means a person who attends counseling alone. A couple means two persons, not necessarily married, who attend sessions and are counseled together by the same counselor. A family may or may not include a couple, but must include a parent or guardian and a child who attends sessions and are counseled together by the same counselor.
MORE THAN ONE COUNSELING MODALITY
Clients at the Center may request more than one treatment modality. For example: a family who is seeking family counseling may also request individual child treatment. Or one or both partners in couples counseling may request individual adult counseling in addition to their couples work. The general Center policy is that a client may be in only one treatment modality at a time.

Exceptions that may be granted to this general policy based on the individual case and therapeutic needs of the clients. Therefore, if a student/counselor would like the Center to consider a treatment plan that involves more than one simultaneous counseling modality for a client, the following procedures will be followed:

1. Discuss the rationale for an exception with your individual supervisor
2. Complete the request form outlining the request and the rationale signed by both the student/counselor and the supervisor
3. Submit the written request to the clinic Director for review. The clinic Director will have the final approval authorization.

If the request is approved:

1. Clients will be notified that all treatment will be reviewed every semester and may or may not receive approval for the next semester.
2. Clients are aware that they are financially responsible for all treatment provided.

Supervision
If you are receiving specific case supervision, aside from your primary supervisor, it is the specific case supervisor’s responsibility for signing notes and managing the case.

FEES
UCD students are eligible for free sessions. For clients who are members of the greater Denver Metro community, there will be a sliding fee scale which will be used to determine payment for counseling services based on family size and annual household income.

COUNSELING CENTER ASSESSMENT OF PSYCHOLOGICAL SYMPTOMS
CCAPS occurs during intake and for every walk in session.
Procedure for repeated measures in CCAPS
The CCAPS should be repeated for ongoing clients on a bi session schedule beginning with the 2nd session.

ADMINISTER
1. Counselor informs front desk that a client is scheduled to take the CCAPS (by noting in the schedule appointment “CCAPS”).
2. If a transfer client has never completed a CCAPS as a baseline, please have them do so ASAP. Then follow the protocol for repeated administrations as with new clients.
3. When client reports in for a session, the front desk will inform the client that their counselor has requested that client repeat CCAPS. Let the client know that this should take about 3 minutes and that the results will be discussed with client during the session.
4. Front desk sets the client up to complete the CCAPS
5. When client has completed the data form, front desk will inform counselor and print the results of the CCAPS.

6. Counselor will review CCAPS in the student room, comparing current results to past administration.

7. Counselor will take notes on any significant changes which include:
   a. Change up or down in “color” of a category
   b. Change in critical items

8. Counselor will notify BTG supervisor before starting the session if CCAPS results show evidence of significant risk factors

**DISCUSSION**

1. Counselor will bring CCAPS results to waiting room and pick up client for session

2. Counselor and client will together review the results of the CCAPS noting and discussing significant changes

3. Counselor and client will determine if and how the results of the repeated message will inform and adjust the focus of their sessions as well as the overall treatment plan.

4. Counselor and client will discuss whether or not the CCAPS discussion has been helpful.

5. Counselor and client will then determine the focus of the session and proceed.

**DOCUMENTATION**

1. Counselor will note significant changes in the CCAPS in the assessment section of the DAP note, including any changes in the focus of the session and the treatment plan

2. If in the current CCAPS, the client has endorsed any of the critical items, counselor conduct a formal risk assessment and record the results in the assessment and plan sections including specific steps that have been taken to increase safety and welfare of the client.

3. Counselor will seek out consultation of supervisor on call when appropriate (if elevated risk level, and current safety concerns

4. Counselor will report significant changes to primary supervisor ASAP.

5. Individual supervisor will audit and review documentation and including status at termination.

**MINOR POLICIES**

**POLICIES FOR WORKING WITH CHILDREN AND YOUTH**

**INTAKES**

If a potential client requests an intake and s/he is over 15 years old, s/he may have the intake with no guardian consent, no guardian signatures, and no guardian present. However, if the client is over 15, comes to the intake with a guardian, it is recommended that unless the client requests differently, that the parent is included in the intake and co-signs all authorization forms.

For potential clients under 15 years old, a guardian must co-sign all forms in the intake packet. The parent is in the room during the intake process with clients under 15 years old.
When scheduling the first session with a minor, inform the guardian that the parent authorization to treat a minor must be signed before the session can begin.

**FIRST SESSION (AGE <15)**

**PAPERWORK:**

1. Counselor must have a guardian(s) sign their personal disclosure statement. (The client can co-sign if they like.) Give a copy of the disclosure to the guardian (and client if desired).
2. Counselor must also bring the “PARENT AUTHORIZATION TO TREAT A MINOR” form (located in the forms bin in the student room) to the first session and have the guardian sign.
3. It is expected that during the first session, you bring in the minor and guardian to sign the forms above.
4. It is best practice, but not legally required, to have both guardians sign the disclosure and authorization form if possible. In some cases, this will not be possible (one parent’s whereabouts are unknown) or unsafe (domestic violence, restraining orders, etc.). Consult with a supervisor for specific situations, and document in the file if there was a reason the other guardian was not notified of client’s treatment.
5. A guardian has a right to look at their child’s file at anytime – so be thoughtful about how your progress notes are written.

**DISCUSSION:**

1. It is highly recommended that once paperwork is signed, that the counselor, minor, and guardian have a discussion about how to keep the guardian informed about the progress of treatment. It is important to have this discussion with both the guardian and minor present, so it is clear and transparent from the very beginning of the counseling relationship about how confidentiality will be treated. A sample conversation may be as follows:

   *As your child’s counselor, it is important that your child feels s/he has some privacy with me. However, as the child’s parent, it is also important that you are informed on your child’s progress in counseling. What I would like to suggest is that we plan to have you come in at the end of session either every week or every other week for about five minutes and (insert client’s name) and I will tell you about how things are going in counseling. Additionally, I promise that I will always let you know if there is a situation revealed to me that would endanger your child.*

   Note: If this is what you, the client, and the client’s guardian agree to, be sure to ask your client what s/he wants to discuss with their guardian prior to inviting the parent in at the end of session.

2. If you have a client with whom you plan to do play therapy with as a primary approach, it is also helpful to explain how play therapy works to parents. There are some sample information flyers you can give to parents explaining play therapy that you can use, or you can just have a discussion with the guardian about play therapy. A sample conversation may look something like this:

   *For children, counseling often works best if we work in their first language, which is through playing. By using toys, art, and other mediums, we can help your child working through their troubles in a way that is less threatening to them than attempting to sit down and have an adult-like discussion with them. I want to assure you that if you ask your child about our sessions, and they talk about playing with puppets or painting, please know that we are not just “playing” with them, but we are continuing to work on their challenges through alternative methods.*

3. It is also important to talk to the parent and child about the mid-session break and ask how they want that to work. Generally, unless the child has been a long-term client, we prefer to not leave children under 10 years old alone in the counseling room during break, as it can be scary for them.
(and a liability for us). Children may wait in the waiting room with their guardian during the break, or the guardian may come into the counseling room during the break. This is important to discuss so parents know they should not leave the waiting room of the clinic during their child’s session.

4. Parents will often, in their anxiety to have the counselor understand their child better and improve behavior faster, feel the need to tell you in front of the client about recent problems with their child during the first session (e.g. “Last night Susie screamed at me about doing chores and then also threw a pencil in class today”). This can be difficult to manage, because you don’t want the parent to feel dismissed, but you don’t want to have your client’s immediate impression of therapy as a place where all their “bad” behaviors are discussed. It can be helpful to listen to the parent briefly, empathize that the situation must be stressful for them because it is clear that they care deeply about their child, and that you are hopeful things can improve, then gently dismiss them from the session.

FIRST SESSION (AGES 15-18)

PAPERWORK:
1. Client will sign the counselor’s personal disclosure statement and be given a copy of the disclosure. If the guardian is involved, it is best practice, but not legally required, to have the guardian also sign the disclosure form and receive a copy.
2. A minor consent form is NOT required, but may be used if the guardian is present.

DISCUSSION:
1. If the guardian is present: It is highly recommended that once paperwork is signed, that the counselor, client, and guardian have a discussion about how to keep the guardian informed about the progress of treatment. It is important to have this discussion with both the guardian and client present, so it is clear and transparent from the very beginning of the counseling relationship about how confidentiality will be treated.
2. If the guardian is not present or aware of client’s involvement in treatment: It is important to define when we will have to involve the guardian (see following section) when reviewing confidentiality with the client.

DANGEROUS BEHAVIORS
The Center’s policy is to involve guardians when any minor is engaging in dangerous behavior. This includes clients aged 15-18 who come to counseling without their guardian’s knowledge. The laws are vague about what is considered “dangerous” for minors. For example, a counselor would not be able to break confidentiality if an adult client was cutting on themselves (without suicidal intention). With minors, this is not as clear of a distinction in the law. Consult with a supervisor on these “gray” areas. Some examples of areas where we would likely include guardians may include: significant cutting, high risk substance abuse, unsafe sex when someone is HIV positive or knowingly engaging in sex with someone who is HIV positive, drinking or using drugs excessively when pregnant, dating violence. The best approach in these situations is to encourage the teen to self disclose to their guardians, with the option of having the counselor be present as a support to the client and family.

PARENTAL CONSENT FOR MINORS
All minors (under 15) will be required to have parental or guardian consent for services. In cases where minors live with a legal guardian, a court document must be presented giving the guardian the right to provide permission for mental health services. For clients 16-18yrs old, the center strongly recommends written parental consent.
1. In order to provide counseling for a child under the **age of 15**, the Center requires signed parental consent from the child’s legal guardian/guardians.

2. In cases of divorce, a parent who has medical decision making powers custody of the child may give consent. “Legal Custody” is a designation as a result of a court action.

3. In case of divorce, if parents have “joint medical decision making powers”, then both parents must sign the consent forms.

4. If a parent has “sole custody” of a minor child that parent with the authority to make all major decisions concerning the child’s health, education and general welfare. His or her consent is all that is required by the Center to provided counseling for the minor child. In emergency situations, the non-custodial parent may consent to necessary medical treatment for a minor child. Even in those situations where a non-custodial parent does not have the right to control the patient’s care, he or she can request the patient’s medical records. (C.R.S. 14-10123.5)

5. A parent of a minor, by a properly executed power of attorney, may delegate another person, for a period not exceeding nine months, any of his or her powers regarding care, custody and decision-making responsibility, including the power to consent to medical care and treatment (C.R.S. 15-14-104)

6. Health care providers should assume that no other person possesses the authority to authorize a minor’s medical record. The primary exception to this rule is where a court has awarded legal custody to another family member or institution. Under Colorado law a court may award legal custody of a minor to another party when it is in the minor’s best interest. Any court appointed guardian is awarded the power to authorize medical care and treatment for the minor.

1. Minors of at least **fifteen years of age** can consent to treatment without parental notification. However, there are some specific limits to confidentiality:

2. If your parent or legal guardian inquires about whether you were receiving counseling at our center, by Colorado law, we will disclose that we are providing services to you.

3. Your counselor will contact and inform your parent or legal guardian if situations where your health and/or safety is at risk, with our without your consent.

4. The law does not require a signed release of information for your parent or guardian to obtain records prepared in the course of providing mental health services to you. Therefore, if your parent or guardian were to request a copy of your records, we will comply with that request, with our without your consent.

5. A person who is 15-18 who is living separately and apart from his parent or guardian and is managing his or her financial affairs or who is married and living separate and apart from parent or guardian is not considered to be a minor under Colorado law.
6. Since the law does not address or preclude who may make appointments from minors age 15-18, the Center permits parents or legal guardians to make appointments for their minor children.

Who must give consent to treat a minor child?
If the couple is married one parent must sign, but it is best practice that both parents sign. If the couple is separated/ no longer together but not formally divorced: both parents*
If the couple is divorced: The parent who has decision-making authority. The courts usually determine this in the case of divorce by decree or court order. At times there will be a joint decision-making and in that case both parents must sign consent. Parents must produce the legal document that states who has decision-making authority before first session can occur. *
*If one parent cannot attend the session to sign in person, they may get their signature notarized and then send in via another family member, fax or mail. Parents who have decision-making authority both have access to the child’s file.

COMMON QUESTIONS WHEN WORKING WITH CHILDREN

When must authorization be obtained?
By the beginning of the first counseling session. If a parent and child arrives for a session prior to all the authorizations being in place, you must let them know you cannot see them for counseling. If you are very clear about this when scheduling the appointment over the phone it will hopefully not be an issue.

Who is responsible for obtaining authorization?
The ongoing counselor. If one parent came to the intake, and the other parent has decision-making powers but will not be involved with counseling, it is good practice for the counselor to call the other parent personally to inform them of their hope to work with their child, obtain the authorization and ask if the parent would like to meet them or has any questions.

If the client is over 15 years old, must I get authorization?
Legally, no. If the client comes with their parents to session, it can be good practice to have the parent sign if it is a comfortable relationship.

I have a 13 year old who is coming to individual child therapy. What do their parents do during session?
The parent must stay in the waiting room during the session for any client under 15 years old.

I have a transfer client who I don’t believe has both parents’ signatures authorizing treatment. What do I do?
Always check before seeing the client. Call the parent who has been the contact and explain that we have a policy regarding obtaining authorization for working with children. If the parent is divorced, they must either a) produce the court document stating that they have sole custody or b)get you the notarized signature from the other parent or c)put you in contact with the other parent to come in to sign the form. If the parents are married/cohabitating, they must bring in the other parent’s signature (notarized or the other parent can come in person and sign). Keep a copy of the court order with decision-making orders in client file.

What do I do during the mid-session break with my child client? He/She is too young to be in the room alone.
Get the parent from the waiting room to wait in the therapy room with your client. In general, we don’t leave kids under 10 alone in a therapy room unless they are very comfortable and established here.
How should I communicate to the parent about a child’s progress in therapy?
In the first session, bring the parent in the beginning of the session to sign your disclosure form. During that time, with the child present, ask how the parent wants to be informed re: therapy. Generally, we have parents come in 5 minutes before the end of every session or every other session and we talk about what occurred in therapy in front of the child in vague terms (i.e. “Maria and I played a question and answer game. Maria talked about a child in her class who is frustrating her”). In session with the child, you will want to let the child know you will soon be bringing their parent in, and ask the child what they want their parent to hear, and preferably encourage the child to communicate directly to the parent. I would also strongly suggest talking to the parent in the very first session during the disclosure how often times children don’t just “talk” about their problems in the way adults do, but they show us their problems and work them out through play, art, and metaphor. This helps mitigate the common problem of parents wanting the counselor to just get their child to talk out all their problems in an adult-like manner, and not understanding that therapy can still be helpful even if the child doesn’t talk out their problems.

In session, my client reported that the parent whom they only live with two weekends a month is hitting them.

What do I tell the parents?
The parent with decision-making powers must be informed. Our general policy is to also tell the parent who is named as the abusing parent as well. Ask your supervisor for guidance.

My client, age 14, just told me in session that she has older friends (16 & 17) who let her drive their cars after they have all been drinking. What do I do?
The parent with decision-making powers must be informed. This would fall into the area of “safety risk” where we need to notify the parent. Be overt with the client that you need to inform their parent and that you would like the client to be involved. Be aware that the parent may need/ask for guidance on how to handle the situation with their child.

AUTHORIZATION TO TREAT A MINOR INSTRUCTIONS
Both parents of a minor child must sign the authorization for treatment forms and all clinic disclosure forms prior to the minor child’s first scheduled session. One parent’s signature may be hand-delivered or faxed to the clinic only if that document has been signed and notarized.

- If you are a parent and have never been married to the minor child’s other parent, both parents still must execute all clinic documents.
- If you are a parent and are legally separated, have a decree of final dissolution of marriage/divorce, and/or have obtained an order allocating parental responsibilities/custody providing for joint decision-making authority, both parents are still obligated to execute all clinic documents. You are required to provide a copy of all Court Orders regarding the minor child with your paperwork.

Other circumstances:
- If you are a parent and are legally separated or have a decree of final dissolution of marriage/divorce, and/or have obtained an order allocating parental responsibilities/custody order providing for sole decision-making authority, then the parent with sole decision-making responsibilities may execute the
You are required to provide a copy of all Court Orders regarding the minor child with your paperwork.

- If you are a person other than a parent who has obtained an order allocating parental responsibilities/custody for the minor child, then that custodian may execute all clinic documents. You are required to provide a copy of all Court Orders regarding the minor child with your paperwork.

- If you are a person other than a parent who has obtained legal guardianship of the minor child, then the legal guardian may execute all clinic documents. You are required to provide a copy of all Court Orders regarding the minor child with your paperwork.

- If you are a person other than a parent who has obtained temporary guardianship/custodian of a minor child by consent of a parent through a power of attorney/delegation of power by parent or guardian, that individual may execute all clinic documents only if such power of attorney/delegation of power has not expired and a copy is provided with your paperwork.

- If one parent has been absent or his/her whereabouts are unknown, please provide the clinic with details as to your efforts to contact the other parent and the current circumstances.

**CHILD ABUSE AND NEGLECT REPORT INSTRUCTIONS**

Review the facts of the case in light of the legal definition of child abuse or neglect as it appears at C.R.S. 19-3-303:

Child abuse or neglect means an act or omission in one of the following categories:

a. Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fractures, soft tissue swelling or death (not justifiably explained or the product of an accident.

b. Any case in which a child is subjected to sexual assault or prostitution

c. Any case in which a child is in need of services due to guardian’s failures to provide adequate food, clothing, shelter, medical care or supervision that a prudent parent would take

Additional reasons for considering a report include:

a. A runaway and/or a children who is beyond the control of parents or a danger to parents

b. when there is a need to protect the child in the home due to:
   1. domestic violence
   2. gang activity
   3. drug activity and exposure

The statutes on sexual assault on a child are as follows:

C.R.S. 18-3-405: prohibits sexual assault on a child: “Any actor who knowingly subjects another not his or her own spouse to any sexual contact commits sexual assault on a child if the victim if the victim is less than 15 years of age and the actor is at least four years older than the victim.” Applying this statute, a child who is 14 years old could consent to relations with a 17 year old, but not with an 18 year old.
C.R.S. 18-3—402 also defines sexual assault to include a situation where, “the victim is at least 15 years of age, but less than 17 years of age and the actor is at least 10 years older than the victim and is not the spouse of the victim.” Applying this statute, a 16 year old can consent to relations with a 25 year old, but it is a crime when the victim is 16 years old and the actor is 26 years old.

*Under 16 years old, consent must be less than 4 years age difference.*

*Under 18 years old, consent must be less than 10 years age difference.*

If the alleged abuse is not from a member of the household or a relative, or an adult, the report is made to the Police Department (e.g. Child sexually or physically assaults a school mate)

**Note:** If the incident being reported occurred while the client was a minor and/or was exposed to the abuser, however, currently she/he is an adult (over 18) there is no duty to report, unless you have strong reason to suspect that the accused abuser does have access to minor children (e.g. A step parent who is still in the home with minor children or a gymnastics coach who is still coaching minor children). The client always has the right to report past abuse. The distinction is we that we as providers do not have an obligation to report.

Any student counselor who suspects child abuse/neglect as defined above should first seek consultation from a Clinic supervisor. If a supervisor agrees a report should be made and/or a consultation call should be made to social services, the following procedures should be followed:

a. Complete the pink information sheet entitled: Report of Abuse and/or Neglect

b. Make the call to the appropriate county social service agency. Your supervisor will have the numbers.

c. If a consultation, state that you are a counselor at the Center and you are calling to receive consultation about whether you need to file a report. In this situation, you may give the facts of the case and not the identifying details (name, etc)

d. If you are reporting, you will give the intake worker all the details and identifying information you have available.

e. If you actually do make a report (vs. a consult only) you and your supervisor will sign the form and then submit it to the director for signature. After the report has been signed by all, it should be put in the client’s chart.

f. In most cases, you will inform the clients that a report needs to be made. You may or may not include them in the actual reporting. You can try to assure them that you want to continue to work with them and you do not have a choice not to report. You are mandated by law to do so. You can also let them know that the fact that they are seeking counseling is seen by social services as very positive. Of course, the hope is to maintain a therapeutic relationship, but even in cases where the clients threaten to leave counseling, our duty to report takes precedence over maintaining a therapeutic relationship.
Note: It is not up to us to decide whether or not abuse/or neglect is occurring. It is our duty to report our suspicions/concerns. It is the responsibility of social services to investigate assessment and make a determination.

CASE MANAGEMENT
For UCD student clients in need of case management services, a referral to the CU Denver Office of Case Management in the Dean of Students Office may be provided. The Office of Case Management can be contacted at: 303-352-3579.

GUIDELINES FOR INTERNATIONAL STUDENTS REQUESTING REDUCED COURSE LOAD LETTER
The SCCC will write a letter of support for an international student who, due to mental health distress or impairment, is not able to successfully manage the course load of twelve (12) credits which is required by their sponsor and/or U.S student visa. However, specific conditions must first be met:

1. A student must complete an intake and two (2) additional counseling sessions.
2. The assessment of distress level and impairment confirms the need for a course load reduction.
3. A student signs a written release of information which gives the SCCC consent to share our recommendation and mental health assessment with the CU Denver Office of International Student Services and other designated recipients.

REDUCED COURSE LOAD TEMPLATE

__________________  (student name) is undergoing treatment for an illness or medical condition.

Due to the condition for which I am treating __________________ (student name), it is my professional recommendation that __________________ (student name) take a reduced course load.

I understand that the normal full-time course load is 12 credits, but because of this medical condition, I recommend that s/he take only _______ credits this semester.

____________________________

Signed by a
Licensed medical doctor or Doctor of osteopathy or
Licensed clinical psychologist, Colorado License Number PSY..._________