COUNSELING PRACTICUM I

Lecture 8

Record Keeping

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Introduction

It is one thing to conduct counseling for clients and another challenging thing doing it professionally. Most beginning counselors are not fully aware of ethical standards and legal implications in the counseling profession. It is during supervision sessions that the same is communicated by the supervisor. One of the ways to show case ethical practice is the way the beginning counselor uses the counseling professional documents in client work.

Expected Learning Outcomes

At the end of this lecture, you will be able to:

(i)Identify common professional documents used during internship practicum

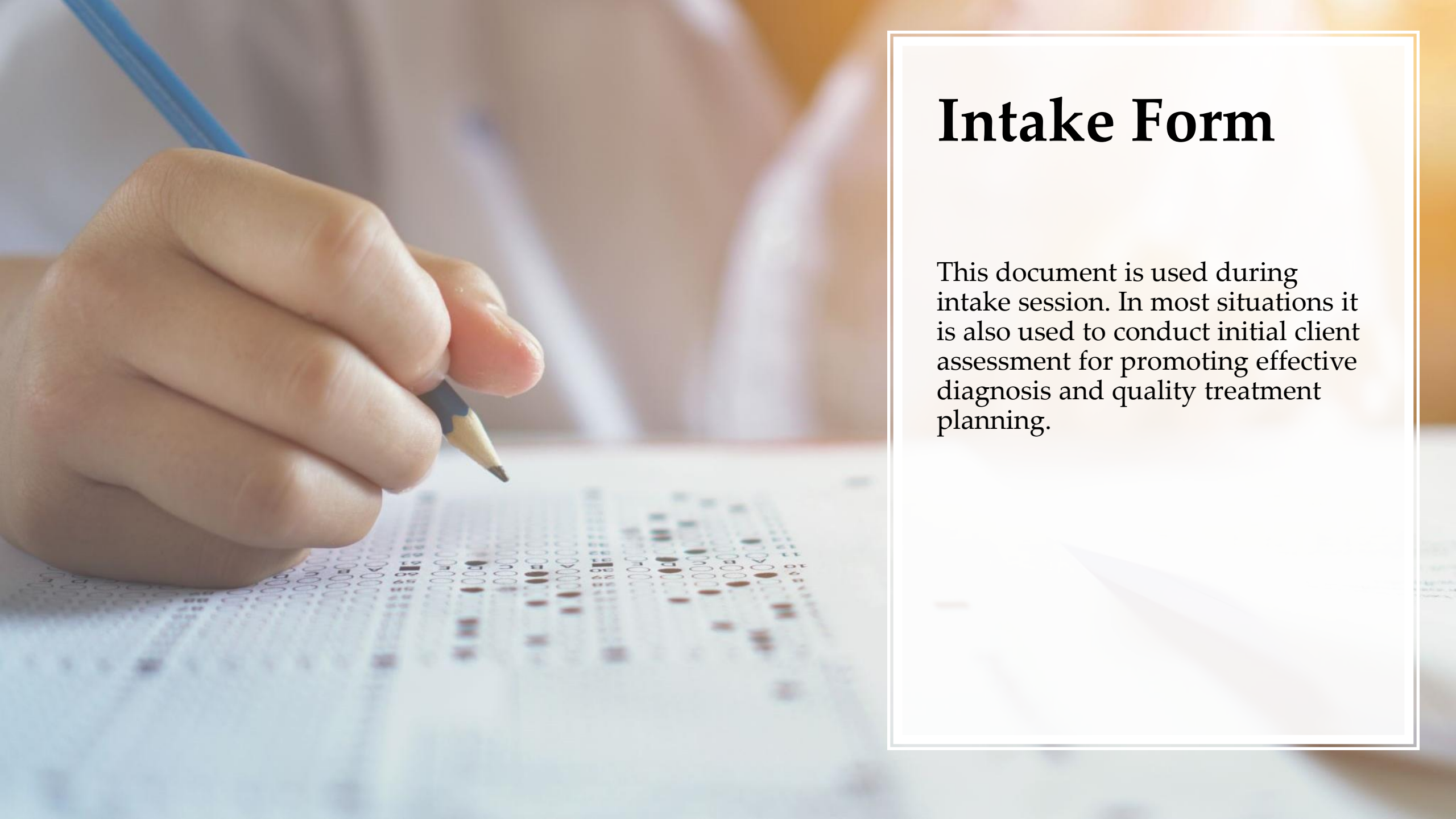
(ii)Explain the functions of professional documents used in counseling practice

Contract Form

This document also referred to as consent form differs from one organization to another, use and style of counseling. Some consent forms have details that are contained in the intake form while some have details limited to just contracting. General information in some consent forms include norms to be observed during counseling, session duration, cost per session, other parties to be contacted, next of kin contact and time schedule, relevant significant contacts, role of the client and counselor, provision for therapy termination, details of issues presented for therapy among others

Contract Form

The therapist tries to his/her level best to tailor make counseling intervention with available resources to meet the client's needs and expectations for seeking therapy. Sometimes the level of competence will determine the kind of TPs a counselor will make

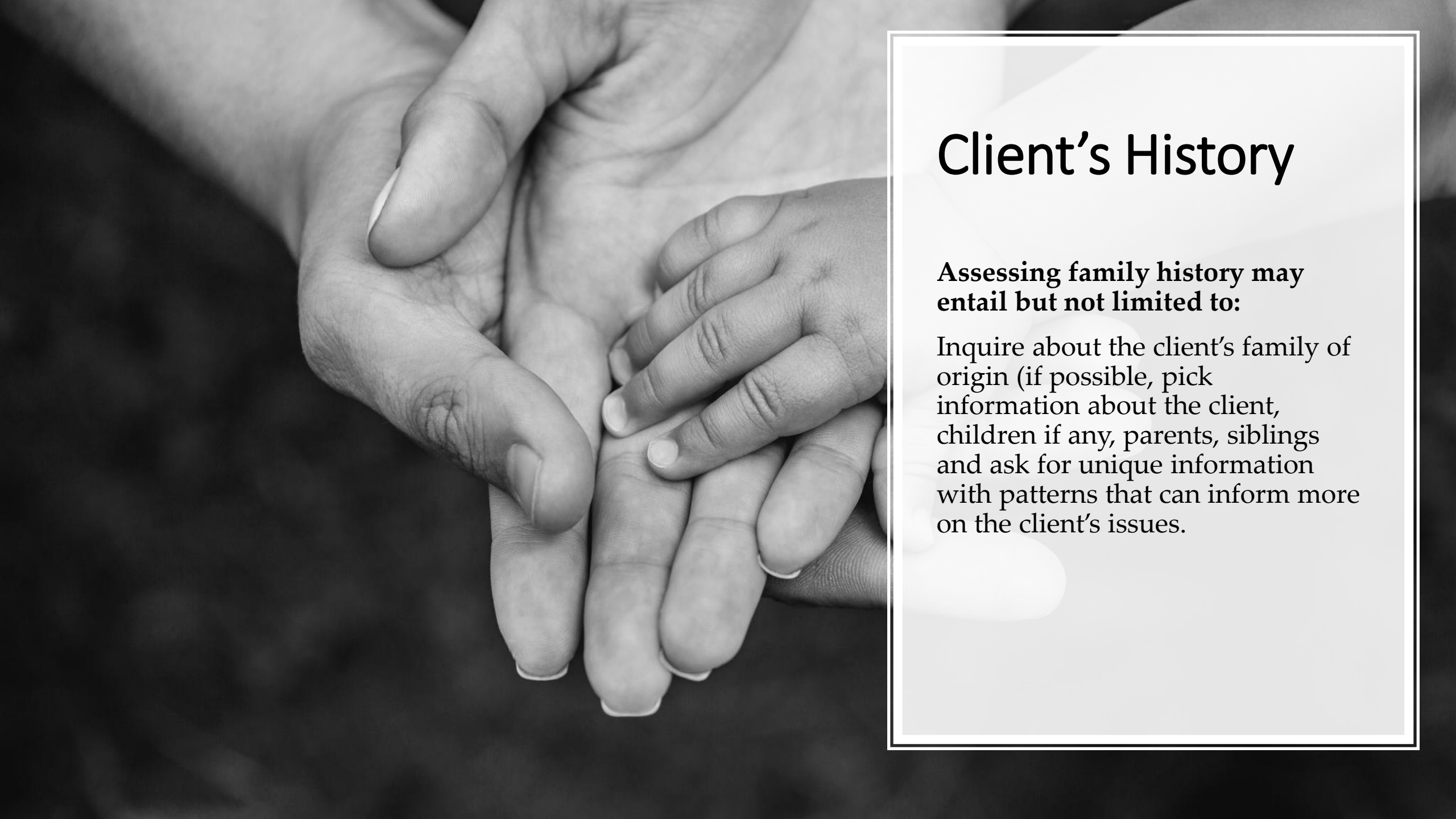


Intake Form

This document is used during intake session. In most situations it is also used to conduct initial client assessment for promoting effective diagnosis and quality treatment planning.

Client's Bio Data

Personal	Social	Education	Career/Job
Age, marital status, gender, children, residence, reason for seeking therapy, referral agency	Social networks (relatives, support groups, welfare) Referral agency, Contact persons	Level, certification, grade, competencies	Vocation, career, expertise, self-employment, employer



Client's History

Assessing family history may entail but not limited to:

Inquire about the client's family of origin (if possible, pick information about the client, children if any, parents, siblings and ask for unique information with patterns that can inform more on the client's issues.

Client's History

This helps you to pick negative patterns that could have played a role in perpetuating the client's psychological distress. Some of the patterns may include anger issues, separation and divorce, drug abuse, violence among others. Some positive patterns like skills and competencies in certain areas may include sports, athletics, medicine, teaching, entrepreneurship, creativity, innovations, and research

Therapy Expectations and Goals

This entails asking the client what they expect to gain form therapy. This helps formulate the therapy goals both from the client and you as the therapist. As a therapist you may be guided by theory of choice and/ or client's data. It is helpful to see your client from many angles not just what they expect form therapy because they may be blind to their needs due to mental distress.

Tracking Developmental Path

This will require you to take history about your client in different developmental stages to pick challenges they experienced, how the resolved them and what is remaining as unfinished business. Most of the unfinished business form background for psychological conflict and distress. This helps you to see what to resolve first and avoid piling up of psychological distress.

Assessing Cultural Background

This may include finding out about the ethnic background, cultural traditional practices, beliefs, and affiliations and how they inform the behavior of the client in relations to what they bring for therapy. Some cultural beliefs and practices that sideline some people from others may indeed contribute to abuse of their rights. Then this could be true of your client.

Routine Life

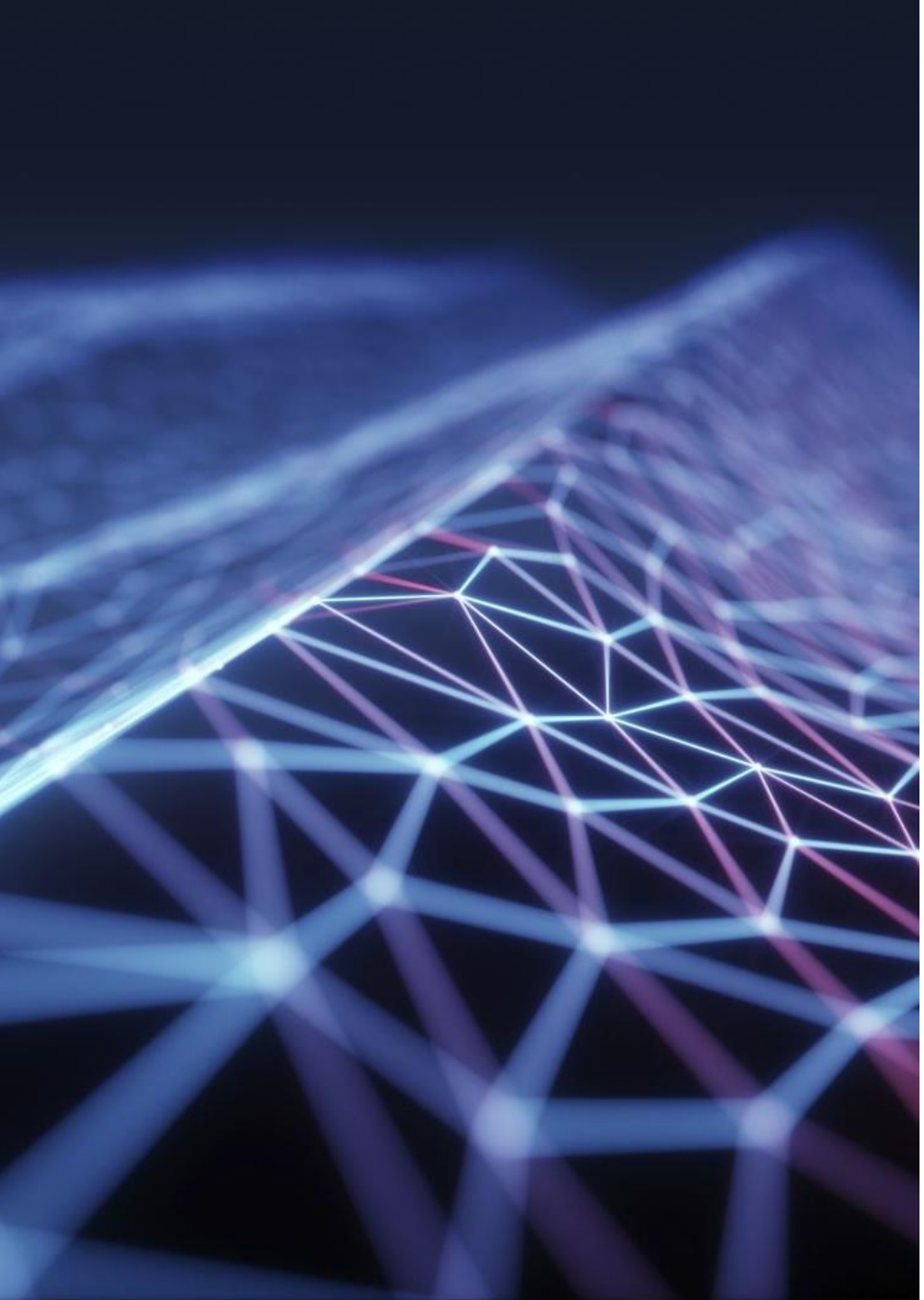
A client will reveal how they spend their time when they share their routine habits and behavior. Some are productive while some are destructive. You can also pick who they spend time with and how they impact their lives in return.

Clinical Assessment and Diagnosis

This will entail you using all the knowledge learned relevantly in assessing the client's issues, needs, opportunities and underlying issues. Making a diagnosis may require you to take the DSM – tool and relate with the client's signs and symptoms. You can correlate thus with the theoretical constructs too

Assessment and Diagnosis

This level requires expertise, experience and consultation during internship to avoid making the wrong diagnosis hence inappropriate ineffective treatment. Suitable treatment planning is best informed by appropriate clinical assessment and diagnosis. Appropriate treatment planning is derived from appropriate treatment goal setting translating to appropriate treatment implementation and positive treatment outcome.



Other Areas

Other areas may be included in an intake /initial assessment form may include,

- Medical history,
- Drug abuse history,
- Legal history,
- Psychiatric history,
- Mental health assessment and recommendations for therapy

The interns need to record the client's information as gathered during the sessions. At times it is a small, printed notebook with summary guidelines where an intern just fills in the information. The function is to track client's clinical movement in therapy, accreditation purpose, referral, legal requirement and as a clinical supervision requirement. Some details in the case notebook are also found in the intake and supervision form. The client code is meant to conceal the identity of the client to the third party; it is an ethical practice requirement for the safety of the client.

Client Case Record Workbook

Client Progress Record

May include a section for your name, client's name (for confidentiality you can code), date, session number, out of possible total sessions, venue (location), the supervisor's name (site or school supervisor), session objectives, case summary, presenting problems, case formulation, clinical assessment, diagnosis and treatment goals/plans, implementation and techniques used, realized goals and this unrealized.

Progress Record : Self Evaluation

There is a section for self-evaluation (done very honestly) and one for supervisor's remarks and areas you may need help from the supervisor or supervision group.

Most interns would like to impress they are doing well. This may not be helpful because they need genuine feedback to grow through feedback.

Log in Form

This document indicates in summary the work covered by the intern during the practicum. It outlines the different sections or departments the intern served; type of counseling done, hours covered in each category, supervision received during the week and proof of supervision sessions attended and work done by appending relevant signatures. Document (a) is mostly used during internship while form (b) is used for accreditation purpose or clinical supervision and monitoring of client progress in normal practice.

Sample Outline

Dates (By Week)	One-on-one Counseling	Group Counseling	Seminars Workshops Talks, community service	Weekly Supervision (Hours – site and school)	Total Hours for the Week	Site Supervisors Signature

Details include name of the counselor, date (start and end dates), supervisor, client code, initial reason for seeking counseling, number of sessions structure, treatment goals set, Treatment goals that were achieved, those not achieved, reasons for terminating counseling (is it end of therapy, dissatisfaction, need for specialized care, client's wish?), current client's status and your own observation.

In case of referrals made indicate who or where, sign the document and the clients to sign as well

Termination Form

Community Service Guideline

One of the requirements for interns is to engage in community service . The following steps will help in planning and reporting such an activity

Step 1: Identify the community (age, group, institution, physical setting village, town, school)

Step 2: Assessment what the community needs (type of psychosocial need, counseling need, education, training, coaching)

Step 3 : Objectives and Strategies to address the needs (do you need resource, mobilization- human, material mode of delivery, approaches)

Step 4 : Community service work plan (showing the programme with time allocation day, date, month), resources required, objectives, monitoring and evaluation methods)

Step 5 : Follow up plan (dates, tasks, responsible party)

Group Work

Group Counseling Tips

- Find out what you want to do
- Find out what the group will be like (type, form)
- Identify tasks for the group
- How will you choose who joins the group?
- How will you manage the group?
- How will you measure group outcome?
- How will build the group cohesion?
- How will you terminate the group?

Client Characteristics

Most counseling approaches are designed for people who NOT severely impaired in their verbal and intelligent levels,

Moderately organized in their lives (GAF 60- 70 scale and above because they can follow through their scheduled appointments,

Agree on tasks and discuss their concerns.

Support systems at times is required though for difficult clients.

Nature of Counseling Problem

- Most common concerns include relationship and communication difficulties,
- Confusion about goals and direction,
- Poor or unclear self-image,
- One who is indecisive,
- Struggling with troubling behaviors or habits,
- Depression or anxiety difficult coping with change, crisis, or loss
- History of treatment failures,
- People in denial, those who externalize their difficulties (blame other factors or people), oppositional attitudes

Steps to Developing a TP

1

Step One: Problem selection (must be primary specific to keep track) secondary problems can be dealt with later but allow the client to join in TP development

2

Step Two: Problem Definition (use DSM, ICD /11) and back up with past experiences

3

Step Three: Goal development (measurable treatment statements global, long term goals that indicate a desired positive outcome)

Steps

- **Step Four**

Objective Construction – They must be smart with a at least two objective for one problem the client has presented

- **Step Five**

Intervention creation - Based on client's needs, goals and matching therapeutic interventions, counselor's training, and experience

- **Step Six**

Diagnosis Determination

NB: An appropriate diagnosis is based on an evaluation of the client's complete clinical presentation (still use DSM- IV TR Multi axial Diagnostic Criteria)

DSM - IV – TR GUIDE

The current DSM 5 does not include this criteria for assessment and diagnosis of a client's psychological needs and concerns.

However, DSM – IV - TR is still applied in mental health assessment in clinical settings

It is a step to step guide for students who are beginning clinical work in counseling too.

Must Remember Documents

The following professional counseling documents are important to remember if you find the agency you will be serving will nothave their own

- Client intake
- Case Book/Record keeping file
- Supervision Log
- Termination Form
- Referral Form

Conclusion

This lecture has explained what treatment planning all is about, importance and benefits of treatment planning in counseling, factors to conder while developing a good treatment plan and steps to follow when developing treatment plan. It is quite helpful for interns to know how to do treatment planning during practicum to avoid all the pitfalls that follow poor or no treatment plans during therapy.

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