Mayor of Los Angeles Office of Public Safety
Building Healthy Communities

After Action Report for Safe Spaces L.A. Pilot Project

Submitted by:

The Muslim Public Affairs Council
www.mpac.org
August 31, 2017

Table of Contents

Executive Summary

Aligning with the objectives of the City of Los Angeles Mayor's Office *Building Healthy Communities* grant to support prevention and intervention behavioral and mental health services, the Muslim Public Affairs Council (MPAC) accepted $20,000 in seed funds to pilot the Safe Spaces model. The Safe Spaces model is a public health model for building community resilience and promotes the core values of civic engagement, public safety and healthy identity formation. The model is focused primarily on the underserved population of Muslims, and was piloted at one site, the Islamic Center of Southern California (ICSC).

The results from this experimental period garnered over 100 people having interventions through individual, couples and family therapy either as limited or returning cases, and over 4,000 people receiving promotion and prevention services as defined by the Substance Abuse and Mental Health Services Administration's behavioral health model. At this location, Muslims and other populations were served. Deliverables and goals of the grant were observationally met with one exception (expansion to a second site), and positive outcomes progressively increased at this site over an eight-month period. It was determined that services allocated to one site was the best use of funding given the interests in proving the concept and the limits on the number of hours funding could support. To have divided funding into two sites at this stage would have potentially muddled or weakened the outcomes of the pilot program.

The grant's overall goal was to increase community resilience and inclusion, and to offer culturally appropriate social services to individuals and families through education, outreach, assessment, treatment and referrals.

Goals were reached by fostering relationships and partnerships with mosques, training of the Safe Spaces model to key members of the staff and leadership, and identifying and building relationships (including MOUs) with other agencies, such as the Department of Mental Health in Los Angeles County. With the development of the Community Resource Team (CRT), and partnering with a mental health professional who the community recognized as trustworthy, it was established how quickly the model could become a sustainable one. Seven members of the staff and board of the Islamic Center of Southern California participated in a Safe Spaces orientation, a four-hour workshop which introduced them to the program model, structure, goals, and activities. They agreed to form their own Community Resource Team and implement the program through August 2017. The CRT agreed to continue to meet beyond the grant period, indicating both sustainability and community empowerment. The Mayor's Office, the

Community Resources Team, and the mental health professional expressly stated their commitment to uphold all Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines (which provide standards for the electronic exchange, privacy and security of health information), and prioritize the confidentiality and anonymity of its clients.

Below is a snapshot of results from this preliminary period.

Community Wellness Programs

From March through August, the Community Resource Team organized a total of 11 community outreach programs to promote general wellness and explore taboo topics across the ICSC community. Exploring such topics is important in shrinking the gap of cognitive dissonance that is created often when people are in a state of fear or insecurity. The overall outreach efforts reached more than 4,000 people across the ICSC community and were aimed at offering a healthy space to discuss difficult and challenging topics. These included:

- Safe Spaces L.A. Orientation - 7 people
- 2 Let's Be Honest Forums: Conversations about Taboo Topics - 75 people
    - Adult Education Program - Topics discussed: parent-child relationships, pre-marital relations / marriage, mental health, gender, identity, political engagement
    - Youth Group - Topics discussed: relationships (parental and romantic), self-confidence, Islamophobia, and mental health
- 1 Youth Group session on reflective listening - 30 people
- 2 Speeches about self-care and mental health - 1,500 people
- 3 Reflections during the month of Ramadan - 2,350 people
- 2 Suicide Prevention workshops at ICSC's Family Night - 85 people
- 1 Adult Education session on mental health and seeking help - 25 people
- 1 Health & Wellness Day, with teachings about self-care, a guided visualization for relaxation and a yoga class - 100 people

Attendance at Community Wellness Programs

February	April	May	June	July	August	**Totals**
57	25	2,280	1,500	130	100	**4,092**

Client Services / Treatment

Through word-of-mouth and direct contact following community engagement, community members began to come in for client services. Regular appointments were offered on Fridays and Sundays on an outpatient basis, starting in late April through the end of August. A total of 67 cases were handled between late April through the end of August, with a total of 200 client sessions and 33 cases reaching closure.

Therapy/counseling sessions set aside for direct services filled quickly. Within one week of starting direct services, there were seven new cases spanning a variety of issues. After the first full month (May), there were 25 new cases and 20 ongoing cases. By the end of the pilot, there were more than 34 ongoing and 33 closed cases. (Note: The number of cases are not equivalent to the number of individuals, as treatment/interventions included from one to 10 individuals at a time.) The table below charts the growth in client counseling services during the five-month pilot.

Client Counseling Cases / Treatment & Intervention Activities

	April	May	June	July	August	Totals
New cases	7	25*	2	29*	4	67**
Ongoing cases	7	20	22	20	23	34
Closed cases	0	3	9	10	11	33

** Includes a group therapy session*

*** Each case was an individual, couple, family or group. The total number of people served through cases was more than 100*

Return Visits from Ongoing Cases

	April	May	June	July	August	Totals
Return Visits	0	37	36	44	16	200

All clients completed informed consent forms before engaging in counseling sessions (see Appendix). Clients presented a wide range of issues which led them to seek therapy, such as depression, family issues (communication, coming of age / transition, anxiety), suicidality, eating disorder, adjustment disorder (adjusting to a change in their environment or part of life they're in - loss of job, home, marriage), marital issues, substance abuse, trauma (sexual, physical,

psychological trauma), or domestic violence. Threats of public violence did not appear from any of the over 100 individuals who participated in counseling/therapy sessions. When considering the continuum of influences that create cognitive closures, rigid thinking, insecure attachments and the ability to be exploited by nefarious groups, there were indications that these symptoms could exist or be exploitatively created and led toward violence (either public or interpersonal) if left untreated, in a portion of cases. None of the cases in the pilot program reached the level of needing assistance from law enforcement or reporting to any other agency. On the same continuum for some communities that have difficulty in discussing sexuality, there is an opening for a symptomology to take root that makes people vulnerable to exploitation by nefarious groups. The promotion, prevention and intervention techniques employed by the Safe Spaces model narrow the possibility of potential exploitation by addressing the learned, conditioned and/or traumatogenic communal vulnerabilities at the macro-level, the meso-level and micro-level of society. Where clients needed treatment/interventions outside of the scope of services, clients were referred to the relationships built with Umma Clinic, MiNDS Network, and the Department of Mental Health.

The Safe Spaces Model
& Pilot Program Deliverables

MPAC is a community-based public affairs nonprofit that promotes and strengthens American pluralism by improving public understanding and policies that impact American Muslims by engaging our government, media, and communities. The Safe Spaces Initiative is a public health model for building community resilience developed by the Muslim Public Affairs Council in 2014, and is a first-of-its kind program aimed to combat public violence by empowering communities with a model that promotes the core values of civic engagement, public safety and healthy identity formation. MPAC has worked to improve and enhance this model, incorporating the feedback of community leaders, civil rights experts, behavioral health professionals, and academics around the country.

The revamped *Safe Spaces: Tools for Building Healthy Communities*, released in 2016, focuses on public education, access to counseling and behavioral health services. While it went into trial phase in 10 cities around the country in 2017, Los Angeles was the only city which secured funding to implement the program.

Rather than accepting the notion that the only way to deal with violent extremism is through widespread surveillance and the use of informants, Safe Spaces presents alternatives to address social protective factors that strengthen the social fabric. It relies on community-led and community-driven programs that benefit communities beyond the national security context. As such, Safe Spaces is designed as an *alternative* to both heavy-handed law enforcement tactics and government-led countering violent extremism (CVE) programs.

Safe Spaces is about empowering communities in a way that promotes public health, public safety, and civic engagement. U.S. faith leaders and youth workers entrusted with the responsibility of caring for and uplifting community members require additional resources, training and support to meet individuals' needs that go beyond the spiritual realm.

Adult attachment insecurity often caused by displacement (e.g. immigration and refugees), or through lack of group identification (e.g., through group alienation, people who identify as LGBTQ), is correlated with increased instances of cognitive closure, a lower tolerance for ambiguity, and a more pronounced tendency for dogmatic thinking (Mikulincer, 1997). Individuals with insecure attachment are also more likely to not think clearly and adopt stereotypes (Mikulincer, 1997), e.g., the rise of neo-Nazis and White supremacists. Similarly, insecurities, cognitive closures, and dogmatic thinking play a role in increasing vulnerabilities towards violent groups such as ISIS.

The same predisposition to rigid thinking is apparent in the tendency of insecure individuals to make judgments that does not take all information into account (Green-Hennessy & Reis, 1998; Mikulincer, 1997). Cognitive closure, dogmatism, and conservatism may be strategies to hold onto a sense of self (Bowlby, 1980). In contrast, greater confidence is established in secure individuals, allowing them to be less defensive in relation to opening their minds to information that challenges their existing assumptions (Fonagy & Allison, 2014).

Similarly, Mikulincer (1997) asserted insecure individuals are more easily threatened and can be emotionally overwhelmed. Once epistemic trust has been lost, its absence creates an apparent rigidity (Fonagy & Allison, 2014). Many ethnic groups have experienced identifiable intergenerational traumas due to effects of historical colonization all over the world, including Native Americans (Laird, 2017). Further, the residual effects of American slavery had a profound effect on the psychological dispositions of the African-American Muslims (Laird, 2017). These intergenerational traumas have created symptomatic distrust, displacement and sometimes dislocation. This can often cause a loss of epistemic trust (Laird, 2017). This can create a circumstance whereby a person is unable to learn from or intake information from people other than those whose cultural cues they can identify with (Csibra & Gergely, 2009).

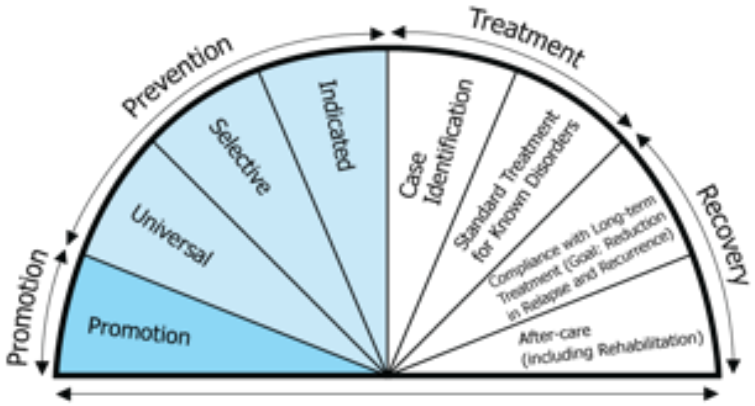
Building programs with vulnerable communities who may have intergenerational traumas or insecure attachments trust is very necessary. Services that have recognizable cultural cues that can create trust with community members are necessary when creating resilient-informed communities. Being able to help communities create protective factors of resiliency through promotion, prevention and intervention can create healthy communities, while also helping minority communities develop resilience in the face of discrimination, marginalization and oppression; thus, decreasing negative social stressors and behaviors. Communities that have cultural cues that are different from mainstream culture are minority cultures. The majority of Muslims in America are included in minority cultures.

When a community is a part of the solution to perceived problems and issues within the community, there is more success in resolving issues. Feeling understood in therapy restores

epistemic trust in learning from social experience, and at the same time regenerates a capacity for social understanding (Fonagy & Allison, 2014). Improved social understanding alongside increased trust makes new information about oneself and others to be positively seen, acquired and internalized (Fonagy & Allison, 2014). This is more often a solution than the intervention of government-led actions that do not consider culturally competent approaches to any given community. This would apply to all community types, but even more critically to any minority or marginalized communities that have often experienced traumas and detachment, or insecure attachment in childhood and throughout the lifespan.

The Safe Spaces model implements not only aspects of research as previously described, but also the behavioral health trajectory as described by the Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health and Human Services. This trajectory includes four stages: Promotion, Prevention, Treatment and Recovery.

Behavioral Health Trajectory



Courtesy of Substance Abuse and Mental Health Services Administration

A premise of the Safe Spaces model is that healthy individuals are not inclined toward violence. The Safe Spaces' approach to supporting healthy communities focuses on resilience, and is rooted in equal parts Promotion, Prevention and Treatment. This was accomplished by promoting community wellness and setting up support and resources for client services.

Weisburd, Davis and Gill (2015) hypothesized through an experimental program in Minnesota called "collective efficacy programming" that better relationships between communities and public safety can be the result of innovative social programs that start with meeting communities where they are and forging positive relationships between the community members, starting with recognizing the needs of a community and helping that community establish health. Through informal social control, communities can be contributors to the health of the overall society while at the same time establishing healthy views and relationships with public safety.

Although the foundational concepts of Safe Spaces can be broadly applied to underserved and marginalized populations in the Los Angeles pilot of this model, it was applied primarily to the Muslim population. The pilot also served others within the community that were in proximity to the service location.

The deliverables of the Safe Spaces L.A. Pilot Program were to:

1. Form a Community Resource Team to organize and implement promotion/prevention and treatment/intervention activities at the participating site(s)
2. Organize three community outreach and wellness events focused on promotion/prevention, including Let's Be Honest Forums
3. Partner with a mental health professional to provide counseling for community members, and organize and present community wellness programs alongside the Community Resource Team
4. Establish and ensure compliance with confidentiality agreement, reporting and referral protocols
5. Conduct evaluation and determine next steps with CRT

During the implementation of the outreach and wellness activities, community members began requesting programs on specific issues/challenges. The centerpiece of our community wellness programs is MPAC's Let's Be Honest Forum, which creates safe space for candid conversations about taboo topics both modeled by diverse professionals who serve on a panel and anonymous questions shared by audience members. In a reflection of the adaptive approach of Safe Spaces Los Angeles, each Community Resource Team meeting led to additional events, each event led to more community dialogue, more dialogue led to new client referrals, and the client referrals gave us further insight into the types of challenges the community was facing. This led to more responsive, relevant, and focused-programming. Community members both accepted and took ownership of both the prevention/promotion activities (community wellness programs) and treatment/intervention activities (client counseling services).

By the end of the pilot project, community wellness programs became a part of ICSC's regular programs because of the success and positive feedback from our events. ICSC's Sunday Program now focuses regular sessions related to wellness and self-care. The Youth Group now also includes regular Let's Be Honest Forums and activities to support resilience in the face of family, academic, social and other challenges.

Recommendations

This section discusses both the lessons learned from this pilot project and recommendations for continuing and expanding this work. These are divided into general recommendations and recommendations particular to the Safe Spaces model as implemented with a Muslim population.

Expanding the Safe Spaces Model

- Work with the assumption that there is a real hunger for community wellness and self-care / self-empowerment programs and the more they are offered, the more that people will participate in them. Consistent program delivery is critical for normalizing open dialogue and encouraging people to seek help if needed.
- The community is interested in client services. However, trust must be created. Introducing the mental health professional in a variety of settings in any community utilizing the Safe Spaces model will increase familiarity and trust with them and likely result in increased referrals. Having the mental health professional be a member of the community, authentically, is critical for Safe Spaces to have an impact.
- Protecting client confidentiality is the most critical portion of the program, and was discussed regularly in regards to the client intake forms, the location of counseling sessions, and any/all reporting about the clients and services offered.
- There should be no ambiguity in the boundaries of legal and ethical obligations. It is important that all key stakeholders discuss and define these at the outset to have clarity about these issues, particularly around interventions. All key stakeholders should meet before implementing any programming. Information can be shared and communicated which defines what is legally and ethically shared about anyone participating in public community wellness programs and /or private counseling sessions.
- The grant funds were a critical factor in the success of the pilot program because it allowed the site to contract with a mental health professional and offer consistent reliable services with accountability. Without the financial resources of the grant, it would not have been possible for over 100 clients to be seen once, let alone repeatedly over a period of time. Resources to pay mental health professionals, trainers and speakers also enhances the caliber of programs. When expanding this model, additional financial support for a social worker can be quite useful for case management.
- Creating a Community Resource Team with staff and volunteers who are already a part of the site of delivery can make communication and participation easier.
- The Community Resource Team was designed to include a clergy member, a youth coordinator, an administrator/board member and specialized professionals (mental health professional, social worker, attorney, parent advocate) to be available for a multi-dimensional group approach and for client referrals. Expanding this group to

include other providers of related content could be advantageous for community building and creating resilient-informed communities. Specifically, adding content relevant providers such as a social worker or legal expertise would add value to the CRT.

- The Community Resource Team would be better served to have a three-tier system rather than a single team. The first tier would consist of the original CRT group. A second tier would be made up of key people who need to be notified in urgent and emergent consultations and situations, and may include: a legal professional, a board member from the site, and a psychotherapist or psychologist. A third tier would be made up of specialized professionals who can assist community members in need with social services, such as finding employment, housing and food. This would be helpful for referrals related to client needs that come out of a CRT discussion of community members' needs. Additionally, the CRT may benefit from having access to an individual with law enforcement experience, who can provide consultation as needed for community members and/or clients who maybe facing challenges in this area or may require referral.
- Additional funding generated from community members served through client / intervention services should be considered by any population utilizing the Safe Spaces model to sustain its program. Like the theory of nonprofit model, it is important to have community buy-in not only in acceptance of services, but also financial support of them. When clients receiving behavioral and mental health services have even a minimal financial responsibility, they tend to remain committed to the work or treatment. A sliding fee scale can be used to ensure that no one is turned away for financial hardship.
- Some investment in evidenced-based assessments during client / intervention sessions that can demonstrate the efficacy of the program might be useful, if deemed relevant and appropriate for the therapeutic setting.
- Design a custom evaluation tool. Create a pre- and post- survey of community stakeholders to assess their attitudes toward community wellness and self-care, open dialogue and their community's willingness to engage in such activities or seek or mental/behavioral health services.
- For some communities, having accessible services on-site is crucial to the development of and expansion of services in the Safe Spaces model. It was helpful to many or even most of those served in the pilot program because it was convenient and, for some, the mosque location provided cover to utilize services. However, it is dependent on the individual and the community. It was a detraction when individuals believed by having services at the mosque would compromise their privacy. Allocated private, unlabeled space for client services within the site also supports their privacy and confidentiality.

Working with the Muslim Population

- Buy-in from mosque leadership is important in implementing programming at any mosque. Attempts to create buy-in tend to work best when done in a one-to-one setting.

Many Muslims comes from cultures which emphasize human connection by face-to-face interactions.

- Funding is better received by most Muslim communities when they come from foundations and local government for the purpose of providing social and mental health services. They are less inclined to support such programs when they are funded through law enforcement agencies, federal or local. Identifying financial support from local communities, private donors and/or foundations are important steps which should be pursued.
- Community wellness programs should be offered across a range of programmatic spaces, including adult education, youth group, sermons, workshops, and community service. The Let's be Honest Forum uncovered new issues every time it was offered, and is a valuable approach to both modeling and fostering civil dialogue on sensitive subjects from diverse perspectives. Including panelists with diverse professional and social experiences is critical for modeling civil dialogue and diversity of opinions.
- Having the Community Resource Team members all be Islamic Center staff made the conversations immediate and actionable, since key decision makers were on the team.

Conclusion

Overall, the Safe Spaces L.A. pilot program developed a successful proof of concept through a quasi-experimental observation of measuring increased participation in services over a period of six months. Through the duration of the pilot program, promotion, prevention and treatment/intervention services were offered as described by the Substance Abuse and Mental Health Services Administration (SAMHSA) behavioral health model.

Observation of increased utilization suggests success in the intended program outcomes. This needed to be quasi-experimental and data driven to protect the confidentiality of the community members. It was clear that these services made a tangible difference in the ICSC, evidenced by the desire of the community to sustain services not previously offered or sustained and also to expand on them.

This was accomplished utilizing and implementing culturally competent promotion/prevention and treatment/intervention services that have been held in multiple locations on-site and offsite, as ICSC events. It subsequently led to the establishment of monthly wellness/self-care themed days. Community members who did not share their personal challenges previously within the mosque, now participate in both community wellness programs (promotion/prevention) and client counseling services (treatment/intervention).

New referrals and cases appeared on a weekly basis. After every promotion/prevention program, multiple participants asked how they can have more promotion/prevention programming or client counseling services. Sometimes they inquired for others within the community who need client counseling services also. This can be expected when the services offered are congruent with cultural and spiritual cues, as evidenced by much research conducted in psychology, psychotherapy, marriage and family therapy and systems theory.

Despite the early hesitancy of the broader community to embrace this program, the ICSC community members have seen benefit and would like it to continue. Without this program, most of the participants would not be able to afford care nor would they avail themselves of public services they do not trust. To suggest that they just avail themselves of services from governmental agencies such as the Department of Mental Health neglects the very tangible and sometimes intangible reality of epistemic trust that is necessary for some, if not most, participants who were a part of this pilot program.

Epistemic trust was developed by providing culturally competent prevention and intervention strategies and treatment. Fonagy & Allison (2014) asserted that epistemic trust is created with

community members by creating attachments with people who may have insecure attachments through familiarity with cultural cues and understanding what is meaningful to a given people. Helping people who are facing challenges helps *everyone*, since healthy, whole people generally do not engage in actions that are destructive towards themselves or others. Meeting people where they are socially, spiritually, mentally is essential for the wellness not just of individuals but also of society at large.

Supporting community wellness through programs and services is appreciated by community members, which is best accomplished with mental health professionals and educational programs. Understandably, community members do not view these services favorably when they are offered through a national security lens. Although law enforcement has taken a service role in some communities, its priority is maintaining law and order. A law enforcement-based approach fails to create change, and is primarily based on the concept that the probability and severity of punishment deter crime (Garoupa, 1997). Although there has recently been a movement toward community-based policing in order to create change, a different more flexible model is required that allows change to occur, especially for populations having experienced trauma (Van Der Kolk, 2014). Health-based community-led models allow for change to occur (Salsberg et. al, 2015; Minkler & Wallerstein, 2011; Wilson & Yoshikawa, 2007). The success of the Safe Spaces L.A. program and programs which may be modeled on it in the future would do well to focus on being community-led and community-centered through a public health and community wellness lens.

As this pilot program proceeded, another local Los Angeles Muslim community expressed interest in the program. Implementing the same foundational pieces of the Safe Spaces model can be replicated across other communities, as well. The model is based on building healthy communities, as explained in the SAMHSA behavioral trajectory model. Many communities feel disenfranchised in our current American landscape. Those who feel a sense of injustice, loneliness, alienation and/ or who seek violence through group identification (e.g. gangs, ISIS, neo-Nazis groups) often do out of a sense of a lack of belonging or nihilism. Offering the ability to build healthy communities to identify with, be a part of and work through an individual's issues can provide an alternative to addressing the nation's problems with violence and aggression.

When we support individuals in their journey for a happy and productive life, we also support in our collective well-being. As the old saying goes, "Hurt people hurt people." On the other hand, it's also true that "helped people help people" and "healed people heal people." The Safe Spaces model is one promising approach to promoting and supporting wellness at the local level.

References

Bowlby, J. (1980). Loss: sadness and depression. London, UK: Hogarth Press and Institute of Psycho-Analysis.

Csibra, G., & Gergely, G. (2009). Natural pedagogy. *Trends in Cognitive Sciences, 13,* 148-153.

Csibra, G., & Gergely, G. (2011). Philosophical transactions of the Royal Society of London Series B, Biological Sciences.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy, 51*(3), 372-380.

Garoupa, N. (1997). The theory of optimal law enforcement. *Journal of Economic Surveys, 11*: 267-295.

Green-Hennessy, S., & Reis, H. T. (1998). Openness in processing social information attachment types. *Personal relationships*, 5, 449-446.

Laird, H. (2017). Creating a positive change in attitudes toward psychotherapy and mental illness and reducing stigmas in the American Muslim community. (unpublished)

Laird, H. (2017). Genograms and the American Muslim community. (unpublished)

Mikulincer, M. (1997). Adult attachment style and information processing: Individual differences in curiosity and cognitive closure. *Journal of Personality and Social Psychology, 72*(5), 1217-1230.

Salsberg, J., Parry, D., Pluye, P., Macridis, S., Herbert, C. P., & Macaulay, A. C. (2015). Successful strategies to engage research partners for translating evidence into action in community health: A critical review. *Journal of Environmental and Public Health.*

Van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York: Viking.

Appendix

Heather R. Laird, MFTi #90017
Joseph L. Futerman, PhD, LMFT, supervisor
424-354-8095
617 W. 7th Street | Suite 821 | Los Angeles, CA 90017

Informed Consent for Psychotherapy or Consultation

Name_____ Date of Birth_____

Birthplace_____ SSN_____

Cell Phone_____ Home Phone_____

Address_____

City_____ Zip Code_____

Current Medication/s_____

Physician_____ Psychiatrist_____

In case of emergency, please contact:

Name_____ Relation_____

Phone/s_____

Name_____ Relation_____

Phone/s_____

Cancellation Policy: If you miss or cancel an appointment without at least 24 hours notice, you will be responsible for full payment.

Confidentiality: All information disclosed in sessions is confidential. No information will be revealed to anyone without your written permission unless disclosure is required by federal and state law. State law and professional ethics require therapists to maintain confidentiality except for the following situations:

1. If there is suspected abuse or neglect of a child, elder, or dependent adult.
2. "Tarasoff" situations in which serious threat to a reasonably well-identified victim is communicated to the therapist.
3. If I have reasonable cause to believe you are a danger to yourself, I may be obligated to take protective measures such as seeking hospitalization or contacting family or others who can help provide protection.
4. If you are required to sign a release of confidential information by your medical insurance.
5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. **Think carefully and consult with an attorney before you sign away your rights.**
6. Clients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. Secrets cannot be kept by the therapist from others involved in your treatment process.
7. I may at times speak with professional colleagues about our work without asking permission, but your identity will be disguised.
8. Clients under 18 do not have full confidentiality from their parents.
9. Other potential limits to confidentiality:
    - All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files but some are stored in secured electronic devices.
    - Cell phones, portable phones, faxes, and e-mails are used on some occasions.
    - All electronic communication compromises your confidentiality.

Fees: Your fee is covered by a grant provided by the Muslim Public Affairs Council, which received funding from the City of Los Angeles' Public Safety office. No payment is expected at each session. However, if this grant ends, and new payment arrangements are needed, the full fee for sessions is between $150-250. Telephone calls may be charged at the same rate as personal consultation plus any telephone company charges. I will always inform you prior to charging you for telephone contact. Cost of living increases may occur on an annual basis.

*Note alternate fee arrangement: _____

_____

_____

Availability: I am available for regularly scheduled appointment times. Dates of vacations and other exceptions will be given out in advance if possible. Telephone appointment times can be arranged if necessary.

Emergency service can be obtained from the following resources:
By calling 911
Suicide Prevention Center 1-310-391-1253
Domestic Violence Hotline 1-800-978-3600
Rape Crisis Hotline 1-310-392-8318

Termination of Treatment: The therapist may terminate treatment if payment is not timely, if the treatment plan is not followed (if client continues to engage in dangerous practices, comes to sessions inebriated, etc.), or if some problem emerges that is not within the scope of competence of the therapist. The usual minimal termination for an ongoing treatment process is three to six sessions but a satisfying termination to long-term work may take longer.

Clients are urged to consider the risks that major psychological transformation may have on current relationships and the possible need of psychiatric consultation during periods of extreme depression or agitation. Not all people experience improvement from psychotherapy. Therapy may be emotionally painful at times. Patients have the right to refuse or to discontinue services at any time.

Agreement for Psychotherapy Consultation

I have read this informed consent completely and have raised any questions I might have about it with my therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations.

I understand that my therapist is responsible for maintaining all professional standards set forth in the ethical principles of her professional association as well as the laws of the state of California governing the practice of psychotherapy and that she is liable for infractions of those standards.

I understand that I will be fully responsible for any and all legal and/or collection costs arising as a result of my contact with my therapist, including appropriate compensation for her time involved in preparing for and doing court work.

I understand that my therapist may occasionally make teaching and research contributions using disguised client material. By consenting to treatment I am giving consent to this process of professional contribution and the right to use disguised material without financial remuneration.

This agreement constitutes the entirety of our professional contract. Any changes must be signed by both parties. I have a right to keep a copy of this contract.

Client Signature	Date
Heather Laird, MFTi	Date

Informed Consent for Telephone, Electronic, and Mail Contact

Important Note: Ordinary privacy precautions such as voice scramblers, pin codes, voice mail boxes, and locked fax, mail, and computer rooms are by no means foolproof, so that ***your confidentiality is always compromised*** when communicating by electronic devices or mail. Nor is deletion or shredding of private material a totally safe means of disposal, so that you are always at risk of breaches in confidentiality when electronic or mail communication of any type is used for private information. Your use of such means of communication with your therapist or consultant constitutes implied consent for reciprocal use of electronic and mail communication as well.

It is the consensus of mental health professionals that reliable and valid psychotherapy and consultation are ***always*** conducted in a face-to-face setting, so that nonverbal communications can be taken into consideration. Body language, voice tone, pacing, emotional overtones, eye contact, and other variables are an important part of counseling or psychotherapeutically oriented professional services. However, there may be times or circumstances under which telephone, e-mail, postal, or other kinds of communication may have a limited value, such as:

1. Brief, between-session contact calls, e-mail, or mail messages.
2. Long distance communication when either party is out of town or otherwise unavailable.
3. Long distance communication when therapy seems near its natural termination and either party relocates, making regular standard sessions impossible. Electronic communication is *always* incomplete without standard, agreed-upon, and periodic face-to-face contact.
4. Limited long distance consultation may be appropriate when specialty or expertise is an issue. However, considerations of reliability and validity without regular face-to-face contact necessarily limit the kinds of interventions the consultant can make to (1) general questions about the client's concerns, (2)

general theoretical considerations or advice, and (3) recommendations as to what kinds of professional consultation to seek locally.

I am aware of the limited validity and reliability of telephone and other kinds of electronic and mail communication as suggested above. I am further aware that I am not guaranteed confidentiality when I contact or receive such contacts from my therapist or consultant. I understand that the purposes for engaging in telephone, electronic, or mail communication must be limited in scope and time and that the validity and reliability of information given and received is necessarily limited. This consent supplements other or previous agreements.

Client Signature _____ Date _____

Therapist _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given to you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at 424-394-8095.

If you have any questions about my *Notice of Privacy Practices,* please contact me by phone at 424-394-8085, or at 617 W. 7th Street, Los Angeles, 90011.

I acknowledge receipt of the *Notice of Privacy Practices* of Joseph L. Futerman

Client Signature _____ Date _____