The Twelve Core Functions of the Substance Use Counselor

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603-528-6060

COURSE OUTLINE

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OVERVIEW

- The 12 core functions were developed back in 1980 by a small group of States trying to determine what functions a Substance Abuse Counselor needed to perform to be considered competent. In 1993, the Global Criteria was added to the Core Functions to help define more clearly what went into performing the Core Functions. These Core Functions and Global Criteria are recognized and used worldwide as guidelines in the Certification/Licensing of Substance Abuse Counselors.

I. SCREENING:

The process by which the client is determined appropriate and eligible for admission to a particular program.

Global Criteria:

1. Evaluate psychological, social, and physiological signs and symptoms of alcohol and other drug use and abuse.
2. Determine the client's appropriateness for admission or referral.
3. Determine the client's eligibility for admission or referral.
4. Identify any coexisting conditions (medical, psychiatric, physical, etc.) that indicate need for additional professional assessment and/or services.
5. Adhere to applicable laws, regulations and agency policies governing alcohol and other drug abuse services.

II. INTAKE:

The administrative and initial assessment procedures for admission to a program.

Global Criteria:

6. Complete required documents for admission to the program.
7. Complete required documents for program eligibility and appropriateness.
8. Obtain appropriately signed consents when soliciting from or providing information to outside sources to protect client confidentiality and rights.

David Parisi, LICSW, MLADC
Licensed Clinical Social Worker
Mastered Licensed Alcohol and Drug Abuse Counselor
Village West 603-528-6060
Post Office Box 7271
Gilford, New Hampshire 03247

DATE OF INTAKE_____

NAME _____ DOB _____ SEX _____

PARENT GUARDIAN _____ SS# _____

ADDRESS _____ MAILING _____

_____ _____

PHONE (HOME)_____ (WORK) _____

EMPLOYER_____ MARITAL STATUS _____

ADDRESS _____ REFERRAL SOURCE_____

_____ PHYSICIAN _____

INSURANCE INFORMATION

SPONSOR _____ COMPANY _____

CERT# _____ ADDRESS _____

GROUP#_____ _____

_____

EMPLOYER_____

PHONE _____

FEE_____

I understand that by signing this application, I am agreeing to treatment provided by David Parisi ACSW and hereby give permission for any and all necessary information to be provided to my insurance for the purposes of payment for services rendered by David Parisi ACSW. I also understand that if the insurance company does not cover or partially covers costs, that I am responsible for the balance.

SIGNATURE _____ DATE_____

WITNESS_____ DATE_____

Date of Contact _____ Caller_____

Name of Client _____ DOB _____

Address_____

Home Phone _____Work Phone _____Cell Phone _____

What kind of service being requested? _____

What is the precipitator? _____

_____

Court Ordered? _____Yes _____No

Who is referring you for services/ how did you hear about us? _____

_____

When are you available for appointments? _____

_____

Ins? ? _____Yes _____No Type of Ins _____

If DCYF referral for 2110, does client have Medicare, Medicaid, or other Ins? _____

Other questions depending on client presentation: _____

_____

Are you now or have you been involved in counseling anywhere else & if so where/when?

_____

For DWI clients-how many lifetime DWI's do you have? _____

What was your BAC? _____

Notes: _____

_____

_____

_____

_____

HORIZONS COUNSELING CENTER
PATIENT NOTICE

This notice describes how medical and drug and alcohol related information about you may be used and disclosed by HORIZONS COUNSELING CENTER and how you can get access to this information. Please read it carefully.

General Information

Information regarding your health care, including payments for health care, is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1966 (HIPAA), 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 C.F.R. Part 2. Under these laws, Horizons Counseling center (Horizons) may not say to a person outside Horizons that you attend the program, nor may Horizons disclose any information identifying you as an alcohol or drug abuser, or disclose any other protected information except as permitted by federal law.

Horizons must obtain your written consent before it can disclose information about you for payment purposes. For example, Horizons must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must sign a written consent before Horizons can share information for treatment purposes or for health care operations. However, federal law permits Horizons to disclose information without your written permission:

1. Pursuant to an agreement with a qualified service organization / business associate;
2. For research, adult or evaluations;
3. To report a crime committed on Horizons' premises or against Horizons personnel;
4. To medical personnel in a medical emergency
5. To appropriate authorities to report suspected child abuse or neglect;
6. As allowed by court order.

For example, Horizons can disclose information without your consent to obtain legal or financial services, or to another medical facility to provide health care to you, as long as there is a qualified service organization / business associate agreement in place:

Before Horizons can use or disclose any information about your health in a manner which is no described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

Your Rights

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. Horizons is not required to agree to any restrictions you request, but if it does agree then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

You have the right to request that we communicate with you by alternative means or at an alternative location. Horizons will accommodate such requests that are reasonable and will not require an explanation from you. Under HIPPA you have the right to inspect and copy your own health information maintained by Horizons except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPPA you also have the right, with some exceptions, to amend health care information maintained in Horizons records and to request and receive an accounting of disclosures of your health related information made by Horizons during the six years prior to your request. You also have the right to receive a paper copy of the notice.

Horizons' Duties

Horizons is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Horizons is required by law to abide by the terms of this notice. Horizons reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. Your counselor will give you a written copy of the revised notice at your first appointment following the change in the terms notice.

Complaints and Reporting Violations

You may complain to Horizons and the Secretary of the U.S Department of Health and Human Services if you believe that your privacy rights have been violated under HIPPA. You may make a complaint to Horizons by contacting the Director by phone or in writing. You can make an appointment with the Director to discuss your complaint and to attempt to resolve it. If you are unable to resolve your complaint with the Director, you may meet with a complaints officer from the Board of Directors designated by the President of the Board of Directors. You will not be retaliated against for filing such a complaint.

Violation of the Confidentiality Law by a program is a crime. Suspected violation of the Confidentiality Law may be reported to the U.S Attorney in the district where the violation occurs.

Contact

For further information, contact Jacqui Abikoff, Executive Director, 25 Country Club Road Suite 705, Gilford, NH 03249, 603-524-8005.

Effective Date

This notice became effective on April 14, 2003.

I hereby acknowledge that I have received a copy of this notice.

_____ _____

Signature Date

David Parisi, LICSW, LADC
Licensed clinical social worker
Licensed Alcohol and Drug Abuse Counselor
Village West 603-528-6060
Post Office Box 7271
Gilford, New Hampshire 03247

I _____ authorize _____
Program/agency

_____To disclose to _____ To receive from

_____
Program/agency

The following information:

_____Substance use/abuse history
_____Social history
_____History of psychiatric treatment
_____Course and results of treatment
_____Medication history
_____Psychiatric evaluations
_____Progress notes
_____Diagnostics summary and diagnoses
_____Psychological evaluations
_____Legal History
_____Intake summary/ assessment
_____Treatment plans
_____Discharge summary
_____Verbal exchange of information
_____ Evaluations (Substance abuse, mental health)

_____other: _____

_____**I understand that the information released may include information pertaining to substance abuse and or dependency**

_____ **I understand that the information released may include information pertaining to HIV infection, AIDS or tests for HIV**

The purpose of the disclosure authorized in this consent is:
_____

I understand that my alcohol/drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that my behavioral health records are confidential and protected from unauthorized disclosure. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent/ authorization shall be valid for one year from the date below and shall expire automatically one year from date below.

I understand that I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to sign consent form for a disclosure for other purposes.

I understand that prepayment for copies of my records as well as payment for services rendered may be required for copies of my record when released to anyone other than a medical provider, facility or institution.

I have read this release and understand its contents. I have also been provided a copy for this form.

_____ _____ _____
Client Signature DOB Date

_____ _____ _____ _____
Signature of Person Signing for Client Relationship to Client/ Authority to Sign Date

III. ORIENTATION:

Describing to the client the following: general nature and goals of the program; rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program; in a non-residential program, the hours during which services are available; treatment costs to be borne by the client, if any; and client's rights.

Global Criteria:

9. Provide an overview to the client by describing program goals and objectives for client care.
10. Provide an overview to the client by describing program rules, and client obligations and rights.
11. Provide an overview to the client of program operations.

IV. ASSESSMENT:

The procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of a treatment plan.

Global Criteria:

12. Gather relevant history from client including but not limited to alcohol and other drug abuse using appropriate interview techniques.
13. Identify methods and procedures for obtaining corroborative information from significant secondary sources regarding client's alcohol and other drug abuse and psycho-social history.
14. Identify appropriate assessment tools.
15. Explain to the client the rationale for the use of assessment techniques in order to facilitate understanding.
16. Develop a diagnostic evaluation of the client's substance abuse and any coexisting conditions based on the results of all assessments in order to provide an integrated approach to treatment planning based on the client's strengths, weaknesses, and identified problems and needs.

HORIZONS COUNSELING CENTER

390 Union Avenue
Laconia, New Hampshire 03246
603-524-8005

David Parisi, ACSW, CADAC Jacqui Abikoff, ACSW, CADAC

M.A.S.T.

MICHIGAN ALCOHOLISM SCREENING TEST

1.	Do you feel you are a normal (Social) drinker?	Yes	No (0)
2.	Have you ever awakened in the morning after drinking and found you could not remember parts of the evening before	Yes	No (2)
3.	Does your wife/husband/parents ever worry about or complain about your drinking?	Yes	No (1)
4.	Can you stop drinking without a struggle after one or two drinks?	Yes	No (2)
5.	Do you ever feel badly about your drinking?	Yes	No (1)
6.	Do you ever limit your drinking to certain times or places?	Yes	No (0)
7.	Do your friends/relatives think you are a normal drinker?	Yes	No (2)
8.	Are you always able to stop drinking when you want to?	Yes	No (2)
9.	Have you ever attended a meeting of Alcoholics Anonymous	Yes	No (5)
10.	Have you gotten into fights when drinking?	Yes	No (1)
11.	Has your drinking ever created problems between you and your spouse?	Yes	No (2)
12.	Has your spouse/family ever gone to anyone for help about your drinking?	Yes	No (2)
13.	Have you ever lost any friends because of drinking?	Yes	No (2)
14.	Have you ever gotten into trouble at work/school because of drinking?	Yes	No (2)
15.	Have you ever lost a job because of drinking?	Yes	No (2)
16.	Have you ever neglected your obligations, your family or your work for two or more days in a row because of drinking?	Yes	No (1)
17.	Have you ever been told you have liver trouble?	Yes	No (2)
18.	Do you ever drink before noon?	Yes	No (1)
19.	Have you ever had DT's (delirium tremens), severe shaking, heard voices or or seen things that weren't there after heavy drinking?	Yes	No (2)
20.	Have you ever gone to anyone for help about drinking?	Yes	No (5)
21.	Have you ever been hospitalized because of drinking?	Yes	No (5)
22.	Have you ever been a patient in a psychiatric unit when drinking was part of the problem?	Yes	No (2)
23.	Have you ever gone to a mental health clinic, doctor, counselor or clergyman with an emotional problem when drinking was part of the problem?	Yes	No (2)
24.	Have you ever been arrested, even for a few hours, because of drunken behavior	Yes	No (2)
25.	Have you ever been arrested for drunk driving (DWI)?	Yes	No (2)

M.A.S.T. Scoring:

Three points a warning of an alcohol problem.

Four points indicates a strong possibility of a drinking problem

Five points is indicative of a drinking problem which is interfering in one's life.

Ten points is indicative of alcoholism

Center for Behavioral Health

Intake Assessment- Bio-psychosocial History

[Ten (10) Pages]

(Complete each section in narrative form, addressing each identified item in each section)

Patient Name _____

Today's Date _____ Intake Date _____

Presenting Problem (Include patients reason for entry, referral system, self-identified problem and recent stressors)

_____

_____

_____

_____

_____

_____

_____

Medical Status (Include description of general health; history of present/past diseases, illnesses, accidents, surgeries, disabilities, nutritional problems, eating disorders, other known diagnoses, use of medications, primary care physician [name, address and phone number], insurance)

_____

_____

_____

_____

_____

*Current Medical Needs: _____

_____

_____

_____

_____

_____

Mental Health History (Include any past or current treatment or counseling episodes for mental health issues or problems: dates, lengths, types, medications taken, medication reactions, doctors / facility names; include history of suicide and/ or homicide ideation and attempts, abuse/ neglect history; gambling history and current activity)

_____
_____
_____
_____
_____

Is this a patient with a co-occurring disorder? Yes No (specify information-include diagnoses, date of diagnosis, doctor, psychotropic medications taken, behaviors of diagnosis, etc.)

_____
_____
_____

Current Mental Health Needs?

_____
_____
_____

Employment Status (Include past and current job history, employment type, lengths, special training / licenses) Reason left._____

_____
_____

***Current Employment Needs**:

_____
_____
_____

Legal Status (Include past history of arrest, convictions, time served in jail/ prison; current criminal justice involvement, pending legal cases, probation/ parole officer/ court information and names; court requirements)

_____
_____
_____

***Current Legal Status**: _____

_____

Family History (Include description of family of origin, locations and relationships with all family members; Include history of family substance use/abuse, current family substance abuse patterns, history of any known co-occurring disorders in the family; Include childhood relations with family, abuse history /ethnic variables, traditions in family.)

History of physical, sexual, or emotional abuse, history of domestic violence or witnessing of domestic violence:

Relationship History (Include past and present relationship history, marriages, divorces, separations, current living arrangements, drug use or domestic violence in relationship, sexual orientation, sexual identity, sexual problems or issues)

Children (Include ages, names, sex, legal status, physical location, medical/physical problems, current activities; Include current relationship with children)

Developmental History:

Military History (Include branch of service, length of service, discharge type)

_____

_____

Religious Preference (Include denomination and impact that belief system will have on recovery)

_____

_____

Social Activities (Include past and current social activities, changes in time spent in activities, time spent alone or with others; Include favorite past times (i.e. sports, reading, etc.)

_____

_____

Abilities and Strengths of Patients (As reported by Patient) _____

_____

_____

Needs, Performances and Expectations for Treatment (As reported by Patient) _____

_____

_____

Immediate Referrals Given: _____

_____

Mental Status Exam:

Appearance (Describe): _____

_____

_____

Attitude towards Interviewer: (Check all appropriate)
Friendly _____ Hostile_____ Cooperative_____ Uncooperative _____
Over Friendly _____ Indifferent _____ Other_____

Behavior: (Describe)
Overactive _____ under active _____ Disorganized _____
Purposeful _____ other (describe) _____

Affect: (Check all appropriate)
Depressed _____ Elated _____ Labile _____ Appropriate _____
Inappropriate _____ Wide range _____ Shallow _____ Flattened _____
Afraid _____ Angry _____ Other _____

Thought Process (Check all appropriate)
Logical _____ Illogical _____ Tangential _____ Conversational _____
Confusing _____ Rambling _____ Pressured _____ Circumstantial _____
Slowed _____ Blocked _____ Mutism _____ Loose Association _____

Thought Content (Describe)
Normal _____
Abnormal _____
Delusions_____
Hallucinations_____
Preoccupations _____
Obsessions_____
Compulsions _____
Other _____

2. Orientated to: Time _____ Place _____ Person _____
Describe lack of orientation _____

3. Suicidal/ Self manipulation ideation: Yes _____ No _____

4. History of Injury to others: Yes _____ No_____
If yes, describe:
_____

Intellectual Functioning: Average _____ Above Average _____ Below Average _____

Memory: Can patient immediately recall three items that are said out loud by counselor?
Yes _____ No_____
If no describe: _____

Can Patient recall three previously stated Items – five minutes later?
Yes _____ No_____
If no describe: _____
_____

Recent Memory: Can patient describe recent meal content?
Yes _____ No_____
If no describe: _____
_____

Can patient identify when and where they were born?
Yes _____ No _____
If no describe: _____
_____

Can patient recall two previously asked questions?
Yes _____ No_____
If no describe: _____
_____

Can patient identify past historical information during the interview?
Yes _____ No_____
If no describe: _____
_____

Insight: (Check all appropriate) _____ None _____ Limited _____ Fair _____ Good
Judgment: (Check all appropriate) _____ None _____ Limited _____ Fair _____ Good
Describe:_____
Are you eating: (explain)
_____
Are you sleeping: (explain)
_____
Other notes:
_____
_____
DSM-V Diagnosis:

V. TREATMENT PLANNING:

Process by which the counselor and the client identify and rank problems needing resolution; establish agreed upon immediate and long-term goals; and decide upon a treatment process and the resources to be utilized.

Global Criteria:

17. Explain assessment results to client in an understandable manner.
18. Identify and rank problems based on individual client needs in the written treatment plan.
19. Formulate agreed upon immediate and long-term goals using behavioral terms in the written treatment plan.
20. Identify the treatment methods and resources to be utilized as appropriate for the individual client.

Clients Name: _____ Date_____

DOB: _____

#	Problem	Date	Goal	Plan

Signature: _____ Date: _____

VI. COUNSELING

(Individual, Group, and Significant Others): The utilization of special skills to assist individuals, families or groups in achieving objectives through exploration of a problem and its ramifications; examination of attitudes and feelings; consideration of alternative solutions; and decision making.

Global Criteria:

21. Select the counseling theory(ies) that apply(ies).
22. Apply technique(s) to assist the client, group and/or family in exploring problems and ramifications.
23. Apply technique(s) to assist the client, group and/or family in examining the client's behavior, attitudes, and/or feelings if appropriate in the treatment setting.
24. Individualize counseling in accordance with cultural, gender, and lifestyle differences.
25. Interact with the client in an appropriate therapeutic manner.
26. Elicit solutions and decisions from the client.
27. Implement the treatment plan.

BOMB SHELTER

16 yo female with a questionable IQ, HS dropout, pregnant.

36 yo female physician, known to be a racist.

65 yo male rabbi.

46 yo male concert violinist, Muslim, who served 7 years for dealing drugs.

39 yo female prostitute.

26 yo female architect and her 25 yo husband who spent the last 9 months in a psychiatric hospital, heavily sedated. They refuse to be separated.

32 yo male attorney who's homosexual

34 yo police officer with a gun which can not be taken from him, thrown off the force for brutality.

37 yo female chemist who is sterile

VII. CASE MANAGEMENT:

Activities which bring services, agencies, resources, or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contacts.

Global Criteria:

28. Coordinate services for client care.
29. Explain the rationale of case management activities to the client.

VIII. CRISIS INTERVENTION:

Those services which respond to an alcohol and/or other drug abuser's needs during acute emotional and/or physical distress.

Global Criteria:

30. Recognize the elements of the client crisis.
31. Implement an immediate course of action appropriate to the crisis.
32. Enhance overall treatment by utilizing crisis events.

IX. CLIENT EDUCATION:

Provision of information to individuals and groups concerning alcohol and other drug abuse and the available services and resources.

Global Criteria:

33. Present relevant alcohol and other drug use/abuse information to client through formal and/or informal processes.
34. Present information about available alcohol and other drug services and resources.

X. REFERRAL:

Identifying the needs of a client that cannot be met by the counselor or agency and assisting the client to utilize the support systems and community resources available.

Global Criteria:

35. Identify need(s) and/or problem(s) that the agency and/or counselor cannot meet.
36. Explain the rationale for the referral to the client.
37. Match client needs and/or problems to appropriate resources.
38. Adhere to applicable laws, regulations and agency policies governing procedures related to the protection of the client's confidentiality.
39. Assist the client in utilizing the support systems and community resources available.

XI. REPORT & RECORD KEEPING:

Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries and other client related data.

Global Criteria:

40. Prepare reports and relevant records integrating available information to facilitate the continuum of care.
41. Chart pertinent ongoing information pertaining to the client.
42. Utilize relevant information from written documents for client care.

XII. CONSULTATION WITH OTHER PROFESSIONALS IN REGARD TO CLIENT TREATMENT/SERVICES:

Relating with in-house staff or outside professionals to assure comprehensive, quality care for the client.

Global Criteria:

43. Recognize issues that are beyond the counselor's base of knowledge and/or skill.
44. Consult with appropriate resources to ensure the provision of effective treatment services.
45. Adhere to applicable laws, regulations and agency policies governing the disclosure of client-identifying data.
46. Explain the rationale for the consultation to the client, if appropriate.