The Twelve Core Functions of the Substance Use Counselor

DAVID PARISI LICSW, MLADC
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.
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: ______________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________
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 not 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 HIPAA 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 ____________________ Diagnostics summary and diagnoses
__________________ Social history ____________________ Psychological evaluations
__________________ History of psychiatric treatment ____________________ Legal History
__________________ Course and results of treatment ____________________ Intake summary/ assessment
__________________ Medication history ____________________ Treatment plans
__________________ Psychiatric evaluations ____________________ Discharge summary
__________________ Progress notes ____________________ Verbal exchange of information
__________________ other: ____________________ Evaluations (Substance abuse, mental health)

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 (HIPAA), 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.
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.
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
Patient Name

Today’s Date ___________________________ Intake Date ___________________________

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

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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)

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*Current Medical Needs: ____________________________

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**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—including 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.)

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

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__________________________________________________________________________________________________

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)

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__________________________________________________________________________________________________

__________________________________________________________________________________________________

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

__________________________________________________________________________________________________

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__________________________________________________________________________________________________

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__________________________________________________________________________________________________

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: ______________________________

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<th>Problem</th>
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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.
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.