Policy Title: 8001V.1 Assessment Procedures and Type of Care Policy
Patient Age Group: (X) N/A ( ) All Ages ( ) Pediatric ( ) Adult

Purpose:

The purpose of this policy is to outline the procedures for conducting initial and ongoing assessments at Centro Savila Behavioral Health Services. The policy will also describe the types of care to be provided to clients based on assessment outcomes, including the need for any further assessments or referrals to other providers. This process is aimed at ensuring that all clients receive appropriate, individualized care based on their specific mental health needs and treatment goals.

Scope:

This policy applies to all clinical staff and administrators involved in the assessment, intake, and treatment planning processes at Centro Savila. It governs the process for initial assessments, ongoing reassessments, and the determination of appropriate treatment interventions for clients.

Definitions:

1. **Initial Assessment:** A comprehensive evaluation conducted at the beginning of treatment to gather information about the client's mental health, medical history, social circumstances, and treatment goals. The initial assessment serves as the foundation for the development of a personalized treatment plan.
2. **Ongoing Assessment:** Regular evaluations conducted throughout treatment to monitor the client's progress, assess the effectiveness of interventions, and adjust the treatment plan as necessary.
3. **Comprehensive Assessment:** An in-depth assessment that may include standardized diagnostic tools, mental health screenings, substance use assessments, and psychosocial evaluations to determine the client's mental health needs and diagnosis.
4. **Type of Care:** The specific mental health or behavioral health services offered to a client based on the results of their assessment. This can include individual therapy, group therapy, case management, and other clinical interventions.
5. **Referral for Further Assessments:** The process of recommending or referring a client for additional evaluations if needed. This may involve referrals to specialists (e.g.,

psychiatrists, substance use counselors, or medical professionals) or for specific diagnostic tests if indicated during the initial or ongoing assessment process.

Policy:

Centro Savila is committed to providing comprehensive, individualized care to all clients based on thorough and accurate assessment procedures. This policy ensures that assessments are performed in a structured, consistent, and ethical manner, and that clients are provided with the most appropriate treatment options based on the results of these assessments.

Key Objectives of the Assessment Process:

1. To gather sufficient clinical information to formulate a complete understanding of the client's needs, challenges, and goals.
2. To identify appropriate and individualized care and treatment options based on the client's assessment results.
3. To identify the need for any further assessments, referrals, or specialized care that may be necessary.
4. To regularly reassess clients during treatment to track progress, adjust interventions, and ensure continued care that is responsive to the client's evolving needs.

Procedure:

1. Initial Assessment Procedures:

- **Scheduling the Assessment:**
  - Once a client requests services, an intake appointment will be scheduled with a qualified clinician (licensed therapist, counselor, or case manager).
  - During the scheduling process, the client will be informed of the necessary documentation to bring, such as identification, insurance information, and any relevant medical or psychological records.
- **Components of the Initial Assessment:** The initial assessment is comprehensive and typically includes:
  - **Presenting Problem:** Understanding the reason the client is seeking services (e.g., depression, anxiety, trauma, substance use).
  - **Mental Health History:** A review of the client's mental health history, including any previous diagnoses, treatments, hospitalizations, and medications.
  - **Physical Health and Medical History:** Understanding any medical conditions that may affect the client's mental health (e.g., chronic illness, neurological conditions).
  - **Substance Use History:** Assessing any current or past substance use issues, including alcohol, drugs, and other substances.

    - **Psychosocial Evaluation:** Assessing the client's relationships, family history, social supports, employment, and any major life stressors (e.g., divorce, job loss, trauma).
    - **Risk Assessment:** Identifying any immediate safety concerns, including suicidality, self-harm, or harm to others.
    - **Functional Assessment:** Understanding the client's daily functioning, including their ability to engage in work, school, social activities, and self-care.
    - **Strengths and Resources:** Identifying the client's personal strengths, support systems, and coping strategies.
- **Assessment Tools:**
    - The clinician may use standardized diagnostic tools (e.g., depression/anxiety inventories, substance use screenings) to assist in the assessment process and ensure consistency and accuracy in diagnosis.
- **Development of Treatment Plan:**
    - Following the initial assessment, a treatment plan will be developed in collaboration with the client. The treatment plan will include:
        - Specific goals for treatment (e.g., reducing symptoms of depression, managing anxiety).
        - Interventions to be used (e.g., cognitive-behavioral therapy)
        - Estimated duration of treatment and frequency of sessions.
        - Any referrals or additional assessments needed (e.g., psychiatry, substance use treatment).

2. Ongoing Assessment Procedures:

- **Regular Reassessment:**
    - Ongoing assessments will be conducted periodically throughout the course of treatment. These assessments are designed to:
        - Monitor progress toward treatment goals.
        - Evaluate the effectiveness of interventions.
        - Make necessary adjustments to the treatment plan.
        - Assess any emerging needs or concerns (e.g., new symptoms, life changes).
    - The frequency of ongoing assessments will depend on the client's needs, but will typically occur at least every 3-6 months, or more frequently if needed.
- **Standardized Follow-Up Assessments:**
    - Clinicians will use standardized tools to assess treatment progress and outcomes. This may include symptom rating scales, client self-report questionnaires, and feedback from the client regarding their treatment experience.
- **Adjusting the Treatment Plan:**
    - If progress is not being made or if new issues arise during the ongoing assessment, the clinician will collaborate with the client to adjust the treatment plan. This may involve:
        - Changing therapeutic interventions (e.g., switching to a different modality of therapy).

        - Referring to additional resources (e.g., psychiatric consultation for medication evaluation, community resources for housing or employment assistance).
        - Reassessing the frequency of sessions or type of care needed.

3. Referral for Further Assessments:

- **Identifying the Need for Additional Assessments:**
    - During the assessment process, the clinician may determine that further evaluation is necessary. This may include:
        - **Psychiatric Evaluation:** If there is a need for a more in-depth evaluation for medication management or diagnosis of a serious mental health condition.
        - **Substance Use Assessment:** If substance use is identified as a concern and more specialized treatment is indicated.
        - **Medical Assessment:** If the clinician believes there may be underlying medical conditions affecting the client's mental health.
        - **Trauma or Abuse Evaluation:** If history or indications of trauma or abuse emerge during the assessment that require specialized intervention.
- **Making Referrals:**
    - If additional assessments are necessary, the clinician will work with the client to facilitate referrals to appropriate specialists, whether internal or external to the organization.
    - A referral may involve providing the client with the contact information of a specialist, coordinating with the referral provider, or assisting the client in scheduling an appointment.

4. Documentation and Confidentiality:

- **Accurate Record-Keeping:**
    - All assessments, including initial assessments, ongoing evaluations, and any referrals, will be documented thoroughly in the client's record.
    - Documentation will include:
        - The findings of the assessment.
        - The type of care provided.
        - The treatment goals and plan.
        - Any referrals or recommendations for further assessments.
- **Confidentiality:**
    - All assessment information will be kept confidential in accordance with HIPAA regulations and Centro Savila's confidentiality policies. Only those involved in the client's care will have access to assessment data, and all client records will be securely stored.

Staff Responsibilities:

1. **Clinical Staff (Therapists, Counselors, Psychiatrists):**
    - Conduct thorough and accurate assessments at the beginning of treatment and throughout the treatment process.
    - Develop treatment plans based on assessment findings, incorporating client input and goals.
    - Regularly reassess client progress and adjust treatment plans as necessary.
    - Refer clients to specialists for further assessments when indicated.
2. **Administrative Staff:**
    - Schedule initial assessments and ensure clients are informed of what to expect during the process.
    - Ensure that necessary documentation (e.g., intake forms, insurance information) is collected prior to the assessment.
3. **Supervisors and Clinical Managers:**
    - Oversee the assessment and treatment planning processes to ensure quality care.
    - Review cases where clients may need additional assessments or referrals and assist with coordination.

Client Rights:

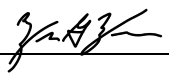
- Clients have the right to be informed of the assessment process, including the types of care to be provided, the goals of treatment, and any further assessments or referrals that may be needed.
- Clients have the right to participate in their treatment planning and to provide feedback on their progress and any concerns regarding their treatment.

Policy Review:

This policy will be reviewed annually or as needed based on regulatory changes, best practices, or feedback from staff and clients.

Approved by: William G. Wagner, Executive Director
Date: 11.12.24

Signature:

Item	*Date*	*Signature*
Executive Director	11/12/2024	

Deputy Director	11/14/2024