Policy Title: 8004V.1 Assessment Procedures for Identifying Reasons for Admission or Treatment
Patient Age Group: (X) N/A ( ) All Ages ( ) Pediatric ( ) Adult

Purpose:

The purpose of this policy is to establish standardized procedures for determining the reason(s) a client is seeking admission to or treatment at Centro Savila. Understanding the client's reason for admission is essential to ensuring that the services provided meet their unique needs, facilitate appropriate treatment planning, and guide the allocation of resources. This policy aims to ensure that each client's presenting concerns are thoroughly assessed, and that they are matched with the most appropriate level of care.

Scope:

This policy applies to all clinical staff involved in the intake, assessment, and treatment planning process at Centro Savila Behavioral Health Services. The policy outlines the steps for evaluating the reasons for a client's admission and guides clinical decision-making for treatment appropriateness and planning.

Definitions:

1. **Reason for Admission or Treatment:** The primary issue, concern, or set of circumstances that leads an individual to seek behavioral health services. This includes mental health symptoms, emotional distress, behavioral problems, social challenges, or other life stressors affecting the client's overall functioning.
2. **Presenting Problem:** The specific issue the client is presenting during the intake assessment. This could include mood symptoms (e.g., depression, anxiety), behavior issues (e.g., substance use, aggression), relational problems (e.g., family or work stress), or trauma-related concerns.
3. **Clinical Need:** The extent to which a client requires behavioral health interventions to address the presenting problem and achieve stabilization, improvement in symptoms, and overall functioning.
4. **Admission Criteria:** The criteria used to assess whether a client's needs align with the services offered at Centro Savila, including clinical need, urgency of care, appropriateness for outpatient vs. inpatient care, and the resources available.

Policy:

Centro Savila is committed to providing client-centered care. A thorough understanding of the **reason for admission or treatment** is essential in developing a tailored treatment plan that addresses the client's individual concerns. The reason for admission will guide the clinical assessment, determine the level of care required, and inform treatment planning.

Key Areas of Assessment:

1. **Presenting Problem:**
    - The client's primary reason for seeking treatment will be explored during the intake process. This includes gathering detailed information about:
        - **Psychological Symptoms:** For example, depression, anxiety, trauma responses, mood swings, or emotional distress.
        - **Behavioral Issues:** These may include substance use (e.g., alcohol or drug use), self-harm, aggression, or impulsivity.
        - **Social Stressors:** These may involve relationship issues, family conflict, employment stress, or financial difficulties.
        - **Recent Life Events or Crisis:** Significant events such as loss of a loved one, a traumatic experience, or major life transitions (e.g., divorce, relocation) may be impacting the client's mental health.
2. **Clinical Need for Services:**
    - After identifying the presenting problem(s), the clinician will assess the severity of the issue(s) and determine the clinical need. This includes:
        - **Impact on Functioning:** How the presenting problem(s) are affecting the client's ability to manage day-to-day tasks such as work, school, family life, and self-care.
        - **Risk Assessment:** If the client's presenting issue involves potential harm to themselves or others (e.g., suicidal ideation, self-harm, violence), a risk assessment will be conducted to determine the level of care and safety precautions required.
        - **Co-occurring Conditions:** Assessing if there are any co-occurring conditions (e.g., substance use disorders, medical conditions) that may require integrated or specialized care.
3. **Clinical Diagnosis and History:**
    - The clinician will assess the client's mental health history, including:
        - **Previous Diagnoses or Treatments:** Any prior diagnoses (e.g., depression, PTSD, bipolar disorder) or treatments (e.g., therapy, hospitalization, medications).
        - **Family History:** A review of any family history of mental health conditions, substance use, or other behavioral health issues that may be relevant.

        - **Medical History:** A review of any medical conditions (e.g., chronic illness, neurological issues) that might affect mental health or require coordinated care.
4. **Social and Environmental Factors:**
    - Clinicians will assess external factors influencing the client's mental health. These can include:
        - **Social Support:** The availability of family, friends, or community support systems.
        - **Housing and Financial Stability:** Any concerns about homelessness, unstable housing, or financial stress.
        - **Work or School Stress:** The impact of job-related stress, unemployment, or academic challenges.
        - **Cultural Considerations:** Any cultural, ethnic, or religious factors that may influence the client's treatment or need for specialized approaches.
5. **Urgency of Care:**
    - The reason for admission will also determine the urgency of treatment. Clients may be categorized into:
        - **Emergent:** Clients in crisis or at imminent risk of harm to themselves or others will be referred for immediate intervention or higher levels of care if necessary (e.g., inpatient or emergency psychiatric care).
        - **Non-Emergent, But Urgent:** Clients who require prompt but not immediate care, such as those experiencing significant emotional distress or behavioral symptoms that affect their functioning but do not pose immediate danger.
        - **Routine:** Clients who present with concerns that are less time-sensitive but still require professional intervention, such as ongoing therapy for mild to moderate mood disorders or life stressors.

Procedure:

1. Initial Intake Appointment:

- **Scheduling:**
    - Clients can access services through self-referral, referral from another healthcare provider, or through community-based referrals. Intake staff will schedule an appointment and ensure clients complete necessary forms before the assessment.
- **Client Information Collection:**
    - Administrative staff will collect basic demographic information, insurance details (if applicable), and client consent forms. Clients will be asked to complete an intake questionnaire that helps identify their reasons for seeking treatment, as well as any immediate needs or concerns.
- **Initial Assessment by Clinical Staff:**
    - During the first clinical session, the clinician will:

        - **Explore the reason for admission:** The clinician will ask open-ended questions to better understand the client's presenting problems and the circumstances that led them to seek services.
        - **Assess the severity and impact of the issue(s):** The clinician will explore how the presenting problems affect the client's daily life, mental health, and overall functioning.
        - **Identify risk factors:** If relevant, the clinician will assess for suicidal ideation, self-harm, or harm to others, and develop a safety plan if necessary.

2. Clinical Need Assessment and Determination of Treatment:

- **Severity and Suitability for Services:**
    - Based on the intake assessment, the clinician will evaluate whether the client's needs align with the services provided at Centro Savila. For example:
        - **Outpatient Therapy:** If the client's symptoms are manageable with outpatient therapy (e.g., individual or group therapy), they will be scheduled for appropriate follow-up appointments.
        - **Intensive Outpatient Program (IOP) or Case Management:** If the client has more complex needs, such as co-occurring disorders (e.g., substance use and mental health conditions), an IOP or case management services may be recommended.
        - **Referral to Higher Level of Care:** If the client requires more intensive care, such as inpatient care or a psychiatric hospitalization, the clinician will assist the client in obtaining a referral to an appropriate facility.
- **Admission Decision:**
    - The clinical team will make a decision on admission based on the comprehensive assessment of the client's reason for treatment, clinical need, and available resources. This decision is made with a client-centered approach, considering the client's treatment preferences and goals.

3. Treatment Planning:

- **Individualized Treatment Plan:**
    - After the initial assessment and determination of appropriate care, the clinician will work with the client to develop a tailored treatment plan. The plan will address:
        - The client's **presenting problem(s)** and clinical goals.
        - **Treatment modalities** (e.g., psychotherapy, psychiatric care, case management).
        - **Referrals to additional services** (e.g., substance abuse counseling, medical care).
        - A **timeline** for follow-up assessments and treatment progress.
- **Informed Consent:**
    - Before initiating treatment, the client will be provided with information about their treatment options, including the benefits and risks. The client will be asked to sign an informed consent form agreeing to the treatment plan and goals.

4. Ongoing Monitoring and Reassessment:

- **Periodic Reassessments:**
  - The client's progress will be monitored, and reassessments will be scheduled periodically to ensure the treatment plan is effective. Adjustments to the plan will be made as needed based on changes in the client's condition, new stressors, or challenges.
- **Collaborative Care:**
  - If applicable, the clinical team will coordinate with other healthcare providers (e.g., medical doctors, psychiatrists, case managers) to ensure that the client's care is comprehensive and integrated.

Staff Responsibilities:

1. **Clinical Staff (Therapists, Psychiatrists, Case Managers):**
   - Conduct comprehensive assessments to determine the client's reason for seeking treatment.
   - Assess the severity of the presenting problem(s), the client's clinical need, and the appropriate level of care.
   - Develop an individualized treatment plan in collaboration with the client.
   - Provide ongoing therapy, monitoring, and coordination of care.
2. **Administrative Staff:**
   - Schedule intake appointments and assist clients with the completion of necessary forms and questionnaires.
   - Ensure that consent forms and basic demographic information are collected before the assessment appointment.

Confidentiality:

All information gathered during the assessment process will be kept confidential in accordance with HIPAA regulations and Centro Savila's privacy policies. Clients will be informed of their rights to privacy and the limits of confidentiality, especially in cases involving safety concerns.

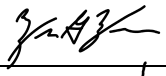
Client Rights:

- Clients have the right to understand the reasons for their admission and the treatment process.
- Clients have the right to participate in the development of their treatment plan.
- Clients can request referrals to other professionals or services if they feel their needs are not being met.

This policy ensures that Centro Savila delivers high-quality, individualized care that addresses the unique needs and reasons for admission or treatment of each client. By thoroughly assessing and understanding each client's concerns, we are able to provide the most appropriate and effective services.

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

Signature:

Item	*Date*	*Signature*
Executive Director	11/15/2024	
Deputy Director	11/14/2024