Policy Title: 8005V.1 Assessment Procedures and Documentation Policy
Patient Age Group: (X) N/A ( ) All Ages ( ) Pediatric ( ) Adult

Purpose:
The purpose of this policy is to establish clear procedures for the assessment process at Centro Savila. This policy ensures that assessments are conducted in a comprehensive, consistent, and clinically responsible manner while maintaining accurate documentation of relevant treatment history, therapeutic interventions, clinician identification, family involvement, and sources of clinical data.

Scope:

This policy applies to all clinical staff involved in the assessment process for clients receiving services at Centro Savila Behavioral Health Services, including but not limited to licensed clinicians, assessment specialists, and case managers.

Policy Overview:

Centro Savila Behavioral Health Services is committed to providing high-quality, client-centered care. In order to ensure comprehensive care, accurate clinical decisions, and effective interventions, detailed assessments are conducted and documented for each client. These assessments are foundational to determining appropriate treatment plans and monitoring progress throughout treatment.

Assessment Procedure:

1. **Client Intake and Initial Assessment:**
    - Upon initial contact, clients will be provided with appropriate intake documentation, which includes consent forms, privacy information, and relevant policies.
    - A comprehensive clinical assessment will be conducted by a licensed clinician to gather information regarding the client's presenting issues, mental health history, substance use history (if applicable), and psychosocial background.
    - The clinician will assess the client's current functioning, history of mental health or substance use treatment, and any factors affecting the client's overall wellbeing.

2. **Documentation of Previous Treatment Dates:**
    - **Previous Treatment History**: Clinicians must document the client's previous mental health or substance use treatment history, including dates of treatment, names of previous providers, and types of interventions received (e.g., psychotherapy, medication management, inpatient/outpatient treatment).
    - **Verification**: Wherever possible, prior treatment information should be verified with the client's previous treatment providers or by obtaining release of information consent to contact those providers.
    - **Progress or Outcomes**: Clinicians will document any relevant outcomes or progress made in prior treatment episodes, including any referrals or recommendations made by prior providers.
3. **Clinician Identification:**
    - All assessment documentation must include the full name, professional credentials (e.g., LCSW, LPC, LPCC, or other licensed clinicians), and the date of the assessment conducted.
    - Clinicians are responsible for ensuring that their documentation is accurate, clear, and signed with their credentials for accountability and transparency.
4. **Therapeutic Intervention and Client Responses:**
    - **Interventions**: Clinicians will document all therapeutic interventions or techniques used during the assessment and any follow-up recommendations. This includes, but is not limited to, trauma-informed care, family therapy, and others.
    - **Client Responses**: Documentation will include a clear description of how the client responded to each intervention, whether the interventions were effective, and any challenges faced during the initial phase of treatment.
    - **Treatment Recommendations**: Based on the assessment, clinicians will outline initial treatment recommendations, including the type of therapy, frequency, and any potential referrals (e.g., case management, family therapy).
5. **Sources of Clinical Data:**
    - **Self-Report**: The client's self-report during the assessment is the primary source of data regarding the client's presenting issues, history, and personal experiences.
    - **Collateral Information**: Whenever possible, clinicians will gather collateral information from relevant sources, including family members, past clinicians, medical professionals, or schools (with proper consent).
    - **Psychological Testing**: If relevant, results from standardized psychological assessments or screenings (e.g., GAD-7, etc.) will be included in the documentation.
    - **Medical Records**: If applicable, prior medical or psychiatric records will be reviewed and included in the documentation, with the appropriate releases signed by the client to allow sharing of information.
6. **Relevant Family Information:**
    - **Family History**: Clinicians will inquire about relevant family history, including any known mental health or substance use disorders, history of trauma, or significant relational issues within the family.
    - **Family Involvement**: When appropriate and with the client's consent, clinicians will involve family members in the assessment process to gather additional context and to better understand family dynamics that may impact treatment. This may

include conducting family sessions or gathering information from significant family members.
    - **Family Support**: Documentation will note the client's level of family support or involvement in their mental health treatment, including any family therapy recommendations.
7. **Assessment Review and Treatment Planning:**
    - Following the assessment, the clinician will review the collected data and formulate an individualized treatment plan in collaboration with the client.
    - The treatment plan should reflect the identified needs, goals, and the therapeutic modalities chosen for the client's treatment.
    - The treatment plan should be signed by the clinician and shared with the client, ensuring mutual understanding and agreement.
8. **Confidentiality and Record Maintenance:**
    - All assessment records must be maintained in a confidential and secure manner, in accordance with HIPAA regulations and other relevant state or federal laws.
    - Documentation should be stored in the client's electronic health record (EHR), with restricted access to authorized personnel only.
    - Assessment data will be reviewed periodically and updated in the client's treatment records as necessary.

Quality Assurance and Compliance:

- **Internal Review**: Clinical supervisors will regularly review documentation to ensure compliance with this policy and to monitor the quality of assessments and treatment planning.
- **Audits**: Random audits of clinical files may be conducted to verify adherence to assessment and documentation standards.

Policy Review:

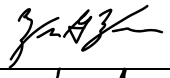
This policy will be reviewed annually by the Clinical Leadership Team at Centro Savila Behavioral Health Services to ensure it remains current with best practices, regulatory requirements, and the needs of the organization.

Approval:

This policy has been reviewed and approved by the Executive Director and the Clinical Leadership Team of Centro Savila.

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