**Quarterly Assessment Observation Form**

Care Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor (LCC): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Session status: Assessment Observation

**Pre-Assessment Observations**

* In addition to the assessment, what is the plan for this session?
* Did the CC explain the mission of the WFNJ SAI/ BHI program is and what we do?
* Did the CC ask the client if they knew why they were referred to us? In addition, what they would like from this meeting?
* How did the CC explain the assessment process and further explain our ASI assessment tool and the different sections we use in order to capture information?
* Was confidentiality, as well as the limits to confidentiality, reviewed with the client?
* Did the CC clearly explain that this is a WFNJ initiative and treatment counts towards their work activity requirement?
* Were the client’s rights clearly explained and HIPAA notification reviewed?

(If more than one EOC, the supervisor should ask the CC if they reviewed the client’s previous EOCs in preparation for this assessment.)

**Interpersonal Alliance and Competence**

* How did the CC develop a rapport with client and what skills were used to achieve that rapport? For example, communication style, instilling hope, friendliness, empathy, active listening, motivational interviewing strategies, etc.
* Did the CC pay attention to discrepancies during the ASI and what was done to clarify, e.g., asking other questions outside of ASI, probing, clarification, or confrontation.

**Assessment Documentation**

* In the Drug/Alcohol section was the CC able to capture a comprehensive picture of the client’s history and present substance use disorder? Did the CC utilize DSM indicators as a framework of questioning to accurately obtain a diagnostic impression, including abuse or dependence (use of specifiers)?
* In the Psychiatric section was the CC able to capture a comprehensive picture of the client’s psychiatric history and current symptoms? Did the CC appropriately assess for trauma, suicidal ideation, or the need for immediate crisis intervention? Did the CC utilize DSM indicators as a framework of questioning to obtain an accurate diagnostic psychiatric impression (use of specifiers)?
* In the Medical section was the CC able to identify untreated medical conditions or ailments that needed medical attention

**Review of Assessment with Client**

* How did the CC share the assessment findings and treatment recommendation with client? Were they clearly explained to the client? Did the CC work through the client’s reaction and readiness to change, was there appropriate use of MI techniques?
* Did the CC develop a mutually agreed upon clinical service plan with the client?

**Treatment Referral and Linkages**

* What did the CC do in order to help facilitate treatment for either inpatient or outpatient services? For example, calling providers, setting up phone screens, providing client with contact numbers, gave client business card, utilize initial contracts, provide recipient treatment form, and provide information about specific program or admission information, etc.
* Did the CC try to address clients other needs outside of SA/MH, such as DV issues, housing, employment, education? If so, did the CC provide resources, referral information, or community partnerships to help link them to services?
* If TANF and the client responded YES to “having a child with special needs,” did the CC ask if the child was receiving services? If client said NO, did the CC provide information to client, such as early intervention, head start program, Children’s Home Society, etc?
* If the assessment involved crisis intervention, what steps were taken by CC to ensure client safety?
* If a child safety issue was discovered, what did the CC do, or say, to the client to ensure child safety? Was a hotline call indicated? Did the CC seek DCP&P assistance with client, make phone call with client present, etc.
* What steps did the CC take to remain in contact with the client if the client was homeless?

**Post-Assessment**

* Was the recommended ASAM LOC congruent with the ASI severity ratings and comments?
* Was appropriate ASAM level of care determined and how did they come up with LOC?
* Was the CC able to formulate an appropriate D4 statement?
* Did the CC choose the appropriate diagnostic category?
* What steps did the CC take to remain in contact with the client if the client was homeless?