South Dakota Department of Social Services

Department of Social Services
Office of Licensing and Accreditation
3900 W Technology Circle, Suite 1
Sioux Falls, SD 57106

Program Name: Lewis & Clark Behavioral Health Services

Recommendations for Mental Health Services

The following administrative rules were found to be out of compliance in low numbers, or were in compliance, but the Office of License and Accreditation saw potential for future noncompliance and is recommending changes to procedure. In some cases, if recommendations are not corrected, they may become plans of corrections in the future.

Recommendation-1	
Rule #: 67:62:06:06 (3)	**Rule Statement: Personnel Policies and Records.** The agency shall maintain written personnel policies and records for all staff including provisions for equal employment opportunities. Each agency shall maintain a personnel file or record or both for each staff member including contracted staff, interns, or volunteers. The file includes the following: (3) The completion of appropriate pre-hire screening will be evident for staff that provide direct services to vulnerable populations.
Area of Noncompliance: There were no central registry (child abuse and neglect) screenings in employee files. The Office of Licensing and Accreditation recommends completing central registry screenings for each employee who works with youth under the age of 18.	

Clinical Recommendation-1	
Rule #: 67:62:08:07 (3)	**Rule Statement: Treatment Plan.** The initial treatment plan shall be completed within 30 days of intake and shall include the mental health staff's signature, credentials, and dates of signature, and the clinical supervisor's signature and credentials if the mental health staff does not meet the criteria of a clinical supervisor as defined in subdivision 67:62:01:01(08). Evidence of the client's or the client's parent or guardian's participation and meaningful involvement in formulating the plan shall be documented in the file. This may include their signature on the plan or other methods of documentation. The treatment plan shall: (3) Include interventions that match the client's readiness for change for identified issues.
Area of Noncompliance: Most reviewed mental health treatment plans contained a specific goal where the stated purpose was "readiness for change". However, nowhere on the treatment plan was the actual readiness for change listed. The Office of Licensing and Accreditation recommends stating the client's readiness for change somewhere in the treatment plan to ensure each goal is meeting the client's readiness for change.	

Plan of Correction Items for Mental Health Services

The following administrative rules were found to be out of compliance. In a State accreditation review, Administrative Rule requires a plan by the agency to bring these items into compliance in order for accreditation to be renewed. Failure to provide a plan could result in suspension or revocation of accreditation.

<table>
<tr><th colspan="3">Clinical POC-1</th></tr>
<tr><td>Rule #:
67:62:08:05
(3)</td><td colspan="2">Rule Statement: Integrated Assessment. A mental health staff member shall meet with the client and the client's family if appropriate, to complete an integrated assessment within 30 days of intake. The integrated assessment includes both functional and diagnostic components. For children under 18 years of age, the mental health staff shall obtain permission form the parent or guardian to meet with the child, and at least one parent or guardian shall participate in the assessment. The assessment includes the following components:

(3) Identification of readiness for change for problem areas, including motivation and supports for making such changes.</td></tr>
<tr><td colspan="3">Area of Noncompliance: Several reviewed integrated mental health integrated assessments had documentation of readiness for change, while others did not. Overall, the documentation of readiness for change in the reviewed integrated assessments was inconsistent.</td></tr>
<tr><td colspan="2">Corrective Action (policy/procedure, training, environmental changes, etc): We have added Readiness for Change as an individual section on the mental health assessment and made this a required field so the document cannot be signed without it being completed.</td><td>Anticipated Date Achieved/Implemented:

Date 7/25/2022</td></tr>
<tr><td colspan="2">Supporting Evidence: The revised assessment document has been attached</td><td>Position Responsible:
Brenda Hoxeng</td></tr>
<tr><td colspan="2">How Maintained: The verification of completion of the Readiness for Change will be added to the Quality Assurance report and reviewed quarterly.</td><td>Board Notified:
Y ☒ N ☐ n/a ☐</td></tr>
</table>

Signature of Agency Director: [redacted]	Date: 7/27/22

Please email or send Plan of Correction to:

Department of Social Services
Office of Licensing and Accreditation
3900 West Technology Circle, Suite 1
Sioux Falls, SD 57106

Email Address: DSSLicAccred@state.sd.us

The Department of Social Services, Office of Licensing and Accreditation has reviewed and accepted the above plan.

Signature of Licensing Staff: [redacted]	Date: [redacted] 7/25/22

LEWIS & CLARK BEHAVIORAL HEALTH SERVICES, INC.

Assessment

Client Name: **Client ID:**

Clinician Name: **Date:**

Assessment date:

Assessment type: (•) Initial ( ) Update ( ) Annual

Population type: (•) Adult ( ) Child

☐ DD ☐ SA ☑ MH ☐ Autism

Referral Type:

Current Living Arrangement:

Current Employment Status

Current Primary Care Physician:

Presenting problem:

Legal Issues:

Desired Outcomes of Service (Hopes and Dreams) As Specified By The Person/Guardian:

SU Assessment

Substance Use

- ☐ Past Substance use admitted or suspected
- ☐ Family has a history of substance use
- ☐ Client has a history of substance use
- ☐ Client admits to current substance use
- ☐ Current substance use is suspected

Comment

Details of substance Use

Substance Abuse Symptoms/Consequences (reported or observed)

- ☐ Odor of substance
- ☐ Slurred speech
- ☐ Withdrawal symptoms

RDLCustomSDLAssessment

- [ ] Increased Tolerance
- [ ] Blackouts
- [ ] Loss of Control
- [ ] Related arrests
- [ ] Related Social Problems
- [ ] Frequent Job/School Absence
- [ ] None

Other Comments

Periods of Abstinence:

How long did the abstinence last? Was the abstinence voluntary or involuntary? When was the last period of abstinence? Risk of withdrawal?

Gambling (Factors which contribute to gambling.)

Previous / Current Treatment

Previous Substance Use Treatment? ○ Yes ○ No

Current substance use treatment? ○ Yes ○ No

Previous medication assisted treatment? ○ Yes ○ No

Current medication assisted treatment? ○ Yes ○ No

List Providers

If current Substance Abuse symptoms, referral to SU or co-occurring Tx? ○ Yes ○ No

If Yes, where referred. If No, provide reason.

Is the client interested in medication assisted treatment?

○ Yes ○ No ○ Not applicable

If Yes, where referred. If No, provide reason.

Risk of Relapse:

- [ ] Add Substance Use Issues to Needs List

Psychosocial Adult

Family and Developmental History / Medical History (past and current relational and family situation) ○ Yes

- [ ] Add health issues to needs list

Medications ○ Initialize Medications ○ List Medications ○ No Medications ○ Unknown

- [ ] Add Medications to Needs List

RDLCustomSDLAssessment

List has been reviewed with client. Medication list needs to be modified. ○ Yes ○ No

Note efficacy of current and historical medications and their side effect:

Client experienced abuse or neglect either as victim or perpetrator and / or has had a previous traumatic incident? ○ Yes ○ No Concerns ○ Unknown

☐ Add Abuse / Neglect / Trauma to Needs List

test

Are there cultural / ethnic issues that are of concern or need to be addressed? Describe cultural / ethnic values / beliefs. ○ Yes ○ No Concerns ○ Unknown

☐ Add Cultural / Ethnic Values to Needs List

Work History and Current Employment

Educational Challenges/Barriers

☐ Add Education Status to Needs List

Please discuss any issues with school, number of schools attended, and current and past academic performance. Include highest level of education.

Mental health treatment history. List previous diagnosis, family history, treatment history / efficacy, etc. ○ Yes ○ No history reported ○ Unknown

☐ Add Mental Health History to Needs List

Please list previous diagnosis, family history, treatment history/efficacy, etc.

Customer is At risk of....

☐ Loss / lack of placement	Due to:	Behavioral Issues
☐ Loss of support?	Due to:	Behavioral Issues
☐ Expulsion from school?	Due to:	Behavioral Issues
☐ Hospitalization?	Due to:	Behavioral Issues
☐ Involvement with the criminal justice system?	Due to:	Behavioral Issues
☐ Elopement from home?	Due to:	Behavioral Issues
☐ Loss of financial status?	Due to:	Behavioral Issues

Communicable Disease Risk Assessment

Have you had any of the below factors that may have put you at risk for a communicable disease such as HIV/AIDs, STDs, Hepatitis B or C, or TB?

- Unprotected sexual relations with more than one partner during the past 24 months? ☐
- Sexual relations with anyone who is infected with HIV/AIDS, Hepatitis, or an STD? ☐
- Sexual relations with anyone who injects drugs? ☐
- Injected drugs or shared needles? ☐
- Received money, drugs, or other favors for sexual relations? ☐

☐ Add Communicable Disease Risk to Needs List

Anxiety

Have your feelings caused you distress or interfered with your ability to get along socially with friends or family? ○ Yes ◉ No

How often have you felt nervous, anxious, or on edge?

How often were you not able to stop worrying or controlling your worry?

How often is stress a problem for you handling such things as: Health, Finances, Family or Social Relations, Work

How often do you get the social and emotional support you need?

☐ Add Anxiety to Needs List

PHQ-9

PerformedDate:

PerformedTime:

Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

2. Feeling down, depressed, or hopeless

3. Trouble falling or staying asleep, or sleeping too much

4. Feeling tired or having little energy

5. Poor appetite or overeating

6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down

7. Trouble concentrating on things, such as reading the newspaper or watching television

8. Moving or speaking so slowly that other people could have noticed, Or the opposite - being so fidgety or restless that you were moving around a lot more than usual

9. Thoughts that you would be better off dead, or of hurting yourself

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Total Score : **Depression Severity :**

Comments :

Additional Question

Please check any of the following THAT WILL occur within 1 day of this PHQ9 Assessment

- ☐ Additional Evaluation For Depression Performed
- ☐ Referral For Depression Ordered
- ☐ Depression Medications Ordered
- ☐ Suicide Risk Assessment Performed
- ☐ Pharmacological Intervention
- ☐ Other interventions or follow-up for the diagnosis or treatment of depression

Documentation of follow-up plan

Did Client refuse assessment or was it Contraindicated ? ○ Yes ○ No

Supports

Support 1

- ○ Current ○ Not Current
- ☐ Paid Support ☐ Clinically Recommended
- ☐ Unpaid Support ☐ Customer desired

Mental Status

General Appearance

- ☐ Add to Needs List
- ☐ neat/clean ☐ poor personal hygiene/self care ☐ well-groomed ☐ appropriately dressed
- ☐ younger than stated age ☐ older than stated age ☐ overweight ☐ underweight
- ☐ eccentric ☐ seductive ☐ unkempt/disheveled ☐ other/comment

Intellectual Assessment

- ☐ Add to Needs List
- ☐ appears above average ☐ appears average ☐ appears below average ☐ possible IDD
- ☐ documented IDD ☐ other/comment

Communication

- ☐ Add to Needs List
- ☐ normal ☐ uses sign language ☐ unable to read ☐ need for Braille
- ☐ hearing impaired ☐ does lip reading ☐ English is second language
- ☐ translator (sign or spoken language) needed ☐ other/comment

Mood

- ☐ Add to Needs List
- ☐ unremarkable ☐ cooperative ☐ anxious ☐ tearful ☐ calm ☐ labile

☐ pessimistic ☐ cheerful ☐ guilty ☐ euphoric ☐ depressed
☐ hostile ☐ irritable ☐ dramatized ☐ fearful ☐ suspicious
☐ other/comment

Affect

☐ Add to Needs List
☐ primarily appropriate ☐ restricted ☐ blunted ☐ flattened ☐ detached
☐ primarily inappropriate ☐ other/comment

Speech

☐ Add to Needs List
☐ normal for age & intellect ☐ logical/coherent ☐ tangential ☐ sparse/slow
☐ rapid/pressured ☐ soft/mumbles/inaudible ☐ circumstantial ☐ loud
☐ rambling ☐ other/comment

Thought/Content/Perceptions

☐ Add to Needs List
☐ unremarkable ☐ paranoid ☐ grandiose ☐ obsessive ☐ bizarre
☐ flight of ideas ☐ disorganized ☐ auditory hallucinations ☐ visual hallucinations
☐ tactile hallucinations ☐ other/comment

Behavior/Motor Activity

☐ Add to Needs List
☐ normal/alert ☐ restless/overactive ☐ poor eye contact
☐ agitated/tense ☐ peculiar mannerisms ☐ self-destructive
☐ slowed/lethargic ☐ destructive to others or property ☐ compulsive/repetitious
☐ tremors/tics ☐ other/comment

Orientation

☐ Add to Needs List
☐ oriented to person, place and time ☐ not oriented to person ☐ not oriented to place
☐ not oriented to time ☐ other/comment

Insight

☐ Add to Needs List
☐ good ☐ fair ☐ poor ☐ lacking ☐ other/comment

Memory

RDLCustomSDLAssessment

☐ Add to Needs List

☐ good/normal ☐ impaired short-term ☐ impaired long-term

☐ other/comment

Reality Orientation

☐ Add to Needs List

☐ intact ☐ tenuous ☐ poor ☐ other/comment2

Risk Assessment

Suicidality /Other Risk to Self

☐ Current Suicidality / Risk to Self ☐ Previous Attempts / History

☐ No Current or Previous History of Suicidality / Other Risk to Self

Details (list current and previous behaviors, dates, method and lethality)

☐ Add Suicidality/ Other Risk to Self to Needs List

Physical Aggression/ Sexual Aggression / Other Risk Factors

☐ Current Physical / Sexual Aggression/ Risk to Others

☐ Prior Physical Aggression / Sexual Aggression / Risk to Others

☐ Homicidal

☐ No Current or Previous History of Physical Aggression / Sexual Aggression / Risk to Others

☐ Add Homicidality / Physical Aggression / Risk to Others to Needs List

Other Risk Factors

☐ No known other risk factors

☐ Add Other Risk Factors to Needs List

Diagnosis

DSM5/ICD10	**DSMIV/ICD9**	**SNOMED**
ICD/ DSM Description		
Remission	**Specifier**	**Type**
Source	**Severity**	**Order**
Rule Out	**Billable**	

DSM5/ICD10	DSMIV/ICD9	SNOMED
ICD/ DSM Description		
Remission	Specifier	Type
Source	Severity	Order
Rule Out	Billable	

DSM5/ICD10	DSMIV/ICD9	SNOMED
ICD/ DSM Description		
Remission	Specifier	Type
Source	Severity	Order
Rule Out	Billable	

Summary/Level of Care

Treatment

Is client in eval status? (•) Yes ( ) No

Does the client meet SPMI/SED criteria'? ( ) Yes ( ) No

Stage of Change

Indicate stage of change

Additional Information

Strengths

Clinical Interpretive Summary / Dimensions

RDLCustomSDLAssessment

Integrate and interpret from a broader perspective all history and assessment information. Identify any co-occurring disabilities or disorders. Identify needs beyond the scope of the program and specify referrals for additional services. Include symptoms that justify the diagnosis and strengths that could contribute to stated outcomes. Include important biographical facts or events in the person's life. Indicate if releases were obtained.

Transition/Level of Care/Discharge Plan

Level of Care (recommendation and justification):

Transition/Level of Care/Discharge Plan

Criteria –*How will the staff/client/parent/guardian know that a change in level of care is indicated?*

- ☐ **Reduction in symptoms as evidenced by:**
- ☐ **Attainment of higher level of functioning as evidenced by:**
- ☐ **Treatment is no longer medically necessary as evidenced by:**
- ☐ **Other:**

Estimated Discharge Date:

Safety/Crisis Plan

Safety Plan

◉ Initial Safety Plan ○ Review ☐ Client has current crisis

Warning Signs of a Crisis

What are my thoughts, feelings, behaviors, or moods that indicate that a crisis may be developing?*

Coping Strategies

What can I do to make sure that I am personally safe?*

Support Systems

Name	Relationship	Address	Phone

Next Review

Review Safety Plan Every Days [Next Review date:]