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.

<table>
<thead>
<tr>
<th>Recommendation-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule #: 67:62:06:06 (3)</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

| 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. |

<table>
<thead>
<tr>
<th>Clinical Recommendation-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule #: 67:62:08:07 (3)</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

| 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. |

Updated 2/24/2016
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>
<thead>
<tr>
<th>Clinical POC-1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rule #: 67:62:08:05 (3)</td>
</tr>
</tbody>
</table>
| **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. |

**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.

| 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. | Anticipated Date Achieved/Implemented: |
| | Date 7/25/2022 |

**Supporting Evidence:** The revised assessment document has been attached

**Position Responsible:** Brenda Hoxeng

| How Maintained: The verification of completion of the Readiness for Change will be added to the Quality Assurance report and reviewed quarterly. | Board Notified: |
| | Y ☒ N ☐ n/a ☐ |
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.
<table>
<thead>
<tr>
<th>Assessment</th>
<th>Client ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name:</td>
<td>Date:</td>
</tr>
<tr>
<td>Clinician Name:</td>
<td></td>
</tr>
<tr>
<td>Assessment date:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment type:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial</td>
<td>☒</td>
</tr>
<tr>
<td>Update</td>
<td>☒</td>
</tr>
<tr>
<td>Annual</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population type:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>☒</td>
</tr>
<tr>
<td>Child</td>
<td></td>
</tr>
<tr>
<td>DD</td>
<td></td>
</tr>
<tr>
<td>SA</td>
<td></td>
</tr>
<tr>
<td>MH</td>
<td>☒</td>
</tr>
<tr>
<td>Autism</td>
<td></td>
</tr>
</tbody>
</table>

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)
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

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  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

Performed Date:

Performed Time:

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:

RDLCustomSDLAssessment
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

RDLCustomSDLAssessment
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
Reality Orientation

- Add to Needs List
- Intact
- Tenuous
- Poor
- Other/Comment

Risk Assessment

Suicidality / Other Risk to Self

- Add to Needs List
- 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

- 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

<table>
<thead>
<tr>
<th>DSM5/ICD10</th>
<th>DSMIV/ICD9</th>
<th>SNOMED</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD/ DSM Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remission</td>
<td>Specifier</td>
<td>Type</td>
</tr>
<tr>
<td>Source</td>
<td>Severity</td>
<td>Order</td>
</tr>
<tr>
<td>Rule Out</td>
<td>Billable</td>
<td></td>
</tr>
</tbody>
</table>
### DSM5/ICD10 | DSMIV/ICD9 | SNOMED
--- | --- | ---
Remission | Specifier | Type
Source | Severity | Order
Rule Out | Billable | |

### Summary/Level of Care

**Treatment**

Is client in eval status? 

Does the client meet SPMI/SED criteria’?

**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**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
</table>

**Next Review**

Review Safety Plan Every Days [Next Review date:]

RDLCustomSDLAssessment