67:16:41:04. Diagnostic assessment requirements.

(1) A diagnostic assessment must be completed within 30 days of the recipient's first face-to-face visit with a mental health provider. On-going assessment and identification of changes in the recipient's needs and strengths must occur throughout treatment and must be documented in progress notes or other clinical documentation. Three face-to-face interviews designed to assist in the formulation of a diagnostic assessment are covered. For children under 18 years of age, the mental health staff shall obtain permission from the parent or legal guardian to meet with the child, and at least one parent or legal guardian shall participate in the assessment. Psychiatric therapeutic procedures or psychiatric somatotherapy provided before the diagnostic assessment is completed are considered noncovered services.

(2) A diagnostic assessment must include all of the following components:

(a) A face-to-face interview with the recipient;

(b) Identification of the strengths of the recipient and the recipient's family, if appropriate, previous periods of success and the strengths that contributed to that success, and potential resources within the family, if applicable;

(c) Presenting problems or issues that indicate a need for mental health services;

(d) Identification of readiness for change for problem areas, including motivation and supports for making such changes;

(e) Relevant family history, including family relationship dynamics and family psychiatric and substance abuse history;

(f) Behavioral observations and an examination of the recipient's mental status, including a description of anomalies in the recipient's appearance, general behavior, motor activity, speech, alertness, mood, cognitive functioning, and attitude toward the symptoms;

(g) Current substance use and relevant treatment history, including attention to previous mental health and substance use disorder or gambling treatment and periods of success, psychiatric hospital admissions, psychotropic and other medications, relapse history or potential for relapse, physical illness, and hospitalization;

(h) A review of the records that pertain to the recipient's medical and social background and history, if available;

(i) Contact with the recipient's relatives and significant others to the extent necessary to complete an accurate psychological evaluation for the purpose of writing the assessment report and developing the treatment plan; and

(j) Formulation of a diagnosis that is consistent with the findings of the evaluation of the recipient's condition, including documentation of co-occurring medical, developmental

disability, mental health, substance use disorder or gambling issues, or a combination of these based on the diagnostic evaluation.

(3) A diagnostic assessment must include the following components, if applicable:

(a) Educational history and needs;
(b) Legal issues;
(c) Living environment or housing;
(d) Safety needs and risks with regard to physical acting out, health conditions, acute intoxication, or risk of withdrawal;
(e) Past or current indications of trauma, domestic violence, or both; and
(f) Vocational and financial history and needs.

(4) The mental health provider must complete, sign, and date the diagnostic assessment before providing mental health treatment. The signature is a certification by the mental health provider that the findings of the diagnostic assessment are accurate. The certification date is the effective date of the diagnostic assessment.

Source: 22 SDR 6, effective July 26, 1995; 37 SDR 53, effective September 23, 2010; 46 SDR 50, effective October 10, 2019.
General Authority: SDCL 28-6-1.
Law Implemented: SDCL 28-6-1(1)(2).

Cross-Reference: Clinical record requirements, § 67:16:41:08.