**67:62:08:07. 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 date 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(8). 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:

(1) Contain either goals or objectives, or both, that are individualized, clear, specific, and measurable in the sense that both the client and the mental health staff can tell when progress has been made;

(2) Include treatment for multiple needs, if applicable, such as co-occurring disorders that are relevant to the client's mental health treatment;

(3) Include interventions that match the client's readiness for change for identified issues; and

(4) Be understandable by the client and the client's family if applicable.

A copy of the treatment plan shall be provided to the client, and to the client's parent or guardian if applicable.

**Source:** 43 SDR 80, effective December 5, 2016.
**General Authority:** SDCL 1-36-25, 27A-5-1.
**Law Implemented:** SDCL 1-36-25, 27A-3-1, 27A-5-1(2)(3)(4)(5).